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REPORT TO DONORS

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PROGRAMME DEVELOPMENT AND FINANCIAL STATEMENTS

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FOREWORD

The unanimous endorsement of the pioneering and innovative work of non-governmental organisations, especially IPPF, by all governments represented at the International Conference on Population in Mexico City augurs well for a future of intense and dedicated effort throughout the Federation. The Conference emphasised the need for increased resources for population activities. The value of family planning programmes, which were specific to the needs of the community and devised and implemented by the people themselves, in improving the health and welfare of women and children and enhancing the quality of life, was underscored.

IPPF, whose philosophy and experience is voluntarism, free choice and a broad base in the community, stood poised for a programme of activity reflecting the heightened interest in population and family planning expressed so forcefully by the international community.

However, the International Conference on Population also brought forth a policy position by the United States imposing conditions on grant recipients which posed difficulties for the autonomous Associations within the Federation. We face grave uncertainty today regarding our funding position as a result of the change in the population policy of the United States Government. This casts a shadow over the future we had looked forward to with such confidence.

This report is presented to donors at a time of serious financial stress to the Federation. After years of support and encouragement IPPF is now threatened with the loss of its American grant. We hope that negotiations can be entered into which will prevent substantial cuts in IPPF-supported family planning programmes in developing countries and will allow the close relationship between IPPF and USAID to continue. Meanwhile, we have no choice but to ready ourselves with a contingency plan which, while effecting economies, will have the least dislocation of existing programmes, the most cost-effective utilisation of the institutional infrastructure so painstakingly created over the years, and a redoubling of effort at harnessing resources to meet even part of the shortfall.

IPPF's past record is the most important evidence we have of our ability to apply your funds wisely and responsibly in the service of the millions of men and women in developing countries who need our help. The Federation has committed itself to playing a role in furthering the recommendations of the International Conference on Population. It can only do so with your continued and strong support.



Bradman Weerakoon
Secretary General

INTRODUCTION

When representatives of donor governments and private fund raising campaigns met in London last December, the most notable impressions they left behind were their confidence in IPPF as a cost-effective channel for family planning assistance and their satisfaction at the dedication with which IPPF was pursuing new and better programme directions. The Federation was encouraged to expand its pioneering role, even if some of its activities occasionally drew criticism or even opposition.

Family Planning Associations, it was suggested, should continue to be 'brave and angry'. IPPF should make its work better known and should not shy away from putting forward topics for discussion on which universal agreement was not necessarily to be expected. IPPF's capacity for facing problems squarely, drawing them to public and political attention and embarking on unpopular causes was clearly valued, as was the evidence that its actions spring not from centrally-directed policies but from its grassroots experience and the process of consultation between its members at all levels. This legitimization of IPPF's role and salute to its independence helped provide the Federation with the strength and commitment to move ahead with confidence in 1984 and to contribute substantially to the International Conference on Population.

In this Report to Donors, which follows closely upon that conference, it may be useful to describe the Federation briefly for the benefit of those readers who have not had a close association with it in the past or who may have been puzzled by some of the considerable publicity given to IPPF during the past few months.

IPPF AIMS AND OBJECTIVES

The International Planned Parenthood Federation is a world-wide voluntary family planning movement, linking Family Planning Associations in 118 countries. It represents a people's movement and derives its policies, purposes and strengths from its members. Through them, IPPF offers to millions of men and women the information and services which enable them to plan and space their children. The goals and activities of IPPF are inspired by a deep concern for human well-being and the enrichment of parenthood and family life.

Member associations are autonomous, indigenous organizations with locally-elected volunteer leadership. This is an essential condition of a federated structure. Associations have always had the right, in the light of local needs and subject to local customs, values, norms of behaviour and laws, to respond in socially acceptable ways to family planning needs. The fact that decision-making is localized in this way ensures respect for local values in all FPA activities. In turn, it is the representatives of national FPAs who reach consensus, through discussion and dialogue at regional and international levels, on the broad policies and strategies which guide the work of the Federation as a whole. This consensus is well illustrated in the Regional Overviews contained in this Report to Donors, which also give some interesting insights into local interpretations of international policies.

IPPF believes that family planning is a basic human right of all individuals and couples and that a balance between population, resources and the environment can lead to a better quality of life for all. The right to family planning remains fundamental and valid, independent of demographic considerations.

Realizing the interaction of demographic variables and their impact on personal and community living, IPPF has adopted broad approaches and strategies in its programmes whereby family planning education and services are provided not in isolation, but closely linked with measures to lower mortality and morbidity and to promote primary health care, especially for mother and child. Frequently included in such programmes are vocational training of women in income-generating skills, literacy, youth programmes, rural development and other related subjects. Respect for the user's informed, voluntary choice about methods of family planning is paramount in all these programmes.

STRATEGIC ADVANCES IN FAMILY PLANNING: IPPF'S CONTRIBUTION

IPPF is the acknowledged pioneer of important programme strategies that are of proven value and are today largely taken for granted.

Community services

The idea of community-based distribution of contraceptives, familiarly known as CBD, was introduced into family planning programmes as long ago as 1972, with innovative FPA projects in Brazil and Sri Lanka. The objective was, and remains so to this day, to reach into communities in the rural areas and on the urban fringes of crowded cities with information and services which were otherwise not possible due to the absence of the more conventional health and welfare facilities. The idea spread quickly to other countries until today these outreach services are provided by some 50 grant-receiving FPAs which reported recruiting more than 700,000 new acceptors by this route in 1983. Acceptors motivated by CBD workers to utilize government and other facilities would add many more to this figure.

CBD is one of the 'appropriate and practicable channels' recommended by the International Conference on Population for the rapid extension of family planning coverage of all couples and individuals, especially in rural areas.

IPPF keeps this approach to service delivery under regular review. In 1982 the Central Council concluded that such services offered an efficient and effective way of expanding the availability and increasing the acceptability of family planning for large numbers of people in urban and rural areas. Guidelines have been laid down on choice of methods, availability of back-up facilities and education and counselling. Service providers include local shopkeepers, teachers, village leaders, housewives and others willing to act as focal points for highly localized delivery systems. A number of policy, legal and administrative obstacles may impede the scope and acceptance of CBD services. Where consistent with the protection of user safety, IPPF has advised FPAs to work towards the removal of such obstacles in order to ensure easy and equal access to contraception.

Planned Parenthood and Women's Development

In 1976 IPPF put forward the concept of Planned Parenthood and Women's Development, introducing the first projects into the field a year later. IPPF has always regarded improvement in the condition of women as a primary objective of its work and in 1972 it had adopted a policy urging greater emphasis on the inter-relationship of family planning and the status of women, recognizing that the status of women directly influences the acceptance of family planning while at the same time the availability of family planning education and services directly contributes to the status of women by conferring a basic human right and consequent social and economic benefits. It recommended its members to press for measures which, inter alia, would divert an appropriate share of national resources into creating greater education and employment opportunities for women as a means of increasing their status and creating a more favourable climate for the acceptance of family planning. Two years later, in anticipation of International Women's Year, IPPF reinforced its earlier policy by urging FPAs to get actively engaged in women's programmes.

In 1976 the outline of a comprehensive approach integrating family planning with education, income-generation, vocational training, literacy, home economics and a range of other efforts to raise the status of women was conceived. Projects began in the field in several countries in 1977. Today PPWD programmes are prominent in at least 60 grant-receiving FPAs.

The value of linking family planning with women's development has been proven by evaluations which show increased family planning practice in addition to other lasting benefits for women. The World Bank, in its World Development Report 1984, said: "Once they are able to earn an income, women may acquire higher status in the home, thus enabling them to talk more openly about birth control with their husbands. Although a significant number of women use contraception without the knowledge of their husbands, open discussion leads to longer and more effective contraceptive use". The same report pointed out that projects for women, even on a modest scale, contribute to enhancing the value of daughters, raising the age of marriage, encouraging the practice of breast-feeding — in the interests of reducing infant mortality and prolonging birth intervals — and making the practice of contraception easier. The Bank, like the International Conference on Population, urges governments to give more attention to women's development. It is important to recognise, however, that these initiatives began in the private sector and much of the initiative still resides there, especially in the seriously neglected area of improving the lot of rural women. Commenting on the plight of rural women, the Bank report says "the potential of the private sector to provide family planning services has hardly been tapped" in many countries. "Family planning offers the greatest potential benefits for the poorest people, whose mortality and fertility rates are usually the highest of any group".

IPPF's PPWD programme clearly anticipated the outcome of the International Conference on Population. A special section of its recommendations is devoted to The Role and Status of Women. There are six specific recommendations under a general observation that: "The ability of women to control their own fertility forms an

important basis for the enjoyment of other rights; likewise the assurance of socio-economic opportunities on an equal basis with men and the provision of the necessary services and facilities enable women to take greater responsibility for their reproductive lives."

Community participation

It is a short step from women's development to the notion of community participation, where, as the World Bank has acknowledged, "private family planning associations and NGOs have led in experimenting with new ways to involve clients and communities". Strategies have included consultation with local leaders, training local people as paid or volunteer workers, consulting and training traditional midwives and healers, establishing local management or review committees, encouraging local contributions of money and labour, and organizing groups of family planning acceptors to reinforce effective use and to engage in other community projects. IPPF is obviously well placed for this pioneer effort because of the strong grassroots base which underlies its membership network. The objectives are to encourage local people to make choices for themselves, to set their own priorities, among which family planning itself may not at first be visible, and to help them organize themselves towards their common goals. The Bank comments that "private family planning associations are well suited to implement these approaches: they are small, decentralized, well-staffed, highly motivated, have greater control over service quality and are less confined by the bureaucratic constraints of government".

Over the years donors have from time to time expressed their doubts about the wisdom and cost-effectiveness of integrating family planning with other development efforts and IPPF's stated policy on 'integration of family planning with development' has sometimes been called into question. Today, however, when taken together with women's development and community participation, IPPF is surely right in believing that "when there are many urgent development problems in a society, it is inappropriate to deal with a single factor, such as excessive family size, without adopting a caring attitude to the family and the community as a whole". Since community participation presumes the existence of other local resources, it follows that, as IPPF's policy states, "this widening of the frontiers of action and approach can be facilitated by drawing into the planned parenthood movement volunteers and organizations whose interest and enthusiasm can be engaged by the prospect of contributing more than family planning knowledge and services to the development of the family and the community".

Primary Health Care

Community participation is at the root of Primary Health Care, now a major preoccupation of the World Health Organization. An informal group representing WHO, UNICEF, IPPF and OECD is collecting evidence of the processes and effectiveness of this approach so that governments which provide major international development assistance can take this into account when framing their own aid policies. WHO is independently making a global assessment of how NGOs can become more effective, with appropriate support from their governments, in the campaign for

primary health care within the objective of Health for All by the year 2000. Family planning is recognized as a strong preventive measure in this context.

Preventive health care, particularly for mothers and children, is a natural partner for family planning since family planning makes critical contributions directly to this goal as well as providing the environment in which nutrition, sanitation, disease prevention and other health needs can be taught. A study of 25 countries, quoted by the World Bank, suggests that if births were spaced two to six years apart, infant mortality would decline by an average of 10 per cent, and child mortality would decline by 16 per cent. As stated in IPPF's publication "Human numbers, human needs", "Improvements in health are the main cause of falling death rates, but they also encourage birth rates to fall, as parents may be reluctant to have fewer children until they are convinced that more of them will survive to adulthood". Thus it is crucial to build family planning into the health efforts now directed to the officially-designated least-developed countries where infant mortality can be as high as 200 per 1000 live births.

Meeting the needs of young people

IPPF has had to be especially courageous in its efforts to raise public consciousness about the reproductive health needs of adolescents. As early as 1969 the Federation recognized that the problems related to adolescent fertility should not just be ignored in the vain hope that they would go away. Since then programmes for young people have been developed in many countries. Indeed, about half of all fertility-related programmes for young people have been initiated by IPPF affiliates. FPAs have provided population, family life and sex education for young people, particularly in settings outside school. At the same time IPPF has urged governments to include such education in school curricula. By 1982 'meeting the needs of young people' had been elevated to the status of a priority action area, identified as such in the Federation's Three Year Plan.

In 1984 IPPF published two reports on this issue which were controversial. The first was the discussion (not policy) document on The Human Right to Family Planning, the report of an international working group whose findings were made known to the 1983 Donors' Meeting. Among its many conclusions, this report makes the point that the right of everyone to have full access to fertility regulation information and services applies equally to young people. It recommends that "FPAs should urge governments to ensure that a full range of appropriate fertility regulation services, including information, education and counselling, is made available and accessible to adolescents, both married and unmarried. Services for these groups should be sensitive to their needs, cultural and socio-economic environment and stage of maturation, and take into account other relevant personal and medical considerations". It goes on to advise that the right of the adolescent to privacy and confidentiality should be respected: "Parental consent should not be made a prerequisite for the provision of contraceptives".

Both this and the subsequent publication on Adolescent Fertility emphasize the role of parents in providing guidance and support to young people in these aspects of their

lives. Adolescent Fertility is the outcome of a consultation of experts which took place in 1983 at the Rockefeller study centre in Bellagio. It analyses the risks adolescents face from abortion, sexually-transmitted diseases and early pregnancies, draws on data from a number of countries, makes suggestions about the nature and scope of counselling and describes appropriate approaches to reproductive health management for adolescents. Although it is in line with current practice in several countries, the notion of protecting the confidentiality of adolescents seeking contraceptive help drew critical reaction from the popular press. This demonstrated the extent of the ignorance and intransigence which still surrounds contraceptive counselling and the preparation of young people for responsible parenthood.

The Bellagio consultation led to the definition of a youth policy for IPPF which encourages FPAs to initiate, strengthen or support programmes which contribute to the total development of young people, helping them to cope with the process of physical and emotional maturation and make responsible decisions about their sexuality and fertility. "They should aim to prevent unwanted pregnancy and encourage the postponement of childbearing until biological and emotional maturity has been reached." The policy puts priority on disadvantaged young people, wherever they may be, and on early adolescents who are particularly vulnerable. It states: "In many situations the right of young people to family planning education and services is denied. FPAs should seek ways of removing legal, administrative and other barriers to the availability of adequate education and services. Such services should be culturally sensitive, humane and sympathetic and should ensure confidentiality and privacy. However, the role of parents or other members of the community who may be able to assist with care and support to the young person should be carefully considered."

Like all IPPF policies, this potentially controversial statement has the consensus of all member associations in both developed and developing countries. The autonomy of FPAs has already been described: it is up to each of them how they wish to interpret this broad policy in the light of local needs and circumstances. Some FPAs have adopted vigorous campaigns on behalf of the rights of young people and have launched pioneer projects to provide counselling and services. Many PPWD projects are directed towards the special needs of young women in this regard. Advocacy is critical, since governments tend to shy away from this sensitive area and leave to the private sector the task of facing the general public with the truth about a situation they would often prefer to pretend did not exist. Last year, donors were unanimous in looking to IPPF to take the lead in meeting the growing needs of increasing number of young people at risk of contributing to the high incidence of unwanted pregnancy everywhere in the world.

All these strategies are reflected in IPPF's Three Year Plan 1985-87 which is the basis for the work programmes of the Federation for which it seeks donor support. There is one further critical area of neglect where pioneer work is now urgently needed and this is to involve men, as well as women in family planning programmes. This means

encouraging men to both support and share in the practice of contraception, not an easy task in view of the considerable traditional and cultural obstacles which stand in the way. The issue is intrinsically linked with those described above since the more that can be done to raise the status of women, involve the community in solving its own problems, improve knowledge of measures promoting family and community health and meet the needs of young people, the more inevitable becomes the involvement of men in all these programme areas.

FAMILY PLANNING METHODOLOGY

IPPF does not carry out primary research in human reproduction and contraceptive technology, on the grounds that there are other bodies more competent to do so. It does, however, accept responsibility for ensuring that the clients of its family planning programmes are able to exercise full and informed choice from among all safe, effective and acceptable methods of contraception. Because of the different needs and preferences of individuals, **FPAs are urged to offer the widest possible range of options and to provide full advice and counselling about each of them.**

The Medical Department is currently co-ordinating a new study on the acceptability and use-continuation of contraceptive methods. Six FPAs have been selected for the initial phase of the study — Guatemala, Hong Kong, Jordan, Kenya, Nepal and Trinidad & Tobago — and preliminary data collection is already under way. The study will provide the Federation with first-hand information on why acceptors discontinued use of certain contraceptive methods, and the extent to which they are satisfied with the quality of service, education and counselling offered by FPAs. The results of this study will have a significant impact on the design of service delivery programmes, taking as a starting point the new data on the perceptions of the couples to be served, in order that programmes can be closely tailored to local needs and quality of services can be ensured.

IPPF is a major purchaser and distributor of contraceptives, passing on to FPAs the benefits of bulk purchase and international quality control. All products supplied by IPPF have been approved by its International Medical Advisory Panel (IMAP) which keeps all methods regularly under review. IMAP also studies the implications of trends in contraceptive research and provides advice to FPAs on clinical and community-based service management as well as on **helping infertile couples** and other clients with special needs and problems.

To assist FPAs to meet the needs of clients wishing to practise so-called 'natural family planning', **IPPF has added a handbook on "Periodic Abstinence"** to the range of medical handbooks that are produced for family planning personnel. A manual on "Breast Feeding, Fertility and Contraception" was also published recently to support the worldwide campaign to reinforce this practice.

IPPF does not perform or actively promote abortion. Its policy is that contraception is the first line of defence against unwanted pregnancy. However, by the very nature of the Federation, it cannot limit the actions of member associations whose autonomy it

respects. Less than one per cent of IPPF's total budget goes to meet requests from a few associations for financial assistance to 'abortion-related activities'. An elaborate account system has been in operation for 10 years to segregate the funds of one donor government from this modest response to developing countries who look to IPPF for help.

In 1983 IPPF distributed contraceptives to FPAs to a total value of nearly US\$7 million, including 'in-kind' commodities from the United States to a value of US\$2.6 million. This covered about 17.5 million cycles of oral contraceptives; 56 million condoms, 780,000 intrauterine devices; 16.8 million foaming tablets and 490,000 doses of injectable contraceptives. In addition, IPPF supplied medical and clinical equipment to a value of US\$396,000, audio-visual equipment worth US\$137,600, office equipment at US\$125,900 and transport, mainly jeeps and mobile units, at a cost of US\$443,800. In order to improve the efficiency of its international purchasing and distribution, IPPF contracted the purchasing function to the International Development Procurement Services (INDEPS) in Washington under a two-year experimental agreement.

Family planning associations report annually to IPPF on the number of new and continuing acceptors who come to their clinics or receive their contraceptives through the non-clinical services provided by them. Although useful in showing trends, these figures are in many ways unsatisfactory since they do not include the many more acceptors who are motivated to seek information and services from other sources, including government health centres, as a result of the educational work done by FPAs in the field. It might be expected that as national programmes expand and FPAs direct their attention to ensuring that these facilities are fully utilized, the number directly served by FPAs would decline. However, in recent years such a decline has been minimal and in the period 1981-1983 clinic attendance actually rose by 5.5 per cent. A decrease of 14 per cent in those using non-clinical services is believed to be the result of inevitable variations from year to year and of the difficulty of extracting acceptor data from some country projects of which such services may be one among many programme components. The general pattern of new and continuing acceptors of FPA services supports the conclusion of the IPPF Forward Look Study that it is still important for FPAs to maintain direct family planning services in order to fill gaps in government programmes where these exist, to pioneer services in countries without government programmes and to provide a base for training of family planning personnel and ensure that high standards of service are set and maintained.

PROGRAMME MANAGEMENT

IPPF's ability to expend donor funds efficiently and effectively with maximum results in terms of acceptance of family planning depends largely upon the capacity of its grant-receiving FPAs. FPAs vary greatly in years of experience, quality of volunteer and staff leadership, extent of branch and local networks and ability to do innovative pioneering work under adverse circumstances while at the same time sustaining efficient administration and financial management. Upgrading FPA skills is a major

preoccupation of IPPF, as can be seen from the training programmes and workshops described in the Regional Overviews. The task becomes more demanding as new ground is broken in poor countries with little or no previous family planning experience and chronic shortages of management skills in all social sectors. Such is the case in many African countries, particularly the francophone countries where family planning is just beginning. These problems are, in turn, exacerbated by the loss of trained personnel to other public sectors where pay and career prospects may be more attractive. The battle to develop and retain skills needed for family planning programmes is a continuing one in almost every developing country, even though some FPAs have become highly proficient at projecting their image as good employers and at drawing on the skills of highly professional volunteers to assist and inspire paid staff.

One of the ways in which IPPF ascertains the needs problems of FPAs is through the process of **Overall Programme Evaluations (OPEs) and Management Audits (MAs)**. The recent trend is to carry out combined missions which accomplish both these tasks at the same time. So far this year, OPEs and MAs have been carried out jointly in Paraguay, Benin, Sarawak and Zambia. MAs have also taken place in several other countries in Latin America, Asia and Africa. Reports of these missions describe many different types of problems, such as those of setting clear objectives against which performance can be measured, adhering to reporting requirements or meeting the required standards of financial management. They include proposals on how the team and the FPA, in discussion together, believe that these and other problems can be overcome. Regional Directors have special responsibility for ensuring that, as far as possible, the recommendations are implemented within an appropriate time frame.

Resource Development

To meet the needs of its members in developing countries, IPPF raises funds from both government and private sources. Each year it draws up a global budget on the basis of the three year plans and annual work programmes submitted by nearly 100 national associations. The latest estimate of income to IPPF from all sources in 1984 is \$52 million. Of this, more than \$50 million comes from governments. In 1984 the United States is the Federation's largest donor, followed by Japan, Sweden, Canada and the United Kingdom. FPAs are encouraged and assisted to find local resources to expand their programmes, including in-kind contributions such as clinic premises, as well as direct government and private grants. In 1983 **FPAs reduced their overall dependence on IPPF funding to just over 50 per cent of budget, generating the rest from other foreign and national sources.** The level of self-support is expected to increase in 1984 in response to a vigorous campaign by FPAs. The present degree of independence and self-reliance, an ultimate objective for all FPAs, has so far been achieved through the efforts of the long-established Associations, while newer FPAs, especially in Africa, remain almost 100 per cent dependent on funds from IPPF. It is hoped that the level of self-support will further increase in 1985, designated as Resource Development Year by the IPPF Central Council.

Thirty member associations in developed countries have been able to establish total

financing from within their own countries and several of these also raise funds to help meet requests for financial assistance from other countries. These Associations, mainly in Europe and North America, also contribute their knowledge and experience generously to the Federation as a whole. It should be noted that some of these Associations face serious family planning problems of their own, partly as a result of the growth of organized opposition to family planning but also of the economic recession and of pro-natalist policies to halt declining birth rates. In these circumstances concern for the human right to family planning is critical.

Some grant-receiving countries do not at present belong to IPPF regions and are therefore not described in the Regional Overviews. Full information about them is, of course, available. China, with its widely publicized population policy and well-developed family planning programme, is the most important example. The China Family Planning Association was formed in 1980 with the objective of assisting the government programme by motivating people to accept family planning, especially at the grassroots level. It also aims to represent people and their views on family planning and therefore has a very important advocacy role. The Association's Three Year Plan identifies strategies to strengthen family planning publicity, increase the management and professional skills of personnel, strengthen the organization at central and branch level and participate in international conferences and other inter-country activities.

The Secretariat

As reported last year, the IPPF International Secretariat, reorganized over the past few years, now reflects the shape of a typical family planning organization with technical assistance available to all sectors. In addition to the functional departments, all IPPF regions are served by Regional Bureaux located in London. There is a regional field office in New York and field offices in Kuala Lumpur, Kathmandu, Nairobi, Mbabane, Lomé, Dakar, Tunis, Amman, Antigua, Barbados and Quito.

The objectives of the Secretariat are 1) to support Associations in providing improved family planning and related programmes and to identify new programme thrusts; 2) to advocate that family planning be included in international activities and public debates that influence government policies and programmes; 3) to assist and complement the role of volunteers in maintaining the Federation as a strong pioneering, independent organization to carry out family planning and related programmes to improve the quality of life, and 4) to take responsibility for resource development, financial accountability and donor relations as directed by the Central Council.

IPPF AND THE GLOBAL MOVEMENT OF PARLIAMENTARIANS

The movement to establish groups of Parliamentarians on Population and Development grew out of the need to create understanding among legislators of all political affiliations, of the fundamental interrelationship between development, population and family planning. It began with a partnership between the United Nations Fund for Population Activities (UNFPA), IPPF and a group of parliamentarians from Japan. From there, the movement has spread to other countries

bringing policy-makers together at national, regional and international levels. A Global Committee has now been set up to encourage the formation of similar groups in countries where they do not yet exist; and to liaise with regional parliamentary groups and international programme-implementing agencies like UNFPA and IPPF.

Over the past five years a number of Declarations on Population and Development have been adopted at major gatherings of parliamentarians outlining policy actions and defining the contributions that legislators can make to creating and sustaining a climate that is favourable to the development and implementation of population policies and family planning programmes. Recommendations have been made for expanding the availability of family planning services and increasing the resources allocated to them. Parliamentary groups have done a great deal to support the family planning movement in national circumstances when opposition forces have threatened to weaken public support. IPPF has been active in supporting the parliamentary groups especially in Latin America and Africa and FPAs have made substantial contributions to the formation of national groups. An International Parliamentary Assembly was held in Mexico City immediately following the International Conference on Population in order to review and ensure commitment to the implementation of its recommendations.

INTERNATIONAL CONFERENCE ON POPULATION

IPPF made a substantial contribution to the International Conference on Population held in Mexico City in August 1984, 10 years after the World Population Plan of Action was adopted at Bucharest. As reported last year, IPPF made its own review and appraisal of the plan and forwarded its commentary to the United Nations. It participated in three of the four preparatory Expert Groups and attended both sessions of the Preparatory Committee. The Federation sent a delegation of volunteers and staff to the Conference, led by the President, Mrs. Avabai Wadia, of India, who addressed the plenary session.

Two special issues of People magazine were produced in support of the Conference, the first in January, to describe some of the major issues with which it would be concerned, and the second in July to focus on the special demographic, development and environmental problems facing the host country of Mexico. Special funds from the Canadian government enabled this issue to be widely distributed in Spanish as well as in English and French, the usual languages of publication. With Canadian support and the help of the Simon Population Trust, a handbook on "Human numbers, human needs" in English, French and Spanish editions was also published for the Conference.

The Conference will be a major landmark in the history of family planning with its strong endorsement of family planning as a basic human right, as an essential element in efforts to improve the conditions of women. The Conference was also unanimous in its reaffirmation of the place of population in development; in its support to enhancing the role of women in society; and its recognition of the contribution made by non-governmental organizations to development programmes, including family planning. In all these areas, achievements were acknowledged while at the same time the danger of complacency and the urgency of meeting remaining needs was recognized.

The Conference consistently stressed the primacy of individual rights and national sovereignty. References to basic human rights, especially as they relate to people's desires regarding the number of their children, were strengthened. A recommendation urging governments to set quantitative targets for their fertility policies was expanded to stress that individuals and couples should be able to exercise their responsibilities to the community 'freely and without coercion'.

The concern for people is also reflected in several recommendations which call for the participation of communities in the design and implementation of population programmes and development activities. The role of NGOs in facilitating this participation is also recognized.

Many recommendations deliberately specify a role for non-governmental organizations and it was evident that IPPF was in the minds of many delegates who wanted these clauses. NGOs are associated, for instance, with the call to "allocate the necessary resources to family planning services, where these services are inadequate and are not meeting the needs of a rapidly growing population of reproductive age". Governments are also asked to "bear in mind the innovative role which non-governmental organizations, in particular women's organizations, can play in improving the availability and effectiveness of family planning services".

In an important umbrella recommendation, the Conference declared: "National non-governmental organizations are invited to continue, in accordance with national policies and laws, their pioneering work in opening up new paths and to respond quickly and flexibly to requests from governments, inter-governmental and non-governmental organizations, as appropriate, for further implementation of the World Population Plan of Action. Governments are urged, as appropriate, within the framework of national objectives, to encourage the innovative activities of non-governmental organizations and to draw upon their expertise, experience and resources in implementing national programmes. Donors are invited to increase their financial support to non-governmental organizations."

FUTURE CHALLENGES FOR IPPF

There is an undercurrent of urgency about family planning programmes in almost all the recommendations emerging from the International Conference on Population. This coincides with the consensus among developing countries, most notable in the Kilimanjaro Declaration from Africa, that they are ready to take action in national policy and programme implementation if the assistance to do so is forthcoming.

The health infrastructures of most developing countries are still fragile and health budgets are low in comparison with other areas of national expenditure. Much of the initiative will remain in the private sector for the foreseeable future. Drawing on data from the World Fertility Survey, the World Bank notes that in virtually all countries surveyed, the number of women of childbearing age who want no more children exceeds the number using some kind of contraception. While measurements of unmet needs are often in dispute, the Bank calculates that when those who for one reason or

another are not exposed to the risk of unwanted pregnancy, are excluded, 6 to 12 per cent of women of childbearing age in Egypt, Kenya and the Philippines have an unmet need for contraception. These are all countries with long-standing national programmes. In Bangladesh, Korea and Peru, where women were asked if they wanted to limit and/or to space births, responses showed that 16 to 33 per cent of women have an unmet need for contraception. This figure would be higher if women who are breastfeeding or who are using inefficient methods of contraception are also considered to have an unmet need.

IPPF's task is to keep up the momentum in family planning programmes by illuminating and finding new responses to these needs. It is a task that must be done country by country by local people who know best what is wanted by and for their own societies. Strenuous efforts to develop local resources must be matched by international assistance on a scale commensurate with the urgency and seriousness of the new blueprint endorsed at Mexico in August 1984.

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION
SECRETARIAT ESTABLISHMENT — APPROVED POSTS**

INTERNATIONAL OFFICE

POSTS

Secretary General's Office	2
Evaluation and Management Audit Department	15
Deputy Secretary General's Office	2
Programme Development Department	7
Medical Department	3
Europe Bureau	4
Arab World Bureau	5
Indian Ocean Bureau	4
Africa Bureau	7
East, South East Asia & Oceania Bureau	4
Western Hemisphere Bureau	3
Assistant Secretary General's Office (Policy, Information and International Relations)	2
Policy Unit	3
Information & Public Relations Department	20
Executive Secretary & Conference Office	4
Assistant Secretary General's Office (Management Services and Resource Development)	2
Coordination, Planning and Training Unit	2
Resource Development Unit	2
Finance Department	17
Personnel and Administration Department	20
Purchasing and Supply Department	5

Sub-Total 133

Dakar Field Office	4
Lome Field Office	9
Nairobi Field Office	12
Mbabane Field Office	4
Kuala Lumpur Field Office	5
Kathmandu Field Office	3
Tunis Field Office	2
Amman Field Office	2
Cairo Field Office	1
New York Regional Field Office	27

Sub Total 69

TOTAL 202

PROJECT STAFF NOT INCLUDED IN ABOVE TOTAL

Resource Development Expansion Programme funded by PCC/PPF	1
WHR Projects funded by AID	9
Donor Accounting	2
Hewlett Foundation Project	1
Mellon Foundation Project	2

Sub-Total 15

TOTAL 217

FINANCIAL REVIEW

1. 1983 ACTUAL INCOME AND EXPENDITURE

IPPF's 1983 Audited Accounts show that expenditure exceeded income, resulting in a deficit of \$3,085,000. The approved budget and actual results for 1983 are summarised in the following table:

	Approved Budget	Actual Results	Decrease
	\$'000	\$'000	\$'000
Income	49,660	45,048	4,612
Expenditure	<u>49,138</u>	<u>48,133</u>	<u>1,005</u>
Deficit	<u>522</u>	<u>3,085</u>	

Income was affected by an exceptional accounting adjustment to the amount received from the Swedish International Development Authority, in order to reflect more correctly the period to which the grant relates. The adjustment is fully explained in a note to the Audited Accounts.

Actual expenditure was 2% below approved budget.

1984 ESTIMATED INCOME AND EXPENDITURE

A comprehensive review of the 1984 approved budget was carried out in late August, and this shows that IPPF will have a deficit of \$690,000 at the end of the year. The figures are summarised below:

	Approved Budget	Actual Results	Decrease
	\$'000	\$'000	\$'000
Income	55,276	52,080	3,196
Expenditure	<u>57,496</u>	<u>52,770</u>	<u>4,726</u>
Deficit	<u>2,220</u>	<u>690</u>	

This latest estimate takes into account the continuing devaluation of nearly all currencies of the world against the US dollar, resulting in lower income to IPPF.

In view of the uncertainty surrounding exchange rates, this estimate will be reviewed during November and, if appropriate, a more up-to-date forecast prepared.

3. 1985 PROJECTED INCOME AND EXPENDITURE

At its meeting in September 1984, IPPF's Budget and Finance Committee recommended a 1985 budget to the Central Council (meeting in November 1984) as follows:

	\$'000
Income	55,069
Expenditure	<u>58,733</u>
Deficit	<u>3,664</u>

4. WORKING CAPITAL AND CASH FLOW

The following table traces the recent history of movement in the levels of IPPF's Working Capital at the end of each year.

	Actual 1979 \$'000	Actual 1980 \$'000	Actual 1981 \$'000	Actual 1982 \$'000	Actual 1983 \$'000	Latest Estimate 1984 \$'000	Budget 1985 \$'000
Income	45,923	50,240	48,596	48,971	45,048	52,080	55,069
Expenditure	45,261	41,174	48,967	48,610	48,133	52,770	58,733
Surplus/ (Deficit)	662	9066	(371)	361	(3,607)	(690)	(3,664)
Working Capital/ 1 January	8,876	9,327	11,355	11,471	12,058	8,337	7,647
Add Surplus for Year	662	2,066		361			
Less Deficit for Year			(371)		(3,085)	(690)	(3,664)
Staff Reserve Fund					(1,215)		
Other Adjustments	(211)	(38)	487	226	579		
Working Capital 31 December	<u>9,327</u>	<u>11,355</u>	<u>11,471</u>	<u>12,058</u>	<u>8,337</u>	<u>7,647</u>	<u>3,983</u>
Working Capital as a % of following year's expenditure	19.4	23.2	23.6	25.0	15.8	13.0	6.5

Note of Table

Other Adjustments: these relate to movements in Fixed Assets etc. during the financial years in question.

It is important to understand the IPPF's Working Capital is not wholly held in cash, but also in the form of various current assets and liabilities. For the purpose of the table above, Working Capital has been calculated at the end of each financial year. An analysis of the figures at the end of 1981, 1982 and 1983 shows:

	1981		1982		1983	
	\$'000	%	\$'000	%	\$'000	%
Bank Balances	5,002	34	6,203	41	8,745	71
Cash Grants paid in Advance	218	1	115	1	505	4
Other Current Assets	9,511	65	8,887	58	2,971	25
	<u>14,731</u>	<u>100</u>	<u>15,205</u>	<u>100</u>	<u>12,221</u>	<u>100</u>
Less: Current Liabilities	3,260		3,147		2,669	
Staff Reserve Fund	—		—		1,215	
End of Year Working Capital	<u>11,471</u>		<u>12,058</u>		<u>8,337</u>	

WORLD INCOME AND EXPENDITURE SUMMARIES 1981 - 1985

	1981 Actual	1982 Actual	1983 Actual	1984 Latest Estimate	1985 Budget
	\$'000	\$'000	\$'000	\$'000	\$'000
<u>INCOME</u>					
Governments	44,860	45,761	42,104	46,134	49,201
Private Sources	1,372	876	933	897	900
Collaborative Projects	2,365	2,334	2,011	1,375	1,175
Funds for Secretariat Projects				3,674	3,793
TOTAL INCOME	<u>48,597</u>	<u>48,971</u>	<u>45,048</u>	<u>52,080</u>	<u>55,069</u>
<u>EXPENDITURE</u>					
Africa	8,211	8,770	9,034	9,865	11,445
Arab World	1,834	2,010	2,421	2,922	3,443
East, S.E. Asia & Oceania	3,832	4,125	4,321	4,514	4,727
Europe	50	54	103	234	234
Indian Ocean	5,037	5,484	6,197	6,276	7,431
Western Hemisphere	13,311	13,702	13,129	13,747	14,021
Countries Not in IPPF Regions	898	640	651	930	1,192
Projects in Collaboration with other Agencies	2,809	3,820	3,183	2,550	2,550
Secretariat Operations and Projects	12,180	10,777	12,066	13,910	16,527
Programme Development Fund					
Other Budget Items	752	789	(385)	1,305	1,135
Reserve Fund					250
Difference in Currency Transaction	1,178	396	216		
TOTAL IPPF GRANTS	<u>50,092</u>	<u>50,567</u>	<u>50,936</u>	<u>56,253</u>	<u>62,955</u>
LESS: In-Kind Commodities	<u>1,124</u>	<u>1,957</u>	<u>2,903</u>	<u>3,483</u>	<u>4,222</u>
	<u>48,968</u>	<u>48,610</u>	<u>48,133</u>	<u>52,770</u>	<u>58,733</u>
Surplus/(Deficit)	(371)	361	(3,085)	(690)	(3,664)

$$\frac{13}{55} = 25\%$$

WORLD SUMMARY OF INCOME 1981 - 1985

	1981 Actual	1982 Actual	1983 Actual	1984 Latest Estimate	1985 Planning Figure
	\$'000	\$'000	\$'000	\$'000	\$'000
<u>GOVERNMENTS</u>					
Australia	314	356	286	311	342
Canada	3,303	3,421	4,232	4,566	5,581
Denmark	1,277	1,481	1,567	1,473	1,490
Federal Republic of Germany	2,396	2,276	2,197	2,175	2,214
Finland	147	167	186	166	200
Japan	8,000	9,000	9,500	9,500	9,500
Netherlands	1,237	1,269	1,206	1,058	1,184
New Zealand	201	185	164	157	170
Norway	3,356	3,627	3,681	3,541	3,758
Sweden	7,725	7,481	3,897	7,237	7,708
United Kingdom	4,365	4,437	4,077	4,080	4,224
United States of America	12,263	12,000	11,000	11,000	12,000
Other Countries	276	61	111	870	870
SUB-TOTAL	<u>44,860</u>	<u>45,761</u>	<u>42,104</u>	<u>46,134</u>	<u>49,201</u>
<u>PRIVATE SOURCES</u>					
Population Crisis Committee		11	37		
Associations:					
Canada	79	127	40	30	30
United Kingdom-Population Concern	118	148	158	150	150
United States of America	311	195	210	200	200
Interest	526	152	374	350	350
Sales of Publications etc.	338	243	70	-	-
Miscellaneous			44	167	170
SUB-TOTAL	<u>1,372</u>	<u>876</u>	<u>933</u>	<u>897</u>	<u>900</u>
<u>COLLABORATIVE PROJECTS</u>					
Japan/UNFPA	1,175	1,261	1,172	1,175	1,175
PCC Projects	458	220	340	200	
USAID/PIPOM		436	100		
DANIDA - Calcutta Project	150	150			
CIDA - for Africa		124	275		
CIDA - Mexico ICP			5		
SIDA - for CRESALC	582	143	52		
UNFPA - for Lesotho			26		
Univ. of N.Carolina - for Tanzania			41		
SUB-TOTAL	<u>2,365</u>	<u>2,334</u>	<u>2,011</u>	<u>1,375</u>	<u>1,175</u>
<u>SECRETARIAT PROJECTS</u>					
PCC - Resource Development				200	200
AID - IHR				1,954	1,810
CIDA - Africa				321	
- Special Projects				385	
WHR - Mellon				102	183
- Hewlett				100	100
- Others				125	125
SIDA - CRESALC				44	
Netherlands - India				00	
UNFPA - Africa				91	276
WHO				33	
Univ. of N.Carolina - Africa				54	
CIDA - Asia Pacific Meeting				17	
Pathfinder - Arab World				15	
Rockefeller - Manual				13	
earmarked for Youth and PPWD					1,060
Publication Sales				118	30
SUB-TOTAL				<u>1,674</u>	<u>1,793</u>
TOTAL INCOME	<u>48,597</u>	<u>48,971</u>	<u>45,048</u>	<u>52,080</u>	<u>55,069</u>

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS
(ALL COSTS SHOWN IN US\$'000)

<u>WORLD</u>	<u>SUPPLIES PURCHASED BY IPPF</u>				<u>PROJECTED EXPENDITURE 1985</u>
	<u>ACTUAL EXPENDITURE</u>		<u>ESTIMATED EXPENDITURE</u>		
	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	
Contraceptives	3290.2	3859.8	4073.8	4170.2	4760.8
Medical & Surgical	574.0	396.1	396.8	349.3	539.5
Audio Visual Equipment	91.1	223.5	137.6	180.8	149.7
Office Equipment	106.7	193.5	125.9	208.5	252.2
Transport	593.5	454.9	443.8	701.2	818.4
Prior Year Adjustment	(206.3)	-	-	-	-
TOTAL	4449.2	5127.8	5177.9	5610.0	6520.6

<u>AID SUPPLIES DONATED TO IPPF</u>					
Contraceptives	1123.8	1957.4	2802.6	3482.5	4222.0
FULL TOTAL	5573.0	7085.2	7980.5	9092.5	10742.6

WORLD SUMMARY OF EXPENDITURE (By LOCATION)
1983 Actual

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Africa	7320.8	1712.6	9033.4	1525.1	(739.6)	9818.9
Arab World	1955.2	466.1	2421.3	1292.8	(534.4)	3179.7
East, S.E. Asia & Oceania	3330.9	989.6	4320.5	10860.2	(3019.2)	12161.5
Europe	102.5	0.5	103.0	114.3	(37.8)	179.5
Indian Ocean	4824.4	1372.8	6197.2	2195.8	(668.2)	7724.8
Western Hemisphere	9759.2	3369.9	13129.1	15286.6	279.4	28695.1
Countries Not in IPPF Regions	446.9	204.3	651.2	204.5	(16.0)	839.7
Projects in Collaboration with Other Agencies	3183.2		3183.1			3183.2
Secretariat Operations and Projects	12066.0		12066.0			12066.0
Other Budget Items	(385.3)		(385.3)			(385.3)
Difference in Currency Translation	215.6		215.6			215.6
TOTAL	42819.4	8115.8	50935.2	31479.3	(4735.8)	77678.7

RECONCIATION WITH 1983 AUDITED ACCOUNTS

Total IPPF Grants as above	50935.2
LESS: In Kind Commodities	2802.6
Total Expenditure per Audited Accounts	<u>48132.6</u>

WORLD SUMMARY OF EXPENDITURE (By Location)

1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Africa	7396.0	2469.2	9865.2	1891.4	307.2	12063.8
Arab World	2630.9	290.8	2921.7	894.5	(20.3)	3795.9
East, S.E. Asia & Oceania	3306.3	1207.1	4513.4	11077.3	103.8	15694.5
Europe	98.7	134.8	233.5	106.9	(4.9)	335.5
Indian Ocean	5237.4	1038.8	6276.2	2536.5	476.6	9289.3
Western Hemisphere	10098.2	3649.1	13747.3	19232.7	1274.0	34254.0
Countries Not in IPPF Regions	627.5	302.7	930.2	208.2	19.2	1157.6
Projects in Collaboration with Other Agencies	2550.0		2550.0			2550.0
Secretariat Operations and Projects	13910.0		13910.0			13910.0
Other Budget Items	1305.0		1305.0			1305.0
TOTAL	47160.0	9092.5	56252.5	35947.5	2155.6	94355.6

WORLD SUMMARY OF EXPENDITURE (By LOCATION)

1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Africa	8278.4	3166.4	11444.8	2099.5	-	13544.3
Arab World	2949.8	492.7	3442.5	1798.0	-	5240.5
East,SE Asia & Oceania	3644.5	1082.4	4726.9	11604.6	-	16331.5
Europe	79.0	154.8	233.8	152.0	-	385.8
Indian Ocean	6056.7	1374.4	7431.1	3221.0	-	10652.1
Western Hemisphere	9855.7	4165.6	14021.3	18545.1	-	32566.4
Countries Not in IPPF Regions	885.7	306.3	1192.0	192.5	-	1384.5
Projects in Collaboration with Other Agencies	2550.0		2550.0			2550.0
Secretariat Operations and Projects	16527.0		16527.0			16527.0
Other Budget Items	1135.0		1135.0			1135.0
Reserve Fund	250.0		250.0			250.0
TOTAL	52211.8	10742.6	62954.4	37612.7		100567.1

EXPENDITURE SUMMARY - Countries Not in IPPF REGIONS

1983 ACTUAL

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
China	288.5	-	288.5	-	-	288.5
Cuba	60.3	53.8	114.1	-	(2.6)	111.5
Israel	94.0	-	94.0	21.5	(13.3)	102.2
Vietnam	4.1	150.5	154.6	183.0	(0.1)	337.5
TOTAL	446.9	204.3	651.2	204.5	(16.0)	839.7

EXPENDITURE SUMMARY - Countries Not in IPPF Regions
1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
China	500.1	-	500.1	-	-	500.1
Cuba	47.4	82.7	130.1	-	-	130.1
Israel	80.0	-	80.0	25.2	19.2	124.4
Vietnam	-	220.0	220.0	183.0	-	403.0
TOTAL	627.5	302.7	930.2	208.2	19.2	1157.6

EXPENDITURE SUMMARY - Countries not in IPPF regions

1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Ghana	750.0	-	750.0	-	-	750.0
Cuba	45.7	74.3	120.0	-	-	120.0
Israel	80.0	-	80.0	26.5	-	106.5
Vietnam	10.0	232.0	242.0	166.0	-	408.0
TOTAL	885.7	306.3	1192.0	192.5	-	1384.5

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US\$'000)

COUNTRIES NOT WITHIN REGIONS

	<u>SUPPLIES PURCHASED BY IPPF</u>		
	ACTUAL EXPENDITURE	ESTIMATED EXPENDITURE	PROJECTED EXPENDITURE
	<u>1983</u>	<u>1984</u>	<u>1985</u>
Contraceptives	146.7	211.9	156.0
Medical & Surgical	46.9	62.0	130.6
Audio Visual Equipment	5.5	28.8	11.3
Office Equipment	-	-	8.4
Transport	-	-	-
	<hr/>	<hr/>	<hr/>
TOTAL	<u>199.1</u>	<u>302.7</u>	<u>306.3</u>

<u>AID SUPPLIES DONATED TO IPPF</u>			
Contraceptives	<hr/>	<hr/>	<hr/>
	-	-	-
FULL TOTAL	<u>199.1</u>	<u>302.7</u>	<u>306.3</u>

IPPF SECRETARIAT

SUMMARY OF EXPENDITURE (BY ACTIVITIES)

	1983 ACTUAL \$'000	1984 LATEST ESTIMATE \$'000	1985 BUDGET \$'000
	<u> </u>	<u> </u>	<u> </u>
Volunteer Activities	1295.1	986.1	1219.5
Field-Related Activities	4177.4	5074.4	5849.8
Secretariat Activities	9058.7	7849.8	9457.5
	<u> </u>	<u> </u>	<u> </u>
TOTAL	<u>14531.2</u>	<u>13910.3</u>	<u>16526.8</u>

INCOME OF NON-GRANT-RECEIVING ASSOCIATIONS

The summary below gives details of 1983 Income advised by certain non-grant-receiving members of the IPPF. Figures are taken from Annual Reports or Estimates given by member Associations.

REGION	COUNTRY	1983 INCOME S'000
EUROPE	Austria	63.4
	Denmark	269.3
	Federal Republic of Germany	371.2
	Finland	877.0
	France	489.1
	Ireland	550.0
	Sweden	305.4
	United Kingdom	2,616.6
E & SE ASIA & OCEANIA	Japan	3,495.0
	New Zealand*	1,251.0
WESTERN HEMISPHERE	Canada**	254.0
	United States of America	203,700.0

* year ended March 31 1984

** National Office only

AUDITORS' REPORT

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION
INTERNATIONAL OFFICE**

31 December 1983

**PRICE WATERHOUSE & CO.
CHARTERED ACCOUNTANTS**

**AUDITORS' REPORT TO THE MEMBERS OF
THE CENTRAL COUNCIL OF THE INTERNATIONAL PLANNED
PARENTHOOD FEDERATION**

We have audited the financial statements on the following pages in accordance with approved Auditing Standards.

In our opinion these financial statements, which have been prepared under the historical cost convention, give under that convention a true and fair view of the state of affairs at 31 December 1983 of the International Office of the International Planned Parenthood Federation and of its income and expenditure for the year then ended.

PRICE WATERHOUSE

Chartered Accountants

18 July 1984

INTERNATIONAL PLANNED PARENTHOOD FEDERATION — INTERNATIONAL OFFICE

ORGANISATIONAL STRUCTURE AND NATURE OF ACTIVITIES

The International Planned Parenthood Federation — International Office — monitors and co-ordinates activities carried out world-wide by the regional and field offices of the International Planned Parenthood Federation and individual Family Planning Associations and grant-receiving countries. It also carries out various international projects concerned with family planning frequently in collaboration with other international agencies and controls and assists in community based distribution of contraceptives.

Principal sources of revenue of the International Planned Parenthood Federation are grants and donations from governments and from the fund raising activities of family planning associations and other organisations.

The International Office provides technical assistance and advisory services to family planning associations throughout the world. It grants financial assistance to the associations both in terms of monetary and non-monetary grants.

The International Office also acts as an executing agency for various projects financed and carried out in partnership with other organisations.

In order to carry out these tasks the International Office provides, inter alia, the following services to family planning associations:

1. Assistance in the formulation and development of information, education and training programmes, including the application of audio visual and mass media materials.
2. Assistance with medical and clinical activities, advice on family planning technology and maintenance of clinical services statistics.
3. Promotion of national and local fund raising campaigns, advice and materials support.
4. Assessment of the conduct and effect of programmes and assistance to improve local capacity to plan, programme, report and evaluate.

INTERNATIONAL PLANNED PARENTHOOD FEDERATION — INTERNATIONAL OFFICE

The International Planned Parenthood Federation (“IPPF”) is a registered charity incorporated under the International Planned Parenthood Federation Act 1977. The members of the IPPF are the Associations. They account separately for any funds they receive including those from the International Office of the IPPF and accordingly their activities are not dealt with in these financial statements.

STATEMENT OF ACCOUNTING POLICIES

1. GRANTS AND DONATIONS RECEIVED

All grants and donations are considered to be available for unrestricted use unless specifically restricted by the donor. They are taken into account in the year that the gifts are designated by the donor as having been made.

2. OTHER INCOME AND EXPENDITURE

Other income and expenditure is accounted for on an accruals basis with the exception of the purchase of commodities where the value of orders placed, but not shipped are expensed immediately. Expenditure incurred on projects in collaboration with other organisations includes administrative expenditure applicable to them.

3. FIXED ASSETS

Freehold property is stated at the value transferred from the ESEAOR regional office. Leasehold property is stated at cost less accumulated depreciation. Provision is made for depreciation in equal annual instalments over the period of the relevant lease. The cost of office furniture and equipment is written off on acquisition.

4. CURRENCY TRANSLATION

Balance and transactions in currencies other than in US dollars have been expressed in US dollars on the following basis:

Balance Sheet —	Rate ruling at 31 December 1983 \$1.45 = £1.00 (1982 \$1.62)
Income and Expenditure —	At an average rate for the year \$1.51 = £1.00 (1982 \$1.74)

Differences arising on currency translation are shown in the Statement of Income and Expenditure.

