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REPORT TO DONORS:

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FOREWORD

The Report to Donors is usually concerned with the work of IPPF during the current year, and its prospects for the future. This year, the Report is a little different, in that it includes a retrospective assessment of thirty years of the IPPF.

Our Thirtieth Anniversary seems to be an auspicious moment to summarize our achievements, as well as to recognise the huge tasks still to be accomplished. IPPF does not dwell in the past, but there are occasions when it is important to remind ourselves of the struggles which have been overcome since those first eight countries came together in 1952 in Bombay, India, and founded what was the only family planning organization in the world, with a budget of less than \$5,000.

Today, as this Report indicates, IPPF's 114 members contribute to the world's family planning needs in a variety of ways, to suit their local circumstances, but they are united by the common objectives of ensuring access to family planning as a basic human right, and of spreading recognition of the role of population as a crucial element in the development process.

These Associations are becoming steadily more efficient, as well as effective. Over the last five years, the difference between their actual spending and their budgeted figure has not exceeded 2 per cent. Last year, grant receiving Associations generated 47 per cent of their funds from outside IPPF; and the proportion of funds they generated from sources within their own countries has risen to more than 31 per cent of their total income.

Meanwhile, IPPF's Shift of Emphasis policy has resulted in those countries which are most in need receiving a 30 per cent increase in funds over the past two years. As a result of Secretariat reorganization, the proportion of IPPF funds allocated to the work of the International Secretariat has fallen for the third successive year.

As we begin now to prepare for the World Population Conference in 1984, with its reassessment of the original Plan of Action agreed at Bucharest, I believe that IPPF is in a uniquely favourable position to take advantage of new options as well as to continue its existing and valuable contribution to world family planning needs. I believe too that the confidence which has been placed in use by our donors is, and will continue to be, justified.

Carl Wahren
Secretary-General

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INTERNATIONAL REVIEW

“The largest generation of children in human history will be the parents of tomorrow. . . ways have to be found of using human wit and wisdom as much as money itself in bringing about improvements in their lives.” (UNICEF)

There is no longer any argument that family planning is one of these ways. It contributes directly to the enhancement of human well-being by lowering fertility, increasing birth intervals, reducing infant mortality and improving maternal and child health. This is one among many synergies of development. As UNICEF has stated, a web of them links almost every aspect of development: female literacy catalyses family planning programmes; less frequent pregnancies improve maternal and child health; improved health makes the most of pre-school or primary education; education can increase incomes and agricultural productivity; better incomes and better food reduce infant mortality; fewer child deaths tend to lead to fewer births; smaller families improve maternal health; healthy mothers have healthier babies. . . and so it continues in an interlocking pattern.

PART 1: 1952-82: THE FIRST THIRTY YEARS

IPPF has been demonstrating human wit and wisdom in all parts of the world for the past 30 years, mustering many thousands of local volunteers whose efforts double and triple the value of the development dollar and assist the formation of local institutions which are now recognized as the bedrock of the development process. With the growing support and confidence of its donors, IPPF has been able to support the creation of autonomous, flexible, catalytic, indigenous organizations, led by volunteers, joining together spontaneously in an international movement while preserving extensive local diversity and independence.

It is no wonder that IPPF's examples have led the way to integrated development and community self-help; no wonder FPA programmes and projects seek above all to address basic human needs, and no wonder that in the decades ahead the primary focus will be on the burgeoning numbers of young people, especially those who, by numbers and by countries, constitute the poor majority.

In the 30th year of IPPF's existence it is appropriate to review briefly how this situation has come about and to draw from this vast store of experience some conclusions for the future.

The pioneering role of IPPF against almost overwhelming hostility has been chronicled so often as to need no repetition. A few reminders will suffice. In 1952 when IPPF was founded in Bombay, only India had a government family planning programme.

No United Nations agency was supporting family planning and there was no international recognition of family planning as a human right. The eight founder Family Planning Associations, led by public-spirited men and women, braved a powerful opposition to birth control. Over the next two decades government family planning programmes gathered

momentum, responding in one country after another to the vigorous demonstration and promotional efforts that were made by the voluntary sector. International assistance in population and family planning grew from a token expression of concern to a programme of considerable size.

