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Family Planning  
International Assistance

The International Division of  
Planned Parenthood Federation of America, Inc.

# **FPIA: 1984-1986 A Strategic Plan**

March 1984

Family Planning International Assistance (FPIA) is the International Division of the Planned Parenthood Federation of America. FPIA was established in 1971 to respond to the family planning assistance needs of non-governmental organizations and government institutions in developing nations. Assistance is provided to those who need it most and use it best.

FPIA's assistance program was founded on the belief that:

- family planning is a basic human right;
- family planning programs can and do result in benefits to individuals, families, communities and nations; and
- family planning, together with other needed socioeconomic programs, can have a major impact on development.

FPIA believes that there still are many places in the world where good family planning projects are needed; that there are many ongoing development projects to which family planning can be added; and that there are areas where new development projects can be started with family planning as an essential component. Furthermore, FPIA believes that the need is so great that both private and governmental efforts are required to meet the challenges posed by population growth-related problems.

By working through local voluntary agencies, as well as government institutions, FPIA's program is reaching millions of individuals with family planning information and services. FPIA provides leadership in assisting and working with community groups that people know and trust in the development of efficient, resource-effective, innovative and self-sustaining family planning programs that reach people, involve them and help them to meet their own family planning needs.

Strategic planning is never an easy task, and the FPIA strategic plan for 1984-1986 could never have been written without the cooperation of many, many FPIA staff persons, both in the regions and New York. To the regional directors and their dedicated, hard-working staffs, I offer my sincere appreciation for the outstanding efforts that were made. And to Connie O'Connor, FPIA's Deputy Chief Operating Officer, I offer my admiration and congratulations for her direction, coordination and synthesis of this highly significant project. The development of this plan was a group effort and we all can take pride in the result.



Dr. Daniel Weintraub  
FPIA Chief Operating Officer  
PPFA Vice President for  
International Programs

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## I. INTRODUCTION

### A. BACKGROUND

Family Planning International Assistance (FPIA) always has placed a high priority on effective and efficient planning, attempting to strengthen the planning process as growth and program needs dictate. In 1977, FPIA initiated a system of Management by Objectives. Each regional office submitted annual workplans detailing, by project, what would be accomplished and how the monies allocated would be spent. The plan was monitored and updated through the preparation and submission of monthly budget reports.

In January, 1983, FPIA initiated strategic planning--including mission statement, objectives, means and tactics commonly used to reach the objectives, and considerations for strategy development. Since PPFA's Cooperative Agreement with AID/W was due to be signed during the first quarter of 1983, a decision was reached to begin with a one year plan. Each region undertook a systematic analysis of its current program, deciding what was viable and should be continued, what should be abandoned, and what should be undertaken that was new and different. The one year plans which were developed included strategies for each country within each region. Regions were informed that in 1984, a three year plan would be developed based on the new Cooperative Agreement.

### B. RATIONALE

FPIA's rationale for developing a three year strategic plan is as follows:

- to address AID/W's ongoing need for a clear rationale for continued funding in a time of limited resources;
- to increase FPIA's capability to make decisions systematically, to organize efforts to carry out decisions and to measure decisions through systematic feedback;
- to increase FPIA's capability to monitor progress in reaching objectives;
- to increase FPIA's control over its environment;
- to continue to address 1981 evaluation findings; and
- to decrease time involved in plan preparation by planning over a longer time period.

With strategic planning, FPIA is better able to balance short and long range goals --- to decide what will not get done if we do not commit resources to it today, and what needs to get done now to reach a future goal. FPIA has encouraged its regional offices to be critical regarding extending the present program into the future and to plan for the systematic abandonment of that which is no longer productive.

C. METHOD

The three year strategic plan is based on Planned Parenthood Federation of America's Cooperative Agreement with AID/W. Therefore, most of the numerical factors stated in the plan's overall objectives are those contained in the Agreement. To begin the planning process, FPIA/Administration reviewed and re-stated its mission, goals and the tactics commonly used to achieve objectives. Seven, specific, overall objectives were described covering project development, commodity and technical assistance. Two additional objectives provide for an overall evaluation and for developing strategies which will result in grants for project activities from sources other than AID/W.

At a meeting held in November, 1983, FPIA's Regional Directors were provided with instructions and a format for developing the plan, and one day was devoted to discussion and problem-solving regarding the planning activity to be undertaken. Back in the field, Regional Office staff generally began to plan by prioritizing countries. This was carried out considering AID/W priorities, the anticipated life of continuing projects, regional budgets, Planned Parenthood's goals and policies, and FPIA philosophy, objectives and staff resources. Budgets were drafted and objectives set which would contribute to meeting FPIA's overall objectives. The next steps were to gather country data, to discuss them, and to set specific objectives for each country based on FPIA tactic statements.

FPIA's tactic statements describe the basic approaches to be used in carrying out a pre-determined strategy by:

- extending existing family planning service of government and non-government institutions to new geographic areas or to new populations;
- initiating family planning service in institutions not currently involved in service provision;
- providing parallel or complementary services;
- transferring management technology;
- training staff (invitational travel);

- working with resistant populations, adolescents, religious and high-risk groups;
- utilizing local resources; and
- supplying family planning commodities to projects and non-project institutions.

Once objectives were set, the regions were ready to write a strategy for each country. To facilitate writing the strategies, each region received (as part of its written instructions) the following series of strategic considerations:

- State of development of the family planning program in each country including:
  - current population growth rate in the country;
  - type and quality of family planning services currently available;
  - segments of the population being reached, not reached by the current programs;
  - types of contraception in current use; and
  - types of service providers --- government, private sector, bilateral, PVO.
- Government plans, AID and USAID mission strategies.
- Type of program FPIA, AID/W and USAID currently is funding.
- Rationale for continued PVO---FPIA support to the country.

Finally, to ensure continuity, a formula was provided to be used in presentation of the material. Upon completion, all regions submitted their plans to FPIA/New York for analysis and integration into FPIA's overall three year plan. As with last year's submission, each regional office will receive written and verbal feedback on its plan. Plans will be monitored on an ongoing basis and will be updated yearly.

## II. FPIA STRATEGIC PLAN (1984-1986) SUMMARY

### A. PPFA'S GOALS, POLICY AND PHILOSOPHY

The Planned Parenthood Federation of America (PPFA) has six goals, one of which deals specifically with international family planning: "To address the need for fertility regulation services throughout the world." PPFA works to achieve this goal at the national and affiliate levels through its support of IPPF, through its own international division (FPIA) and by enlisting its resources to develop attitudes favorable to the continuation and expansion of overseas family planning programs.

In 1971, by accepting a grant from the U.S. Agency for International Development (AID), PPFA became involved with AID in a common goal of development. Through FPIA, its international division, PPFA works overseas to provide leadership in encouraging local individuals and community groups, agencies and institutions to develop innovative, effective, self-sustaining family planning programs which will reach local populations, involve them and eventually enable them to meet their own family planning needs.

PPFA's policy statement with regard to its international division supports the development of programs fashioned to conform with local customs. PPFA's policies include tailoring a time frame for each project and working to guide each project to maturity so that when assistance terminates, an infrastructure will have been created which can carry the family planning effort forward under its own momentum.

### B. FPIA'S MISSION, GOALS AND OBJECTIVES

In developing its strategic plan, FPIA has worked under, and been guided by, PPFA's goals, policy and philosophy. FPIA's mission statement and goals for the three year period, as refined and restated during the planning process, follow:

#### Mission

FPIA responds to the family planning assistance needs of developing nations, through the provision of funds, commodities and technical assistance.

#### Goals

1. To fund family planning services in areas of unmet need.
2. To upgrade existing family planning services.
3. To establish new family planning service models.

- 4. To ensure continuation of service following phaseout of FPIA support.

Objectives

The numerical and dollar values which are contained in FPIA's three year objectives are derived from FPIA's Cooperative Agreement with AID. Since funds are allocated yearly, however, based on their availability and FPIA performance, provision has been made to revise objectives, as required.

The completion of the first five objectives is the primary responsibility of FPIA's regional offices. Objectives one through four cover aspects of project development, i.e., number of projects, type of projects, dollar value allocated to project development and planned increase in number of clients to be served. The project funding levels (objective two) are weighted in response to AID priorities. Africa funding levels increase by approximately 7%, Latin America by about 6%, while Asia's decreases by over 12%.

Objectives six through eight are the primary responsibility of FPIA's headquarters. Over the next three years, FPIA plans to increase its capacity to provide technical assistance (objective seven) and to conduct a comprehensive evaluation of its subgrant program (objective eight).

- Project Development

1. By December 31, 1986, FPIA will have 140 active family planning projects. By region, no more than 10% of these projects will be obligated at \$300,000 or more, no more than 25% will be obligated at \$50,000 or lower, and 65% will be between \$50,001 and \$299,999.
2. Regional budget funding levels will increase or decrease as follows:

|       | <u>CY 1984</u> |         | <u>CY 1985</u> |         | <u>CY 1986</u> |         |
|-------|----------------|---------|----------------|---------|----------------|---------|
|       | \$             | %       | \$             | %       | \$             | %       |
| ARO   | 2,076,322      | (30.52) | 2,558,022      | (31.61) | 2,876,459      | (32.73) |
| APRO  | 2,328,228      | (34.22) | 2,598,484      | (32.12) | 2,636,000      | (30.00) |
| LARO  | 2,398,636      | (35.26) | 2,935,939      | (36.28) | 3,275,000      | (37.27) |
| TOTAL | \$ 6,803,186   |         | \$ 8,092,445   |         | \$ 8,787,459   |         |

3. Working in a minimum of 40 LDCs, FPIA will develop 30 FP/MCH clinic projects, 50 CBD and 15 VSC service projects, 20 adolescent and/or women's projects, 15 training projects, 10 IEC projects, and 5 other, including commodity logistics, natural family planning and other types of projects.

4. FPIA will increase its number of family planning service clients as follows:

|      |   |     |   |           |         |
|------|---|-----|---|-----------|---------|
| 1984 | - | 10% | - | 1,100,000 | (total) |
| 1985 | - | 10% | - | 1,210,000 | (total) |
| 1986 | - | 10% | - | 1,331,000 | (total) |

● Commodities

5. FPIA will increase its non-AID-initiated institutional (non-project) contraceptive commodity distribution to include 150 institutions.

6. Working in 50-60 LDCs, FPIA will distribute family planning commodities to men and women as follows: 72,000,000 cycles of oral contraceptives, 225,000,000 pieces of condoms and \$2.75 million of related family planning equipment and supplies through local family planning projects.

● Technical Assistance

7. FPIA will increase its capacity to provide a minimum of 3,000 days of technical assistance to its subgrantees by:

- hiring a New York-based Technical Specialist who will provide assistance to projects, as requested by regional offices.
- using New York staff to provide technical assistance in areas of their expertise, i.e., management, data collection and record systems, commodities, program development, monitoring and finance.
- disseminating, from FPIA/New York, improved management information.
- producing, by FPIA/New York, of three manuals:
  - Grantee Technical Assistance
  - Medical Practices
  - Income Generation

- using consultants (U.S. and Third World).
- providing training, by New York or other regional staff members, to regional offices, as requested by RO staff.
- Evaluation
  8. FPIA/New York and Regional Offices will evaluate 10 medium (\$50,001 - \$299,999) projects, 2 small (\$50,000 and under) projects and 1 large (\$300,000 and over) project, in five or more countries. Of these projects, 7 will be CBD, 2 clinic/MCH, 2 adolescent and 2 training or IEC. Twenty percent will have the lowest number of users and 60% will be in the medium range. Two evaluations will be case studies in project effectiveness and two will examine innovative CBD models. The remaining evaluations (9) will confirm reports, sample the number of users and test project dynamics such as the relationship between administration, host country environment and other significance/effectiveness factors.
- Other
  9. FPIA/New York and Regional Offices will work together to develop strategies which will result in grants for project activities from sources other than AID/Washington.

C. FPIA STRATEGY SUMMARY

Plan Overview

The mid 1983 world population was estimated at 4.7 billion. Excluding China, which has a population of about 1.0 billion, 68% of all people live in developing nations. It is instructive, and alarming, to compare the available demographic data for the more developed world with similar data for the less developed countries (excluding China). In the more developed countries (MDCs), for example, the rate of natural population increase is 0.6%; at that rate, the population will double in 118 years. In the less developed countries (LDCs), the rate of natural increase is 2.4%; the population in these countries will double in 29 years. In the MDCs, the crude birth rate is 15, the total fertility rate is 1.9, the infant mortality rate is 19 and the percent of the population under age 15 is 23. The comparable figures for the LDCs are 37, 5.2, 105 and 41.

Continued rapid population growth in these LDCs will make even more extreme the severe problems that already affect them: ecological devastation, unemployment, underemployment, runaway urbanization, political and social disruption, wife and child abuse, malnutrition, illiteracy --- problems suffered by millions of people. The human tragedies already taking place on our finite planet are overwhelming. Most of the governments of the world, however, and most of the caring people in the world, have recognized that family planning is a realistic and essential component of any blueprint for change. Through access to safe, effective and comprehensive family planning services, individuals, communities and nations can be helped to alleviate the vicious cycle of poverty and resignation.

There is no doubt that the need is great. But the fact of the matter is that the resources required to meet that need are limited. And that is why it is essential to prioritize and to maximize every dollar expended.

It also is a fact that priorities often conflict, especially in an environment of limited resources, depending on the perceptions, data base and philosophy of those setting the priorities. FPIA's significance and effectiveness criteria, for example, have been adopted by AID/W to evaluate project proposals, yet there are those who legitimately feel that other criteria also should be used. Some believe that FPIA funds should be concentrated in LDCs not currently receiving AID bilateral funds. Others believe, just as strongly, that FPIA has a meaningful role to play even in AID bilateral countries. Recently, Africa has assumed a higher priority, both for AID and for PPFA. However, it is a fact that Asia currently accounts for 58% of the world's population and that African countries have, only relatively recently, achieved independence; they have limited absorptive capacities. USAID missions and LDC national governments often effectively advocate increased funding for their respective countries --- but at the expense of other, just as needy, nations. There also are legitimate questions and dilemmas as to if/when FPIA should phase out of successful, long-running, ongoing projects and, if so, how. Groups in the United States, and around the world, differ in their support for various contraceptive methods and the ways in which contraception can best be provided. There also are legitimate differences of opinion as to policy versus program, service versus education, quantity versus quality.

One of the purposes of a strategic planning process is to adjudicate these conflicting demands, answer these difficult questions and provide a guide or roadmap in a changing environment. Often, the resolution of problems and difficult questions is not a simple "yes, we'll work in that country" or "no, we won't." Rather, the planning process forces one to think about the appropriate levels of funding and the types of activities that should be undertaken.

For 1984-1986, FPIA has identified 28 high priority countries. Even these countries, however, have been prioritized. As a result, 72% or \$17.1 million of FPIA's projected 1984-1986 subgrant budget of \$23.7 million, has been apportioned to eleven countries: Brazil, Mexico, Nigeria, Egypt, Indonesia, Thailand, Bangladesh, India, Kenya, Nepal and Turkey. These countries have large populations and significant numbers of individuals without access to family planning services. Thirty-nine percent of the projected 1984-1986 subgrant budget has been allocated to high priority countries in which AID has no bilateral programs: Brazil, Mexico, Nigeria, Turkey and Colombia. External donor agencies, such as FPIA, can make the difference in these important nations.

FPIA plans to consolidate its program in Asia, fund larger programs in Africa, increase the numbers of commodity logistics projects and provide increasing levels of technical assistance. FPIA will build on its successful track record of CBD programs in Africa and its successes with income generation programs in Latin America. There will be an increased emphasis on anticipated project life and on program continuation after phaseout of FPIA support. Low cost, replicable programs, based on outstanding Asian project models, also will be emphasized as well as efficiency measures to provide service to more clients at a decreased cost.

To some extent, FPIA will develop and maintain projects in countries where we currently have no presence or a limited program. The rationale is that those areas which are neglected today will require greater inputs of time and money in the future. In other areas, FPIA will terminate project assistance based on performance, budgetary considerations and staff demands. To compensate for the increasing demands on FPIA staff time, greater use will be made of technology transfer between projects using the invitational travel mechanism. Cooperation with other donor agencies will be maximized since these agencies represent potential sources of support after phase-out of FPIA funding.

FPIA will continue to work with women's groups and adolescents, and will continue its cafeteria method approach to the provision of services, including voluntary sterilization, natural family planning and temporary methods such as oral contraceptives, condoms and foam. FPIA also will seek to significantly increase the number of non-project, non-AID-initiated, commodity recipients.

It has been said that "if you don't know where you're going, any road will take you there." However, it is not necessarily true that "if you do know where you're going, only one road will take you there." FPIA's strategic plan is based on a detailed analysis of the best data currently available, a projected budget and a changing environment. The plan allows for revision in light of budget changes, new data and unforeseen events. It is a roadmap to the future, a guide to what might be, should be and, hopefully, will be.

### Africa Region

The 1983 estimated population of Africa, over five hundred million, is expected to double by the year 2007. With 45% of the population under age 15 and 3% over age 65, the region's annual rate of natural population increase is 3.0%. Some African countries are experiencing even higher growth rates. On a regional basis, Sudan, Egypt, Nigeria, Ghana, Kenya, Tanzania and Cameroun are the African countries with the largest populations. Each has been allocated a significant proportion of FPIA's projected, 1984-1986, African budget. In aggregate, from 1972 to the present, FPIA has provided Africa with nearly 8 million dollars in project and over 5.5 million dollars in commodity assistance.

During the next three years, seventy-eight percent of ARO's projected \$7,500,000 budget will be allocated to seven countries: Nigeria, Egypt, Kenya, Zambia, Togo, Sudan and Liberia. These countries account for thirty-seven percent of the total African population (excluding South Africa). Cameroun, Ghana, Ivory Coast, Lesotho, Mauritius, Senegal, Sierra Leone, Swaziland, Tanzania, Upper Volta and Malawi are projected to receive the remaining twenty-two percent. As an FPIA high priority country, and one that currently does not receive AID bilateral funds, Nigeria has been allocated twenty-three percent of the Africa budget total.

Africa is not Asia, nor is it Latin America. Africa poses the greatest challenge to FPIA's goal of supporting family planning services in areas of unmet need. To meet this challenge, and to make an impact with relatively limited resources, FPIA has developed a two part strategy.

First, in high priority countries where FPIA already has a significant presence (English and Arabic-speaking Africa), the focus will be on larger projects and/or large, efficient, commodity distribution systems. Some of these projects will be outgrowths of successfully managed efforts (e.g., Sierra Leone-01, Kenya-06, Swaziland-01) while others will be new such as Zambia-04 and Sudan-03. The interest of government officials in family planning, the support of USAID missions and the managerial capability of proposed implementing agencies will be key to success. Several medium priority countries may become high priority. In Tanzania and Ghana, for example, FPIA already funds a nucleus of successful projects and could expand if political tensions lessen and debt rescheduling takes place. Uganda also may take on more importance as the political situation improves and managerial capability to implement programs is strengthened.

Second, in countries with high fertility rates and evidenced demand for family planning, FPIA will focus on high risk projects requiring extensive, quality technical assistance, particularly in program management and planning. Such projects generally will be small (\$40,000 - \$80,000) and will have high initial per user costs because of: the need to include other health components; heavy emphasis on training; and intensive IEC at the individual and community levels. Most of the countries which fit into this category are in francophone Africa (e.g., Togo, Senegal, Upper Volta, and Ivory Coast) but Malawi, which legalized childspacing in October, 1982, fits here also. Building on the strengths of ARO's French-speaking staff, FPIA will develop small, well-managed, high-quality service projects which will help influence opinion leaders and encourage family planning expansion. Upper Volta, for example, where FPIA-funded projects will be highly visible, may be a test case. Togo, where the recently-funded Togo-02 training project is already highly political, and may grow quite large, holds an even stronger possibility of influencing the government's policies and practices. Finally, the strengthening of private sector efforts in these countries, including coordination with IPPF affiliates, will help make family planning, now a service for the elite, available to poor urban women and, later, to the rural poor. In countries where the issue of family planning is still highly sensitive or even politically explosive, it is highly appropriate for PPPA/FPIA (a private, voluntary, nongovernmental organization) to be in the vanguard and to assume the risks involved.

ARO's strategy also includes stressing IEC, training, and innovative approaches to service delivery as well as invitational travel. This reflects the still sensitive environment vis-a-vis family planning in Africa, the need to ensure that every person has the information necessary to make free, informed decisions about fertility regulation and the fact that IEC components have contributed significantly to the success of many ARO projects.

Over the next three years, about half of FPIA funded projects in Africa will train service providers, educators, opinion leaders and others. Some projects (Liberia-01, Togo-02 and Nigeria-13) will provide clinical training, while others (Kenya-09, Tanzania-04, Ghana-03 and Egypt-02) will train field and CBD workers. Invitational travel grants will achieve specific training needs which cannot be met in-country, particularly in francophone Africa and Malawi. Also, training in specific areas such as natural family planning, voluntary sterilization and IUD insertion techniques will remain a priority. Innovative programming (e.g., private sector, labor unions, male field workers, supervisory structures, transportation, appropriate IEC, etc.) will be stressed.

Four years ago, many thought community-based distribution could not be implemented. Today, between 40-50 percent of ARO projects have CBD components and, more significantly, projects are becoming less conservative and more innovative in their CBD income generating activities.

Several ARO projects will be completed or phased out in the period 1984-1986 (e.g., Mauritius-02, Kenya-05, Kenya-08, Kenya-09, Swaziland-01, Nigeria-04, Ghana-04). In order to do this, ARO will continue to: discuss phaseout, self-sufficiency and other donor support with grantee officials; reflect phaseout in long range plans; seek other donor support well in advance; build strong and well-trained project staff; and create demand by emphasizing IEC.\*

#### Asia and Pacific Region

The 1983 estimated population of Asia was over 2.7 billion and that of the South Pacific, 24 million. This population is expected to double by the year 2020. FPIA has, in prior years, concentrated its development efforts in countries with the largest populations, i.e., Bangladesh, India, Indonesia, Nepal, Thailand, Turkey and the Philippines. In Oceania, projects have been developed in Papua New Guinea, Fiji and the Solomon Islands. In aggregate, from 1972 to the present, FPIA has provided the Asia Region with nearly 21 million dollars in project and over 18 million dollars in commodity assistance.