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**STATEMENT OF INCOME AND EXPENDITURE AND FUND BALANCES
FOR THE YEAR ENDED 31 DECEMBER 1983**

		NOTE	US DOLLARS	US DOLLARS
1982				
US DOLLARS	INCOME			
	Grants from Governmental sources:			
355,704	Australia		285,785	
3,420,631	Canada		4,231,770	
1,480,698	Denmark		1,567,034	
167,420	Finland		185,597	
2,276,382	Federal Republic of Germany		2,197,385	
9,000,000	Japan		9,500,000	
1,269,284	Netherlands		1,206,407	
184,492	New Zealand		163,622	
3,627,326	Norway		3,681,434	
7,481,060	Sweden	1	3,896,610	
4,437,000	United Kingdom		4,077,000	
12,000,000	United States of America		11,000,000	
61,329	Others		111,284	
45,761,326				41,103,928
	Grants from private sources:			
11,000	Population Crisis Committee Planned Parenthood Federation of America		37,000	
195,243	Population Concern/UK FPA		210,000	
148,316	Planned Parenthood Federation of Canada		158,354	
127,215			39,667	
481,774				445,021
	Other income:			
151,704	Bank interest		374,170	
116,635	Sales of publications		69,965	
1,494	Membership fees		1,375	
123,946	Miscellaneous income		42,543	
393,779				488,053
	Income from collaborative projects:			
1,261,530	Japan/UNFPA		1,171,600	
435,678	USAID/PIPOM		100,000	
956	Population Crisis Committee		339,793	
150,000	Denmark for India		—	
47,748	Sweden for CRESALC		51,993	
123,700	Canada for Africa		275,237	
—	Canada for Mexican International Conference on Population		5,036	
—	UNFPA for Lesotho		25,404	
—	University of North Carolina for Tanzania		41,400	
2,019,612		3		2,010,463
48,656,491	TOTAL INCOME			45,047,465

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**STATEMENT OF INCOME AND EXPENDITURE AND FUND BALANCES
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

1982 US DOLLARS	NOTE	US DOLLARS	US DOLLARS
EXPENDITURE			
Cash grants to Associations:			
7,359,223		7,320,805	
1,678,672		1,955,244	
3,136,616		3,330,935	
50,000		102,500	
4,562,900		4,824,427	
10,702,619		9,748,157	
210,323		446,912	
27,700,353			27,764,980
Commodity grants to Associations:			
1,060,260		1,342,107	
299,294		416,978	
822,650		860,474	
4,400		—	
579,744		651,768	
1,931,832		1,837,549	
429,583		204,262	
5,127,763			5,313,138
3,813,990	3		3,158,202
6,477	4		25,000
3,549,300	5		2,181,600
7,227,424	6		9,859,422
788,962	7		(385,263)
395,751			215,612
48,610,020			48,132,691
48,656,491			45,047,465
46,471			(3,085,226)

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**STATEMENT OF INCOME AND EXPENDITURE AND FUND BALANCES
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

FUND BALANCES	Note	General	Staff reserve fund (Note 17)	Total
At 31 December 1982				12,709,056
Balance at 31 December 1982 of funds earmarked for specific projects, transferred to current liabilities				<u>(314,540)</u>
Adjusted balance at 31 December 1982		12,394,516	—	12,394,516
Transfer of funds from Africa regional office	8	580,139	—	580,139
Transfer to staff reserve fund.		(925,000)	925,000	—
Transfer funds from IPPF-WHR		—	290,000	290,000
Deficit for the year		<u>(3,085,226)</u>	<u>—</u>	<u>(3,085,226)</u>
		<u>\$8,964,429</u>	<u>\$1,215,000</u>	<u>\$10,179,429</u>

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

BALANCES SHEET — 31 DECEMBER 1983

1982 US DOLLARS	NOTE	US DOLLARS
CURRENT ASSETS		
114,600		
6,202,633	9	504,854
8,759,313		8,745,079
114,176	10	2,485,229
—	11	201,853
14,728		172,423
		111,664
15,205,450		12,221,102
LESS: CURRENT LIABILITIES		
10,000		158,409
2,355,242		1,357,932
551,482	12	—
230,698	13	120,976
314,540	14	1,032,114
3,461,962		2,669,431
11,743,488		9,551,671
536,680	15	529,193
114,348	16	98,565
12,394,516		10,179,429
Representing:		
12,394,516		8,964,429
—	17	1,215,000
12,394,516		10,179,429

Emile P Elias — Treasurer
 Thomas Ng — Chairman of Central Council
 18 July 1984.

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1983**

1 GRANT FROM SWEDISH GOVERNMENT

The Swedish government, whose fiscal year runs from 1 July to 30 June, have asked that their grant be apportioned in order to reflect the redesignation of the amount applicable to the period covered by these accounts. This redesignation of Swedish government grant has the result that no accrual has been made this year for the grant receivable on 1 January 1984. In future, grants from the Swedish government should, effectively, be accounted for in the period in which they are received.

The effect of this chapter at 31 December 1983 has been a reduction of income, current assets and the general fund by US\$3,726,708.

1982		US DOLLARS
US DOLLARS	2 OTHER GRANTS FROM GOVERNMENTAL SOURCES	
13,479	Nigeria	33,784
20,000	Korea	20,000
—	China	20,000
10,000	Indonesia	10,000
—	Pakistan	7,747
5,498	Mauritius	5,404
5,405	Tunisia	5,405
1,822	Thailand	2,000
4,000	Barbados	4,000
—	Sudan	2,600
—	Jamaica	344
1,125	Philippines	—
61,329		111,284

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

3 PROJECTS IN COLLABORATION WITH OTHER AGENCIES

	IPPF	1983		IPPF	1982	
		Income Others	Expend- iture		Income Others	Expend- iture
Japan/UNFPA	1,136,656	1,171,600	2,308,256	1,112,193	1,261,530	2,373,723
Population Crisis Committee	—	339,793	339,793	488,612	956	489,568
Sweden for CRESALC	70,483	51,993	122,476	193,573	47,748	241,321
Canada for Africa	—	275,237	275,237	—	123,700	123,700
Canada for Mexico	—	5,036	5,036	—	—	—
USAID/PIPOM	—	100,000	100,000	—	435,678	435,678
University of North Carolina for Tanzania	—	41,400	41,400	—	—	—
UNFPA/Lesotho	—	25,404	25,404	—	—	—
Denmark/Calcutta	—	—	—	—	150,000	150,000
	<u>1,207,139</u>	<u>2,010,463</u>	<u>3,217,602</u>	<u>1,794,378</u>	<u>2,019,612</u>	<u>3,813,990</u>

Income — IPPF represents amounts allocated to collaborative projects from the grants received by the International Office during the year.

Income — Others represents specific grants received by the International Office for collaborative projects.

Expenditure comprises \$3,158,202 (1982 — \$3,813,990) for funds advanced directly by the International Office for projects implemented by other operating agencies and \$59,400 (1982 — \$Nil), included in Cash Grants to Associations, for projects implemented by Family Planning agencies.

1982

US Dollars

4 GRANTS TO OTHER AGENCIES

—	CEFPA	25,000
477	David Owen Centre	—
6,000	Others	—
<u>6,477</u>		<u>25,000</u>

5 CASH REMITTANCES TO REGIONAL OFFICES

1,344,300	Africa	—
<u>2,205,000</u>	Western Hemisphere	2,181,600
<u>3,549,300</u>		<u>2,181,600</u>

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

6 SECRETARIAT OPERATING EXPENSES

1982 US Dollars		Total US Dollars	Management US Dollars	Operations US Dollars	Policy Management Information and International Relations US Dollars	Services and Resource Development US Dollars
3,573,938	Personnel costs	4,091,521	544,222	1,706,332	717,131	1,123,836
187,986	Consultancies	241,291	71,833	107,610	19,280	42,568
1,358,147	Travel fares and expenses	2,872,049	490,881	1,537,095	437,162	406,911
993,895	Occupancy	1,036,171	—	169,292	197	866,682
159,577	Telephone and telex	215,474	—	—	—	215,474
109,456	Postage	202,276	—	80,237	1,095	120,944
15,526	Amortisation	11,028	—	—	—	11,028
508,745	Printing and publication costs	544,867	—	226,452	306,683	11,732
116,236	Professional fees	148,355	43,071	—	180	105,104
43,716	Other expenses	316,297	12,137	210,198	37,972	55,990
80,400	Washington office	—	—	—	—	—
67,530	Project cash grants	—	—	—	—	—
104,556	Commodity grants	93,475	—	—	—	93,475
162,801	PPBR Training	—	—	—	—	—
57,325	Value added tax unrecoverable	86,618	—	—	—	86,618
(312,410)	Prior year adjustments	—	—	—	—	—
7,227,424		9,859,422	1,162,144	4,037,216	1,519,700	3,140,362
	Prior year adjustments comprise:					
(113,293)	Transfer of funds for PCC Commodity purchase	—				
(199,117)	Provision made for commodity purchases which were not actually incurred	—				
(312,410)		—				

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

1982
US Dollars

7 EXCEPTIONAL ITEMS

487,842	Secretariat rationalisation	—
150,000	Overaccrual on prior year provision for recruitment expenses for new Secretary General (1982 — provision for recruitment expenses)	(85,263)
151,120	Redundancy settlement and related legal costs	—
—	Liability on Calcutta project written back	(300,000)
788,962		(385,263)

8 FUNDS OF FORMER REGIONAL OFFICES

On 1 January 1983 the Africa Regional Office was closed and its activities were transferred to the International Office (1982 — Europe and ESEAOR regional offices were transferred). Its reserves were incorporated into the accounts as follows:

	1983			1982
	Africa US\$	Europe	ESEAOR	Total US\$
Current assets	627,458	65,832	273,735	339,567
Less: Current liabilities	(47,319)	(8,563)	(38,359)	(46,922)
Net current assets	580,139	57,269	235,376	292,645
Fixed assets	—	—	65,156	65,156
	580,139	57,269	300,532	357,801

9 CASH GRANTS PAID IN ADVANCE TO ASSOCIATIONS

100,000	East and South-East Asia and Oceania	504,854
4,600	Africa	—
114,600		504,854

These grants represent payments made to Associations in 1983 from their 1984 budgeted allocations, being funds required in early January for the performance of their programmes.

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

1982		US Dollars
US Dollars		US Dollars
10 RECEIVABLE FROM NON-IPPF SOURCES		
195,243	Planned Parenthood Federation of America	200,000
—	United States of America	1,500,000
—	Planned Parenthood Federation of Canada	43,667
3,449,452	Sweden	—
4,000,000	Japan	—
150,000	Danida	—
—	Expenditure recoverable on UNFPA/Lesotho collaborative project	25,404
964,618	Miscellaneous amounts receivable	716,158
<hr/>		<hr/>
8,759,313		2,485,229
11 RECEIVABLE FROM ASSOCIATIONS		
7,266	Africa	127,143
55,610	East and South-East Asia and Oceania	15,964
—	Europe	20
—	Indian Ocean	462
11,407	Arab World	2,580
32,980	Western Hemisphere	52,042
6,989	Countries not members of IPPF Regions	3,642
<hr/>		<hr/>
114,180		201,853
12 PAYABLE TO REGIONAL OFFICES		
397,029	Africa	—
9,500	Indian Ocean	—
144,953	Western Hemisphere	—
<hr/>		<hr/>
551,482		—
13 PAYABLE TO ASSOCIATIONS		
15,606	Africa	39,321
72,019	East and South East Asia and Oceania	—
—	Europe	2,163
44,639	Indian Ocean	15,233
57,083	Middle East and North Africa	52,040
41,351	Western Hemisphere	12,107
—	Countries not members of IPPF Regions	112
<hr/>		<hr/>
230,698		120,976
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**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

1982	US Dollars		
US Dollars			
	14 DEFERRED INCOME PAYABLE TO OTHER AGENCIES ON PROJECTS IN COLLABORATION		
219,044	Population Crisis Committee		279,251
95,496	Sweden for CRESALC		42,503
—	Canada for Africa		532,771
—	Canada for Mexico		71,589
—	Netherlands for India		100,000
314,540			1,032,114

15 LOANS TO ASSOCIATIONS AND STAFF

These loans are interest bearing and the Federation considers that the amounts are fully recoverable.

16 FIXED ASSETS

Cost	Freehold property US Dollars	Short leasehold property US Dollars	Total US Dollars
At 1 January 1983	80,603	194,675	275,278
Exchange adjustment	(1,653)	(20,428)	(22,081)
Additions	—	—	—
At 31 December 1983	78,950	174,247	253,197
Amortisation			
At 1 January 1983	—	160,930	160,930
Exchange adjustment	—	(17,326)	(17,326)
Charge for year	—	11,028	11,028
At 31 December 1983	—	154,632	154,632
Net book amounts			
At 31 December 1983	78,950	19,615	98,565
At 31 December 1982	80,603	33,745	114,348

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION —
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1983
(CONTINUED)**

17 STAFF RESERVE FUND

The staff reserve fund has been created with a view to setting aside funds to cover approximately 75% of the total contingent liability of staff redundancy and related costs of the entire secretariat, including overseas offices, in the event that the International Office ceased operations. The amounts set aside in 1983 represent a proportion of the total funds required. The Central Council of the Federation has decided that both the International Office and the Western Hemisphere Region Office will make further annual transfers to the staff reserve fund, so that by 1987 the fund balance will total at least \$2,845,000 in order to cover approximately 75% of the estimated total contingent liability.

AFRICA REGION

REGIONAL OVERVIEW

GENERAL ENVIRONMENT

Not only is Black Africa now unable to feed herself, but the prospects of her being able to do so in the foreseeable future seem remote. At the thirteenth FAO biennial African Regional Conference held in Zimbabwe in July 1984 forty African states committed themselves to relying chiefly on their own efforts to end the continent's food crisis: since 1960 the amount of food produced in Africa has increased by less than 2% p.a. and the rate of production is now falling, but over the same period the population has increased by well over 2% and the rate is now rising (being 3.2% during the eighties). The World Bank estimates that nearly 200m. people (more than 60% of Africa's total population) eat fewer calories each day than the UN thinks are required to provide a survival diet, and according to the FAO if cereal production continues to lag behind the growth of population the continent will only be 56% self-sufficient by 2000.

The prospects for increasing food production are not encouraging: African towns are doubling in size every ten years (if this trend continues half the population will live in towns by the end of the century), and these urbanites, rather than consuming the four major staples of millet, sorghum, cassava or maize, are prepared to pay for the convenience of bread and rice, as a result of which the towns are largely fed by imported cereals while the rural areas become increasingly stuck in the rut of subsistence agriculture. The outlook concerning protein also gives cause for concern: in the Sahelian countries livestock raising already fails to supply enough meat for domestic consumption, and milk imports have jumped five-fold over the past decade. In addition Africa is again afflicted by the usually fatal cattle diarrhoeal disease of rinderpest, which has returned after a twenty year period of quiescence to kill tens of thousands of animals in a band of countries stretching from Mali to Tanzania, and could easily spread further south to some of the biggest cattle rearing areas on the continent which have already been hard hit by drought.

In many parts of Africa the fragile topsoil, unable to withstand the combined assault of drought and the demands made on it by ever-growing populations, is vanishing. The best publicised manifestation of this is the relentless southward march of the Sahara. A recent USAID report states that if the present rate of overcutting trees in the Sahel persists until 2000, native woodlands will only be able to supply 20% of the region's fuelwood demand. The FAO estimates that although above 40% of the Sahelian flocks and herds died in the early seventies they are now up to their earlier strength. Many of their owners have altered their habits and now remain around the wells and relief lorry routes, with the result that the animals have fatally overgrazed the surrounding vegetation, reducing the affected areas to desert. The effects of these and other pressures are disturbing: in their May 1984 report the UN Environment Programme states that sand now covers six million extra hectares every year. Nor is

the erosion of Africa's precious topsoil confined to the Saharan fringe — the agricultural practices of the inexorably growing number of people have also taken a serious toll. In Ethiopia, where nine out of ten people work on the land either on rain-fed subsistence farms or as herdsmen, the steady growth in population has forced people to graze too many cattle on poor pastures, as well as intensively to cultivate marginal land; the Government estimates that half the land in Ethiopia suffers from severe erosion. By the mid-seventies, largely as a result of her increasing population, large tracks of marginal land in Kenya became barren as the rain washed the topsoil into dams and rivers. Lake Baringo is now filling up at a rate of 1 cm. a year — five million tonnes of soil lost to human use. Agricultural potential is also affected by the decrease of river and underground water. In West Africa the shallow water table not far from the surface, upon which people draw for their domestic and irrigation needs, has been drastically reduced or has completely dried up. In 1984 the flow of the Senegal River only reached one third of its usual volume, as a result of which it failed to overflow its banks, thus denying riverside crops their water supply. The present weakness of the outflow current of The Senegal, The Gambia and The Casamance means that the sea is now surging in; in 1984 it reached 300 km. up The Senegal, as a result of which the small farmers' rice near the banks has died, not only gravely affecting their livelihood but also wiping out an important source of food to nearby urban centres.

It is evident that the situation is serious, and also that it is exacerbated by the pressures exerted by the rapidly increasing number of people. It is therefore very encouraging that the Second African Population Conference in the Kilimanjaro Declaration of January 1984 noted "with concern the serious and worsening food situation as well as the devastating effects of natural and man-made disasters".

POPULATION POLICIES/FAMILY PLANNING

There is no doubt that rapid population growth in Africa is placing much pressure on the fragile African environment which it is manifestly unable to withstand, thus mortgaging the welfare of future generations. There are, however, additional reasons why the sub-Saharan states urgently need to formulate and implement policies to reduce population growth, reasons which are clearly articulated by the World Bank in its 1984 World Development Report: rapid population growth "... exacerbates the awkward choice between higher consumption now and the investment needed to bring higher consumption in the future. Economic growth depends on investment — all the more so if human skills are scarce and technology limited. But if consumption is low already, the resources available for investment are limited; faster population growth makes investment in 'population quality' more difficult. . . . The costs of rapid population growth, moreover, are cumulative. More births now make the task of slowing population growth later more difficult, as today's children become tomorrow's new parents. . . . Worst of all, inaction today could mean that more drastic steps, less compatible with individual choice and freedom, will seem necessary tomorrow to slow population growth". The World Bank goes on to argue that there are two broad justifications for governments to encourage people to have fewer children. The first is

the divergence between the benefit of numerous children as conceived by the family and the disadvantages to society at large: the public services (health, education, road construction/maintenance, communications infrastructures) which increase jobs, and therefore income, are heavily subsidised by the public sector, and rapid population growth inevitably reduces the resources available for investment and, therefore, for future growth.

A further justification is that people may be having more children than they wish, or than they would want if they had more information about, and better access to, contraceptive methods — "... fertility declines everywhere have been eventually tied to increasing use of contraception . . . It follows that programs to provide publicly subsidised information and access to modern methods of contraception can reduce fertility".

The World Development Report draws attention to the need to make a clear distinction between a population policy to lower fertility and government support for family planning services. The latter has wider social goals than fertility reduction but more limited population goals than an overall population policy, while a population policy involves explicit demographic goals, and, involving as it does a wide range of policies both direct and indirect, requires for its effective implementation clear direction and support from the most senior levels of government to ensure an interministerial approach to setting policy and monitoring its results. "Family planning programs and other socio-economic policies that can reduce fertility are often pursued by government to achieve overall development objectives, irrespective of their effect on fertility. What distinguishes countries with a population policy from those without one is an explicit demographic objective and the institutional mechanisms to translate that objective into effective policy."

About half the governments in Sub-Saharan Africa provide family planning services for health and human rights reasons, but with no demographic purpose stated; but it can not be denied that the facilities are very limited, being provided by private associations through an already greatly overstretched public health system which is barely able to reach the vast majority in the rural areas. There are only very few Black African countries which have explicit policies to reduce rapid population growth, although recently there have been indications of concern in two or three others. The explanation is not hard to find: population control is a particularly sensitive political issue wherever different groups are competing for resources; desired family size (often between six and nine) is very high; compared with other regions of the world infertility affects a disproportionate number of people and, fourthly, the lack of up-to-date and reliable demographic data (which would overwhelmingly demonstrate the magnitude and consequences of rapid population growth) results in political commitment to the promulgation and implementation of a policy to reduce growth being largely absent. Many countries, particularly the francophones, have no tradition of census-taking, and in the countries where censuses have been conducted the results, through fear of provoking serious political controversy, have never been published. As a result the size and growth rate of numerous countries are not known to any reasonable degree of certainty.

There are, however, a number of encouraging signs that things are beginning to change. The Second African Population Conference held in Arusha, Tanzania in January 1984, which was attended by more than two hundred delegates from thirty African countries and UN agencies, issued the Kilimanjaro Declaration which, inter alia, noted "with great concern the rapid rate of population growth in recent years and the stresses and strains which this increasingly imposes on African governments' development efforts and on the meagre resources at their disposal", and cited among its objectives the "achievement of population growth rates that are compatible with the desired economic growth and social development goals". The following recommendations are of particular interest:

"population should be seen as a central component in formulating and implementing policies and programmes for accelerated socio-economic development and should receive appropriate resources in socio-economic development plans".

"In order to integrate population in the development planning process, governments are urged to create or strengthen high-level population units which ensure adequate integration of population and development policies and programmes especially in rural areas".

"African governments should undertake regular programmes of conducting population censuses at least once every ten years".

The Organisation for African Unity (OAU) is also concerned: the Secretary General presented his report on the Population and Development Policy Programme of the OAU Secretariat to the Population Conference in which he frankly admitted that "progress towards integrating population variables into the socio-economic development planning process has been very slow". He went on to state that the OAU Policy Programme "is designed to draw on necessary political support to promote and co-ordinate activities leading to the formulation of appropriate population policies in OAU Member States. These will enhance national efforts in improving the living standards of most Africans. The activities leading to the ultimate programme objective involve the improvement of understanding and appreciation of the linkage between population factors and socio-economic development parameters, and the integration of population phenomena into national development planning processes".

These most encouraging attitudes had been anticipated by the Region and by FPAs. In April 1983 the Centre for African Family Studies (CAFS) held a very successful seminar on Population and Social Development in Zimbabwe which was attended by forty MPs from Botswana, Kenya, Malawi, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe, whose recommendations included an intensification of efforts to get population/FP included in national development plans. The frank exchange of thought-provoking ideas acted as a catalyst in prompting several MPs to insist that their FPAs should hold similar gatherings at the national level. In October 1983 the Region together with the Senegal FPA organised a seminar for twenty parliamentarians from the French-speaking countries of Benin, Guinea, Ivory Coast, Mali, Senegal, Togo and Zaire. This was opened by the Senegalese Minister for Social

Affairs, and, inter alia, recommended the integration of demographic variables in economic and social planning and governmental support of organisations concerned with family planning. In April 1984 a most successful Leadership Education Seminar, organised by the Regional Bureau was held in Sierra Leone for forty-three participants from Nigeria, Ghana, The Gambia, Liberia and Sierra Leone. The seminar was opened by the Mayor of Freetown; the keynote address was given by the Minister of Planning, and the recommendations included that population activities should be properly co-ordinated at national level and should form an integral part of socio-economic activity. A further leadership education seminar is planned for the fourth quarter of 1984 for those francophone countries which did not participate in the Dakar seminar, namely Burundi, Cameroon, Comoros, The Congo, Madagascar, Mauritius and Rwanda.

At the national level Associations have also been very active: in October 1983 The Gambia FPA, in collaboration with the legislature, organised a conference on Family Planning and Development which was opened by the Vice-President of The Gambia. This brought together about twenty MPs and many observers from all over the country, and the recommendations included that the Government should set up a Population Commission to monitor population growth and the implementation of family planning programmes. In March 1984 the Madagascar Association followed up their first (1982) parliamentarians seminar with a second designed to increase the participants' awareness of the links between population and development and to influence them to include population matters in their development plans. In May 1984 the FPA of Tanzania organised a seminar for sixty-five leading parliamentarians and government ministers on Population and Development the aim of which was to obtain increased support for the FPA at district, regional and national level. It was opened by the Secretary General of the Ruling Party and chaired by the Speaker of Parliament, and made thirteen recommendations which all fell within four broad areas; the need for increased research and improved data collection; the need for increased education, information and motivation; the need for increased comprehensive services in family health and family planning to be made accessible throughout the country, and the need to review existing laws and policies in family welfare and the status of women and to make them more supportive of national welfare objectives.

In July 1984 a highly successful two-day seminar on Population and Development for national leaders was held by Kenya's National Council for Population and Development. This was attended by about two thousand people including cabinet ministers, assistant ministers, MPs, senior civil servants, leaders drawn from provinces and districts throughout the country, and representatives of international agencies, of the Region and of the Kenya FPA. The Vice-President of Kenya chaired the seminar throughout. The President of the World Bank delivered the keynote address and local press coverage was extensive. Kenya's target is to reduce the annual population growth rate from 4.1% to 3.5%, and it was recommended, inter alia, that all government ministries and agencies and all NGOs should specify population components in their development programmes and activities and should pursue them effectively, and that each District Development Committee should develop strategies to achieve the national target in reducing the growth rate. In common with its eastern neighbour, the

Government of Uganda also takes the question of population and family planning very seriously; in 1981 the Government formulated a population policy, one of the objectives of which was to lower the annual population growth rate from 3.0% to 2.6%, always bearing in mind the social and cultural attitudes of the people. In December 1983 the Minister of Health addressed the FPA's annual general meeting and stated that the Government's Revised Recovery Programme on Health would emphasise the expansion of programmes of mother and child welfare, including family health education and child spacing. Additionally a Family Health Advisory Committee (formed by the Ministry of Health) would be involved in the co-ordination of family planning activities throughout the country. By way of reinforcing these top-level developments the FPA is planning a seminar for those involved in the practical implementation of such policies, namely district commissioners and administrative secretaries from all the districts in the country with the aim of making them fully conversant with the country's population policy; with the impact of rapid population growth on development; with the health advantages of spacing births, and with an appreciation of the need to support family planning for the success of the population policy. There is also increasing high-level Government and Party concern in Zambia over the rapid population growth in the country (estimated at 3.1%) upon which the Association is going to capitalise in the second half of 1984 by holding a seminar for parliamentarians, with the aim of familiarising them with the situation and with the immediate and long-term problems which are generated by rapid and unplanned population growth.

It must always be remembered that behind the welter of population statistics lie individual couples whose decision regarding the number of children they will have is a critical factor determining population growth rates, in which regard information about and access to family planning services are of paramount importance. It is not only on its stand regarding population matters that the Kilimanjaro Declaration will go down in history as a document of the greatest significance, but it will also do so on the issue of family planning where it similarly marks a turning point in the thinking of African leaders. Hitherto many governments in Africa not only felt that family planning was too sensitive a matter to be talked about openly but also that it had no contribution to make to the welfare of the people. Kilimanjaro has rendered such views obsolete. The Declaration noted that "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so" a stand also supported by the OAU, and then went on to recommend that governments should

- recognise the usefulness of family planning and child spacing on the stability and well-being of the family;
- ensure the availability and accessibility of family planning services to all couples or individuals seeking such services, free or at subsidised prices;
- incorporate FP services into the maternal and child health services;
- pay special attention to educating the grass-roots population on the health, social and demographic value of family planning;

— incorporate information on family planning and the element of family life education into training programmes for women, men and young people.

It is noteworthy that, almost without exception, the leadership education seminars organised by the Region and/or the FPAs made similar recommendations or discussed these issues which are of such critical importance in achieving an increased knowledge and wider acceptance and use of effective contraceptive methods.

In devoting ten recommendations to the improvement of the status of women the Kilimanjaro Declaration resoundingly endorsed the now indisputable evidence that a vital factor in the acceptance of effective methods of contraception is a woman whose status in the community does not depend on her fecundity alone (a view promoted further by the 1984 International Conference on Population whose recommendations included those which urged that efforts should be made to remove barriers to women's education, training, employment and access to health care). If a woman has had nine or more years of education and/or if she has some decision-making power in the household based upon her economic independence, it is made abundantly clear by numerous surveys that she will wish and be able to exercise a degree of control over her own fertility which would otherwise be denied her in a social context where traditional customs enforcing abstinence have almost completely broken down.

The African Region and the FPAs are making their contribution to increasing the opportunities available to women to obtain economic independence through the Planned Parenthood and Women's Development (PPWD) programme which, in large measure thanks to the generosity of the Swedish International Development Authority (SIDA), has developed (and plans to continue) many small-scale income-generating projects for women into which family planning is integrated. These projects began in the anglophone African countries some nine years ago, and, with the appointment of a francophone consultant in 1982, the PPWD programme is now making rapid strides in the French-speaking countries.

Seven recommendations in the Kilimanjaro Declaration reflected the concern felt regarding high infant mortality rates in the Region and the acute problems facing young people regarding the ever-increasing rate of adolescent pregnancies and the frequent corollary of clandestine abortion and sexually transmitted disease. There is no FPA in the Region without a project on either family life education (FLE) or adolescent fertility management (AFM), and increasingly Associations are succeeding either in having FLE incorporated into the school curriculum (Ghana) or in getting its inclusion accepted by the educational authorities (Kenya, Sierra Leone, The Gambia, Mali, Benin, Togo, Mauritius, Tanzania, Zaire and Madagascar). IPPFAR's future plans include the encouraging of FPAs to incorporate a greater degree of involvement by young people in their activities, the development of projects which include counselling, and, where possible, the provision of information and services. The training programmes run by the Centre for African Family Studies (CAFS) contain a significant element of Family Life Education and Adolescent Fertility Management, and CAFS has also developed curriculum guidelines on FLE for teachers and those

engaged in training young people which has been distributed throughout the anglophone countries and is shortly to be followed by the French translation, while both regional and Association francophone programmes will benefit from the recent allocation of youth responsibilities to a francophone Programme Officer.

The populations of African countries are predominately (80%) to be found in the rural areas, a situation which presents family planners with numerous difficulties when trying to reach them in the first instance, and subsequently to keep them regularly supplied. The Region has been growing increasingly concerned at the failure of government MCH/FP services to keep up with the demand for family planning, particularly in the rural areas, and, along with Associations, has felt that the time is ripe for the institution of alternative methods of service delivery. In July 1983 the Programme Officer (Medical) and the Regional Supplies Co-ordinator attended an intensive course on the development and management of community based family planning services (CBS) in Bangkok, after which they organised two CBS sub-regional workshops in the same year, one in Nigeria and the other in Kenya, at which useful contacts were made with CBS project managers and much valuable information and literature was gathered and disseminated. In October 1983 one FPA participant from Ghana, Kenya, Nigeria and Sierra Leone attended a general course in Bangkok on the development and management of community based family planning health and development, while in February 1984 five senior FPA trainers from the same countries attended a ten-day Bangkok training course on CBS. In April 1984 it was the turn of the francophones: the Region, in collaboration with the Arab World Region, sent senior FPA personnel and other family planning professionals from Benin, Burkina Faso, The Congo, Guinea, Madagascar, Mali, Rwanda, Senegal, Togo and Zaire to Morocco for a ten-day workshop on CBS, which recommended that in-country CBS workshops should be held and that there should be a variety of outlets (pharmacies, agricultural extension workers, teachers, TBAs) for the renewal of pill supplies and for the issuing of non-prescriptives.

Associations in the Region have already manifested a lot of enthusiasm for the CBS approach: in Kenya two pilot projects, each with fifteen lay educators distributing orals (with a check list), condoms, creams and foaming tablets are going well, and in August 1983 two FPAK representatives visited Zimbabwe to learn from their CBS programme. In Madagascar, the Association has inaugurated, with a commendable degree of innovation, a postal distribution service to reach clients in remote areas; in neighbouring Mauritius twenty-six condom vending machines were in operation during 1983, through which 42,780 pieces were sold. In Nigeria the Association trained thirty-five agents in the distribution of non-prescriptives in 1983; the PPA of Sierra Leone started pilot CBS projects for the distribution of non-prescriptives in the west and north of the country; the FPA of Uganda introduced CBS in 1983 in the south-west and started mobile clinics in the Kampala suburbs, and in The Gambia twenty-two TBAs provided services.

ASSOCIATIONS' PERFORMANCE AND RELATIONS WITH GOVERNMENT

The overall picture of Associations' performance and their relations with government is satisfactory. With a few exceptions Associations have performed creditably, and generally relations with governments are good. As governments become increasingly aware of and concerned about the deleterious consequences of rapid, unplanned population growth on both socio-economic development and on the environment, it can confidently be anticipated that their appreciation and support of FPAs will grow steadily.

In Nigeria there is the National Population Commission, and the Government's 1984/86 plan noted with concern the high rates of abortion and abandoned newborns. Furthermore, since 1983 a major bilateral Nigerian Government/US programme has taken off which comprises population/family planning information and education; manpower development and training; clinical service delivery, and a research/evaluation programme, which involved INTRAH, CDC, JHPIEGO, the Population Council and FPIA; while since late 1983 the Federal Ministry of Health has been taking steps to coordinate the activities of international and national organizations (including the Association) involved in population/family planning programmes. However, there is still some room for improvement in the collaboration between the Government (especially the Ministry of Health) and the Planned Parenthood Federation of Nigeria, regarding the integration of family planning with MCH services.

The Madagascar Government has not promulgated any official policy on family planning and, although the Association does not meet with any significant hindrance in its activities, the integrated approach has not moved as fast as one would have expected.

The Government of Togo has long hosted a Regional Field Office and has always supported family planning; but, until quite recently, the Togo Family Welfare Association (ATBEF) did not find it easy to provide family planning services. However, ATBEF has performed reasonably satisfactorily in the circumstances, while the Madagascar and Nigerian Associations, undeterred, press vigorously on and record satisfactory programme implementation although working in very difficult economic conditions.

On the other hand, an entirely different situation is to be found in Lesotho. Although the involvement of the Government of Lesotho in the provision of family planning education and services is minimal and at least 50% of the population is Roman Catholic, the attitudes legitimised in official pronouncements and the facilities made available to the LPPA are among the most favourable imaginable.

In its 1977/81 Plan the Government committed itself to reducing the annual population growth from 2.4% to 2.0%, and in 1980 adopted ten policy guidelines aimed at integrating population factors into national development, which included the

following : that population and family planning education can be integrated into all formal and non-formal education programmes for adults and adolescents. Furthermore, the Government has a campaign, in collaboration with the Church and other relevant organizations, to make Lesotho nationals aware of population growth rates and socio-economic development and the positive aspects of fertility regulation. In addition to this encouragement, the Government has made all its facilities available to LPPA, including Ministry of Health facilities and personnel; the training facilities of the Ministry of Agriculture; the free use of radio time and newspaper space; management training facilities; the use of the Long Distance Teaching Centre for the production of information materials at a subsidised rate, and the provision of free transport by District Administrators.

The situation prevailing at the Burkina Faso (formerly Upper Volta) Association is somewhat unsettled. Although not operating in such a remarkably favourable climate as the LPPA, the Government does nothing to hinder the operations of the Association, but AVBEF has not managed to capitalize effectively on this positive attitude of the Government. Some management problems still exist and the Region has repeatedly assisted AVBEF to improve its financial and programme management.

The situation in the Ivory Coast Association has improved slightly and the Secretariat has been continuing its long-standing efforts to try and develop a viable organization from a restricted volunteer group, with a view to opening AIBEF up to a wider and more dynamic membership.

Another francophone Association which is still struggling to improve its capacity is Senegal's ASBEF, which was revived with government backing in 1979. In Senegal the Government is concerned about the rapid population growth rate : at the October 1983 Dakar meeting of francophone parliamentarians, the Senegalese Minister for Social Development warned the representatives of seven countries about the growing gap in West Africa between annual population growth rates of between 2.7% and 3.2% and the annual increase in food production of only around 1.0%. In February 1984 the Ministry of Social Welfare convened a meeting of all national organizations and government departments concerned with population and family planning, with the aim of making recommendations to Government on a population/family planning policy. From 1979 ASBEF experienced a number of vicissitudes, but the Region had hoped that by the start of 1984, after a great deal of technical assistance and with a completely new group of senior staff, the problems had been overcome and that this would correspondingly be reflected in significantly better performance. Progress is being made, the staff has been upgraded and the leadership of senior volunteers is being improved. Although the programme implementation so far in 1984 has not been up to standard, the situation is being monitored closely and technical assistance continues to be given as needed.

Although the Government of Benin has not promulgated a population policy, like the Government of Senegal, it has also long been a strong supporter of the Family Planning Association, giving the CNBPF the use, free of charge, of the mass media

and other infrastructures to enable the message to be spread and contraceptives to be distributed, and encouraging the Association to work with its mass organizations for the mobilisation of women and young people. Unfortunately volunteer/staff relations are not satisfactory and this has adversely affected the management of the headquarters office. As part of its continuing efforts to seek a solution to the problem, the Region arranged for an OPE mission to be sent in July 1984, and it is sincerely to be hoped that the team will have been able to contribute to a resolution of the situation.

Like all families, Africa has her "problem children", and the difficulties in the above-mentioned Associations should not detract unduly from the solid progress made by the majority of FPAs in the Region. It has already been indicated that, among the francophones, the Madagascar FPA is doing well; on the mainland the Zaire Association, with its competent and committed staff, is achieving good programme implementation in a country where the daunting economic conditions (in October 1983 the currency was devalued by over 500%) mean that the majority of less dedicated people work only part-time in a job for which they receive full-time remuneration. The attitude of Government is generally favourable, although everybody working in the family planning field has to keep a weather eye open for Roman Catholic opposition which has the potential to be very powerful; the Government is, nevertheless, moving ahead with its major joint USAID project (US\$14 million) for the inclusion of family planning in the primary health care service. To the Northwest, successive Governments of Sahelian Mali have long been favourably disposed towards family planning. The FPA received recognition in 1972; two years ago a Memorandum of Understanding was drawn up between the Ministry of Health and AMPPF, and the press, radio and television carry news reports, features and discussions on family planning and FLE; further, thanks to the support of the Government, the FPA is able to collaborate closely with state-organized mass mobilisation groups for women, workers and young people. The problems of women were receiving much attention, with the National Union of Malian Women, the Labour Union and youth organizations having embarked on campaigns whose object is to awaken the citizens' conscience to problems including the dangers of repeated, closely-spaced pregnancies, infanticide and female circumcision. AMPPF's performance is fair, but the Region feels strongly that it could be much better if the high proportion of elderly staff were replaced by younger, better qualified people, a change which the Secretariat has repeatedly been urging, but so far with little success.

In the West African anglophone countries it is encouraging to be able to report that both relations with government and FPA performance in The Gambia, Sierra Leone, Liberia and Ghana are on the whole excellent. The government of The Gambia has for at least a decade been favourably disposed towards family planning, and, with the publication of its 1981/6 Development Plan, came out in favour of "the simultaneous reduction of both mortality and natural population growth rates" through integrating family planning into the MCH services, involving other government departments in FP motivation activities and in giving strong support to GFPA. In the Plan the Government also assigned its role to GFPA, which includes the following: "GFPA

will be encouraged to participate in, and contribute to family planning/MCH and primary health care services in areas where government still lacks qualified personnel. GFPA will endeavour to sustain the Government's commitment to family planning." As well as providing duty-free concessions the government also allows the Association rent-free premises for its headquarters and rural clinics and provides free radio time; in January 1984 a Memorandum of Understanding was signed between the FPA and the MCH/FP department of the Ministry of Health. It is hoped that when the results of the 1983 census become available that the government will be spurred on further to support an increase in family planning activities. The Association has on the whole performed creditably over the years, but it has a poor record regarding the realistic forecasting of projected expenditure and it is essential that improvements are made in this; improvements would also not come amiss in the area of project development which currently leaves a certain amount to be desired.

Although the government of Sierra Leone has not yet promulgated a population/FP policy its attitude is favourable: a National Population Council was set up in September 1982 with PPASL as one of its members, and its terms of reference include advising the government on the formulation of a population policy; the promotion of an integrated approach to family planning, and the co-ordination, promotion and integration of population activities, including FP, into development planning. At the January 1984 Arusha Population Conference the government authorities stated that they were in favour of extending the provision of family planning services. Fortunate as it has been since 1979 with dedicated volunteers and staff, PPASL has improved out of all recognition: quality reports are received on time; Association activities are no longer almost exclusively capital-based; collaboration with both governmental and non-governmental agencies is good, and innovative projects are being undertaken. In neighbouring Liberia, the President is the Chief Patron of FPAL, and the government, concerned at the very high rate of infant and maternal morbidity/mortality, in 1983 endorsed the integration of family planning into the national health services, saying that responsible parenthood was just as important as a responsible fiscal policy in contributing to an improved standard of living. A working committee headed by the Ministry of Planning and Economic Affairs was also set up "to identify problems and issues affecting the population and make proposals towards the formulation of a national population policy". For a number of years FPAL's performance has been poor, with continual Secretariat assistance failing to have any appreciable effect, but as from mid-1983, with the appointment of a dynamic lady volunteer to the Chief Executive post, there has been a dramatic change: the recommendations of the November 1982 OPI have been implemented; a strong volunteer base has been established at branch level as well as in the capital; quality reports are received on time; staff morale has risen; financial administration has improved; some clinics have been integrated into the government MCH structure; good relations have been established with other agencies, and innovative projects are being introduced aimed at young people, at slum dwellers and at the rural areas. The well documented support of the Ghanaian authorities for family planning and population related policies goes back to the sixties, a situation from which the PPA of Ghana has always benefited and used to its full advantage. The Association's general management and programme

implementation continues to be remarkably good given the extremely difficult economic circumstances in which it is having to operate.

There is also strong government support for family planning and for the Association in Ethiopia, where FGAE collaborates closely with the mass organisations for workers, young people and women. Like the Tanzania Association, FGAE is charged by government with training FPA personnel, an area in which they have had great success with 75% of trainees being allocated to supply FP services after graduation, which has ensured the rapid advance of the government MCH/FP programme. The results of Ethiopia's first census should be available by the end of 1984, and, as it is believed that the government attaches considerable importance to the results, it is hoped that the formulation of relevant policies will follow. If such policies do materialise it can be guaranteed that FGAE, which is excellently managed and has a solid record of good programme implementation and innovative projects, will play its part to the full in contributing to the implementation of any new directives. The government of Kenya, with its aim of reducing population growth from 4.1% p.a. to 3.5% p.a., has long been a supporter of family planning. The Ministry of Health has recently formed a committee to co-ordinate CBD activities, and will pay special attention to the standardisation of the range of contraceptives being provided to ensure that clients attending clinics can be resupplied through CBD. Unfortunately the FPA of Kenya has in the past significantly failed to match the record of her neighbouring Ethiopian FPA in so far as seizing favourable opportunities provided by government is concerned. This was largely due to the hesitation of the volunteers in getting to grips with staff problems.

At least this did not prevent FPAK from inaugurating its innovative lay-educator project or from directing its activities towards young people, men and income-generating projects for women, all of which have been continued under the new chief executive who took up post in May 1983. Since her appointment the new incumbent has also pushed forward the Association's out-reach programme, contraceptives now being provided from forty-one service delivery points as well as from the ten long-established static clinics, and a revolving fund is being set up for viable women's groups.

As noted above the attitude of the Ugandan government towards family planning is very positive. The Ministry of Health has been given a mandate to co-ordinate MCH/FP activities nationwide, and will be establishing a Family Health Advisory Committee with the responsibility of guiding the government on how best to implement the plan, and the FPA will have an important role to play in assisting the Ministry in this. It is to be hoped that the Association will be able to maximise the opportunities which the authorities are anxious to make available, as, over the past two years, EPAU's performance has suffered somewhat as a result of insufficient delegation and supervision, and an element of political division among the staff.

Although not unsatisfactory, the official attitude of the government of Tanzania towards FP/population has never so far been as positive as that of its neighbours,

Uganda and Kenya, but it is anticipated that after the May 1984 National Seminar on Population and Development commitment should increase. But relations with the Association, UMATI, have without exception always been excellent, with UMATI having its government-defined role as educating the public and assisting government in promoting child spacing as part of MCH policy, and like the FGA of Ethiopia, having been charged with training; since 1975 approximately three thousand health and non-health personnel have been trained to promote and deliver FP services. Unfortunately a significant number of the Tanzanians are assigned duties which do not include family planning work. During the past two years, since the return of a most effective chief executive who has restored morale to her competent and dedicated staff, UMATI has regained its former vigour (previously lost for a few years under very weak senior management), and it is to be hoped that the Association will tackle some of the barriers currently obstructing the wide dissemination of family planning services, e.g. although MCH aides are the primary service providers, the majority are not permitted to prescribe or distribute steroids; the fact that no non-gynaecologist can prescribe injectables; the existence of laws prohibiting the sale and/or supply of contraceptives to unmarried women, and the fact that contraceptives are not on the government's Essential Drugs List for health centres and rural dispensaries which means that much of UMATI's time is taken up in their procurement and distribution.

Zimbabwe has an estimated population growth rate of 3.4% p.a., about which the government is concerned, and it has plans to issue a national population policy after the analysis of the 1982 census data is completed. There is a Primary Health Care programme whose aim is to make health services available to rural communities in which there is a strong family planning component to enable families to space their children, in addition to which the government supplies the Child Spacing and Family Planning Council with about two-thirds of its funds. The strength of official support for the Council is further manifested by the fact that at the CSFPCZ it is in the process of becoming a para-statal body under the Ministry of Health when its services will be formally integrated into every appropriate ministry. Although not yet a member of the Region the Council is keen so to become, and the Region looks forward formally to welcoming an organisation whose CBD programme, with its four hundred plus educator/distributors who provide FP and referral services, is the showpiece of Africa, and whose innovativeness in youth and PPWD programme is most encouraging.

The Mauritian FPA, very firmly rooted in the country after thirty or so years of operation, has not allowed the strong government support it enjoys to allow it to grow complacent, and continues to lead the way with innovative projects; the number of recently installed condom vending machines has been increased while collaboration with IPAVS has resulted in a growing number of clients coming forward to voluntary surgical contraception. The Association is also collaborating with the recently established Ministry of Youth, with the result that an FLE programme has been introduced into secondary schools and will be introduced into primary schools. Despite a population growth rate of 3.1% p.a. the government of Zambia has no specific policy on population/family planning as a priority area for the quality of life for both mother and child, in addition to which FP is provided in all hospitals and

health centres as part of the MCH services, and government has always allowed the Association to function freely and to distribute contraceptives to other organisations which provide services. In the past the FPA of Zambia, despite continual assistance from the Region, has been plagued for a number of years with serious management problems, and so was not in a position to make the best of the favourable environment, but with the benefit of a new group of senior volunteers and staff who have been provided by the Secretariat with appropriate training and technical assistance, it is anticipated that improvements will be effected. One area where action is urgently needed concerns young people: there is a distressing increase in teenage pregnancies, illegal abortion and sexually transmitted disease, but there is still as yet no family life education in the school curriculum. The Association is trying to get this deficiency remedied through a project which aims at highlighting these problems, and it is hoped that evidence from the project will contribute towards persuading the authorities to consider more favourably the incorporation of FLE into school curricula.

The Africa Region used to have two governments who were affiliated members, Botswana and Swaziland. However, in 1984 the latter relinquished its membership in favour of the Family Life Association of Swaziland, a vigorous FPA which has covered a great deal of ground since its inception in December 1979, and which it is hoped will become a member of the Region in 1985. FLAS has the benefit of working in a very favourable environment: the government's current five year plan states "The coverage of FP services will be increased with emphasis on the education of males with the aim of reducing the population growth rate"; family planning is integrated into MCH services, and a special FP sub-unit has been set up by the Ministry of Health in the Public Health Section which is responsible for family planning services. In the one remaining government affiliate, Botswana, the climate is no less favourable: since 1975 the aims of the National Family Planning Programme have included the reduction of infant, neonatal and maternal morbidity/mortality and the enabling of parents to plan the size of their family. The 1981 census indicated a population growth rate of almost 5.0% p.a. (although it is thought to be nearer 3.0% p.a.), in the light of which the following statement in the government's 1979/85 Development Plan is significant: "It is an important aim of the health policy . . . to make family planning advice and materials available to all potential parents and by doing so to achieve a reduction in the population growth rate".

It will be appreciated from the foregoing that, although there may be one or two Associations who would benefit from stronger government commitment to population/family planning, the overwhelming majority of those countries where the Region has a member Association, or with whom it is in contact (see below 'New Countries'), are not only wholeheartedly in favour of family planning and the FPA, but are also increasingly becoming convinced of the need to take seriously the rapid population growth they are all, without exception, experiencing. It is also clear that, despite the difficulties which will inevitably occur from time to time in a branch of the IPPF family as large as the Africa Region, overall Associations are performing creditably in circumstances which, given the prevailing infrastructural and economic

problems, are not easy. This unspectacular but nevertheless solid achievement should not be undervalued.

CENTRE FOR AFRICAN FAMILY STUDIES (CAFS)

As from January 1983 CAFS operated under its new constitution as an autonomous body with IPPFAR, and had a successful year. In August 1983 a francophone Deputy Director was appointed, since when regular training courses in French have been organised: in November a francophone course on the communication of FP messages was held in Madagascar, and in December a course on project development and management was held in Togo. CAFS' activities in 1983 also included the production of a teachers' guide for family life education, and curriculum guidelines were produced in English which are now in the process of being translated into French. In addition to the successful anglophone parliamentarians seminar on population and development held in Zimbabwe (see above) CAFS collaborated with DANIDA in running a course for Family Life Training Supervisors, and with Columbia University's Centre for Population and Family Health in organising a consultation on Contraceptive Technology Update. Collaboration with Columbia continued in 1984 with the joint organising of a similar anglophone four-week course held in the first half of the year; there was also collaboration with the Association for Social Work Education in Africa with whom an anglophone training workshop on family welfare for social work educators was held during the same period. The francophones were not neglected: 1984 has seen the running of the integrated family welfare course and a management course for senior family planning staff for both English and French speakers, while in March a course in communication in family planning was held for francophones in Dakar.

NEW COUNTRIES

The growing concern about the high levels of infant and maternal morbidity/mortality among a significant number of highly placed influential people (often women) in the 'new' countries indicates that the introduction of organised family planning will be welcomed and encouraged if recent experience in Guinea, Rwanda, The Congo and Mozambique is anything to go by. The contacts the Africa Region has carefully nurtured with the Republic of Guinea are now coming to fruition: despite an antipathetic official attitude to family planning under the previous government, representatives from Guinea were nevertheless permitted to participate in a regional training course of paramedicals, to attend the June 1983 and 1984 Regional Councils with observer status and to participate in the October 1983 Population and Development Seminar held in Dakar. The new government is taking a very different approach: the Minister of Social Welfare and Women's Development, a lady doctor who has been trained in tubal ligation, was personally very distressed by the previous regime's lack of concern for maternal and child health. She has been given broad powers by the new government to promote social welfare through every possible channel, and she favours the region's approach to family planning. The financial uncertainties currently afflicting the Federation permitting, the outlook for the establishment in the near future of an FPA, backed by high-level official encouragement, is good.

Rwanda has one of the highest population densities in the world: on farming land it is 271 persons per sq. km., and there is now a critical shortage of arable land. Their first full census in the late seventies revealed not only a larger population than had previously been assumed, but also a growth rate of 3.6% p.a. when government plans had been based on a growth rate of 2.6% p.a. Not long after the National Office of Population (ONAPO) was established, which is administered by a Board of Directors and headed by an experienced woman assisted by a well-trained and efficient staff, whose responsibilities include the development of a strong MCH/FP programme. Since 1980, the Region's relations with Rwanda have been confined to supplying ONAPO with contraceptives, but 1984 saw the implementation of an IPPF funded three-year project aimed at promoting family planning and integrating activities into two development projects in the very densely populated prefectures of Kibuye and Gisenyi.

Responsibility for family planning in The Congo lies with the Direction des Services de Santé Maternelle et Infantile et de l'Education pour la Santé (DIRSMIES), which is directed by a woman assisted by a small team of professional staff who work closely with relevant government departments and also with other organisations operating in the country who are involved in population/MCH/FP work. DIRSMIES' main functions include the planning of MCH/FP programmes for the country and, in collaboration with other bodies, ensuring that everything possible is done to promote these programmes, a role which has the full support of the Government which wants to see the integration of MCH services into all the country's health centres as a contribution to reducing infant and maternal morbidity/mortality. Although not yet a member of the Region, an excellent relationship between The Congo and the Region has developed: in May 1984 an Agreement was signed by which Government authorised the establishment of the Fifth Field Office (which for the past two years has been operating from Lomé) in Brazzaville; three IPPF-funded projects for training doctors, paramedicals and social workers will be implemented before the end of 1984, and, thirdly, DIRSMIES has drawn up a 1985/7 Three Year Plan, some components of which will be funded by IPPF. The Plan responds well to the country situation and the Region will be assisting them in training people in family life education; public health, and family planning for doctors, TBAs, midwives social workers. Additionally the Region will provide a certain amount of equipment which is essential for the satisfactory implementation of family planning in the health centres.