Although there had been a sudden upsurge in the development of government programmes in the 1960s, the private sector grew more rapidly in terms of numbers of countries. By 1973 there were some 40 national family planning programmes at various stages of development while IPPF membership had increased to 80 national FPAs. Today there are FPAs in 114 countries, including the members of the Caribbean Family Planning Affiliation.

At the international level IPPF has played a catalytic role among other agencies, including the United Nations, and can claim considerable credit for the growth in international commitment. The agencies of the United Nations – UNICEF, WHO, FAO and ILO – accorded consultative status to IPPF in the early 60s, and in 1973 on the eve of the World Population Conference IPPF was granted Category I Consultative Status with the Economic and Social Council, indicating the broad inter-relationship between population and development issues which was beginning to emerge.

As more financial resources became available to family planning programmes, this was reflected in the expanding capacity of FPAs, in their acceptor figures and in the growth in numbers and variety of their innovative pilot projects. The first government grant to IPPF was made by Sweden in 1966 and the number of donors grew from five governments in 1969 to 28 in 1980, while private support also grew.

From a geographical point of view the most striking developments in the early 1970s were to be found in Latin America, where the private sector predominated and where, through their endeavours, family planning barriers began to crumble, especially the restrictions on public information and education. In 1973 IPPF was funding FPAs in 27 countries in Latin America and the Caribbean.

GLOBAL SURVEY OF UNMET NEEDS

In 1972 and 1973 IPPF carried out the first-ever global assessment of unmet needs in family planning, the results of which were published in 1974. This survey was conducted on a small budget and over a limited time period but represented a systematic attempt to obtain information on a worldwide basis, with the exception of the Soviet Union and China.

The survey showed that about one-third of the world's adult population had sufficient knowledge in 1971 of at least one effective method of contraception, with significant variations between urban and rural populations. It was estimated that about 500 million women in the world were at risk of unwanted pregnancy and that only one-third of them were regularly practising contraception. In the developing world this rate fell well below 20 per cent. Most of those practising family planning were doing so without help from organized programmes and at least half were thought to be using traditional methods.

An IPPF report in 1973, commenting on these findings, said: "In the world as a whole, family planning has still to be taken to some 350 million women of fertile age who are estimated not to practise it at present. Leaving aside China, where the estimate of 70 million non-users is far from precise, the 350 million include about 28 million women in Latin America, 22 million in the Middle East and North Africa, 32 million in East and West Africa and over 80 million women in the Indian Ocean Region. . . the task is great and the need is urgent".

The IPPF Unmet Needs Survey illuminated many of the obstacles to family planning — the age at marriage, legal restrictions, religious and cultural barriers and the low status of women. IPPF concluded in 1973 that "family planning must be integrated with the whole process of development", reaching this conclusion in advance of the World Population Conference in Bucharest in 1974.

METHODS OF CONTRACEPTION

IPPF was in the forefront of the application of modern methods of contraception since it was in the clinics of its pioneering Family Planning Associations that the early experiences were gained. While research to improve contraceptive technology was still urgently needed, there were some remarkable advances in the early 1970s which made family planning safer, more effective and more acceptable to the majority of people.

IPPF's Central Medical Committee had become the international authority on contraceptive standards, annually reviewing the evidence of safety and effectiveness from all over the world. The manuals issued under its authority were the guidebooks for clinical practitioners and trainers. As WHO became increasingly involved, collaboration between the two bodies was established.

Risks and troublesome side effects of the Pill were monitored by the Committee, which in 1973 considered that "the health benefits almost certainly outweigh the risks of use in nearly all cases". Among IUDs, Copper 7 and Copper T were already being tried in the early 1970s. Sterilization was gaining in popularity, with clinical trials on improved tubal clips and clip applicators taking place and improvements being made in the specifications for laparoscopes. Research was already under way to make sterilization reversible but the shortage of skilled manpower in most countries was an obvious inhibition. IPPF medical and science panel at this time were receiving promising reports of laboratory research into the methods of the future, including injectable contraception and immunological approaches. It was estimated that in 1972 about \$110 million was spent on research related to fertility control, but it was also noted that it took up to 10 years or more for new methods to go through the range of tests and trials leading to approval for general clinical use.