Over the next three years, APRO's project budget of \$7,562,712 has been apportioned so as to provide 36% to Thailand and Indonesia, 15% to Bangladesh, 13% to India, 11% to Nepal, 9% to Turkey and 6% to Sri Lanka. The remaining 10% will be committed to projects in Jordan, Pakistan, and the South Pacific.

FPIA's overall strategy in Asia and the South Pacific is to decrease FPIA financial assistance by promoting self-sufficiency and other donor support, and to consolidate and strengthen the region's subgrant and commodity assistance programs. By December 31, 1986, APRO will have terminated assistance to twenty-three of its current forty-eight projects, and will be managing a total of twenty-nine projects. FPIA's Asia program will be designed to demonstrate that AID/W-funded PVOs do have a significant role to play in countries receiving AID bilateral funds.

In Bangladesh, FPIA will continue to roll over its successful IUCW program and also will continue its experimental Mukti Judha project. Funding will not be continued, however, for the highly successful CWF and FPSTC programs as both of these projects may be eligible for support from the USAID bilateral program and other donors. FPIA has submitted a request to

\* ARO plans to seek increased funding support from USAID missions. Such support, if obtained, could free current limited resources for reprogramming.

USAID/Bangladesh for bilateral support through the centrally funded AID Cooperative Agreement. If approved, this will allow FPIA to carry out new project development in Bangladesh, and to continue to monitor CFWP and FPSTC. In India, FPIA will concentrate its programming in Uttar Pradesh, the state with the largest population (110 million) and a contraceptive prevalence rate of 11%, as against the country average of about 24%.

FPIA has provided almost seven million dollars to support family planning projects in Thailand and Indonesia. The governments of these countries have had strong family planning programs and have made family planning a priority in their five year plans. FPIA projects have both complemented and supported the governments' programs. If the gains made in these countries are not maintained, however, by the end of the century the population is estimated to increase by 55% in South Asia and 24% in East Asia.

In Thailand, FPIA will continue to support a portion of the ASIN voluntary sterilization program, a revamped, more effective youth project with PDA, and the Hilltribes and Refugee programs. In Indonesia, support will continue for projects which provide voluntary sterilization on a fee-for-service basis, for trade unions and for adolescent programs.

In Nepal, Pakistan and Sri Lanka, FPIA will use project models successfully implemented in Bangladesh to expand service delivery in rural areas which have low contraceptive prevalence rates.

In Turkey, FPIA will assist the government to reach its objectives by continuing and expanding its project with the Turk-Is Labor Union. FPIA also will continue to be a major provider of commodities and will work with the Health and Social Assistance Ministry to improve its commodity distribution system.

Consolidation and strengthening of the regional subgrant program will be achieved, in many cases, through the implementation of "umbrella" agency programs. Such agencies will be assisted to promote aggressive marketing and distribution of temporary method contraceptives. The establishment of family planning councils, in Indonesia and Thailand, for example, will assist FPIA to prioritize funding support and direct such funding to effective implementing agencies in unserved and/or underserved areas. APRO will provide appropriate technical assistance and guide successful grantees towards institutionalization of their programs. Such agencies also will be assisted to establish cost-cutting measures and to obtain support from other donors, including national governments.

Latin America Region

The 1983 estimated population of Latin America was 390 million and that of the Caribbean, 31 million. This population is projected to double by the year 2014. With almost one hundred million women of reproductive age, the region's average annual population growth rate is about 2.3%, compared with a world average of 1.8%. Brazil, Colombia, Mexico and Peru are the Latin America countries with the largest populations; they also have received the greatest amount of project assistance from FPIA, followed by Ecuador, Costa Rica, Haiti, Guatemala, the Dominican Republic, Honduras, Panama and El Salvador. In aggregate, from 1972 to the present, FPIA has provided the Latin America Region with nearly \$20,400,000 in project and over \$18,200,000 in commodity assistance.

Over the next three years, LARO's projected budget of \$8,609,575 has been apportioned so as to provide 50% to Brazil, 31% to Mexico, 8% to Peru and 5% to Ecuador. The remaining six percent will be committed to Bolivia, Colombia, the Dominican Republic, Honduras and Haiti.

FPIA's strategy includes program expansion and new project development in its mature program countries: Brazil, Ecuador, Mexico and Peru. Assistance to Colombia, however, will decrease because its population growth rate has dropped from 3.4% in 1964 to under 2.0% today. Additionally, PROFAMILIA (the Colombian project FPIA has supported) has become increasingly capable of generating income to support its own operating costs.

In Brazil, FPIA's strategy, which is supportive of USAID's interests, stresses low cost, highly visible, community-based service and distribution projects. Through these projects, over 232,000 Brazilians will receive family planning services at a cost of approximately six dollars per user.

Currently, there is a moratorium on new project development in Brazil caused by problems with debt repayment and nuclear proliferation safeguards. LARO has contingency plans, however, which will allow rapid shifting of monies to other countries should the situation continue.

LARO's Mexico program has made great strides in working with the private sector. Six community-based distribution programs currently serve approximately 90,000 persons at a cost of seven dollars per user per year. FPIA will continue to fund these projects and will expand the innovative project with the Federation of Private Family Planning Associations (FEMAP). Direct funding also will be provided for three public sector programs.

FPIA's strategy in Ecuador and Peru has been to fund low cost, income generating programs suitable for replication on a national or regional level. In Ecuador, CEMOPLAF has assumed 48% of current project costs. In Peru, APROSAMI has established a system of over 100 CBD posts in nine of Lima's poorest zones. This project also has one of the lowest annual costs per user --- \$1.60 --- in Latin America. Over the next three years, FPIA's program will continue to support CBD in Peru and will reach out to new areas and populations. In Ecuador, support of current projects will continue and FPIA will work with the USAID mission to initiate a voluntary sterilization program.

LARO also is committed to new project development in Bolivia, Haiti, and Honduras, countries in which FPIA currently has no programs, and, to a lesser extent, to project development in the Dominican Republic. All of these countries have high fertility rates, ranging from 6.6 in Bolivia to 4.7 in the Dominican Republic. Annual population growth rates are over 2.5% with the exception of Haiti's 1.7%, which is attributable to high infant morbidity and emigration.

Because of budget constraints and commitments to continue ongoing projects in other countries, however, the amounts available for these countries are minimal. However, LARO's plans are designed to maximize the potential of each dollar expended. Bolivia, for example, is a pronatalist country and has a limited capacity to absorb inputs. LARO will work with existing projects, therefore, to build this capacity. Haiti's spending on health care is the lowest in the region, with 95% of the GOH program being funded from outside sources. LARO will support USAID's strategy in Haiti, by building family planning leadership. Projects will be identified in which service delivery networks can be upgraded. Technical assistance will be provided in administration and FPIA's management systems will be integrated. In Honduras, FPIA will concentrate on working in geographic areas and with women's groups not covered by the existing program. Using LARO staff as a resource, FPIA will provide these countries with more than the usual technical assistance and monitoring.

LARO's strategy also includes technology transfer between FPIA projects. To that end, LARO will support invitational travel between Brazil and Mexico. The anticipated end result will be the development of an FPIA-assisted project in Brasilia based on the FEMAP model. LARO also plans to continue to promote exchanges between Peru and Brazil through invitational travel and programming.

Income generation, primarily through charging for service and the sale of contraceptives, has been a successful component of projects in Brazil, Mexico, Peru and Ecuador. It is an important part of LARO's strategy in that it assists projects in moving towards self-sufficiency. As such, it is a model which FPIA will attempt to replicate in new programming efforts.

LARO's strategy, as well as ARO's and APRO's, also includes coordinating with other private voluntary agencies to ensure that project efforts are not duplicated and, where feasible, complement the work of other donors. The relationship of FPIA regional offices with other donors involves ongoing sharing of project documents and ideas, including problem solving over issues such as commodity shipments to countries with complex import regulations. As the country plans indicate, every effort has been made to document the work of other donors, thereby ensuring that the FPIA three year plan has taken their efforts into consideration.

Family Planning International Assistance

1984-1986 STRATEGIC PLAN

ARO REGIONAL BUDGET

| COUNTRY      | 1984        | 1985        | 1986        |
|--------------|-------------|-------------|-------------|
|              | CONTINUING  | CONTINUING  | CONTINUING  |
| CAMEROUN     | \$ 45,000   | \$ 50,000   | \$ 60,000   |
| EGYPT        | 786,000     | 299,000     | 449,000     |
| GHANA        | 29,000      | 34,000      | 12,000      |
| IVORY COAST  | --          | 82,000      | 90,000      |
| KENYA        | 180,000     | 360,000     | 337,000     |
| LESOTHO      | 10,000      | --          | --          |
| LIBERIA      | 64,000      | 166,000     | 140,000     |
| MAURITIUS    | 40,000      | --          | --          |
| NIGERIA      | 225,000     | 581,000     | 695,000     |
| SENEGAL      | --          | 130,000     | 130,000     |
| SIERRA LEONE | 20,000      | 85,000      | 90,000      |
| SUDAN        | --          | 187,000     | 213,000     |
| SWAZILAND    | 90,000      | 90,000      | --          |
| TANZANIA     | 50,000      | 75,000      | 44,000      |
| TOGO         | 150,000     | 90,000      | 207,000     |
| UPPER VOLTA  | --          | 91,002      | 85,000      |
| ZAMBIA       | --          | 238,000     | 262,000     |
| T O T A L S  | \$1,689,000 | \$2,558,002 | \$2,814,000 |
|              | NEW         | NEW         | NEW         |
| MALAWI       | --          | --          | 62,459      |
| NIGERIA      | 250,000     | --          | --          |
| UPPER VOLTA  | 37,322      | --          | --          |
| AFRICA*      | 100,000     | --          | --          |
| T O T A L S  | \$ 387,322  | --          | \$ 62,459   |
| GRAND TOTAL  | \$2,076,322 | \$2,558,022 | \$2,876,459 |

\* These are projects not identified by country.

Family Planning International Assistance

1984-1986 STRATEGIC PLAN

APRO REGIONAL BUDGET

| COUNTRY         | 1984        | 1985        | 1986        |
|-----------------|-------------|-------------|-------------|
|                 | CONTINUING  | CONTINUING  | CONTINUING  |
| BANGLADESH      | \$ 508,500  | \$ 306,000  | \$ 300,000  |
| INDIA           | 74,060      | 323,465     | 465,000     |
| INDONESIA       | 482,507     | 330,000     | 435,000     |
| JORDAN          | 59,397      | --          | --          |
| NEPAL           | 272,870     | 291,000     | 249,000     |
| PAKISTAN        | --          | 112,000     | 171,000     |
| PHILIPPINES     | --          | --          | --          |
| FIJI            | 20,000      | --          | --          |
| SOUTH PACIFIC   | --          | --          | 95,000      |
| SOLOMON ISLANDS | --          | --          | --          |
| SRI LANKA       | 4,000       | 150,000     | 223,000     |
| TURKEY          | 132,000     | 180,519     | 242,000     |
| THAILAND        | 408,821     | 328,000     | 381,000     |
| EAST ASIA*      | --          | --          | --          |
| T O T A L S     | \$1,962,155 | \$2,020,984 | \$2,561,000 |

-continued-

Family Planning International Assistance

1984-1986 STRATEGIC PLAN

| <u>APRO REGIONAL BUDGET</u> |             |             |             |
|-----------------------------|-------------|-------------|-------------|
| COUNTRY                     | 1984        | 1985        | 1986        |
|                             | NEW         | NEW         | NEW         |
| BANGLADESH                  | --          | --          | --          |
| INDIA                       | \$ 6,278    | \$ 105,000  | \$ --       |
| INDONESIA                   | 7,500       | 140,000     | --          |
| JORDAN                      | --          | 45,000      | --          |
| NEPAL                       | 7,500       | --          | --          |
| PAKISTAN                    | 76,397      | 7,500       | --          |
| PHILIPPINES                 | --          | --          | --          |
| FIJI                        | --          | --          | --          |
| SOLOMON ISLANDS             | --          | --          | --          |
| PAPUA NEW GUINEA            | --          | --          | --          |
| SRI LANKA                   | 71,459      | 40,000      | --          |
| SOUTH PACIFIC               | --          | 80,000      | --          |
| TURKEY                      | 30,000      | --          | 75,000      |
| THAILAND                    | 84,811      | 160,000     | --          |
| EAST ASIA*                  | 82,128      | --          | --          |
| T O T A L S                 | \$ 366,073  | \$ 577,500  | \$ 75,000   |
| GRAND TOTAL                 | \$2,328,228 | \$2,598,484 | \$2,636,000 |

\* These are conference/workshop-type projects

Family Planning International Assistance

1984-1986 STRATEGIC PLAN

| <u>LARO REGIONAL BUDGET</u> |             |             |             |
|-----------------------------|-------------|-------------|-------------|
| COUNTRY                     | 1984        | 1985        | 1986        |
|                             | CONTINUING  | CONTINUING  | CONTINUING  |
| BRAZIL                      | \$1,303,218 | \$1,240,000 | \$1,300,000 |
| BOLIVIA                     | --          | --          | 70,000      |
| COLOMBIA                    | 75,000      | 100,000     | 75,000      |
| DOMINICAN REPUBLIC          | 131,196     | --          | --          |
| ECUADOR                     | 137,778     | 100,000     | 159,000     |
| HONDURAS                    | --          | --          | 51,000      |
| MEXICO                      | 494,841     | 779,000     | 1,009,000   |
| PANAMA                      | --          | --          | --          |
| PERU                        | 256,603     | 178,000     | 248,300     |
| T O T A L S                 | \$2,398,636 | \$2,397,000 | \$2,912,300 |
|                             | NEW         | NEW         | NEW         |
| BRAZIL                      | --          | --          | 100,000     |
| BOLIVIA                     |             | 64,421      | 35,000      |
| COLOMBIA                    | --          | --          | --          |
| DOMINICAN REPUBLIC          | --          | --          | --          |
| ECUADOR                     | --          | --          | --          |
| HAITI                       | --          |             | 27,000      |
| HONDURAS                    | --          | 40,000      | --          |
| MEXICO                      | --          | 150,000     | 200,000     |
| PANAMA                      | --          | --          | --          |
| PERU                        | --          | --          | --          |
| T O T A L S                 |             | \$ 538,939  | \$ 362,700  |
| GRAND TOTAL                 | \$2,398,636 | \$2,935,939 | \$3,275,000 |

| COMMODITY PLANNING CHART |                                |                                |                                |
|--------------------------|--------------------------------|--------------------------------|--------------------------------|
| Country                  | Institutional<br>Accounts 1984 | Institutional<br>Accounts 1985 | Institutional<br>Accounts 1986 |
| Algeria                  |                                |                                |                                |
| Angola                   |                                |                                |                                |
| Benin                    |                                |                                |                                |
| Botswana                 |                                | 2                              | 1                              |
| Burundi                  |                                |                                | 1                              |
| Cameroun                 |                                |                                | 2                              |
| Cent. African Rep.       |                                |                                |                                |
| Chad                     |                                |                                |                                |
| Comoros                  |                                |                                | 1                              |
| Congo                    |                                |                                | 1                              |
| Egypt                    |                                |                                | 2                              |
| Ethiopia                 |                                |                                |                                |
| Gambia                   |                                |                                |                                |
| Ghana                    |                                |                                |                                |
| Guinea                   |                                |                                |                                |
| Ivory Coast              |                                |                                | 1                              |
| Kenya                    |                                |                                |                                |
| Lesotho                  |                                | 1                              |                                |
| Liberia                  |                                |                                |                                |
| Malagasy                 |                                | 1                              |                                |

Family Planning International Assistance

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1984-1986 WORKPLAN

COMMODITY PLANNING CHART (continued)

| Country      | Institutional<br>Accounts 1984 | Institutional<br>Accounts 1985 | Institutional<br>Accounts 1986 |
|--------------|--------------------------------|--------------------------------|--------------------------------|
| Malawi       | 3                              | 3                              |                                |
| Mali         |                                |                                |                                |
| Mauritania   |                                |                                |                                |
| Morocco      |                                |                                | 2                              |
| Mozambique   |                                |                                |                                |
| Niger        |                                |                                |                                |
| Nigeria      | 2                              | 3                              | 3                              |
| Rwanda       |                                |                                | 1                              |
| Senegal      | 2                              | 1                              | 1                              |
| Seychelles   |                                | 1                              |                                |
| Sierra Leone |                                |                                |                                |
| Sudan        |                                | 2                              | 2                              |
| Swaziland    |                                |                                |                                |
| Tanzania     |                                | 1                              | 2                              |
| Togo         |                                |                                |                                |
| Tunisia      |                                |                                |                                |
| Uganda       | 1                              | 1                              | 2                              |
| Upper Volta  |                                |                                | 1                              |
| Zaire        |                                |                                |                                |
| Zambia       | 5                              | 3                              |                                |
|              |                                |                                |                                |

Family Planning International Assistance

ARO

1984-1986 WORKPLAN

COMMODITY PLANNING CHART (continued)

| Country   | Institutional<br>Accounts 1984 | Institutional<br>Accounts 1985 | Institutional<br>Accounts 1986 |
|-----------|--------------------------------|--------------------------------|--------------------------------|
| Zimbabwe  | 2                              | 1                              | 2                              |
| Other     |                                |                                |                                |
| T O T A L | 15                             | 20                             | 25                             |

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1984-1986 WORKPLAN

COMMODITY PLANNING CHART

| Country          | Institutional<br>Accounts 1984 | Institutional<br>Accounts 1985 | Institutional<br>Accounts 1986 |
|------------------|--------------------------------|--------------------------------|--------------------------------|
| Afghanistan      |                                |                                |                                |
| Bahrain          |                                |                                |                                |
| Bangladesh       |                                | 1                              | 3                              |
| Burma            |                                | 1                              | 1                              |
| Cambodia         |                                |                                |                                |
| Fiji             | 2                              | 2                              | 1                              |
| Indonesia        |                                |                                |                                |
| India            | 1                              | 2                              |                                |
| Israel           |                                |                                |                                |
| Jordan           |                                | 1                              | 2                              |
| Korea            |                                |                                |                                |
| Laos             |                                |                                |                                |
| Lebanon          |                                |                                |                                |
| Malaysia         |                                |                                |                                |
| Maldives         |                                |                                |                                |
| Nepal            |                                |                                |                                |
| Pakistan         |                                | 1                              | 1                              |
| Papua New Guinea | 5                              | 5                              | 5                              |
| Philippines      | 1                              |                                |                                |
| T O T A L        | 9                              | 13                             | 13                             |

Family Planning International Assistance

LARO

1984-1986 WORKPLAN

COMMODITY PLANNING CHART

| COUNTRY            | Institutional<br>Accounts 1984 | Institutional<br>Accounts 1985 | Institutional<br>Accounts 1986 |
|--------------------|--------------------------------|--------------------------------|--------------------------------|
| Barbados           |                                |                                |                                |
| Bolivia            | 3                              | 2 / 3                          | 4 / 4                          |
| Brazil             | 4                              | 3 / 3                          | 4 / 4                          |
| Cayman Islands     |                                |                                |                                |
| Chile              |                                |                                |                                |
| Colombia           | 1                              | 1 / 1                          | 1 / 1                          |
| Costa Rica         | 1                              | 1 / 1                          | 1 /                            |
| Dominica           |                                |                                |                                |
| Dominican Republic | 1                              | 1 / 2                          | 2 / 1                          |
| Ecuador            | 2                              | 1 / 2                          | 2 / 2                          |
| El Salvador        | 1                              | 1 / 1                          | 2 / 1                          |
| Guadeloupe         |                                |                                |                                |
| Guatemala          | 1                              | 1 / 1                          | 2 / 1                          |
| Guyana             |                                |                                |                                |
| Haiti              | 1                              | 1 / 1                          | 2 /                            |
| Honduras           | 1                              | 1 / 1                          | 2 / 1                          |
| Jamaica            |                                |                                |                                |
| Mexico             | 4                              | 2 / 3                          | 5 / 1                          |
| Montserrat         |                                |                                |                                |
| Nicaragua          |                                |                                |                                |

Family Planning International Assistance

LARO

1984-1986 WORKPLAN

COMMODITY PLANNING CHART (cont'd.)

| COUNTRY        | Institutional<br>Accounts 1984 | Institutional<br>Accounts 1985 | Institutional<br>Accounts 1986 |
|----------------|--------------------------------|--------------------------------|--------------------------------|
| Panama         | 1                              | 1 / 1                          | 2 / 1                          |
| Paraguay       | 1                              | 1 /                            | / 1                            |
| Peru           | 2                              | 1 / 1                          | 1 / 1                          |
| St. Kitts      |                                |                                |                                |
| St. Lucia      |                                |                                |                                |
| St. Vincent    |                                |                                |                                |
| Trinidad       |                                |                                |                                |
| Uruguay        |                                |                                |                                |
| Venezuela      |                                |                                |                                |
| Other (Belize) | 1                              | 1 /                            | 1 /                            |
| T O T A L      | 25                             | 19 / 21                        | 30 / 19                        |

PRIORITY COUNTRY CHART

| High Priority | Medium Priority     | Low Priority                |
|---------------|---------------------|-----------------------------|
| Cameroun      | Benin               | Algeria                     |
| Egypt         | Botswana            | Angola                      |
| Ivory Coast   | Burundi             | Cape Verde                  |
| Kenya         | Congo               | Central Africa<br>Republic  |
| Liberia       | Comoros             |                             |
| Malawi        | Djibouti            | Chad                        |
| Nigeria       | Gambia              | Equatorial Guinea           |
| Senegal       | Ghana               | Ethiopia                    |
| Sierra Leone  | Guinea              | Gabon                       |
| Sudan         | Guinea-Bissau       | Libya                       |
| Swaziland     | Lesotho             | Mauritania                  |
| Togo          | Malagasy Republic   | Mozambique                  |
| Upper Volta   | Mali                | Niger                       |
| Zambia        | Mauritius           | South Africa                |
|               | Morocco             | Southwest Africa/<br>Nambia |
|               | Rwanda              |                             |
|               | Sao Tome & Principe | Tunisia                     |
|               | Seychelles          |                             |
|               | Somalia             |                             |
|               | Tanzania            |                             |
|               | Uganda              |                             |
|               | Zimbabwe            |                             |
|               | Zaire               |                             |

**Family Planning International Assistance**

APRO

1984-1986 WORKPLAN

PRIORITY COUNTRY CHART

| High Priority                                      | Medium Priority                    | Low Priority   |
|--|------------------------------------|--|
| Bangladesh<br>India<br>Nepal<br>Pakistan<br>Turkey | Indonesia<br>Sri Lanka<br>Thailand | Fiji<br>Jordan<br>Papua New Guinea<br>Philippines<br>Solomon Islands<br>Tonga<br>Vanuatu |

PRIORITY COUNTRY CHART

| High Priority   | Medium Priority  | Low Priority  |
|---|--|---|
| Bolivia<br>Brazil<br>Colombia<br>Dominican Republic<br>Ecuador<br>Haiti<br>Honduras<br>Mexico<br>Peru | Costa Rica<br>El Salvador<br>Guatemala<br>Panama<br>Paraguay | Barbados<br>Belize<br>Cayman Islands<br>Guadeloupe<br>Guyana<br>Jamaica<br>Montserrat<br>Nicaragua<br>St. Kitts<br>St. Lucia<br>St. Vincent<br>Trinidad |

BANGLADESH

- OBJECTIVES:
- Concentrate the utilization of available funds to appropriately expand services provided by the International Union of Child Welfare in conjunction with the Ministry of Social Welfare and the Barisal Mukti Judka (Freedom Fighters) Association. It is expected that with support estimated at US\$300,000 to \$400,000 per year, these two PVOs, not eligible for bilateral funds, will serve approximately 203,000 people between 1984 and 1986.
  - Seek additional sources of funds from USAID/Bangladesh to allow FPIA to continue support to two mature, but model, NGO projects, to expand FPIA programming to new NGOs and to assist the GOB to implement its plan to involve Union Parishad Population Committees in the national family strategy.
  - To build a local management capability in planning, administration, performance assessment and financial management skills through technical assistance and study grants.