In contrast with these francophone countries, there is in Mozambique a somewhat ambivalent attitude towards family planning, and the Region will have to proceed with due tact and circumspection. On the one hand the Third Congress of the ruling party in 1977 recognised the need for and assigned high priority to MCH/FP as a contribution to reducing infant and maternal mortality, and recommended the integration of family planning into the MCH programme. The 1980 census revealed a population of twelve million and high pregnancy wastage and infant mortality at 114 per thousand; in the same year the government established MCH/FP as an organised activity throughout the country. However, at the moment these facilities exist in name rather than in action, as there are virtually no trained people to staff them; a centre for training nurses in MCH/FP was recently established, and its first trainees (fifty-three nurses) will be graduating this year, while a training course for TBAs will be starting in

1984. Over the past few years Mozambique has accepted a considerable amount of assistance from UNFPA, and in July 1984 UNFPA and FAO jointly sponsored a national seminar on "Population and Rural Development". Help has also been received from UNESCO which has been carrying out training in communications with an MCH/FP emphasis, and there is no reason to suppose that these organisations will not be permitted to continue their assistance. There are on the other hand some views prevailing which could, if not treated with due respect by those promoting family planning, cause Mozambicans to react unfavourably to its further promotion: the Ministry of Health was intending to launch a public education campaign on contraceptive methods but then suddenly held back, probably in response to pressure from those in Government who strongly disapprove of extra-marital or adolescent sex (this despite the fact that in some parts of the country it was sanctioned by custom for mere girls in their early teens to start child-bearing — a tradition which greatly contributes to high infant and maternal mortality/morbidity rates). A second significant factor is that of the comparatively high rates of sterility revealed by studies undertaken by the National Women's Organisation (OMM); in traditional society the lack of children constitutes grounds for divorce, as do repeated miscarriages. In addition to the concern regarding infertility there are also certain elements in the OMM which are not entirely sympathetically disposed to family planning, feeling that the overriding need at the moment is to replace those lost in the liberation war. The Region is aware that it will have to tread carefully in promoting family planning in Mozambique; however, it is most encouraging that they are happy to host a major conference IPPF hopes to hold in February/March 1985 entitled "Family Planning in the Portuguese and Spanish Speaking Countries of Africa". This will bring together representatives from Mozambique, Angola, Guinea Bissau, Cape Verde, Equatorial Guinea, Sao Tomé and Il Principe to explore the forms of possible assistance aimed at creating awareness of the need for family planning and possible avenues for the provision of services by various agencies.

INTER-AGENCY COLLABORATION

The good collaboration with other agencies noted in last year's Report has continued to develop very satisfactorily, with Associations pressing on with promoting institutional membership and with carrying out projects with governments and other organisations, so as to ensure that duplication is avoided and that resources are maximised. Nor have efforts slackened at the Field Office level. The collaboration with Nairobi-based population-related agencies continues. Among other things discussions were held with representatives of the Kenya FP Private Sector Programmes and with : the African Medical Research Foundation; IPPF was represented at the inaugural meeting in November 1983 of the Adolescent Fertility Association of Kenya which will be developing programmes to tackle the problems of teenage pregnancy, and was also represented at meetings of the African Association of Literacy and Adult Education which will, inter alia, be providing population education through national adult education associations in Africa. In 1983 the Head of Population, Africa Bureau, USAID Washington, visited the Field Office and discussed a number of issues affecting family planning in Africa, and contacts were maintained with INTRAH, Population Communication Services, Columbia University, the Carnegie Foundation

and JHPIEGO. In 1984 a Pathfinder Fund team visited the Field Office, as did a team from Population Concern, both teams being particularly interested in the Kenya FPA programme. Contact with USAID continued, focussing on the improvement of family planning service delivery through improved supply and logistics management with the USAID mission contracting the East and Southern African Management Institute (EASAMI) to execute a training project for supplies personnel from government, private and NGO sectors involved in family planning, in which the Regional Supplies Co-ordinator was involved; he was also involved in a further meeting with USAID which addressed itself to the problems of procurement, warehousing and distribution. FPIA invited the Regional Supplies Co-ordinator to join a mission to Zambia to look at improvements which could be made in supply and logistics systems there. In February a joint IPPF/WHO inter-agency planning meeting, attended by representatives from seventeen agencies, was held at which it was agreed that country situation analyses were required in order to establish the problems faced by young people which should be followed up by in-country programmes to meet their needs. While visiting Kenya in March to evaluate their assistance there the SIDA team visited the Nairobi Field Office and briefed IPPF on the trends they had observed. The fifth meeting of the ECA Africa Regional Co-ordinating Committee for the Integration of Women in Development was held in Addis Ababa in May, and attended by twelve member states, the UN agencies, the OAU and two NGOs, one of which was IPPF. IPPF was represented by a Regional Council member and the Programme Officer (PPWD) who presented a statement explaining the importance of family planning as a factor in women's development, with the request that this vital matter for women be discussed at the 1985 End of Women's Decade meeting. Co-operation with INTRAH continued with a meeting being held in June to discuss joint IPPF/CAFS/INTRAH training programmes and future areas of collaboration were outlined.

Although only set up in 1982, the Dakar Field Office quickly managed to get itself widely known, and this has resulted in several agencies getting and keeping in touch, including USAID, FPIA, ILO, UNESCO, The Council for Negro Women and UNFPA; one of the many beneficial results of the UNFPA contact is that their Senegal representative presented a paper at the IPPF-sponsored October 1983 francophone Parliamentarians Conference held in Dakar entitled 'Population Growth and Development in Africa'. To the east the Lomé Field Office maintains its collaboration with USAID and FPIA, while its long-standing excellent relations with World Neighbours continue.

Nor has the Regional Bureau been inactive: contacts have been maintained with USAID/Washington, while the Communication Programme Services section of John Hopkins University has been in touch with IPPFAR regarding the possibilities of providing funds for family planning motivational materials in Zaire and other francophone countries. In May 1984 a three-person team, one of whom was from the Africa Bureau, went to Rome for a consultation with FAO where discussions on areas of collaboration previously identified were pursued further and other possibilities were explored. The FAO expressed its full support for the recently-formed African Home Economics Association (one of whose Honorary Officers is a member of the CAFS staff); it was agreed that FAO would assist the Centre for African Family Studies in

strengthening its training activities, and FAO communication projects were identified into which population concepts could be included. IPPF, raised the issue of the fertility related problems being faced by young people, and expressed the view that there seemed to be certain channels for reaching young people which had not been fully exploited, for example the Young Farmers' Associations, and FAO responded positively to this and other suggestions. In August 1984 the Bureau was visited by the head of the Tunis Office of the Association for Voluntary Sterilisation (AVS), which has responsibility for the francophone countries of Africa, who was anxious to increase the already established AVS/IPPFAR links, and possibilities for further collaboration are being explored. The Bureau has also collaborated closely with UNFPA, IPPF having been appointed the executing agency for providing a contribution to two major UNFPA MCH/FP projects, one with the Government of Swaziland and the other with the Government of Lesotho, the Medical Officer for the latter who will be taking up post in November 1984. Reports from the Swaziland Project Supervisor show that, among other things, a successful ten-day workshop for district clinic supervisors and matrons on the Management and Administration of the National MCH/FP Programme was held in May 1984; a most useful ten-day visit to the Zimbabwe Child Spacing and Family Planning Council by two members of the MCH/FP programme, and that a thorough analysis and work plan of the IEC needs of the National MCH/FP programme had been drawn up.

Collaboration with other agencies has also led to a great deal of field activity: in April 1983 a grant of US\$800,000 was given to IPPF by the Canadian International Development Agency (CIDA) for the implementation of four projects in Africa of which three have been completed and one will be very shortly: CIDA funds were used for the October 1983 seminar for francophone parliamentarians in Dakar, to send thirty state midwives from Benin, Guinea, Madagascar, Togo and Niger to a six-week training course in Cotonou in August/September 1983, to send representatives from four anglophone FPAs to a course in Bangkok in October 1983 on the development and management of community based family planning, health and development, and to produce a set of programme support materials (which will shortly be complete) which consist of a giant flip-chart on family planning and nutrition; a film on family life education and responsible living (which has a choice of commentary in French, Wolof or English); a post-film game; a cassette tape presentation, and a slide set on sexually transmitted disease with a presenter's guide. The Japanese Organisation for International Co-operation in Family Planning (JOICFP) has been collaborating with IPPF on the inauguration of integrated parasite control/nutrition/family planning projects in the Africa Region. The first of these was started in 1982 in Tanzania and is progressing very well, while a second was begun in Zambia in 1983 and is also proceeding satisfactorily. A third agency with which collaboration has also been most fruitful is the Program for International Training in Health (INTRAH) which has supplied the funding for three courses which have been run most successfully by our Tanzania Association, with participants coming from a wide variety of anglophone countries. The first course was held in September/October 1983 for twelve senior nurse midwives on Family Planning and Clinic Skills; the second in May 1984 was a refresher course for fourteen tutors and nurse trainers in FP Clinical Skills, and the third, held in July/August 1984, was for twenty-four nurse tutors and nurse trainers in Clinical Teaching and Training Methods.

EXPENDITURE SUMMARY - AFRICA

REGION

1983 ACTUAL

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Benin	194.0	43.6	237.6	13.4	1.9	252.9
Botswana	-	49.5	49.5	-	-	49.5
Ethiopia	545.7	152.9	698.6	61.9	(3.2)	757.3
Gambia	172.5	33.8	206.3	7.4	(2.9)	210.8
Ghana	198.2	299.4	497.6	116.8	(69.6)	544.8
Ivory Coast	16.4	9.9	26.3	28.3	(3.6)	51.0
Kenya	866.9	49.5	916.4	470.3	(173.0)	1213.7
Lesotho	255.3	33.5	288.8	37.8	35.5	362.1
Liberia	482.5	38.5	521.0	37.3	(28.1)	530.2
Madagascar	155.3	63.7	219.0	92.9	46.5	358.4
Mali	106.0	30.9	136.9	15.6	21.6	174.1
Mauritius	184.8	9.1	193.9	92.8	(58.5)	228.2
Mozambique	-	5.4	5.4	-	-	5.4
Nigeria	1188.5	135.0	1323.5	348.0	(66.2)	1605.3
Rwanda	-	36.9	36.9	-	-	36.9
Senegal	153.5	19.8	173.3	-	(91.2)	82.1
Sierra Leone	233.6	37.1	270.7	32.0	(5.7)	297.0
Swaziland	28.7	20.9	49.6	-	-	49.6
Tanzania	852.8	159.8	1012.6	30.3	9.6	1052.5
Togo	204.8	11.7	216.5	6.9	(1.7)	221.7
Uganda	172.0	125.4	297.4	17.7	(32.3)	282.8
Upper Volta	79.8	4.4	84.2	2.6	26.0	112.8
Zaire	248.4	187.8	436.2	37.6	(76.2)	397.6
Zambia	315.7	129.4	445.1	14.5	(118.7)	340.9
Zimbabwe	65.4	24.7	90.1	-	-	90.1
CAFS	600.0	-	600.0	61.0	(149.8)	511.2
* Unaudited Accounts						
TOTAL	7320.8	1712.6	9033.4	1525.1	(739.6)	9818.9

EXPENDITURE SUMMARY - AFRICA

REGION

1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Benin	200.6	55.3	255.9	22.0	(5.8)	272.1
Botswana	-	101.1	101.1	-	-	101.1
Congo	-	23.5	23.5	-	-	23.5
Ethiopia	730.9	237.6	968.5	63.5	(2.7)	1029.3
Gambia	160.5	40.9	201.4	58.1	-	259.5
Ghana	100.0	552.4	652.4	104.7	-	757.1
Guinea	-	10.1	10.1	-	-	10.1
Ivory Coast	72.0	23.1	95.1	-	-	95.1
Kenya	823.0	50.7	873.7	473.8	82.4	1429.9
Lesotho	306.4	33.5	339.9	50.3	34.3	424.5
Liberia	485.6	34.3	519.9	52.3	-	572.2
Madagascar	168.7	38.7	207.4	63.1	-	270.5
Mali	137.6	44.1	181.7	18.5	8.5	208.7
Mauritius	123.3	21.2	144.5	61.5	26.3	232.3
Nigeria	1186.2	234.0	1420.2	337.6	164.9	1922.7
Rwanda	-	31.8	31.8	-	-	31.8
Senegal	100.0	9.1	109.1	-	80.7	189.8
Sierra Leone	237.0	52.1	289.1	62.7	1.3	353.1
Swaziland	12.9	48.2	61.1	-	-	61.1
Tanzania	774.9	316.8	1091.7	85.3	(5.4)	1171.6
Togo	245.2	31.9	277.1	30.0	(42.9)	264.2
Uganda	115.2	142.5	257.7	27.9	33.8	319.4
Upper Volta	73.4	8.2	81.6	12.8	-	94.4
Zaire	265.9	223.6	489.5	30.3	(21.6)	498.2
Zambia	278.4	99.0	377.4	8.0	-	385.4
Zimbabwe	108.6	-	108.6	-	-	108.6
CAFS	500.2	5.5	505.7	329.0	(46.6)	788.1
New Request	189.5	-	189.5	-	-	189.5
TOTAL	7396.0	2469.2	9865.2	1891.4	307.2	12063.8

EXPENDITURE SUMMARY - Africa

REGION

1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Benin	208.3	75.8	284.1	27.6	-	311.7
CAFS	587.6	12.4	600.0	222.1	-	822.1
Congo	29.1	32.3	61.4	-	-	61.4
Ethiopia	739.0	350.3	1089.3	63.5	-	1152.8
Gambia	174.6	42.1	216.7	85.0	-	301.7
Ghana	262.2	577.8	840.0	136.2	-	976.2
Guinea	38.2	11.5	49.7	-	-	49.7
Ivory Coast	66.4	7.5	73.9	36.0	-	109.9
Kenya	922.0	163.5	1085.5	385.5	-	1471.0
Lesotho	359.3	49.0	408.3	56.3	-	464.6
Liberia	514.0	39.7	553.7	59.8	-	613.5
Madagascar	151.6	69.6	221.2	92.5	-	313.7
Mali	183.3	92.8	276.1	5.4	-	281.5
Mauritius	161.1	18.9	180.0	61.5	-	241.5
Mozambique	22.5	75.0	97.5	-	-	97.5
Nigeria	1274.0	256.5	1530.5	433.2	-	1963.7
Rwanda	32.0	23.0	55.0	-	-	55.0
Senegal	153.5	15.4	168.9	0.4	-	169.3
Sierra Leone	202.4	65.8	268.2	156.6	-	424.8
Swaziland	113.0	59.6	172.6	17.1	-	189.7
Tanzania	750.0	281.5	1031.5	72.8	-	1104.3
Togo	276.6	67.3	343.9	20.9	-	364.8
Uganda	210.4	252.5	462.9	31.2	-	494.1
Upper Volta	100.5	29.5	130.0	1.6	-	131.6
Zaire	290.2	375.1	665.3	35.7	-	701.0
Zambia	351.6	122.0	473.6	98.6	-	572.2
Zimbabwe	105.0	-	105.0	-	-	105.0
TOTAL	8278.4	3166.4	11444.8	2099.5		13544.3

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US\$'000)

AFRICA

	<u>SUPPLIES PURCHASED BY IPPF</u>		
	<u>ACTUAL EXPENDITURE 1983</u>	<u>ESTIMATED EXPENDITURE 1984</u>	<u>PROJECTED EXPENDITURE 1985</u>
Contraceptives	927.3	1457.8	1719.0
Medical & Surgical	57.0	59.9	130.1
Audio Visual Equipment	38.2	47.9	49.8
Office Equipment	41.9	42.9	57.2
Transport	247.4	293.3	423.1
	<hr/>	<hr/>	<hr/>
TOTAL	<u>1311.8</u>	<u>1901.8</u>	<u>2379.2</u>
	<hr/>	<hr/>	<hr/>
	<u>AID SUPPLIES DONATED TO IPPF</u>		
Contraceptives	<u>370.5</u>	<u>567.4</u>	<u>787.2</u>
FULL TOTAL	<u>1682.3</u>	<u>2469.2</u>	<u>3166.4</u>

TANZANIA

FAMILY PLANNING ASSOCIATION OF TANZANIA (UMATI)

COUNTRY BACKGROUND

Tanzania became an independent country in 1961 and is a one-party socialist state. The executive power lies with the President, elected by popular vote for five years.

Tanzania covers an area of 945,087 sq kms including the islands of Zanzibar and Pemba. Mainland Tanzania has a largely tropical climate, but away from the coastal areas most of the country is sub-tropical and forms a plateau 900 — 1,200 metres above sea-level.

The country is divided into 25 regions. The regions are divided into 80 districts. Below this area the wards to which the villages report. The Government has put emphasis on resettling the scattered population into villages as the smallest socio-economic units. A village council is elected to administer all village matters.

Agriculture accounts for 40 per cent of the GNP and 70 per cent of exports but much of the farming is at subsistence level. Agriculture, forestry and fishing employ about 90 per cent of the labour force and contributed 41 per cent GNP in 1980. The chief cash crops are coffee, cotton, tobacco, cashew nuts, sisal and tea. Mineral deposits have not been fully exploited. Transport and communications are scanty and the road network serves mainly the coastal, central and north-central parts of the country. Tanzania's economy has been badly affected since the 1974 increase in oil prices. The labour force has been increasing at a rate of three per cent since 1967. The country is in deficit with respect to food supply and 260,000 tons of food were imported in 1982. Per capita GNP is low (\$299 in 1983) but its distribution is more even than in most developing countries. In 1970, the Government initiated a communal village scheme, with a view to raising rural standards of living and agricultural production and developing local industries.

The population estimated in 1983 at 20.5 million is ethnically diverse and comprises over 130 ethnic groups. Swahili is the primary language but English is spoken widely in the urban areas. Over 60 per cent of the mainland population and 97 per cent of the population of Zanzibar are Muslims. Thirteen per cent of the country's population are Christians, predominantly Roman Catholic.

Education at all levels is free. Villages are encouraged to build their schools and run adult literacy classes. Over 90 per cent of the school-age children can now expect to receive at least seven years of education. Adult literacy rose from 33 per cent in 1967 to 73 per cent in 1978. The focus of development is on the rural areas in accordance with the philosophy of UJAMAA (collective or co-operative efforts). The priority is on universal primary education, manpower training, the housing

sector and extension of health services to rural areas rather than the previous target of increasing per capita income. MCH is a primary concern. Priority has been given to preventive health care to raise life expectancy and lower infant and maternal mortality rates. At present 60 per cent of mothers and children have access to health services.

The state operates hospitals and health centres. In 1980 there were 128 hospitals (including 60 run by voluntary agencies), 161 rural health centres (25 constructed annually), 2,088 rural dispensaries (including 300 run by voluntary agencies; 100 being built annually by the Government) and village-based health posts. In 1980, privately owned medical facilities were nationalised.

The country is sparsely populated with an average density of 20 person per sq km. There is, however, wide variation in population size and density from region to region, ranging from 7 persons per sq km in Rukwa to 670 persons per sq km in Dar-es-Salaam. Urban population is estimated at about 15%. The Government of Tanzania actively discourages rapid urban population growth as a matter of policy.

As a whole the population of Tanzania is now growing at an estimated 3.2 per cent annually with a crude birth rate of 46 and a crude death rate of 14 per thousand. A higher population increase has occurred in areas of high density, which are also better agricultural areas. There have been changes in recent years in some of the factors affecting fertility. Although legal age at marriage is 18 and 15 for males and females respectively, some studies have shown that 56 per cent of women in the age group 15-19 are single and that in the age group 20-24 the proportion of single women is still around 14 per cent. It is also being observed that age at marriage is slowly rising. The incidence of divorce and re-marriage is high in Tanzania and polygamy is accepted. Total fertility is estimated at 6.9.

As in other developing countries mortality has rapidly declined in Tanzania, from an estimated 22 per 1,000 in 1967 to 14 per 1,000 in 1982. Because of improved health services mortality is expected to further decline. Life expectancy is now estimated at 52 years. However, infant mortality is still high at 102 per 1,000, malnutrition being its chief cause.

Basic socio-demographic data

Total population	20.5 million
Crude Birth rate	46 per 1,000
Crude Death rate	14 per 1,000
Rate of natural increase	3.2% per annum
Number of years for population to double	22 years
Infant mortality rate	102 per 1,000
Life expectancy	52 years
Total female population	9.4 million
Population at risk	22% of total population
Total Fertility rate	6.9 per woman
Mean age at marriage	18 years
Maternal mortality	2 per 1,000
Sex ratio	96
Total rural population	85%
Population 0-14 years	46%
Population abut 65 years	4.1%
Dependency ratio	100:101
GNP per capita (US \$)	299

Official Policies and Attitudes

Tanzania can be classified as having an implicit population policy, concentrated on child-spacing as an integral element of health policy, particularly focussed on improving maternal and child health. Various statements by the President of the country since 1969 and as recently as 1982 indicate his interest in this policy and endorsement of the two basic principles of the World Population Plan of Action, namely, the right for couples to "decide freely and responsibly the number and spacing of their children" and the need to make available to couples the "information, education and means to do so." In 1982 the President urged the Parents' Association (WAZAZI) to come up with a policy on child spacing and consider the question of uncontrolled births seriously. UMATI was urged to intensify the dissemination of information on the importance of child-care and family planning.

As early as 1973 the ruling Party in the country reinforced the need to implement a child spacing programme and officially recognised the role of UMATI in educating the public and assisting the Government in promoting child spacing as a part of maternal and child health policy. This action provided the basis for the definition of UMATI and Ministry of Health roles in family planning in 1974. The Ministry also issued directives in 1974 to all Regional Medical Officers to provide family planning services in their regions if the need for them is expressed by married women. (This limitation still exists). The Ministry has thus far extended services to about 800 of the 2,000 MCH clinics which are a part of the primary health system and to all hospitals, and UMATI is recognised officially as a partner in this work, with the responsibility of motivating people, training staff for MOH and supplying and

distributing contraceptives.

Since 1973 the Government has had explicit policies on the redistribution of the population and internal migration. The redistribution policy was expressed in the establishment of the Ujamaa Village Programme, intended to improve the availability of social services, increase production, and promote self-reliance. Up to now some 9,000 Ujamaa villages have been organised, involving the movement of millions of Tanzanians from small, isolated villages in regions sparsely populated. Internal migration from rural to urban areas is controlled by the requirement to obtain work permits. There is still a wide variation in the density of population among regions due to soil fertility, natural resources, historical and development factors. It is, however, the explicit policy of Government to give priority to rural development and discourage rapid urbanisation.

The policy of Government concerning Family Life Education is not so clear and well-developed. Such education for adults is already a part of the programme of the Institute for Adult Education and the National Functional Literacy Centre. The FLE Project in the Office of the Prime Minister is also providing materials and training in professional institutions, and some teacher training but so far there is no policy to include such materials in the school curriculum at either primary or secondary levels.

There is obvious concern about the problems of adolescent pregnancies (girls are suspended from school when this happens) and lack of service provision to unmarried girls, although service is provided after delivery. This concern is highlighted by the fact, as already observed, that 56 per cent of girls in the 15-19 age group and 14 per cent in the 20-24 age group are unmarried. The rates of children born out of wedlock is high and the rate of illegal abortion is also said to be high and increasing, although statistics are obviously unreliable in this area.

There is no policy, implicit or explicit, concerning limitation of the number of children per family and the total fertility rate stands at 6.9 per women. The size of families is declining in the urban populations for economic reasons and as a result of higher levels of education but the average size of family in the rural areas remains high together with continuing high infant and maternal mortality rates. There is growing recognition of the need to promote smaller families among planners, development administrators and others concerned with the balance (or imbalance) between the rate of economic growth and rate of population growth. Since the Second National Development Plan (1969-74) demographic information has been taken into account in planning manpower requirements and extension of health and education services. The Government also encourages smaller families through some indirect ways e.g. tax relief is provided for parents with up to four children and maternity benefits for working women are only available up to four children and with a minimum three years interval between births. There is also provision for travel allowance for up to four children once every two years when going on leave.

There is a growing interest amongst some Members of Parliament on the relation of population to development. At a recent seminar on Population and Development organised by UMATI for 40 MPs, they called for, among others, the introduction of FLE in schools, strengthening the family planning component of the MCH programme, enhancement of the status of women, the formation of a population commission to advise the government on population matters, and requested UMATI to organise similar seminars for the rest of the MPs and policy makers. The Secretary-General of the Party invited UMATI to attend Party meetings at all levels to educate the members on the importance of family and encouraged the co-operation of UMATI with the mass mobilisation organs of the Party, particularly WAZAZI (Parents Organisation), UWT (Women's Organisation), VIJANA (Youth Organisation) and JUWATA (Workers Organisation).

Family Planning

The family planning services are an integral component of the MCH programme which is a part of government's deliberate policy to extend as rapidly as possible a comprehensive and integrated system of health care to the majority of the population, especially the vulnerable groups of mothers and children. The programme deliberately concentrates on prevention, with a focus on family health, as a means of achieving greater long-term health benefits. Thus family planning services are offered at all government health centres in mainland Tanzania, (although Tanzania is a union of the former Tanganyika and the Islands of Zanzibar and Pemba, family planning services as part of government MCH services are provided only on mainland Tanzania), where there are presently 150 hospitals, 240 rural health centres and about 2,600 dispensaries. Some Mission health centres also offer family planning services. Generally the distribution of the MCH/FP clinics varies greatly from region to region — some have only 20% of all health centres with MCH/FP clinics while others have up to 80%.

It is estimated that about 6 per cent of the approximately six million women at risk are currently using some form of modern contraceptive method. Oral contraceptives are preferred by the majority of acceptors with the IUD ranking second in demand. There is a demand for the injectables but this must be administered by, and at the discretion of, a gynaecologist and is not generally given to women with less than 7 children or to women below the age of 25. All contraceptives are provided free.

Public Opinion

Generally the public has been quite receptive to the ideals of planned parenthood. The Party mass mobilisation organs in the country e.g. WAZAZI, UWT, VIJANA and JUWATA have had close working relationships with UMATI and have helped to spread the message widely in the country. The mass media have also given valuable support in the dissemination of information and education about population and family planning matters. In this connection, the existence and use of a single lingua franca (Kiswahili) which is understood throughout the country has been an enormous advantage. The religious groups have been co-operative with UMATI and some, like the Protestant groups, have assisted in running education

programmes and family planning clinics in their own centres. UMATI's own information and education programme has greatly enabled the FPA to enjoy support and Government structures has greatly enabled the FPA to enjoy support and confidence at all levels of the Party, Government and amongst the general public. Through the programme, UMATI has built up a large grassroot volunteer force that continues to be instrumental in creating a favourable public climate for family planning.

Constraints to Family Planning

Notwithstanding the increasing favourable public climate, there are still certain limitations to the family planning programmes imposed by social and cultural factors. Among politicians, religious leaders and village elders, many are still opposed to family planning. There is a strong belief amongst some sections of opinion leaders that family planning is a western intervention and should, therefore, be avoided. High infant mortality, particularly amongst the rural population, acts as a deterrent to family planning practice. Traditionally, children have been considered economic assets although in urban and in some densely populated rural communities, harsh economic realities and particularly compulsory primary education has brought a degree of change in this attitude. In Zanzibar there is no organised family planning programme due to the attitude of Mulsim leaders, although the island has a very high density of population.

There are restrictive regulations regarding the prescription of certain contraceptives by certain cadres of health personnel. For example, at village level, MCH aides are officially designed as the primary family planning services providers, but the majority are not permitted to prescribe or distribute steroid contraceptives since they were not formally trained in family planning. On the other hand general practitioners (doctors) and non-gynaecologists are not allowed to prescribe injectable contraceptives. Other laws prohibit the sale or supply of contraceptives to unmarried women, although because of the erosion of traditional taboos against premarital sex particularly amongst the urban population, pregnancy and abortion among unmarried girls has increased, with all the attendant implications for their health and welfare.

Inadequate numbers of trained personnel for family planning services delivery is also a serious constraint. Since UMATI's training programme started in 1975, the Association has trained about 3,000 health and non-health personnel for promoting and delivering family planning services, but a significant number of them find themselves assigned duties which do not involve the rendering of family planning services. The need for in-service training to up-grade family skills is considered a necessity, as is the need for orientation of health administrators to make them aware of the importance of family planning, but there are not sufficient facilities to meet these needs. The unavailability of data and absence of planning skills present another constraint to effective and realistic planning at sub-national and village levels. This constraint has rendered it difficult for UMATI and even the government agencies to satisfy family planning needs at these levels. For example, UMATI has been unable to procure and deliver adequate contraceptive requirements at these

levels because it is not in a position to have the necessary information on the usage and forecast of these requirements.

Communications also pose difficulties in the efforts to spread family planning information and services. Road transport in particular is very difficult due to the undeveloped road network and lack of adequate number of vehicles. This problem has been aggravated by the very harsh economic situation which has prevailed in the country for a number of years.

Family Planning Factors for the Future

According to the government health plan, between 70-80% of the rural population will have access to a health facility within a radius of 10 km by 1985/87. This implies an expansion in MCH/FP facilities, which in turn will require UMATI and other agencies to intensify and expand their motivation and training programmes as well as increasing and improving contraceptive supplies and distribution systems. At the same time, recent developments in the islands of Zanzibar and Pemba mean that UMATI will have to extend its services and activities to those islands where hitherto family planning has been unknown. These development will further be facilitated by the emphasis that the Union Government has put on the Primary Health Care Programme and Health for All by the Year 2000.

The President's speech urging the Parents' Association to come up with a policy on child spacing and to consider the question of uncontrolled births seriously, has resulted in the Parents' Association drawing up a Three Year Educational Programme for its different functionaries at regional and district levels. This will mean increased activities in the area of family life education and responsible parenthood.

Inevitably UMATI and other relevant agencies will actively be involved. Already the government, through the Prime Minister's Office, has initiated action towards drawing up a family life education programme for the different levels of school in the country. There has been some consideration given by the organisations concerned (including UMATI) to the desirability of establishing a National Population Commission to study and advise the Government on population issues and policies. A recommendation to this effect has been forwarded to the Prime Ministers Office and the recently concluded MPs' Seminar on Population and Development endorsed the same idea.

Relations with and Assistance from other Organisations

There are several Tanzanian NGOs working in the field of MCH/FP, often with contributions from international NGOs:

- EMAU is funded by the Christian Council of Tanganyika and aims to provide appropriate information to youths and adolescents on matters relating to growing up, marriage, family life, etc.
- The Christian Medical Board is funded by the World Organisation of the

Ovulation Method Billings (WOOMB) and has started an education project for natural family planning. The board intends to expand the project all over the country but due to financial constraints this will probably not be possible.

- Family Planning International Assistance (FPIA) is cooperating with JUWATA (Workers Organisation) in Dar es Salaam, with the Seventh Day Adventists Mission in Arusha and with the Bumbuli Hospital in Sini (near Tanga) with projects aimed at increasing the acceptance of family planning and the availability of contraceptives. In order to assist in this project, UMATI trained nurses who are now working in the JUWATA FP clinic.
- JOICFP, through IPPF, contributed US\$60,000 during 1983 to a Family Planning, Nutrition and Parasite Control project in Moshi (Kilimanjaro Region). UMATI is supervising the project and is responsible for reporting its progress to IPPF.
- The Seventh Day Adventists Church and the Lutheran Church are training village health workers in Arusha.

The multi-lateral agencies working in the field of MCH/FP in Tanzania are FAO, ILO, UNFPA, UNICEF and WHO.

FAO and ILO are cooperating on a Family Life Education Project which is now under the Prime Minister's Office. The project has started in the regions of Morogoro, Arusha and Mara.

Since 1971, UNFPA has funded the publication of Tanzania's census results, FLE seminars and population education and communications projects. In addition UNFPA supplies oral pills to the MCH-programme through UMATI. UNFPA and UMATI also cooperate in the field of training. Their budget for the period 1984-86 is expected to be about US\$750,000 a year. UNFPA also contributed towards the funding of the MPs seminar in Population and Development organised by UMATI in May 1984.

UNICEF's programme has expanded considerably over the last two years — from US\$5 million to US\$18 million in 1983. Around \$1 million of this budget is designated for MCH services. Other activities include water supply and sanitation, child nutrition, primary education, child development services with emphasis on pre-school service, and community development. UNICEF is currently involved with the training of Village Health Promoters, a project now being launched by the Ministry of Health.

Bi-lateral donor assistance to MCH/FP has come from, amongst others, CIDA, DANIDA, Finland, NORAD, SIDA and USAID. DANIDA, Finland, NORAD and SIDA have mainly contributed to the construction of rural institutions for primary health care including nutrition and family planning, to institutions for staff training, equipment, drugs and to vaccination programmes. SIDA expressed interest in collaborating with UMATI and the Government in the field of education, and

the possibility of SIDA supplying paper to UMATI's programmes is being considered.

USAID has in the past contributed contraceptives and training for MCH personnel but since 1981, has suspended direct aid as a result of Tanzania's financial difficulties. They are, nevertheless, still involved in projects through multi-lateral channels, including food assistance through the Catholic Relief Service and financial assistance to AMREF who are involved in a health worker training scheme.

The Canadian High Commission has given assistance to UMATI to help Magulilwa Ujamaa village in Iringa in constructing and equipping a day care centre.

Some American universities and organisations are also working in the field of family planning. Columbia University is funding the first phase of a three year project (US\$85,000) with the Evangelical Lutheran Church in Tanzania, to provide additional support to their Masai Health Services Project. Phase II of the project will be approved pending, amongst other things, the feasibility of adding a major family planning component. The John Hopkins Physician Training Programme (JIPIE-GO) has a nine month agreement for US\$100,000 with the Kilimanjaro Christian Medical Centre in Moshi to support a Reproductive Health Training Programme. The programme will train medical officers and graduate nurses from district and rural hospitals from all parts of Tanzania in the essentials of family planning, the basis of infertility and up-dated concepts of reproductive health.

INTRAH is financing the training of traditional birth attendants in villages in Arusha covering basic hygiene and timely referral of at-risk cases. Training of trainers is also included in the programme which will be organised in different regions every year. In addition, INTRAH is assisting in training UMATI's own trainers and is also financing courses for some paramedical trainers from other African countries.

The Association for Voluntary Sterilisation has sponsored four workshops for training of district volunteer clerks in various family planning methods and family planning communication skills in collaboration with UMATI.

THE ROLE OF THE ASSOCIATION

The Association has identified the following unmet needs:

- a) Low levels of awareness on the interplay between population variables and overall socio-economic development of the country.
- b) Lack of adequate trained manpower to promote, train, advise and provide family planning services.
- c) Low level of utilisation of available family planning facilities.
- d) Inadequate availability of equipment and contraceptives.

- e) Need to coordinate and synchronise the motivational, training, commodity supply and service delivery activities.
- f) Male motivation.
- g) Restrictive family welfare laws and regulations which make the females a disadvantaged group.
- h) Provision of Family Life Education to both in and out-of-school youths.
- i) Research into family planning and its acceptance and practice among the Tanzania communities.
- j) Resources for family planning and related activities.

The unmet needs enumerated above are a real concern to the success of the family planning programme in Tanzania. Although there is some political awareness and the importance of an association like UMATI has been recognised, there is a genuine need for population education within the ranks of the elite and technocrats. While trained manpower is certainly a real problem, there is an urgent need to ensure that the facilities that have so far been established are utilised, and this should certainly attract the attention of UMATI which was assigned the specific responsibility of motivation.

It is known that male chauvinism is still predominant and programmes geared to changing the male attitudes will greatly assist in paving the way for liberalising even the restrictive family planning welfare laws. Although FLE programmes are not yet institutionalised it is gratifying that a number of other national organisations (Women, Youth, Parents, Workers, etc.) and the government have taken up the challenge and therefore UMATI should seek to collaborate with those agencies rather than take on the leading role.

As a result of the above unmet needs the role that UMATI has identified for the years 1985-87 is as follows:

To Advocate for the promotion of education on the population problems and responsible parenthood, and consolidate and expand family planning services. UMATI will also train, advise and search for possible alternative methods of family planning services delivery. It will also continue with the procurement and distribution of contraceptives and equipment to the institutions responsible for delivering family planning services.

The creation of awareness and motivation of the general public to accept and practice family planning is still an important consideration in defining UMATI's role since in the government's MCH/FP programme, UMATI has the assigned responsibility for motivation and also because it has been identified that even the

existing service delivery facilities are not being fully utilised. In addition, the procurement and distribution of contraceptives through IPPF/UNFPA will become more problematic as the programme expands. Even with only 6% of women in the reproduction age group using modern contraceptives, UMATI commodities absorb over 15% of its budget although UNFPA is furnishing a share of the oral pills and expects to provide 4.4 million cycles over the period 1984-86. In the short run, IPPF and UNFPA should expect to continue providing the necessary contraceptives but in the longer term the Government needs to become self-sufficient in this area. Under these circumstances UMATI should strive to lobby for the inclusion of contraceptives on the government's Essential Drugs List for the health centres and rural dispensaries so that in the long run its responsibility for the procurement and distribution of contraceptives would be minimised. Furthermore UMATI is in a privileged position to play the role of advocating policy changes which would accelerate the acceptance of family planning. A few of these policies are embedded in law but most of them are the result of over cautious regulations or directives of MOH made at a time when there were controversies over particular methods or, indeed, resistance to the basic idea of family planning.

THE PAST PERFORMANCE OF THE ASSOCIATION

The programmes and activities in which UMATI has been engaged may be classified into four categories:

- Information and Education;
- Training;
- Medical and Clinical; and
- Supply of Contraceptives.

UMATI's I&E programme is the main programme upon which rests the achievement of many of the Association's broad aims and objectives.

Recognising that the main role that the government assigned to UMATI in 1974 was that of information and education of the general public and in particular in support of the government MCH/FP programme, UMATI has greatly contributed to creating general awareness and understanding of family planning through its I&E activities.

However, neither the programme as a whole nor the individual project within it have been fully evaluated in order to ascertain their efficiency and effectiveness. The information and education given in the programme is too general and does not meet the specific needs of different audiences in a society in which attitudes are changing. It is true that awareness has been created but what is now required is a redirection of approaches for motivation towards changing behaviour to facilitate the practice of family planning. The question of male motivation, for example, has not been given the attention it deserves, although male attitudes continue to be a major obstacle in acceptance and practice of family planning. The educational and audio-visual materials produced are basically female-orientated and have not encouraged the male to feel responsible. Again, the materials have tended to carry

the same message throughout the country without regard to differing special characteristics of various areas of the country. This approach to the information and education programme has led the Association to a situation whereby some topical issues affecting its work have been left unanswered. For example, the Billings Crusade for the 'natural method' in May 1983 has not had any programmatic reaction from UMATI to date. The approach adopted to implement the I&F programme whereby UMATI staff, whether at headquarters or from the field, directly motivate the populace, through talks, seminars, film shows, discussion groups, etc., is itself a limiting factor as far as the numbers reached are concerned. In a situation faced with so many difficulties — communication problems, limited resources, size of country (geographic and population), etc. it cannot be expected the dramatic results can be achieved. The Regional Health Educators for example, are expected to fulfil all their diverse functions in the village Branch programme as well as conducting talks, seminars, films and exhibitions, workshops etc. The problems of supervision, high cost of programmes and lack of clear and specified indications of acceptable output have made programme implementation difficult.

Until very recently UMATI has been the only organisation providing training to health personnel to prepare the ground for the MCH/FP service delivery programme. Although the MCH is now engaged in some training activities, and training in family planning has been incorporated into the teaching curricula of all health personnel, yet UMATI continues to play a very important role in training health personnel for the expanding MCH/FP services. It is foreseen that in future UMATI will continue to be called upon to complement Government efforts in training new staff, providing refresher courses and teaching new skills to various categories of service delivery staff.

UMATI has been involved in training mainly for MCH and its own staff but it has also been engaged at various levels in the training programmes organised by other agencies and institutions. Another important contribution of UMATI has been the practical training facilities provided by the UMATI clinics. This tradition is maintained by providing practical training for medical students, nurses, other trainees and students of relevant institutions in UMATI clinics.

UMATI's training programmes are well-planned and well-organised, and the quality of training given is generally recognised as good. It is also noteworthy that UMATI places priority on the appropriate target groups, i.e. physicians and paramedical staff of MOH.

The Medical and Clinical section has been providing advisory services to the MOH including Regional Medical Officers (RMO), District Medical Officers (DMO) and MCH Co-ordinators on medical standards for family planning, on the reliability of existing and new contraceptives, on research findings on acceptability, side effects, relation to return of fertility, reversibility of sterilisation, etc, drawn from both national and international experience.

Until 1977, IPPF was the only source of contraceptive supply to the MOH through UMATI. IPPF continued its supply of all methods of contraceptives until 1980 when UNFPA started providing oral pills through UMATI. However, the supply from UNFPA was not adequate and consequently there was a sharp decline in the number of acceptors over the next few years. This decline coincided with the withdrawal of IPPF supply from 1981 and the gradual deterioration of general economic conditions in the country since 1979. Since there are no major sources of supply in the country a sizeable demand for contraceptives has remained unmet.

The present supply position remains precarious and the future uncertain. The supply of oral pills provided by UNFPA is inadequate to meet the demand and UMATI, as the supply co-ordinator, has rationed distribution of contraceptives to the MCH clinics. IPPF remains the only source for the supply of all other types of contraceptives other than oral pills; the MOH is thus totally dependent on UNFPA and IPPF for the supply of contraceptives. This situation has become a little confusing because of the large quantities of USAID-supplied oral pills in stock which are not very popular and only a small quantity is used. There has been concern with the safety of using these pills which have been in store for more than five years.

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

Strategies and Projects

Strategy I

Increase people's awareness of the contribution of family planning and responsible parenthood towards improved family health and national development.

This strategy is relevant to the advocacy part of the role which has been identified. Through this strategy it is hoped that leadership education in population and development will be strengthened to increase the appreciation of different categories of leaders, policy makers and implementors of the importance of their commitment to effecting and implementing national population/family planning policies and programmes.

Six projects have been developed under this strategy:

1. Motivation activities in villages surrounding MCH/FP clinics;
2. Motivation seminars for specialised groups;
3. Motivating Trainers in Non-Medical Institutions in Population and Family Planning;
4. Pilot Project for Motivation Activities in Zanzibar and Pemba;
5. Production of FP motivation materials for special groups;
6. Workshop for writing a primer.

Strategy II

Train physicians and non-physicians in contraceptive technology and appropriate delivery of family planning services.

This strategy responds to the training role that UMATI has been playing for the late nine years and, according to the unmet needs and recommendation of the OPE, it is appropriate that it is continued.

The five projects that have been developed under this strategy are:

1. Training of Nurse Midwives/Paramedicals in Contraceptive Technology;
2. UMATI Model Clinics;
3. Dar Rural Family Planning Clinics & Supervision and Training;
4. Training of Physicians in Contraceptive Technology; and
5. FP Clinical and Communication Skills Course for Village Health Workers in Bagamoyo District.

Strategy III

Advise and search for replicable alternative ways of delivering family planning services.

This strategy is in keeping with UMATI's role of advising and searching for possible alternative methods of family planning service delivery. Although UMATI does not engage in direct service delivery (this function is carried out by the MOH) it is its duty as a pioneer organisation to advise on possible new approaches to a greater proportion of the population, especially to the population in remote and disadvantaged areas.

Two projects have been proposed under this strategy:

1. Pilot Project on Integration of Day Care Centres with MCH/FP and Nutrition.
2. Integrated FP Nutrition and Parasite Control Pilot Project.

Strategy IV

Improve UMATI's executive and management capacity.

This is a relevant strategy as UMATI has just gone through a re-organisation of its organisational and management structure. Furthermore, as a result of the OPE recommendations, the association is in the process of rationalising its fieldwork operations. It is therefore appropriate that efforts are made to strengthen and consolidate the changes and improvements that are taking place.

The projects that have been proposed for the plan period are:

1. Seminar for Senior volunteers and staff;
2. Workshop in Supervision and Evaluation of FP Programmes;

3. Representation at International Meetings/Conferences;
4. Evaluation of IEC Materials;
5. Evaluation of IPAVS Seminars for Medical Staff on Effective Resource Utilisation;
6. Evaluation of Pilot Projects on Integration of Day Care Centres with MCH/FP Nutrition.

Strategy V

Ensure availability of contraceptive supplies and medical equipment in all MCH/FP clinics.

In the short term the strategy is relevant since UMATI is the main agency for procuring and distribution of contraceptives. However as the demand for contraceptives rises it would be in the longer term interest of UMATI to fight for the inclusion of contraceptives in the Government's 'List of Essential Drugs' so that they form part of the 'drug kits' to health centres and rural dispensaries. This is because it is becoming increasingly difficult for UMATI to mobilise adequate resources for the procurement of the total contraceptive requirements for the entire country.

Strategy VI

Resource Development.

For the long term, this strategy is a priority as UMATI is almost entirely dependent on external sources of funding for its activities. It is recognised that it is high time UMATI started vigorous efforts to mobilise local resources for its expanding activities.

One project has been developed for the plan period which proposes the acquisition of one tank truck in 1985 which will be leased/hired to an oil firm for the transportation of different brands of fuel to stations in various regions of the country.

THE ASSOCIATION'S RESOURCES

Non-IPPF Income

The Association is virtually dependent on IPPF as a major donor.

There are indications, though there are no contractual commitments yet, that UMATI may receive funds for certain earmarked projects from other donors such as PIACT, Canadian High Commission and NORAD.

Voluntary Contributions

UMATI has an executive committee of 60 members and in addition there are four sub-committees. The Executive Committee meets twice a year. On average the sub-

committees have a membership of 10 people and meet twice a year except for the fund raising committee which meets once every month. The sub-committees are Finance, Planning and Administration; Medical and Training; Information and Education; and Law.

The bulk of the fieldwork activities of the Association is carried out under the supervision of volunteers on branch committees which are assisted by Village Volunteer clerks (VVCs). The duties and functions of a VVC include:

- a) ensuring that monthly branch meetings are held and the minutes and reports of activities of the branch are submitted to the district level regularly;
- b) recruiting new UMATI members in collaboration with the branch executive committees;
- c) collecting membership fees and remitting them to the district headquarters;
- d) working with the Executive Committee in visiting homes, MCH clinics and places of work to inform and educate people about and distribute educational materials in family planning;
- e) compiling and submitting to district headquarters all reports emanating from the branches;
- f) acting as a link between District headquarters and the branches under his/her supervision;
- g) establishing and fostering good working relations with Party and Government leaders at ward, village and cell levels.

At the district level, the UMATI volunteers select a District Volunteer Clerk (DVC) who is responsible for the co-ordination of all UMATI activities and supervising the VVCs in the District. The DVC is also responsible for the training of VVCs in the district and rendering assistance to village branches in connection with their work.

The DVCs (about 80) and VVCs (about 150) are paid only small honoraria to cover their transport costs and meal allowances. In practice they work almost full time on UMATI's work. It is estimated that if the above groups of volunteers were not available for UMATI fieldwork activities, the Association would have to incur expenditures of about US\$400,000 annually. During the plan period, this category of volunteers will gradually be phased out in favour of full-time paid co-ordinators at the district level.

In-Kind Contributions

The most significant in-kind contribution is the tax exemption granted by the Government. This is estimated at approximately US\$640,000 each year of the plan period. Accommodation for regional, district and branch offices and time allowed on radio are other in-kind contributions from the Party and Government.

THE ASSOCIATION'S MANAGEMENT CAPACITY

During 1983 UMATI continued to consolidate the efforts begun in 1982 to improve its programme development, as well as financial and management capacities. The revitalised executive leadership brought about a new sense of confidence in and commitment to the work of the Association and improved the morale of the staff. As a result of implementation of the recommendations of the Management Audit carried out in 1982, UMATI adopted a new organisational structure and recruited the required staff so that by the beginning of 1983 the Association had a full complement of staff. Consequently the preparation of key documents on the work of the Association showed a marked improvement in 1983 as compared to previous years. Similarly the process of developing projects and programmes of the Association took on a new and realistic bottom-up approach, while the supervision and monitoring of the fieldwork activities were given more attention than had been the practice before.

One of the crucial developments in the running of UMATI affairs in 1983 was the marked improvement in the volunteer/volunteer and volunteer/staff relations. Led by a Chairman who is in a Regional Commissioner and member of the Central Committee of the Party, both the volunteers and staff leadership enjoy the confidence and respect of the public and private sectors of the Tanzanian society.

In September 1983 an Overall Programme Evaluation (OPE) of UMATI was carried out. The OPE found that UMATI had established close working relationships with the Party, Government agencies and other non-governmental organisations in the country. It also found that the tripartite role of information and education, training and supply of contraceptives which had been assigned to the Association by the Government in 1974 had been successfully carried out, although they were still valid and consistent with the status and objectives of UMATI. A number of recommendations were therefore made to introduce certain elaborations/adjustments to make the work of UMATI even more effective.

These elaborations/adjustments include further selectivity in target groups for information and education activities, stepping up training and delivering non-prescription contraceptives through community based channels. The OPE report was positively received by the Association and the 1985-87 Three Year Plan incorporates the implementation of many of those recommendations.

ZAIRE

COMITE NATIONAL DES NAISSANCES DESIRABLES (CNND)

COUNTRY BACKGROUND

Zaire is a country which cuts across the Equator and is situated between 4 degrees latitude north and 2 degrees latitude south. With a surface area of 2,345,000 square kilometres, Zaire is one of the largest countries on the African continent. It shares a common border with the Central African Republic, the Sudan, Angola, Zambia, Uganda, Rwanda, Burundi, Tanzania, the People's Republic of the Congo and the Angolan territory of Cabinda.

Zaire's relief resembles an amphitheatre which is open to the west: the centre of the country is shaped like a "bowl", consisting to a large extent of virgin forests and swampland, surrounded by plateaux (in the north and south) and mountain chains (in the east and south west) where the majority of the population lives.

Zaire is a mosaic of ethnic groups (of which there are more than 450) who speak different languages and dialects. However, more than 90% of Zaireans speak at least one of the four national languages. In 1982 the average population density was estimated at 12 people per square kilometre. This density differs from one region to another and varies between 3 and 30 people per square kilometre. In some rural districts of Kivu, this density increases to over 100 (in 1978 the rural district of Walungu had 150 inhabitants per square kilometre). The population of Zaire is relatively young: more than 50% of its inhabitants are aged less than 20 years.

There are no accurate statistics on demographic data and family planning, it is however estimated that there are more than 6 million women of child-bearing age. This figure constitutes slightly more than 45% of the total female population of Zaire. In 1982 the crude birth and death rates were estimated at 46 per 1,000 and 16 per 1,000 respectively. The infant mortality rate was between 150 and 200 per 1,000 and it was estimated that at least one child in three dies before the age of 5. Life expectancy at birth was 44 years for men and 47 years for women.

The average age at first marriage was between 16 and 18 for girls and 21 and 24 for boys.

Polygamy, although declared illegal according to the law of 4th January 1951, is very widespread. The proportion of people in polygamous relationships varies considerably from one region to the next. However, as a general rule, polygamy is more common in the rural areas than the urban centres. In some rural areas more than 40% of the married women are living in polygamous relationships.

Family Planning Postion

Two recent surveys carried out in the country in collaboration with the University of Tulane (USA) revealed the following information:

The urban population is reasonably well informed about modern methods of family planning: more than 60% of women aged 15 or over are aware of modern methods of contraception.

The attitude of the people towards modern methods of contraception is still not very favourable, particularly in the rural areas (the inhabitants of which make up approx. 75% of the whole population). When modern methods of contraception were proposed to 471 women in Lower Zaire during home visits in July 1982, they were rejected by 272 women for a variety of reasons, chief of which were absence of husband from home, pregnancy, desire for another child, opposition of husbands, sterility and preference for traditional methods.

There is a low usage of modern contraceptive methods (7% in Kinshasa, 5% in Matadi, 3% in some rural areas of Lower Zaire).

Much interest is shown in postponing or spacing births, 77% of the women from the towns of Lower Zaire and 65% of the women from the rural areas who were interviewed did not, at the time of the study, wish to become pregnant. Birth-spacing is felt to be particularly beneficial for mother and child. When interviewed, most women admitted using one or more of the traditional methods such as post-natal abstinence, whether or not associated with polygamy, prolonged breast-feeding, coitus interruptus, magic charms, etc. Most couples also affirmed that the current socio-cultural context made the use of these traditional methods increasingly difficult.

In most cases, desired family size is 6.2 or only loosely defined ("as many as God gives us").

The Government is trying to reduce the high morbidity and death rates to improve the geographic distribution of the population and to assist individuals to space births so as to have the number of children they desire.

It had been planned that in 1982 the Government would carry out a national census of the population with the assistance of the UNFPA. Unfortunately, the Government of Zaire was unable to obtain the necessary additional funds needed for the census and, consequently, project activities were postponed.

Being aware, however, that no population policy is effective without a minimum of demographic data, the Zairean authorities have recently agreed to a budget of more than 80 million zaires to conduct a general census of the population in 1984.