Within the spreading IPPF network there were many different attitudes to abortion. In Europe many laws were already quite liberal and there were movements elsewhere for change; by contrast, in Latin America family planning was vigorously promoted as an alternative to abortion and there were plenty of signs that the Church and governments would strenuously

resist attempts to reform prohibitive laws. IPPF, taking the advice of its members, concluded in 1971 that contraception is the first line of defence against unwanted pregnancy and adopted a policy which advocated humane treatment of women who underwent abortions and increased attention to the provision of contraceptive information and services to such women. This position was to be reaffirmed in 1979.

SERVICE DELIVERY

The entry of WHO and UNICEF into family planning programmes confirmed the contributions that family planning could make to maternal and child health. Governments generally found it logical and politically convenient to place responsibility for family planning within the Ministry of Health. To a considerable extent the work of the private sector had led to this development, since many of the early pioneers of national Family Planning Associations were doctors and the first service posts were clinics. By the end of 1973 most clients of IPPF-supported programmes received their information and supplies from clinics, many of which were mobile units. But the limitations were clear even if the solutions had still to be found. Most developing countries, where family planning needs were greatest, lacked any real health infrastructure. Health centres were inaccessible to most villagers and rural communities were often totally isolated from them. Where it existed, medical care was curative, not preventive like family planning.

By the end of 1973 the idea of community-based distribution of contraceptives was already being discussed and the experiences in Colombia, Japan and Thailand were being studied. The IPPF Central Medical Committee debated the question of Pill distribution outside the clinics and concluded that "whoever normally meets the health needs of the community, whether doctor, nurse, traditional midwife, pharmacist or storekeeper, can be an appropriate person to distribute oral contraceptives". As a result of this advice, the IPPF Governing Body decided in October 1973 to give high priority to the promotion and expansion of these new distribution services.

INFORMATION AND EDUCATION

The early 1970s saw significant changes in the process of public education in family planning, following the greater understanding of the cultural and traditional influences on personal decision-making. In 1973, in a resolution which also gave approval to the publication of "People" magazine, the IPPF Governing Body called for the integration of family planning education into general community development and for experimental work to reach new target groups, especially rural women, men and young people. It was recognised that while the mass media can be effective in creating awareness, person-to-person contact, of the most informed and sensitive kind, is needed to recruit satisfied consumers. A 1973 IPPF report noted that family planning is a service not a product; a sense of need must be created before showing how and where that need can be met. Population education and sex education for young people had become important features, although little progress had been made in revising school curricula to this end.

LEADERSHIP AMONG NGOS

Parallel to the increasing involvement of governments, UN agencies and bilateral donors there was rising interest among non-governmental organizations. IPPF was successful in encouraging many different NGOs, concerned with health, nutrition, child care and the status of women, to recognize the contribution that family planning could make to the achievement of their objectives. This interest was nourished through frequent exchanges of information and experience and participation in the meetings and activities of other organizations. Prior to the United Nations Conference on Human Rights in Teheran in 1968, IPPF took the initiative of convening a consultation of NGOs to discuss the place of family planning in this context and this, among other forms of advocacy, made a significant contribution to the achievement of the now famous clause on the human right to family planning included in the Proclamation of Teheran.

In 1974 IPPF convened in Teheran a conference of NGOs to discuss issues related to the forthcoming Bucharest conference. It went on to participate actively in the NGO Forum at Bucharest, contributing an editorial team to the conference newspaper "Planet". Thus a leadership role for IPPF emerged among NGOs. International organizations with no previous interest in family planning – some of them even hostile to it – gradually came to recognise that their goals, e.g. the improved status of women, could not be achieved without family planning. Many of these NGOs developed their own family planning components which led to the collaborative enterprises which are a significant feature of the next stage of developments in IPPF.

IPPF had anticipated many of the decisions taken at Bucharest. By 1975 it was already engaged in modest experimental projects which placed family planning within the framework of community development. In the next six years the most important advances in family planning were to be in the areas of community-based service delivery, planned parenthood and women's development, integrated community services, including rural development, and law and planned parenthood.