Demographic Data

Population (1983) 96,500,000      Population Growth Rate 3.1%  
Fertility Rate 6.2  
Age of Population 45% under age 15 -- 3% over age 64

The Government of Bangladesh (GOB) through its five-year plan and regular policy statements has a strong population policy. The current goal of this policy is to reduce the growth rate from 3.1% to 1.5% by 1985. The priorities of the current program are to increase sterilization and other clinical methods, and to integrate family planning with health and development programs. In addition, the GOB is increasing IEC through radio and television and is actively training and staffing its field operations.

The GOB, with UNFPA support, operates a large warehouse for family planning commodities with district level distribution for its field programs. Commodities currently are provided by USAID and, in some cases, by UNFPA. A secondary distribution system for NGOs recently has been established with the Family Planning Association of Bangladesh (FPAB) serving as the logistical unit.

BANGLADESH

In Bangladesh, the method of choice is the oral pill followed by condoms and tubectomy. IUDs and vasectomy recently have gained in popularity due to increased incentives offered in the GOB program. Prevalence in modern methods remains low at approximately 11%.

USAID has a large population bilateral program. Through this program, it provides support to the GOB for its sterilization program on a reimbursement basis. A priority for this aspect of USAID's support has been the improvement in the safety of sterilization provision. In addition, the mission has a large program of support for NGOs through population services. The mission provides pills, condoms, IUDs, and sterilization equipment to the GOB which are distributed through the government's TEMO warehouse.

The GOB coordinates and encourages the involvement of NGOs in urban areas and in selected rural areas. The provision of family planning services by NGOs plays a major role in Bangladesh urban family planning. The GOB is considering permitting NGOs to also program services in selected rural areas. While its intention to allow this has been announced, approvals for rural projects have, to date, been limited.

FPIA support to the Bangladesh program has been substantial over the past ten years. CWF, which FPIA has supported since 1975, provided a model, to other NGOs, of the successful nature of women-to-women, door-to-door outreach. FPSTC, a grantee of FPIA's since 1979, currently receives support from the Ford Foundation and USAID, and successfully has involved 36 small VOLAGS, in urban and periurban areas, in door-to-door family planning outreach and has provided the GOB with a link and a coordinating body for NGOs involved in family planning. IUCW also has received FPIA support for the past four years and has been effectively involved in family planning with the Ministry of Social Welfare which is charged with social and economic development of rural areas. This approach of working with the governmental agency at the rural level may be utilized in future FPIA programs of support. FPIA's two other projects, with BPPA and Mukti Judha, have allowed FPIA to involve underutilized sectors (private physicians and Freedom Fighters, respectively) in service delivery.

During the next three year period, FPIA hopes to continue its successful program in Bangladesh by expanding its IUCW program and its experimental Mukti Judha project. FPIA will not be able to continue to provide funds to its well established CWF and FPSTC projects as both are potentially eligible for support from the USAID bilateral program. However, FPIA is currently seeking bilateral funds to continue to monitor these two projects and to expand its programming in Bangladesh. Besides supporting service projects in urban and selected rural areas, FPIA would, with additional support, be able to cooperate with the GOB in an effort to involve grassroots leadership in supporting the country's family planning goals. Finally, FPIA would continue to build local management capability in planning, administration, performance assessment and financial management skills through technical assistance and through study grants.

**Family Planning International Assistance**

APRO

1984-1986 WORKPLAN

BANGLADESH

FPIA will continue to supply IEC materials to Bangladesh but, at this time, no additional commodities, as these are available through an USAID-supplied, NGO system. APRO will continue to track the capability of projects based outside of Dhaka to receive required supplies. If this proves problematic, it will request approval to supply contraceptives directly to these projects.

BOLIVIA

OBJECTIVES: ●To initiate family planning services, while accomodating Bolivia's pronatalist position and USAID mission priorities, FPIA will:

- develop three small (\$35,000) projects which expand the service delivery of successful groups such as FEPADE and COF.
- establish a small scale commodity distribution system with COF, in La Paz, which will provide a steady and reliable supply of contraceptive materials to five ongoing projects.

Demographic Data

|                   |   |                        |             |
|-------------------|---|------------------------|-------------|
| Population (1983) | <u>5,900,000</u>                          | Population Growth Rate | <u>2.7%</u> |
| Fertility Rate    | <u>6.6</u>                                |                        |             |
| Age of Population | <u>44% under age 15 -- 3% over age 64</u> |                        |             |

In 1976, following a census analysis, the Government of Bolivia determined that futher development would require an increase inthe rate of population growth. Government clinics providing family planning were closed and immigration encouraged, particularly to agricultural zones. Opposition to family planning was led by the hierarchy of the Roman Catholic Church, together with conservative political and military elements. Recent government policy continues the pronatalist stance and encourages resettle- ment of the population to eastern agricultural areas. The government also seeks to reduce infant mortality and the mor- bidity caused by infectious diseases and occupational hazards.

Because of the government's position, the USAID mission in Bolivia maintains a low profile re family planning. However, the mission has indicated that it will "indirectly support family planning services delivered by the small, effective group of local private providers who operate successfully without church or government intervention." The mission further notes the possibility of working in sex education, contraceptive techniques and referral into health and other sector projects.

AVS, DA, FHI and IPPF currently are working in Bolivia. Of these groups, the IPPF affiliate Centro Orientación Familiar (COF), is the only agency involved in direct service provision. COF has ten clinics in seven Bolivian cities serving approximately 7,000 new clients per year with a total of 35,000 clients.

BOLIVIA

FEPADE, an indigeneous group working in Cochabamba, served 1,216 women in 1982. To date FPIA/LARO has provided \$23,045 of commodity assistance to eleven institutions. Regular provision of commodities has been difficult because no family planning agency has had duty free import status.

Considering the factors mentioned above, together with Bolivia's high growth rate (2.7%) and its total fertility rate of 6.6 (among the highest in Latin America), LARO's Regional Director visited Bolivia late in 1983 to determine the feasibility of initiating project assistance. Meetings held with COF and FEPADE explored the possibility of working with these agencies to expand their service delivery networks. COF would like to develop four new health centers for working women and to initiate Bolivia's first rural family planning project consisting of family planning posts which would provide family health care and contraceptive methods. Plans also include generation of income through training in human reproduction and contraceptive techniques for the staff of private clinics. FPIA intends to work with COF in the initiation of these projects.

Development Associates has provided two training programs for COF and FEPADE for auxiliary nurses and rural health promoters. Both programs addressed the concept of CBD as well as family planning methods. FPIA will follow up by working with FEPADE in the development of a CBD program.

A common problem noted by COF and FEPADE is the lack of a reliable and steady supply of contraceptive material. FPIA will work with COF, in La Paz, on a small scale distribution system which will begin by serving five ongoing projects.

FPIA's strategy supports USAID by working with effective, successful groups that have operated without church or government intervention.

BRAZIL

- OBJECTIVES:
- To continue to support five community-based FPIA projects, increasing clients served by 16% to 231,525, thereby supporting the USAID position of using NGOs to provide assistance to high visibility programs with potential for influencing public and private sector acceptability of family planning.
  - To expand CPAIMC to include Associacao Brasileira de Entidades de Planejamento Familiar's (ABEPF) innovative, low cost, service model which supports the addition of core staff to establish CBD components. The planned end result is self-sufficiency and the transfer of management technology.
  - To develop three new community-based urban projects (in Brasilia, Sao Paulo, and Parana), which are low cost, replicable and promote acceptability/availability of family planning. (The completion of this activity is based on the resolution of the current moratorium on new project development in Brazil.)

Demographic Data

|                   |                    |                          |                 |
|-------------------|--------------------|--------------------------|-----------------|
| Population (1983) | <u>131,300,000</u> | Population Growth Rate   | <u>2.4%</u>     |
| Fertility Rate    | <u>4.4</u>         | Population Doubling Time | <u>29 years</u> |
| Age of Population | <u>0-14 34.2%</u>  | <u>15-64 56.8%</u>       | <u>65+ 4.0%</u> |
|                   | Women <u>15-49</u> | <u>24%</u>               |                 |

Brazil, the fifth largest country in the world, with 1/3 of the population of the Latin America region, has no official family planning program. There are, however, indications that the traditional opponents of family planning - primarily the church and the military - are slowly yielding. On March 1, 1983, President Figueiredo addressed the opening of Congress, urging the formulation of a national population policy on the grounds that uncontrolled growth induces instability and "social, economic, cultural and political disequilibrium." This gave impetus to a national debate centering not upon whether such a program should be considered but upon what form it should take. Only two weeks after the President spoke, the Parliamentary Group for the Study of Population and Development (GPEPD) was founded, with guidance from BEMFAM. Its 107 members, 94 of whom are congressmen or senators, have conducted lively hearings on the concept of a national family planning program. Witnesses favorable to family planning have included politicians, military officials and physicians, some of whom have leadership roles in FPIA-funded projects.

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Despite the absence of a national program, the federal government has permitted individual states to address family planning needs. This has led to a number of formal agreements between BEMFAM and state Secretaries of Health for the provision of state-subsidized contraceptive services. Without the stabilizing effect of a true national policy, such state-level agreements have been vulnerable to changes in the local political climate. A graphic example of this is in the state of Parana, where BEMFAM's one-time regional affiliate, CLAM, had established over 250 distribution centers. The network, when turned over to the state, was abruptly shut down by a new governor.

No timetable has been set for a national program. The consensus is that should a government family planning program be mapped out, it would be conservative, clinic-based, expensive and too limited to be the sole provider of family planning services. This, together with the constraints imposed on the public sector by Brazil's long term financial crisis, make it likely that the private sector will continue to play a major role in meeting national family planning needs.

There is no USAID mission in Brazil. In recognition of the current lack of public sector involvement, the USAID representative, who assists international donor agencies, has in the past favored PVO support for low cost, high visibility, private sector programs with the potential for influencing both public and private sector acceptability of family planning. In the absence of a bilateral program, AID/W is encouraging Brazil programming by its centrally funded PVOs.

Subsidized family planning services are provided by some 200 private agencies, many of which receive international financial and commodity assistance. In addition to FPIA, IPPF, AVS, Pathfinder, FHI and DA assist a variety of NGOs with service provision, training, IEC and research programs.

All current programs, including FPIA's (described below), are reaching about 992,000 women, or 3.2% of women of fertile age. Other clients purchase contraceptives through pharmacies. Prevalency varies widely from state to state, being high in Sao Paulo (64%) as compared to the less urban Bahia or Piaui (31%).

FPIA believes that programming in urban areas, even with their higher prevalency, is justified in view of the fact that some 68% of Brazil's population is urban and that rural-urban migration continues to build demand in the municipal areas.

FPIA's strategy, supportive of USAID's interest, stresses low cost, highly visible, community-based service and distribution (CBD) models which, through extending family planning services to the segment of the population most in need of them, help promote the

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acceptability of family planning. Over the next three years, increasing emphasis will be placed on self-sufficiency, the transfer of management technology, and the potential for replicability, whether by the government or other NGOs.

1. The five projects currently funded by FPIA served some 190,000 clients in 1982. These CBD programs will increase their contraceptive caseloads by some 5% per year for an overall increase to 231,525 by the end of year three.

- Brazil-03, with CPAIMC, will continue its effective CBD model in Rio de Janeiro, providing temporary methods through its central clinic, 30 community units and 14 mini-posts, and referring VSC clients. The project has demonstrated its ability to raise income through contraceptive sales and is credited with increasing communication and cooperation among family planning agencies in Brazil. CPAIMC has spearheaded the development of ABEPF and will now assist with the transfer of management skills as the project expands to incorporate ABEPF's new service model.
- Brazil-04, with CPAIM in Belem, will diversify its service delivery beginning this year, adding two satellite clinics and eight CBD posts to its clinic program. By initiating CBD activities in low income areas, the project will demonstrate, on a small scale, the replicability of Brazil-03's model. Local perception of non-clinic based service delivery should improve and some project costs will be offset by income generated.
- Brazil-05, with BEMFAM, supports the provision of low cost family planning services throughout the state of Rio de Janeiro. Utilizing 222 CBD posts in 64 municipalities, and providing medical back-up and training in four clinics, the project has been successful in influencing attitudes toward family planning in this politically most visible state. An AID-sponsored evaluation of the project, conducted in June/July 1983, concluded that the project has "legitimized the public sector" by arranging for the delivery of services at the administrative/political levels of nearly all municipalities. The findings of this evaluation encouraged FPIA to plan additional years of funding.

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- Brazil-08, with UPFSP in Santa Amaro, an industrial and residential zone in Sao Paulo, and Brazil-09, with CEPES in the state of Minas Gerais, each have adapted the CBD model in low income communities and are building financial support and local acceptance through coordination of activities with local social agencies, businesses and large industries. The family planning posts of Brazil-09 receive monetary and in-kind assistance from groups as disparate as the Federal University System, the Red Cross, the Itabira Hospital and the Catholic Church. The project's ability to promote the acceptability of family planning in Belo Horizonte will be demonstrated as corporations sign agreements for financial assistance and host institutions assume funding for family planning posts.

These ongoing programs influence public and private sector acceptability of family planning and utilize a variety of mechanisms to increase self-sufficiency.

2. The Association of Brazilian Family Planning Entities (ABEPF) promises to play a dynamic role in the development of family planning in Brazil. As FPIA cannot now fund ABEPF directly, we will fund CPAIMC (Brazil-03) to include and administer ABEPF's new, low cost, service model. This provides for the addition of core staff to small nonprofit ABEPF member institutions, enabling them to establish CBD components and initiate family planning services in their communities. Financial, material and technical assistance will be provided by CPAIMC, and emphasis given to the development of income generation schemes. The end result is expected to be self-sufficiency of the family planning delivery component in each institution and effective transfer of management technology from CPAIMC to ABEPF member institutions. Should the moratorium on new project funding be lifted, this activity will be established under ABEPF alone, independently of CPAIMC.
3. When the moratorium is lifted on new project development in Brazil, FPIA plans to fund three low cost, replicable, community-based, urban projects which will promote the acceptability and availability of family planning in new areas.
  - In the State of Parana we will re-initiate the Brazil-10 project, developed with CLAM, but disapproved by AID due to the funding moratorium. This will reactivate a former BEMFAM national program, support up to 250 health posts staffed predominately by women, and provide training and technical assistance in the provision of services and income generation. It will ultimately restore service to 300,000 women and provide project staff a base from which to seek increased public and private sector acceptance.

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- In Lorena (under ABEPF), LARO will develop a program with SPAPMUC to support provision of clinic services and CBD in that city and others nearby. This will increase the visibility and availability of services in this heavily populated area, paralleling the work now done by Brazil-08, and leading to more rapid widespread acceptance.
- In Brasilia, FPIA plans to develop a program which will follow the Ciudad Juarez model as described in FPIA's Mexico-25 document. The grantee agency will identify, develop, fund and monitor subprojects for the introduction of community-based family planning, education and methods distribution. Differing from ABEPF's approach, which adds a family planning component to an existing institution, this will encourage the development of community agencies willing to accept a primary focus of family planning.

CAMEROUN

OBJECTIVES: ● FPIA gradually will continue to expand its assistance to Cameroun by providing funding to church organizations (especially the Presbyterian Church of Cameroun) so as to extend services to new geographical areas and to respond to commodity requests from non-project institutions.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>9,100,000</u>        | Population Growth Rate | <u>3.0%</u>           |
| Fertility Rate    | <u>5.7</u>              |                        |                       |
| Age of Population | <u>42% under age 15</u> | ---                    | <u>4% over age 64</u> |

Although the Government of the United Republic of Cameroun was, until recently, thought to be pronatalist, several statements by high government officials, including the former president of the republic, indicate that the increasing rate of population growth (about 3% per annum), accompanied by massive migration from rural to urban areas, is of concern to government planners.

USAID/Cameroun strategy is to foster population awareness and promote manpower development through local and outside training and other activities. To date, efforts to introduce family planning on a large scale or through bilateral funding have not succeeded. However, progress slowly is being made. In January 1983, a RAPID presentation was given to government officials, church leaders and medical professionals. With USAID/Cameroun's encouragement, the Pan African Institute for Development (PAID), based in Douala, will include population and family planning courses in its training programs. FPIA is considering the establishment of a working relationship with PAID.

FPIA currently is funding one project in Cameroun with the Djoungolo Hospital, a health facility of the Presbyterian Church of Cameroun. This project, in addition to offering temporary methods of family planning, offers voluntary sterilization in peri-urban and urban areas of Yaounde, the political and administrative capital of Cameroun. It also conducts IEC sessions on family planning in cooperation with the Ministry of Health.

Over the next three years, FPIA plans to gradually expand its activities in Cameroun, particularly in the private sector. FPIA now is providing contraceptives to Presbyterian Church hospitals

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through the church's drug distribution program. Working with JHPIEGO and others, FPIA hopes to expand this effort through technical assistance and programming. Such an effort would undoubtedly absorb the Cameroun-01 project.

COLOMBIA

OBJECTIVE: ● To provide maintenance level support to PROFAMILIA contributing to its provision of service for 31.9% of Colombia's active family planning clients, thereby assisting in Colombia's successful effort to lower the natural rate of population increase.

Demographic Data

|                   |                   |                        |  |
|-------------------|-------------------|------------------------|--|
| Population (1983) | <u>28,000,000</u> | Population Growth Rate | <u>1.9%</u>                                      |
| Fertility Rate    | <u>3.6</u>        |                        |  |
| Age of Population | <u>0-14</u>       | <u>39.4%</u>           | <u>15-64</u> <u>57.1%</u> <u>65+</u> <u>3.5%</u> |
|                   |                   |                        | WOFA 70.2%                                       |

The Colombian Government has offered family planning services free of charge at government run health posts, clinics and hospitals since 1969. The program is operated by the Ministry of Health through its MCH program. Temporary methods are offered in the above mentioned facilities, while voluntary sterilization is available through PROFAMILIA, which acts as the executing agency for the service for the MOH. PROFAMILIA also is involved in training MOH doctors in voluntary sterilization techniques. Due to significant drops in the rate of natural increase (from 3.4% in 1964 to under 2% today), attention has shifted somewhat from Colombia among international donor agencies. Both USAID and UNFPA ceased their assistance programs with the MOH in 1982. This factor, coupled with the government's current position re family planning, is expected to lead to some decline in government service. The government considers the current level of natural increase to be satisfactory and its economic problems have led to the decision to devote scarce resources to MCH and rural integration.

Of urban women, 53% use some type of contraceptive method; among rural women the figure is 37%. Service is provided according to the following breakdown: PROFAMILIA - 31.9%, MOH - 22.9%, Pharmacy - 34.7%, SS - 4.5%, Private Physician - 3.4%, and Other - 2.6%.

AVS, Pop Council, Pathfinder and FPIA provide support to PROFAMILIA. To date, FPIA has provided \$1,551,225 to support the costs of operating ten regional clinics and a total of over 700 affiliated CBD posts. FPIA began funding this large network of clinics and CBD posts in 1980 when funding from other sources was cut. Discussions with the USAID mission and the project were geared toward a phaseout of FPIA support by June of 1984. However, PROFAMILIA has been unable to raise

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adequate support from other sources to serve the 45,000 persons reached through the clinics.

FPIA's strategy, based on all of the factors mentioned above, is to provide approximately \$250,000 to PROFAMILIA over the next three years. LARO staff will work with the project and coordinate with other donor agencies to achieve maximum benefit from the anticipated funding level. A variety of income generating methods will be continued, including PROFAMILIA's providing technical assistance and training for organized family planning groups, and charging a fee for such services.

It is important to note that AID/Washington is in favor of continued support to Colombia.

DOMINICAN REPUBLIC

OBJECTIVES: ● To support USAID mission strategy of providing family planning assistance through private voluntary organizations and the government's plan to increase rural services and the availability of the IUD as a contraceptive alternative, FPIA will fund CONAPOFA to:

- provide IUD insertion training for doctors and nurses in clinics throughout the country, and
- develop an IEC campaign which will promote all available contraceptive methods and service points.

Demographic Data

|                   |                   |                        |                     |             |
|-------------------|-------------------|------------------------|---------------------|-------------|
| Population (1983) | <u>6,247,000</u>  | Population Growth Rate | <u>2.56%</u>        |             |
| Age of Population | <u>0-14 44.8%</u> | <u>15-64 52.4%</u>     | <u>65+</u>          | <u>2.8%</u> |
| Fertility Rate    | <u>4.7</u>        | Women Aged 15-49       | <u>196.9/thous.</u> |             |

The Government of the Dominican Republic (GODR) continues to support family planning and intends to lower the population growth rate through fertility reduction. A goal of the government's program is to increase the availability of the IUD as a contraceptive alternative. Its current national health policy is to extend services to the rural population and to reduce the migratory trend from rural to urban areas.

The USAID mission, in its 1983 CDSS, states that family planning in the Dominican Republic can be effectively increased without a bilateral program. In fact, "the mission strongly encourages this approach." Bilateral assistance will continue for conferences and the production of IEC materials.