Economic and Financial Problems

In spite of some obvious progress, Zaire is still confronted with serious economic and financial problems, which are linked to its geographic position and to the vastness of its territory. Other factors should be considered such as the difficulties in communication, the explosive increase in population (the population growth rate is nearly 3% for a population estimated at 28 million at the end of 1981), the fact that this population is scattered in the rural areas whilst there is a rapid urbanisation of the larger towns, in particular the capital, Kinshasa, (where there were 2 million inhabitants in 1979) and other main regional centres.

Although formerly an important agricultural producer, Zaire now imports many food products: meat, fruit, vegetables, maize etc. From 1975 to 1977 the GNP dropped by 14% and inflation rose to 80% per year, the general price index rose from 100 in 1975 to 2,657 in the second quarter of 1982. In 1979 workers' purchasing power was 10% less than that of 1960 and in 1981 the per capita Gross National Product was only US\$225.

In the health sector, there are 532 hospitals, maternity and specialised units; 2,200 dispensaries and first-aid posts; 1 doctor per 1,000 inhabitants, of whom 30% are in Kinshasa and 1 hospital bed per 1,000 inhabitants. In the field of education, 85% of the population have attended primary school but illiteracy runs at around 65%. The education budget amounts on average to 25% of the total budget.

As far as transport is concerned, Zaire has a well-developed waterway system, which is however under-utilised; 4,985 km of railway tracks which do not completely link up with one another, and a road network in poor condition.

Official Policies, Attitudes, Regulations and Activities devoted to Family Planning

The Government of Zaire has not yet defined a clear policy on population. It has, however, recognised the need to collect demographic data and has created a Committee for Demographic Policy within the National Legislative Council (Parliament) which has been given the task of gathering demographic data for the next conference of the Inter-Parliamentary Union in 1984.

In general, the attitude of the Zairean authorities towards family planning activities is favourable. They accept the idea of family planning integrated in Maternal and Child Health (MCH) services.

In 1975, the State put its entire hospital infrastructure at the disposal of the CNND and in 1982 family planning was recognised by the Department of Health as a necessary component of primary health care.

Public Climate

The attitude of the public towards family planning is still complex and ambiguous. It is nevertheless generally in favour of the idea of family planning and fears of modern

methods of contraception are greatly alleviated once adequate information is provided.

Leaders of the Catholic Church advocate responsible parenthood but most of them officially opposed to the use of modern methods of contraception.

Because of this, in one of the towns of North Shaba, where the Department of Health is conducting a health development project in collaboration with AID, the local bishop practically incited the people to throw contraceptives provided under the project into the river. It is, therefore, necessary to consider traditions and religious beliefs in running a family planning programme; motivation and education is still needed and any unfavourable publicity can ruin the smooth-running of the programme.

Other Christian churches grouped together under the Eglise du Christ au Zaïre (ECZ) are more favourable towards the idea of family planning.

The television and press continue to publish articles and programmes on "wanted births" (the term used for family planning in Zaïre is "naissances désirables" or "wanted births") within the framework of health and family life education.

There has, however, been a reduction in the number of radio programmes on family planning. In 1982, these broadcasts were suspended until further notice by the Department of Information. It would appear that the Central Committee of the Mouvement Populaire de la Révolution (the only existing and ruling party in Zaïre) only accepts these programmes when they are integrated in the overall context of health and development. This explains the attitude of certain politicians who reject the idea of family planning, which they associate with the idea of promiscuity or, literally, birth control.

Constraints to Family Planning

Factors which could hinder the development of the family planning programme in the country are of varying types:

Although they may not be applied, legislation and statutory regulations governing activities connected with contraception are still in force in Zaïre;

Geographical obstacles: Many roads are often impassable during the rainy season. There is also the problem of inadequate telecommunication links in most parts of the country.

Socio-cultural obstacles: These include a multiplicity of local languages (more than 450), an unjustified fear amongst each ethnic group of becoming a minority; excessive importance given to the role of a mother (the more children you have, the more important you are); publication from time to time of alarming articles and communiques on certain methods of contraception; and lack of understanding of the relationship between family planning and national development;

Other obstacles include: lack of funds as well as qualified personnel, materials and equipment for family planning.

Family Planning Factors for the Future

Family planning activities will undergo some important changes in the very near future. The establishment of regional branches of the Association will promote the effective integration of family planning into the activities of a larger number of sectors involved in national development.

The implementation of the health action plan (1982-86) of the Government which recommended the inclusion of family planning activities in primary health services, the implementation of the health services programme in the rural areas — SANRU 86 — and the implementation of other activities by the Eglise du Christ au Zaire (E.C.Z) on behalf of the Department of Public Health and USAID will increase the number of service delivery units for family planning and will consequently increase the need for personnel, contraceptives and other material.

The implementation of the Urban Family Planning Project financed by USAID and the Government of Zaire which will benefit 14 urban centres in the country (1983-87) will certainly allow the "desired births" programme to carry out more effectively the role assigned to it, i.e. the effective coordination of family planning activities throughout Zaire, including the training of personnel, as well as the monitoring and evaluation of services. It will also facilitate the improvement of the medical/health infrastructure, an increase in the provision of contraceptives and other materials and will finally lead to the establishment of additional family planning service delivery centres; especially in the rural areas.

The publication of the national census results will most likely bring the national leaders to accept that the question of population policy should be treated with more seriousness.

As several CNND volunteers have become Members of Parliament, this may perhaps facilitate the promulgation of a family law and of laws favourable to family planning.

UNFPA has sent a team of experts to assess the country's family planning needs. The conclusions of this study may lead to further UNFPA assistance in the formulation and funding of family planning projects.

Family planning activities will, in the very near future, receive an important boost following the expansion of the new structures of the Association (staff and volunteers) throughout the country. This will stimulate and accelerate the integration of family planning into the activities of a larger number of sectors involved in national development.

The promulgation of the Government's decision on the sale of medicines will change the conditions of sale of contraceptives in pharmacies. The continuing economic crisis

will encourage the CNND to look for other sources of funding for the Association's activities.

Other Family Planning Activities

Several other organisations are involved in family planning activities in Zaire. The Office of Women's Affairs is proceeding towards the integration of family planning in the activities of firms and industries. Westinghouse is taking part in a survey on the prevalence of contraception in several cities in Zaire. The Department of Primary and Secondary Education has begun to provide courses on family life education in some schools in the capital. The Zairean Armed Forces now have some trainers — some of whom were trained by the Association — who are responsible for motivation work and non-clinical service delivery in military camps. This is in addition to the medical and clinical work carried out in the military hospitals.

The University of Tulane is funding an experimental CBD project in Lower Zaire in collaboration with the Church of Christ in Zaire (CCZ).

The Catholic and Kimbanguiste Churches have intensified their programme of popularising the practice of natural methods in their parishes.

In many private clinics, doctors and other health workers provide family planning services.

An ever-increasing number of private pharmacists have also begun to sell contraceptives.

The country's large commercial companies have integrated family planning in their medical and social activities.

Assistance from Other Organisations

Besides the UNFPA which has provided considerable assistance in terms of material and personnel in the collection of demographic data and assisted the country in creating an educational project on family welfare for organised groups, other organisations offer support in implementing family planning activities in Zaire.

The FPIA, the University of Tulane and the IPAVS contribute financially to a community-based distribution project referred to as the "Family Education Programme" of Lower Zaire.

On 30th September 1982, the Government of Zaire, represented by the Department of Health, and the American Government, represented by the US Agency for International Development (USAID) signed an agreement to fund a joint project called the "Special Project for Desired Births". This project, which complements

another initiated (also by both Governments) in 1981 regarding primary health care in rural areas, has as its main objective to increase family planning services in 14 main urban centres of Zaire. The objective of these two projects is to make family planning services available to approximately 50% of the entire population.

The "Special Project for Desired Births" which came into effect in January 1983, will be carried out by the Department of Health in collaboration with the Comité National des Naissances Desirables (CNND) and other private organisations including the National Union of Zairean Workers through the intermediary of the "Caisse de Solidarité Ouvrière et Populaire" (CASOP) ("Workers' and People's Solidarity Fund) and the Church of Christ in Zaire (ECZ). The project will run for a period of five years (1983-87) with funding provided by USAID, the Government of Zaire and other donors.

Some of the Association's activities are now continuing thanks to the assistance provided by the International Project which funded a fertility management project in Kinshasa and to an FPIA grant which supported a family planning project in Matonge.

Pathfinder Fund financed the establishment of family planning activities in the region of Kivu.

It must be noted that CNND's participation in the "Special Project for Desired Births" poses some serious problems which might, in the future, affect family planning activities in Zaire. Among these problems, is the need to establish a harmonious relationship between the different partners in the Special Project.

THE ROLE OF THE ASSOCIATION

The CNND was created by presidential decree in February 1973 under the name of the "National Council for the Promotion of the Principle of Desired Births". This decree stipulated that the Council's members would be designated by the President of Zaire but would themselves draw up the internal rules of the Council, being directly responsible to the Office of the President. Following the creation of the National Health and Welfare Council (CNSBE) in November 1974, the CNPPND became responsible to the CNSBE. In November 1975, the CNSBE appointed the Chairman and members of CNPPND, which became the National Council for Desired Births. (CNND) from that date. The tasks of the CNND were not modified by this change. They are as follows:

To identify all public and private organisations which provide advice and education on "desired births".

To inform these organisations of the principles of "desired births" and to provide all necessary support to the activities undertaken.

To evaluate the results of these activities.

To plan and organise information and education campaigns directed at the population

To coordinate the relationships between the national and international organisations interested in the principle of "desired births".

In carrying out these tasks, the nature of the CNND began to change. The interest aroused by its activities led to the development of a more "voluntary" interest amongst its members. This development, together with its contacts with the IPPF, led the CNND to draw up a revised constitution in July 1978 which transformed the CNND into a non-governmental organization called "l'Association Zairoise de Bien-Etre Familial" (AZBEF) ("Zairean Family Welfare Association"). To date, this constitution has not been ratified by the President of Zaire.

Despite all the efforts made in the field of family planning, there are many unmet needs, in terms of family planning education and service delivery, as well as effective coordination of activities.

In view of the difficult economic situation now facing the country and considering CNND's management capacity (limited personnel and inadequate material and financial resources), the Association selected some problems to which it decided to give priority. These are divided into three groups:

- the population's lack of sufficient information with regard to the advantages of family planning;
- poor quality and lack of units and centres providing family planning services;
- lack of effective coordination between family planning units.

In order to try to resolve these major problems, the Association proposes to play the following role during the 1985 to 1987 plan period:

"To support the 'desired births' programme by indicating the advantages of family planning to influential groups within the community, by stimulating the creation of useful and well-equipped family planning units to be integrated into the socio-medical structures of the country and by ensuring the coordination of family planning activities in order to increase the availability of contraceptives in Zaire."

THE PAST PERFORMANCE OF THE ASSOCIATION

Created in 1973 by presidential decree, the CNND functioned as a parastatal organisation until 1978. During this period, the CNND concentrated its efforts on awareness-creation and motivation of the community in the field of "desired births". Most of these activities were limited to urban areas, particularly to Kinshasa.

It was only after 1978, when the CNND became an Associate member of the IPPF, that it began to operate as a non-governmental association. From then on, efforts were made for the Association to become more operational and expand its activities to the interior of the country. By the end of 1982, three regional coordinating branches were

in operation in Kinshasa, Lower Zaire and Kivu. Emphasis was placed on education and motivation of the masses on the need for and advantages of birth-spacing.

In 1983 the Association's programme was satisfactorily implemented. The three regional offices (Kivu, Lower Zaire and Shaba), as well as the Head Office in Kinshasa operated effectively, both in terms of dissemination of family planning information and education and in the delivery of services. CNND's efforts in educating the masses were intensified through its bi-annual Information Bulletin, "Family & Health", Radio/TV discussions on "Desired Births", fieldwork and film projection.

The Association also pursued its policy of integration of family planning services in existing Government health infrastructures, especially in the three regions where it is currently operating. Another area in which the CNND made considerable progress was that of training. In this regard, 17 nurse/midwives and 3 gynaecologists from Lower Zaire and Bandundu were trained in family planning service delivery. A Management Development Seminar was also organised for senior volunteers and staff from both Headquarters and the Regions.

In the implementation of its action-oriented Research project, the CNND was able to review and reprint its client cards as well as contraceptive usage registers. Ten thousand consultation cards and 60 registers were printed in 1983 and distributed to all FP clinics in Kinshasa and in 10 selected clinics in the interior of the country, for pre-testing before these could be supplied to all the other clinics.

The Association also collaborated closely with sister organisations such as the Church of Christ in Zaire, the Ministry of Health, Education and Information, as well as Women's groups, in the implementation of its 1983 Work Programme. There were a few major problems with regard to programme implementation in 1983. The CNND was only able to produce one of the planned two issues of its Information Bulletin, due to financial constraints. There was also the perennial problem of collecting service statistics from the FP clinics in the interior of the country, where communication has always been a major setback for the Association's operations.

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

Strategies and Projects

CNND has adopted three strategies in order to play its role for the 1985-87 plan period. Projects have also been identified for each strategy. All the strategies and projects respond to the unmet family planning needs that influenced the role of the Association; but CNND will have to improve its management capacity, as well as the activities of other relevant organisations involved in population/family planning in Zaire, in order to be able to implement the proposed projects effectively and efficiently.

Strategy 1: Create a positive attitude towards family planning amongst political leaders and other influential groups of the population.

This strategy emphasises the importance of creating awareness amongst politicians and other opinion leaders, with a view to pressurising the Government to adopt a family planning policy. Five projects will contribute to the achievement of this strategy. These include: Information Bulletin, Family Planning Film, Radio Competition on Desired Birth, 'Open Days' on Desired Births; and Kinshasa National Fairs and Regional Fetes.

Information Bulletin

This is an on going project, which was started in 1979. The main objective is to create awareness about the need for and advantages of desired births by publicising the activities of CNND. It is also intended to recruit more volunteers for the Association. Two issues of the bulletin will be published annually and given a very wide circulation throughout Zaire. The project will be funded by both AID and IPPF.

Family Planning Film

This project started with the production of a French language family planning motivational film in 1983. During the plan period, CNND plans to reproduce the same film in the four national vernaculars (Swahili, Lingala, Tshiluba and Kikongo), for use in its motivation-education work in all the eight regions into which Zaire is divided for administrative purposes. Judging by the success scored through the use of the French film, the production and use of this film in the vernacular languages will facilitate family planning motivation, especially in the rural areas, where the knowledge of the French language is extremely limited.

Open Days on Desired Births

This project, which was started in 1984, is aimed at increasing the understanding of and support for the concept of "desired births" among influential and highly-placed opinion leaders, with a view to expanding family planning education and service delivery in Zaire and identifying sources of resistance to CNND's programme. The Association will collaborate with relevant other agencies in selecting participants from various sectors for these two half-day debates/discussions on the concept of desired births. These will include journalists, politicians, religious leaders, teachers, sociologists, economists, etc. This project will certainly help in implementing the strategy on the creation of awareness among opinion leaders.

Radio Competition on 'Desired Births'

This is also an on-going project, started in 1984, which is aimed at assisting CNND to increase the level of understanding about family planning and improving the attitude of the masses and opinion leaders towards birth spacing. Directed particularly to people within the age bracket of 20 to 40 years, the radio competition will be organised on four consecutive Sundays and entitled "Sunday in good company". Participants will compete by discussing well thought out issues on family planning. Prizes will be distributed to winners. Funding will be sought from both IPPF and local commercial houses, especially pharmaceutical companies.

Kinshasa National Fairs and Regional Fetes

The objective of this project is to create awareness among the country's leaders and to encourage them to support the activities of the CND.

Strategy 2: To encourage the creation of units which can provide high-quality family planning services which are integrated into the State health structure, etc.

Clinical Family Planning Services in Rural and Urban Areas

The object of this project is to increase the number of units which can provide family planning services to those needing them in order to increase the number of women protected by modern methods of contraception.

Training in Wanted Births for Rural Development Workers

The objective of this project is to equip rural development and community workers with the knowledge and skill to become capable and trustworthy family planning "messengers" for the rural communities.

The project will be carried out in June 1985 and June 1987 in Kivu and will bring together 30 rural development workers.

Production of Audio-Visual Aids

The project consists of producing, annually, audio-visual aids on family planning every year which can be used to support clinical activities, training and education. It is thus envisaged that 6,000 posters, 6,000 calendars, 6,000 brochures (in local languages), etc. will be produced within the Plan period.

Training in Family Planning for Rural Paramedical Personnel

The project aims at equipping nursing staff from State, mission and other rural hospitals in Zaire with adequate family planning knowledge and skills. CNND plans to organise 30-day training courses, each for 15 nursing staff from rural areas. This project will be implemented throughout the three years of the Plan. The training courses will take place in Kinshasa (1985), Lumbumbashi (1986) and Kisangani (1987).

Strategy 3: To develop the resources and management and coordination abilities of the Association

As can be seen, the third strategy underlines the coordination of family planning activities in Zaire, resource development and the Association's management capacity. Three projects — two of which will begin in 1985 — come under this strategy. These three projects, if properly implemented, will allow CNND to better carry out its work, particularly with regard to the establishment of regional branches, and will give the Association the chance to more effectively fulfil its role as the country's coordinator of family planning activities.

Regional Coordinating Branches

The objective of this project is to establish regional structures so as to strengthen and standardise family planning activities in Zaire.

Volunteers and Staff

The objective of this project is to increase the Association's management capacity by organising an annual three-day training and information seminar for volunteers and staff.

Study on the Prevalence of Contraceptive Usage in Urban Areas

The objective of this project is to assess the knowledge and attitudes of couples towards contraception and to determine the degree of contraceptive usage in urban areas. The study will be carried out in Boma, Bukavu and Goma in 1986 and in Kisangani and Lubumbashi in 1987. This is a continuation of the Association's data collection project, started in 1982 in Kinshasa. The target group will consist of 5,000 adults between the ages of 15 to 45 in each of the above towns.

THE ASSOCIATION'S RESOURCES

Non-IPPF income

Locally, CNND's resources are largely made up of grants from international organisations. Until 1983, the Association did not undertake any fund-raising activities. Volunteers did not pay membership fees and contraceptives were always provided free of charge. Following the recommendations made by the OPE team in August 1983, however, the Association included membership fees for volunteers in its budget and decided to sell contraceptives at a price which everyone could afford. The funds raised in this way, although modest, thus constituted the beginning of the Association's fund-raising activities. The Association needs to increase its efforts in this field if it is to work towards self reliance.

Voluntary Contribution

CNND volunteers come from all walks of life, from scientific as well as socio-cultural fields. They take part mainly in the Association's activities as an advisory, planning and decision-making body. They often take part in seminars as guest speakers or discussion-leaders. They also assist in making radio and TV programmes.

In-Kind contributions

The Association's in-kind contributions are generally made up of services provided to the CNND free of charge by other agencies, such as the transportation of contraceptives, free family planning consultations given by private doctors, free use of meeting rooms for the Association's seminars and meetings, as well as tax exemption on

most of the products and equipment imported by the Association for use in its work.

THE ASSOCIATION'S MANAGEMENT CAPACITY

— Volunteer Structure

CNND is functioning under a provisional constitution: it is no longer the National Committee as created by presidential decree in 1973 as it has gradually developed into a body supported by volunteers, but it has still to be ratified as a non-governmental organisation, when it will then become the Association Zairoise de Bien-Etre Familial. The present volunteer structure is therefore also provisional, whilst awaiting official approval of its constitution and the proper election of volunteer bodies within the framework of the articles of this constitution. The constitution is nevertheless in the final stages of the approval procedure. All that is left is for the President of Zaire to approve the document and existence of AZBEF.

While the constitution has not been formally approved and while AZBEF has not been legally recognised, the recruitment of members can only be unofficial and informal. Membership fees cannot be collected from new members, nor can there be any activities to recruit a larger number of members and no official meeting (whether national or regional) can take place to elect officers. Therefore, as soon as the constitution is approved, steps will be taken to organise national and regional AZBEF meetings and to elect National Executive and Regional Committees. The first step will consist of the (formal) recruitment of volunteer, who will be paid-up members in order to vote at the different levels of volunteer bodies.

Approval of the CNND's legal status by the Government will allow the Association to reorganise its structure, to admit new members to its Executive Committee and, finally, to operate more effectively as a non-governmental organisation.

Since its creation, the CNND has mainly operated in the urban areas, particularly in Kinshasa. From 1981, the Association has tried to extend its activities to the country's provinces. In 1982, two regional coordinating branches were established, one in Matadi (Lower Zaire) and the other in Bukavu (Kivu). A third regional branch was established in Lubumbashi (Shaba) in 1983.

CNND is a well-organised and well-run Association. The Executive Secretary, a former volunteer and appointed in October 1982, knows the IPPF management system well as he had been a volunteer for many years, and the members of staff are competent in their respective areas of expertise and committed to CNND's work.

In August 1983, an OPE of the CNND was carried out and several recommendations were made which should contribute to solving the Association's problems, one of which is the legal status of Association.

THE FUTURE OF THE ASSOCIATION

Zaire is classed by the World Bank as one of the countries with the lowest per capita income in the world. It was classed by the IPPF as one of the countries with the most urgent needs. Although potentially one of the richest countries of the African continent, Zaire has experienced serious economic and financial difficulties over the last ten years. The Association operates a satisfactory programme in difficult circumstances and will continue to receive priority attention from IPPF through the Africa Regional Bureau.

ARAB WORLD REGION

REGIONAL OVERVIEW

INTRODUCTION

The family planning movement in the Arab world is beset by many difficulties, not least of which is the strong opposition voiced by some political and social groups, and the political turmoil in certain countries currently in a state of war.

Given such adverse conditions, it is all the more encouraging to note that, for the most part, the Arab governments' awareness of the population question — and all its implications — has intensified, and in taking a realistic view of the situation in their respective countries, some governments are beginning to seek equally realistic solutions to the population problems.

This was well illustrated at the International Conference on Population in Mexico in August 1984 where the Arab representation was prominent, and countries with a "population problem" were represented by high-calibre delegations, notably Egypt, Sudan, Morocco, Tunisia, Algeria and the People's Democratic Republic of Yemen.

RESOURCE DEVELOPMENT — HUMAN AND FINANCIAL ASPECTS

There is, at the NGO level, a growing awareness of the obstacles confronting family planning, as revealed during the "Arab World Senior Volunteers' Consultation", held in London in June 1984. The participants, representing most of the Region's Family Planning Associations, noted that the fall in the level of volunteerism in family planning at the regional level could lead to serious difficulties; the implications of such a decline are all too obvious given the important role of volunteers in the IPPF structure. Thus, causes were identified. These can be summarised as problems stemming from economical and financial circumstances; time constraints preventing individuals from being positively committed; the sensitivity surrounding family planning issues; the practical problems arising from certain local circumstances that impede voluntary work; and a lack of variety in some FPAs' activities limiting volunteers' participation.

To counteract this decline, agreement was reached on ways to encourage volunteerism:

Motivate volunteers by organising work within the Association and by varying the FPA's activities.

Broaden the base of volunteerism to allow participation by greater numbers of volunteers.

Relax central administrative restrictions to enable volunteers to achieve the basic goals of the Family Planning Association.

Widen the concept of family planning by placing it in a comprehensive social development framework.

Encourage an exchange of visits and experience and increase contacts between volunteers.

Link family planning with social activities and implement projects to recruit new volunteers.

Difficulties in obtaining adequate funding were considered by the volunteers to be another major obstacle to furthering family planning aims and objectives. Aware of the inadequacy of current funding the volunteers were in favour of Associations' developing resources with a view to eventually attaining a greater degree of self-dependence. Proposed steps towards achieving this included:

— International Level

Introducing, at the central level, a more equitable distribution of existing IPPF resources in response to the Region's family planning needs.

Making provision for an emergency contingency fund in the Region.

Seeking funding from international organisations and benefiting from bilateral agreements concluded by certain states relating to family planning programmes.

Attracting funding for MCH projects from Arab leaders provided there can be a wider understanding of family planning within a comprehensive social development programme.

— Local Level

Seeking government funding, directly or indirectly.

Endeavouring to obtain internal financing from companies organisations and from the activities of individual Associations.

Increasing income from the sale of contraceptives and charges for services.

Linking family planning services with social and economic development by means of implementing integrated projects in cooperation with various organisations.

ASSISTANCE IN PROGRAMME DEVELOPMENT

Special Target Areas

The family planning leadership in the Arab World Region is increasingly aware of the need to widen the concept of family planning and integrate it within the economic and social development concerns that are prominent in the Arab countries' goals. Women and youth organisations could be harnessed to participate in the family planning movement if the latter is geared to the needs of these entities. On the basis of IPPF policies and orientations with respect to women and youth, the Arab FPAs have strongly concurred with the importance of developing projects

that cater for their needs. Specialised committees relating to these two special groups have been formed and given specific terms of reference to assist the Regional Bureau as well as the FPAs in this field.

Women's Development

In the area of women's development, one of the priorities has been to collect information and identify needs of FPAs as well as to generate support and mutual relationships between FPAs and women's organisations. This step is crucial before the implementation of projects can be undertaken. Training has been identified as one of the special areas whereby women's capacities should be increased and the Arab World Region has undertaken such activities either directly or in cooperation with other institutions.

Some FPAs have integrated women's development projects within their regular annual programmes so that it is clear that this orientation is not dependent upon the availability of special earmarked funding, thus assuring the continuity of the projects.

Youth

In the area of youth, FPAs in the Region have demonstrated their conviction that youth awareness of population issues is of great importance to the growth of the family planning movement. Through the Cairo workshop held in December 1983, and by means of the development of special projects aimed at youth participation in family planning, the Arab Region has adopted the development of youth-related activities as one of its priority action areas. This concern is not only motivated by the fact that at least half of the Region's population is under the age of 20, and the fact that a sizeable number of the fertile group are in the adolescent years in the Arab Region, but also by the desire of the FPAs to provide the family planning movement with the impetus that only the young generation can provide.

A special effort will be made in the area of youth in 1984-1985 to coincide with the International Youth Year, and to provide Associations with the opportunity to extend their cooperation with youth organisations in their countries.

Assistance to Minority groups

Whether they live in the Arab countries or outside the Region, migrant workers constitute another group having special needs, and to whom the Region is attempting to provide assistance. One example of this is the North African community residing in Europe.

Strengthening Associations' Management Capacity

This area was one of those analysed by the Regional Council in its June 1983 meeting following which strict recommendations were issued to all Associations to undertake new recruitment and training to ensure adequate management of their programmes. Associations have implemented for the most part these

recommendations so that in April 1984 six out of eight Associations concerned by this recommendation sent their new officers to participate in a training workshop held in Amman; a subsequent improvement in the implementation by FPAs of the IPPF requirements was noted.

Other activities of the Arab World Region also reflect this concern to improve the management capacity of the Associations, as the following activities will indicate:

Two Financial Officers workshops — Cyprus July 1984
Workshops for the branches of the Egypt and Sudan FPAs
Evaluation Workshop — Amman, October 1983.

Evaluation Workshop

The introduction of an evaluative approach in the work of all Associations was felt to be of primary importance in order to use the available resources efficiently, to foster the pioneering spirit of the Associations by constantly reviewing their achievements and to search for more efficient ways to promote family planning. Thus, an Evaluation workshop was held on the regional level in October 1983 which stressed the total agreement by all Association representatives (senior management and presidents) with the IPPF guidelines in this respect.

Following this activity, most Associations' Work Programmes included provisions to evaluate every aspect of their activities.

Technical Assistance Visits to Associations

All Associations of the Region were visited at least once by staff and volunteers on the regional level (with the exception of Afghanistan and Lebanon). The purpose of these visits was:

To provide assistance in the preparation of the Three Year Plan

To explain and clarify the new PPBR system relating to planning, programming, budgeting and reporting.

To follow up on the implementation of the recommendations made by the Programme Evaluation and Management Audit Missions.

To monitor programme development

To improve or establish cooperation and coordination between the Associations on the one hand, and governments and International Agencies, on the other hand.

Countries in which the management capacity level has been deemed low (i.e., where the need for assistance was greater) were the prime targets of such assistance, particularly to help define their needs and assist them in defining their role and develop substantial programmes.

The FPAs of Sudan and Egypt have benefited from several workshops held locally with assistance from the Regional Bureau, in which financial and project development training was provided to staff and volunteers on the national and branch level. Similar efforts are underway for the Associations of Yemen and Somalia.

FPAs of a now higher level of management capacity, such as Jordan (East), Iraq, and Syria have also been assisted on a regular basis in 1983 resulting in these Associations selecting and recruiting their current management, preparing Three Years Plans and Work Programme/Budgets of a much better quality and introducing programmatic changes that are more in tune with the real needs in these countries.

In its efforts to implement the Secretariat reorganisation on the field level, i.e. the creation of Field Offices, the Regional Bureau — assisted by the guidelines of the Regional Council — has been constantly assessing the needs of the FPAs and working on developing the type of field structure that would best suit the needs of the Region. It has been felt that, for this structure to be effective, a certain degree of flexibility is needed to allow the Programme Officers to spend sufficient time with each FPA. In addition, the Regional Bureau has undertaken a census of all human resources available amongst the volunteers of FPAs in order to use this volunteer work force in conjunction with the limited staff of the Regional Bureau.

LIAISON WITH INTERNATIONAL AGENCIES IN THE REGION

To implement IPPF's centrally adopted guidelines and policies, regional representations of International Organisations have been contacted by the Arab World Regional Bureau staff and regional volunteers as well as FPAs, to establish working relationships and develop collaborative field projects. Such organisations included UNICEF, and FAO as well as representations of foreign missions.

Furthermore, several FPAs have succeeded in establishing relations with international organisations concerned with family planning, such as Pathfinder, the International Project of AVS, Johns Hopkins University, FPIA and others.

PUBLICATIONS

The Arab World Regional Bureau has been actively seeking to fill the existing gap in the Arab World in terms of arabic manuals and information sources. Thus, it has helped publish a number of documents such as:

“Birth-Spacing in Algeria”

Information leaflets on Breastfeeding, Health and the Pill

FPA's 1983 Annual Report

In addition, several IPPF materials have been translated and published in Arabic: The Human Right to Family Planning; Resource Development Package; Youth and Family Planning; Women's Development; Medical Manual; Field Workers' Guide.

FPA's of the Region have also been seeking to produce their own information materials for their country needs but are facing the same difficulties encountered by the Regional Bureau on a regional level in finding resources to adequately address their needs.

OVERVIEW OF FPA'S PROGRAMMES

FPA's continued in 1983 to promote family planning more effectively and work with national leaders and institutions to advocate a favourable position toward family planning and stimulate an increased participation of the governments and national organisations in the implementation of family planning programmes.

A large number of AWR FPA's introduced changes in their role and activities in order to make their programmes more pertinent to the developing situations in their respective countries, particularly in response to other hardened positions and opposition to family planning. The situation of each FPA, its most pressing problems and future plans, are outlined below:

Afghanistan

The Afghan Family Guidance Association has been active in updating its role in relation to the increased involvement of the Government in the provision of services and has devoted more attention to information activities and training of the Ministry of Health personnel.

The Government provides family planning services. However, no comprehensive population policy has been formulated. AFGA is helping the Ministry of Health in its effort to integrate family planning services in the delivery of basic health care by training the staff needed and providing supplies as well as information support.

Due to the situation in Afghanistan technical assistance to the FGA has not been visible but the information flow between AFGA and the Secretariat of IPPF has been good.

A visit of AFGA is scheduled for the beginning of 1985 to assess the Association's activities and its needs.

Bahrain

The Bahrain FPA was active in promoting family planning information and education. The Association has been successful in mobilising the local press and developing the public's awareness about the advantages of family planning. An indicator of its success has been its profitable fund-raising drive. The Association is no longer involved in service delivery and will focus on conducting information and education activities, and on research and training. The existence of Bahrain FPA in a country of the Gulf has been an occasion for the region to initiate contacts with such countries particularly via the follow-up Bureau for social affairs in which the Gulf countries participate.

Cyprus

The Cyprus Family Planning Association continued its efforts in the field of information and education with particular attention to youth. In recent years, the Association has been conducting seminars and youth meetings to discuss and debate issues dealing with family life education.

The Cyprus FPA operates in three clinics located in Nicosia, Limassol and Larnaca but faces difficulties from the private medical sector which is critical of the FPA's low cost services.

Egypt

Egypt Family Planning Association operates with 24 branches and has succeeded with great speed in establishing a management structure that helps the Central Office in Cairo support and monitor the branches. With assistance from the Arab World Bureau's in-country officer that has been constant, the FPA has proceeded to train its staff and volunteers in all of the branches during 1983 and 1984. Further improvements in branch management are still required. The Government's attention to family planning and population has been renewed and the President of Egypt himself has been involved in two conferences in 1984 on this topic.

Five model centres for family planning services are being set up in five governorates in Upper Egypt and the Delta Area to provide family planning and primary health care services, with an emphasis on preventive medicine and health and nutrition education.

The Association's family planning centres are being upgraded and evaluated to give the Association a chance to orient its effort towards underserved areas and avoid duplication with other sources of services.

Iraq

The impact of the Iran-Iraq war on the attitude of the Iraqi Government toward family planning is evident in the pro-natalist position adopted. The Iraqi FPA continued its role as a family planning advocate and a provider of services. However, it was under pressure to acknowledge the Government's and the peoples' attitude and it stresses the treatment of infertility as one of its major areas. The Iraqi FPA's cooperation with the Iraqi Women's Federation has been a strong factor in allowing the FPA to provide services to women.

The FPA has been successful in convincing the Government to back down from the hard line it took regarding the distribution of oral contraception. The FPA's strong medical membership is reflected in the attention the FPA devotes to medical and nursing training. In the field of information, the FPA publicises the health benefits of family planning by using the mass media, although it is aware of the possible opposition of the public to the idea of reducing births in the context of the war.

The Association provides services in its five clinics using Ministry of Health

personnel and incorporating family planning services with maternal and child health, and basic health and social services with some emphasis on infertility services and some restrictions on providing services to childless couples or young couples with only a few children. An illustration of such integration is the cooperation of the FPA with the Anti-Tuberculosis Society's Social Centre in Baghdad.

Jordan (West Bank)

The Association's activities in the West Bank suffered from the effect of the occupation as restrictions on the ability to hold meetings and on the clinical operations were imposed. The movement of the FPA's members in the field has often been restricted.

Despite these harsh conditions and despite possible opposition from some groups, the FPA has made efforts in the areas of family life education in traditional Islamic schools.

In 1983, an IPPF team visited the FPA for an Overall Programme Evaluation and issued high praises for the FPA's work.

Jordan (East Bank)

The strengthening of the Central Office's managerial capacity, the development of the Association's capabilities for programming and implementing strategies and activities and the consolidation of existing projects remained the general guidelines for the Jordan Association.

The Association started its new information project with the help of the Johns Hopkins University for production of audio-visual materials with an emphasis on commercial advertising of contraceptives. The FPA's involvement in clinical services is gradually being complemented by the Government's intervention so that it may be possible in the near future to have more emphasis from the FPA on education and training to further support advocacy and complement the Government's role.

Lebanon

The Lebanon FPA is a source of support for family planning activities within non-governmental organizations and government socio-medical services. It plays a supervisory role for the Ministry of Health in particular, and the Government in general, in the area of training of health personnel for family planning services delivery.

Contrary to what may be expected, the Association seems to maintain a high level of activity despite the war. The Association does suffer from the war situation (vandalism, theft, absence of security, difficulty of travel and field work) yet it has not abdicated its role and was able to re-locate and diversify its activities as needed.

In the general area of advocacy, the Association played a major role in the repealing of the old provisions of the Penal Code restricting the distribution of contraceptives, in the statement of integration of family planning in health services, and in the creation of the National Population Council.

In the area of training, the Association held training courses for a variety of audiences.

Morocco

The Moroccan FPA maintained its clinical and non-clinical distribution of contraceptives through a network of twelve centres and five mobile distribution teams, an IUD mobile insertion project was started in 1983 as well as a new facility for surgical family planning and infertility treatment in collaboration with the Ministry of Health.

An IPPF Management Audit was carried out in May 1983 which stressed the need for an evaluation of the ongoing activities and a strengthening of the management and volunteer structure prior to the initiation of new projects. The evaluation and training capabilities of the FPA are also to be developed and coordination with the provinces is to be established.

The FPA will build on its success to develop its capabilities in terms of audio-visual production through operation of its new audio-visual studio. It will actively pursue the strengthening of its collaboration with the Ministry of Youth to be able to involve more youth centres in family planning education.

The non-clinical distribution will be improved by developing a network of community based suppliers, and the clinic operations will be upgraded to achieve a higher rate of utilisation by the population.

Somalia

The Somali Family Health Care Association was created in late 1983 and joined IPPF in the same year. Family planning services in Somalia are provided by the health ministry and the role of the Association will be to give information, education and training support to the Government's programme and to work closely with the Women's Union on promoting family planning. This new Association will be a prime candidate for technical assistance in 1985 following the completion of its initial year in 1984 where most efforts were directed toward recruiting required staff, training and setting up the basic structure for the Association.

Sudan

The Sudan FPA has worked on reinforcing the four branches currently in operation on coordination and on the reporting from the branches. The FPA hired new staff in 1983 in all positions.

The Association hopes to work closely with the government and advocate the launching of a population policy which is seriously threatened by the current position of the Sudan Government in which pro-natalist and views dominate. Due to the public attitude, the Association put forward the benefits of a family planning programme for health reasons.

The Association has made some efforts to reach rural women in collaboration with the Women's Union, the Youth Organisations and the religious organisations. The Association received constant assistance from the Regional Bureau in terms of training and project development and continues to be among the priorities for increased assistance.

Syria

The state of war in the region invites the public's attitude to be somewhat opposed to reducing fertility. Syria FPA was active in promoting its information activities, and increasing the involvement of the branches' volunteers in policy formulation and work programme design.

The Syrian Association continued to provide contraception in the 10 clinics it operates in collaboration with the Women's League and the Ministry of Health. The Association has in 1983 upgraded its management personnel; its application of the Programme/Budget system and its compliance with the terms and conditions of the grant were excellent.

Tunisia

The Tunisian FPA has primarily a supporting role for the Government's official family planning programme. In practice, however, this has not materialised as well as hoped for several reasons inherent to the nature of the Governmental programme and to the social and political climate in the country and to the lack of qualified staff.

The Tunisian FPA is focusing on the suburban and rural areas in an effort to bring information and services to the hard to reach portion of the population. Its main thrust has been the development of a corp of educators throughout the country to hold information meetings with the public and the clinic patients.

The Association is seriously hampered by a lack of skilled staff at the Central level. The Regional Council has called upon the Association to remedy the situation through specific actions and several attempts of the Regional Bureau to assist the FPA in implementing the recommendations have been met with polite approval but no action by the Association.

Yemen Arab Republic

The Association's role in 1983 was mainly to distribute contraceptive supplies through hospitals and health centres of the Ministry of Health and other international and foreign-sponsored clinics and institutions. It is about to start running its first model clinic in 1984 to provide comprehensive services and training. The Association was reluctant to actively disseminate information on family planning fearing to raise controversy in a traditional environment, and was involved in very little advocacy. It succeeded in holding a national conference on family planning. It still has to capitalise on the working relationship this conference offered with the Ministry of Health and other national and international organisations.

Staff and volunteers need training and assistance and following recruitments in 1984 and a few evaluative visits by the Regional Bureau it is expected that the Association will be able to emerge from its current state into a more active position in tune with what the country needs.

People's Democratic Republic of Yemen

The Yemeni Council for Family Care became a new member of the Region in 1983.

In 1983 the Association worked closely with youth, women and rural organisations. It provided assistance in the area of health manpower training to the Ministry of Health. The Government is favourable to family planning and plans to integrate its provision in the maternal and child health clinics but it lacks the resources to provide basic health services and the FPA feels the pressure to assist in these basic areas as they are prerequisite to the development of family planning. The Association's major strength has been in mobilising the media, the youth organisations, the Women's Union and the community organisation network embodied in the Committees of Social Defence which have almost limitless prerogatives to influence and intervene in the community affairs.

The Association will need to work more closely with the Centres for Maternal and Child Health to promote and monitor the distribution of contraceptives and is planning to increase its efforts to develop a non-clinical distribution network based on mobile teams.

EXPENDITURE SUMMARY . - Arab World REGION

1983 Actual

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Afghanistan	140.6	108.1	248.7	31.4	(31.2)	248.9
Bahrain	22.5	9.0	31.5	22.4	(12.1)	41.8
Cyprus	31.3	5.8	37.1	11.7	2.2	51.0
Egypt	226.5	-	226.5	943.6	(270.3)	899.8
Iraq	52.4	34.1	86.5	11.0	(5.2)	92.3
Jordan - East	148.1	7.1	155.2	57.8	(16.0)	197.0
Jordan - West	92.7	1.6	94.3	16.6	18.6	129.5
Lebanon	351.1	48.7	399.8	36.6	(72.9)	363.5
Morocco	236.7	91.9	328.6	93.7	(107.1)	315.2
Somalia	40.0	5.9	45.9	-	(5.0)	40.9
Sudan	112.5	22.9	135.4	6.2	(1.4)	140.2
Syria	154.0	37.1	191.1	3.9	(23.1)	171.9
Tunisia	135.5	6.6	142.1	7.8	1.9	151.8
Yemen A.R.	149.7	28.4	178.1	50.1	(20.0)	208.2
Yemen P.D.R.	61.6	58.9	120.5	-	7.2	127.7
TOTAL	1955.2	466.1	2421.3	1292.8	(534.4)	3179.7

EXPENDITURE SUMMARY - Arab World

REGION

1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Afghanistan	158.7	43.5	202.2	12.7	6.3	221.2
Bahrain	40.3	10.0	50.3	17.8	3.6	71.7
Cyprus	28.4	3.0	31.4	12.1	5.7	49.2
Egypt	365.0	-	365.0	578.6	-	943.6
Iraq	126.0	61.6	187.6	9.7	(3.4)	193.9
Jordan - East	160.0	11.6	171.6	127.1	9.8	308.5
Jordan - West	140.0	9.1	149.1	13.3	4.3	166.7
Lebanon	350.0	15.0	365.0	39.1	(25.0)	379.1
Morocco	291.7	7.9	299.6	44.3	(29.9)	314.0
Somalia	80.0	-	80.0	-	-	80.0
Sudan	197.0	33.0	230.0	9.1	-	239.1
Syria	160.0	46.5	206.5	1.1	14.3	221.9
Tunisia	225.8	2.7	228.5	29.6	(10.0)	248.1
Yemen A.R.	188.0	12.0	200.0	-	-	200.0
Yemen P.D.R.	120.0	34.9	154.9	-	4.0	158.9
TOTAL	2630.9	290.8	2921.7	894.5	(20.3)	3795.9

EXPENDITURE SUMMARY - Arab World

REGION

1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Afghanistan	179.4	95.6	275.0	21.8	-	296.8
Bahrain	31.0	11.0	42.0	19.9	-	61.9
Cyprus	30.0	3.3	33.3	14.2	-	47.5
Egypt	452.0	28.0	480.0	958.2	-	1438.2
Iraq	112.5	93.6	206.1	11.6	-	217.7
Jordan - East	172.0	13.0	185.0	148.6	-	333.6
Jordan - West	147.0	3.8	150.8	22.0	-	172.8
Lebanon	403.0	16.7	419.7	106.3	-	526.0
Morocco	405.8	72.6	478.4	449.2	-	927.6
Somalia	84.3	25.7	110.0	-	-	110.0
Sudan	225.8	27.4	253.2	5.2	-	258.4
Syria	197.6	24.1	221.7	1.5	-	223.2
Tunisia	170.0	4.0	174.0	-	-	174.0
Yemen A.R.	183.2	43.3	226.5	39.5	-	266.0
Yemen P.D.R.	156.2	30.6	186.8	-	-	186.8
TOTAL	2949.8	492.7	3442.5	1798.0		5240.5

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US\$'000)

ARAB WORLD

	<u>SUPPLIES PURCHASED BY IPPF</u>		
	<u>ACTUAL EXPENDITURE 1983</u>	<u>ESTIMATED EXPENDITURE 1984</u>	<u>PROJECTED EXPENDITURE 1985</u>
Contraceptives	319.8	157.8	231.3
Medical & Surgical	44.0	16.0	29.5
Audio Visual Equipment	22.5	18.6	17.6
Office Equipment	24.5	21.6	67.2
Transport	30.3	30.2	105.0
	<hr/>	<hr/>	<hr/>
TOTAL	<u>441.1</u>	<u>244.2</u>	<u>450.6</u>
	<hr/>	<hr/>	<hr/>
	<u>AID SUPPLIES DONATED TO IPPF</u>		
Contraceptives	49.1	46.6	42.1
	<hr/>	<hr/>	<hr/>
FULL TOTAL	<u>490.2</u>	<u>290.8</u>	<u>492.7</u>
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LEBANON

LEBANON FAMILY PLANNING ASSOCIATION

COUNTRY BACKGROUND

Lebanon is a country about 210 miles long and about 50 km wide. It has a long coastal sector and is bordered by the Mediterranean from one side and by a range of mountains on the other. Lebanon is adjacent to Syria and occupied Palestine. There is a marked population density in the low coastal area; nearly half of the total population resides in Beirut (the capital city) and its suburbs (known now as the Southern Suburb).

Lebanon's economy relies to a large extent on services and tourism, and therefore has a high urban population. A considerable part of Lebanon's economy depends on migrant workers abroad either in Arab countries or others.

There are two major religious groups in Lebanon: Moslems and Christians. Each group is divided into sects or sub-groups, amounting to 17 lawfully-acknowledged groups.

Educational services are good throughout the country and student enrolment is high. Health facilities are centred in cities. The number of doctors is estimated at 7.5 per thousand, nurses 2.7 per thousand and midwives 9.7 per thousand.

Age at marriage varies according to religion. The minimum legal age at marriage for a Moslem female is 9 years and 12 years for the Christian female. Parents' consent for marriages when the girl is under 18 years is necessary in all cases. Polygamy is not widespread though some Moslem groups allow marriage up to four wives. Practical field studies in Lebanon (Labour Force, family planning study) have shown that the average age at marriage is 21.5 for females and 22.5 for males. Current laws in Lebanon have allowed the employment of children in some trades at the age of 9.

Socio-demographic data:

Total Land Area	10,452 sq km
Total Population	3,300,000 inhabitants
Crude Birth Rate	27 per thousand
Crude Death Rate	7.4 per thousand
Natural Growth Rate	2.0%
Infant Mortality Rate	41.2 per thousand
Life Expectancy at Birth	67.3 years
Population under 15 years of age	41.7%
Population aged 65 years and over	8.7%
Population 15-49 age group	44.5%
Population in urban areas	76%

Illiteracy Rate:	
— males (aged 15 years and over)	30%
— females (15 years and over)	42.9%
Average Family Size	4.7 children
Per Capita GNP	\$1,562
Population Density	236 persons/sq. km.

Official Policies

During 1983-84 the major changes in the official policies were:

- The repealing of the old law prohibiting the sale and advertisement of contraceptives.
- The establishment of health regions of 200 to 300 thousand inhabitants with health centres in each region, each of which is to serve approximately 30,000 people. The law established that family planning is to be provided with maternal child health among other services offered by these centres.
- The promulgation of the law on “mother's milk substitutes” which promotes breastfeeding.
- The law integrating the Office of Social Development (SDO) with the Ministry of Health which then becomes the Ministry of Health & Social Affairs. The structure of the new ministry is under study and among the possible options there is a project for establishing a special division within the Department of Social Affairs which would be labelled Population & Family Services and would be the institution to turn family planning service into a national family planning service.

Public Attitude

It is difficult to empirically assess the public attitude in the current situation of war in Lebanon. However, the FPA has undertaken a contraceptive prevalence survey assisted by Westinghouse and it appears that attitudes of the public, males in particular, are positive. The FPA has tried to keep up its good image in the society by promoting childrens camps activities which may have had a positive effect on parental attitudes towards family planning. A national conference for leaders and parliamentarians was another indication of the support from public opinion and the leadership towards family planning. However under the present war time circumstances and given the loss of lives in many families, family planning may be facing an increased opposition particularly if it is understood as a fertility control measure.

Constraints to Family Planning

The major constraints now lie in the substantial damages done by the war. Lebanon's priorities seem oriented toward security, economic recovery and reconstruction and areas such as family planning may be considered marginal. There is a strong feeling of the importance of the upcoming general census which will be the basis for the plan to reconstruct the country.

The Future of Family Planning

The Association is working toward developing the government's attitude into a population policy and legislation. Positive steps have been achieved in this respect through national seminars and the recent creation of the National Population Council by decree of the Minister of Health.

THE ROLE OF THE ASSOCIATION

The Lebanon FPA identified its role as a pressure group for the removal of legal barriers to the provision of the information on family planning services for contraception. The LFPA aims at increasing the public's and the officials' acceptance of the importance of population issues including family planning, and at providing services in an integrated fashion with the governmental and the non-governmental sectors, particularly by training the personnel of these sectors.

The LFPA assists the government and, in particular, the Ministry of Health, in the area of training Health Personnel for family planning service delivery. The FPA obtained in 1981 a special grant from USAID through the Council for Development and Reconstruction to be spent on training courses for medical and paramedical staff.

Furthermore the FPA is trying to extend its clinical services to all who need them, through its affiliated clinics or other clinics affiliated with NGOs and with the Office for Social Development.

The FPA is therefore working to be a source of support to all family planning activities for all NGOs and government socio-medical services.

The Lebanon FPA, since its establishment 14 years ago, has had significant achievements in several fields. Several studies were done, namely the Family Study in 1971, and the "From House-to-House Study" in the villages of Zahrani, Nabatiya, and later in Bikkaa Districts. Its staff have also participated from time to time in studies at the national level, such as the Study of the Handicapped. A study on contraceptive usage is intended.

In promoting the awareness of family planning, the Association has constantly highlighted several social problems in Lebanon, considering them to have a direct relationship with family planning.

Other Family Planning Activities

Contraceptives are available for wide-scale distribution; pills and condoms are available at most pharmacies but services for other methods such as IUD insertion, female sterilisation, traditional methods, injectables and others are insufficient.

The repealing of the ban on contraceptive sales and advertising (although this ban was not in fact enforced at all) may further enhance the commercial sector's contribution to the spread of contraceptives.

THE PAST PERFORMANCE OF THE ASSOCIATION

Contrary to what may be expected, the LFPA seems to maintain a high level of activity despite the war. The LFPA does suffer from the war situation (vandalism, theft, absence of security, difficulty of travel and field work) yet it has not abdicated its role and was able to relocate and diversify its activities as needed. Two explanations are given by the FPA for their continued success:

1. The war in Lebanon is seldom covering the whole territory; thus there are always areas where work can be done to satisfy a need for services, training, information, research, etc.
2. The war has also created a favourable attitude in the population toward family planning, not out of enthusiasm for the concept itself but out of disillusion from the war and as a result of the economic and social difficulties which parents perceive as an inappropriate environment for raising families and bringing up children.

The achievements of the FPA in 1983 can be summarised as follows:

In the general area of advocacy, the FPA played a major role in the repealing of the old provisions of the Penal Code restricting the distribution of contraceptives, in the statement of integration of family planning in MCH services, and in the creation of the National Population Council.

In the area of services, the FPA continued its activity in both clinical and non-clinical distribution and had in 1983 increased its numbers of new acceptors in comparison with 1982.

These services were provided via 28 clinic outlets run in cooperation with the Ministry of Health and other agencies. The FPA normally would have activities in 46 premises but some were closed for security reasons.

In the area of training, the FPA held training courses for a variety of audiences as follows:- trainers in youth camps, paramedical personnel of the Ministry of Health, Social Development Office and some NGOs, NGO leaders, women leaders, field workers (nurses), students of the University and special personnel such as interviewers and CBD fieldworkers.

The FPA was active in the area of women's development. A national conference to evaluate the status of women was held in April in Beirut with 85 participants, resulting in important recommendations during which a proposal was made to create a national council for women's affairs. The FPA has had a women's development committee since 1978, is involved with various women's associations and centres of the Social Development Office, and undertook studies and publications in this field.

Similarly, the FPA held activities in 1983 to promote male responsibility in family planning.

In the area of publications, the FPA produced several documents, the most important of which may be its book on population policy in the Lebanon which represents the proceedings of a conference held under the same title, in addition to the FPA's bulletin and its educational materials for which a detailed schedule of distribution has been prepared and implemented.