A FORWARD LOOK INTO THE NEXT 10–15 YEARS

IPPF's intentions were consolidated in the recommendations of the Forward Look Study launched worldwide in 1976. The report of the study, published in 1977, was to have a profound effect on future IPPF policies, programmes and criteria for resource allocation. Broadly, the recommendations required IPPF to act in the following ways:

- to press for the removal of legal and other obstacles to the acceptance and conduct of family planning programmes
- to promote more government involvement in family planning and to impose standards of high quality and performance on all who provide family planning information and services
- to encourage and assist implementation of the World Population Plan of Action

- to explore new forms of association with governments and with other agencies to develop an integrated approach to the provision of family planning information and services as part of overall development efforts
- to ensure that the full range of family planning technology includes the availability of sterilization services, appropriate counselling on problems of infertility and sub-fertility and proper concern and help for those who undergo abortions
- to vigorously experiment with new delivery systems to demonstrate how best to meet the needs of those who are likely to be by-passed by conventional services
- to emphasise its general education and out-of-school education programmes and give special attention to family life education and sex education
- to raise the status of women and draw young people into the movement
- to improve programme performance in all directions, including education, training, research and evaluation
- to reinforce the spirit of voluntary leadership and community self-help
- to restore a sense of radicalism in the interests of social reform
- to foster the independence and self-reliance of family planning associations
- to develop within IPPF a lively spirit of interchange of ideas and experience in order to profit fully from federation
- to set clear criteria for better allocation of resources
- to pursue closer relations with other international and national organizations.

In many of these areas IPPF played a leading part since the opportunities to test these new strategies were to be found most easily in the private sector and they suited the indigenous, grass-roots characteristics of the typical voluntary association. Many governments encouraged these experimental approaches and watched the results with growing interest.

COMMUNITY SERVICES

By the mid-seventies family planning services were set to move beyond the clinic and into the market place. Experience had shown that even committed governments often lacked the resources to reach into the rural communities and meet the needs of their poorest citizens. IPPF was encouraged by an inter-agency advisory committee, of which UNFPA was a member, to explore the feasibility of community-based delivery systems on a worldwide scale.

By the end of 1975 some forms of social and commercial marketing schemes were being tried out in 33 countries, many of them spontaneous activities of the national Family Planning Associations. IPPF set up a department to co-ordinate these efforts and to encourage and fund other similar programmes which could demonstrate that, with training and access to medical back-up, non-medical personnel could deliver contraceptive supplies. Shop-keepers, village leaders, teachers, satisfied users and generally public-spirited citizens could help each other and themselves to plan their families.

Early CBD programmes were based on condoms and spermicides but gradually, as legal restrictions were removed, Pill distribution became widespread, although by no means universal. People opting for sterilization or IUDs were referred to clinics or hospitals but most CBD workers were trained to explain these methods.

For the world as a whole CBD acceptors formed nearly 30 per cent of the total new acceptors served by FPAs in 1978 – a 300 per cent increase in just four years.

Evidence was accumulating that CBD was highly cost-effective as well as acceptable to clients, although the variety of pricing policies, record-keeping and evaluative mechanisms made systematic data collection difficult. The number of FPAs undertaking CBD grew steadily during the seventies and today there are some 40 associations involved in some form of community distribution. These activities represent about 80 different IPPF-funded projects. At present CBD programmes overall account for 36 per cent of new acceptors in the Federation as a whole. With the expansion of government programmes it became easier for FPAs to engage in innovations of this kind, since they were no longer the sole providers of services and were encouraged by IPPF to close down their clinics wherever governments could provide alternative coverage.

CBD reflects the Alma Ata concepts of primary health care and decentralised provision of preventive health services, identifying and meeting needs at the community level and utilizing local institutions. A crucial component is education to help users make decisions about family planning and to select and use appropriate contraceptive methods on a continuing basis.

PLANNED PARENTHOOD AND WOMEN'S DEVELOPMENT

As early as 1968 the United Nations Commission on the Status of Women began to draw attention to the relationship between family planning and the status of women. Many research studies have illuminated the positive correlation between education and fertility levels and between gainful employment and family planning acceptance. International conferences and conventions – the 1974 World Population Plan of Action, the 1975 Plan of Action for the Decade for Women and the 1979 UN International Convention on the Elimination of All Forms of Discrimination Against Women – endorsed the link between the status of women and family planning.