Other donor assistance is currently being provided by UNFPA, AVS, Pop Council, Pathfinder, DA and IPPF. Of these agencies, three support the Consejo Nacional de Población y la Familia (CONAPOFA), and four support PROFAMILIA. Approximately 11,000 persons will receive voluntary sterilization services through the AVS project. Pathfinder's CBD program intends to serve 10,000 rural clients and CONAPOFA, with UNFPA assistance, is providing service to approximately 240,000 clients. In 1980, 47% of the urban population and 38% of the rural population were using a method of contraception.

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In February, 1984, FPIA initiated support to CONAPOFA. The project will provide training in IUD insertion for physicians and nurses located in twenty-five clinics throughout the country. An extensive campaign will be undertaken to inform the public of the availability of the contraceptive methods and service points. Introducing these services primarily in rural clinics, the project supports two aspects of the government's plan, i.e., it increases the availability of the IUD as a contraceptive alternative and brings additional medical services to rural areas. The project also supports the mission's strategy which is to encourage PVO support for family planning service activities.

Since a significant number of PVOs and UNFPA are running successful projects in the Dominican Republic, FPIA support will be limited. An assessment of the CONAPOFA project will be conducted in January or February of 1985 and a determination will be made as to the need to continue the project into 1986. Consideration will be given to initiating a male sterilization component.

ECUADOR

- OBJECTIVES:
- To complement USAID mission strategy of improving and expanding existing family planning services, FPIA will:
    - continue to support (Ecuador-04) CEMOPLAF's expansion of its contraceptive distribution components (both urban and rural) by 60%.
    - increase the self-sufficiency of CEMOPLAF from 48% to 70%.
    - establish and continue support to an urban CBD component in the Centro Obstétrico de la Universidad Central de Quito (Ecuador-05) and expand to rural areas with a midwife commodity distribution component.
  - To work with the USAID mission to expand CEMOPLAF service delivery to include voluntary sterilization and to explore possibilities of initiating such service with non-AID funds.

Demographic Data

|                           |                     |                        |             |
|---------------------------|---------------------|------------------------|-------------|
| Population (1983)         | <u>8,000,000</u>    | Population Growth Rate | <u>2.8%</u> |
| Fertility Rate            | <u>5.7</u>          |                        |             |
| Age of Population (Males) | Age 15-49           | 24%                    |             |
|                           | (Females) Age 15-49 | <u>23.5%</u>           |             |

In the new constitution (published in 1978), the Government of Ecuador supports responsible parenthood and appropriate education for advancement of the family. The constitution further guarantees parents the right to have the number of children they can support and educate. While this stance is positive, the government has not formulated a national family planning policy. The 1980-1984 Development Plan addresses population growth in terms of: attracting foreign, and repatriating national, technicians; keeping out unskilled workers; discouraging rural to urban migration; colonizing strategic border areas and promoting investments which will generate employment for a growing population. The National Health Plan has an overall goal to reduce infant, maternal and overall mortality rates. A more specific goal is to increase new fertility regulation clients from an estimated 42,500 in 1980 to 61,000 in 1984. There is, however, no goal for the establishment of family planning services. Since an extremely conservative estimate indicates over 1,000,000 women are in their childbear-

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ing years, the government's new client goal reaches only six (6) percent of the women in need. Government service is provided through the Ministry of Health, the Ecuadorian Institute of Social Security (IESS) and the Family Welfare Department. Little coordination exists between these agencies.

USAID will continue to support the development of a national population policy and will assist public and private family planning institutions. Working with the UNFPA, the mission will support the Population Division, National Statistics and Census Institute and CEPAR in gathering data for policy formation and in promoting public awareness of the population problem. The bulk of its assistance, however, will be provided to the MOH, MOD, IESS, APROFE and CEMOPLAF to enable these agencies to expand and improve family planning service. The mission also plans to initiate a pharmacy-based, commercial retail sales program and to develop local mechanisms for the provision of contraceptives. USAID expects Ecuador's population growth rate to be reduced to 2.4% by the end of the 1980s.

Private voluntary organizations working in Ecuador are IPPF, FPIA and AVS. IPPF funds the bulk of APROFE activities including clinics in Guayaquil, Quito and Cuenca, and CBD activities in five coastal provinces. Combining CBD and clinic figures, APROFE had 29,086 new clients in 1982. IPPF also funds CEMOPLAF's family planning services in Guasmo, Esmeraldas, Quinde, Ibarra, Tulcan and Riobamba. AVS has planned a sterilization project to be implemented in APROFE clinics in Quito and Guayaquil. This project, which is to be funded with non-AID monies, will provide about 4,000 voluntary female sterilizations.

FPIA currently is funding CEMOPLAF (Ecuador-04) and the Centro Obstétrico-Universidad de Quito (Ecuador-05). Support to CEMOPLAF began in 1975 with 2,000 new clients projected. Today, through clinics and CBD in Quito, Santo Domingo, Quevado and Ventanas, CEMOPLAF's FPIA-funded project expects to serve 11,368 new and 8,743 continuing users. CEMOPLAF also has added a contraceptive distribution component which supplies contraceptives (40,300 cycles of pills, 445,300 condoms, 2,000 IUDs, 2,000 bottles of foam and 2,000 tubes of jelly) through its Associated Professionals and National Institutions Programs. By charging for services, CEMOPLAF has assumed forty-eight percent of current project expenses. The Centro Obstétrico project, which began in January, 1984, will serve 2,000 users in Quito's marginal, urban communities. This figure represents 10% of the women of fertile age in the communities to be served.

In deciding to maintain a presence in Ecuador, FPIA has considered:

- the need for family planning assistance as evidenced by the high population growth rate (2.8%) and the high fertility rate (5.7).

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- the USAID mission's strategy which is to support projects which promote family planning, represent the private sector, utilize local resources and generate income.
- the conceptual stance taken by the government which is to make family planning services available to those who want them.

Based on all of the above, FPIA's strategy in Ecuador is to continue to support the services provided by CEMOPLAF and the Centro Obstétrico. These private sector projects are clinic-based with CBD components which facilitate their expansion to reach larger segments of the surrounding population. They are also cost effective owing to their income generation components. In 1984, Ecuador-04 and -05 will reach a combined total of 22,111 clients (excluding those to be reached through Ecuador-04's commodity distribution component).

Since sterilization services are not widely available, FPIA will continue to work with the USAID mission to get the support needed to expand CEMOPLAF's service delivery to include voluntary sterilization as a contraceptive alternative. If this is not feasible, FPIA will consider initiating such service with non-AID funds.

EGYPT

OBJECTIVE: ● In Egypt, FPIA plans to address the still enormous unmet need for family planning services by continuing to: fund projects which have demonstrated an ability to reach large numbers of acceptors, in special groups, at low cost; upgrade existing services through training programs which stress quality care and through technical assistance in record-keeping, logistics, management and contraceptive technology update; and assist projects which develop innovative service structures, particularly a community-based approach to family planning.

Demographic Data

|                   |   |                        |             |
|-------------------|---|------------------------|-------------|
| Population (1983) | <u>45,900,000</u>                                 | Population Growth Rate | <u>2.6%</u> |
| Fertility Rate    | <u>6.0</u>  |                        |             |
| Age of Population | <u>39% under age 15</u> --- <u>4% over age 64</u> |                        |             |

As reflected in the USAID FY 1985 CDSS, the Government of Egypt (GOE) is highly committed to modifying the rate of population growth (estimated at 2.6% per year) and has adopted numerous relevant strategies and policies as part of its development plan. The USAID mission supports the GOE's efforts in family planning and provides substantial financial support through bilateral channels, private voluntary agencies and AID contractors. Despite a very large bilateral assistance program in Egypt, the USAID mission has been highly supportive of FPIA activities over the past several years, and this is expected to continue during the 1984-1986 period. This is because the projects which FPIA funds, although small, operate with sensitive groups which USAID cannot directly fund (i.e., Christian groups) and highly influential groups (e.g., Al Azhar University). Additionally, FPIA projects are involved in highly innovative activities (e.g., CBD, natural family planning, etc.).

Unless there is a significant increase in available subgrant funding, however, FPIA does not intend to develop any large new projects in 1984-1986. However, it is planned that currently funded projects will be continued as follows:

Egypt-01 (Coptic Orthodox Church): After registering as a social service organization (instead of a religious one), the agency will expand its services to rural and urban Egypt as a rollover project through activities of Family Health Care Centers. The agency's family life education and counseling (marriage and pre-marriage) services still focus on Coptic Christians, but its family planning

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and other health services are being used by all religious and ethnic groups throughout Egypt. FPIA staff and consultants will provide technical assistance to this project during 1984-1986 in various functional areas.

Egypt-02 (Coptic Evangelical Organization for Social Services - CEOSS): FPIA will continue to fund this innovative and very successful community-based distribution project which provides services to both Christians and Muslims within a broad context of CEOSS' community development efforts in Minia and peri-urban Cairo. FPIA will encourage the grantee agency to publicize the project's success so that other interested groups can learn from the project's experiences.

Egypt-03 (University of Tanta): This projects assists the University of Tanta, Faculty of Medicine to train fourth year medical students in both contraceptive service delivery and community education and counseling. The agency is also training villagers to take over when the university students move on to other areas. The combination of a university and community-based approach is highly innovative. The project staff also are providing natural family planning counseling to illiterate groups, particularly conservative Muslims.

Egypt-05 (International Islamic Center for Population Studies and Research): FPIA will continue to fund this project. The urban clinics, which are a model of sensitivity, efficiency and cleanliness, are expected to be absorbed by Al Azhar University by the end of the next funding period. FPIA will encourage the expansion of the rural clinic and community-based activities.

Egypt-06 (Al Azhar University, Faculty of Medicine for Girls): This project is in its first funding period and will be closely monitored. It focuses training on female interns and medical students, and may evolve a contraceptive commodities distribution scheme.

FPIA also will continue to provide contraceptive commodities and equipment to requesting institutions. Staff will attempt to identify areas of weakness and to strengthen these by providing appropriate technical assistance or training.

GHANA (medium priority)

Ghana has a population of over 11 million with a growth rate of 3.13%. In the five year Development Plan for 1975-1980, the Ghanaian Government emphasized its view that a high birth rate had impacted negatively on health which it considered one of the primary requirements for economic and social development. The government desires to reduce population growth by reducing fertility. The population of Ghana is inappropriately distributed with massive rural to urban migration. This situation has been exacerbated with the massive return of two million Ghanaians from Nigeria in 1983.

USAID has supported varied population/family planning activities in Ghana since the mid-1960s. USAID bilateral investments have concentrated on institution building, education, staff development, commodities supply and the provision of technical assistance. The primary goal has been to emphasize expanded family planning service delivery, outreach and IEC on a broad scale. USAID had hoped to expand its activities with a primary health care project which would have integrated family planning with MCH/FP, encouraging the Ministry of Health to increase the availability of services, on a country-wide basis, resulting in a higher family planning acceptance rate, particularly in the rural areas. Unfortunately, due to political reasons, the USAID mission activities have had to wind down. FPIA has been advised not to expand project activities although this could change.

FPIA activities in Ghana at this time are critical, especially in view of the unprecedented increase in population due to immigration, and the reduction in USAID activities. The three, ongoing, FPIA-funded projects are with the YMCA (Ghana-03), Christian Council of Ghana (Ghana-04) and APPLE, the Association of People for Practical Life Education (Ghana-05). These programs serve approximately 30,000 family planning clients in six regions of Ghana. Activities are predominantly in rural areas and are community-based. Given the U.S. Government position regarding assistance to Ghana-based agencies and institutions, no new initiatives will be considered at this time. As permitted, FPIA/ARO will continue funding the existing program at present levels of activity. ARO envisions the Ghana-03 project reaching completion in 1984. The Ghana-04 project has an income generation component. With adequate management (to be facilitated by in depth technical assistance in 1984), the project should be able to cover expenses beyond 1985. The Ghana-05 project initiated activities in 1983 and is in an initial phase. FPIA will coordinate closely with the USAID mission to monitor the situation in Ghana and will adjust the country strategy as appropriate.

HAITI

OBJECTIVE: ● To support USAID's priority of building family planning leadership in Haiti, FPIA will identify and fund three projects whose family planning service delivery networks can be upgraded through provision of technical assistance and integration of FPIA management systems.

Demographic Data

|                             |                   |                        |                                  |
|-----------------------------|-------------------|------------------------|----------------------------------|
| Population (1983)           | <u>5,700,000</u>  | Population Growth Rate | <u>1.7%</u>                      |
| Fertility Rate              | <u>5.5</u>        | Unmet Need             | 80% (according to USAID Mission) |
| Age of Population           | <u>0-14 43.6%</u> | <u>15-64 52.9%</u>     | <u>65+ 3.6%</u>                  |
| Fertile Aged Women in Union |                   | <u>730,000</u>         | according to USAID               |

Haiti's President Duvalier has "committed the government to the concept of a small family." Development plans call for a reduction from the current birth rate of 36 per 1,000 to 16 per 1,000 by the year two thousand. Haiti's current population growth rate is 1.75. This rate can be attributed to high infant morbidity and emigration. The fertility rate, however, is 5.5 children per woman. In an attempt to deal with the high infant death rates, the GOH delivers family planning services within the context of MCH.

The Government of Haiti's objective between 1981-1986 is to improve the overall health delivery system, decentralizing to four regional departments. As one of the poorest countries in Latin America (per capita GNP \$297), Haiti's spending on health care has been the lowest in the region. About 95% of the GOH program has been funded from outside sources. Out of eleven donors currently providing family planning assistance, eight are working with the Department of Public Health and Population Division of Family Hygiene. The private sector operates 40% of the health facilities in Haiti. However, according to USAID, it is difficult to differentiate between the role of the public and private sectors, as all family planning activities are considered part of the national program.

The USAID mission's strategy over the next few years is to focus on building family planning leadership by promoting training, management technology and improved service delivery in the private and public sectors. The mission intends to identify agencies which can ultimately become self-financing. Urban and rural CBD will be emphasized, possibly in combination with MCH. An end result of these activities will be the

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reallocation of funding for a more even distribution among health delivery programs in Haiti.

Haiti's high fertility and infant mortality rates, high unmet need for family planning services and the government and mission position on assistance, justify an FPIA presence in the country. However, Haiti has received, and will undoubtedly continue to receive, a considerable amount of development assistance. Since FPIA's resources for new project development are scarce, FPIA's strategy will be to work with the USAID mission and other donor agencies to identify projects which have had some success in providing family planning and to assist these programs to expand and/or to upgrade services. FPIA may support the addition of a CBD or a clinic component, or provide technical assistance geared to increase project efficiency and effectiveness. Additionally, since factories which employ over twenty-five persons must have medical services, FPIA also will explore the possibility of introducing contraceptive distribution in factories. Total assistance over the three-year period will be \$60,000 to \$100,000.

HONDURAS

OBJECTIVE: • To develop several small (\$35,000) projects with organized women's groups or IHSS centers which will provide family planning services in geographic areas not covered by the existing family planning program.

Demographic Data

|                   |                    |                        |                       |
|-------------------|--------------------|------------------------|-----------------------|
| Population (1983) | <u>4,092,000</u>   | Population Growth Rate | <u>3.5%</u>           |
| Unmet Need        | <u>57.5% Rural</u> | <u>43.9% Country</u>   |                       |
| Age of Population | <u>0-14 47.8%</u>  | <u>15-65 49.4%</u>     | <u>65+ 2.7%</u> women |
|                   |                    |                        | <u>15-49</u>          |
|                   |                    |                        | <u>882,400</u>        |

Over the next three years, approximately \$100,000 will be allocated to develop family planning projects in Honduras. As the demographic data above indicates, Honduras is a country with a high population growth rate and a high unmet need for family planning services. The government is in favor of family planning and has initiated a program which integrates family planning services with MCH. The mission "believes higher levels of intermediary support to be the preferred source for population activities."

The government provides family planning service through the Ministry of Health and the Instituto Hondureño de Seguro Social (IHSS) at rural health centers (education and referrals only), medical centers, and at central and regional hospitals. In 1982, including referrals, education and services, 58,378 persons were reached by the GOH program. Bilateral support is provided by USAID to the Honduran Family Planning Association and by the United Nations to the Ministry of Health. All Private Voluntary Organizations (FHI, IPPF, PCS, DA, IPAVS) work with the Honduran Family Planning Association. IPAVS and DA also work with the MOH and IHSS centers, respectively.

The mission (FY83 CDSS) notes that "the GOH has not developed an effective strategy for dealing with the problems of rapid growth rate or for reducing the rate of growth." The government will, however, continue to develop a family planning program within the context of MCH as a means of reducing the unacceptably high infant mortality rates. The mission's strategy is based on the need to reduce the population growth rate to meet government goals and the assessed unmet demand among marginal income women and the modest success of the current programs. The

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mission has established that "the female headed household is a growing phenomenon throughout Honduras particularly among the poorest groups ...and that up to 20% of the female population 15 years and over are single mothers." They further discuss the work of the Honduran Women's Association and the possibility of establishing a women's extension service.

Based on the factors described, LARO's strategy in Honduras is to work with women's groups to establish low cost, contraceptive distribution projects. The projects will be community-based and will stress family planning education for young women. LARO also will work with the government to initiate family planning services in IHSS centers which do not contain a family planning component. LARO's program goals support the mission strategy, consider mission studies and reports and also the government's intent which is to "guarantee Honduran couples the right to family planning education and services." LARO's program will initiate service in areas not covered by current providers. Since all current providers work with the Honduran Family Planning Association (HFPA), LARO will coordinate with the HFPA, keeping all parties informed of FPIA activities.

INDIA

- OBJECTIVES:
- In accordance with the Prime Minister's program that requests NGOs to assist in decreasing the birthrate and increasing prevalence from 24% to 60%, FPIA will provide family planning training opportunities to 10-12 NGO leaders and fund 3 continuing and 1-2 new NGO service projects with an estimated commitment of about \$1.4 million and, by 1987, serving an estimated 275,000 clients.
  - Concentrate new programming and appropriate expansion or realignment of continuing projects in a single state area, Uttar Pradesh (which has the largest population of any state - 110,000,000 - and a prevalence of 11%). Provide training opportunities for 3-5 representatives from potential service provider agencies to build CBD project design, management and monitoring capabilities.
  - In accordance with FPIA's mandate to provide short term funding, continue to coordinate with national and international donor agencies to investigate continuation funding beyond FPIA's period of anticipated support for those projects that successfully institutionalize their family planning services.
  - Respond to the government's goal to increase IUD use by fulfilling the government's request and providing 100,000 CuTs each year until 1987.

Demographic Data

Population (1983) 730,000,000      Population Growth Rate 2.1%  
 Fertility Rate 5.0  
 Age of Population 39% under age 15 -- 3% over age 64

By the year 2,000, the GOI plans to achieve a decrease in the birthrate from 33.0 to 21.0 per 1,000. To do this, the contraceptive prevalence rate must be increased from 24% to 60%. To meet these goals, the government has embarked on a new strategy meant to reach a younger and more rural population. The goal is to increase services at the rural level by increasing the number of health subcenters and the staff assigned to these centers. Staff training will be provided to improve physicians' skills in voluntary sterilization, multipurpose health workers' skills in IUD insertion and pill provision, the health guides' and dais' skills in IEC and outreach, and the local leaders' abilities in understanding the importance of family planning

INDIA

for the nation and the individual's wellbeing. The budget to support the government's family planning program for 1984-1985 is \$469 million, 10% of which is from foreign donors or foreign loans.

Until recently, the GOI has not actively supported the inclusion of VOLAGs in its family planning efforts although many agencies, including CMAI, the Family Planning Association and the Family Planning Foundation, have had large programs supported both through local and international funds. Currently, as the government seeks to increase family planning programs through voluntary acceptance, more attention has been given to the role of the NGOs. In fact, the Prime Minister in her 20 point program called on NGOs to assist the nation to reach its family planning goals.

The USAID-supported Private Voluntary Organization Health (PVOH) project is funded through 1987. It provides the Ministry of Health funds for PVOs working in health, nutrition and family planning. Current funding suggests projects will average \$80,000 per year and utilize approximately 10-20% of their grants for family planning services. Funds from this grant, worth approximately \$17,000,000, may not be used for voluntary sterilization although discussions are in process to eliminate this restriction. The other restriction is that 80% of the funds must be utilized for programming in rural areas.

USAID also provides bilateral support to the GOI through the Family Planning Communications and Marketing Project for the period 1983-1990. USAID's contribution to this project is \$49 million. The project goal is to establish a family planning and marketing system to increase the use of temporary methods from 6% to 20% by 1990. This project will utilize mass communications and a semi-autonomous body, the Contraceptive Marketing Organization (CMO), to oversee the manufacture and sale of temporary methods through a social marketing scheme. An additional component is a demographic analysis.

USAID does not use bilateral funds for the support of NGOs. Rather, it relies on centrally funded PVOs and the PVOH (rupees) project to provide support to NGOs. At this time, FPIA is the only centrally funded PVO providing support to local organizations other than IPPF which provides funding to the Family Planning Association of India (FPAI).

Essentially, the NGO program in India is not coordinated or even tabulated. FPAI is the only pan-India, strictly family planning NGO. Many organizations include family planning in their services. CMAI probably offers the most organized effort, on an across-India basis, of these multi-purpose organizations which include family planning. While the NGO effort is significant, in comparison to the GOI program, it is not nationwide or a major influence at this time.

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FPIA has responded to the Indian situation by initiating support to a well-established, respected and country-wide organization of Christian Hospitals, CMAI. This grant originally was designed to fund (through a reimbursement system to participating hospitals) all family planning services with an emphasis on voluntary sterilization. A major breakthrough for American-based funding was accomplished when this grant resulted in CMAI's agreement to utilize an informed consent form strictly following PD70 requirements. A hospital staff training program, and a community health worker salary grant to hospitals, also were funded under this grant to emphasize community outreach work in the hospitals' family planning programs.

A second grant recently was awarded to a strong and successful women's organization in south India. This agency also had successfully conducted a community-based family planning program in urban slums in connection with its credit cooperative work, and wished to expand its services. This agency has the potential to further expand the provision of family planning education and referral services by slum residents to slum residents, and to serve as a model for other organizations.

Recognizing the difficulty in programming for impact in a country as large as India, FPIA has determined it would be most effective to begin by concentrating its programming in a single state with a significant need for additional family planning resources. Uttar Pradesh, a large state in northern India, was selected for this emphasis. Uttar Pradesh has a population of over 110 million people making it the state with the largest population and with the fourth largest land area in India. Uttar Pradesh has a birth rate of 39.6 (the country's birth rate is 33 per 1,000). Contraceptive prevalence in Uttar Pradesh is 11% (the country average is 24%).