The capacity of the FPA for acquiring knowledge about the country situation is often reinforced by the encouragement it provides to university students to study areas relevant to the FPA.

Youth activities represented another important concern of LFPA in 1983, particularly reflecting the FPA responsiveness to the social injustice that young people faced because of the war whereby their out of school activities were severely curtailed. The FPA provided an outlet for these youngsters through youth camps while gaining at the same time the confidence of the population and creating opportunities for family life education and contacts with the parents.

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

LFPA selected four strategies as follows:

- To increase the participation of policy makers and specialists (academics and experts) in the Association's efforts to explain the family planning concept at the national level for the purpose of planning and adopting a population policy.
- To upgrade people's awareness of population issues and their practical implications and of the role of family planning in social change and development.
- To provide comprehensive family planning services to meet the demand resulting from I&E activities (through traditional clinics and innovative projects which believe in and attract a large social participation).
- To pursue the structural development of the Association and the development of its capabilities to deal with the national current situation, and its ability to meet future demands.

The activities planned by the FPA under these strategies can be highlighted by the following:

- National Conference on Population
- Publications of periodic magazine and activities related to the media
- Training sessions for students and youth on population
- Supporting university students and faculty's involvement in population studies

- Provision of clinical and non-clinical services including efforts to promote education of expecting mothers and education in breast-feeding.
- Promotion of women's centres
- Research on levels of use of contraception and on women's status
- Development of a training centre and upgrading of the FPA's staff and volunteers capacity.

THE ASSOCIATION'S RESOURCES

Non IPPF Income

The FPA's dependency on IPPF funding is approximately 82% to 86% of its total expenditures. This may even increase in light of the difficulty experienced by LFPA in securing added support from other donors and from local sources, as a result of the instability of the situation in Lebanon.

The FPA has been successful in obtaining funding from several sources in and out of the country and in securing in-kind donations and traineeships from universities and specialised agencies. The FPA generates income from its service delivery programme.

Personnel

The projected numbers of personnel are stable over the plan period at 28 as compared to the approved number of 27 in 1984. The costs rise reasonably, yet it has been difficult for the FPA to remain unaffected by the inflationary trends in Lebanon and therefore there were requests in each of the last two years for salary increases; it is not far-fetched to expect similar increases to be put forward in the coming years just to compensate for the high cost of living.

Voluntary contributions

The volunteers play an active role in planning and implementing the Association's programmes and activities. They are active in the structure of the FPA within the administrative staff, the specialised committees and the regional committees.

At the fieldwork level, there are more than 120 volunteer fieldworkers assisting the Association in the provision of rural family planning services (CBFPS), women's programmes, pregnant mothers' programmes, etc.

The management system is controlled by the LFPA Secretary General who acts as the Executive Director. The Executive Committee meets regularly. In addition, there are a dozen standing committees which include a number of Lebanon's leading citizens in addition to LFPA members and which contribute significantly to the Association's work.

THE ASSOCIATION'S MANAGEMENT CAPACITY

The FPA operates from Beirut and from Saida. The latter has been instrumental to the FPA during the incidents in Beirut and is generally the FPA's centre for its CBFPS operations. The LFPA has an executive board, eight special committees that meet regularly, and some regional committees. The staff of the FPA consists of an assistant executive director for administration, an assistant executive director in charge of the CBFPS, three officers for training, information and social and health services. In addition it employs 23 other full time staff.

With the financial officer, the total of junior managers in the FPA is five but there is no executive director to act as the top manager. This role is taken by the Secretary General of the FPA who is on the volunteer level and the staff level respectively the chief decision maker and executive director.

The distinction between volunteers and staff roles is not recognised by the FPA as an important one: there is however a danger that the FPA's demands on the volunteers may become excessive.

THE FUTURE OF THE ASSOCIATION

The FPA's performance, considering the circumstances, can be regarded as commendable. There has been a real effort to survive and challenge the difficulties of the war rather than sit and wait using the war as an excuse. The Syrian FPA became an intermediary for travel, mail, and supplies arrangements and despite difficult channels of communications the FPA has kept up its contractual agreements, sending its reports and submissions within reasonable time.

The absorptive capacity of the LFPA has been consistently higher than that of other FPAs in the Arab World Region, so that a country which accounts for 1.6% of the population of the 14 countries of the Arab World Region, absorbs 16% of the grants allocated to the overall region. However, this in fact reflects more the low level of absorptive capacity of the Region as a whole than any excess in the funding enjoyed by the Lebanon FPA.

Lebanon's economic conditions in the last few years have changed drastically as a result of the destructive war and the previous privileged position of Lebanon amongst the Arab nations in terms of wealth must be now questioned. There are numerous accounts of deprivation, trauma and poverty and the inflation has been excessive. Therefore there may be justification for the LFPA's desire to maintain and if possible increase the level of IPPF funding.

TUNISIA

TUNISIAN FAMILY PLANNING ASSOCIATION

COUNTRY BACKGROUND

Tunisia covers an area of 163,410 square kilometres and had a population of 6.6 million by mid-1981, estimated at 6.7 million in 1982. The population density is 39 to the square kilometre; the arable land is below 50% of the total land.

Tunisia's natural growth rate is estimated at 2.6% in 1981, indicating that the results of the national family planning programmes have remained at a plateau since 1979 and that the objectives of the fifth national development plan (1977-1981), which anticipated a decline to 2.3% in the level of the growth rate, were not reached. Despite the fact that 85% to 90% of the population is aware of the availability of family planning services, only 50% to 55% have ever used a family planning method. Based on a 1977 survey, 17% of women in the reproductive age are using one method of contraception, (the FPA's reported figure is 22% for 1982). These figures reflect the large gap between the knowledge and the practice of family planning. In the rural area the gap is even wider, and the rate of practice is only 7%.

Socio-demographic data:

Population total (in 1000)	6800
Population ages (% of total)	
0-14	41.3
15-64	54.8
65+	3.8
Women ages 15-49 (per 1000)	1488
Dependency ratio (per 1000)	824
Child-women ratio (per 1000)	709
Sex ratio (per 100 females)	102.7
Median ages (years)	18.8
Proportion of urban (%)	51.73
Population density (per sq. km.)	39
Rate of growth (%)	2.5
Natural increase rate (per 1000)	24.9
Crude birth rate (per 1000)	36
Crude death rate (per 1000)	11.1
Infant mortality rate (per 1000 live births)	98
Gross reproduction rates	2.75
Net reproduction rate	2.18
Total fertility rate (per 1)	5.64
Life expectancy, males (years)	57.4
Life expectancy, females (years)	58.4
Life expectancy, total (years)	57.9

Official Policies

In his presentation of the 1982 National Budget to the National Assembly, the Tunisian Prime Minister expressed his concern about the present demographic situation of the country, stating that the 2.6% growth rate was unacceptable "not only at the level of the individual, the family or the education of the children, but also at the national level, in view of the resources of the country and its possibilities in the field of employment opportunities." "For this reason", he added "efforts should be multiplied, if we want to catch up with events and meet the objectives we set forth in the area of birth control".

For the moment, the task of improving the family planning activities and the programmes is handled at the governmental national level by the National Office for Family Planning, the government body which was created in 1973, and which was given the responsibility of running the national family planning programme. The Office is aided in its task by the Supreme Council and the regional councils for Population, as well as government departments, in particular, the Ministry of Health. The responsibility of the National Office for Family Planning is to promote population policies and standards of services, to ensure that adequate training programmes are developed for any personnel involved in providing family planning services and to provide central support in Health Education and Communication, Research and Evaluation, and certain administrative support services. In addition, the major responsibilities of the Office are to coordinate all family planning activities throughout the country and to act as a spokesperson for the Family Planning Programme in general, at the government level. The Office is financially supported by the government, although 70% of its funding is provided by international donors, AID being the main one.

The legislative support for family planning is strong. Abortion is available on request, a legal age of marriage is set at 17 for females and 20 for males. Polygamy is prohibited. Social benefits for families with children are gradually reduced up to 5 children and cut afterwards, and the civil code is favourable to women's development.

The government of Tunisia is one of two donors to the IPPF in the Arab Region and has been active in the creation of the Tunisia FPA.

Public Attitude

The public attitude towards family planning is generally favourable. The different public organisations provide substantial and unconditional help to the government policy in this regard. Mass-media and religious leaders, even after the relative relaxation of government control which started in 1980, did not show opposition to the family planning movement in the country.

Constraints to Family Planning

The main constraint to family planning in the country, as documented by recent studies, is the lack of dissemination of information and services in the suburban and rural areas.

The Future of Family Planning

The Tunisian Government's goal is to increase the prevalence of contraceptive use to 35% of married women of reproductive age, to reduce the crude birth rate to 30 per 1,000 by 1986, and to achieve an annual rate of population growth of 1.6% by the year 2001.

The National Office for Family Planning and Population (ONPFP) has been recently brought under the control of the newly created Ministry for the Family and Women's Union. This may lead to some changes in the way the ONPFP is run as well as in the UNFT (Women's Union) involvement in Family Planning, and it is possible that the Tunisian FPA will be included in the overall scheme of foreseen changes.

Assistance from Other Organisations

The government programme receives substantial financial assistance from different international agencies and organisations channelled through the National Office for Family Planning. The major donors are the USAID through the Population Council, AVS, JHPIEGO, and UNFPA. This has not been extended to the FPA which receives most of its funding from IPPF, and a small donation from the Government. The attitude of donor agencies toward NGOs and the lack of visibility of the FPA as compared to the ONPFP are the main factors for this.

THE ROLE OF THE ASSOCIATION

The current and main role of the ACPF can be broadly interpreted as supporting the National Programme through its extensive membership. The Association's unique volunteer structure at the national and regional levels has played an important part in mobilizing public and political support for the family planning movement and is gradually moving into a position where it participates in the shaping of national policy in this area.

Other Family Planning Activities

Family planning services are provided free of charge throughout the Ministry of Health centres and hospitals and the clinics of the National Programme. Pharmacies sell contraceptives at a subsidised price which is symbolic.

THE PAST PERFORMANCE OF THE ASSOCIATION

The FPA has played a pioneering role by introducing model clinical activities and integrated projects. The FPA played an important role in the field of Information, Education and Training. Activities particularly on the regional level have been focused on information and education.

The link between the national and regional levels will be further strengthened:

- by increasing the input from regions into nationally organised activities and
- by providing increased programme assistance and coordination from the centre to the regions.

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

In its Three Year Plan, the FPA assigns itself the following tasks:

- Continue supporting the National Programme in the field of Information, Education and Training, increase the number of acceptors and decrease the rate of population growth.
- Continue playing a complementary role as far as national efforts are concerned to reduce the gap that exists between knowledge and practice of family planning methods by reducing obstacles in this field.
- Given the low number of family planning acceptors in the suburban and rural areas, continue to plan an innovative role in providing family planning services through projects integrating family planning with community development activities.

The general characteristic of the projects outlined in the Three Year Plan is that they build on the previous year and continue the Association's activities with an effort to expand the integrated services in rural and suburban areas and improve certain aspects of family planning service delivery in hospitals and MCH centres.

The FPA's contribution to the family planning movement in Tunisia and its success in designing innovative approaches is very important to the strengthening and renewal of the national governmental family planning programme.

THE ASSOCIATION'S RESOURCES

Apart from IPPF financial assistance, international support to the FPA has not been significant, particularly with the existence of a governmental programme which is already financed by a wide variety of foreign and international agencies. However, international donors may soon recognize the particular importance of NGOs, as did the Tunisian government itself when it assisted in creating the FPA even after it started its National programme.

The most important resource of the FPA is its personnel structure covering most regions in the country and the FPA is currently reviewing its situation to make the best use of such resources. A plan has been put forward by the Regional Council, to strengthen the FPA central management by appointing programme and finance officers, to efficiently use existing regional personnel and to build up the FPA's capacity to develop new projects.

Although the projections are for stable numbers and costs, the FPA will review its personnel situation by decreasing the number of staff in regions where the FPA's involvement is not in concurrence with its primary role of satisfying unmet needs in areas not well covered by the government's programme. The FPA will also strengthen its central staff to improve its programmes and its management. The high.

THE FUTURE OF THE ASSOCIATION

The current changes occurring in Tunisia may affect the FPA in one way or the other. The creation of the Ministry of Family and Women's Development and the integration of the ONPFP within this new ministry may indicate that the FPA will be given a more prominent role in the Government's plans for the future. In particular the national Organisations in Tunisia, following the example of the PSD Party and of the Women's Union, have always played a supporting role to the executive branch of the Government. Quite often this support was secured by having the same people assume double roles in the executive and the voluntary sectors. The FPA may well be called upon by the Family and Women's Development to undertake parts of the activities needed to stimulate the national programme. The challenge will be to preserve the FPA's freedom of movement and autonomy while working closely with a strong partner.

Economic conditions in Tunisia are good although recent years have seen a considerable rise in the cost of living. The interest that donors manifest toward Tunisia is still important in view of its stability and the serious commitment of its people to family planning. The FPA has not so far been able to attract other funds and remains totally dependent on IPPF for survival.

EAST AND SOUTH EAST ASIA AND OCEANIA REGION

REGIONAL OVERVIEW

INTRODUCTION

The East and South East Asia and Oceania Region (ESEAOR) is a double region of IPPF. It became a double region with the merger of the Western Pacific and the South East Asia and Oceania Regions in December 1974.

ESEAOR has as full members of IPPF the following:

- The Australian Federation of Family Planning Association Inc. (AFFPA)
- Family Planning Association of Fiji (FPAF)
- Family Planning Association of Hong Kong (HK FPA)
- Indonesian Planned Parenthood Association (IPPA)
- Family Planning Federation of Japan (FPFJ)
- Planned Parenthood Federation of Korea (PPFK)
- Federation of Family Planning Association, Malaysia (FFPA,M)
- New Zealand Family Planning Association (NZFPA)
- Singapore Family Planning Association (SFPA), and
- Planned Parenthood Association of Thailand (PPAT)

Of the eleven full-member Associations, three of them, Australia, New Zealand and Japan, are in donor-countries. In 1984, the governments of these three countries contributed over \$10 million to the IPPF. The other seven Associations are grant-receiving FPAs. Out of these, Indonesia, Korea, Philippines and Thailand also contribute annually small sums to the IPPF. Fiji, even though a full member, does not receive any grant from IPPF at the moment.

The Family Planning Association of Papua New Guinea joined the Region as an associate member in 1983.

In addition to the 12 full and Associate members, there are three other grant-receiving Associations from the widely scattered island-countries of the Oceania and South Pacific. These are:

- the Solomon Islands Planned Parenthood Association (SIPPA)
- the Tonga Family Planned Association (TFPA), and
- the Western Samoa Family Health Association (WSFHA)

The Western Samoa Family Health Association was formed in 1983 and has since begun undertaking programme activities. The WSFHA is the successor of the defunct Western Samoa Family Planning Association, which was in operation some years ago.

The potential FPA membership in the region so far 'untapped' is still sizeable — from Burma, Kampuchea, Laos and Vietnam to half a dozen or more island-countries in the South Pacific.

The 15 grant-receiving member FPAs account for 476 million people of the world as at 1984. In terms of land area, the FPAs represented by ESEAOR cover 11,484,567 sq. km. It is anticipated that by the year 2020, these 15 FPAs will account for 691 million of the world population.

ESEAOR encompasses in a nutshell the world's diverse ethnic, religious and linguistic groupings. Demographically the region has one of the highest Crude Birth Rates (CBR) (47% in Solomon Islands) and one of the lowest (CBR) (13% in Japan). Similarly, the Crude Death Rates (CDR) vary widely from 14% in Papua New Guinea to 5% in Singapore. The population-doubling time ranges from a very low 19 years in Solomon Islands to an exceedingly high 102 years in Japan. The same extremes are found in terms of Infant Mortality Rates — 103 per thousand live births in Papua New Guinea to 7 in Japan. Yet another extreme variation in the vital statistic rates is reflected in the expectation of life at birth. In Indonesia, the expectation of life at birth is only 49 years as against 76 years in Japan.

The GNP per capita shows an even greater disparity. On the one end of the spectrum the GNP per capita in Indonesia is only US\$580, whereas in Australia, it is more by a factor of 22 or US\$11,140 per annum.

The enormous heterogeneity of the FPA's country situation in the region in terms of demographic and economic data can be seen from the table below

Countries	Population Mid-1984 (in million)	Doubling Effect	Infant Mortality Rate (IMR)	Life Expectancy	GNP (In US \$)
Indonesia	161.6	33	92	49	580
Malaysia	15.3	29	31	64	1860
Philippines	54.5	27	54	61	820
Singapore	2.5	58	11	71	5910
Thailand	51.7	36	54	61	790
Hong Kong	5.4	59	10	73	5340
Republic of Korea	42.0	43	34	66	1910
Fiji	0.7	29	29	62	1884
Papua New Guinea	3.4	24	103	52	820
West Samoa	0.2	23	40	63	n.a.
Solomon Islands	0.3	19	78	65	660
Tonga	0.2	n.a.	n.a.	n.a.	n.a.
Sub Total	337.8				
Australia	15.5	85	10	75	11140
New Zealand	3.2	90	12	72	7920
Japan	119.9	102	7	76	10080
GRAND TOTAL	476.4				

ESEAOR FPAs' identification of unmet needs and their own role reflect the varying degrees of commitment to population and family planning by governments in the region. Government policies and commitment to family planning vary from a very

strong and unequivocal approach (Singapore, Korea and Hong Kong) to a verbal and luke-warm commitment (Philippines or Malaysia). Whatever the degree of commitment to family planning, it is increasingly clear that there is a general awareness and concern in all countries that there should be a planned growth in population. Several governments have in fact established population targets.

In Fiji, one of the nine health priorities emphasizes the need for reducing the Crude Birth Rate (CBR) from 29 to 25 per thousand by 1985. The third Five Year Plan (1979-1984) of Indonesia has clearly stated the need to achieve a 2.1% growth rate by 1984. Philippines and Thailand have set a goal in their national Development Plan to achieve a population growth rate of 1.6% (1985) and 1.5% (1986) respectively. In Korea, the aim is to achieve a Zero Population Growth (ZPG) by the year 2050, and reduce the concentration of population in its capital city Seoul, from 8 million to 7 million by 1986. Japan and Singapore hope to achieve ZPG by the year 2000 and 2030 respectively.

In order to achieve these demographic goals, some of the countries in ESEAOR have also resorted to changing existing pronatalistic laws and passing new incentive and disincentive measures. The pioneers in this are Singapore and Korea.

This does not mean the FPAs in ESEAOR do not face any constraints or obstacles in the promotion of planned parenthood. In fact, many FPAs feel varying degrees of obstacles. In Korea, while there is a desire to liberalise abortion by the Government, there is a strong opposition from certain segments of the population.

In Singapore, there is pressure for the more educated women (preferably graduates) to have more children; less-educated women have strong incentives and disincentives to discourage them from having more than 2 children. In the Philippines there is at present a concerted thrust to promote natural family planning methods, with a consequent denigration of other methods.

Sectoral opposition to family planning continues in a muted way in almost all of the FPAs in the region. This opposition is often small and from selected political, ethnic and religious groups. Part of the efforts of FPAs have been directed at providing more information to these groups to create greater awareness and hopefully a change in perceptions.

THE ROLE OF THE ASSOCIATIONS

The major role of the FPAs in ESEAOR is to provide both information and motivation concerning family planning and service delivery. Almost 33% of all ESEAOR projects are focused on IEC activities. The next most emphasized activity is service delivery, accounting for 22% of the total number of projects carried out in the region. However, unlike FPAs in other regions, FPAs in ESEAOR appear to use the 'non-clinic' approach for service delivery far more frequently than the direct clinic approach.

Financially, the total medical/clinical budget has leaped from \$1.9 million in 1979 to \$5 million in 1983, an increase of 170%, reflecting a steady expansion in this area of service role.

Training programmes have had an unusual peaking between late 1982 and early 1983 due to the introduction of the PPBR system by IPPF. Consequently out of the total number of 169 projects in ESEAOR, 23 were related to training activities.

A summary position of activities for ESEAOR in 1982 (latest data available) indicates the following:

	Total Number of ESEAOR Projects
IEC	56
MC (service delivery)	37
Training	23
Fund-Raising	5
Evaluation and Research	9
Volunteer involvement/Inter agency co-operation	18
Management/Supervision	4
Other activities	17
TOTAL	169

In 1981 some 213 projects/programmes were carried out by FPAs. The substantial decrease in the number of projects was partly due to the rationalization and merger of small programmes, and similar projects carried out in different geographical areas within an FPA.

The 37 projects on service-delivery carried out by FPAs helped to generate substantial amounts of income from services fees. A summary view of the income generated through family planning services for some of the FPAs in ESEAOR for 1983 is given below. Amounts shown are in US\$'000.

	1983
Hong Kong	864.6
Indonesia	39.0
Korea	3,190.3
Malaysia	36.4
Philippines	28.5
Sabah	227.3
Sarawak	238.1
Thailand	298.8

In terms of the planned expenditure for 1983, FPAs in ESEAOR concentrated their activities on certain areas such as family planning services; information, education and communication activities; training; fund raising etc. A summary distribution by FPAs is shown below in percentage:

	FP Services	I.E.C. Activities	Fund- Raising	Others
Hong Kong	60	18	0	22
Indonesia	20	36	8	36
Korea	44	38	0.1	17.9
Peninsular Malaysia	45	14	2	39
Sabah	28	23	12	37
Sarawak	39	26	0	35
PNG	45	10	0	45
Philippines	54	9	1	36
Singapore	0	29	0	71
Solomon Islands	20	19	2	59
Tonga	56	10	0	34
Thailand: PPAT	20	15	1	64
McCormick	57	0.4	0	42.6

Basically the bulk of the expenditures, as one would expect, is spent on family planning services and IEC activities. The remainder covers administrative costs, contraceptive commodity purchases, Evaluation, Training cost, etc.

In terms of the IPPF 'need index', four of the FPAs in ESEAOR fall under the 'less' or 'least' need index group, with none in the 'most' need index group.

Need Index		FPAs from ESEAOR	
MOST	(20-24)	None	
MORE	(15-19)	Papua New Guinea	(19)
		Indonesia	(19)
		Solomon Islands	(16)
STATIC	(10-14)	Philippines	(13)
		Thailand	(13)
		Malaysia (inc. Sabah & Sarawak)	(10)
LESS	(5-9)	Tonga	(9)
		Korea	(8)
LEAST	(1-4)	Hong Kong	(2)
		Singapore	(2)

The ESEAO Region obtains approximately 11-12% of the total IPPF funds allocated to all FPAs. This grant to FPAs in ESEAO contributes to:

- 28% of sterilization acceptors by all FPAs in the IPPF family.
- 12% of all effective contraceptive methods.
- 33% of all pregnancy tests carried out in all FPAs within IPPF.
- 12% of all new 'clinic' acceptors.
- 14% of all Pap smear and venereal disease services carried out by FPAs.

PROGRAMME HIGHLIGHTS

Hong Kong

In Hong Kong approximately 60% of the FPA's budget has been devoted to medical and clinical activities and 13% to IEC programmes. The Hong Kong FPA maintains a very strong and comprehensive programme service with sperm bank/fertility services, pregnancy tests, sterilization and virtually the provision of all other effective family planning methods. Family Planning service delivery has been extended to cater for specific target groups e.g., the deaf and the mentally handicapped.

In the field of IEC, the Association has shifted the target groups on family-life education (FLE) from within the school sector to out-of-school youth, the handicapped, the newly wed, housewives' groups and workers' groups. The Association has produced materials, video film and slides for purchase and rent. It has also produced a 13-series TV programme called 'Teens' Magazine to disseminate family-life education.

Complementary to the government's hard-line policy on illegal immigrants and refugees, especially from Vietnam, the FPA has set up its own units at the immigrant registration counters, similar to that carried out at the registration centres for marriages, in order to provide IEC and FP services.

One particularly noteworthy feature of the Hong Kong FPA programme is that the number of continuing acceptors is very high (about 74%).

Indonesia

The Indonesian Planned Parenthood Association allocates approximately 36% of the budget on IEC activities, with major emphasis on Family Life Education for adolescents. About 20% of the expenditure is on medical and clinical services — basically catering to middle-class acceptors. The government provides family planning services free of charge to low-income groups and private clinics cater to the needs of high-income acceptors. The number of family planning acceptors achieved through IPPA's programmes has reached approximately 10% of the national target for the year. 51 clinics of IPPA chapters have recruited 21,111 new acceptors in 1983, an increase of 57% from the 1982 total of 13,435 recruited by 43 clinics.

Korea

In Korea the entire national IEC activities are carried out by PPFK. Consequently, the FPA allocates almost 40% of their budget to IEC projects. About 44% of their budget is for Medical and Clinical projects, and all of the 12 clinics provide sterilization services. The number of family planning acceptors recruited through PPFK's service programme has reached approximately 21% of the national total. Total acceptors in 1983 were 63,461 persons, of which 60,104 were new acceptors and 55,823 men and women accepted the FP method of sterilization.

Malaysia

The Malaysian Family Planning Association has been officially assigned a service role. For 1983 the goal was the recruitment of 13% of the national target for new acceptors. Consequently, the FFPAM allocates almost 45% of its budget for Medical and Clinical activities and projects. Because of the low-key approach advocated by the Government in IEC activities, the budget allocated for this area has also been small — about 14% of the total budget. In the Region the Association is well known for youth programme activities. An ESEAOR-FPAs Youth Programme Consultation was held in Penang at the end of 1983 in order to examine youth projects and to find ways to strengthen youth activities implemented in the region.

Philippines

The Family Planning Organization of the Philippines is in a difficult situation. Its FPOP's Medical and Clinical programmes are average, but it now has to contend with Catholic groups campaigning for natural contraceptive methods. This would obviously further weaken the promotion of service delivery of effective methods of contraception. In the comprehensive FP services project and CBD project, the Association recruited approximately 66% and 82% of the planned figures of acceptors respectively. Yet, through its Adolescent Sexuality Education project and Youth Development project, the FPOP managed to recruit over 70% and 103% of the planned figures for youth acceptors.

The Association recruited 75% of the New Acceptor target, 23,571 acceptors representing 7.3% of the National New Acceptors (NA) programme accomplishment. The Association increased the acceptor-share to 8.5% of the National NA target. In terms of continuing acceptors, the Association maintained 35,142 old acceptors in 1983, or 91% of the planned figures of 38,836.

About 54% of the FPA's budget is allocated for medical and clinical projects. Unlike almost all other ESEAOR FPAs, whose second most emphasized area after medical and clinical is IEC, FPOP's emphasis has been on CBD projects. Almost 15% of the budget is allocated for such activities, mainly at the branch/chapter level. IEC activities constituted 9% of the total planned figures.

Singapore

The Singapore Family Planning Association is entirely non-clinical, given the exceptionally efficient service programme of the government. The main emphasis of the FPA has been in the IEC area, particularly on male responsibility and the family welfare. 30% of the total budget is allocated to IEC. In 1983, two training workshops, five FLE seminars, six 'teach-in' sessions and one medical seminar were conducted.

Thailand

In Thailand, the trend is increasingly towards medical and clinical activities. In 1983, the Association recruited 43,522 new acceptors and maintained 121,057 continuing acceptors of all methods. This is followed by the traditionally highly-emphasized IEC programmes. The Association increased its radio and TV broadcast. PPAT also places considerable emphasis on CBD projects. One innovative approach in the CBD field work was making use of the readily available local governments units, e.g., the malaria control unit in the southern province for the promotion of CBD activities.

South Pacific FPAs:

Papua New Guinea

The Association recruited 136 new acceptors in 1983 and provided 21 film shows and 23 talk sessions, as well as similar talk session services for the government — operating state clinics. In addition, there were mail correspondence and telephone services being provided. In 1983, more than 200 letters and an average of 6 calls per day reached the FPA's service center.

One particularly unique FP service introduced by the Association was the condom mail-service order; a total of 21,103 pieces has been channelled through this service activity.

Solomon Islands

Continued emphasis was on IEC activities with a special focus on mother and child health aspect. For 1985, it is expected that a FP radio programme will be implemented.

Tonga

The Association has maintained a good working relationship with the local hospital and the 1983 performance was satisfactory, with a recruitment of some 698 new acceptors.

Western Samoa

The Western Samoa Family Health Association was re-established in 1984 and is expected to maintain a close link with its governmental IEC programme. The long-term aim of the Association is to assist the government in developing mother/child oriented family planning as an integral part of the national health programme.

The non-grant-receiving Associations also have active programmes.

Australia

The Australian Federation of Family Planning Associations through its member state Associations has strenuously and successfully maintained high standards of service delivery. The state family planning associations are now recognized as major preventive health agencies.

The AFFPA itself has achieved a significant success by obtaining official recognition as a non-governmental organization by the Australian Development Assistance Board (ADAB). The AFFPA has actively promoted family planning information as a basic human right and family planning as a preventive health measure. Upon request from the Department of Health, the AFFPA assisted them in counteracting allegations concerning harmful effects from contraceptives as well as in providing family planning services for teenagers. (In certain regions such as Tasmania, over 50% of the family planning clients are teenagers.)

In the 1981-1982 annual report of the Director-General of Health of the Australian government, a total amount of \$780,000 was allocated for family planning programmes to assist in covering the costs of education, training and information activities. In mid 1983, the Australian Federation of Family Planning Associations has been funded as a national secretariat under the Federal Government Community Health Programme grants. Also in early 1984, the government introduced a national medical health scheme to provide all FP clinical services free of charge. Such changes in funding reflect acceptance and support by the community and government.

The Association also provides overseas aid to South Pacific countries. The most recent development was the setting-up of a nursing task-force to prepare a detailed training programme for nurses in family planning practices. This programme is expected to be implemented during the second half of 1984.

On the National Family Planning Day, most associations carried out IEC activities with major media coverage. One association in particular, during its "Sexuality and Family Planning" week to promote community awareness, created an IEC programme with street theatre, radio and TV announcements covered by major national television radio and press.

The Family Planning Association of New South Wales celebrated its 50th Anniversary in November 1983. A doctor and two clients from the first clinic attended a major function for this occasion, in which the State Minister for Health contributed a major educational programme grant to the Association of New South Wales.

For the future, many member associations are considering expanding through diversification of services. As of the present, there are already training programmes for migrant family planning workers as well as conducting certain market survey projects to cater to service needs.

In terms of family planning services there has been a well-marked trend to switch from oral contraceptives to sterilization.

Japan

The Family Planning Federation of Japan (FPFJ) and the Japan Family Planning Association (JFPA) continue to concentrate their efforts on motivational activities, training, CBD activities and counselling on genetics and adolescent problems. Also, health education has become a major component of the JFPA's activities to cater to the changing needs of the people. Booklets called Kenko Techo (Health Notebook) were published in series in co-operation with the National Health Broadcasting Corporation. IEC seminars and training courses were held at prefectural, bloc and municipal levels.

Through certain training courses, more than 300 paramedics became qualified family planning workers. On genetic counselling, there were more than 1,000 inquiries in total.

For the CBD programme, sales of contraceptives were an essential component for self-reliance of the Association. The mobile teams of the Association regularly visited 20 prefectures.

New Zealand

The New Zealand Family Planning Association has 15 branches, which operate 40 clinics throughout the country. Between April 1983 and March 1984, 153,100 acceptors visited 38 clinics compared with 151,804 acceptors among 40 clinics between April 1982 and March 1983.

The New Zealand Government provides a grant to cover clinic staffs' wages; however, applications to increase staff personnel have not met with approval since 1979.

Achievement is worth noting in the field of education, in which programme activities are largely funded by patients' fees. For instance, the Auckland branch has completed — after three years of preparation — a Sex Education Kit prepared for teachers to use in secondary schools; it is now being marketed in various parts of New Zealand. Their audio visual 'Sex, Teenagers and the Media' has also frequently been shown; in particular there have been two recent presentations in the Parliament House's theatre attended by parliamentary members and by senior officials from education circles.

Two other branches have installed an answerphone services offering through recorded tape some basic advice on methods of contraception and their available sources. This service is aimed mainly at young people since the idea of providing an answerphone service arose from findings in a survey of adolescents.

In November 1983, the NZFPA celebrated the 30th anniversary of the opening of the first FP clinic in New Zealand. The occasion attracted much publicity on radio, television and the newspapers.

In line with a commitment to IPPF inter-assistance, the Association also provides technical assistance to Tonga and Western Samoa upon request. A workshop was held to re-establish the Western Samoa Family Health Association in order to educate and motivate people to use the already existing FP facilities.

ACHIEVEMENTS OF THE REGION

Each year the ESEAOR FPAs have generally managed to reach their established goals and planned targets. For certain FPAs such as Hong Kong and Korea, 60% — 70% of the number of planned targets are occasionally reached by the middle of the year of implementation. In the case of some other FPAs underachievement is generally linked either to the reorganization of the FPAs or due to certain national campaigns against family planning activities.

With the exception of a few FPAs in ESEAOR island-countries, the management capacity of the FPAs is of a high standard with full recognition and/or assistance from governments.

EXPENDITURE SUMMARY - ESEAO REGION
1983 Actual

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Hongkong	141.4	72.1	213.5	1467.4	(39.9)	1641.0
Indonesia	692.1	51.4	743.5	823.0	(177.1)	1389.4
Korea	1030.0	50.2	1080.2	7004.9	(2566.0)	5519.1
Malaysia	363.0	119.8	482.8	215.3	(43.7)	654.4
Papua New Guinea	57.3	15.5	72.8	16.8	6.7	96.3
Philippines	607.7	124.5	732.2	159.3	(70.1)	821.4
Sabah	-	64.9	64.9	305.4	(70.6)	299.7
Sarawak	-	125.6	125.6	310.5	(47.6)	388.5
Singapore	67.8	1.1	68.9	24.5	(1.6)	91.8
Solomon Islands	35.6	9.7	45.3	13.3	(11.6)	47.0
Thailand	303.7	328.0	631.7	345.4	(103.6)	873.5
Thailand M ^c Cormick	-	26.1	26.1	173.9	101.8	301.8
Tonga	32.3	.7	33.0	.5	4.1	37.6
Western Samoa	-	-	-	-	-	-
TOTAL	3330.9	989.6	4320.5	10860.2	(3019.2)	12161.5

EXPENDITURE SUMMARY - ESEAO

REGION

1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Hongkong	128.7	167.7	296.4	1539.9	1.5	1837.8
Indonesia	596.7	46.6	643.3	669.5	94.5	1407.3
Korea	992.7	99.8	1092.5	6768.6	8.1	7869.2
Malaysia	365.4	137.6	503.0	803.0	1.4	1307.4
Papua New Guinea	84.5	21.5	106.0	9.2	(12.7)	102.5
Philippines	541.5	67.5	609.0	204.0	52.1	865.1
Sabah	-	53.9	53.9	260.3	(27.5)	286.7
Sarawak	-	67.0	67.0	296.9	(29.4)	334.5
Singapore	70.0	3.9	73.9	28.6	7.2	109.7
Solomon Islands	50.0	9.9	59.9	.9	4.7	65.5
Thailand	385.8	503.8	889.6	390.2	(27.5)	1252.3
Thailand, McCormick	40.0	20.0	60.0	104.5	15.8	180.3
Tonga	31.0	3.1	34.1	1.7	15.6	51.4
Western Samoa	20.0	4.8	24.8	-	-	24.8
TOTAL	3306.3	1207.1	4513.4	11077.3	103.8	15694.5

EXPENDITURE SUMMARY - ESEAO

REGION

1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Hongkong	115.0	118.0	233.0	1631.8	-	1864.8
Indonesia	810.4	29.0	839.4	634.3	-	1473.7
Korea	910.0	80.4	990.4	7369.4	-	8359.8
Malaysia	390.0	275.9	665.9	1249.3	-	1915.2
Papua New Guinea	100.0	3.0	103.0	-	-	103.0
Philippines	670.0	95.7	765.7	227.6	-	993.3
Sabah*	-	-	-	-	-	-
Sarawak*	-	-	-	-	-	-
Singapore	72.0	3.4	75.4	27.9	-	103.3
Solomon Islands	51.0	7.7	58.7	-	-	58.7
Thailand	430.0	428.7	858.7	365.8	-	1224.5
Thailand M ^c Cormick	40.0	25.0	65.0	98.5	-	163.5
Tonga	35.0	7.7	42.7	-	-	42.7
Western Samoa	21.1	7.9	29.0	-	-	29.0
TOTAL	3644.5	1082.4	4726.9	11604.6	-	16331.5

* Combined with Malaysia

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US\$'000)

ESEAO

	<u>SUPPLIES PURCHASED BY IPPF</u>		
	<u>ACTUAL EXPENDITURE 1983</u>	<u>ESTIMATED EXPENDITURE 1984</u>	<u>PROJECTED EXPENDITURE 1985</u>
Contraceptives	655.0	534.4	589.0
Medical & Surgical	87.4	94.2	86.5
Audio Visual Equipment	16.4	34.9	23.7
Office Equipment	20.9	52.2	44.6
Transport	64.1	142.1	85.6
TOTAL	<u>843.8</u>	<u>857.8</u>	<u>829.4</u>

	<u>AID SUPPLIES DONATED TO IPPF</u>		
Contraceptives	<u>129.1</u>	<u>349.3</u>	<u>253.0</u>
FULL TOTAL	<u>972.9</u>	<u>1207.1</u>	<u>1082.4</u>

INDONESIA

INDONESIA PLANNED PARENTHOOD ASSOCIATION (IPPA)

COUNTRY BACKGROUND

Geographical Setting

Indonesia is a sprawling nation which straddles the equator across 5,120 km in three time zones. About 6,000 of Indonesia's 13,677 islands are inhabited, but the five major islands, Sumatra, Java, Kalimantan, Sulawesi and Irian Haya are the most heavily populated. The total land area is 1,919,433 sq. km. The country is divided into 27 administrative provinces, 300 regencies and 62,660 villages.

Demographic Situation and Trends

The population of Indonesia is estimated at 161,500,000. 78% of the population live in the rural areas. About 62% of the population or 91,300,000 people live on the island of Java which has less than 7% of the total land area of the archipelago. The density of the population varies from 690 persons per sq. km in Java to 59 for Sumatra, 55 for Sulawesi, 19 for other islands and 12 for Kalimantan. The major religious groupings are as follows: Muslim 88%, Christians 7.8% and Hindus 3%.

Relevant Background Facts and Figures

The National Census 1980 estimated the number of eligible couples as approximately 24 million, or about 16% of the total population. The National Socio-Economic Survey of 1979 indicated that 77% of eligible couples throughout Indonesia have knowledge of family planning. The number of current users stand at 7,155,000 in 1979 or 29% of the total eligible couples. Java and Bali alone show 5.5 million current users or 31% of the total.

Among acceptors, the majority are pill acceptors at 70%, followed by IUDS 18%, condoms 7% and injections 3%. Vasectomies and tubectomies account for 2% of the total acceptors.

The majority of new acceptors are below the age of 30, the average age of new acceptors decreasing from year to year. In 1971/72 the average age of new acceptors in Java-Bali was 29.5 years; in 1978/79 the average age was 26.2 years and in 1980/81 the figure went down to 26.1 years.

The average growth rate of the population of Indonesia during the period 1971 to 1980 was 2.3% per annum. The highest population growth is noted for Sumatra (3.3% per annum) followed by Kalimantan and Sulawesi, at 2.8% and 2.2% respectively.

Some of the relevant demographic, social and economic figures for 1983 in Indonesia are as follows:

Total Population	161,500
Infant Mortality Rate	90.3
Crude Birth Rate	33.8
Crude Death Rate	11.7
National Increase	2.1
Life Expectancy	For females 60.0
	For males 57.4
Population Density	Per sq km 77
Per Capita Income	\$580

The population of Indonesia is young, with a large percentage of the population under 15 years of age (42% or 61,950,000). Less than 5% belong to the age group above 65 years.

In terms of education 15% of the urban population and 32% of the rural population are illiterate.

Official Policies, Attitudes, Regulations and Activities Devoted to Family Planning

Since 1970, the Government has had a clear policy towards family planning and population, which is reflected by the setting up of an Institution for National Family Planning, and later the National Family Planning Board. The policy is further strengthened by the inclusion of family planning programmes in each of the Five Year Development Plans since 1969/70. The Decision of the Peoples Consultative Body No IV/MPR/1978 stipulates that population and family planning programmes must be implemented throughout Indonesia.

The objective of the Government is to reduce the fertility level. The Crude Birth Rate was 44 per 1,000 population in 1971 and the target is to reduce this to 22 per thousand in 1990. To achieve this goal, programme activities are directed towards two targets: a direct target of increasing the use of contraceptive and an indirect target of developing population activities that support the integrated family planning programmes.

The Association which has pioneered family planning movement in Indonesia since 1957 is named as one of the twenty three implementing units by the Government.

Public Climate

The level of knowledge in family planning among the general population has been increasing, and the attitude towards family planning has become more favourable over the years. Mass communication and community education programmes aimed at creating community awareness and seeking peoples participation in family planning programmes have significantly contributed towards this positive attitude, particularly through the sustained and continuous efforts of the Government. Non-formal community leaders work side by side with other leaders to promote the acceptance of family planning.

The mass media have given wide coverage to family planning and population issues. Professionals such as teachers, lawyers, and doctors, working with politicians at all levels, actively participate in discussing family planning issues. As a result, a draft Bill on Population is expected shortly.

Constraints in Family Planning

Indonesia's geographical consideration is by itself a natural constraint in almost all development efforts. The vastness of the country, and its ethnic, cultural and religious differences provide yet another dimension to its problems. Communication is difficult in most parts of the country. Lack of suitable managerial expertise create more problems at the implementation level.

The main concern of the family planning managers is linked to the wide gap between knowledge and practice of family planning; service delivery in the outer islands can be considered below the optimal level; there is also a high rate of acceptor drop-outs.

Family Planning Factors for the Future

The number of eligible couples will continue to increase and is expected to reach 25 million in 1986. They will be the main target of the Government's programmes, assisted by its implementing units. Special efforts must be mounted to deal with the problem of the large number of drop-outs from the fp programme. There are also pockets of resistance to fp both in urban and in the rural areas. Improving the quality of contraceptive service will feature as a very important programme indicator in the future.

The proportion of the population in the 0-14 and 15-19 age groups is, as indicated, very large; special attention must be paid to programmes catering for the young generation so as to influence their decision on delaying marriage, their attitude towards fp and especially their views on the desired family size and the spacing of children.

Other Family Planning Activities

The implementation of family planning programmes is being done by the 23 fp implementing units under the general supervision and coordination of the National Family Planning Coordinating Board (NFPCB).

Information, Education and Communication programmes as demand creation activities are being implemented by almost all the implementing units, with the Department of Information playing the more dominant role. Contraceptive service delivery is also being carried out by all the implementing units.

At present sterilisation services are rendered only by special hospitals run by the Indonesian Association for Voluntary Sterilisation and IPPF volunteer doctors.

Assistance From Other Organisations

The Association has a long history of pioneerism and professionalism since its inception in 1957. There has been much mutual cooperation and collaboration between the Association and the other organisations involved in population and family planning. The Association enjoys effective working relationships with the NFPCB and the other implementing units, mainly through the Association's representation at the various levels of Government decision-making process.

The Association receives substantial financial support from the national and local Governments, although this is still less than targeted. JOICFP continues to provide financial support towards the integrated fp programme; Pathfinder, the Asia Foundation and recently the International Womens Health Coalition have contributed significant cash and other technical support to the Association.

The Indonesian Association of Voluntary Sterilisation works very closely with the Association in the promotion of sterilisation projects, which hitherto were not covered in the National Programme.

THE ROLE OF THE ASSOCIATION

The Association has selected the following unmet needs for its particular attention.

- (a) It is estimated that there are 10,937,000 eligible couples that have not benefited from fp services, 5,892,000 in Java and 5,045,000 outside Java. In addition to trying to reach a share of these new potential acceptors, the Association will endeavour to maintain a total of 40,000 continuing acceptors, of which 34,000 will be in Java.
- (b) The Association has identified the need to improve and increase the involvement of the male community in the fp programme. It is estimated that a total of 19.5 million males need to be brought into fp awareness programmes. The Association during the Plan period will attempt to cover 233,500 males for direct or indirect participation in the fp programme.
- (c) The youth population of Indonesia is large; it is estimated that there are 35 million people who are classified as youths. The Association intends to reach 118,200 youths in its programme during the next three years.
- (d) Increased community participation in fp may best be achieved through integration project approaches and community development. IPPA intends to cover 5,000 families out of 10 million identified during the Plan period.
- (e) To execute this programme, the Association will have to improve its organisational capacity and increase professionalism amongst its members.

The Association's role, based on the selected unmet needs, during the Three Year Plan (1985-87) can be stated as follows:

- (a) To assist the government in arousing community capability to implement programmes aimed at achieving desired fertility levels through improving quality of service coverage, in order to keep adhering to the NKKBS (the small, happy and prosperous family).
- (b) To assist the community in adopting greater responsibility for improving the quality of the population programme, particularly in the areas of health, welfare and family life education.

THE PAST PERFORMANCE OF THE ASSOCIATION

A total of fifteen projects were approved for implementation in 1983. The Association successfully implemented all the projects and carried out four additional projects during the year.

The 16 comprehensive family planning clinics in 11 provinces continue to provide services not available in other clinics or where such needs are not being met by Government programmes. These clinics succeeded in providing contraceptive services to 20,526 acceptors mainly on IUD and injectables and provided medical services for contraceptive failure, family planning general treatment, pap smear etc.

Programmes for the community-based distribution of contraceptives, through both commercial and non-commercial channels go out in four provinces. The non-commercial approach succeeded in reaching 2,250 new acceptors (86% of the target) and maintained 3,600 continuing users, thereby exceeding its target. On the other hand, the commercial approach was less successful, resulting in shortfalls both in the acceptor target (6%) and income (80%).

The Association's fundraising project "WISMA PKBI" aimed at raising US\$45,000 during the year. The result was encouraging, the net income being \$59,000. The income was derived mainly from renting accommodation in the training centre, where the occupancy rate has nearly reached 100%.

Among the unplanned activities, the International Media Seminar on Women, Children and Population which was funded in cooperation with the Press Foundation of Asia, UNICEF and NFPCB, was a major activity which further strengthened the image of the Association. The Seminar was attended by 20 participants from major Asian countries and 12 local participants.

The Association was particularly successful in its Resource Development effort; 99% of the target for non-IPPF income of \$725,000 was raised locally. The non-IPPF income represents 58% of the total expenditure for 1982.

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

The Association will follow four particular strategies:

- Fertility Reduction through comprehensive family planning services.
- The provision of Family Life Education.
- The integration of Family Planning and Development.
- The development of the Association's organizational abilities.

The Association has given the highest priority to and placed the greatest emphasis on implementing the first strategy, "The increased provision of comprehensive family planning services."

Particularly interesting projects to implement these strategies include:

Comprehensive Family Planning Clinics.

The first comprehensive FP Clinic was initially introduced in 1979 in Jakarta Metropolitan City, popularly known as WISMA PANCAWARGA. The success of the project and the support that it received from both the Government and other external donors prompted the Association to expand and replicate the project. In 1982, seven provinces implemented the project; the total number of clinics is now 12. It is intended to bring the number up to 18, serving a total target of 180,000 people.

Contraceptive Services Through Community Participation

The project is a continuation of the CBD non-commercial projects, aimed at geographical areas not reached by any other family planning programme. Emphasis is given to trans-migration areas and other pockets of population where communication is very difficult and the project covers four provinces. One hundred and eighty five contraceptive distributors will be trained and become agents. Twenty nine thousand families will be motivated and the project hopes to recruit twenty thousand family members as acceptors and maintain 75% continuation rate.

Planned Parenthood and Better Living (PPBL)

The project is on-going and is aimed at expanding coverage and improving acceptability of family planning through welfare improvement and the use of income-generating projects as entry points. The objective is to recruit 5,900 new acceptors and to train them to become family planning workers, providing health care to 2,500 pre-school children; these family planning workers will also motivate a further 12,000 other eligible couples.

Integrated Project of Family Planning — Nutrition and Parasite Control

Started in 1976 in West Sumatra the project has since been expanded to West Java, Aceh, Jambi and South Sumatra. In 1983 it was further expanded to Jakarta, covering both the industrial and urban areas. The objective of the project is to increase the acceptability of family planning and family health through motivation and through the treatment of parasite ingestion, particularly in children.

Family Life Education for Young Mothers

The project is implemented in nine provinces. The objective is to improve the status and attitude of young mothers so that they realise the significance of the small, happy and prosperous family norm. The yearly target is 14,500 young mothers in 1985; 16,700 for 1986 and 17,500 for 1987.

Pria Warga Mulya Male Responsibility

During the plan period the project will be implemented in seven provinces with a total of 21,000 males as the target. The objective of the project is to promote and increase the role of the males as family planning motivators and acceptors.

Development of Centre for Information and Documentation on Population and Family Planning

The project aims to improve on the information, documentation and library services of the Association in the National Office in Jakarta and in four other branches.

THE ASSOCIATION'S RESOURCES

Non-IPPF Income

The Association's non-IPPF income may be categorised as coming from three main sources:

- funds received from external sources,
- funds received from the national and local government, and
- the external donors described in the 3YP as 'External Sources.'

Association's Local Income

It is noteworthy that the Association's local income has shown a favourable trend, increasing steadily in recent years. The Association also receives a substantial number of goods and services 'in kind', the annual value of which is estimated at \$250,000.

In terms of non-financial resources, the Association has a large pool both of professional volunteers who contribute to its specialised work and the lay volunteers at the grass-roots level who are involved with the actual implementation of the programmes of the Association. The Association prides itself on its wide network of speakers, motivators, field-workers, organised womens' and youth groups, etc who are involved with the IEC and motivational work of the Association.

THE FUTURE OF THE ASSOCIATION

IPPA is one of the older voluntary family planning organizations in the region and is located in the largest country in ESEAOR. Indonesia is also a country with a rapidly growing population. It is estimated that the growth rate is currently around 2.3% per annum.

Fortunately for IPPA the government of Indonesia has a clear policy towards population and family planning. The eventual goal is to reduce the crude birth rate to half its present level by 1990.

IPPA has had a long history of close collaboration with the other associations and organizations involved in population and family planning. The Association also enjoys an effective working relationship with the National Family Planning Coordination Board (NFPCB). It also receives substantial support from the National and Local Government.

IPPA has some fifteen or so projects which it has been implementing in different areas. The sixteen comprehensive Family Planning Clinics in eleven provinces continue to provide services not available or because the government has not been able to meet the needs. These clinics alone provide contraceptive services to 20,526 acceptors, mainly on IUD and injectibles. Programmes for community-based distribution of contraceptives through commercial and non-commercial channels were also carried out in several provinces.

IPPA'S work plan is aimed at meeting four particular strategies, i.e. fertility reduction, family life education, integrating of family planning and the development of its own organizational abilities.

Organizationally, IPPA has approximately 100 staff. In addition it has several hundred volunteers spread throughout the country providing valuable services at the grass roots level. In spite of its large operating budget and staff structure, there are some areas of concern in the overall management of the Association. One area in particular has been under-reporting by chapters and branches. This continues to be a major obstacle to the effective programme operations. The quality of their reports has been also a source of concern.

Given the population and several unmet needs, IPPA has a vital role to play in the years ahead. It is not likely that the government or any of the other voluntary organizations can meet the needs of the people fully in the immediate future. This means that IPPA has a vital and significant role to play to supplement and complement the government both in service delivery and other related activities. The only area of concern would be to ensure that the management capacity at various levels can be adequately improved in IPPA to meet the challenges in the years ahead.

PACIFIC ISLANDS

FAMILY PLANNING ASSOCIATIONS IN

THE SOLOMON ISLANDS, TONGA AND WESTERN SAMOA

COUNTRY BACKGROUND

Geographical Setting

The generic term, Pacific Islands, covers an area of 10 million sq. miles and some 12 islands countries, excluding hundreds of smaller islands.

The Pacific Islands include the following:

Cook Island, Fiji, New Hebrides, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Trust territories of Pacific Islands, Nauru and Tokelau. A total of some 4½ million people live scattered all over these islands.