Most of the work of promoting the advancement of women has come from the voluntary sector. Many NGOs have contributed. In 1974, in a resolution pledging its support for international Women's Year, IPPF called on its member FPAs to contribute to national activities and programmes to advance the status of women and to promote understanding that family planning is basic to the status of women.

On the basis of this policy and the recommendations of the Forward Look Study, IPPF's Planned Parenthood and Women's Development Programme was introduced in 1976. It set out, through a wide diversity of small experiments, to demonstrate how women's

aspirations could be raised, leading to their more positive roles in family and community life, participation in decisions affecting the health and quality of life of the family and acceptance of family planning. Where evaluation has been possible, these projects show higher family planning acceptance than in comparable areas where such activities are lacking.

Other findings are that women must express their own needs and be helped to take leadership and collective action to meet them. They need confidence and the independence gained through earning money with new-found skills.

LAW AND PLANNED PARENTHOOD

Legislation is the preserve of governments but law reform responds to public pressure. Non-governmental organizations have done much to identify existing legislation which impedes the progress of family planning programmes. This is not simply the government's declared policies on population, but the myriad other laws and regulations that directly or indirectly affect people's lives and inhibit them from taking family planning decisions. Laws, regulations and policies on the advertisement and distribution of contraceptives continue to restrain the availability of information and services. The same may be said where information and services on abortion are concerned. Ambiguity in the laws relating to sterilization continues to make doctors and potential recipients hesitant to provide or seek out these services. In a similar vein, laws, regulations and policies on family planning services are often inadequate for the purpose of protecting the interests of providers and recipients alike. The law has not kept pace with the rapid developments in family planning technology and delivery systems over the past few years. The result of this lag is constraint and limitation which has often cast the law in a negative role.

Recently more attention has been focussed on the positive role the law can play in eliminating the barriers to family planning. Laws and policies have been changing and positive inroads have been made. For example, in the past ten years at least 30 countries have authorized non-doctors to handle and distribute various forms of contraception. In a score of countries the law on sterilization has been either clarified or changed and sterilization for family planning purposes made legally acceptable. Many countries now expressly permit forms of "sex education" within the school curriculum, and many have changed their laws on abortion.

IPPF contributed to these and other changes by establishing a law and planned parenthood programme which led to the creation of central, regional and national law panels of volunteers who were themselves prominent lawyers and legislators. With the guidance of these experts, IPPF was able to develop guidelines and strategies in all the special areas of concern mentioned above. Literature on these topics was produced for the guidance of those engaged in family planning programmes or in a position to influence law and policy formulation. Distinguished lawyers with experiences of different legal systems and cultures in their turn developed contacts with justice ministers and officials who were concerned to establish the relevant legislative base for the policies adopted on family planning

and population. Monitoring has been carried out jointly with other collaborating organizations. In the final analysis, however, it is in the framework of national legal systems that barriers to IPPF work occur, and it is here that efforts to bring about change must needs be based.

INTEGRATED COMMUNITY DEVELOPMENT

From a policy point of view, one of the most important advances in the late seventies has been the integration of population with development. There have been many debates about whether this is really feasible, given the well-rooted functional approaches to health, education, rural reconstruction, economic planning and other sectors of government in relative isolation from one another. Ultimately it is governments that must make the necessary changes to bring this about, but the field testing has been stimulated by the work of voluntary organizations, usually working in partnership with local institutions, often including local government.

Integration of family planning with mother and child health services is now accepted in most of the world, but the new consensus on integration encompasses a wider range of partners with a strong emphasis on community participation and self-reliance.

IPPF has a long-standing involvement in integration. Many Associations "discovered" integration individually before the Federation did so collectively. FPAs in Asia, such as India and Korea, have led the way since the 60s in providing family planning as part of broader efforts to meet community needs. Strong commitment to the integrated approach to family planning is reflected in the discussions and resolutions of volunteer bodies at the regional and central levels over the years.