Currently, FPIA has proposed support to a small service project with the Allahabad Jaycees. This will be a pilot program and, if successful, it will be expanded in one year's time. In addition, FPIA is planning to modify the CMAI project to allow it to launch a special effort to promote temporary methods through its hospitals in Uttar Pradesh and other northeastern states. IUD training for service providers, and special temporary methods IEC training for the hospital leaders, are planned. In 1985 and 1986, FPIA will begin new projects in areas of Uttar Pradesh identified as most in need of increased family planning services by their district-wide prevalence rates. VOLAG staff management training will be a focus during each year of support for the Uttar Pradesh programs to assure transfer of management capability to the NGO groups providing family planning services.

In support of FPIA's emphasis on temporary methods, FPIA will supply the GOI 100,000 IUDs per year for the next three-year period.

INDONESIA

- OBJECTIVES:
- In support of the Indonesian Government's national development strategy of reducing the population growth rate to 1.7% by 1990, FPIA will support family planning training for 15 NGO leaders, fund four continuing projects and consolidate five ongoing projects into one (short-term basis) that will address local special problems in areas with less than a 30% prevalence rate. An estimated commitment of about \$400,000 per year will provide service to a total of about 193,000 new family planning clients by 31 December 1986.
  - Concentrate continuation project support to private sector organizations not currently eligible for bilateral support but which provide either sterilization services on a fee-for-service basis, family planning to trade union members, or information, education and services to adolescents and their families.
  - In accordance with FPIA's mandate to provide short-term funding, continue to coordinate with the USAID mission and other national as well as international donor agencies to investigate continuation funding beyond FPIA's period of anticipated support for projects that successfully institutionalize their family planning services.

Demographic Data

Population (1983) 155,600,000      Population Growth Rate 2.0%  
Fertility Rate 4.4  
Age of Population 38% under age 15 -- 3% over age 64

The Indonesian Government's goal is to reduce the population growth rate from 2% in 1984 to 1.7% by 1990. The national strategy, according to the Repelita IV, gives priority to the following:

- Women are encouraged to delay first births until after age 20, and plan for two children as the ideal number.
- Integrate nutrition, basic health, income generation and other community development activities with family planning programs.
- Strengthen family planning program institutionalization.

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Because of Indonesia's large geographic area and the different levels of service available in the country, the national family planning program has developed separate strategies and budgets for different provinces.

The USAID mission's bilateral program for 1983-1985 deals with specific problem areas not addressed in the Indonesian national strategies. These problem areas include the following:

- Increasing rate of contraceptive use in low-performing areas, particularly in urban areas, through the introduction of new contraceptive technologies, especially voluntary sterilization;
- Increasing institutional capability through training and technical assistance for management, supervision, and administration; and accelerating decentralization of program planning, implementation, administration and evaluation;
- Utilizing the private sector to provide family planning services on a fee-for-service basis to reduce the government's involvement and expenditures;
- Leading BKKBN into new areas or approaches, e.g., utilizing flexible funds for demonstration projects or first year costs.

The BKKBN successfully has demonstrated the effectiveness of NGO participation in family planning service delivery. National and internationally supported PVOs, and provincial and village level organizations, have provided maximum IEC and service coverage through a network that includes the "bottom sending regular service output reports to the top."

FPIA has provided \$2.4 million of financial, and \$3.2 million of commodity support to Indonesia over a period of 12 years. The main objective of the support has been to finance family planning service delivery at over 200 sites within the Christian and Catholic hospital systems. In recent years, FPIA project awards also have been made to PKMI, YKB, IDI, FBSI, Indonesian Ob/Gyn Association, Dharma Wanita and Muhammadiyah. At present, FPIA is funding ten projects in Indonesia.

Six of the ten current FPIA projects will be terminated by the end of 1983 or in early 1984, three in 1984 and three in 1985. One new project will be initiated in 1984-1985. The purpose of the new project is to replace individual project support to DGI, PERDHAKI, Muhammadiyah and KNPI, whose family planning service programs are not eligible for bilateral support and are not able to function without some external donor support. The project would set up a family planning council mechanism that, on a policy level, would determine which

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national, special interest, service organizations merit continuation support for family planning activities in relation to BKKBN strategies and FPIA priorities. The grantee would be an NGO, facilitating support to such groups, but project policy would also be from BKKBN, insuring no duplication in areas sufficiently served by the government. The council would award small grants to continue service for a limited time period, at the close of which the site would become a contraceptive depot or supported in another manner by the organization. Council staff would be responsible for initiating and maintaining a sub-project monitoring system. FPIA would consider support to such a council for about three years, after which it would be absorbed by BKKBN to institutionalize contributions of special interest groups into the government program. If the design of this project proves acceptable and workable, FPIA would support a conference in early 1985 to get input from many sources on the set-up and initiation of the council mechanism. FPIA also plans to maintain support for 4 projects: PKMI (Indonesian AVS), IDI, (Indonesian Doctors Association), Indonesian Ob/Gyn Association and the Federation of Trade Unions (FBSI).

FPIA's aim is to transfer sterilization subsidy reimbursement for DGI providers to PKMI and to switch government hospitals receiving FPIA-supported subsidies to IPAVS or government funding. The IDI project design provides minimal sterilization reimbursement to private institutions. While the government is developing its VSC capability, these two projects will meet the current demand for sterilization, while at the same time establish means for self-sufficiency by fee-for-service programs.

The Ob/Gyn Association is providing family planning services to university students and families from the area surrounding the campus. It is expected that, once established, the universities will institutionalize the program and phase out FPIA funding in a relatively short time.

The FPIA project with the Federation of Trade Unions (FBSI) currently has set up services for textile and garment workers with the potential for expansion to the cigarette union. As this type of program is not appropriate for bilateral support, we hope to continue providing financial and commodity assistance through 1986.

IVORY COAST

OBJECTIVE: ● FPIA will: respond to requests from private organizations to initiate family planning IEC and services in the Ivory Coast; train potential project staff through invitational travel; and supply commodities to interested institutions.

Demographic Data

Population (1983) 8,900,000      Population Growth Rate 3.9%  
Fertility Rate 6.7  
Age of Population 45% under age 15 --- 2% over age 64

The Ivory Coast is a small country with great contrasts and seeming contradictions. It has one of the highest GNPs in black Africa and there is a strong French influence, particularly in the ultra modern capital city, Abidjan. About 65 percent of the population are animists, 23 percent are Muslims and 12-17 percent are Christians. The population totals about 9.3 million, with about 30 percent estimated to live in urban areas. Despite a population growth rate estimated at 3.9% per annum, the political leaders essentially are pronatalist. At the closing of a seminar entitled "Population and Development" held in Abidjan from December 13 to 18, 1982, the Secretary of State for Planning and Industry said that population size in the Ivory Coast was still small in comparison to the land area and that family planning can only be tolerated for child-spacing purposes and better health of mothers and children, but not for limitation of births. A new (1982) Ivory Coast Penal Code repealed the (French) law of 1920 which made propaganda in favor of contraception a criminal offense. However, for the first time in the history of criminal law, sterilization is now a capital offense.

Despite conservative legislation and the official government stance, the demand for family planning services is quite high. Currently, these services are provided only by private physicians at very high cost. Contraceptives are sold in pharmacies at about US\$1 for a cycle of pills, \$5 for a dozen condoms and \$35 for an IUD. This makes family planning services available only to a limited number of urban upper and middle-income families. Illegal abortion, particularly among young people, is a growing problem in the Ivory Coast.

Although there is no bilateral aid program between the U.S. and the Ivory Coast, USAID maintains a Regional Economic and Development Service Office for West Africa (REDSO/WA) in Abidjan. There also is a regional population officer position within REDSO/WA. Small

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projects by AID-funded, private, voluntary agencies can enhance REDSO/WA's position by initiating activities in this high priority area (See Demographic Factors and Population Activities in West/Central Africa, REDSO/WA, February 1983.) without implying a bilateral commitment by the U.S. Government. It also allows private voluntary organizations to assume the "risks" involved in working in this highly sensitive field.

ARO's strategy in the Ivory Coast is to initiate small service projects, beginning in urban or peri-urban areas, which meet the needs of low income families and demonstrate the benefits of carefully planned and managed family planning efforts. Strong IEC components will be built into all projects, and outside training in family planning/contraceptive technology will be provided to help compensate for the acute shortage of trained personnel. Management technical assistance also will be provided, as the organizations initiating activities will be in the "high risk" category in terms of managerial infrastructures.

Two initial new project development and negotiation visits were made in 1983. ARO staff also attended a seminar on family wellbeing in Korhogo in November, 1983 where numerous contacts were made with health agency and government officials. In 1984, FPIA expects to develop and fund two projects, one with the Association Ivorienne pour le Bien-Etre Familial (AIBEF), and one with the Union General des Travailleurs de Cote d'Ivoire (UGTCI), Textile Workers Union. AIBEF is a nonprofit organization, recognized by the Government of Ivory Coast since September 1979, with an "official" mandate to work in family life education, IEC and family planning. It also has duty free privileges and has successfully imported small, IPPF-supplied, contraceptive shipments. Although IPPF has given AIBEF a small grant to initiate activities, AIBEF is not a full member of IPPF. The FPIA-funded project will provide for a family planning clinic at the University Teaching Hospital, Treicheville (Abidjan), where a nurse and a midwife will provide family planning IEC and services under the supervision of a medical doctor. Two educators will visit MCH clinics in Abidjan and the surrounding areas to provide family planning education and refer prospective clients to the project clinic.

It is anticipated that FPIA support, both management and financial, will assist AIBEF to strengthen its institutional capability and enable it to more quickly assume the role of coordinating/initiating agency vis a vis family planning in the Ivory Coast. Eventually, full IPPF membership, and the phasing out of FPIA support, is envisioned.

The UGTCI is a national confederation of 54 independent labor unions. The union represents about 600,000 workers, about one-third of whom are women. The textile workers union has over a thousand members,

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most of whom are women. The FPIA-funded project will enable the textile workers union to introduce family planning services in three factory dispensaries. Subsequently, the union will select three additional dispensaries each year to include in its family planning program. To enhance the capability of future project staff in the provision of family planning services, three graduates from the mid-wives school will be sent for training to a francophone country.

FPIA's long range objectives for the Ivory Coast are to strengthen institutional capabilities to provide family planning services, particularly in existing infrastructures. FPIA also would like to encourage the local training of medical personnel in contraceptive technology, through its funded projects or new projects, and to expand the availability of contraceptives, particularly in the private sector and parastatals such as the national social security administration.

JORDAN

- OBJECTIVES:
- To continue to support JFPPA's Zarqa clinic for the originally anticipated five year period with an estimated commitment of \$59,397 resulting in service to 4,700 clients.
  - To develop interest and involvement of Jordanian leaders in family planning services by providing 1-2 small grants and 10 Regional Invitational Travel grants. Key individuals will be exposed to successful family planning programs and obtain training in family planning program development skills.
  - To coordinate with USAID, other donors and the grantee agency to investigate continuation funding for JFPPA beyond FPIA's five year period of support.

Demographic Data

|                   |  |                        |             |
|-------------------|--|------------------------|-------------|
| Population (1983) | <u>3,600,000</u>                           | Population Growth Rate | <u>3.6%</u> |
| Fertility Rate    | <u>7.2</u>                                 |                        |             |
| Age of Population | <u>48% under age 15 --- 3% over age 64</u> |                        |             |

The Kingdom of Jordan has no official policy with regard to family planning. However, the government does recognize that economic development and health are affected by high population growth and fertility rates. Therefore, family planning services are provided, on request, at government clinics. Private doctors and pharmacies also provide a wide range of family planning services and commodities to the public.

Although the USAID mission has no family planning bilateral, it actively supports family planning programming by centrally funded agencies. This emphasis reflects the mission's concern over Jordan's rapidly increasing population and the limited resources available to provide for this population. Jordan's birth rate is between 45 and 50 per 1,000 population, and its contraceptive prevalence is approximately 22%.

JFPPA has been recognized as the official NGO family planning agency in the country. Other NGOs may include family planning activities as a component of other services, but only JFPPA may provide family planning services alone. Pathfinder, UNFPA and John Hopkins currently are providing support to Jordan. For the most part, these agencies have supported training, IEC and MCH services.

JORDAN

Since 1975, FPIA has provided \$253,405 of project support to Jordan. Agencies which have received FPIA support include the Near East Ecumenical Commission for Palestine Refugees (\$7,781), Malhas Hospital (\$11,126), General Union of Land, Transportation and Mechanical Workers (\$95,220), Jordan Family Planning and Protection Association (\$136,278 - as of December 31, 1983) and YWCA (\$7,500). In addition, two travel grants (\$5,087) recently were awarded.

FPIA's program for Jordan has recognized the need for family planning services to be more readily available and has attempted to involve already existing health and social service institutions in the provision of quality family planning services. For example: an innovative and respected private hospital was provided support to introduce low cost, quality sterilization services; a labor union's clinics were assisted to provide their members with family planning education and service; and the JFPPA was supported to expand its clinic services in the large town of Zarqa.

In general, FPIA has found grantees resistant to providing active education and outreach to potential family planning clients. This resistance reflects a cultural emphasis on large families. FPIA recently sponsored a workshop of leading Jordanian women to discuss family planning needs and to recommend culturally appropriate family planning services which their agencies would be interested in having FPIA support. While no specific proposals have yet been submitted to FPIA from the workshop attendees, FPIA will follow up with those who attended, and with others, to continue to explore avenues for further provision of family planning services in the country. The provision of travel grants to leading women and men in Jordanian social service and health fields, will provide them with opportunities to: visit countries with innovative family planning programs; study at family planning training programs; or take part in special family planning conferences. This will help to develop the nucleus of support and interest in organizing new avenues in Jordan for family planning. FPIA will continue to support its current grantee in the Zarqa program to mid 1986, providing slightly more than the originally planned five year period of support. To assure smooth phaseout, FPIA will begin discussions of appropriate phaseout activities, including investigating other avenues of support, early in 1984.

KENYA

OBJECTIVE: ● FPIA will continue to operate in Kenya by transferring management technology, training staff, supplying family planning commodities to projects and non-project institutions, and by providing funding assistance to non-governmental institutions that are providing parallel or complementary services.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>18,600,000</u>       | Population Growth Rate | <u>4.1%</u>           |
| Fertility Rate    | <u>8.0</u>              |                        |                       |
| Age of Population | <u>50% under age 15</u> | ---                    | <u>3% over age 64</u> |

The Government of Kenya (GOK) first enunciated a population policy in 1967. On many occasions in 1982 and 1983, the President and other high-ranking government officials strongly verbalized their support for the adoption of family planning methods by Kenyans. Kenya's annual population growth rate is currently over 4%, one of the highest in the world. Consequently, the GOK and international donors have initiated measures aimed at reducing the growth rate. USAID/Kenya is participating in a multi-donor bilateral Rural Health and Family Planning Program which will be implemented over a period of five years. In addition, a four year Private Sector Family Planning Project, funded by USAID/Kenya, began operations in late 1983. The objectives of these two major programs are to correct the present imbalance in service delivery between urban and rural areas by expanding family planning activities to health facilities-both public and private-throughout the country. Since there are about 150, AID-funded, PVO projects in Kenya with health or family planning activities, FPIA increasingly will coordinate its activities with other donors and agencies.

During 1984, it is anticipated that FPIA will cooperate with other organizations based in Kenya to stage or conduct meetings and seminars designed to advance certain family planning-related activities. For example, ARO is planning to provide funds for a conference on Natural Family Planning and Family Life Education. In addition, ARO staff will participate in the proposed URTNA/PCS conference on the development of culturally appropriate media for IEC programs in Africa. Furthermore, FPIA will assist the Private Sector Family Planning Project (PSFPP) through coordination and information sharing.

During the three year period, (1984-1986) ARO will coordinate its commodity assistance to non-project institutions with the Kenya Ministry of Health (National Family Welfare Center), the National

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Council on Population and Development and the PSFPP in order to avoid duplication and to provide appropriate contraceptives, if required.

FPIA will provide funding assistance to agencies whose activities either complement the previously mentioned programs or which are implementing unique programs which can point the way for other efforts. Mkomani Harambee Clinic in Mombasa (Kenya-06) will be encouraged to expand its geographical coverage over the next three years by offering voluntary sterilization and other family planning services (including CBD) in areas of unmet need. The Kenya-04 project will continue to provide clinic-based and community-based services in the peri-urban slum of Kawangware on the outskirts of Nairobi and to demonstrate effective techniques for reaching young urban populations in cultural transition. It also is anticipated that FPIA will continue to support the voluntary sterilization and adolescent fertility components of Chogoria Hospital's SIDA-funded, MCH/FP program for two-three years until the program becomes self-supporting.

Over the period 1984-1986, FPIA will phase out several of its projects in Kenya either through outright termination or, preferably, the acquisition of alternate funding sources. Because of Tumutumu Hospital's successful focus on voluntary sterilization, it is expected that IPAUS will provide funds to expand this program and possibly include it in a larger program with the Presbyterian Church of East Africa. The Kenya-05 project in Western Kenya will probably cover its family planning expenses with income generated from other activities or from other donors and, therefore, FPIA funding assistance is being programmed to cease during this period.

LIBERIA

OBJECTIVE: ● The objectives of FPIA activities in Liberia are to fund family planning services in areas of unmet need, to upgrade existing family planning services, to increase emphasis on logistics planning and management in order to create an effective national commodities distribution network and to ensure continuation of service, following phaseout of FPIA support.

Demographic Data

Population (1983) 2,100,000      Population Growth Rate 3.4%  
Fertility Rate 6.9  
Age of Population 48% under age 15 --- 3% over age 64

The Government of Liberia (GOL) recognizes that continued rapid population growth (3.4%) is seriously hindering social and economic development in the country. At the current rate of population growth, Liberia's population of 2.3 million will double in less than 20 years. The government realizes that it is not wise to rely on economic development alone to reduce fertility. Although the government has no official population policy, the existing national policy aims at shifting emphasis from conventional, curative health services, to preventive services, including family planning integrated into existing MCH care.

USAID/Liberia has identified the need for educating GOL officials with regard to the significance of high population growth, and strengthening existing public and private systems for family planning service delivery through PVO input. FPIA-funded activities complement the USAID/Liberia bilateral programs in the fields of primary health care and health management planning.

FPIA has funded a project with the Ministry of Health and Social Welfare (MOH/SW) for four years to provide inservice training to MOH/SW staff on contraceptive commodities to service sites throughout Liberia. An assessment of this project, conducted by FPIA in 1983, indicates several weaknesses that need to be addressed to improve project performance. However, it also pointed out the need for continued assistance in the area of inservice training by the MOH/SW. Moreover, FPIA and the MOH/SW view the development of a strong, reliable contraceptive logistics system as essential to the expansion of family planning services in Liberia. FPIA plans to continue funding the Liberia-01 project and to provide in-depth technical assistance in the areas of contraceptive logistics, supervision, curriculum development and contraceptive technology by FPIA staff

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members and, if indicated, by outside consultants. FPIA will continue to monitor the project's performance and will determine whether the program should be expanded or phased out based on results and the MOH/SW's commitment.

Although FPIA views Liberia-01 as its most significant activity in Liberia, it also funds two smaller projects which can demonstrate, to the GOL, directions which its family planning program should follow. Liberia-03, with the Christ Pentecostal Church, is introducing family planning successfully in an extremely remote, inaccessible community using community-based distribution. Liberia-04, with the Family Planning Association of Liberia, is providing IEC and services to adolescents in the Monrovia area and also is initiating family planning using fieldworkers in rural areas around Greenville.

An additional benefit which has grown out of the FPIA presence in Liberia has been increased coordination and cooperation which FPIA has facilitated between agencies (funded by FPIA) providing family planning services, particularly the MOH/SW and the FPAL. FPIA's long range strategy in Liberia will depend, to a great extent, on the success of technical assistance visits in 1984, the continuing commitment of the MOH/SW and USAID/Liberia's continuing support.

MALAWI

OBJECTIVE: ● ARO will respond to requests from the Government of Malawi and private voluntary organizations in that country to initiate family planning services, to train staff through invitational travel, and to supply commodities. It is expected that ARO's initial, small inputs of training grants and commodities supplies gradually will increase to the point of service delivery project activities and a nationwide commodities distribution activity as the demand increases.

Demographic Data

Population (1983) 6,600,000      Population Growth Rate 3.2%  
Fertility Rate 6.9  
Age of Population 48% under age 15 --- 3% over age 64

Malawi is one of the twenty poorest countries in the world, with a per capita income of less than US\$1,200. Infant mortality is very high, and early child malnutrition is prevalent, particularly in the 6-24 month age group. According to UNICEF, this is partly due to the practice of weaning a child when a woman discovers that she is pregnant. The current population of this small country is 6.6 million, and the estimated growth rate is 3.2% per annum. However, statistics of this nature are not felt to be reliable by international agencies. Census data still are being analyzed, and a number of surveys are being undertaken, including a family formation survey which will be conducted in early 1984 with assistance from the International Statistical Institute in London. External reports on the Malawian health sector have invariably commented on the acute shortage of trained medical personnel, particularly doctors and nurses. This has contributed to an inadequate planning capability within the Ministry of Health and to few Malawian doctors (about 30 out of a total of 150 doctors in the country) being deployed in administrative capacities.

From independence in 1964 up until September of 1982, childspacing was "officially discouraged" in Malawi. The change in the government's policy is believed to be a result of numerous factors, particularly an increased realization of the health risks of failure to space births, as noted in the recommendations of a UNFPA-financed, Ministry of Health-sponsored conference which took place in August 1981. USAID sponsored a RAPID presentation, which also underscored the need for health and population planning, and a number of individuals in the Ministry of Health took courageous actions in the promotion of this important change in attitude. "Child-spacing now is sanctioned

MALAWI

by the government provided it is part and parcel of the country's maternal and child health (MCH) efforts. The Ministry of Health secured a loan of US\$907,000 from the World Bank (as part of a US\$8.8 million loan for various health activities) and is further refining its plan to integrate childspacing with MCH activities. Despite actions which have been taken, childspacing remains a very sensitive subject in Malawi. The society is rural and traditional, and is dominated by men and elderly chiefs who have little understanding of, and many reservations about, modern contraception.