The Pacific Islands form one of the highest population growth areas in the world, with annual increases ranging from 4.2 per cent to 3.4 per cent. It was not until the mid 1970's that the countries which form the South Pacific Commission would agree to allow the Commission to talk of FP. Across the islands administrators support the need for planned growth in population but say that they cannot sell it directly. While the Pacific region acknowledges a range of population problems, leaders cite political, cultural and religious barriers to open discussion of the solutions. There is resistance to any suggestion of population control and stress is on education and economic development as the only possible tools. Priority needs are identified as employment and community development, with population issues a by-product. In addition to Papua New Guinea, where the family planning situation is rather different from that obtaining in other islands, there are three grant receiving Associations:

The Solomon Islands

Tonga

Western Samoa

SOLOMON ISLANDS

The Solomon Islands have a population of 240,000 and a growth rate of 3.4 per cent. The country's Crude Birth Rate at 44.6 per 1,000 is the highest in the Pacific. The Crude Death Rate at 11.7 is equally high. However, the density per square kilometre is only 9 persons; GNP per capita is US\$430.

The 240,000 Solomon Islanders speak some 72 different languages. In 1979 more than half the population was under 16 years of age. Solomon Islands is one of the few countries in the world where women die younger than men. Part of the reason can be traced to the repeated pregnancies and complications arising from it. Women are literally "worked" to death. The country has six hospitals and 130 clinics.

The government does not have a coherent policy to deal with the problems of population. UNFPA Mission called in to evaluate the country's needs expressed its view that the training of women and young people in rural areas was an over-riding priority before population projects can become effective. The relationship between family size and quality of life must be understood by the population at large.

Most of the effort in family planning now rests with the Solomon Islands Planned Parenthood Association. The association has been operating since 1973, with a current full time staff of 12 persons. Its operation is centred in Honiara on Guadalcanal Island, with field supervisory offices in Santa Isabel, Western and Malaita provinces.

TONGA

Tonga currently has a population of 100,000, with a Crude Birth Rate of 28 per 1,000 and a Crude Death Rate of 8 per 1,000. The annual population growth rate is 2.0% and is low by Pacific standards, but this is also largely due to the heavy out-migration from the kingdom. The GNP per capita is around US\$430.

The kingdom of Tonga covers about 150 islands, although only a third are inhabited. The total land area is about 700 sq. kilometres. According to the 1875 Tongan constitution every male Tongan on assuming a tax payer status gets a bush lot of 3 hectares; this is no longer possible. Tonga's carrying capacity has been stretched to its limits and cannot cope with a doubling of population in the next 30 years.

In recent years there has been an appreciation of the population pressure; for example, at the Vaiola Hospital, administrators report widespread acceptance of family planning by the community. Of Tonga's 19,742 women of reproductive age only 1,380 or 7% are known to be using contraceptives. The most widely used method is the ovulation method. About 600 of the acceptors are on ovulation method, 306 on the pill, 255 on injectables, and 75 on IUD. The rest are using condoms or have been sterilised.

WESTERN SAMOA

The independent state of Western Samoa is situated in central Polynesia with a total land area of 2,831 sq. miles. The population of Samoa is 161,000. The growth rate is 1.3 per cent. The Crude Birth Rate is 29 per 1,000 and the Crude Death Rate is 7 per 1,000. Like much of the Third World more than 50 per cent of the population is under 15 years of age.

The pressure of population and desire for "western" life has led to large out-migration. It has been estimated that 20 per cent of the population of Samoa live abroad, with New Zealand alone having 27,000 Samoans.

The social system and the land tenure practices are based on the extended family system and large families are considered desirable. Life expectancy for men is 61 years and females 63 years.

A population policy was presented to the Government by the Department of Health and Economics. It contains a clear statement by government and recognises:

- the need for giving priority to family planning programmes
- the influence of fertility/mortality on population growth rates
- the need to accelerate economic development and improve the quality of life

Development of family planning started during the 2nd Five Year Development Plan (1971-74). This was brought into consideration when the government became aware of the changing demographic patterns and the health care needs of the population. A decision was hence made to promote a family welfare. This recognised family planning as an integral part of the general health service, mainly the maternal and child health service.

An ICAP study was conducted with the help of WHO. The survey revealed among other things the following:

- the average Samoan family size was 7
- the number of children ever born was 7.3 in 1966, 7.4 in 1971, 6.4 in 1979 and 5.8 in 1981.
- the majority of the men wanted a large family primarily as a source of family labour
- tubal ligation was the most popular method, followed by the Pill and IUD

The family welfare section of the Department of Health is responsible for execution of the family planning aspects. The long term aim is directed towards the promotion and preservation of the health and well-being of the mother and child and thus improve the quality of life.

There is now more appreciation of the population issues. There is a likelihood that the 4th Five Year Plan 1980-1984 would greatly strengthen the maternal and child health and family planning programmes already underway. There is already sign of reduction in fertility but not of such magnitude to ensure sound planning.

THE ROLE OF THE PFAs AND PAST PERFORMANCES

Solomon Islands

The primary role identified by SIIPA, which has been in operation for 10 years, is to:

- improve the health and quality of the Solomon Islands people by providing information and education on the benefits of family planning
- provide family planning services in a family programme
- provide sex education
- co-operate with the government and other agencies in improving family health through the practice of family planning

There was continued emphasis on IEC activities; these programmes were aimed at the health and well being of the mother and child, and adult education courses were held for national leaders.

The service role has also improved — with better acceptor attendance. The two most popular methods are the Pill and Depo-Provera (DP).

Tonga

Tonga Family Planning Association (TFPA) has a good working relationship with the local hospital. The climate of opinion among top government officials is one of support, but with a belief that rapid population growth does constitute a problem.

The TFPA carried out its planned mobile clinic service role. Altogether some 698 new acceptors came to the clinics for various reasons. Some 62 villages in Tongatapu were visited on a three monthly basis for repeating DP injections.

In its IEC programme, the TFPA carried out training for motivators. Radio talks at regular intervals were also given by the volunteers of TFPA.

As a part of a planned change TFPA decided in 1982 to discontinue with the formation of new family planning committees at village level. Instead it was decided to integrate family planning activities into village committees or other village groups.

Western Samoa

The Western Samoan Family Health Association was formed in 1984. The Association hopes to play the following role:

- the long term aim is to assist the government to develop and strengthen mother-child orientated family planning as an integral part of the national health programme.
- to stimulate greater awareness, understanding and public support and participation in responsible planned parenthood
- to help in training and education of staff and community health workers responsible for the delivery of MCH/FP services throughout the country

The Association has a close relationship with the government's IEC programme. Among the wide range of the activities are the following:

- population education programme
- training of traditional birth attendants, Primary Health workers, Village Community women's committees, and other health workers
- IEC activities at village level using the services of influential orators, who can convey the message to the community

Solomon Islands

The SIPPA has several small projects planned for 1985. The list of projects includes sex education courses for parents, a mass communication campaign on family planning, radio programmes and newsletters, fieldworker training, all contraceptive distribution at the community level.

All in all there are some 36 projects to be carried out in 1985; some with a budget as small as \$100 and the largest no more than \$1,000.

Tonga

The kingdom of Tonga has set as a target the reduction of the birth rate from 28 per 1,000 to 25 per 1,000 by 1985. In the long run the national efforts have to reach 20,000 women of reproductive age. Also the youth and men are considered as targets for IEC since they have a strong influence on family planning behaviour.

Towards this end TFPA will work to:

- strengthen youth involvement in family planning
- promote at the grass-root level the national objective on birth rate
- stimulate women at the child bearing age to be responsible for their family size and be knowledgeable in FLE and health aspects
- strengthen male involvement in family planning
- integrate family planning work with other development efforts eg. agriculture
- extend family planning services to other islands
- encourage and support income generating projects especially among youth and women
- plan and develop income generating projects eg. Holiday beach resort
- train staff to improve their knowledge and competence

During 1985, TFPA hopes to carry out projects in youth, women's development and male involvement.

THE FUTURE OF THE ASSOCIATIONS

The projects covered by the Solomon Islands and Tonga are many but small. For the newly founded Association of Western Samoa, the projects have yet to be evolved as part of a building up process. Although there is clearly a need for IPPF training in these FPAs, to conform to IPPA's budgeting and programming system, it is considered prudent at this stage to consolidate the present position, eliminate weaknesses and achieve a small increase in programme activity.

Accordingly, the ESEAO Regional Council has endorsed the proposed budget for 1985, which allows for a marginal expansion in programme activity. It is hoped that with the planned IPPF inputs for the South Pacific islands, there will be better planning, reporting and implementation of programmes.

Given that the FPAs in the South Pacific are 'young' and new to the IPPF's system, but with a high need level, there is a case for a steady growth in support.

EUROPE REGION

REGIONAL OVERVIEW

INTRODUCTION

The 30 countries which comprise Europe differ widely in their economic, social, cultural and political characteristics. Far from being homogenous, the Region contains countries at many different stages of development. But regardless of these differences, all face one common problem: economic recession.

Economic recession, because of such accompanying problems as unemployment, mostly in Western European countries, and cuts in public service spending, has profound effects on family life and sexual relationships. Women, for instance, tend to be hit particularly by a loss of employment opportunities. These and other social factors face FPAs with new problems.

In parts of Europe there is a growth of organised opposition to family planning and sex education, and consequently to the work of Planned Parenthood Associations. Some of this opposition has arisen from political conservatism, some from religious sources, some from governments who adopt pronatalist policies in the face of declining population growth, and some from consumer groups with objections to existing contraceptives and their mode of delivery.

There is wide disparity, in many European countries, between the stated legal position and/or government commitment, and the actual provision of planned parenthood services and sex education.

Europe is characterised by relatively low fertility, with a total fertility rate of about two children per woman, in some countries under population replacement level. Nonetheless, birth rates range widely both within and between different countries within Europe. Migration, both from within and outside Europe, is a widespread phenomenon, with significant implications for the organisation, delivery and accessibility of planned parenthood services.

Fertility regulation is practised extensively in Europe. However, the numbers of couples using the methods of contraception available differ widely according to the country concerned.

Medically skilled, first trimester abortion is legal (or tolerated) in about two-thirds of European countries, covering about five-sixths of women in Europe. The incidence of induced abortion varies across Europe.

The IPPF Europe Region reaffirms its belief in the individual right to free choice in parenthood and this is consistently expressed in the priority given by the Region in helping existing and emerging European FPAs to face the religious, cultural and

political obstacles which might arise out of the wide sphere of psycho-social influences that affect sexual behaviour.

In the foregoing context, the Regional Work Programme intends to implement the needs and rights of individuals in helping them to plan their sexual and family lives. Regional activities include: the completion of projects concerned with adolescent services, the impact of law on planned parenthood service provision; and the inauguration of a project investigating opposition to planned parenthood and FPA strategies to challenge this.

MEMBER COUNTRIES

AUSTRIA -- Österreichische Gesellschaft für Familienplanung (ÖGF)

Throughout Austria, there are presently about 170 clinics dealing with family and partner counselling, including contraception. All of these clinics are fully state-subsidised, but run by a number of different interest groups, ranging from the archdiocese on the right to feminist group on the left. ÖGF run 5 clinics in Viennese hospitals, specialising in problems of contraception and abortion. The number of clinics has slightly increase during the last year. Working relations with the governmental and non-governmental bodies depends on personal contacts. The national role of the ÖGF remains that of watchdog of government activity.

Together with a pharmaceutical firm (CILAG), the ÖGF has prepared a publicity campaign to promote the diaphragm with physicians.

BELGIUM — Fédération Belge pour le Planning Familial et l'Education Sexuelle (FBPFES) Belgische Federatie voor Gezinsplanning en Seksuele Opvoeding (BFGSO)

The Liberal-Social Christian democrat coalition remains in power. With respect to the Francophone region, efforts to simplify and rationalise the family planning situation has resulted in formal governmental recognition of family planning centres, and the FBPFES contributed significantly to the preparation of the necessary legislation. Within the Dutch-speaking region, new legislation is under review.

Certain subsidies have decreased. On the other hand, the opportunity of benefitting under the Government programme to combat unemployment has risen, permitting the Federation to recruit new workers with subsidies, leading to an extension of the work of the centres. The FBPFES comprises the Dutch-speaking CGSO, which has 12 centres, and the French-speaking branch, which has 36 centres, all subsidised by the Government for their counselling and educational work. The centres of the Francophone branch undertook around 29,000 gynaecological consultations, and 23,000 psychosocial counselling consultations over the previous year, as well as

providing sex education courses for schools.

The documentation centre of the CGSG handles around 400 requests for information per annum, and there has been an increased demand for information from Belgian radio television for several of their popular medical and social problems. During 1983, much energy was spent negotiating with the government concerning new regulations covering counselling centres. Lobbying work will remain an important part of future activities.

BULGARIA — Family Development Council of Bulgaria (FDCB)

In recent years, Bulgarian families have become increasingly sympathetic to family planning. The use of modern contraceptives has grown considerably during 1983, particularly IUDs. There is a nationwide supply network providing contraceptives (the pill and IUDs). Since 1984, postcoital contraception has been available. However, no sterilisation services exist. The first Bulgarian-made IUD is undergoing tests at present.

FPA activities co-exist with those of other agencies (demographic, sociological, medical, the Fatherland Front, the Movement of Bulgarian women etc.). In 1983, the Council expanded its activities in the regions — Plovdiv, Blagoevgrad, Petrich, etc. These branches provide family planning services, including information and education.

A number of national and regional conferences were held which dealt with questions of contraception and prevention of abortion. Members of the Council have lectured on a regular basis to public organisations, the mass media and young people. The Council is also represented in the BUL PO2 Sterility project, financed by the Government and the UNFPA.

DENMARK — Foreningen for Familieplaaning (FF)

In 1976, it was provided by Statute that women were entitled to seek advice on contraceptive methods in clinics in addition to receiving this guidance from GPs. Consequently, clinics were established in the various countries. The Government is now introducing a Bill with the objective of freeing the countries from this obligation, against the advice of the FF. It was argued that this would lead to a deterioration of the facilities for seeking advice, particularly as far as young people are concerned.

The Municipality of Copenhagen, which covers 90% of the expenses for the running of the FF's two clinics has reduced the 1984 FF budget for these centres by about 5%, advising the Association to rationalise procedures.

The FF is preparing to expand its information services, altering its Constitution to include '(the promotion of) information about and scientific research into family

problems of a somatic, psychic, social and sexual nature'.

FINLAND — Väestöliitto

Väestöliitto is the only organisation in Finland dealing with population and family policy. In this respect the Federation acts as a pressure organisation and a provider of special services which supplement State health services. These include: family counselling clinics, medical genetics counselling and so on. In family education, the Federation's long term aim to establish a family education course was furthered with the Federation able to hire a salaried employee to plan these courses for the year 1985. The financial basis for this project was secured by the TV campaign, 'Take Care of the Family' which was organised, together with three other bodies and lasted throughout 1983. The family education course centre will train specialists from different occupations who work with families. Väestöliitto's awareness of the problem of involuntary infertility has led to a decision to organise a workshop on this topic in collaboration with the IPPF in September 1984.

There were 10,300 visits to Väestöliitto's family counselling clinics in 1983, from 6,300 clients. An increase in the numbers attending for infertility treatment and family crisis counselling has prevented the organisation's involvement in research and publication activities.

FRANCE — Mouvement Français pour le Planning Familial (MFPF)

The new state policy of reducing expenditure has led to the postponement of social reforms and threatens the further development of existing services, including family planning. The government contribution to family planning has not decreased on the whole, notwithstanding sizeable discrepancies according to the kinds of projects and channel of funding — either national (confederation) or local (departmental associations).

Some projects mentioned in previous reports to IPPF Europe are still ongoing: the adolescent project; agit-prop type information, educational activities and training in the area of sexuality for people involved in different occupations — social workers, health workers, teachers, union organizers, association members, etc.

One project has been completed with the publication of the survey and proceedings of the 1982 Colloquium 'Contraception from the Woman's Perspective'.

Within the framework of a campaign for good abortion facilities, it was disclosed at a press conference that 1900 illegal abortions had been documented, and information forwarded to relevant Ministers.

FEDERAL REPUBLIC OF GERMANY — Pro Familia

The objective of the new government to give special importance to families and married couples will have an impact on its funding policy towards social service institutions. It is thought that PRO FAMILIA has been too privileged financially in the past and that religious organisations have to be given a higher profile. This will mean that PRO FAMILIA will have to compete in the future much harder with other organisations for governmental funding. Not only that, there are plans to encourage religious organisations to engage in family planning activities.

It is the opinion of the present conservative government that PRO FAMILIA's high profile must be reduced, and this is happening. On the other hand PRO FAMILIA's role in the opposition movement, (opposition parties, women's movement, non-religious social welfare organisations) against the family and social policies of the government, is growing and its expertise in the field of family planning and sex education is acknowledged and demanded.

Although the political conditions have aggravated the work of PRO FAMILIA, it is at the same time a challenge to reconsider self-critically its past activities and to develop new perspectives and visions. The political impact PRO FAMILIA will have, will depend on its capacity not only to react to politics but to create new ideas and true alternatives to the conservative dream of "new motherhood".

Apart from continuation of usual activities, PRO FAMILIA has engaged in the following new activities in 1984:- creation of a brochure on all methods of "natural family planning"; a brochure on the condom; a brochure from 6 migrant groups on all existing family planning services; training for group counselling; training on interprofessional co-operation within PRO FAMILIA clinics. In addition, an experimental training programme on female sexuality will be evaluated.

The co-operation within the IPPF Europe Region is satisfying especially on a bilateral basis. PRO FAMILIA counsellors have participated in the Regional information exchange and travelled to Vienna and Milan. The working relations with European organisations are close (e.g. WHO EUROPE).

Although scientific literature has reported postcoital contraception research and techniques for more than 10 years, most doctors and other health professions are still not aware of or ignore the possibility of a back-up method for the morning after. Consequently, PRO FAMILIA organised, together with university clinics at a local level, information meetings for doctors in order to persuade them to participate in the programme.

In addition PRO FAMILIA has documented and analysed 1,239 requests for postcoital contraception.

GERMAN DEMOCRATIC REPUBLIC — Ehe Und Familie (EFA)

The activities of existing centres for family planning and counselling (Ehe-und Sexualberatungsstellen) have been expanded. All these centres, subsidised by the Ministry of Health, are working together with local clinics in the field of legal abortion and special problems in contraception and psychotherapy. Contraceptives (free of charge) are mostly prescribed by gynaecologists and GPs in outpatient clinics. The staff of the family planning centres are nowadays especially interested in partnership problems.

Members of the EFA participated in the IXth Congress of Gynaecologists of the GDR in Berlin, where they demonstrated the results of a comparative study of different types of IUD. A new IUD was developed and clinically tested in the GDR, called 'Medusa'. In 1984 the device will be available for women. Two leading members of EFA published a scientific article of modern trends in the application of contraceptives in the "Zeitschrift für Ärztliche Fortbildung der DDR". EFA has developed a step-by-step programme for qualification of counsellors in the field of partnership problems and sexuality ("Eheberater"). In the meantime, a training — course was held in Dresden in November 1983. Special co-operation activities exist between EFA and the Association for Psychology and Psychotherapy. The EFA has seen the publication of the textbook of sexual medicine ("Lehrbuch der Sexualmedizin") by Aresin and Guenther.

HUNGARY — Hungarian Scientific Society for Family and Women's Welfare (HSSFWW)

The Presidium of the Society advocated prescription of oral contraception and postcoital contraception, forwarding recommendations to the National Institute of Obstetrics and Gynaecology. Consequently the Society took part in the preparation of a major report: 'Birth Control in Hungary' for the Supreme Counselling Body of the Ministry of Health — the Scientific Health Council.

This material gave a survey of the situation of birth control in Hungary, noting deficiencies.

Meetings: debate with the title, 'Means of the Socialist Law in the stabilisation of Family Life', Budapest, 9th March 1983; joint meeting of the Presidium of the Association of Hungarian Jurists; conference with the title: 'Questions of Family Care', Budapest, May 1983; joint meeting of the Society, the Patriotic People's Front and the Hungarian Psychiatric Association; international symposium under the title 'Family Planning in Practice', Miskolc-Tapolca, May 1983. (with 2 Austrian, 1 Polish, 4 Czechoslovak, 3 West German and 11 East German specialists); a scientific session under the title 'Ten Years of our Population Policy'; and General Assembly, Gyula 20 -- 21 October 1983.

Training programmes: the members of the Society participated in the teaching of 'preparation for family life' in schools (for teachers, students and physicians). The

members of the Society were also involved in the following courses organised at the Women's Clinic in Debrecen, and financed by the WHO and UNFPA: 'Training Courses on Methods of Family Planning' for Greek specialists; 'International Postgraduate Training Course on Methods of Family Planning' for specialists from developing countries.

IRELAND — Irish Family Planning Association (IFPA)

The persistent recession in the Irish economy, with increasing unemployment and a fall in spending power, continued to present financial problems to both the IFPA and its clients. In the absence of any grants or subsidy the Association must ensure that its services pay for themselves and this has forced increases in charges (which may now be deterring the most needy cases despite a policy of waiving fees in the case of financial hardship), and a 12 month pay freeze for IFPA staff.

Moves by certain area health boards to provide family planning services under public auspices met with some resistance from the organised medical profession, which, despite its poor record in this field, is now claiming that family planning should best be provided by family doctors. That represents a very significant change in attitude over the course of a decade. The Health Board continued its liaison with the IFPA, particularly in the Dublin area, which may lead to the creation of a limited public service provision during 1984.

Meanwhile, the IFPA has increased its service provision somewhat with the addition of Rubella immunisation and microbiological investigation of vaginal infections. No headway was made in the provision of female sterilisation, but vasectomy services were increased and the demand for psycho-sexual counselling continued to grow.

The demand from doctors for training for a diploma in family planning now issued by a joint committee representing various family planning and medical interests (including the IFPA) grew further during the year and special training courses for both doctors and nurses were and are being provided by the IFPA.

A total of ten tutors in sex education have been trained jointly between the IFPA and the Northern Ireland branch of the U.K. FPA. These will provide, during 1984 and thereafter, weekend and other courses for teachers, youth leaders and others with continuing collaboration between Northern Ireland and the Republic. The demand for these and other courses continued to grow and the IFPA began to develop its own resource material by way of videotape presentations and draft curricula for use in schools. There has also been a significant request for sex education in the field of mental handicap.

During 1983 plans were formulated for the provision, by late 1984, of special services for adolescents, including a telephone call service manned by young people themselves, trained by the IFPA. Planning was also started on a European regional

project to identify and counteract the organised opposition to family planning which has grown in recent years.

ITALY -- Unione Italiana de Centri Educazione Matrimoniale Prematrimoniale (UICEMP)

There have been some changes in 1983. The fall of the government and the consequent elections have heavily postponed important Bills of law such as a law on sterilisation and a law on sex education in schools.

The quality of the services given by state clinics is deteriorating due to the indifference of politicians and the shortage of staff. In fact governmental cuts are severe in the health system, which means that retiring staff or staff absent for long periods are not replaced.

UICEMP is still most dependent on IPPF funding. In 1983, the health ministry finally accepted the association's funding programme. The branches have begun to finance the UICEMP Secretariat, but their contribution is still very small compared with the amount of activities to be undertaken.

1983 was a very important year for UICEMP which succeeded in organising 4 successful new activities:

1. Adolescent project: Five branches (Milan, Turin, Genoa, Rome, Palermo) opened weekly sessions for adolescents. In these sessions counselling and information on contraceptives and sexual matters are given free of charge. Contraceptives are distributed free of charge. Only gynaecological examinations required payment in 3 out of the 5 branches. Telephone counselling is available in all the 5 branches throughout the week. The activity was a complete success as far as attendance of young people is concerned. The demand is overwhelming. A booklet on sexual matters was printed in March 1984 (20,000 copies).

2. National conference on "Resistance to Contraception": held in Milan in November 1983 and attended by about 200 participants (Mostly gynaecologists and psychologists). In 2 days work all the aspects — anthropological, ethical, political, psychological, etc — of resistance to contraception were examined and discussed. A book containing the reports and the discussions will be published in 1984.

3. Southern Italy conference on "The Consultorio in a Changing Society": held in Palermo in December 1983. About 130 participants attended it; most were civil servants of the health local units which will have to organise the state clinics.

The round table discussion concerning the family planning situation in Southern Italy was particularly interesting. The initiative had an important impact in local press and T.V.

4. Information and Education material: 5 new leaflets were prepared on the subjects of: pregnancy, abortion, smear and breast examination, hereditary diseases and STDs. These 5 new leaflets will accompany the 5 existing ones on contraceptives.

They are intended to be a first information tool for our clients and for people attending our services. They are also meant to stimulate state family planning clinics to develop their own material.

LUXEMBOURG -- Mouvement Luxembourgeois pour le Planning Familial et l'Éducation Sexuelle (MLPFES)

The MLPFES has four centres: Luxembourg/Ville, Esch/Alzette, Ettelbruck and Differdange. These centres have offered 10,600 consultations (of which 9,000 are offered by Luxembourg/Ville centres). The clientele are mainly young (65% under 25 years) but there has been an increase in women of menopausal age, who prefer to talk with our female physicians rather than male GPs.

Most of the young prefer oral contraceptives, although those between 25 — 35 years of age are increasingly requesting diaphragms and cervical caps with spermicide.

A not insignificant percentage of our clients prefer three or six-monthly injections of Depo Provera — 600 injections annually.

PPA activities include: sex education, contraception, infertility treatment (AIH-in house; AID conducted in Nancy, France), cervical smears, breast examinations, tests for and treatment of STDs, menopausal problems, marriage counselling, and counselling for sexual and psychosexual problems.

During 1981 — 82 a campaign against the procuring of women for prostitution resulted in arrests, prosecutions and sentences by the police, and stricter surveillance of the areas in which this was taking place — a more rigorous application of the law covering 'red-light districts'.

In 1982, an organisation was established (Info-Viol) for victims of rape. These victims are received by the family planning centres in the day-time, and by the state maternity hospital at night and over weekends. They receive the victims and assess the gravity of the assault. Postcoital contraception is available for women who are unprotected at the time of assault. Female volunteers are on call 24 hours a day to help women through the process of notification of rape, if they so wish.

Since February 1984, the MLPFES has had a physician at the disposal of male homosexuals to test for and treat STDs, and help clients with consequent identity problems if they require such counselling. No cases of AIDS have yet been notified.

For 5 years the Movement has given radio broadcasts every three weeks on different problems of family planning and activities within the family planning centres. These broadcasts are listened to by one-fifth of the population. The greatest success so far has been with a series of programmes on 'the first time' — a discussion of the problems raised by the first coitus. For her work in fighting to remove the

taboo surrounding sexuality, the head physician of the Luxembourg centre, was named 'woman of the year' for 1983, which was very helpful to the image of the organisation.

NETHERLANDS — Rutgers Stichting (RS)

The bad economic situation persists. Like most of the health and social services, Rutgers Stichting remains rather uncertain about its future, but there are no longer any threatening political efforts to lower its subsidies. However, an ongoing discussion about the restructuring of both health work and social work may also constitute a threat.

Rutgers Stichting is the only nationwide institution offering medical, sexual and psycho-sexual services, in addition to sex education programmes. The organisation fills the gaps in public or government funded services in these areas. More than 100,000 people visited the Stichting's medical services last year, the therapists saw about 10,000 clients and 50,000 people were in contact with the educational services. Over 150,000 people asked for information by phone. The streamlining of the organisation, forced through the loss of government subsidies, did work in 1983. Some of the effects will be visible in the longer term. Further losses of subsidies were stemmed through the rigorous campaigning activities of the Rutgers Stichting, unlike many other organisations in the health and social work-field.

The most visible activities of Rutgers Stichting were in the Autumn, when a big publicity campaign was launched, the theme of which was: "Make love always with . . . a good contraceptive".

NORWAY --- Norsk Forening for Familieplanlegging

Last year, the Parliament passed new law on health services in the community and from January 1984 every citizen has the right of access to the health services. This includes family planning, and the community has an obligation to inform the public about sexuality and family planning. The Association has already started with a series of meetings in secondary schools with pupils (14-16 years old), parents and teachers.

The financing of this new health service law is somewhat problematic, so the future will tell whether this right really will be realised.

The Association is funded from membership fees and grants from the Bureau of Health for special meetings and courses about family life, the role of the father, and for publications about family planning and handicapped people.

The Association has no service of its own as this is a governmental/community obligation. However it is represented on committees discussing family planning and health service/health information together with other organisations appointed and financed by the Bureau of Health.

The NFF has produced in co-operation with Gyldendal (a well known publisher) a leaflet about handicapped people, and is working on a dictionary for young people and a leaflet for elderly people. It has held open meetings about parents and children in family life and about the role of the father and the changing role of the male. This is been part of an extensive debate in newspapers and among experts.

POLAND — Towarzystwo Rozwoju Kodziny (TRR)

The general political situation is stabilising, albeit with latent unsolved problems and conflicts. A shift in emphasis in the policy of the state away from the traditionally pronatalist policy is apparent even if only seldomly expressed openly in public by officials. TRR began two years ago, and continued in 1983, patient but multiplex activities in favour of a neutral, instead of pronatalist, national policy, persuading the population through the use of mass media that very high fertility is a negative force in the process of overcoming Poland's socio-economic crisis. This activity is actively challenged by the Church, though without the aggressiveness typical of earlier years.

A new phenomenon is the pressure group activity of some women's organisations aimed at the Ministry of Health to improve the availability of contraceptives (for example the Women's League and some young female journalists have produced sharp critical TV programmes and newspaper articles). These groups have established good working relationships with the TRR, and as a consequence of united activities the Ministry was compelled to increase the importation of contraception from Hungary, Yugoslavia, Korea and the GDR. Unfortunately this has not solved the problem entirely.

The national role of the TRR, after some decline in prominence during 1982-83, is again high. While the ministry is criticised in the mass media for the shortages in contraceptives, the Association is regarded as the sole body taking proper care of family planning and sex education. Three members of TRR have been appointed members of a Ministry of Education advisory body for family life education.

The general economic situation in the country remains grave, although there is a slight improvement during 1983 — the first time since 1977 (GNP growth of 5%). The situation of the TRR has also improved to a much greater degree, thanks to a donation from the Ministry of Health covering 57% of the TRR budget (1982 = 53%). This means that of the total TRR budget of zlo 58.7 million 31.1 million came from the Ministry of Health, and 9.1 million from the local branches. The TRR received 3.3 million zlotys, net profit from the TRR subsidiary: Securitas, which manufactures contraceptives. A further 14.9 million was received in income from the central TRR agencies. As a result, income and expenditures are now well balanced.

The TRR is composed of 42 branches, most with their own sub-structures from 2 to 12 per branch; the average number of sub-structures per branch is 6. However,

there are 2 branches which stand alone (4 branches ceased to act after the 1980/82 crisis).

After a disastrous decline in membership during 1980-81, since 1982 we are recovering lost members and institutions. In comparison with 1982, TRR now has 2,270 new full members; 15,093 more supporting members, but a loss of 13 collective members. Total membership increased during 1983 by 12% to 144,000.

At present TRR operates 20 counselling centres, two of them particularly for young people (Warsaw, Cracow). These counselling centres served, together, 5,353 clients — an unsatisfactory number. The 2 youth counselling centres served 410 persons. Measures are recommended in order to increase the number of people which can be served by these centres, particularly in the provincial towns.

PORTUGAL — Associação para o Planeamento da Família (APF)

General elections took place in April 1983. As a result a new government was formed by a coalition (Socialist Party/Social Democratic Party). Due to the economic crisis, the government is reducing its investment in health and education. The number of family planning clinic services in health centres and maternity hospitals has never been enough for the needs of the population. However, until 1979, new services were being established at a satisfactory rate. Since 1980, due to the policy of the Conservative government at that time, the national family planning services have been seriously depleted. In mid-1983, the Health Ministry integrated the clinic services into the health/social security system. This integration was, itself, important but it was implemented in such a rapid way that several gaps were left — particularly in the area of mother and child care and family planning services.

Recently, two laws have been approved by parliament: one concerns voluntary termination of pregnancy, and the other about sex education and family planning. Concerning the former, the law now states that abortions can be performed for therapeutic reasons, rape, or if the woman's health (physical or psychological) is in danger. The law on sex education states that the government supports such education as a human right, particularly for young people.

The APF has made a statement on: the abortion issues, legal barriers preventing adolescents' access to family planning, and the prohibition of voluntary sterilisation as a contraceptive method. This statement was sent to members of parliament, the Ministry of Health, the Ministry of Education, and the mass media, having great impact on public opinion.

SWEDEN — Riksförbundet för Sexuell Upplysning (RFSU)

Due to Sweden's economic situation RFSU received less government funding during 1983. RFSU was therefore forced to charge more for its services, courses,

education activities, pamphlets, etc., which had earlier been supported by the state or had been self-financed.

RFSU engages in information and education activities to alter public opinion. Our clinics provide: advice, counselling, psychotherapy and help to victims of sexual assault.

The RFSU Sales Organisation retails barrier contraceptives and aids for handicapped people in order to finance other RFSU activities. In 1983, RFSU celebrated its 50th anniversary. Instead of "birthday gifts" RFSU asked for financial contributions to a project which has preliminarily been called "Research about the Father". An "Open House" was arranged to which people close to RFSU were invited, among others the Minister of Social Affairs. A big jubilee poster, giving information about the activities of RFSU, was produced. In connection with the IPPF Europe Region Council Meeting in Stockholm in May and the RFSU Annual Meeting, a joint birthday party was arranged.

Courses: as usual, RFSU arranged courses on "Sexuality: Society Living Together" (3). As a consequence of the engagement in the male role, RFSU arranged a new type of course called "The Hollow Father", the aim of which is to encourage men to recognise more fully their responsibility as father. Three courses were arranged, based on the experiences gained at the clinic: "How to Meet and Work with the Problem of Rape" (2) and "How to Meet and Work with Sexual Counselling for Young People" (1). ALL RFSU courses utilise professional groups.

TURKEY — The Family Planning Association of Turkey (FPAT)

FPAT activities which started to regress in 1979 due to financial difficulties made great strides in 1983 when IPPF financial support was reinstated in 1982 and also due to good planning and programming to meet needs in this field.

Projects implemented gave gratifying results and the FPAT succeeded in getting the support and co-operation not only of the Ministry of Health, but the universities, hospitals, public and private companies and organisations. The moral and material support these institutions provided was highly instrumental in the degree of project success.

FPAT is expanding its services considerably this year both within existing branches in various parts of Turkey and by opening new branches.

There is much need for work in the field of family planning education and application in our country. FPAT activities are complementary to state activities in certain respects, or of a pioneering nature in others.

Although the use of modern contraceptives is increasing steadily, it is still not at the desired level. Activities geared to education and motivation have been emphasised to increase usage.

Links with government and decision makers: close contact was initiated and maintained particularly with members of parliament for the liberalisation of abortion and sterilisation. The purpose as well as benefits for the country were explained during meetings.

In order to have Family Life Education integrated into the secondary school curricula, representatives of related ministries were invited to the meeting organised within the scope of the project (see below) as were the representatives of other related organisations. The importance and necessity of the subject was emphasised during the meeting.

Training programme for students teachers: The "Family Planning" course which started in 1980 was given again this year on a voluntary basis by the FPAT executive Director.

Family Life Education project: This project is the fruit of FPAT efforts to incorporate Family Life Education in its activities since 1974.

UNITED KINGDOM — Family Planning Association (FPA)

Following the handover of the majority of its clinics to the NHS between 1974 and 1976, the U.K. FPA developed its role in the provision of information and education relating to family planning — a role which was further extended during 1983. The Family Planning Information Service handled a total of nearly 25,000 inquiries from lay and professional members of the public in its London Office, whilst those with by Regional Offices brought the total to over 100,000.

In addition FPIS distributed more than 5 million leaflets and fact sheets nationally.

Consumer enquiries centred mainly on contraception, pregnancy and fertility problems though an increasing number of requests for information about sexually transmitted diseases and psycho-sexual counselling were received.

As well as everyday public service work, the work of FPIS involves a number of specific projects which last year included:

Pharmacists Project

The FPA/FPIS has been liaising with the Pharmaceutical Society of Great Britain since 1980 on a project with the long term aim of increasing the role and status of the pharmacist in health education, particularly family planning, and using the pharmacists as an economical and effective channel for distributing information and free literature to individuals. Following the publication of an investigation designed to assess the likely commitment of pharmacists to this idea, the project continued with a trial distribution of information materials to over 700 pharmacists; the reception of which by pharmacists and their clientele was to be examined for a fixed three-month period. The results of this trial, published in September 1984, confirm that a nationwide pharmacy based contraceptive information service is a realistic

proposition, and should be developed accordingly.

In collaboration with London Weekend Television and the Brook Advisory Centres the FPA last year made a public service announcement with the objective of raising awareness of the need for contraceptive planning in young men. After initial conflicts with the Independent Broadcasting Authority over the wording of the announcement, it was finally transmitted in December 1983. The 30 second feature focussed on a discussion in a hamburger bar between a group of young men during which the point was made that unintended pregnancy was not merely the responsibility of the girl involved. Following the transmission, FPA and Brook staff manned a TV "phone-in", giving advice on contraceptive provision for young people.

The FPA launched a campaign in May 1984, aimed at making post-coital contraception more widely available to the public. Pre-publicity over preceding months ensured that the campaign received maximum cover in all the media. A concise statement prepared by the Medical Advisory Panel was produced, to serve as a handy reference for doctors providing a post-coital contraceptive service.

YUGOSLAVIA -- Family Planning Council of Yugoslavia (FPCY)

In the previous two years, there has been some shortage in the import of contraceptives as a result of economic difficulties. This situation has now been overcome. The FPCY collaborated with responsibilities government authorities on this matter.

During 1983, besides other activities, the FPCY organised a large conference on the theme "Results Obtained to Date on the Inclusion of the Humanisation of Relations between the Sexes at all Levels of Children and Youth Schooling into school curriculum". The aim of this conference was to review the implementation of previously adopted conclusions and recommendations of the FPCY on this matter.

The results achieved in the Republics and Provinces were presented in nine papers. 38 participants represented social, political and professional organisations and relevant government bodies. After broad discussion on the theme, it was concluded that some positive results have been achieved in this work. These themes are more effectively integrated into the curricula of primary and secondary schools, not within one particular subject, but in all relevant subjects: biology, hygiene, literature, history, etc.

At the Conference, special attention was paid to the broader involvement of mass media in family planning education for youth and adults, through the specialised programmes already in existence for family, parents and children. It was pointed out that a team of experts had to be engaged to ensure the quality of such programmes and multidisciplinary approach to family planning. Equality of the sexes in society, family and marital life has to be tackled in these programmes also,

considering it is one of the important issues for improvement in family planning behaviour.

During the past year, the FPCY was also engaged in the preparation of the Symposium on the theme "Population Policy in Yugoslav Socialist Self-Management of Society". With this aim, the Organisational board was formed of 26 members, representatives of corresponding organisations and government institutions, as well as scientists, well known in this field.

The aim of this Symposium is to explore problems in the population domain, the relationship between a population policy and family planning and to review results and experiences in the realisation of the constitutional right to family planning, and to decide upon future tasks in this field. The Symposium will be held in the first half of 1984.

NON-MEMBER COUNTRIES

CZECHOSLOVAKIA — Section for Family Planning and Parenthood Education of the Czechoslovak Sexology Society (SPRVR)

The members of SPRVR were very active during the year 1983 writing studies, papers and articles on the family planning and parenthood problems, which appeared in the main Czechoslovak papers and journals and have become very popular. In "Rud Právo" — the main Party paper — and in "Vlasta" official journal of the Union of the Czechoslovak women, articles on family planning, abortion law, and contraception were published. In "Mlady Svet" journal of the Union of the Czechoslovak Youth the panel discussion on the current problems of family planning and parenthood education appeared.

In 1983, an international comparison of 24 European countries covering the population development and population policy measures including comparative information on family planning and parenthood education legislation and practice was finished and published. For the chapter in question material from the IPPF, Europe Region was used.

In Olomouc (North Moravia) in September 1983 a seminar on parenthood education and its effectiveness was organised by the Palacky's University. The Main papers were prepared by the members of SPRVR.

In 1985, 4th September, a seminar of socialist countries on adolescent sex and education for family life will take place in Czechoslovakia, prepared by SPRVR.

MALTA — Min-Naha-Tan-Nisa

The group Min-naha-tan-Nisa was set up in February 1980: full membership is open to all women who agree with the aims and policies of the group. The policy of

the group has been to tackle issues of importance to women generally, so as to mobilise the broadest spectrum possible and so as to raise consciousness about women's general condition.

Quite early on, the need was felt to include male associate members in sub-groups working on issues that relate to both men and women. So, for example, both the on-going campaign for the reform of the Family Law and the introduction of divorce, as well as the group writing a book in Maltese on sex education are co-ordinated by women and men.

In our first meeting the group decided to campaign for the introduction of a government-run free family planning service. We gave priority to this issue because we felt that one of the major factors that prevented women from participating more actively in society was the fact that we had little control over our bodies. At the time the only organisation that gave family planning advice was run by the Catholic Church which, because of its anti-contraceptive ideology, only gave information about the so-called natural methods.

Our campaign included meetings women from different areas and sections of Maltese life, and a detailed report identifying the main areas and requirements of a comprehensive family planning service.

The campaign paid off in May 1981 when governments announced the opening of three Family Welfare Clinics.

SPAIN — Comisión Gestora Nacional para la coordinación de Centros de PF. (CGN)

Since 1983 the number of FP centres in Spain has increased from 160 to 200 in 1984, most of those 40 new services are integrated with municipal primary health care centres. The Ministry of Health finally prepared several specific budgets for family planning which, after approval, aim to extend existing services.

This is a first step towards the integration of fp services into the network of social security primary health care services. A second initiative, under review, is to transfer contraceptive costs to the social security system. In the Ministry of health plan, in terms of personnel, a psychiatrist or psychologist (outside the mental health service) trained in sexology is foreseen.

At the beginning of 1984, Spain joined the UNFPA. In the near future, this may favour the promotion of family planning, particularly in the fields of information and training of health personnel. Contacts have been established with the UNFPA by the CGN.

EXPENDITURE SUMMARY - EUROPE

REGION

1983 ACTUAL

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Italy	43.0	-	43.0	14.6	(11.0)	46.6
Portugal	27.5	-	27.5	63.8	(7.8)	83.5
Spain	2.0	-	2.0	-	-	2.0
Turkey	30.0	0.5	30.5	35.9	(19.0)	47.4
TOTAL	102.5	0.5	103.0	114.3	(37.8)	179.5

EXPENDITURE SUMMARY - Europe

REGION

1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Italy	23.3	4.8	28.1	53.6	-	81.7
Portugal	33.1	-	33.1	6.6	-	39.7
Spain	1.8	-	1.8	-	-	1.8
Turkey	40.5	130.0	170.5	46.7	(4.9)	212.3
TOTAL	98.7	134.8	233.5	106.9	(4.9)	335.5

1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Italy	13.8	4.9	18.7	54.0	-	72.7
Portugal	24.6	0.1	24.7	24.5	-	49.2
Turkey	40.6	149.8	190.4	73.5	-	263.9
TOTAL	79.0	154.8	233.8	152.0	-	385.8

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US\$'000)

EUROPE

SUPPLIES PURCHASED BY IPPF

	ACTUAL EXPENDITURE 1983	ESTIMATED EXPENDITURE 1984	PROJECTED EXPENDITURE 1985
Contraceptives	-	4.1	4.1
Medical & Surgical	-	1.4	3.1
Audio Visual Equipment	-	0.5	1.3
Office Equipment	-	3.1	1.2
Transport	-	-	-
	<hr/>	<hr/>	<hr/>
TOTAL	-	9.1	9.7
	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>

AID SUPPLIES DONATED TO IPPF

Contraceptives	0.5	125.7	145.1
	<hr/>	<hr/>	<hr/>
FULL TOTAL	0.5	134.8	154.8
	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>

INDIAN OCEAN REGION

REGIONAL OVERVIEW

CHARACTERISTICS OF THE REGION

The Region comprises five countries, some of them among the most highly populated in the world. Together they contain nearly one billion people, among whom are some of the poorest. All Governments are fully committed to family planning and most of them have made a serious attempt to provide family planning information and services. But the demographic picture remains hardly changed, except perhaps in Sri Lanka.

It is not surprising that in such an alarming situation the governments have set themselves ambitious targets in their national plans. One would like to hope, but can hardly expect them to be achieved. In Bangladesh the Government aims at reducing the total fertility rate from 6 to 4.1% in the five years of the plan period (1985-90) This requires a reduction of the crude birth rate from 42 to 32 per thousand, or an increase of current use rate from 22% to 40% — in effect doubling the present 5.5 million current users. In India family planning takes a high priority in the Prime Minister's 20 point programme for socio-economic development. The demographic objective of the 5 Year Plan is to stabilise the country's population by the year 2001. This calls for the reduction of the net reproductive rate from the present 1.8 to 1, with a birth rate of 21 as against the current 33.9, and a projected death rate falling to 9 from 12.5. The plans of Nepal are no less ambitious, aiming to reduce the annual rate of growth to 1.2% by the end of this century, as against the current 2.3%. The objective of Pakistan's 5th. Five Year Plan (1978-83) was to reduce the population growth rate to 2.5% by the end of that period, but obviously this has not been achieved and the rate of growth remains at nearly 3%. It is only in Sri Lanka that the signs are encouraging. It has reduced its crude birth rate to 26.8 per 1000 which is quite an achievement; but with a death rate as low as 6.1 per 1000 the rate of natural increase remains at nearly 2%. The net increase due largely to migration is in the region of 1.7%, but this migration is of a temporary nature to the Middle East and does not really help the situation in the long term.

One may ask what chance there is of success given the vast unmet needs in family planning. In Pakistan the World Fertility Survey showed the current use rate as 7% and an awareness rate of 75%. But the latter figure must be qualified by the fact that 43% of fertile couples do not intend to plan their families. In Nepal the Fertility Survey reported current use as 2.3%, but here again 39% of the sample claimed that they did not intend to use any method in the future. In Nepal there has since been some progress as the more recent Contraceptive Prevalence Survey shows the current use rate as 6.8%; but there is still a very large gap to bridge.

The extension of contraceptive services alone will not help to bridge this gap. While infant mortality remains high, literacy low, and the status of women depressed, the extension of family planning information and services will not make a real impact.

Infant mortality ranges from 150 per 1000 in Nepal to 123 in India, with Sri Lanka alone registering a low figure of 37. Family planning, therefore, must be accompanied by primary health care measures and particularly efforts to combat infant mortality.

Perhaps the most important element in this picture is youth, 40% or more of the population in these countries is under the age of 15, with Sri Lanka being the exception, with 36%. Programmes for youth therefore must take a high priority with the FPAs and governments, but unfortunately although there are many good youth programmes, they are still not strong enough. India has an excellent population education programme pioneered by the FPA and now taken over by the government. But the bulk of this young population is out of school, and do not form a captive audience. The physical difficulties of communication compound the problem. The FPAs have many excellent women's development programmes, but they have hardly made any impact on the status of women. In fact, in Pakistan there are efforts being made to deprive them even of their present rights, and set the clock back by centuries.

RURAL PROGRAMMES

Whether young people, women, or couples in need of family planning most of them are to be found in the rural areas, where the bulk of the population of the Region resides. 95% of Nepal's population live in rural areas, some of which are only to be reached on foot after a journey of several days. In the other countries about 70% of the population is rural. When infrastructures do not exist for taking the essentials of life to these people, it is not conceivable that they can ever be reached with family planning information and services — that is not unless the community can help itself.

This is, or should be, the most important aspect of programmes of all FPAs. Many of them have developed excellent community participation programmes in which the poor communities are contributing not only their time and energies, but even their money towards the programme. In this they are using a centuries old tradition of self-help, without which these communities would not have survived in the absence of organised intervention and assistance from the State. In India local village institutions are mobilised to help their own communities with information and in the distribution of contraceptives. The long term goal is to make them almost totally self-reliant. It is a slow and difficult process, but tangible progress is being made. In the Karnataka Project, for instance, the community raised 49% of the cost of project activities, while in the Malur Project the community contributed 51% of the project costs. In addition they organised various family planning activities, including the distribution of condoms. These are only some examples. In Sri Lanka the FPA works through village level committees consisting of volunteers drawn from the local community. Through them projects are initiated but the FPA moves out after a period of two years, leaving behind a group of trained volunteers to continue with family health and family planning activities. In 1983 246 such groups were formed bringing the total to 560. These volunteers are trained to carry out simple base line surveys, prepare registers of eligible couples and motivate them. Acceptors are referred to the nearest government clinic. When the FPA moves out of an area after two years, the volunteers are institutionalised in the form of Rural Family Welfare Societies.

Following the success of two experimental societies set up in 1982, 37 such societies were established in 1983. The community is involved similarly in Bangladesh, Nepal and Pakistan. In Pakistan the Rural Family Welfare Centres have been the backbone of the FPA's programme and its success has induced the government to adopt the same model in its own programme. These centres, apart from providing contraceptive advice and services, are a focal point for organising the community to carry out community development activities of their own, including family planning. All these activities including the Family Welfare Centres of the FPA are managed by local communities.

All these projects have been successful to a greater or lesser degree in increasing the acceptance of family planning, but more important than counting acceptors annually is the fact that the values and norms of the community itself are being changed.

SERVICE DELIVERY

Service delivery continues to occupy an important place in the family planning programmes of all countries except Sri Lanka. Here the FPA only run a model clinic at its headquarters and an experimental clinic in a provincial town, whose objective is to test the extent to which fees can be shared for high quality family planning services before it is put out of the reach of the people who need them most. While service delivery programmes fill a large gap in the government programme, one may question whether the allocation of resources to such services as against other programme objectives truly reflects the role of the FPA. Perhaps the time has come to shift more of these resources to those programmes which can make a real impact in the long term, namely youth, women and rural community development programmes. It is difficult for the FPAs to do this when faced with the crying need for services and pressures from the government on them to supplement the government's own service delivery programme.

In most of these countries the government places a very heavy emphasis on sterilisation to the neglect of spacing methods. The sterilisation programmes have been tied up with cash incentives. There is no doubt that such incentives have increased the acceptance of sterilisation, but it has dangers and the FPAs must continue to act as watchdogs to ensure that the principle of voluntary choice is not in any way placed in jeopardy. The response to incentives is tempting some governments to develop even more elaborate packages of incentives.

Apart from such dangers the fact also remains that the bulk of the population we are concerned with are young. To neglect spacing methods is to deny them the ability to space their families and to that extent to deny them the human right to voluntary planning of their family size. The government in India has recently become alive to the need to pay more attention to spacing methods and a programme is being developed in collaboration with USAID over a seven year period.

The main contribution of the FPAs to the service delivery programme, apart from providing a cafeteria of methods, has been to take the services to rural areas through mobile teams. The Indian programme has developed a great deal of expertise in this, while the mobile services have increased very rapidly in Nepal. Vasectomy is popular only in Nepal. In all other countries female sterilisations account for the bulk of sterilisations performed by FPAs or Governments.

Laparoscopy is becoming increasingly popular. It has a distinct client preference, as well as support from the medical profession. But questions have been raised about the standards maintained in the mobile laparoscopic services. The FPAs must continue to ensure that these standards are maintained, both in their own programmes, as well as in the government programmes. At the same time more attention needs to be paid to mini-laparotomy which could have certain advantages as compared to laparoscopy.

The injectables are not widely used in relation to other spacing methods, but promise to be a very cost-effective way of providing a spacing method. One of the main drawbacks, of course, is the controversy surrounding them which has spilt over from the western press and the attitudes of western governments within their own countries. However, as far as the client is concerned the modest programmes that are now in existence have shown that it is a method that many women strongly favour. In order to help FPAs to expand these programmes a visit was arranged to Chiang Mai followed by a workshop, as a consequence of which the FPAs have submitted project proposals for expanding the injectable programme and introducing it where it does not exist. In India injectables have not been permitted but the government now seems to be changing its attitude and the FPA India will seek permission of the government to initiate a modest trial programme.

Traditional methods continue to be important in all countries, but what is surprising is that in Sri Lanka which has made such remarkable progress in its family planning programme, recent statistics show that the trends are being reversed and an increasing number of women are turning to traditional methods, as against the modern methods. The reasons for this are not clear, though the scare stories about the pill and injectable may have made some contribution to this change. However that may be, remembering that fertility in the west was reduced even before modern methods were available, one must seriously consider whether couples should not be helped to practice traditional methods more effectively if this is all they will accept culturally. This is not to say that every effort should not be made to promote the use of the more effective modern methods.