The USAID mission in Malawi is convinced that childspacing is one of the most important areas where development assistance is needed. The mission is committed to childspacing (family planning), but must follow a slow, cautious path which is responsive to the Malawi Government's felt needs and priorities. Without a doubt, this is the only sensible manner to proceed at this time. An USAID/REDSO/East and Southern Africa overview of population and childspacing activities in Malawi recommended that FPIA become involved in the area of contraceptive supplies, technical assistance and, possibly, project support to private groups.

FPIA previously has provided family planning commodities and invitation travel grants for nurses to attend the Margaret Sanger Center's Nurse Practitioner Course and for one representative of the Private Hospital Association of Malawi (PHAM) to attend a Natural Family Planning Conference in Hong Kong.

It is expected that, in 1984, ARO will concentrate on increasing the availability of contraceptives throughout the country and respond to requests for assistance from the MOH, PHAM and private health facilities, particularly with regard to manpower development. Currently, FPIA assistance is anticipated for the MOH to train more nurses in family planning service delivery in order to release the currently overburdened physicians and enable them to train others in family planning. By 1986, we envision that the initiatives undertaken in 1984, and followup in 1985, will lead to FPIA playing a significant role in the delivery of childspacing services in Malawi. There has been an indication of interest on the part of the government to train Traditional Birth Attendants, and to establish a contraceptive supply network and service delivery structure. In the private sector, FPIA plans to assist with natural family planning and other childspacing activities as requested.

MEXICO

- OBJECTIVES:
- To continue assistance to six private sector CBD programs increasing clients served by 10% thereby supporting USAID strategy of promoting the private sector as both an agent for direct service delivery and as a model for larger government programs.
  - To continue to support the Federation of Private Family Planning Associations (FEMAP) in its development and management of subgrants increasing grants managed from 4 to 13, thereby complementing the GOM strategy of promoting private sector service provision and resulting in the transfer of management capability from a national organization to other national agencies.
  - To support the GOM in its goal to reduce the population growth rate to 1.9 by 1988, FPIA will assist:
    - IMSS by funding a physician/nurse/midwife IUD insertion training program;
    - CONAPO by funding a national IEC campaign, and
    - DGPF by participating in funding and improving an internal commodity distribution system.

These activities also support USAID in its priority of supporting public sector programs that utilize the already developed infrastructure.

- To develop projects with the private sector which reach adolescents and the rural population, complementing the GOM's qualitative goal of making service accessible to all Mexican couples and the priority it has placed on serving adolescents.

Demographic Data

Population (1983) 75,700,000      Population Growth Rate 2.5%

Fertility Rate 4.7

|                   |                          |  |                          |
|-------------------|--------------------------|--|--------------------------|
| Age of Population | <u>0-14</u> <u>42.9%</u> | <u>15-49</u> <u>46.1%</u>              | <u>50-64</u> <u>6.8%</u> |
|                   | <u>65+</u> <u>4.2%</u>   | Women of fertile age <u>17,770,115</u> |                          |

MEXICO

The Government of Mexico's family planning program, one of the strongest in Latin America, served 53.4% of total contraceptors in 1982. President de la Madrid has publically proclaimed population programs as a key to the government's economic development plan and as necessary to raising Mexico's standard of living.

Three major public health institutions provide national family planning services: Instituto Mexicano de Seguro Social (IMSS), for non-state salaried workers, with a projected coverage in 1983 of 1,807,682 users; Instituto del Seguro Social y Servicios Sociales de los Trabajadores del Estado (ISSSTE), for mostly urban public-sector workers, with a projected coverage in 1983 of 227,571 users; and Secretaría de Salubridad y Asistencia (SSA), for Mexicans not reached by other plans, with a projected coverage in 1983 of 753,555 users. Government programs are primarily clinic-based and are promoted by mass media campaigns. National population policy is coordinated and implemented through the Consejo Nacional de Población (CONAPO).

Mexico's National Development Plan (1982-1988) calls for: reducing the growth rate according to regions and social groups, from the current 2.5% to 1.9% by 1988; establishing the basis for reaching a growth rate of 1.0% by the year 2000; and achieving a "more rational distribution of the population within the national territory," primarily by reducing the rural exodus to major metropolitan areas. National program priorities for 1983-1988 are: 1) goals establishment; 2) rural areas; 3) youth population; 4) male population; 5) training programs and 6) evaluation. The GOM will seek international financial assistance for service delivery, training activities, social research, biomedical research, and IEC activities. The projected 1988 goal of 4,392,606 users is broken down for each public health network as follows: IMSS - 2,900,049 users; SSA - 1,083,380 users; and ISSSTE - 409,177 users.

USAID's overall strategy is to "strongly but quietly" support the official population policy of reaching a 1% growth rate by the year 2000. The mission plans to achieve this by identifying "targets of opportunity" that are legitimate Mexican institutions capable of carrying out cost-effective population policy, research and service delivery programs. As there is no bilateral program, USAID will meet funding needs through AID contractors. The following have been identified as priorities:

- Increasing the private-sector's role in provision of services and, by virtue of its flexibility, promoting the private sector as a mechanism for improving the cost-effectiveness of public-sector programs;

MEXICO

- Providing support to innovative, public-sector programs that utilize the already developed infrastructure;
- Promoting workshops, seminars, and projects such as RAPID 2 that concentrate on assessing administrative and/or institutional policy barriers that constrain services availability;
- Supporting operations research; and
- Involving local researchers in an international network of biomedical research.

International donors' activities will be channeled into the following areas: FPIA and Pathfinder - broad based service delivery; IPAVS - voluntary sterilizations; John Hopkins - training for clinical methods; CDC and Westinghouse - prevalency surveys; Development Associates - paramedic training; Population Council - population academics; PIP (John Hopkins) - IEC development; and Columbia University and FHI, operational and biomedical research.

FPIA's six private sector, CBD-oriented programs with an aggregate objective of 95,000 users, serve primarily urban and suburban marginal communities:

- Mexico-18 (Monterrey) is FPIA's lowest cost-per-user project in Mexico. A pilot for the integration of private-sector activities with the public health structure, it has served as a model for new project initiatives throughout the country.
- Mexico-20 (Matamoros) has been instrumental in creating the Consejo de Planificación Familiar del Noreste, a local non-profit organization designed to coordinate goals and better utilize family planning resources in the area. Through cooperative agreements with SSA, it provides integrated MCH and medical services to marginal communities.
- Mexico-22 (Coatzacoalcos), by coordinating family planning activities with DIF health centers and the Civil Hospital, is able to provide integrated health services to its clients. It also has introduced a family planning component to SSA's health delivery posts in rural areas.
- Mexico-23 (Celaya) will introduce cost-effective models by initiating and administering four satellite programs in out-lying towns. It also is establishing a clinic with local resources. The project director has strong support from local and state officials and was responsible for two new project initiatives in the state.

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- Mexico-24 (Ciudad, Juarez) introduced CBD delivery in Mexico and serves as a model for other PVO-funded programs throughout the region. Highly innovative and successful, it is the only FPIA project with a commodity distribution objective, commercial retail sales, and rural area components.
- Mexico-26 (Mexico City), a roll-over of Mexico-03, will reach an estimated 25,600 new users. The project is unique in that it directs its efforts towards young adults (ages 16-24). The project will interact with local organizations to develop a support network specifically designed for youths.

In addition to these six private-sector agencies, FPIA funds Mexico-25 (The Federation of Private Family Planning Associations), the first project in Latin America that will initiate, fund and manage four subprojects in cities with 100,000 or more inhabitants.

FPIA's six CBD-oriented projects serve as examples of how PVO funding to private associations can complement a strong public-sector population policy. They have been successful because they respond in innovative ways to the need for family planning and have the support of local public institutions. Mexico-25 complements the GOM strategy of promoting the private sector's role in the provision of services. In addition, it serves as an innovative project design for the transfer of management technology from a national organization to other national agencies.

FPIA's strategy over the next three years is to continue funding for the six CBD projects and to expand FEMAP enabling it to develop 12-14 new subprojects. This strategy dovetails with USAID's in that it promotes the private sector as an agent for direct service delivery and as a model for larger government programs.

FPIA believes that good national programs are a mix of public and private activities. Therefore, direct funding will be provided for three public sector programs. FPIA will work with IMSS in a service project designed to reach post-partum and rural women. This project is expected to increase IMSS service delivery. Assistance also will be provided to CONAPO and DGPF's education and promotional efforts, supporting the GOM's strategy of providing appropriate family planning education for the Mexican population.

FPIA also will develop a new project which will serve adolescents, providing an additional model for cost-effective service and supporting the GOM's goal to reach adolescents.

NEPAL

- OBJECTIVES:
- In response to His Majesty's Government's Five Year Plan which called for a reduction of the birth rate from 40 to 38 per 1,000 by 1985, and emphasized the importance to this effort of class organizations, NGOs, local panchayats and the improved status of women, FPIA will provide continued funding to expand the geographic coverage of such agencies and involve more women in the provision of services. FPIA is planning an estimated commitment of \$1,175,859 resulting in service to about 235,000 clients by the close of 1986.
  - In accordance with Nepal's population program priorities to upgrade the skills of personnel involved in providing family planning services, FPIA will provide family planning training opportunities to 12 NGO or class organization officials to improve their management or technical skills in family planning.
  - In response to FPIA's mandate to provide short term funding, FPIA will investigate income generation possibilities and continue to coordinate with international donor agencies and His Majesty's Government (HMG) regarding potential sources of ongoing support for those projects that successfully institutionalize their family planning services.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>15,800,000</u>       | Population Growth Rate | <u>2.3%</u>           |
| Fertility Rate    | <u>6.5</u>              |                        |                       |
| Age of Population | <u>42% under age 15</u> | ---                    | <u>3% over age 64</u> |

Nepal's current Five Year Plan (1980-1985) has as its population goal, the reduction of the birth rate from 40 to 38 per 1,000 by the end of the plan period through a significant increase in the current low (7%) contraceptive prevalence rate. To reach this goal, HMG has the following program priorities: to integrate family planning into development projects; to emphasize programs that help to raise the status of women; to integrate family planning with MCH; to involve in the family planning effort class organizations (ESO, Women's Organizations, Youth Organizations, Peasants' Organizations and Labor Organizations), NGOs, and local panchayats through training and program implementation; to control immigration; to train physicians/paramedical staff in family planning skills; to increase incentives to family planning physicians; to increase the number of facilities

NEPAL

providing voluntary sterilization; to popularize temporary methods; to stress self-reliance through CRS; and to increase IEC and client follow-up.

USAID's involvement in HMG's policies and family planning activities is close, as the mission funds significant segments of the government's major family planning and health service projects (Family Planning and Mother and Child Health Project, and Integrated Health and Community Program), family planning personnel training, research, and contraceptive supplies and logistics.

Both HMG and USAID actively support and oversee NGO involvement in Nepal's family planning program as both view community-based organizations as providing key leadership in changing attitudes necessary for the acceptance of family planning. The current nongovernmental sector involvement in family planning has three major components:

- 1) Voluntary sterilization services through FPAN clinics (FPAN receives IPPF and IPAVS funds);
- 2) A CRS project to distribute contraceptives in scattered areas throughout Nepal and to use mass media to advertise the availability of these contraceptives (CRS is a semi-private organization receiving USAID support); and
- 3) NGO and class organizations, IEC, CBD and sterilization referral projects funded by FPIA to provide family planning and MCH education in underserved districts scattered throughout the country.

FPIA, in response to the family planning needs of Nepal, began programming in 1974 and has provided, through project and training support, a total of \$943,246. This support has concentrated on the development of viable NGO service institutions and the utilization of existing networks to provide local leadership in support of family planning. The majority of FPIA-funded service sites are in remote rural areas where regular government health and family planning outreach has yet to be established. FPIA has funded organizations of women, youth, ex-servicemen (Gurkas), and Red Cross members.

FPIA's further role will be to continue assisting HMG to reach its remote, often illiterate, and underserved population with IEC, community-based delivery of conventional contraceptives, and referrals for clinical methods. FPIA plans to expand the geographic coverage of the Ex-Servicemen and the Red Cross projects, phase out the Mother's Club project which, to date, does not appear to have the capacity for expansion, and fund one additional agency emphasizing the involvement of women in family planning. In these future projects, the possibility of adding components of IUD training, service and follow-up through a camp system will be considered as will improving IEC for other temporary methods.

NIGERIA

OBJECTIVE: ● FPIA plans, within budgetary constraints, to be responsive to USAID's increased emphasis on Nigeria by focusing on areas where FPIA possesses special expertise, namely: (1) increasing availability of contraceptives through commodity shipments and technical assistance; (2) assisting in initiating and improving the quality of services, particularly in private sector organizations such as mission hospitals and through community-based programs; and (3) assisting selected in-service training programs combined with community and clinic-based service delivery components.<sup>1/</sup>

Demographic Data

Population (1983) 84,200,000      Population Growth Rate 3.3%

Fertility Rate 6.9

Age of Population 48% under age 15 --- 3% over age 64

AID's Nigeria Strategy was drafted in November 1982 and will be updated in early 1984. It reflects AID's desire, based on the conclusions of the Washington Working Group on Nigeria (WWGN), to assist the Nigeria mission to marshal AID resources for the Nigeria population program. The AID strategy takes note of the fact that demographic data for Nigeria are approximate and that the National Population Commission (NPC) considers improvement, collection and analysis of such data to be a high priority. The strategy also notes that despite a high GNP, basic health indicators are low, particularly among women and children. Population pressures are evident, particularly in cities where there is a great deal of unemployment and underemployment. Nigeria, which was once an exporter of food, is no longer self-sufficient in agriculture.

Currently, Nigeria does not have a clearly articulated population policy. The Nigerian Government's position on population is seen to be evolving, with relatively strong statements on the need to decrease family size being included in the Fourth National Development Plan (1981-1985). Although private organizations operating in Nigeria (UNFPA, the PPFN, etc.) have enjoyed government support, it is unclear how the division of responsibility re family planning service delivery will be made at government levels. It appears that family

<sup>1/</sup> It is difficult to formulate a firm strategy for Nigeria at this point because both the funding situation (i.e., AID-funded PVOs and USAID bilateral involvement in Nigeria) and the political situation (following a military coup d'etat December 31, 1983) are in flux.

NIGERIA

planning, provided through the Primary Health Care Program (initiated in 1981), will be shared by the Federal and State Ministries of Health and the NPC. The Director of National Health Planning is committed to the expansion of family planning services. A number of Nigerian leaders also are openly supportive of family planning, but it is not clear what the new military government's position will be. Although Moslems (47%) and Catholics make up a significant proportion of the population, religious leaders have, by and large, not been outspoken against family planning. The Christian Council of Nigeria has stressed the need for family planning. The Planned Parenthood Federation of Nigeria (PPFN), an IPPF affiliate, is one of the main advocates for family planning in Nigeria, but stresses appropriate cultural contexts and places emphasis on health benefits.

The Nigerian social environment is characterized by a population which has a low level of literacy (between 25-35%), places a high value on children (desired number averages 6-8), accepts "traditional methods" (prolonged lactation and abstinence), has a low-level knowledge and practice of modern contraception, and has increasing awareness of the advantages of limiting fertility, particularly in urban areas. The Nigerian Fertility Survey (NFS) Preliminary Report (March 1983) indicated that child mortality is dropping significantly, whereas fertility rates continue to be high. At the time of the survey, contraceptive use was almost negligible, with 14 per cent of the sample never using and only six per cent of married women currently using any form of contraceptive. The NFS, which is part of the World Fertility Survey, concluded that the currently high level of fertility is likely to continue for some time.

Currently, external donor family planning activity in Nigeria is minimal, apart from the IPPF program. The UNFPA budget recommendation was for over \$17 million, but only about \$400,000 actually was allocated. There are a fair number of small projects, many of them operations or demographic research. They are funded both by local agencies (NISER, NPC, Universities of Benin, Ife, Ibadan and Lagos) and by external agencies (RTI, FHI, Columbia University, WHO, Batelle, etc.). Training, mainly of doctors and nurses, has been conducted through U.S. and Nigerian universities, with funding (mostly via AID) from Pathfinder, FPIA, University of Chicago, JHPIEGO, INTRAH, etc. The AID strategy statement notes that: "There may be little, among the options we can influence, that is more effective to increase demand for family planning services than to make them readily available." AID believes that the major focus of its strategy consideration should be in the areas of increasing availability of family planning services. This is consistent with FPIA's philosophy, as well as conforming to FPIA's experiences, on a small scale, in Nigeria and other African countries. FPIA, therefore, will concentrate its efforts on activities which result in increased availability of services.

NIGERIA

FPIA presently funds three projects in Nigeria. These projects are concentrated in the densely populated Oyo State. The major objective of Nigeria-04, with the University of Ife, is to increase the number of clinic-based service delivery points and to initiate a depot holder program. The project also provides in-service training for nurses and has implemented a strong income generation (through the sale of contraceptives) program and a small community-based distribution scheme. Nigeria-10, with the Baptist Hospital, Ogbomosho, plans to strengthen its voluntary sterilization program and provide other family planning services in three outlying dispensaries. Nigeria-12, in Ibadan, with the Nigerian Association of Sports Medicine, provides counseling to young adults, IEC in area schools and family planning services and contraceptives to adults and young adults at a youth center and at various service points outside of Ibadan. Although FPIA's currently funded projects in Nigeria are small, each incorporates highly significant approaches to the successful delivery of family planning services.

In late 1983, FPIA staff worked with a team (from CDC/Pathfinder/FPIA/APHA) which explored ways and means of increasing the flow of contraceptive commodities to Nigeria, projected contraceptive commodities requirements and suggested possible venues for such shipments. FPIA will facilitate AID-initiated contraceptive commodities shipments to Nigeria in 1984-1986 and expects to continue to be active in contraceptive commodities logistics, technical assistance and shipments both to the private and public sector.

In early 1984, FPIA plans to work with the Lagos State Ministry of Health to develop and fund a project which will strengthen services in Lagos State through in-service training of staff and assistance in logistics and service delivery. FPIA also will make exploratory new project development visits to Nigeria, focusing on community-based and/or private sector projects. Finally, FPIA will participate in coordination and planning activities in Nigeria and in Washington, designed to prevent duplication and to make optimum use of scarce human and financial resources.

PAKISTAN

- OBJECTIVES:
- To support the Government of Pakistan in its new policy of strengthening voluntary agency involvement in the country's family planning program (designed to reduce the birth rate from 40.3 to 36.2 per 1,000), FPIA will provide support to 23 major NGOs in 325 locations throughout Pakistan through a member agency association. The estimated FPIA commitment will be \$670,680 through 1986 and result in service to 81,945 clients by the end of the period.
  - To build a local management capability in planning, administration, performance assessment and financial management skills, provide outside training opportunities to 15 NGO and GOP officials involved in the NGO program, and to provide \$7,500 of small grant support in local training of leaders involved in the establishment of the NGO Coordinating Council.
  - In recognition of FPIA's mandate to provide short term funding, to coordinate closely with the GOP to secure government and other international donor support for the continuation of the successful service sites of the NGOs receiving support to initiate family planning programming.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>95,700,000</u>       | Population Growth Rate | <u>2.8%</u>           |
| Fertility Rate    | <u>6.3</u>              |                        |                       |
| Age of Population | <u>45% under age 15</u> | ---                    | <u>3% over age 64</u> |

After determining that the government's family planning programs of the last ten years had not been successful, new leadership in the Planning and Development Ministry developed a strong population policy for the sixth five year plan (1983-1988). The population goals of this plan are to raise prevalence from 6.8% to 18.6% by 1988, to provide MCH services, to reduce the birth rate from 40.3 to 36.2 per 1,000 and to reduce population growth from 2.8% to 2.6%.

The government plans to reach these goals by significantly increasing NGO outreach/IEC involvement, developing support of multisectoral linkages, encouraging local participation, training personnel in other government programs in family planning/MCH, undertaking bio-medical research to improve methods of family planning and undertaking social and demographic research to improve understanding of fertility decline correlates.

PAKISTAN

For the 1980-1984 period, the USAID mission has provided \$28 million to support activities of the GOP population plan. These activities include evaluation, training, research, contraceptive supplies and logistics.

Recognizing that earlier government programs have not been successful, the mission strongly supports the government's stated goal to increase NGO involvement. Because the mission does not have funds approved for program support for family planning services, it has encouraged centrally funded agencies to program in Pakistan and to provide technical assistance to the government as it organizes the voluntary sector for involvement in its family planning program.

Current NGO involvement in family planning is concentrated in the Family Planning Association (FPAP), which basically initiated the family planning movement in Pakistan. FPAP has a varied program with service areas throughout the country. Besides its independent clinics and service centers, FPAP has provided contraceptives and service grants to other NGOs wishing to add family planning services to their other activities. Before the government introduced new leadership into the family planning program, FPAP was targeted to coordinate all NGO involvement in family planning. Under the new leadership, FPAP will continue its role as a service provider. The NGO Coordinating Council, headed by the Minister, himself, will provide the necessary coordination. FPIA was the first funding agency to follow the Coordinating Council's procedures in negotiating a proposal for NGO support.

While FPIA discontinued support to Pakistan from 1980 to 1984, FPIA did support, during the period 1975-1979, two urban CBD programs in large slum areas, and one rural family planning clinic which utilized traditional village agents as outreach personnel. Financial support provided during this period totaled \$302,997.

Recently, FPIA was invited by the GOP to resume support to Pakistan by providing funds and project planning assistance to NGOs recommended to FPIA by the NGO Coordinating Council. FPIA has proposed support for an association of voluntary health and social service agencies to coordinate with its member agencies the addition of a family planning IEC and service component to their current programs. If this project proves successful, FPIA will expand its support to Pakistan's voluntary agency effort in family planning through this coordinating agency, and will expand the sites involved in the program and develop the management of this coordinating unit through training opportunities and technical assistance.

FPIA also has discussed assistance to the GOP in developing its NGO Coordinating Council through small grants and invitational travel.