An important element in the service delivery programme is the Contraceptive Retail Sales Project programme which now exists in Bangladesh, Nepal and Sri Lanka. The Sri Lanka project which is the oldest has achieved a remarkable degree of success and a recent survey shows that 80% of condom users and 36% of pill users depend on the CRS programme for their supplies. While the two other programmes remain highly subsidised, in Sri Lanka an effort is being made to recover costs. In 1983 the sales revenue exceeded the operational expenditure (i.e. excluding the cost of contraceptives which is still a high cost item of the Sri Lanka programme).

Faced with the financial constraints that may lie ahead the FPA Sri Lanka is charging fees for its other services as well. In 1983 its clinic at the headquarters recovered 76% of its costs. The only other clinic run by the FPA now charges a full fee. It is fully self-sufficient but the question remains as to whether it is serving the needs of the people who really require its services. This will be reviewed in 1984 and the activities continued or terminated.

While efforts to increase self reliance in the face of possible cuts in the grants are laudable, the question is how far one can go before putting family planning services out of the reach of the neediest, and this is a serious problem. If the financial climate changes for the worse, it is a question that other FPAs will also have to face.

MALE INVOLVEMENT

This is the weakest area in all programmes of all FPAs despite the fact that the Indian Ocean Region contributed about 60% of all male sterilisations in IPPF. The largest contribution comes from India as may be expected, but even here out of the total sterilisations only 12% were vasectomies. As a matter of fact male sterilisation decreased by 18% from 82-83. The main strategy of the FPAs has been to reach the males through programmes in factories, but for a variety of reasons these have met with little success, although they provided a captive audience. More recently some FPAs have made an effort to reach them through organised occupational grouping, such as taxi drivers associations, etc., but the most promising project has been a project in India to concentrate on newly married males in a village where the mean age for marriage of females is very low. The aim is to persuade them to postpone the first pregnancy using members of their own peer groups as motivators. One has still to see whether this approach will prove to be more successful.

THE FUTURE

The Parliamentarians movement in India and Sri Lanka has helped to take the subject of family planning out of the political arena. All political parties in the two countries have agreed not to make it a party political issue. This is a significant step forward. It has strengthened the courage of the governments of the day. The political will has long existed, if the recent meeting of the Asian Parliamentarians Forum is any indication, they will help to match this with increased political commitment. It is only in Pakistan that the matter remained in doubt. Although strong statements have been made recently in support of population and family planning by government spokesmen (despite rejection by the Islamic Ideology Committee which is an advisory body to the government) one hesitates to hazard a guess as to what the future may hold in that country.

All FPAs are now held in high regard by their national governments, who see them as important parties in the national programmes. This is a far cry from the days — of not so long ago — when they were looked upon as well-meaning but ineffective groups of amateurs.

But this is no cause for complacency. The FPAs need to ask whether they are truly meeting the needs of the hour. All of them have benefited from the shift of emphasis in the allocation of IPPF's resources. Sri Lanka being low on the needs index is the only exception, taking a small reduction in the grant over the last few years. So far they have shown themselves capable of absorbing these increases in funding. But the time has come for them to pause and examine the vehicle in which they are travelling; and to take a look at the map to reassure themselves that they know where they want to go, and are travelling in the right direction in order to get there. They are conscious of the first need. They are attempting to streamline their organisations, and improve their management, in some cases with the assistance of an outside consultant.

It is the second need that is more difficult. It calls for a reappraisal of their roles. In most cases this may point to the conclusion that resources must be shifted away from service delivery to other programme priorities that are more important in the wider perspective. It is not easy to come to terms with this.

They may also have the lesson painfully brought home to them, that external sources of assistance can be capricious.

"Fund raising" from sources other than IPPF, or within the country is not the alternative either. True self reliance must be sought through local self help. The now partly self-supporting community projects must be nursed into their final phase of total self-reliance.

EXPENDITURE SUMMARY - INDIAN OCEAN REGION
1983 ACTUAL

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Bangladesh	631.9	290.9	922.8	124.8	(10.0)	1037.6
India	2618.2	119.9	2738.1	1062.7	(550.9)	3249.9
Nepal	415.6	140.1	555.7	560.5	(82.8)	1033.4
Pakistan	862.7	118.5	981.2	198.9	19.2	1199.3
Sri Lanka	296.0	703.4	999.4	248.9	(43.7)	1204.6
TOTAL	4824.4	1372.8	6197.2	2195.8	(668.2)	7724.8

EXPENDITURE SUMMARY - Indian Ocean REGION

1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Bangladesh	790.4	376.0	1160.4	273.1	8.0	1441.5
India	2351.1	149.4	2500.5	677.6	353.2	3511.3
Nepal	679.7	15.0	834.7	880.8	54.6	1770.1
Pakistan	1079.7	121.2	1200.9	434.4	72.7	1708.0
Sri Lanka	336.5	243.2	579.7	270.6	8.1	858.4
TOTAL	5237.4	1038.8	6276.2	2536.5	476.6	9289.3

EXPENDITURE SUMMARY - Indian Ocean REGION

1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Bangladesh	1083.9	435.1	1519.0	302.5	-	1821.5
India	2782.3	81.0	2863.3	935.8	-	3799.1
Nepal	818.5	216.1	1034.6	952.7	-	1987.3
Pakistan	1063.5	328.3	1391.8	774.2	-	2166.0
Sri Lanka	308.5	313.9	622.4	255.8	-	878.2
TOTAL	6056.7	1374.4	7431.1	3221.0	-	10652.1

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US\$'000)

INDIAN OCEAN

	<u>SUPPLIES PURCHASED BY IPPF</u>		
	<u>ACTUAL EXPENDITURE 1983</u>	<u>ESTIMATED EXPENDITURE 1984</u>	<u>PROJECTED EXPENDITURE 1985</u>
Contraceptives	476.6	416.9	444.8
Medical & Surgical	60.1	27.5	50.0
Audio Visual Equipment	20.2	26.1	24.2
Office Equipment	7.6	16.5	31.6
Transport	74.2	144.8	143.5
TOTAL	<u>638.7</u>	<u>631.8</u>	<u>694.1</u>

	<u>AID SUPPLIES DONATED TO IPPF</u>		
Contraceptives	<u>721.0</u>	<u>407.0</u>	<u>680.3</u>
FULL TOTAL	<u>1359.7</u>	<u>1038.8</u>	<u>1374.4</u>

PAKISTAN

FAMILY PLANNING ASSOCIATION OF PAKISTAN (FPAP)

COUNTRY BACKGROUND

Pakistan has three distinct topographical regions — the Himalayan and Hindukush mountain range in the north-west, an arid plateau in the west and the fertile plains of the Indus river basin spreading from north-west to south-west. To some extent, these regions represent some of the major ethnic distributions in the country.

Three quarters of the country's population live in the rural areas and are basically dependent on agricultural activities. Unemployed or underemployed young people from these rural areas find their way into urban centres, speeding up the process of urbanisation.

The country has a very uneven population distribution, mainly because of its physical features. More than half of its population live in one of its four provinces — Punjab. About one quarter live in another province, Sind. About half of the Sind people are urban. Rural Sind has more than 68,000 small settlements.

About one third of the population are below the poverty line. In large areas of the country drinking water is the major problem.

The country faces problems of immigrating, political refugees and emigration of its young people to the Middle East. In addition, it faces the serious problem of land erosion due to deforestation, water-logging and salinity.

Migration is a complex problem. Emigration of the young labour force, particularly to the Middle-eastern countries, brings substantial income to the country, but also creates various social problems.

Basic Socio-demographic data

The main statistical indicators are as follows:-

Total Population	88 million
Area	803,000 square kilometers
Population below age of 15	45%
Women in reproductive age	20%
Child-Women ration (per 1000)	714
Dependency ratio	103 per 100
Population density per sq. km.	105 persons
Crude birth rate (per 1000)	40.3 per thousand
Crude death rate (per 1000)	11.6 thousand

Infant mortality	100 per 1000 live births
Gross reproductive rate per woman	3.1
Net reproductive rate	2.54
Total fertility rate	662 per 1000
General fertility rate	274 per 1000
Male and female ratio	111 male per 100 female
Life expectancy: Male	52.9 years
Female	51.8 years
Literacy rate	26.7
Increase in labour force (1951-1980)	14 million

According to the Pakistan Fertility Survey, 1975, the current use rate was only 7% against an awareness rate of 75%. This is an exceptionally wide gap. The situation is made more complex by the fact that 43% of fertile couples do not intend to plan their family size. The data from the World Fertility Survey is somewhat out of date now, but unfortunately there is no more recent information available. It is estimated that the current use rate has improved in recent years.

Official Policies

One of the objectives of the Fifth National Five Year Development Plan (1978-1983) was to reduce the population growth rate to 2.5% by the end of 1983. Obviously this has not been achieved due to lack of seriousness in action. However, the Population Welfare Plan, 1981-84, which forms part of the Sixth National Five Year Development Plan (1983-1988) embodies an integrated approach to family planning and community development issues, such as raising standards of living, better nutrition, better health care and education, and employment of women. The plan emphasises male responsibility for family welfare, the importance of breast feeding, and advocacy of late marriage.

The demographic targets of the Sixth Plan are to raise the current use rate from 7% to 20% by 1988. It is planned to reduce the CBR from 40 to 33 per 1,000. In order to meet these targets some 3 million births will have to be averted.

Constraints to Family Planning

All the development programmes face similar constraints. But family planning has an added disadvantage because of its very sensitive nature, and the entrenched opposition of orthodox groups who wield a strong influence over the common people.

Recently the Islamic Ideology Council pronounced against family planning as a way of life. This generated debate both within and outside Pakistan. It may not have much effect on educated sections of the community, but could influence the less educated and have some inhibiting effects on the programme.

The Future

The National Population Welfare Plan (1981-84) indicates that the policy makers have shown increasing commitment to population programmes in recent years. Their commitment will be the single most important factor in the immediate future. It will be extremely important to ensure the support of religious leaders and community leaders, particularly in the rural areas. An atmosphere has to be created where the media and press can promote family planning without inhibition. The participation of disadvantaged groups, such as women and out-of-school youth should be secured. With increasing support, and a sense of direction from the policy makers, it should not be impossible to improve and expand the programme significantly.

The FPAP has given serious thought to the reorganisation of its structure and operations. It has decided to move out of the branch structure and develop work units. Thus all the branch activities and field projects will be divided into some 500 manageable work units, supervised by professional staff members. Volunteers at the 'Board' level will concentrate their attention on advocacy, expansion of the movement, and resource development. The FPA is embarking on a serious resource development programme. This new structure has the merit of eliminating a hierarchical layer and involving the volunteer "workers" more directly in planning and programme development.

Other Family Planning Activities

In addition to the FPAP, there are a number of agencies directly or indirectly involved in family planning activities. By 1979 thirteen projects were completed under the Pakistan/UNFPA Agreement. Some of the on-going UNFPA/ILO projects implemented by Government are related to the development of health and family planning personnel, family planning services through Hakeems, Population Education in the organised sector, training for medical and para-medical workers, delivery of MCH services and community based family planning. The World Food Programme, WHO, ADB, USAID and the British Overseas Development Administration are the main agencies contributing to population related activities.

THE ROLE OF THE ASSOCIATION

Unmet Needs

The family planning unmet needs in Pakistan are basically those related to the welfare of the family. They are the wellbeing of the child, mother, and of disadvantaged groups. If family planning is to be taken to the people who are most in need of it, the programme must be rooted in the isolated rural communities among which the vast majority of the population is scattered.

The FPAP faces the challenge of promoting family welfare as a crucial variable in the community development. It has to be made acceptable to society as an essential development activity.

Convincing the religious leaders of the importance of family planning for general development and individual welfare is the major task that lies ahead. The political commitment of Government must be translated into political will, and express itself in serious action. The FPAP has a vital advocacy role to play in bringing about, hopefully, this transformation.

Taking all these factors into account, the FPA has defined its role as follows:-

“In view of the restructured Population Welfare Plan in the 5th. and 6th. Plan Period based as it is on FPAP's experience, the FPAP will continue to give the lead in trying out newer, simpler and more cost-effective approaches, and analysing and documenting its experience for demonstration and replication.

The advocacy role of the FPAP is still of primary importance in the prevailing climate to obtain public support for the movement. There is a need for supplementing the National Programme in the service, training and communication areas and complementing it particularly in the areas of Youth, Womens' Development, Male Involvement, and Volunteer participation.

Further in view of the large unmet needs in this sector the FPAP will continue to strengthen its resource development efforts with a view to self-reliance and institutionalising the movement”.

It has identified the following strategies to fulfil the above role:-

1. To strengthen the role of the non-governmental sector in the National Population Welfare Programme.
2. To advocate and promote family planning as a basic human right.
3. To extend coverage and quality of family planning services.
4. To educate and organise Youth for the family planning promotion.
5. To bring women into the main-stream of development.
6. To encourage a greater sense of involvement and practice of family planning among men.
7. To strengthen FPAP's resource development.

THE PAST PERFORMANCE OF THE ASSOCIATION

The FPA programmes have been expanding at a reasonable pace over the recent years. Given the difficult situation their performance has been encouraging. During 1983, the Association assisted the implementation of major Government programmes on reproductive health services, literacy, mass education, Family Welfare Centres and family planning through traditional medical practitioners, (Hakeems).

The FPA received about 10% of its financial resources from sources other than IPPF. The UNDP was the major donor, contributing \$32,700 for women's development through income generating activities.

IPPF assistance increased by 10% over the previous year. The major expenditure, about 32% of the 1983 budget, was incurred under IEC activities. These comprised the development of educational materials, use of mass media like the press, TV, radio, publication of the "Sukhi Ghar" journal and organising film shows.

More than 20% of the budget was spent on community based programmes in remote areas. Such programmes were carried out with the help of private allopathic practitioners, traditional medical practitioners (Hakeems) traditional midwives (Dais), rural communities, and slum communities. The FPA has also initiated a highly imaginative project for utilising the far flung network of post office agents.

Non-clinical outlets provide services to an increasing number of clients. The number of continuing acceptors for oral pills and injectables was 9,200 and 70,000 respectively — which is quite encouraging. If the side-effects caused by these methods are treated promptly, the acceptance of these methods could increase considerably.

Another 20% of the budget was spent on clinical activities which include the model clinics of Lahore and Karachi. In addition to contraceptive and sterilisation services, these clinics provide anti-natal and post-natal care. Sterilisation services are also provided by the extension surgical units through nine collaborating hospitals of the country. The costs of this are met by the Government. Other activities under this sub-heading cover the use of private medical practitioners in family planning and the training of Dais.

The FPA trained Dais, out-reach workers, volunteers, Hakeems, medical and para-medical personnel as part of its training programme. Under the evaluation programme the effectiveness of contraceptives was assessed in terms of births averted.

The Management Information System was reviewed. Different documents and reports were verified against actual performance.

The FPA served 57,500 new and 49,700 continuing acceptors in 1983. The new acceptors by method are as follows:-

Condoms	14,359		26%
Orals	10,647		19%
Injectables	10,354		19%
IUD	9,354		17%
Tubectomy	5,324		10%
Vasectomy	111	less than	1%
Others	<u>4,827</u>		<u>9%</u>
Total	54,976		100%

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

The FPAP has devised seven strategies to fulfil its role. More than half of its total expenditure will be spent under the most important strategy that aims at strengthening the role of the NGO sector in the National Population Welfare Plan.

The NGO sector is interpreted in a very broad sense, to include groups that may not be formally organised, such as traditional healers and birth attendants. Given the difficulties and shortcomings of the Government programme, and the inhibitions arising from the present religious and cultural climate, this is indeed a well calculated strategy.

Following the major reorganisation of the Association's structure into project units called "Work Units", several activities will be implemented to improve performance. Training and personnel development is one major area under this strategy. Major projects will be assessed and expanded to the more remote areas. The Family Welfare Centres, which have been the backbone of the Association's out-reach services, will be strengthened and considerably expanded. Traditional doctors (Hakeems) will be persuaded to provide family planning education and services. Under this strategy, the Association has an ambitious plan to demonstrate the decline of fertility in two selected districts — Islamabad and Qasur.

The next major strategy, advocacy and promotion of family planning as a basic human right, responds to the major need of the country which is to win the support of influential groups by effective use of the mass media, such as radio, television, and the press. The FPA will produce special motivational literature designed for selected groups.

It will also communicate its message with the help of booklets, posters, calendars, teaching aids and the monthly journal "Sukhi Ghar". Some 10% of the budget will be spent on these activities.

About 7% of the resources will be spent on the extension of family planning services and the improvement of their quality. This includes the sterilisation and contraceptive services provided by the model clinics of Karachi and Lahore, as well as mobile extension services. In addition, it continues the Reproductive Health Service project, clinical services in the formal sectors and the private practitioners project. The highly successful Hospital Patients Motivation Scheme will be discontinued in view of the fact that this approach has now been incorporated in the government programme. Clients in private hospitals will continue to be contacted under a different project activity. There is also a project to sterilise women by chemical methods planned from 1985 onwards.

Young people are given due attention in the Plan. One strategy is to educate youth for family planning promotion. Youth cells will be established to organise youth activities and collaborate with agencies concerned with their welfare. Similarly,

under another strategy, programmes will be conducted to improve women's skills and enhance their role in society. Women will be trained in income generating activities such as tailoring, block printing, carpet weaving, pottery, embroidery and will also be motivated to space and plan their family size.

The Plan also aims at educating and encouraging males for responsible parenthood and family welfare. Projects specifically designed for the greater involvement of men in family planning are the objectives of the communication project, industrial project, the postal employees project, and the Hujra project. The latter again is another imaginative project which will use an existing local social institution to good effect.

The Association has seriously planned to increase its level of self-reliance, and is drawing up a good resource development programme. In addition to continuing the raffles, a pathological laboratory will be set up in 1985 which is expected to generate a substantial income. A feasibility study for setting up a nursery or a junior school and the retail sales of medicines and stationary are among the activities being considered.

About 8% of the total 1985 budget will be spent on project support costs. These will cover the cost of staff travel and office services. Another 9% will be spent on administrative and general service costs. Personnel costs take the largest share of the AGS costs.

THE ASSOCIATION'S RESOURCES

The Plan projects income of almost 25% from non-IPPF sources. The major portion of this is expected to come from national sources. The Government will contribute the largest sum — about half of the \$790,000 projected.

The fund raising programme is also expected to make a significant contribution. Among the international agencies the Save the Children Fund will make a substantial contribution of some \$75,000 for the training of traditional midwives (Dais).

The FPA's 1983 programme was executed by 519 staff members. Their number will be increased to 747 in 1985 to implement the increasing activities.

Voluntary Contributions

At the "Board" level the volunteers make invaluable contributions to the development of FPA policy and programme guidelines. Their professional background and social standing provides the Association with influence and leadership. The community volunteers form the bedrock of the movement. It is impossible to compute their input in monetary terms. However, it is estimated that their annual contribution is worth not less than \$550,000.

THE ASSOCIATION'S MANAGEMENT CAPACITY

The Association has functioned through its 12 branches and 12 "Work Units". As part of the recent reorganisation it is proposed that all of the Association's branch activities and special projects will be restructured into "Work Units". With the expansion projected during the Plan period, their total number will increase to about 500. These "Work Units" will be supervised by 5 Regional Directors.

The concept of the "Work Unit" as distinct from formal branches can provide useful lessons to other FPAs in the Region.

The FPA has improved its performance over the years, although it has to operate in a difficult environment. The need for organisational development of the FPA has been recognised as the key element for further improvement of its performance. Personnel development and effective supervision are some other areas that need more attention.

However, the death rate has also fallen to a low of 6.1 — one of the lowest in the world. The result is that the rate of natural increase is little different from that of the neighbouring countries.

Heavy emigration (of a temporary nature) to the Middle East in recent times has, however, reduced the net increase to 1.8%. Usually only one partner among married couples emigrates. This has implications for the family planning programme, and may have something to do with trends in acceptor figures and methods used.

The World Fertility Survey (1975) showed that knowledge stood at 91% while practice was 32% among current married women. The Contraceptive Prevalence Survey (1982) indicated that knowledge had increased to 99% and practice to 54.9%. But the increases have been proportionately larger with traditional methods — the rhythm method from 8% to 13% of current users; withdrawal from 1.5% to 4%; and other traditional methods from 3.7% to 6.8%. Sri Lanka has one of the highest rates for traditional methods among the countries surveyed by WFS or CPS.

The only modern method which showed a larger increase was female sterilisation from 9.9% in 1975 to 17% in 1982. The use of pills and condoms registered a small increase while the use of the IUD declined by 47%. The Contraceptive Prevalence Survey showed that 67% of currently married women did not want any more children. But only 24% of them were using a modern method. 40% resorted to traditional methods and the balance were unprotected. The average number of children desired was 3.2.

Another interesting trend is that though the proportion of urban population was increased in the past, the trend has been checked, and appears to be going into reverse. Between 1971 and 1981 it has fallen from 22.4% to 21.5% — largely due perhaps to the investments being made in peasant agriculture and in the provision of services such as roads and electricity to the rural areas.

Official Policies

The Government of Sri Lanka is firmly committed to family planning and population is an important element of the national plan. The national family planning programme aims to increase the use of modern methods to 50% by 1986 as against the present 27% and to increase the current use of all methods to 60% as against the present 55%. All this to be achieved by 1986. Targets have been set for each method, with sterilisation at 27% and injectables, IUDs, pills and condoms ranging from 4%-7%.

In order to encourage sterilisation the Government provides incentives to acceptors as well as to surgical teams.

The public attitude towards family planning is highly favourable, although occasionally fears are raised by both minority and majority ethnic, linguistic and religious groups. The main hard-core opposition now comes from two minority

religious groups, the Catholics and the Muslims.

A consensus has been established among all political parties, which recognise family planning as a national priority above party politics.

Constraints to Family Planning

One of the main constraints is the lack of trained personnel, especially medical personnel, because of the large exodus to other countries. This has affected the family planning programme as well as other development programmes very severely.

The lack of resources is another constraint as the Government has to make difficult decisions allocating limited resources as between family planning and developmental activities. The national budget also carries a heavy burden of social welfare services, especially free education and health services for all, and subsidised food for certain sections of the community.

The Future

The major resettlement scheme referred to earlier will occupy the attention and resources of the Government in the next few years. This undertaking has major implications for family planning and the FPA in partnership with the Government will have to pay greater attention to the family planning needs of the resettled population.

It was only very recently that the Government agreed to start population education activities in schools. This is important considering the high proportion of the population under the age of 15. Both the Government programme as well as the FPA programme must in the years to come gear themselves to meet the needs of young people. The problems of the young population are bound to increase in the next few years as a result of the rapid economic and social changes that are taking place in the country. The high demand for sterilisation also means that adequate facilities must be provided to meet this demand. Furthermore, the percentage of male sterilisations is very small when compared to that of female sterilisation. A serious attempt must be made to motivate males.

The trend towards traditional methods also poses a question. The causes and implications of this trend must be carefully studied.

Other Family Planning Activities

There are three agencies apart from the FPA concerned with family planning. They are Community Development Services which conducts research training and provides family planning services; Population Services International which is a relatively small organisation and concentrates mainly on the training of Ayurvedic practitioners for the distribution of contraceptives; and the Sri Lanka Association for Voluntary Surgical Contraception which promotes voluntary sterilisation among

various groups. Other NGOs such as the JC's, the Women's organisations, Lions Clubs and the YWCA also organise family planning education programmes as part of their activities with the assistance of the FPA.

The UNFPA is funding a 4 year programme aimed at improving the availability of services and the improvement of primary health care facilities.

Assistance from Other Organisations

The FPA has received considerable support from other international NGOs such as the IPAVS, the University of Colombia and more recently, the Regional Training Service Agency in Hawaii.

Unmet Needs

Some of the more pressing unmet needs are:

1. Trained medical and para-medical personnel.
2. The involvement of youth through a comprehensive population education programme.
3. Although the level of knowledge is high, there is a need both to increase motivation as well as extend the delivery of services in order to close the gap that now exists between knowledge and practice.
4. The demand for sterilisation has obviously been very high. There is a need to promote other modern spacing methods, and allay the fears associated with them.

THE ROLE OF THE ASSOCIATION

The FPA has defined its role during the period 1985 to 1987 as follows:-

“The Association will support the National FP programme enlisting greater volunteer effort to carry out motivational activities, conducting Population Education Programmes for Youth, providing training in service delivery, improving contraceptive availability while demonstrating their safety and efficacy, and developing resources for the Association's future activities.”

It is an appropriate role in the context of the national situation and the unmet needs that have been identified.

The FPA's main strength is in the rural areas, working with village people. It carries greater credibility than Governmental agencies. It has been successful in mobilising large numbers of volunteers in the rural areas.

THE PAST PERFORMANCE OF THE ASSOCIATION

1983 was another successful year and the programme was well implemented. Expenditure exceeded the projected budget by 7%. The riots that broke out in the middle of the last year caused some disruption to the programme, particularly the Contraceptive Retail Sales Programme (CRS), and the Rural Family Health Programme which are the two largest components of the FPA's activities.

The CRS Programme lost nearly 1,000 of its retail outlets. Despite these difficulties the programme was maintained and income from sales exceeded operational expenses (i.e. excluding the cost of the contraceptives) by 23% or \$25,000. This is three times the surplus achieved in the previous year. The income from the project has been increasing over the years. Prices have been increased while at the same time "in-kind" contraceptives are being substituted for the more costly brands which were initially used. This is being done according to a phased programme so as not to disturb a market which has been built up with so much effort. Today, about 85% of condom users, and 36% of pill users depend on the CRS programme for their supplies. Changing established brands and price structures must be done carefully.

The FPA has attempted to supplement this programme with a community based distribution programme using rural volunteers, but this has hardly made progress for a number of reasons. It is potentially another useful component in the delivery network for condoms.

The most important aspect of the FPA's activities is undoubtedly the Rural Family Health Programme, through which the FPA has taken family planning into the rural areas. The activities are planned and implemented by local groups. In 1983 246 such groups ("Grass Roots Level Action Committees") were formed in addition to the 217 that were already in operation in the previous year, in selected village areas. The volunteer workers are trained to carry out base-line surveys, prepare registers of eligible couples and carry out motivational activities. 6,500 such volunteers, mainly young people between the ages of 18-32, were trained during the year — an even better achievement than 1982 when 4,200 such volunteers were mobilised and trained for these tasks.

The FPA moves out of a project area after two years leaving behind a core of trained volunteers to continue with these activities, depending largely on their own resources. They are institutionalised in the form of Rural Family Welfare Societies. Following the success of two experimental societies set up in 1982, 37 such societies were established in 1983.

The work of these action committees is supplemented throughout the country by a "Volunteer Force" which increased by 6,500 in 1983 to a total of 21,000. These volunteers are estimated to have contributed in 1983 a total of 1.8 million person hours work, worth about \$476,000. Even if this figure is halved, it represents a

sizeable contribution to the FPA's resources in relation to the IPPF Grant which has accounted for \$296,000.

The FPA continued to run its model clinic at the Headquarters. It provided a full range of contraceptive services, served as a base for various research projects and trained medical personnel. 12 Government doctors were trained in vasectomy and 2 in tubectomy. The Government had arranged for the training of 44 doctors, but was unable to release them for training. In recognition of the useful service provided by the FPA the Government made a grant of approximately \$25,000 towards the cost of the training.

Minimum charges were introduced in the clinic which recovered 76% of its costs — an increase of 41% over 1982.

A second clinic in Kandy was converted into a full fee levying service in the middle of 1983. It is intended to be fully self-sufficient. The experiment will be reviewed in 1984 and the activity continued as such, or terminated.

An innovation introduced in 1983 was a sex education programme for young people. Initially this was a localised project, mainly for urban children in school. It was very well received. The media highlighted this activity and newspapers started their own question and answer columns. Questions are referred to the FPA for answers, and where necessary, those needing further guidance are referred to the FPA's Counselling Centre by the newspaper columns. This initiative has revealed the real need for sex and family life education which has been neglected by both the Government and the private sector.

The Youth Programme also made good progress in 1983. Youth clubs have been established and its members have assisted in a variety of educational programmes, including population education programmes in schools. It was only recently that the Government agreed to introducing population education in schools and depends on the FPA to help in establishing this activity.

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

The Plan is based on six strategies through which the FPA expects to fulfil its role. The most important of them is undoubtedly the strategy for increasing the effectiveness of the National Programme through motivational activities, particularly in the rural areas.

Central to this strategy is the Community Management Rural Family Health Project, which works through local action groups and rural volunteers. It accounts for 82% of the total expenditure in 1984.

When the FPA moves out of these project areas, it will institutionalise the trained volunteers left behind in the form of Family Welfare Societies. 37 such societies

were established as at the end of 1983. The plan is to establish 48 in each of the years 84-87. They will be provided with an initial capital of \$200, for income generating activities to support their projects. Any profits will be shared with the FPA.

The volunteer Force will be expanded over the plan period and their activities and training will be supported by a Volunteer Development Fund in which contributions from the volunteers will be matched by the FPA.

The Contraceptive Retail Sales Programme will increase its outlets from 3,131 to 3,500 in 1984 and by 5% in each of the succeeding years of the plan. While nearly all operational costs are now recovered through sales revenue, the plan envisages recovery of the cost of contraceptives at the rate of 10% a year, with complete self-sufficiency as the final goal.

The CRS Programme which is now operated through wholesalers will be supplemented by a project for direct distribution to retailers. This experiment was tried out this year, and will be extended, since it has shown success.

Efforts will be made to establish a community based distribution programme through rural volunteers — an activity that has had very limited success in the past. 240 distribution units will be established in rural areas as part of the Rural Family Health Programme.

Other activities planned over the next three years include:

- The continuation of the Headquarters' clinic, providing training for 20 doctors each year; a mobile injectable service in three selected villages; and various research projects, with the emphasis on spacing methods.
- Sex education; family life education.
- Youth and Womens' programmes.
- Training of welfare/counselling personnel in Governmental institutions.
- Collaboration with other NGOs.

Together they represent a balanced programme in relation to needs, with the main emphasis on motivational activities in rural areas, based on community support, and with total community self reliance as the goal.

Contraceptives and Commodities

A major cost item has been the supply of contraceptives (condoms and orals) for the CRS Programme. As mentioned earlier the FPA is substituting the in-kind brands for the more expensive brands that have been in use from the inception of the project in order to reduce costs. However, these costs still remain fairly high at \$190,000 in 1985, reducing to \$175,000 in 1987. The major part of this expenditure

by far is on the "Preethi" condom. The quantities decline from 30,000 gross in 1984 to 25,000 gross in 1987, but the costs increase from \$150,000 to \$155,000. The other big cost item, Eugynon, declines from 200,000 cycles in 1984 to 50,000 cycles in 1987 and the costs from \$37,000 in 1983 to \$12,000 in 1987. It is important that the FPA makes every effort to substitute the free brands for these items and gradually attempts to recover the cost of the other brands as long as they remain on the market.

THE ASSOCIATION'S RESOURCES

IN 1985 the FPA will depend on the IPPF cash grant for only 56% of its expenditure budget. It is noteworthy that 90% of the non-IPPF income is derived from local sources in 1985, and is projected to increase to 96% by 1987. The major contribution comes from sales revenue generated by the CRS Programme.

The IPPF cash grant for 1983 was \$296,000, but a substantial part of IPPF support is by the way of cash commodities which cost \$157,000 in 1983 and is budgetted at \$188,700 in 1984.

Since the FPA ranks low on IPPF's needs index, it has developed a number of resource development projects which together constitute an important component of the programme. Some of these are supported from income raised locally. But the FPA must be careful about embarking on projects of a commercial nature, which may not only distract it from its main business of family planning, but present a confused image to the public.

Voluntary Contributions

Perhaps the most important resource of the FPA is its large army of rural volunteers, who carry out the rural programmes in 600 villages. They number about 21,000 and were estimated to have contributed 1,833,978 person hours of work. This included simple base-line surveys, home visits, advice on family health, referrals to Government clinics for family planning and primary health care services, and conducting programmes for youth and women. Their services were valued at over \$400,000 in 1983.

In-Kind Contributions

Local agencies of the Government provide vehicles for the rural programmes, doing 20,000 miles of running in 1983. They have also provided office accommodation for seven District Action Committees. The Municipal Corporation provides the building, water and electricity for one of the two clinics. Free storage space is provided for contraceptives by workers who pack them for the CRS Programme. Village communities also donate materials and facilities for local centres, and food for volunteers working on community development projects.

The total value of all these contributions is projected at \$47,000 in 1985 against an estimated contribution of \$33,000 made in 1983.

THE ASSOCIATIONS' MANAGEMENT CAPACITY

The Association has developed over the last few years a sound management capacity. This is confirmed by IPPF evaluation teams who commented on the sophisticated financial management. A good staff training programme was conducted in 1982. One of the main problems in the past has been finding good marketing staff for the CRS Programme. The demand for such staff, and therefore the turnover, has been high.

A new kind of expertise will have to be developed for the resource development projects and investment funds that the FPA plans to establish. The services of a consultant were provided and his report is being studied. Proposals for implementing his recommendations will be formulated shortly.

WESTERN HEMISPHERE REGION

REGIONAL OVERVIEW

The selection of Latin America as the setting for the International Conference on Population is a reflection of the enormous advances made by this part of the world in understanding population issues and in providing its people with family planning information and services. Mexico itself has established a national effort that is among the most comprehensive of all official programmes in an explicit effort by its government to achieve a balance between population and resources.

Yet for all these advances, great difficulties continue to confront the family planning associations in the Western Hemisphere. The favourable attitudes on the part of some governments are too new to be deep-seated, and the associations remain exposed and vulnerable to changes of regime. Even those associations which seemed most firmly established in the structure of national life, working with the government through signed accords, can suddenly find themselves out in the cold — along with the national programme — when a new administration assumes power. Despite the favouring trend in the Region, individuals that are not convinced of the importance of family planning can be elected to high office or named to key ministries.

Latin American governments, furthermore, have scant tradition of working with NGOs and can object to what they view as intrusions in official spheres. The groundwork for national programs has invariably been laid by the pioneering efforts of the IPPF affiliates. Yet when governments establish programs, they sometimes see the private association as an unwanted competitor rather than as a source of innovative co-operation. The association is left floundering in its attempts to redefine its role vis-a-vis the government program.

Family planning continues to have its enemies in Latin America in the political extremes of both right and left and in conservative religious movements. Associations have been subject to attacks orchestrated throughout Latin America in search of targets of opportunity. They have sometimes found good targets and have caused damage to programs. After subsiding somewhat in the last few years, these attacks have revived, to become even more violent in 1983.

The Caribbean associations, although they work in a generally favourable climate, encounter similar difficulties from time to time. Associations everywhere in the Western Hemisphere are faced with an unrelenting need to carry out leadership education. In 1983, the special program of Population Information for Policy Makers (PIPGM) completed 2½ years of work in five selected countries of Latin America — Brazil, Ecuador, Guatemala, Honduras, and Peru. That Brazil should announce a national program, as it did in 1983, resulted from 20 years of effort by the Brazilian association, and involved education directed toward professional and

religious leaders as well as the political structure, and toward the creation of a favourable public opinion.

Of first importance in the Region has been the growth of a movement among parliamentarians interested in population and development. The Inter-American Parliamentary Group (IAPG) was born in a regional meeting of parliamentarians held in Brasilia in December, 1982. The movement took shape in 1983 with efforts directed toward the organization of national groups of parliamentarians that will eventually constitute the elements making up the IAPG. IPPF/WHR is co-operating wholeheartedly with this movement. A special grant from the Mellon Foundation has enabled the Regional Office to assist in providing legislators and opinion leaders, at their request, with information on critical issues of population and development.

The insulation of the associations from the shifting winds of politics requires them to seek the eventual goal of financial self-sufficiency. The Regional Office continues to implement a well developed regional strategy which includes resource development workshops and provides associations with direct technical assistance in fund raising. The grant-receiving associations in the Western Hemisphere expended a total of about \$30 million on programme in 1983, of which less than half came from IPPF's grants in cash and commodities.

In 1983, the Regional Office received a three-year grant of \$200,000 from the William and Flora Hewlett Foundation in support of technical assistance to resource development activities. An interesting aspect of this grant is that it provides matching funds — up to \$20,000 per association — when funds are raised locally from diversified sources. The grant should therefore serve not only to stimulate local fund raising but to offer local donors an extra reason for providing their support.

The Regional Office continued to serve as an executing agent for two USAID grants in the Caribbean area; one to CPFA, and another to seven countries of the Eastern Caribbean in support of activities in population and development. Still another grant is used to expand family planning activities in Ecuador. The management of these major efforts has called for the establishment of field offices — in Antigua, Barbados and Ecuador, respectively. In 1983, the Regional Office became executing agent for grants made by the United Nations Fund for Population Activities (UNFPA), one to expand family life education and family planning services in Guyana, the other to promote population education and extend non-clinical services into rural areas of Suriname.

In 1983, the family planning associations in Latin America and the Caribbean attracted 651,008 new acceptors to the practice of family planning in their 1,334 clinics. In addition, they brought in 574,673 new acceptors through community services based on 11,984 distribution posts. They also handled the needs of 2,753,000 continuing acceptors. To these figures should be added some 700,000 new acceptors enrolled in family planning by the Planned Parenthood Federations of

Canada and the United States, plus the services the two Federations provided to somewhat more than 3 million continuing acceptors.

Thus, the associations continued on the whole to deliver effective performances. If there is a surprise in this, it is to be found in the achievement of program goals in the countries of Central America where violence and civil war continued to take their toll. The association in El Salvador has persisted in working in all provinces, refusing to be hampered by continuing combat.

In Guatemala, a supervisor and a worker were killed as they went about their tasks of bringing family planning to indigenous groups in rural areas. This special program was restructured to take it out of the most dangerous areas, but it has continued nonetheless, and with considerable success. In Grenada, despite chaos and invasion, the association doubled the number of its new acceptors.

In Argentina, the association's new four-story headquarters was severely damaged by a bomb planted there by members of a right-wing terrorist group. Association personnel received threats against their lives through anonymous telephone calls. They went ahead anyway, repaired their headquarters, and reopened it as soon as they could. The incident, and their courage in facing it, had the ultimate effect of generating an enormous outpouring of sympathy for the association as it continued to work in a country that has taken the lead in the Region in expressing pronatalist values.

The technical assistance requested by the associations in the Western Hemisphere — particularly in management development, leadership education and resource development — continued in 1983 to make heavy demands on the Regional Office, as indeed it should. The office nevertheless continued the streamlining process through seeking to reduce overhead costs. Supporting activities — such as information and education, library, publications statistics and evaluation — were grouped together in one Division of Program Support in the interests of efficiency. Also in 1983, the Region complied with the Central Executive Committee's request to establish a regional Bureau in London.

ANGUILLA

The Anguilla Family Planning Association (AFPA) provides information and education in support of a government programme of services in this smallest community in the world (total population: 7,700) to have an IPPF member. The association has found the major unmet need in "the lack of awareness among adolescents, particularly in rural areas"

ANTIGUA AND BARBUDA

The Antigua and Barbuda Planned Parenthood Association (ABPPA) assisted the government in 1983 to prepare staff and facilities to begin offering services through

a national programme. The association will provide support from that programme through information, family life education, research and training, the operation of its own clinic and community services in the capital city.

ARGENTINA

As the Asociación Argentina de Protección Familiar (A.APF) survived the bombing of its headquarters, the atmosphere improved for family planning as the government showed signs of moving away from an inflexible pronatalism. The association has succeeded in setting up a service network of 17 co-operating clinics in prestigious locations, including university teaching hospitals.

ARUBA

The government provides the major support to Aruba's Foundation for the Promotion of Responsible Parenthood (FPRP) in return for a national programme carried out in the association's clinic, in outside centres and through a network of co-operating physicians. A favourable birth rate and low infant mortality indicate that the association has presented its message with success.

BARBADOS

The Barbados Family Planning Association (BFPA), affiliated in 1954 as a charter member of the Region, has provided the country with a national programme that succeeded in reducing the growth rate to 0.9% by 1983, lowest in the Western Hemisphere. The entry of government into services has freed the association to concentrate on working with youth and promoting male motivation.

BERMUDA

YHED Teen Services, a private group working in co-operation with the Ministry of Health, joined the Caribbean Family Planning Affiliation (CFPA) in 1982. Teen Services operate a multimedia campaign against unwanted teenage pregnancy.

BOLIVIA

While generally favouring higher rates of population growth, government policy is unsettled, enabling the Centre for Family Orientation to make family planning available through labour unions and community organizations and a network of collaborating physicians. In 1983, COF helped unions in Santa Cruz and Sucre to open family planning clinics.

BRAZIL

It used to be said that the Sociedade Civil Bem Estar Familiar no Brasil (BEMFAM) was IPPF's largest affiliate in the Third World because it was at work

in the largest country without any government programme. In 1983, Brazil's Federal Government announced that a national programme would at last begin — under the administration of the Ministry of Health. Twenty years of work by BEMFAM paved the way for this change in national policy, during which time, the association developed a nationwide clinical network and the largest of all programmes of community services, offering family planning on a statewide basis in seven of Brazil's 20 states.

BRITISH VIRGIN ISLANDS

Family Tree centres its attention on family health and welfare. In schools and communities, it provides consultation services on parent-child relationships, parenting effectiveness and male participation in family planning.

CANADA

The 50 affiliate members of the Planned Parenthood Federation of Canada are scattered over 4,000 miles from Nova Scotia to Vancouver Island and north to the Yukon and the Canadian Arctic. The Federation's achievements have given rise to backlash attacks by conservative religious groups, and these jeopardized the support which the national government has provided to the Federation. A vigorous and aggressive response to attack has helped the Canadians to stabilize their threatened situation.

CARIBBEAN

The Caribbean Family Planning Affiliation (CFPA) is a subregional grouping unique within IPPF's structure, that provides affiliation to 18 small associations in Caribbean countries and territories. These are Anguilla, Antigua/Barbuda, Aruba, Bermuda, British Virgin Islands, Curacao, Dominica, Grenada, Guadeloupe, Guyana, Martinique, Montserrat, St. Kitts-Nevis, St. Lucia, St. Maarten, St. Vincent, Suriname and the U.S. Virgin Islands. Some 1,750 miles separates Bermuda from Trinidad-Tobago, and over this considerable distance, CFPA serves as a communications link, providing a forum for the exchange of experience and offering its members technical assistance, particularly in information and education. From its headquarters in Antigua, CFPA is engaged in a massive effort to advance family life education and strengthen programmes directed toward youth.

CHILE

The Asociación Chilena de Protección de la Familia (APROFA) continues to move into the breach as the government withdraws from family planning services. This was the first national program in Latin America, with the association working only in information, training, research and as a channel for contraceptive supplies. It has managed to return to services through co-operative arrangements with other organizations, such as the Red Cross and the Child Nutrition Corporation. It is

centering its service activities in remote provinces and in pockets of poverty that are most likely to be missed by the government.

COLOMBIA

Through its 28 clinics and its 3,534 distribution posts, the Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA) attracted 268,000 new acceptors in 1983. Of those who came to the clinics, 51,295 requested voluntary sterilization, a figure which included 676 men. This inventive association, the first in the Region to organize community services and to develop mass-media campaigns on a nationwide scale, is engaged in an ever larger programme of social marketing, which places contraceptives in retail outlets at subsidized prices. A majority of Colombians who practice family planning do so through organized services and most of these are served by PROFAMILIA.

COSTA RICA

During 1983, the Asociación Demográfica Costarricense (ADC) continued its efforts to consolidate the national family planning programme after it had been suspended for four years by an administration opposed to it. It is back once again providing mass media support to the government's programme of services. At the same time, it has taken a fresh interest in youth as a problem of unwanted teenage pregnancy has become evident in Costa Rica. It is developing participatory approaches to young people outside of school.

CURACAO

The Foundation for the Promotion of Responsible Parenthood (FPRP) is paid by the government of the Netherlands Antilles to provide information and research, education and training in support of the government's services. The Foundation operates one model clinic where it can conduct practical research and succeeded in getting more centres opened in 1983. Curacao's low birth rate testifies to the success of the Foundation's partnership with government.

DOMINICA

Both the country and the association, the Dominica Planned Parenthood association (DPPA), are continuing their recovery from the 1979 hurricanes that destroyed the island's agricultural base. In the improved conditions evident in 1983, the association reviewed and restructured the information programme it carries out in the field in support of government services. The reinvigorated association launched a community-based contraceptive marketing project and began providing high school students with family life education.

EL SALVADOR

The country is in a state of civil war. In spite of this, the Asociación Demográfica

Salvadoreña (ADS) achieved a series of difficult programme objectives. Distribution posts for community services were increased by one-third in 1983, bringing them to a total of 1,814, while almost quadrupling the number of acceptors (to over 16,000). The increase in voluntary sterilizations — to 6,043 — was in high degree due to the community programme's successful referral services. It was the year in which community posts were established in all provinces, even in those most affected by the conflict.

GRENADA

The Grenada Planned Parenthood Association (GPPA) continued to expand its community distribution posts, and achieved increased in new acceptors both in its clinic and in the field in spite of war and invasion. Its remodeled community outreach education programmes functioned uninterrupted through the political crisis.

GUADELOUPE

The Association Guadeloupéenne pour le Planning Familiale continued to receive technical assistance from the CFPA in the development of multimedia campaigns intended to invigourate the government's programme of services.

GUATEMALA

The Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM) continues to be a regional leader in family planning. It consistently records the highest number of male sterilizations in Latin America. In spite of the violence through which Guatemala has been passing, APROFAM has reached most of its programme targets. It is conducting special programmes for youth and for women's development. It is at last showing success in the most persistent and most comprehensive effort in the region to bring the family planning message to indigenous peoples.

GUYANA

The Guyana Responsible Parenthood Association (GRPA) completed two years of an expanded programme in family life education directed toward a severe problem of unwanted teenage pregnancy. In co-operation with the government, GRPA has been placing family planning services in national health centres. An additional 25 centres were added to the system in 1983, bringing the total to 108 out of 163 centres in the country.

HONDURAS

The Asociación Hondureña de Planificación de la Familia (ASHONPLAFA) achieved a major goal in 1983 when the Ministry of Public Health prepared a "Sub-

Program for Family Planning" to be applied in 1983-86. Meanwhile, the association continues to provide services, in its own two clinics and through community services available at 1,059 distribution posts. ASHONPLAFA is developing a new focus on youth, and in 1983 presented more than 100 courses in family life education.

JAMAICA

Increasingly, the Jamaica Family Planning Association (JFPA) serves as a laboratory for the national programme it helped to create. This has directed the association into special programmes directed towards youth, male motivation, rural populations and the advancement of women.

MARTINIQUE

The Association de Martinique pour l'Information et l'Orientation de la Famille (AMIOF) provides information and education in support of services that are incorporated into the government's maternal health care programme.

MEXICO

The Fundación Mexicana para la Planificación Familiar (MEXFAM) continued in 1983 the reorganization called for in response to the expansion of government services. MEXFAM delivered its services through 37 clinics and a community programme embracing the State of Veracruz. A pilot effort to reach indigenous groups was carried out via railroad car in two northern states. MEXFAM was headed for a new role in which the association will act as a watchdog on the comprehensive programme carried out by the government.

MONTSERRAT

The Montserrat Family Planning Association (MFPA) has begun implementing a national information plan developed with CFPA technical assistance in collaboration with the government. The information campaign will seek to increase knowledge of family planning while supporting clinical and community services.

NICARAGUA

The Asociación Demográfica Nicaraguense (ADN) is carrying out its work in a state of national emergency with critically difficult situations in some parts of the country. Nonetheless, the ADN continued to offer clinical and community services and to provide support to an emerging government programme.

PANAMA

The Asociación Panameña para el Planeamiento de la Familia (APLAFA) completed construction of its new headquarters in San Miguelito, the fastest growing urban area in the nation, where its programmes place their main emphasis

on youth. Some 17,000 people, most of them teenagers, attended APLAFA's seminars and training courses in 1983.

PARAGUAY

The Centro Paraguayo de Estudios de Población (CEPEP) completed a reorganization which succeeded in producing increases in the number of acceptors. This was helped by an experimental use of radio in the interior of the country as a means of promoting CEPEP's clinics. The association has a major interest in advancing sex education in the country.

PERU

The Instituto Peruano de Paternidad Responsable (INPPARES) operates community health centres in two low-income suburbs of Lima and another in Nazca Province, as well as clinical outreach programmes in Cuzco and Quillabamba and a center for the prevention of induced abortion in Arequipa. INPPARES is planning an expanded course of action in an improved national climate in which the government announced its intention to invigourate its national programme.

PUERTO RICO

The Asociación Puertorriqueña Pro-Bienestar de la Familia (APPBF) fashioned its aggressive response to the loss of its financial support due to budget stringencies emanating from Washington, D.C. In 1983, the Department of Social Services renewed its contract with the association after a 14-month interruption and prospects appeared favourable that support from the Commonwealth Legislature might be renewed.

ST KITTS-NEVIS

The St. Kitts-Nevis Family Planning Association (SKFPA) employs outreach workers to conduct home visits in support of the government's programme of services. The association operates its own model clinic, which was relocated from an outlying location to the capital city, and also provides community services. A national information plan was developed with CFPA technical assistance.

ST. LUCIA

To its links with the health community, educators and the mass media, the St. Lucia Planned Parenthood Association (SLPPA) has forged links with industry to provide information directly in factories. A community program began operation in 1983, and a national information plan was developed with CFPA technical assistance.

ST. MAARTEN

The Foundation for the Promotion of Responsible Parenthood (FPRP) provides information and education in support of services made available by the Government of the Netherlands Antilles.

ST. VINCENT

The St. Vincent Planned Parenthood Association (SVPPA) centres its work on family life education in a country where services are provided by the government. It is pioneering ways of involving parents and teachers in programmes aimed at youth.

SURINAME

The Stichting Lobi (LOBI) maintains a steady level of clinical services while strengthening its relations with government in a national atmosphere that was at first hostile to its work. It conducts extensive youth education and training.

TRINIDAD AND TOBAGO

The Family Planning Association of Trinidad and Tobago (FPATT) is planning to restructure its community programme into a social marketing project. It continues to operate two model clinics and to carry out an extensive informational activity in support of government services.

UNITED STATES

The Planned Parenthood Federation of America (PPFA), with 190 affiliates serving some 1.5 million clients annually in more than 700 clinics, is the largest private health network in the United States. In 1983, the Federation was still locked in battle against forces "which would reverse the gains made by women in this century". As PPFA declared: "Whereas few movements in modern history have contributed more than family planning to the quality of life, efforts to reverse this progress nevertheless persist".

U.S. VIRGIN ISLANDS

The U.S. Virgin Islands Family Planning Association (VIFPA) has begun information activities based on a baseline study of contraceptive knowledge. Special emphasis has been placed on constructive dialogue with religious leaders.

URUGUAY

The Asociación Uruguaya de Planificación Familiar e Investigaciones sobre Reproducción Humana (AUPFIRH) is taking advantage of an increasingly open political climate to expand its works with public and private agencies. In doing so, it has concentrated on three basic programme thrusts: integration into government agencies, including the armed forces, community services in marginal areas and developing a network of doctors to provide services in the interior of the country.