PERU

- OBJECTIVES:
- To extend family planning services to new geographic areas and groups by:
    - developing a project in Puno to reach the largely unserved Indian population.
    - expanding Peru-18 to work in new areas up to thirty miles outside of Lima.
  - To support the USAID mission's goals of encouraging use of private sector resources to complement national initiatives, FPIA will fund APROPRO\* to develop a plan of action (and later a project) which will involve the industrial/private sector in family planning IEC, service and training.
  - To increase the Trujillo (Peru-09) project's interaction with and support of MOH health posts, resulting in the government's gradual assumption of the family planning service components in those posts.
- \* Apoyo a Programas de Población

Demographic Data

|                   |                   |                        |  |
|-------------------|-------------------|------------------------|--|
| Population (1983) | <u>19,200,000</u> | Population Growth Rate | <u>2.8%</u>  |
| Fertility Rate    | <u>5.0</u>        | Unmet Need             | <u>54% of WOFA at risk -- 32% use no method and 22% use traditional or ineffective methods</u> |
| Age of Population | <u>0-14 42.3%</u> | <u>15-64 45.4%</u>     | <u>65+ 3.4%</u>  |

A full scale Peruvian Government program remains in the planning stages. However, since the Bermudez administration adopted a national population policy, as part of 1975-78 National Development Plan, a reported 32% of Peruvians now obtain public services (28% MOH posts, 1% Social Security Offices and 3% other government-run outlets). These services legally are limited to voluntary surgical sterilization and IUD insertion, with the majority of temporary method users (urban or rural) relying on private sources. With multi-lateral assistance from UNFPA and the WHO, and with bilateral assistance from USAID, the government has been carrying out demographic studies, training MOH personnel, and stockpiling commodities in anticipation of launching an integrated MCH/FP program on a national scale. In the meantime, most public health posts do not offer contraceptives and stockpiled commodities lie in regional MOH warehouses.

PERU

In 1981, the Belaunde government set up the National Population Council (NPC). The purpose of the NPC was to determine the best means of implementing a national level family planning program and to coordinate public and private family planning resources to meet that end. In June, 1983, representatives of the NPC presented the "Future Population Programme" at the UNFPA meeting on the Peru Needs Assessment Report. The program involves five basic components: data collection and analysis, analysis of population dynamics, policy formulation, family planning program development and IEC activities. Both Peruvian law and the NPC require that family planning services be integrated with MCH, nutrition, food distribution, or rural development programs. Apparently, no freestanding operations will be sanctioned. It is estimated that the program will require \$12,213,000 from 1984 to 1987.

Another variable which will affect government plans and USAID strategy is the anticipated \$30 million World Bank integrated health program. This program may take responsibility for the national program in the regions in which it operates.

The USAID mission strategy involves supporting the National Population Council's initiatives by providing bilateral assistance and by coordinating private FPAs\* and international donor agencies. In 1984, the USAID bilateral program will continue to provide significant funding and material assistance to the MOH and the NPC to extend integrated MCH/FP services to low income zones of urban areas. It is probable that this program, initiated in 1981, will soon involve the development and implementation of a national-level CRS project as well as financing of a PCS-assisted national IEC campaign. USAID also will encourage better use of private sector resources to complement the national program's public sector allotting \$150,000 for FPIA use in supporting an institution building project with the APROPRO group. USAID views this group of prominent private sector leaders as a prime potential motivator of that sector with its considerable resources and political influence.

UNFPA, USAID, IPPF and FPIA are involved in direct service provision in Peru. DA has provided training for CBD fieldworkers and nurse midwife interns, and FHI is funding contraceptive and female sterilization studies. During 1984, IPPF program objectives include serving an estimated 39,000 clients complemented by FPIA projects which will serve approximately 45,000 new and continuing users.

Currently, FPIA funds three projects in Peru, two in Lima and one in the northern coastal city of Trujillo:

\* Family Planning Agencies

PERU

- Peru-06, with the Department of Ob/Gyn - Universidad Cayetano Heredia, is FPIA's oldest Latin America project. It trains medical students in family planning and mini-laparotomy and has a large service component reaching 15,100 clients. The project, funded since 1973, was recently extended an additional sixteen months at USAID/Lima's request.
- Peru-09, with the MCH Department, Ob/Gyn Section, Universidad de Trujillo, has expanded from its central clinic to include a dynamic CBD model in Trujillo's marginal communities. During this funding period, the project will expand to encompass 120 CBD posts. The regional MOH and USAID have expressed interest in taking over this project.
- Peru-18, with APROSAMI, has quietly established a system of over 100 CBD posts located in nine of Lima's poorest zones. It has one of the lowest costs per user (\$1.60) in Latin America. A recent assessment conducted by USAID was most favorable re the work of this project.

FPIA's recent strategy in Peru has been to fund low cost, income generating, community-based distribution programs suitable for replication on a national or regional scale. This strategy has been successful as witnessed by the interest shown by USAID and the MOH in taking over FPIA's CBD projects.

Over the next three years, FPIA's program will continue to support CBD programs in Peru. Our strategy will expand to support USAID goals and the plans of the National Population Council.

1. FPIA will fund APROPO to develop a plan (and later a project) which will involve the Peruvian private sector in family planning. A key group composed of representatives from the industrial and financial community will be assembled to plan a definite role for the private sector from IEC, to training, to service delivery, to commodity distribution involving pharmaceutical companies in commercial retail sales. This project supports the mission in its goal to encourage private sector initiatives to complement the national program.
2. FPIA will work with Peru-09 to increase the project's interaction with and support of up to thirty additional MOH Health posts. Family planning services will be initiated at posts and the MOH will take-over the contraceptive component. This supports the goal of the National Population Council (NPC) to "better use existing facilities by incorporating family planning into their regular activities."

PERU

3. FPIA will extend family planning services to new geographic areas and groups. A project will be developed in the Lake Titicaca region which will serve the Puno Indians, an unserved segment of the Peruvian population. Additionally, Peru-18's CBD program will expand to reach the population up to thirty miles outside of Lima. This supports the NPC in its goal of "increasing IEC and service to rural areas," and the mission's intent which is to bring family planning to "pueblos jovenes" which are expanding around urban areas.

SENEGAL

OBJECTIVE: ● FPIA will complement USAID's bilateral assistance to Senegal and the assistance provided through the IPPF affiliate by responding to requests from institutions in the private sector to initiate and/or expand family planning services and to supply commodities.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>6,100,000</u>        | Population Growth Rate | <u>3.0%</u>           |
| Fertility Rate    | <u>7.1</u>              |                        |                       |
| Age of Population | <u>45% under age 15</u> | ---                    | <u>3% over age 64</u> |

Senegal is a small country (196,192 sq. kms) with a population estimated at six million. The annual population growth rate is about 3%. Although the Senegal World Fertility Survey (1978) reported that half of all women were married by 15.6 years of age and that the average parity of married women was over seven, there is some indication of increasing contraceptive practice, particularly in urban areas. The IPPF sub-regional office in Dakar estimates prevalence of modern contraceptives at about 2%. Contraceptives are widely sold in pharmacies, although they are expensive. The IPPF affiliate, "Association Senegalaise Pour le Bien-Etre Familial (ASBEF)," which receives support from the Government, IPPF and USAID, reports that its "model clinic" is increasingly well patronized. Many individuals report using traditional methods (such as withdrawal), but illegal abortion also is a growing problem, as evidenced by increasing press coverage. Senegal is one of the few African countries where a multiparty democratic system is institutionalized. In Senegal, individuals and organizations are free to initiate health and development projects without interference from the government. On the other hand, with a population which is 80% Muslim, the government is understandably hesitant to openly espouse family planning or a population policy. Still, the government has provided assistance to ASBEF and has indicated its support for integrated MCH/FP by entering into a bilateral agreement with USAID/Senegal for a training and service program jointly administered by the Ministry of Health (MOH) and the Ministry of Social Services (MOSS).

The USAID mission in Senegal has been supportive of FPIA initiatives to complement bilateral efforts through projects in the private sector. During a visit in October 1982, FPIA discussed its strategy with USAID representatives and obtained concurrence to fund a small grant to the National Council of Negro Women, International Division, West African Regional Office. Through this grant, FPIA sponsored a workshop for the "Federation des Associations Feminines du Senegal" in project design. The workshop assisted representatives of these

SENEGAL

associations to prepare and submit project proposals for FPIA-funding consideration. It is anticipated that these projects eventually may be combined to form one single large project under the auspices of the Federation. FPIA also will work with the "Federation des Association Feminines du Senegal," to increase family planning awareness and usage through IEC activities in urban, peri-urban and rural areas. A commodity distribution program may be developed with the Federation or one of its member associations.

FPIA will maintain close relations with the National Council of Negro Women with a view to utilizing this organization's capabilities in management technical assistance to FPIA-funded projects in Senegal and elsewhere. FPIA also may work with other organizations (such as Church World Services, Association Protestant d'Entraide de Dakar and Confederation Nationale des Travailleurs du Senegal) and will respond to requests to provide commodities, logistics technical assistance (particularly with the USAID Family Health Project) and training in family planning techniques.

SIERRA LEONE

OBJECTIVE: ● During the period 1984-1986, existing family planning services provided by a nongovernmental institution (the Sierra Leone Home Economics Association, SLHEA) will be extended to new geographic areas in order to complement services offered by the Government of Sierra Leone (GOSL) and the Planned Parenthood Association of Sierra Leone. In addition, it is anticipated that management technology will be transferred to the SLHEA in order to enable this agency to administer a country-wide commodities distribution system by 1986.

Demographic Data

Population (1983) 3,800,000      Population Growth Rate 2.8%

Fertility Rate 6.1

Age of Population 44% under age 15 --- 3% over age 64

Although the GOSL has not enunciated an official population policy, the favorable reception given Ms. Faye Wattleton, President of the Planned Parenthood Federation of America, in late 1982 by President Siaka Stevens, and the subsequent establishment of a National Population Council indicates its growing awareness of the potential problems posed by an annual 2.8% population growth rate. In addition, USAID/Sierra Leone is concentrating its limited resources on improving health delivery systems through a Family Health Initiatives Project and has stated its positive support for PVOs to take direct action in the family planning field.

FPIA currently is funding two projects in Sierra Leone. Sierra Leone-04 (Nixon Memorial Hospital) offers voluntary sterilization and other family planning services in an up-country area that was previously unserved. The present program with the SLHEA is anticipated to expand its activities as a roll-over project (Sierra Leone-05). Its current counseling and IEC programs will be extended beyond the Hastings Peninsula where the country's capital (Freetown) is located, to gradually encompass all of Sierra Leone. In addition, the project is expected to add prescription methods to the range of contraceptives it already supplies, and to initiate community-based distribution in major population centers. In order to streamline FPIA's operations in Sierra Leone, FPIA hopes to amalgamate the Sierra Leone-04 project with Sierra Leone-05.

SOUTH PACIFIC

- OBJECTIVES:
- In response to the rapidly increasing population growth rate in the four largest countries in the South Pacific, FPIA will shift its support to contraceptive and educational materials distribution as project activities are phased out. The actual market for contraceptive distribution will be defined by the close of 1984.
  - Continue to provide skill development training in the development and management of family planning programs. Between 1984-1986, FPIA will provide training opportunities for up to ten government and NGO leaders.
  - In accordance with FPIA's mandate to provide short term funding, continue to coordinate with USAID mission and other national and international donor agencies to investigate continuation funding beyond FPIA's period of anticipated support for those projects that successfully institutionalize their family planning services.

Demographic Data

| <u>Country</u>   | <u>Population (1983)</u> | <u>Growth Rate</u> | <u>Fertility Rate</u> |
|------------------|--------------------------|--------------------|-----------------------|
| Fiji             | 700,000                  | 2.5%               | 3.6                   |
| Papua New Guinea | 3,079,000                | 2.5%               | 6.3                   |
| Solomon Islands  | 300,000                  | 3.5%               | 6.2                   |
| Vanuatu          | 114,500                  | 2.8%               | -                     |

Of the nine countries included in the USAID South Pacific Country Development Strategy Statement (1983-1987), four have manifest population problems. These four also have the largest populations in the South Pacific. They include: Fiji, Papua New Guinea, Solomon Islands and Vanuatu.

A summary of the status given to family planning, by three of these nations, follows. Also, included is the Tongan Government position on family planning. Tonga is one of two islands that has included population in its development plan. The other is the Solomons. The Vanuatu Government has adopted a neutralist stance regarding population.

- Fiji

Family Planning is the primary responsibility of hospitals and field staff. Motivation of new family planning acceptors is carried out during antenatal and postnatal consultations. The government encourages involvement of NGOs in family planning.

SOUTH PACIFIC

● Papua New Guinea

There is no stated government policy on population. Family planning services are available, free of charge, at all government facilities established for MCH services.

● Solomon Islands

The 1980-1984 National Development Plan expresses an intention to reduce the annual population growth rate to 3%, but no strategy to accomplish this was spelled out. Current emphasis is placed on health education to create demand for family planning services.

● Tonga

The Fourth Development Plan (1981-1985) aims at reducing the birth rate to 2.5% by 1985. The strategy is to improve the quality of family life through education and opportunities for families to be planned. Family planning is part of an integrated MCH/FP program carried out by 29 public health nurses from four hospitals and six health centers.

USAID's South Pacific Strategy Statement for FY 1983 states the following: "The South Pacific Regional Development Office plans to expand its role in this area through requests for increased central funding to Family Planning International Assistance (FPIA). The organization... appears to have the best combination of attributes: flexibility in programming, capacity to monitor and presence in the region. FPIA also has the interest and ability to continue to develop support activities for other private and voluntary organizations in the region including selected government and regional agencies."

More recent information on the mission strategy for family planning will be obtained in 1984.

There are IPPF affiliates in PNG (two offices), the Solomon Islands, Fiji and Tonga. These affiliates are monitored by the FPA in New Zealand. Programs in each location generally are clinic-based with education and some outreach components. Missionary hospitals on each island generally provide family planning services through their health networks. Catholic service programs in Tonga and the Solomons provide NFP.

In the face of minimal government intervention re population and family planning programs, and with the encouragement of USAID, FPIA has responded to the rapid population growth of the South Pacific by concentrating programming efforts in the four largest countries.

SOUTH PACIFIC

Pioneering CBD efforts are supported with SIPPA in the Solomons and Soqo Soqo Vakarama in Fiji. Youth programming and IEC materials development have been financed in PNG. Total project assistance over the past six years is valued at \$503,792. The value of commodities provided is valued at \$161,089.

After three years of full programming in the South Pacific, FPIA expects the Fiji Government to assume the CBD efforts of Soqo Soqo by the end of 1985, and the IPPF program in the Solomon Islands to absorb the CBD activities in 1984. The PNG materials development project will be completed in 1984, and the Lifeline youth program is actively fund raising to find alternative project support no later than early 1986. It is expected that FPIA programming in the South Pacific will have greater impact over the next three years with a shift from project financing to regional commodity and educational materials distribution. To be cost effective, a recipient agency must be located which has implementation capability on at least four to five islands. Implementation involves receipt of the commodities, distribution and monitoring. A secondary purpose of the project would be to also make educational materials available; these materials would include information on NFP. It is expected that this project will be underway by mid 1985 and, by early 1986, will displace project work currently being supported.

Over the next three years, FPIA will continue to make training opportunities available to actual and potential family planning service providers from the Islands. Five will attend the PCF adolescent training seminars and five will be trained in family planning management at PDA.

SRI LANKA

- OBJECTIVES:
- Responding to Sri Lanka's plateaued prevalency level (30%), the government's emphasis on voluntary sterilization and the differential birth rates in various geographical areas, FPIA will concentrate support to its two current grantees for temporary methods programming in geographical areas of greatest need.
  - In addition, FPIA will identify a new organization to work with young couples in education and temporary methods service with an estimated commitment of \$165,000.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>15,600,000</u>       | Population Growth Rate | <u>2.2%</u>           |
| Fertility Rate    | <u>3.6</u>              |                        |                       |
| Age of Population | <u>35% under age 15</u> | ---                    | <u>4% over age 64</u> |

Sri Lanka has a birth rate of 27.6 per 1,000 which has only declined by 1.8 points since 1960. This minimal decrease can be accounted for by the large increase, in the same period, of women in the reproductive age group.

The GOSL recognizes that population growth causes impediments for development and, therefore, will provide needed family planning services. For those utilizing voluntary sterilization, reimbursements covering costs due to loss of work and travel are provided by the government. The GOSL operates a widespread FP/MCH program through government clinics and hospitals with multipurpose outreach health workers. This service currently is being upgraded through an increase in the number of multipurpose workers and an improvement in their training.

Voluntary sterilization has been selected as a major program priority and, as a result, insufficient attention has been given to educating couples regarding birth spacing as an alternative. Thus, a growing number of young couples are postponing the practice of family planning until they have achieved a desired family size.

After a recent review into the viability of providing AID bilateral family planning support, the mission's current view is that the GOSL does not wish to receive support due to its other development program priorities. Thus, the mission has encouraged FPIA to continue its programming, particularly in high birth rate areas and particularly for increasing acceptance of temporary methods.

SRI LANKA

Sri Lanka has an active NGO program although it is limited to only a few major providers. Currently, there is only minimal coordination or overview provided by the government to the NGO sector. However, there is a government council established to fulfill this function.

The Family Planning Association of Sri Lanka operates a rural, community outreach program, staffed by volunteers, and a nationwide CRS program. FPASL receives support from IPPF. The Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC), funded by IPAVS, provides IEC and motivation for sterilization, and serves in a leadership role to establish medical and counseling standards for the sterilization services provided in the country.

Two other agencies, Population Services and Community Development Services, also provide family planning services and are funded by FPIA. FPIA initiated support to Sri Lanka in 1974 and, subsequently, has provided \$465,685 of funding for community-based family planning services and referral. In the past, FPIA support has emphasized both voluntary sterilization and temporary methods. Most recently, this support has emphasized temporary methods to meet the current need in Sri Lanka for these services.

Recognizing the important role NGOs may have in assisting the Sri Lankan family planning program to broaden its service base, FPIA will continue to support Population Services and Community Development Services in their efforts to provide CBD programs in areas with particularly high birth rates. In addition, FPIA will assist both agencies to continue these services with reduced support from FPIA. In the case of CDS, FPIA is supporting an income generation chicken farm. In the case of Population Services, FPIA support for small organizations to provide CBD is planned around the use of CBD workers for 2-3 years, followed by a depot supply system.

In order to focus on the family planning needs of young married couples, FPIA will identify a new agency already serving young people, and discuss the possibility of developing a temporary methods family planning component with that agency.

FPIA also will discuss with the GOSL the possibility of FPIA support for enhancing the activities of its NGO Coordinating Board so as to better utilize the efforts of the NGO service providers.

SUDAN

OBJECTIVE: ● FPIA will fund agencies to establish new family planning service models and to ensure the provision of services to peri-urban and urban areas. FPIA also will respond to requests for the transfer of management technology and family planning commodities. The focus of FPIA's efforts will be on contraceptive supplies and logistics, both in the public and private sector (Southern Sudan). Projects in other areas are expected to strengthen/balance and complement FPIA's program in the Sudan.

Demographic Data

Population (1983) 20,600,000      Population Growth Rate 3.0%  
Fertility Rate 6.6  
Age of Population 44% under age 15 --- 3% over age 64

Sudan is the largest country in Africa with an area of about one million square miles, a population of over 20 million people and a rate of natural increase of 3.0% per year. The Government of Sudan has expressed satisfaction with the current rate of natural increase and fertility. However, it does support family planning information and services as part of its maternal and child health program. The Government of Sudan also encourages research into the interrelationship between economic development and population trends with a view towards identifying components of a sound population policy.

The USAID mission considers that there is a need to make low cost health care services, nutrition and family planning information available to the rural poor. However, due to infrastructural deficiencies and Sudan's vast size and highly dispersed population, provision of health services is currently a costly undertaking. In order to reduce costs, USAID proposes that regional and provincial level staff be strengthened and that there be greater involvement of potential beneficiaries. Contraceptive logistics is a high priority in the Sudan. FPIA has responded with a project to assist the National MCH/FP Project to establish a national contraceptive distribution network. This program will ensure supplies to government family planning service providers throughout the country. The USAID mission also is proposing a Contraceptive Retail Sales program with People's Pharmacies throughout the country.

The proposed Sudan-04 project with the University of Gezira in Wad Medani (a rural community), is expected to demonstrate an innovative service delivery model which may be replicated in other rural areas. This project is particularly significant because it responds to GOS and USAID concerns that too much donor assistance is being provided in urban areas around the capital and too little in rural communities.

SUDAN

The program will train Traditional Birth Attendants to provide community-based information and services.

The Sudan-02 program in the peri-urban slum area of Hag Yousef has taken steps towards initiating a community-based distribution program in its catchment area. The program is expected to expand to other industrial slums and may be rolled over in 1986 depending on significance and performance indicators. The project is providing services to a very large community which has little access to health facilities.

By 1986, FPIA-funded activities initiated in 1984 are expected to be functioning smoothly and serving increasing numbers of people throughout the country. In addition, contacts obtained through commodities shipments (initiated in 1983) to four refugee groups in Southern Sudan (Lalmba Association, Sudan Council of Churches, International Rescue Committee and Save the Children Fund) may result in program and commodities assistance to this underserved region. Coordination with the United Nations High Commissioner for Refugees in the Sudan will facilitate this development. FPIA's approach to program development and technical assistance will enhance the transfer of management technology required to strengthen institutional capabilities for the delivery of family planning services in the Sudan. This is a key area of need, particularly in government programs.

SWAZILAND

OBJECTIVE: ● The objectives of FPIA activities in Swaziland are to fund family planning services in areas of unmet need through assistance to the Family Life Association of Swaziland (FLAS) and to ensure the continuation of services following phaseout of FPIA support.

Demographic Data

Population (1983) 600,000                      Population Growth Rate 3.3%  
Fertility Rate 6.9  
Age of Population 46% under age 15 --- 3% over age 64

The Government of Swaziland (GOS) has no explicit population policy. However, the GOS is aware that Swaziland's 3.3% population growth rate and 6.9 fertility rate are detrimental to development. Childspacing has been included within current, government, primary health care and maternal health service programs.

The USAID mission has identified rapid population growth as one of four interrelated problem areas which are retarding the growth of Swaziland's economy. A major goal established by USAID/Swaziland is to achieve an attitudinal change in the Swazi leadership and people regarding the need to check or reduce population growth rates. The Family Life Association of Swaziland specifically has been identified by the USAID mission as a major vehicle in providing the necessary family planning information and education.

FPIA has funded the bulk of FLAS' recurrent costs since its inception four years ago. During that time, FLAS has grown from a tiny organization which focused on family life education and IEC, to a fairly large, professionally run organization which provides services through two clinics/branch offices in Mbabane and Manzini, training to government and other personnel, and IEC in various places throughout the country. In addition, FLAS has successfully managed small grants from other organizations such as INTRAH, IPPF, CIDA and the USAID mission (under Special Population Assistance Funds) and has maintained or increased its support in government and the private sectors.

Provided that expansion occurs in a manageable fashion, FLAS has the capability of expanding further, possibly to the point where its activities become nationwide and can impact on country-wide fertility rates. There also is the possibility of expansion into the private sector (through private companies) and of "exporting" the lessons learned to other FLE/FP programs in sub-sahara Africa.