EXPENDITURE SUMMARY - Western Hemisphere REGION

1983 Actual

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Anguilla	3.9	0.7	4.6	0.1	(2.9)	1.8
Antigua	53.3	6.0	59.3	13.9	(1.3)	71.9
Argentina	163.9	23.5	187.4	92.6	2.5	282.5
Aruba	9.1	2.7	11.8	61.9	-	73.7
Barbados	85.2	16.5	101.7	246.4	(19.0)	329.1
Bolivia	113.2	50.7	163.9	18.2	(5.4)	176.7
Brazil	2150.8	881.3	3032.1	2219.0	530.5	5781.6
Caribbean	82.4	0.1	82.5	238.9	(8.2)	313.2
Chile	701.5	448.6	1150.1	41.9	(48.8)	1143.2
Colombia	1560.0	870.7	2430.7	4633.1	61.9	7125.7
Costa Rica *	291.4	320.3	611.7	105.2	84.5	801.4
Curacao	12.0	5.9	17.9	136.1	(6.1)	147.9
Dominica	28.3	7.7	36.0	1.0	1.7	38.7
Dominican Republic	337.9	61.9	399.8	898.8	(43.3)	1255.3
Ecuador	285.8	104.7	390.5	218.6	(85.8)	523.3
El Salvador	437.3	43.0	480.3	1571.4	(113.8)	1937.9
Grenada	67.8	25.2	93.0	52.7	(1.4)	144.3
Guatemala	461.6	74.0	535.6	2103.4	(209.8)	2429.2
Guyana	35.0	24.3	59.3	47.7	6.2	113.2
Honduras	329.4	37.1	366.5	892.5	86.7	1345.7
Jamaica	60.9	20.4	81.3	105.9	29.3	216.5
Mexico	963.3	10.4	973.7	217.5	(198.6)	992.6
Montserrat	27.2	0.7	27.9	8.5	(4.8)	31.6
Nicaragua	245.0	24.7	269.7	53.8	30.2	353.7
Panama	129.2	2.2	131.4	115.9	(8.2)	239.1
Paraguay	314.9	64.6	379.5	109.5	(17.1)	471.9
Peru	245.4	112.8	358.2	87.6	13.8	459.6
Puerto Rico	-	35.0	35.0	504.5	224.0	763.5
St. Kitts	41.0	16.4	57.4	15.1	(3.8)	68.7
St. Lucia	60.3	11.2	71.5	32.0	9.0	112.5
St. Vincent	29.8	-	29.8	0.7	-	30.5
Surinam	94.0	15.5	109.5	102.7	(39.1)	173.1
Trinidad & Tobago	181.0	9.9	190.9	332.9	5.3	529.1
Uruguay	157.4	41.2	198.6	6.6	11.2	216.4
* Unaudited Accounts						
TOTAL	9759.2	3369.9	13129.1	15286.6	279.4	28695.1

EXPENDITURE SUMMARY - Western Hemisphere REGION
1984 Latest Estimate

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Anguilla	4.5	1.6	6.1	1.1	1.2	8.4
Antigua	53.3	7.4	60.7	50.2	(11.2)	99.7
Argentina	150.0	29.7	179.7	108.0	-	287.7
Aruba	10.1	4.6	14.7	56.3	3.0	74.0
Barbados	86.0	16.6	102.6	261.7	22.8	387.1
Bolivia	139.1	35.3	174.4	59.0	7.6	241.0
Brazil	2185.0	990.0	3175.0	3087.1	845.1	7107.2
Caribbean	98.9	1.1	100.0	288.7	(2.3)	386.4
Chile	688.1	740.9	1429.0	69.6	(7.9)	1490.7
Colombia	1515.8	762.5	2278.3	4793.8	680.2	7752.3
Costa Rica	335.1	227.2	562.3	322.1	-	884.4
Curacao	10.0	7.3	17.3	139.8	(0.1)	157.0
Dominica	38.2	6.6	44.8	5.1	-	49.9
Dominican Republic	356.0	19.6	375.6	628.4	-	1004.0
Ecuador	315.4	50.6	366.0	340.7	28.0	734.7
El Salvador	465.0	73.1	538.1	1599.1	(100.7)	2036.5
Grenada	74.5	19.8	94.3	11.6	-	105.9
Guatemala	506.1	68.7	574.8	2107.7	-	2682.5
Guyana	48.3	57.8	106.1	112.5	-	218.6
Honduras	364.9	6.3	371.2	1890.9	(2.8)	2259.3
Jamaica	70.0	32.9	102.9	71.0	-	173.9
Mexico	967.7	38.5	1006.2	233.6	-	1239.8
Montserrat	25.8	2.0	27.8	12.5	7.4	47.7
Nicaragua	281.7	25.8	307.5	43.6	(69.3)	281.8
Panama	134.6	0.4	135.0	207.8	-	342.8
Paraguay	235.0	23.2	258.2	97.4	(56.4)	299.2
Peru	298.5	250.1	548.6	299.7	(61.1)	787.2
Puerto Rico	14.5	30.0	44.5	1643.0	-	1687.5
St. Kitts	38.1	9.3	47.4	4.9	-	52.3
St. Lucia	60.3	35.0	95.3	46.9	-	142.2
St. Vincent	25.5	0.6	26.1	4.2	-	30.3
Surinam	106.0	11.6	117.6	125.3	(15.7)	227.2
Trinidad & Tobago	226.0	20.8	246.8	478.9	-	725.7
Uruguay	170.2	42.2	212.4	30.5	6.2	249.1
TOTAL	10098.2	3649.1	13747.3	19232.7	1274.0	34254.0

EXPENDITURE SUMMARY Western Hemisphere REGION
1985 Budget

All Figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms.	Total			
Anguilla	3.8	4.2	8.0	1.1		9.1
Antigua	55.0	6.2	61.2	70.4		131.6
Argentina	150.4	52.9	203.3	85.0		288.3
Aruba	9.8	6.1	15.9	62.3		78.2
Bahamas	28.7	4.7	33.4	-		33.4
Barbados	83.9	23.0	106.9	260.0		366.9
Bolivia	132.9	49.1	182.0	127.5		309.5
Brazil	2055.3	750.0	2805.3	1358.6		4163.9
Caribbean	103.8	0.8	104.6	231.8		336.4
Chile	725.0	615.4	1340.4	41.9		1382.3
Columbia	1329.1	1221.6	2550.7	4697.6		7248.3
Costa Rica	373.9	333.8	707.7	457.5		1165.2
Curacao	9.3	11.5	20.8	134.5		155.3
Dominica	38.5	3.0	41.5	10.9		52.4
Dominican Republic	359.2	113.3	472.5	858.6		1331.1
Ecuador	319.3	49.6	368.9	553.9		922.8
El Salvador	523.7	96.2	619.9	1982.9		2602.8
Grenada	73.6	18.9	92.5	21.8		114.3
Guatemala	476.7	132.3	609.0	2194.0		2803.0
Guyana	51.9	84.3	136.2	36.9		173.1
Honduras	374.4	45.4	419.8	1768.3		2188.1
Jamaica	65.9	42.3	108.2	80.0		188.2
Mexico	1013.9	1.5	1015.4	661.2		1676.6
Montserrat	27.3	1.8	29.1	18.6		47.7
Nicaragua	240.5	114.7	355.2	148.2		503.4
Panama	128.6	3.7	132.3	181.1		313.4
Paraguay	189.2	15.4	204.6	122.8		327.4
Peru	253.7	200.0	453.7	287.5		741.2
Puerto Rico	29.2	18.9	48.1	1221.6		1269.7
St. Kitts	38.2	9.5	47.7	11.6		59.3
St. Lucia	59.8	42.3	102.1	41.3		143.4
St. Vincent	22.8	1.2	24.0	6.0		30.0
Surinam	110.0	32.9	142.9	116.1		259.0
Trinidad & Tobago	212.3	20.5	232.8	635.3		868.1
Uruguay	186.1	38.6	224.7	58.3		283.0
TOTAL	9855.7	4165.6	14021.3	18545.1		32566.4

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURES BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US\$'000)

WESTERN HEMISPHERE

	<u>SUPPLIES PURCHASED BY IPPF</u>		
	ACTUAL EXPENDITURE	ESTIMATED EXPENDITURE	PROJECTED EXPENDITURE
	<u>1983</u>	<u>1984</u>	<u>1985</u>
Contraceptives	1548.4	1387.3	1616.6
Medical & Surgical	101.4	88.3	109.7
Audio Visual Equipment	34.8	24.0	21.8
Office Equipment	31.0	72.2	42.0
Transport	27.8	90.8	61.2
	<u>1743.4</u>	<u>1662.6</u>	<u>1851.3</u>
TOTAL	<u>1743.4</u>	<u>1662.6</u>	<u>1851.3</u>

	<u>AID SUPPLIES DONATED TO IPPF</u>		
Contraceptives	<u>1532.4</u>	<u>1986.5</u>	<u>2314.3</u>
FULL TOTAL	<u>3275.8</u>	<u>3649.1</u>	<u>4165.6</u>

DOMINICAN REPUBLIC

ASOCIACION DOMINICANA PRO-BIENESTAR DE LA FAMILIA (PROFAMILIA)

COUNTRY BACKGROUND

The Government of the Dominican Republic has renewed its support for family planning programs and given greater consideration to population issues as they relate to the serious socio-economic problems that currently prevail in the Dominican Republic. The Ministry of Health officially opened the deliberations of the Fifth World Conference on Voluntary Surgical Contraception which took place in Santo Domingo in December, 1983, and clearly expressed its commitment to make services available to satisfy unmet demand.

The role of the Association, in the coordination and management of the Conference as well as in the visibility of its activities in sterilization, area, confirmed the institution's maturity and the acceptability of this philosophy and programs in the national environment. There was no adverse public reaction despite wide coverage of the event by the media. The interaction with journalists on the subject of surgical contraception made evident the need to improve the information available to opinion leaders (including journalists) on family planning and population issues.

The Association's relations with the government continues to improve during 1983 as can be attested by the cooperation and support received from and given to various government agencies. PROFAMILIA has done a strong follow-up to the 1982 Brasilia Conference of Parliamentarians and, as a result, there is a movement to create a Commission on Population and Development in the National Congress during 1984.

The National Family Planning Program (PNPF) includes the activities of CONAPOFA, the rural health system Atención Rural Dispersa (ARD) and PROFAMILIA. As of December 1983, 20% of the women of fertile age were covered by the program. This, in terms of the data available from the National Fertility Survey of 1980, means that the PNPF is covering 80% of the people practicing family planning in the Dominican Republic.

The public sector offers services in 450 health posts, 36 urban hospitals and two national maternities. The education and information components of the public program are weak. The lack of an educational policy for adolescents is a significant void which the FPA is trying to fill.

Catholic groups have been promoting "natural" methods as opposed to the use of "artificial" contraceptives but there has been no direct opposition to family planning.

The population totals 6.1 million, of whom 45.2% live in rural areas in condition of poverty. Infant mortality is estimated at 67 per thousand nationally, and gastrointestinal and parasitic diseases elevate the rate considerably in rural areas. The rate of natural increase is estimated to be 2.4% which represents an encouraging decline from the 3.1% of 1970.

A special reference has to be made to the acute worsening of the economic situation experienced during the first part of 1984. The impact of drastic fiscal policies under consideration, social unrest and the political instability that arise from the first two considerations, cast shadows on the national climate for the remainder of 1984. Furthermore, the excellent planning ability demonstrated by the FPA in recent years will be put to the test during 1985, since there is an unusually high degree of uncertainty about future fluctuations in the foreign exchange and inflation rates.

THE ROLE OF THE ASSOCIATION

PROFAMILIA has described its role as follows:

To contribute to the improvement of the quality of life in the Dominican Republic within the context of a national development policy and to raise the level of awareness among national leaders and decision makers about the incidence of demographic factors and trends on the overall socio-economic development process so that it will lead to more rational and effective planning for development.

The Association's role has evolved out of intellectual conviction and practical experience. PROFAMILIA's legitimacy as an institution interested in the welfare of the Dominican family is widely recognized. The credibility of both volunteers and staff and public opinion regarding the FPA rank it high among charitable organizations in that country.

THE PAST PERFORMANCE OF THE ASSOCIATION

PROFAMILIA's activities during 1983 have met with greater success than ever before. The Association began to implement new projects, undertook the responsibility of coordinating a World Conference of 350 participants from 76 different countries and received several requests from world famous organizations to small national groups inviting members of the professional staff to make expert presentations to influential audiences. All these were accomplished above and beyond the implementation of the continuing program.

I&E and training activities included the use of radio, TV, printed materials, community talks, film showings, lectures, seminars, and training workshops. The 180 radio programs produced reached most of the country through several radio stations in 258 broadcasts. Forty eight 30-minute weekly TV programs were also broadcast. Correspondence received from the audience was used for evaluation purposes and to adjust the program's content and scope according to community

needs and perceptions. Small group activities reached more than 10,000 people, including adolescents in high schools and community workers in labor unions and government agencies and soldiers in the armed forces, while the documentation center and library provided information services to more than 300 professionals and college students working on public health or population-related topics. Some 92,000 copies of educational materials were distributed, a significant increase over the 63,000 used throughout the program during 1982.

The Institute for Studies on Population and Development (IESPD), which functions as a specialized unit outside PROFAMILIA's headquarters experienced some difficulties in reaching the full scope of its intended audience. The quality of the materials produced was high, and PROFAMILIA was able to trace the impact of published data to the highest level in the national government.

The FPA's medical and clinical program included operation of a Center for Research and Services on Human Reproduction (CINSERHA — formerly the Model Clinic, reorganized in 1982), conducting medical research on new contraceptive technology with support from the Population Council, and delivery of surgical contraceptive services in cooperation with public and private centers. PROFAMILIA reported 4,625 new and 3,105 continuing acceptors at the clinic at the end of 1983. The number of voluntary sterilizations performed during 1983 was 7,533 (7,415 female and 118 male acceptors).

The CBD program maintained 157 distribution posts (37% rural and 63% urban) and reached 10,205 new acceptors in 1983, compared to 10,153 in 1982. The CBD program was an important source of referrals for voluntary sterilizations (464 female and 12 male). In addition, considerable progress was made in the coordination of activities with the ARD.

The 1984 program is proceeding according to plan and appears to be repeating last year's success.

THE ASSOCIATION'S THREE YEAR PLAN 1985-1987

Strategies and Projects

PROFAMILIA has designed six strategies to carry out its stated role during the 1985-87 period:

Strategy I. To bring family planning services to marginal groups and those living in areas where other services are not readily available or are not meeting existing demand.

CINSERHA

The activities of this model Center will include:

- a. Serving 9,000 continuing acceptors and increasing those numbers at a rate of 5,000 new acceptors per year.
- b. Conducting research on new contraceptive technology under the auspices of the Population Council.
- c. Training medical and paramedical personnel of the PNPF. This project is to be supported by the Population Council and the IPPF in partnership with the government.

Voluntary Surgical Contraception.

Voluntary sterilization services will be provided to 15,800 female and 200 male acceptors, and will be performed at 51 private clinics in 19 provinces.

Community Based Distribution.

This project will cover rural areas in 10 provinces with 2,000 inhabitants or more, (mostly in Cibao, one of the poorest regions of the country) and in marginal urban areas of that region and Santo Domingo. The FPA plans to reach 10,240 new acceptors in 1985, with a 10% increase in subsequent years. Six promoters, one supervisor, and a project coordinator will supervise community volunteers who operate on a commission basis. The supervisors will provide educational, information and training support to the project, while the CBD program in general will act as a referral mechanism for IUD insertion in clinics and voluntary surgical contraception. This project will be financed by general program funds.

Family Planning for Working Women in Santiago.

This innovative project will continue to offer services to women who cannot attend family planning clinics during regular hours. Located in Santiago, the most industrialized city in the Dominican Republic, the project aims to serve almost 2,500 acceptors during 1985 and refer an additional 10% for permanent contraceptive methods. Pathfinder is expected to cover 39% of the expenses, and the fees from patients to provide 22%. The clinic should be self-sufficient by 1988.

Strategy II. To carry out information and education activities directed to different segments in society in order to meet an increasing demand for knowledge on issues related to family planning, sex education and family welfare.

Radio and Television.

The FPA proposes to continue and improve its mass media project using radio (254 programs) and television (50 programs). PROFAMILIA will design and produce its own TV programs to reach the rural and urban poor, with an emphasis on youth (estimated number of people in reproductive age in the audience: 500,000 for radio and 50,000 for television).

Center for Adolescents.

Four years ago the authorities of a major public secondary education institution agreed to the establishment of this center. The FPA plans to continue with the training of adolescents as multipliers and will utilize the school population to test a newly developed curriculum for sex-education until June 30, 1985. At that time, the project will be expanded to 14 additional high schools under the Secretary of Education's control, and PROFAMILIA will retain the responsibility for providing adequate technical assistance.

Training of Youth Leaders and Social Club Officers.

The Association of Santo Domingo social clubs which represents 71 neighborhood organizations and their 13,000 members has agreed to include sex education and family planning as a topic in their regular educational efforts.

Family Life Education for Home Economics Students.

Development Associates will fund the training of 900 students attending classes at the Ministry of Education's vocational schools in Santo Domingo.

Family Planning Training for Leaders of Community Organisations.

This is a small innovative project to train 60 leaders of community organizations in areas where CBD program operations need to be strengthened.

Strategy III. To encourage by means of pilot projects the development of women and men living in marginal conditions, so that they can experience a sense of improvement in the quality of their lives.

Integral Women's Development.

This project aims at improving the health of women in rural communities while providing mechanisms for their integration into the mainstream of economic activity. The project will cover 1,000 families in five rural communities and will work with 150 women in economic partnership, through a revolving fund for cooperative loans.

This project is to be fully financed by the United Nations.

Integration of Urban Marginal Women to Food Production.

This project involves the cooperation of the Ministry of Health, the CBD staff, several national NGOs and the US Peace Corps. Women in the slums of Santiago, the major industrial city of the Dominican Republic will cultivate legumes, will sell half their production at cost in the community, and the rest for profit in local markets.

Strategy IV. To carry out activities that will educate opinion leaders and decision makers, increasing their awareness and understanding, so that demographic factors

are included in development planning.

Center for Studies on Population and Development.

PROFAMILIA continues to assign a great deal of importance to the activities of the IEPD. The Centre will publish articles on population and development through the press, produce bulletins and hold seminars and workshops.

This project is to be financed by the USAID mission in the Dominican Republic.

Documentation Center and Library.

The importance of Profamilia's Documentation Center and Library has been strengthened by the establishment of the IEPD. In order to improve the support that the Center can provide to the IEPD, the staff has been trained by the CEPAL-Chile.

Public Relations.

This project will consolidate and articulate the institution's public relations initiatives. It will include income generating activities such as the production of PROFAMILIA's Calendar.

Strategy V. To carry out activities and socio-economic studies leading to institutional growth and resource development.

Local Resource Development.

This project is financed from the general fund and aims to raise income locally.

The FPA hopes to receive \$99,090 in cash contributions in 1985, \$110,400 in 1986, and \$143,002 in 1987.

Strategy VI. To develop and strengthen the institutional presence in the interior by means of decentralized branches.

One project covers the activities of three employees working in Santiago (Cibao), where a valuable core of volunteers has been instrumental in promoting the image of the FPA.

Several project activities are also supported from this branch.

Project Support

The salaries of departmental heads, their support staff and their per-diem expenses related to supervisory functions are the main items budgeted under this category.

Administration and General Services

Due to unprecedented changes in inflationary rates, the Association had to adjust

salaries on three occasions during 1983 and in early 1984. There is a moderate increase (13%) planned in 1985 to provide for salary adjustments.

Contraceptives and Commodities

In 1983 the use of oral contraceptives has shown a marked increase. The Association is requesting contraceptives mostly to support CBD activities.

THE ASSOCIATION'S RESOURCES

Non-IPPF Income

The FPA has been able to secure increasing non-IPPF support for its programs, and special emphasis has been given to local fund raising activities. In all areas, diversification of income sources has been a major objective.

Non-IPPF income covers almost 75% of the current budget. In 1982, the United Nations Voluntary Contribution Fund for the Women's Decade and the USAID mission in the Dominican Republic made grants to PROFAMILIA for the first time, recognizing unmet needs and the FPA's positive public image.

Personnel

In recent years, the association had to increase its personnel in response to a substantial program expansion. The ratio of personnel costs to total expenditures from 1984 onward would be approximately 40%.

Voluntary Contributions

The strength of the FPA in the context of other worthy charitable organizations in the Dominican Republic is due largely to the active involvement of prestigious volunteers. It would be difficult to overestimate the value of this kind of support.

In-Kind Contributions

In-kind donations have been significant in recent years. The national coverage provided by the mass media during 1983 had a real market value of \$61,000.

495 press items were published in nine national newspapers, including 92 interviews on population related issues and 359 news releases on other substantive issues, in addition to simple announcements about PROFAMILIA events.

The national telephone company sponsored the publication of four pamphlets (1,000 each) on health and family planning topics.

The radio and television time donated would have cost more than US\$40,000 at current rates.

ASSOCIATION MANAGEMENT CAPACITY

A Management Audit took place in May 1983. Its preliminary findings confirmed that PROFAMILIA is a dynamic and well managed organization. The staff is competent and efficient, the volunteer involvement has always been considerable, and the cooperation between volunteers and staff continues to be excellent, to the benefit of the morale of the Association and the quality of its performance.

THE FUTURE OF THE ASSOCIATION

The FPA has submitted a well-balanced and conceived Three Year Plan. PROFAMILIA's public image, the credibility of its staff, the volunteer support, the Association's role and its strategies are excellent and provide a solid example to the Federation.

A Management Audit conducted in June, 1983 produced a report which is consistent with the information provided by the Association, and confirms that PROFAMILIA is well managed by an effective staff and is directed by capable a group of involved volunteers.

The "Needs Index" for the Dominican Republic does not reflect the severity of the socio-economic situation of this country, or its unmet family planning needs. Large sections of this country present the most serious conditions of deprivation, malnutrition and large family size, common to countries ranked much higher in terms of "need". The public sector, although committed to action, does not fulfil its own family planning goals. The low prevalence of contraceptive use and the people's response to PROFAMILIA's program indicate a substantial demand that is not being met by any other sources.

In 1984, the country has plunged into the most serious economic crisis in its history and unprecedented inflationary pressures may create severe difficulties for the FPA.

ECUADOR

ASOCIACION PRO-BIENESTAR DE LA FAMILIA ECUATORIANA (APROFE)

COUNTRY BACKGROUND

Ecuador, with a population of 9.1 million inhabitants, has one of the highest rates of natural increase in the Region: 3.1%. If this rate persists during the next 22 years, Ecuador will have to support a population more than double its current size. Although the country's GNP increased annually by 6-8% in the 1970-80 period, (due primarily to oil exports), it declined by 2.3% in 1983. A similar fall is projected for 1984. Ecuador's economic growth is constrained by several fundamental problems including a decline in state revenues due to the fall in oil prices, increased capital flight, slackening investment, persistently high inflation (estimated at 65% in 1983), stagnating exports and a resultant plunge in international reserves. As a result, unemployment and under-employment have reached records, currently affecting 60% of the rural population and 40% of the urban population. At least 80,000 new jobs need to be created yearly to ameliorate this situation. Instead, the number of jobs is decreasing. The poor economic situation is heightening political tensions in Ecuador. Presidential elections have been held this year, and the new government took office in August, 1984.

Within this situation, Ecuador continues to show most of the indices of an underdeveloped country, including: a majority of the population in rural areas with poor health and education; an increasing rural to urban migration leading to sprawling urban slums; an infant mortality rate of 81 per 1000, with 7% of all deaths to children under 5; and a total fertility rate still at a high 5.34 children per woman.

The Ecuadorian Constitution declares: "The State favours responsible parenthood and the education appropriate to promoting the family; it guarantees the right of parents to have the number of children they can maintain and educate." Despite this, the current elected government is less favourable toward family planning than the previous military government, and the population factor is not included in any government planning documents. The UNFPA supports MCH-family planning programs (in the provinces of Guayas and Chimborazo only) within the Ministry of Health, as well as providing contraceptives for the entire country — but in decreasing amounts, with ever less emphasis on the family planning component. The government officially offers family planning services in its health clinics, but does not promote those services. Family planning is not an official part of the medical school curriculum, and therefore many government health service doctors have not received any training in this area. The planning body (CONADE) promotes geographical redistribution of the population and economic and social development, but not family planning.

In addition to the Ministry of Health programme, the Social Security system and the Armed Forces offer family planning services. The FPA collaborates with several governmental agencies at national, provincial and local levels.

While there is support for the FPA and family planning at some government levels and among the mass media, the challenge to the FPA is still great because of negative attitudes or inertia among some official sectors as well as among some university and religious groups. APROFE is developing new strategies for working with leadership groups via the IPPF/WHR Leadership Education project.

USAID considers Ecuador a priority country, and during 1981-82 signed major grant agreements to support both private and public family planning efforts. IPPF/WHR is the executing agency for the \$2,922,999, 4-year Cooperative Agreement with three private organizations: IPPF affiliate, APROFE (to support clinics in Quito, Guayaquil and Cuenca and six other cities); CEMOPLAF (to open new clinics in the Guasmo area of Guayaquil, Esmeraldas, Tulcan and four other cities); and CEPAR (for information, training, and research activities). This grant, which began in October 1981, has enabled the WHR to open a field office in Quito.

There are an estimated 1.86 million women at risk in Ecuador. Recent studies indicate that 39.9% of those in union use modern contraceptive methods and 26.5% of all fertile-age women use reliable methods, with only 7% using traditional methods (rhythm, douche and coitus-interruptus). Contraceptive usage rates are higher in urban than in rural areas. Throughout the country, there is still a considerable gap between knowledge about contraceptives and their use.

THE ROLE OF THE ASSOCIATION

Based on the following unmet needs:

A firm commitment to family planning by national and local government;

Better coordination among the organizations which work in family planning in order to achieve better national coverage throughout the country;

Better communications with acceptors, especially younger people, concentrating on sex education;

Making family planning available to rural people (51.1% of the total population);

Making low-cost contraceptives more readily available to the poorest people in the society;

Increasing sterilization facilities and making sterilizations available in the small towns, thus increasing coverage to include rural areas.

Training for the non-specialized medical sector of the country which is not trained in family planning in medical school;

Initiating training programs for educators and students of normal schools, so that family planning and sex education can be included in the educational system of the country

The FPA defines its role as follows:

“APROFE will create an interest among those in leadership positions in order to raise public consciousness to the need for an adequate national family planning policy, committing the country’s national and local leaders to it, and giving this policy a priority role in the organizational norms of the country so that the Ecuadorian people will commonly practice family planning.

“The Association will not only be the motor for planning and executing this policy, but will also coordinate the efforts of public institutions and other private organizations, with support to: (1) information and education programs for the entire country, with special emphasis on young people, and sex education; and (2) clinical, collaborating doctors, CBD at prices within the economic reach of the acceptors, and voluntary sterilization services in urban and nearby rural areas.

“APROFE will also complete the education of the medical and paramedical sectors of the country with adequate training in the field in family planning, and initiate the training of educators and students of the teacher training schools (normal institutes).”

The FPA’s stated role is consistent with the country situation. The FPA fills gaps and moves into new areas as needs are identified. The Association is mobilizing general community support for family planning and sex education in order to show government decision-makers that mass support exists for these activities. It is also working directly with leaders. As government services have become more widespread the FPA has assumed new program roles, including CBD, sterilization, and the use of private doctors and midwives in strengthening service delivery and the postpartum component in maternity hospitals, as well as placing more emphasis on reaching youth and marginal populations.

THE PAST PERFORMANCE OF THE ASSOCIATION

The Ecuadorian Association is engaged in an aggressive expansion of its activities and scope, made possible in part by an influx of new funds from USAID and the Pathfinder Fund. APROFE has engaged in the following recent events of note:

The CBD program now functions in five coastal and two mountain provinces; by the end of 1983, the FPA had established 841 CBD posts which registered 9,769 new acceptors during the year, a 14% increase over the previous year; it also maintained 10,589 active users, a 138% increase over 1982; in 1983, APROFE opened four small support clinics in the capital cities of provinces served by the CBD program. In mid-1984, it is opening two more clinics, plus moving the Cuenca clinic to its own facilities.

The FPA registered 22,270 new acceptors in its seven clinics, four experimental clinics, and collaborating doctors and midwives projects in the same period, 3,949 female voluntary sterilizations were performed. During 1984, the Association is adapting space in Guayaquil and Quito in order to expand its voluntary sterilization services for which there is considerable demand.

The planning of the commercial retail sales program, run by a separate organization, Multex, is in its final stages, though some government dicta need to be modified before products can be sold.

The Quito Office is now well established, forming the base for I&E, training and leadership education activities there, as well as offering clinical services, soon to include voluntary sterilizations.

The leadership education project emphasized reaching political leaders during the 1983-84 election campaigns. Now it is expanding to deal not only with elected officials, but with others, including the military, business, media, and Church leaders. The Association's Executive Director is adviser to the Archbishops of Ecuador's three major cities. They are working together to establish natural family planning services.

The FPA trained 153 medical and paramedical professionals and CBD staff (including seven doctors trained in minilaparotomy) and volunteers in 1983, as well as 46 of its speakers. In 1984, it has begun having regular meetings of clinic directors.

APROFE continues its I&E program with radio spots, mini-dramas, seminars, conferences, publications, media coverage, and training activities, as well as the ongoing PP/WD project in the Guayaquil slums. With IPPF/WHR assistance, APROFE is modernizing its I&E program.

Since April, 1983, APROFE has had an evaluation officer on staff who provides ongoing feedback on the functioning of all projects. This has greatly facilitated decision-making on project development.

THE ASSOCIATION'S THREE-YEAR PLAN 1985-1987

Strategies and Projects

Strategy 1. The Association will motivate the general population, with special emphasis on youth and on rural people, providing education and training aimed at involving people in family planning programs. It will also contact decision-makers, including national and local government officials and representatives of the private sector, in order to obtain their support to develop an appropriate population policy for Ecuador. APROFE will also promote improvement in the status of women at home, in the community, and in their general lives, and understanding the relationship between population and the environment.

Information, Motivation and Family Planning and Sex Education for the General Public. With emphasis on reaching young people and the population of the marginal urban and rural areas, the FPA will carry out seminars, workshops, and talks on family planning and sex education for 116,000 people during the 1985-87 period. It will also carry out training courses for 300 women participating in the PP/WD project, operate libraries in Quito and Guayaquil, produce printed and audio-visual materials (including folders, flip charts and slide sets) and utilize the print and broadcast media to publicize family planning and Association services.

Consciousness Raising Among Formal Leaders about the Population Problem in Ecuador. In order to obtain support for public and private family planning programs, the FPA will hold six meetings for 30 leaders and six colloquia for 90 leaders yearly. These high-level leaders will include representatives of the political, government, business, military, professional, social and labor sectors.

Training in Sex Education and Family Planning. Utilizing courses, seminars and workshops on family planning and sex education, the FPA will train: 240 medical and paramedical personnel, with practical work done in the pilot clinics; 50 facilitators who will in turn train 2,700 primary and secondary school educators, vocational counselors, and teachers and students from normal schools; and 90 of APROFE's own instructors who work on an honorarium basis in the Association's courses and talks. The FPA will also conduct two updating workshops for its own staff. These activities will be funded by Development Associates.

Strategy 2. Insofar as possible, given the resources available, the Association will satisfy the demand for family planning created by its motivational efforts in urban and rural areas, by providing services in existing clinics and those to be established, by collaboration with volunteer physicians, through community-based distribution posts by the social marketing of contraceptives, and by voluntary sterilization. It will also offer training for personnel directly or indirectly involved in the development of the Association's activities, and will install laboratories for the early detection of cervical cancer among women practicing family planning through APROFE's services.

Clinical Services. Since the public sector gives little attention to family planning services, APROFE will continue to offer educational and clinical services via: (1) pilot clinics in Ecuador's three major cities, Guayaquil, Quito and Cuenca; these clinics offer all methods, including sterilization, and serve as training and research centers as well; 20 doctors per year will be trained in sterilization techniques; (2) clinics in Babahoyo, Manta, Machala, Milagro, Ambato and Loja, in support of the CBD project, offering back-up for problems as they arise; if funds are available, new clinics will be established in three other sites; (3) experimental clinics run by doctors in their private clinics who use APROFE's signs, contraceptives and price scales; by the end of 1983, experimental clinics existed in Ibarra, Riobamba, and Manta; new ones will be opened if the need arises; (4) the Association is opening its own laboratory in Guayaquil during 1984 to offer Pap smears, pregnancy tests and

other laboratory services; (5) 160 collaborating physicians and midwives will continue to receive APROFE's training, information materials, and contraceptives; by the end of the 3YP, APROFE expects to have about 200 collaborators. Through these services, the Association expects to reach 29,625 new and 25,567 follow-up acceptors in 1985, plus 4,130 voluntary sterilizations. In the succeeding years, the FPA projects approximately 5% increases yearly.

Community-Based Distribution of Contraceptives. APROFE will continue working in the five coastal and two mountain provinces currently covered by the CBD project. During 1985, the Association will select six coordinators from the indigenous populations of two mountain provinces, train them, and then have them identify with their communities the factors that would most motivate their fellow indigenous peoples toward family planning. APROFE will experiment with new methodologies, including combining MCH promoted not only by fieldworkers, but also by mini soap operas and radio spots, flyers, and bus advertising. The number of distributors will increase from 1,070 in 1985 to 1,280 in 1987. They will offer family planning to 24,000 new and 44,000 follow-up acceptors during the plan period. Pathfinder funds this project.

Project Support

Project support includes staff who oversee more than one project (e.g. the Director of Operations, the Evaluation Officer and the Quito Office Coordinator), and general costs such as travel, vehicle maintenance, equipment and supplies, and utilities.

Administration and General Services

Administration costs decrease slightly as a percentage of total budget from 15% in 1984 to around 13% for each year of the 3YP. In light of the programmatic expansion APROFE is undergoing, it may be necessary to increase the Association's management capability by hiring new middle-level managers. This is in line with the recommendations of the 1984 evaluation of the USAID/Ecuador project. The administration staff, especially the Executive Director, also work in some program areas.

Contraceptives and Commodities

Because of the tremendous expansion of its clinical and CBD services in 1983-84, the FPA has increased its contraceptive usage by 15-20% in the past year. Similar growth is expected in the 1985-87 period. During the 3YP, APROFE requests replacement of audio-visual and office equipment, in addition to contraceptives.

THE ASSOCIATION'S RESOURCES

Non-IPPF Income

During the past few years, APROFE has increased its funding sources so that by 1983, only 46.8% of its budget came from IPPF's regular budget. An additional 23.5% comes from IPPF/WHR funding via projects with USAID. Thereafter, the proportion of funding from non-IPPF sources is uncertain. The FPA has budgeted optimistically, assuming that grants from Development Associates, The Pathfinder Fund, and IPPF/WHR (USAID/Ecuador Mission) will continue throughout the 3YP period. At the same time, the Association expects to more than double its local income sources between 1984 and 1985, primarily because of fees for new sterilization and laboratory services. If the Association is correct in its optimism, it will obtain 35-40% of its income yearly from non-IPPF sources. If this does not occur, the Association will be forced to cut back radically its programmed activities.

Personnel

The Association's major increase in personnel occurred during 1983, with expansion of the clinical and CBD projects. A similar increase occurs between 1984 and 1985 in the same areas. No further major increase in personnel is projected during the 3YP period.

Voluntary Contributions

APROFE has been very successful in obtaining voluntary contributions which enable the FPA to increase its reach. Among these contributions are: about 90 people who coordinate the I&E activities with a variety of groups, schools and individuals, especially in Guayaquil and Quito; the current 1000 CBD distributors (increasing to 1,280 by 1986), who promote family planning in their communities; the more than 160 collaborating doctors and midwives who offer family planning in their towns; the instructors in the PP/WD projects; and the FPA's Board of Directors. All but the Board receive small incentives for their work, much less than they would receive for similar time spent on other jobs.

In-Kind Contributions

The Association receives a number of in-kind contributions, including transportation and locales for its seminars and talks, and radio and press publicity. If it had to pay for these items, its 1985 budget would increase by about US\$8,600.

THE ASSOCIATION'S MANAGEMENT CAPACITY

The FPA maintains its headquarters in Guayaquil, a subsidiary office in Quito, and clinics in seven cities. With new funding, the FPA will establish new clinics in other major cities. Collaborating doctors and midwives, as well as the CBD program, function in other parts of the country. Relations between volunteers and staff appear to be good.

Following the OPE recommendations insofar as possible, the FPA has expanded the number of volunteers from Quito on the Board, established the Quito Office, and has begun purchasing some commodities locally, thereby decreasing costs to the IPPF.

The Executive Director became full-time in 1983, and is taking steps to improve the quality and effectiveness of the Association's management, in line with evaluation and consultants' recommendations.

The FPA's planning, budgeting and reporting are good and the Association has complied with IPPF's terms and conditions of grant. The quality of its reporting is good, though reports are usually late.

THE FUTURE OF THE ASSOCIATION

Ecuador continues to have one of the highest rates of natural increase in the Region (3.1%), accompanied by high infant mortality and a poor showing in other socio-economic indicators. In order to deal with this situation, the FPA is presently engaged in an aggressive expansion of its activities. Among its current initiatives are: increasing clinical and CBD services; establishing a commercial retail sales arm; increasing the Association's geographic coverage in information and services; and a leadership education project. These activities will continue to be emphasized during the Three Year Plan period, with special attention given to youth, rural people, and high-level leaders from the political, business, military, professional and labor sectors. During the 3YP period, the FPA will consolidate these activities through strengthening its administration via improved training and supervision of staff. It will also augment its voluntary sterilization services with new clinics to be established in Quito and Guayaquil, and develop new projects to reach indigenous people. If additional funds are available, the Association has submitted two Plan B projects.

A majority of the Ecuadorian population lives in conditions of extreme poverty in urban slums and impoverished rural areas. Ecuador's socio-economic situation is worsening, with GNP in 1983 declining by 2.3% reflected in unemployment and under employment rates which have reached record levels (currently affecting 60% of the rural population and 40% of the urban population). The need for family planning in Ecuador remains great, as there continue to be an estimated one million women at risk and a considerable gap between knowledge about contraceptives and their use. The Association's management is improving in order to undertake the current expansion of activities.

Ecuador's economic growth rate, which had been increasing, has been constrained by several fundamental problems, including a decline in revenue due to falling oil prices, increased capital flight, slackening investment, stagnating exports, increasing foreign debt, and a resultant plunge in international reserves. This has resulted in two new economic problems for Ecuador: galloping inflation and repeated unofficial devaluations of the sucre which is exchanged on the parallel market. The Association presented a 1985 budget at an estimated exchange rate of 95 sucres to the dollar. The estimate was later raised to 120 sucres, based on exchange rate projections made by the WHO and other international sources. Similar changes have been made for 1986 and 1987.

IPPF MEMBER ASSOCIATIONS

COUNTRY	ASSOCIATION	REGION
Afghanistan	Afghan Family Guidance Association, PO Box 54, Kabul.	ARAB WORLD
Argentina	Asociación Argentina de Protección Familiar (AAPF), Aguero 1566 — (1425) Buenos Aires.	WH
Australia	The Australian Federation of Family Planning Associations, Suite 603, Roden Cutler House, 24 Campbell Street, Sydney, NSW 2000.	ESEAO
Austria	Österreichische Gessellschaft für Familienplanung, Universitätsfrauenklinik 11, Spitalgasse 23, A—1090 Wien.	EUROPE
Bahrain	Bahrain Family Planning Association, PO Box 20326, Manama.	ARAB WORLD
Barbados	Barbados Family Planning Associaton (BFPA), Bay Street, Bridgetown.	WH
Belgium	Fédération Belge pour le Planning Familial et l'Education Sexuelle, 51 rue du Trone, 1050 Bruxelles.	EUROPE

COUNTRY	ASSOCIATION	REGION
Benin, People's Republic of	Comité National du Benin pour la Promotion de la Famille, BP 1486, 47 rue de la Princesse Ahlouikponouwa, Cotonou.	AFRICA
Bermuda	Chief Medical Officer, Department of Health, PO Box 1195, Hamilton.	WH
Bolivia	Centro de Orientación Familiar (COF), Edificio Guadalquivir, Oficina No. 106, Primer Piso, Mezzanine, Avenida 20 de Octubre, esq. Rosendo Gutierrez, Casilla Expresa 7522, La Paz.	WH
Botswana	Ministry of Finance & Development Planning, Private Bag 8, Gaborone.	AFRICA
Brazil	Sociedade Civil de Bem Estar Familiar no Brasil (BEMFAM), Rua Esmeraldino, Bandeira No. 120, Na Estação do Riachuelo, Rio de Janeiro RJ.	WH
Bulgaria	Family Development Council of Bulgaria, Institute of Obstetrics and Gynecology, Medical Academy, Zdrave 2, Sofia 1431	EUROPE
Canada	Planned Parenthood Federation of Canada (PPFC), 151 Slater Street, Suite 200, Ottawa, Ont. K1P 5H3.	WH

COUNTRY	ASSOCIATION	REGION
Caribbean	Caribbean Family Planning Affiliation, PO Box 419, St. Mary's Street, St. John's, Antigua.	WH
Chile	Asociación Chilena de Protección de la Familia, Casilla 16504, Correo 9 — Providencia, Santiago de Chile.	WH
China, People's Republic of	China Family Planning Association, 2 Nan Chun Cheng Street, Xi Zhi Men, Beijing.	
Colombia	Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA), Calle 34, No. 14—52, Bogota.	WH
Costa Rica	Asociación Demográfica Costarricense, Apartado Postal No. 10203, Calles 18 y 20, Avenida Central, Casa No. 1811, San José.	WH
Cuba	Sociedad Científica Cubana para el Desarrollo de la Familia (SOCUDEF), Calle 4 No. 407 (entre 17 y 19), Vedado, La Habana.	WH
Cyprus	Family Planning Association of Cyprus, 25 Bouboulinas Street, Nicosia.	ARAB WORLD
Denmark	Foreningen for Familieplanlægning, Aurehøjvej 2, 2900 Hellerup.	EUROPE

COUNTRY	ASSOCIATION	REGION
Dominican Republic	Asociación Dominicana Pro-Bienestar de la Familia, Inc., Apartado Postal 1053, Calle Socorro Sanchez No. 64, Zona Postal 1, Santo Domingo, D.N.	WH
Ecuador	Asociación Pro-Bienestar de la Familia Ecuatoriana, Apartado Postal 5954, Noguchi 1516, y Letamendi, Guayaquil.	WH
Egypt, Arab Republic of	Egyptian Family Planning Association, 5 Talaat Harb Street, Cairo.	ARAB WORLD
El Salvador	Asociación Demográfica Salvadoreña, Apartado Postal 06 1338, 19 Calle Poniente 4, 7a Avenida Norte, Edificio K, San Salvador.	WH
Ethiopia	Family Guidance Association of Ethiopia, PO Box 5716, Addis Ababa.	AFRICA
Fiji	Family Planning Association of Fiji, Inc. PO Box 619, Suva.	ESEAO
Finland	Vaestöliitto, Kalevankatu 16, 00100 Helsinki 10.	EUROPE
France	Mouvement Français pour le Planning Familial, 4 Square St. Irénée 75011 Paris.	EUROPE
Gambia	Family Planning Association of The Gambia PO Box 325 Kanifing, Banjul.	AFRICA

COUNTRY	ASSOCIATION	REGION
German Democratic Republic	Ehe und Familie, Sektion der Gesellschaft für Sozialhygiene der DDR. Leninallee 70, 25 Rostock.	EUROPE
Germany, Federal Republic of	Pro Familia: Deutsche Gesellschaft für Sexualberatung und familienplanung e. V. Cronstettenstrasse 30, 6 Frankfurt am Main 1.	EUROPE
Ghana	Planned Parenthood Association of Ghana, PO Box 5756, Farrar Avenue, Accra.	AFRICA
Guatemala	Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM), 9a Calle 0-57, Zona 1, Apartado Postal 1004, Ciudad de Guatemala.	WH
Honduras	Asociacion Hondurena de Planificación de la Familia, Apartado Postal 625, Avenida Principal, entre: Colonias Alameda-Ruben Dario, Tegucigalpa. D.C.	WH
Hong Kong	Family Planning Association of Hong Kong, 186-192 Lockhart Road Ground, 1st, 2nd & 3rd Floors, Hong Kong.	ESEAO
Hungary	Hungarian Scientific Society for Family and Women's Welfare, Buday László u. 1—3, 1024 Budapest.	EUROPE
India	Family Planning Association of India, Bajaj Bhavan, Nariman Point, Bombay 400 021.	IO

COUNTRY	ASSOCIATION	REGION
Indonesia	The Indonesian Planned Parenthood Association, PO Box 18 KBY, Jalan Hang Jebat III/F.3, Kebayoran Baru, Jakarta Selatan.	ESEAO
Iran	The Family Planning Association of Iran, PO Box 2851, Tehran.	IO
Iraq	The Iraqi Family Planning Association, PO Box 6028, Maari Street, Mansour City, Baghdad.	ARAB WORLD
Ireland	Irish Family Planning Association, 15 Mountjoy Square, Dublin 1.	EUROPE
Israel	Israel Family Planning Association, PO Box 11595, 66 Bograshov Street, Tel-Aviv 63429.	
Italy	Unione Italiana Centri Educazione Matrimoniale Prematrimoniale (UICEMP) Via Eugenio Chiesa 1, 20122 Milano.	EUROPE
Jamaica	Jamaica Family Planning Association Ltd., PO Box 92, 14 King Street, St. Ann's Bay.	WH
Japan	Family Planning Federation of Japan, Inc., Hoken Kaikan Bekkan, 1-1, Sadohara-Cho, Ichigaya, Shinjuku-ku Tokyo 162.	ESEAO

COUNTRY	ASSOCIATION	REGION
Jordan	Jordan Family Planning & Protection Association, PO Box 19999, Jerusalem. <i>(Please do not include Jordan in this address: it is complete as it stands.)</i>	ARAB WORLD
	Jordan Family Planning & Protection Association, PO Box 8066, Amman.	
Kenya	Family Planning Association of Kenya, PO Box 30581, Nairobi.	AFRICA
Korea, Republic of	Planned Parenthood Federation of Korea, CPO Box 3360, Seoul.	ESEAO
Lebanon	Lebanon Family Planning Association, PO Box 118240, Corniche Mazraa, Al Maskan Building, Beirut.	ARAB WORLD
Lesotho	Lesotho Planned Parenthood Association, PO Box 340, Maseru 100.	AFRICA
Liberia	Family Planning Association of Liberia, PO Box 938, Monrovia.	AFRICA
Luxembourg	Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle, 18-20 rue Glesener.	EUROPE
Madagascar, Democratic Republi of	Fianakaviana Sambatra, BP 703, Tananarive.	AFRICA

COUNTRY	ASSOCIATION	REGION
Malaysia	Federation of Family Planning Associations, ESÉAO Malaysia, 81 A Jalan SS 15/5A, Subang Jaya, Selangor.	
Mali	Association Malienne pour la Protection et la Promotion de la Famille, BP 105, Bamako.	AFRICA
Mauritius	The Mauritius Family Planning Association 30 Sir Seewoosagur Ramgoolam Street, Port Louis.	AFRICA
Mexico	Fundacion Mexicana para Planificacion Familiar Calle Juarez 208, Tlalpan, Mexico 22 DF.	WH
Morocco	L'Association Marocaine de Planification Familiale, PO Box 1217 RP, 6 Ibn El-Cadi, Quartier des Orangers Rabat.	ARAB WORLD
Nepal	Family Planning Association of Nepal, PO Box 486, Katmandu	IO
Netherlands	Rutgers Stichting, Correspondence: Postbus 17430, 2502 CK, s Gravenhage. Street Address: Groot Hertoginnelaan 201, 2517 ES, s Gravenhage.	EUROPE

COUNTRY	ASSOCIATION	REGION
New Zealand	The New Zealand Family Planning Association Inc., Correspondence: PO Box 68200, Newton, Auckland 1. Street Address: 218 Karangahape Road, Auckland 1.	ESEAO
Nicaragua	Asociación Demográfica Nicaragüense, Apartado Postal 4220, Iglesia del Carmen 1 Cuadra al Norte ½ al Oeste, Managua.	WH
Nigeria	Planned Parenthood Federation of Nigeria, PMB 12657, 2 Akinmade Street, Anthony Village, Ikorodu Road, Lagos.	AFRICA
Norway	Norsk Forening for Familieplanlaegging, c/o Kari Kromann Dept. of Social Medicine, Rikshospitalet, Pilestredet, Oslo 1.	EUROPE
Pakistan	Family Planning Association of Pakistan, Family Planning House, 3-A Temple Road, Labore.	IO
Panama	Asociación Panamena para el Planeamiento de la Familia, Apartado Postal 4637, Edificio Multifamiliar No. 2a, Panama 5.	WH
Papua New Guinea	PO Box 7123, Boroko.	ESEAO
Paraguay	Centro Paraguayo de Estudios de Población, Edificio "El Dorado" 80 piso, Juan E. O'Leary y Manduvirá, Asunción.	WH

COUNTRY	ASSOCIATION	REGION
Peru	Instituto Peruano de Paternidad Responsable (INPPARES), Gregorio Escobedo 115, Jesus Maria, Lima.	WH
Philippines	Family Planning Organization of the Philippines, Inc., Correspondence: PO Box 1279, Manila. Street Address: 50 Dona M. Hemady Street, Quezon City.	ESEAO
Poland	Towarzystwo Rozwoju Rodziny, Ul. Karowa 31, Warsaw.	EUROPE
Portugal	Associacao para o Planeamento de Familia, Rua Artilharia Um 38—2º, Dto., 1200 Lisbon.	EUROPE
Puerto Rico	Asociación Puertorriquena Pro-Bienestar de la Familia, Apartado Postal 2221, Calle Padre las Casa No. 117, El Vedado, Hato Rey, Puerto Rico 00919.	WH
Rwanda	Office National de la Population BP 914, Kigali.	AFRICA
Senegal	Association Sénégalaise pour le Bien-Etre Familial, BP 6084, Dakar.	AFRICA
Sierra Leone	Planned Parenthood Association of Sierra Leone, PO Box 1094, 22 Pultney Street, Freetown.	AFRICA

COUNTRY	ASSOCIATION	REGION
Singapore	Family Planning Association of Singapore, Singapore Council of Social Service Building, 11 Penang Lane No. 05-02, Singapore 0923.	ESEAO
Somalia	Somali Family Health Care Association PO Box 2356, Mogadishu.	AFRICA
South Africa	Family Planning Association of South Africa, (currently 412 York House, 46 Kerk Street, Johannesburg 2001.	suspended)
Sri Lanka	Family Planning Association of Sri Lanka, PO Box 365, 37/27 Bullers Lane, Colombo 7.	IO
Sudan	Sudan Family Planning Association, PO Box 170, Khartoum.	AFRICA
Swaziland	Ministry of Health, PO Box 5, Mbabane.	AFRICA
Sweden	Riksförbundet för Sexuell Upplysning, Box 17006, Rosenlundsgatan 13, S. 10462 Stockholm.	EUROPE
Syria	Syria Family Planning Association, PO Box 2282, Al Jala Street, Saegh Bldg. 25, Damascus.	ARAB WORLD
Tanzania	UMATI (Uzazi Na Malezi Bora Tanzania), PO Box 1372, Dar es Salaam.	AFRICA
Thailand	Planned Parenthood Association of Thailand, PO Box 1658 Bangkok	ESEAO

COUNTRY	ASSOCIATION	REGION
Togo	Association Togolaise pour le Bien-Etre Familial, BP 4056, Lomé.	AFRICA
Trinidad & Tobago	Family Planning Association of Trinidad & Tobago, 141 Henry Street, Port of Spain.	WH
Tunisia	Association Tunisienne du Planning Familial, 9 rue Essouyouti, El Menzeh, Tunis.	ARAB WORLD
Turkey	Türkiye Aile Plânlamasi Dernegi, Ataç Sokak No. 73/3 Ankara.	EUROPE
Uganda	Family Planning Association of Uganda, PO Box 30030, Kampala.	AFRICA
United Kingdom	Family Planning Association 27-35 Mortimer Street, London WIN 7RJ.	EUROPE
United States	Planned Parenthood Federation of America, Inc., (PPFA), 810 Seventh Avenue, New York, NY 10019.	WH
Upper Volta	Association Voltaïque pour le Bien-Etre Familial, BP 535, Ouagadougou.	AFRICA

COUNTRY	ASSOCIATION	REGION
Uruguay	Asociación Uruguaya de Planificación Familiar e Investigaciones sobre Reproducción Humana (AUPFIRH), Correspondence: Casilla de Correo No. 10.634, Distrito I, Montevideo. Street Address: Avenida Luis P. Ponce 1574, Montevideo.	WH
Vietnam, Socialist Republic of	Vietnam Gynaecological, Obstetrical & Family Planning Association (VINAGOFP), 43 Trang Thi Street, Hanoi.	
Yemen, Arab Republic	Yemen Family Planning Association, Near Ministry of Information, PO Box 795, Sana'a.	ARAB WORLD
Yemen, People's Republic of,	Democratic Yemeni Council for Family Care PO Box 4589, Aden.	ARAB WORLD
Yugoslavia	Family Planning Council of Yugoslavia Bulevar Lenjina 6, 11070 Belgrade.	EUROPE
Zaire	Comité National des Naissances Désirables BP 15.313 Kinshasa.	AFRICA
Zambia	Planned Parenthood Association of Zambia, PO Box 32221, Lusaka.	AFRICA

IPPF CENTRAL COUNCIL (as at September 1984)

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