FPIA's and FLAS' long range goal always has been to assure continued support through IPPF affiliation and a variety of income generation

SWAZILAND

activities. Both activities actively are being pursued but negotiations for IPPF affiliation, in particular, are taking longer than anticipated. FPIA does not intend to withdraw its support to FLAS in a precipitous manner and, moreover, will continue to support balanced expansion, encourage income generation and promote IPPF affiliation.

TANZANIA (medium priority)

FPIA activities in Tanzania currently are being reviewed in light of the U.S. Government (USG) suspension of assistance to this country. FPIA-funded projects are being extended for limited periods of time through the use of non-AID funds. FPIA will seek funding from outside sources to maintain projects. In addition, commodity requests from non-project institutions have been placed "on hold" until the USG makes a determination whether such shipments are allowed. Nevertheless, in anticipation that current problems will be resolved in the period 1984-1986, FPIA is planning to expand its provision of commodity assistance to nongovernmental organizations in Tanzania. The Government of Tanzania (GOT) gave tentative approval for population programs in 1983 and there is a growing realization among its leadership that the annual population growth rate of 3.3% is seriously undermining the country's already fragile economy. Given a considerable potential for implementation of family planning projects both in the private sector (especially among church-related PVOs) and parastatals, Tanzania could become a high priority country for FPIA assistance early in 1985.

THAILAND

- OBJECTIVES:
- Complement the Royal Thai Government efforts to maintain the impressive family planning achievements of recent years by concentrating programming so as to: institutionalize the provision of family planning services in over 1,000 private medical institutions; encourage newly married couples to space the births of their children with effective use of temporary methods; and utilize community organizations to provide services in areas not appropriately served or underserved by the government program. As a result, it is expected that approximately 224,600 people will benefit from services supported by grants totaling not more than \$300,000 - \$400,000 per year.
  - In accordance with FPIA's mandate to provide short term funding, continue to coordinate with the USAID mission and other local as well as international donor agencies to investigate continuation funding beyond FPIA's period of anticipated support for those projects that successfully institutionalize their family planning services.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>50,800,000</u>       | Population Growth Rate | <u>2.0%</u>           |
| Fertility Rate    | <u>3.9</u>              |                        |                       |
| Age of Population | <u>40% under age 15</u> | ---                    | <u>3% over age 64</u> |

The Royal Thai Government's five year development plan (1982-1986) proposes to reduce the population growth rate from 2.0% to 1.5% by 1986. Priority programs include upgrading and improving government services and the expansion of family planning programs in high fertility areas. The 1982 contraceptive prevalence survey identified these areas generally to be in the southern and northeastern provinces, with pockets of unaddressed family planning needs in other specific places.

The RTG supports the expansion of NGO-sponsored family planning services, IEC and training programs, and donated \$40,000 to private organizations in 1983. In addition, one PVO receives commodity supplies from the government. The others, however, rely on external donor commodity provision. It is doubtful that the token financial support will be continued or if a mechanism can be developed to supply PVOs with government-purchased commodities. The RTG/MOPH stresses that

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its first priority must be to strengthen and institutionalize government family planning services before its dwindling external resources can be diverted to NGOs. The RTG faces a phaseout of the USG bilateral support for population assistance by 1987.

In 1983, the Ministry of the Interior issued a policy supporting the promotion of family planning services as a part of rural development activities. This action permits the RTG to effectively develop programs to meet its intent to support family planning efforts at the community level. Program options include developing additional alternatives to services provided at government clinics and outposts as well as incentives to utilize the available government services. This policy also will permit the RTG, for the first time, to provide direct program support for the rurally situated hilltribe peoples.

The USAID mission's position has been to support the RTG through the following priority programs which:

- Train and increase the number of auxiliary midwives to insert IUDs;
- Support community level IEC and service programs in addition to government clinics and outposts;
- Improve commodity logistics systems;
- Continue support to VSC services at a reduced level; and
- Conduct small operations research programs.

USAID encourages and supports external donor assistance to NGOs in Thailand. For the past two years, the mission has indicated that these donations should be maintained and strengthened to support the RTG family planning program when bilateral support is phased out in 1987.

There are primarily four NGOs that receive external donor support to supplement the RTG family planning services program. These are: Thailand Association for Voluntary Sterilization (TAVS); Planned Parenthood Association of Thailand (PPAT); Population and Community Development Association (PDA); and the Association for Strengthening Information on the National Family Planning Programme (ASIN).

Since 1974, FPIA has provided \$4,263,501 in project support, as well as commodities valued at \$2,955,295. The intent of the support was to allow NGOs to support and complement RTG population programs. The bulk of FPIA funding went to ASIN to provide voluntary sterilization service subsidies to its member institutions. Annually, over

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the last six years, ASIN members accounted for 40% of all sterilizations provided in Thailand. Another grant allowed PDA and PPAT to provide family planning services in three refugee camps as sub-contractors to the RTG/MOPH. In addition, FPIA project support initiated and maintained family planning service provision to the northern hilltribes, first through McCormick Hospital and, currently, thru PDA. PDA also has utilized FPIA support to provide information, education and services to youth. For example, youth volunteers associated with the project have worked at various jobs during PDA-sponsored (FPIA-supported) vasectomy fairs.

FPIA will consider continuing voluntary sterilization subsidies to ASIN institutions in the south, the northeast and urban slum areas, if ASIN is able to raise funds to support approximately 50% of its direct costs and to seriously explore the feasibility of RTG subsidy support to its active members in the other regions of Thailand. To capitalize on the participation of over 800 private medical institutions in the national family planning program through sterilization subsidy support, FPIA will explore with ASIN the feasibility of continuing to supply temporary methods to its members through a mass mailing program.

FPIA will phase out support to the current PDA youth project and seek to roll over this support for a youth program that actively promotes temporary method information, education and services to newly married couples in urban and rural areas. It is hoped that funds available for this type of project can be matched with other resources to enlarge the potential of such a youth program. FPIA also will track efforts by the National Family Planning Program to research the family planning needs of Thai "youth." If this research is carried out, it will help to identify more effective routes to reach youth clientele.

FPIA will continue support to the PDA "Hilltribes Project" and to the MOPH "Refugee Camp Project" while exploring the feasibility of both of these projects receiving direct support from the RTG as a result of the Ministry of the Interior's support for population programs. Both projects would be maintained at current funding levels.

FPIA will phase out its support to Mahidol University's family planning programming in urban slum areas. The project has resulted in some concrete definition of the most effective approaches to service provision. Its last year of operation will be devoted to institutionalizing these learned approaches with the Bangkok Metropolitan Authority which has ongoing responsibility for service provision in the slums.

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In order to institutionalize the programming relationship between NGOs and the RTG, FPIA will develop a family planning council mechanism to support NGOs in the south with the capacity to include family planning in their service programs. Final decisions regarding project support would be the decision of the recipient agency (PDA) in conjunction with government officials at the appropriate levels. If this approach is successful, FPIA envisions expanding it in 1985-1986 to include programming for youth, private practitioners and other programs which are not appropriate for direct government support.

TOGO

OBJECTIVE: ● FPIA proposes to address the unmet need for services in Togo by a gradually expanding program through the Ministry of Health (MOH) which will provide: training to various cadres of staff; contraceptives and logistical support; and assistance in the areas of supervision and service delivery. FPIA also will support small, innovative projects with the private sector.

Demographic Data

|                   |   |                        |             |
|-------------------|---|------------------------|-------------|
| Population (1983) | <u>2,470,000</u>                                  | Population Growth Rate | <u>2.6%</u> |
| Fertility Rate    | <u>6.5</u>  |                        |             |
| Age of Population | <u>47% under age 15</u> --- <u>3% over age 64</u> |                        |             |

Togo falls into the category of francophone countries which are marginally pronatalist and where family planning is not widely available in the public sector. It is a small country (56,800 sq. kms) with a small population (2.47 million). Nevertheless, its annual population growth rate is estimated at 2.6 percent with approximately half the population under the age of 15. The crude birth rate is 50 per 1,000 with infant mortality estimated at 148 per 1,000. In some rural areas, total child mortality (age 0-5) approaches 50 percent. Life expectancy is 41 years. The nationwide physician/population ratio is 1/16,000 but in the plateau or central zone, the ratio is 1/60,000 and in the savannah, 1/90,000. IPPF has an area office in Lome and other agencies, such as AVS and the UNFPA, have initiated limited family planning activities.

Although the Togolese Government has not yet demonstrated a clear commitment to family planning, and although some archaic laws still are on the books, there is evidence that there is growing support for family planning. The Minister of Health, for example, has taken a personal interest in the FPIA-funded, Togo-02 training project. The USAID-funded Family Health Training Center is operational, after four years of delays, and staff seconded to Togo-02 are getting adequate support.

The objective of the Togo-02 (MOH) project in the first funding period is to upgrade existing family planning services by providing technical training in family planning to 120 health professionals. During this funding period (CY 1984), FPIA also will conduct a commodities needs assessment. Depending on performance, it is envisioned that the project gradually will expand to implement a nationwide contraceptive logistics system, strengthen ongoing supervision of staff, and continue its training activities. Eventually, these activities would have to be funded either through a bilateral assistance program or via funds channeled to FPIA in addition to the current Cooperative Agreement.

TOGO

FPIA provided a grant to the Cooperative d'Epargne et de Credit d'Agou-Nyogbo (HESIACOOP) to train volunteer educators and enroll new family planning clients. The project worked through Bethesda Hospital. While the initial \$5,000 grant was with non-AID funds, FPIA is seeking AID funding to continue this effort, which is expected to pioneer CBD in Togo.

Currently, FPIA activities are concentrated in the southern region of Togo. FPIA will contact officials of the Togolese Women's Union and Togolese Workers' Union to discuss possible integration of family planning into their current activities. If officials of these unions demonstrate an interest, it is expected that a community-based distribution (CBD) program may be designed.

In addition to its funding strategy, FPIA currently is exploring the possibility of opening a sub-regional office in francophone Africa. One of the likely locations is Togo. Should this occur, it would strengthen FPIA's presence in Togo and, by facilitating the provision of technical assistance, would enable FPIA to have a greater impact on policy decisions. A feasibility study will be made in 1984 which will determine FPIA's course of action in this regard.

TURKEY

- OBJECTIVES:
- To complement the Health and Social Assistance Ministry's family planning services in their service outlets, and to continue and expand the Turk-Is Labor Union's family planning program which provides similar family planning services in government-sponsored workers' clinics/hospitals. The FPIA estimated commitment totals about \$837,000 and will result in service to about 139,500 workers by the end of 1986.
  - To assist the Health and Social Assistance Ministry to meet one of its Master Plan's goals, improvement of its commodity distribution system, by providing about \$260,000 to establish a commodity management, distribution and monitoring system reaching all areas of the country.
  - To encourage health and family planning leaders in government and the voluntary sector to consider emphasizing NGO involvement in Turkey's family planning program, by providing 12 Regional Invitational Travel grants for these leaders to attend workshops, training courses and conferences which focus on NGO involvement in family planning and the development of the NGO sector.

Demographic Data

Population (1983) 49,200,000      Population Growth Rate 2.1%  
Fertility Rate 4.3  
Age of Population    38% under age 15 --- 4% over age 64

The Turkish Government recently formulated a Master Plan for increasing family planning education and services in order to achieve a decline in fertility from 4.3 to 2.5 children per married woman by the year 2,000. With a current birth rate of 31 per 1,000 population, the government's program will strive to increase the prevalence of modern contraceptive methods from 20% to 60%-70% during the next 20 years. The plan's intent is to accelerate the current increase in the use of modern methods by intensifying the education and training programs, by opening a series of new family planning clinics, and by improving the present distribution system of contraceptive commodities. The Master Plan notes that: Turkey now has 11 family planning education centers; during 1984 an additional nine centers will be opened. In the past year, the government has initiated a public education campaign which includes television advertisements,

TURKEY

national family planning stamps and other promotional efforts. In cooperation with the Ministry of Education, family planning education programs have been introduced into the primary and secondary school systems. Resources permitting, these programs will be expanded in 1984. A total of 19 new full-service family planning clinics in provincial hospitals were opened in October and there are plans to open another 30 in 1984. Law number 2827, which came into effect on May 27, 1983, brought together all population planning services (Government of Turkey, Health and Social Assistance Ministry - General Directorate of Family Planning and Mother-Child Health, Master Plan, Ankara 1983).

There is no USAID mission in Turkey; however, the American Embassy Labor Attache is USAID's liaison person monitoring centrally funded, AID-supported agencies working in Turkey. USAID, like the Turkish Government, recognizes the importance of and the need for family planning in order to reduce population pressures affecting Turkish economic development. Although Turkey has no bilateral AID program, it has been identified as a priority country for centrally funded AID family planning programming.

There is only minimal NGO involvement in the Turkish family planning effort. Private doctors and pharmacists provide a major share of the family planning services to this increasingly urban nation. The only NGO permitted by law to provide family planning services in Turkey is the Family Planning Association of Turkey (FPAT) which currently operates only a minimal program and does not receive international funding.

FPIA has provided \$535,232 of family planning project support since it began programming in Turkey, in 1975. Earlier programs emphasized model development for community-based delivery of services. The current project, with the Turk-Is Labor Unions Confederation, provides family planning education for workers, and clinic-based services through government-sponsored union worker clinics. The estimated dollar value of FPIA commodity support to Turkey totals, to date, about \$1,845,400.

With the establishment of a new democratic government with a strong population policy, FPIA believes it now will be able to assist the government to reach its family planning objectives by continuing and expanding the Turk-Is Labor Union's family planning education and services project so that a major sector of the Turkish population (union workers) is provided with these services. In addition, FPIA will continue to be a major provider of family planning commodities to Turkey. In this regard, FPIA will assist the Health and Social Assistance Ministry to improve its commodity distribution system to assure that commodities are available throughout the country and that their distribution is well managed and monitored.

TURKEY

Finally, FPPIA will continue its earlier discussions and development activities to encourage the family planning policy makers and the concerned leaders in government and in the voluntary sector to consider increasing NGO involvement in Turkey's family planning program. Utilizing regional travel grants, such individuals will be invited to attend appropriate workshops and conferences, and to visit countries with particularly active NGO programs.

UPPER VOLTA

OBJECTIVE: • FPIA's strategy in Upper Volta over the next three years essentially is to become a catalyst for change through: assistance to small, influential groups; provision of training in contraceptive technology and commodities logistics; provision of management technical assistance and coordination efforts with other donors; and personal contacts with key officials in government and the family planning association. It is felt that with an appropriate, low key funding and technical assistance program, FPIA may be able to influence the family planning stance of the government and PVOs.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>6,700,000</u>        | Population Growth Rate | <u>2.4%</u>           |
| Fertility Rate    | <u>6.5</u>              |                        |                       |
| Age of Population | <u>45% under age 15</u> | ---                    | <u>3% over age 64</u> |

The Government of Upper Volta has no clear population policy. However, during three FPIA staff visits to Upper Volta, high level government officials, including those in the Ministry of Health, have indicated that an integrated MCH/FP program may be well received by the authorities. The total population of Upper Volta is approximately 6.7 million. The annual growth rate is estimated at 2.4% but it is probably higher. Upper Volta is one of the least developed countries in the world, with an average per capita income of less than US\$210. Infant and young child mortality is very high. The health infrastructure is inadequate, and there are very few medical personnel trained in family planning service delivery. Although there is a IPPF-affiliated family planning service association, it is not yet actively involved in service delivery. Family planning services, to date, only have been available to the urban elite who can afford commercially available contraceptives at high prices. The need for family planning services in Upper Volta is underlined by the number of illegal abortions in Ouagadougou and other major towns. Little is known about traditional fertility regulation practices, or receptivity to contraception, among the rural people in Upper Volta.

The USAID mission is very supportive of family planning initiatives. In the past, the mission has sponsored interested individuals from government institutions and private organizations to attend short-term training courses on population and related subjects. The mission also has requested a population officer and has facilitated PVO initiatives. The UNFPA has a small program in Upper Volta, and hopes to encourage the initiation of family planning services over the next few years in government facilities.

UPPER VOLTA

In response to the USAID mission's concerns and requests from private organizations, FPIA developed a project with the Midwives' Association to open a clinic for family planning services and training. The midwives will also provide, in conjunction with the Ministries of Education and Health, sexuality education in secondary schools and MCH clinics. The proposed project coordinator attended a management training course at the University of California, Santa Cruz. When this project is approved, FPIA will closely follow the management and implementation of project activities, and provide technical assistance as needed. The Upper Volta Nurses' Association also has expressed the desire to initiate similar activities in a middle class suburb of Ouagadougou. FPIA will consider funding the Association and ensure that its initiative will not be duplicative of the Upper Volta-01 project.

ZAMBIA

OBJECTIVE: • ARO will continue to fund new family planning service delivery models in Zambia and will provide support to agencies and organizations to ensure the continuation of family planning activities in the country. A steady expansion of FPIA's program is envisioned. Through a number of key projects, ARO hopes to effect considerable technology transfer, specifically in the areas of program planning, management and supervision, and commodities logistics.

Demographic Data

|                   |                         |                        |                       |
|-------------------|-------------------------|------------------------|-----------------------|
| Population (1983) | <u>6,200,000</u>        | Population Growth Rate | <u>3.2%</u>           |
| Fertility Rate    | <u>6.9</u>              |                        |                       |
| Age of Population | <u>47% under age 15</u> | ---                    | <u>3% over age 64</u> |

Zambia has a population of approximately six million people and an estimated population growth rate of 3.21%. The government has indicated that the fertility and population growth rates are satisfactory, and it promotes childspacing as an integral part of MCH and the national family health program. However, due to budgetary constraints, health care continues to concentrate on curative rather than preventive programs. It has been estimated that about 2-3% of the fertile women at risk of pregnancy are currently practicing family planning. The demand for family planning to limit family size is stronger in urban than in rural areas. In rural areas, childspacing is more the desire than family limitation. There is evidence that there has been a chronic shortage of contraceptives in the country to meet the existing demand and although nurses, midwives and traditional birth attendants have received training in family planning information and services (as part of a UNFPA Family Health Project), there has been little follow-up of the trainees to determine if they are providing services.

The USAID mission considers the reduction of the population growth rate as its fourth priority after economic pricing, production efficiency and management improvement. The USAID mission has concentrated its limited resources to assist the Government of Zambia in the area of agriculture. FPIA is one of only a few AID-funded PVOs which has been permitted to fund population activities in the country. A pre-assessment of population, maternal and child health and family planning was conducted by USAID/REDSO/East and Southern Africa. It was noted that population and fertility-related problems have negatively impacted the general welfare of the country, that the health status of mothers and children (the rural population has a higher proportion of mothers and children) is low and that steps taken by institutions responsible for health and population have been inadequate. USAID feels that

ZAMBIA

donor services should strengthen the capability of local institutions to develop sound population strategies and effective service delivery programs.

In response to this environment and in order to strengthen the service delivery infrastructure in Zambia, FPIA's strategy involves assisting the government, through the Ministry of Health and the University Teaching Hospital, to establish a reliable, nationwide (particularly the rural areas) contraceptive distribution network and a supervisory structure to follow up the activities of the nurses trained in family planning service delivery. Family planning service providers in Lusaka (urban) will be closely supervised and provided with contraceptives and supplies from the University Teaching Hospital to ensure that the urban demand for services is met. In addition, physicians will be trained to provide the necessary medical backup to the nurses who previously were trained by the UNFPA Family Health Project. The Zambia-02 project will continue to provide information and service to peri-urban areas of Lusaka through a static clinic at Makeni and a mobile unit. It also provides contraceptives to selected private voluntary agencies.

To strengthen the Planned Parenthood Association of Zambia's (PPAZ) relations with rural communities, FPIA has proposed to fund a one-time chiefs' seminar to be conducted for traditional leaders to gain their support for family planning. It is expected that this will facilitate the PPAZ's movement into rural service delivery. FPIA staff, in conjunction with IPPF, also will provide technical assistance in commodities logistics to PPAZ. ARO also will explore the possibility of assisting the private sector (mines, factories, etc.) in Ndola, through the PPAZ, to provide family planning services.

Other new initiatives may include staff support for a trainer with the Pan African Institute of Development and, if requested, assistance may be provided to the Zambia Flying Doctors to provide services to rural areas. ARO will continue to respond to commodities requests from mission groups and other private organizations in Zambia.

AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D.C. 20523

April 11, 1984

MEMORANDUM

TO: SEE DISTRIBUTION

FROM: S&T/POP/FPSD, Joseph M. Loudis *Joseph M. Loudis*

SUBJECT: FPIA - 1984 - 1986 Strategic Plan - Country Priorities

This Strategic Plan represents FPIA's latest effort to prioritize program and commodity assistance on a country - specific basis.

FPIA is distributing copies of the Plan to all AID population/health officers in the field.

Summary Statement

For 1984 - 1986, FPIA has identified 28 high priority countries. Even these countries, however, have been prioritized. As a result, 72% or \$17.1 million of FPIA's projected 1984 - 1986 subgrant budget of \$23.7 million, has been apportioned to eleven countries: Brazil, Mexico, Nigeria, Egypt, Indonesia, Thailand, Bangladesh, India, Kenya, Nepal and Turkey. These countries have larger populations and significant numbers of individuals without access to family planning services. Thirty-nine percent of the projected 1984 - 1986 subgrant budget has been allocated to high priority countries in which AID has no bilateral programs: Brazil, Mexico, Nigeria, Turkey and Colombia. External donor agencies, such as FPIA, can make the difference in these important nations.

FPIA plans to consolidate its program in Asia, fund larger programs in Africa, increase the numbers of commodity logistics projects and provide increasing levels of technical assistance. FPIA will build on its successful track record of CBD programs in Africa and its successes with income generation programs in Latin America. There will be an increased emphasis on anticipated project life and on program continuation after phase-out of FPIA support. Low cost, replicable programs, based on outstanding Asian project models, also will be emphasized as well as efficiency measures to provide service to more clients at a decreased cost.

To some extent, FPIA plans to develop and maintain projects in countries where they currently have no presence or a limited program. The rationale is that those areas which are neglected today will require greater inputs of time and money in the future. In other areas, FPIA expects to terminate project assistance

based on performance, budgetary considerations and staff demands. To compensate for the increasing demands on FPIA staff time, greater use will be made of technology transfer between projects using the invitational travel mechanism. Cooperation with other donor agencies will be maximized since these agencies represent potential sources of support after phase-out of FPIA funding.

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