At the international level, IPPF's work in the field of education, with young people and the Planned Parenthood and Women's Development Programme, has been firmly based on the integrated approach. Efforts to work with a variety of other non-governmental organizations, whether professional groupings such as teachers, home economists, social workers or community-centred groups such as co-operatives or trade unions, youth and women's organizations, have all been aimed at linking family planning with broader community and family concerns.

Many FPA integrated projects address broad community concerns. They link family planning with agricultural improvement, clean water supplies, better sanitation, conservation of the environment, other aspects of rural development and the formation of co-operatives to increase earning capacity.

Inter-agency co-operation is normally a necessary precondition since it can stimulate the formation of groups dedicated to self-improvement. A special type of integrated community development programme has been pioneered by the Japanese Organization for International Co-operation in Family Planning (JOICFP), in which three specific components, i.e. parasite control, family planning and nutrition, are offered to the community. The three components are concerned with different aspects of preventive health care and are intended to be mutually reinforcing.

Parasite control and nutrition are chosen as partners for family planning because they require relatively low technology and expenditure and address frequently occurring problems. Parasite treatment has an immediate and demonstrable effect of great psychological importance in creating credibility, and in paving the way for family planning acceptance. The three components are also seen as a nucleus of activities which have the potential to expand into a complete primary health care approach relying on community self-help.

It is sometimes argued that when family planning is offered together with other services family planning risks taking a secondary place. Other tasks may carry more prestige and/or the need for them might be perceived as more urgent. In practice, this problem is mainly encountered in situations where family planning has been added as an extra rather than built in as an integral part of a comprehensive service. Even where family planning is not an immediately visible component, there is evidence that people who have been first helped to improve their living conditions through craft training, income-generating activities, etc. become more receptive to family planning. For others, motivation to prevent pregnancy may not always be strong enough to cope with the demands of using contraceptives. Making services more acceptable by combining them with other highly valued welfare measures helps to reinforce sustained contraceptive use.

Most integrated activities have so far been carried out on a pilot or demonstration basis and are small-scale. Testing new approaches to service delivery is inevitably costly in the early stages. A pilot project requires relatively more input at all stages of development and implementation than continuing programmes. If calculations are carried out on the cost of the services per acceptor, integrated projects generally compare favourably with family planning services on their own.

IPPF'S ROLE AS A SUPPLIER OF COMMODITIES.

IPPF's supply line, which also reaches some government programmes, plays a vital role in providing material support to programmes all over the world. It includes contraceptives approved by IPPF, clinical equipment, audio-visual hard and software, and transport vehicles of all kinds. In addition to \$1.1 million of contraceptives supplied "in kind" by USAID, nearly \$4.5 million was spent on commodities of all kinds in 1981, including \$3.3 million on contraceptives. More than 13 million cycles of 17 different brands of oral contraceptives were distributed. However, efforts are now being made through the International Medical Advisory Panel to limit the number of brands provided. In addition IPPF supplied 33 million condoms, more than 700,000 of four different types of intra-uterine devices, 355,000 doses of the injectable contraceptive Depo-Provera, 8.5 million foam tablets and various quantities of aerosol foam, jellies, creams and diaphragms. Transport continued to be a major item of supply in 1981. Half of the transport commodities were purchased locally to ensure spares and maintenance facilities would be available. The total amount spent on transport was just over \$590,000. A further \$574,000 went for medical and clinical equipment.

PUBLICATIONS

A major contribution to awareness and the transfer of experience within IPPF was made over many years by "IPPF News". This modest news-sheet was spreading information about family planning to all corners of the world when the subject was taboo in almost all public media and when it was virtually impossible for doctors, social workers and other interested activists to get any of the pertinent facts or to be put in touch with interested people in other countries. Gradually a whole new literature sprang up on population and related topics and IPPF made changes in its publications strategies to take this into account.

On the eve of the World Population Conference in Bucharest in 1974 IPPF launched "*People*", a magazine which provides independent, inter-disciplinary coverage of population and development. The magazine has gained international respect for the breadth, accuracy and lucidity of its coverage and for its first-hand reporting. By developing media contacts in many countries and a wide network of users for its News/Features service to the press, it has contributed materially to the wider understanding of population and family planning issues.

At present "*People*" and the informal news bulletin "*Open File*" appear to be meeting the information needs of the Federation efficiently; "*People's*" importance for IPPF's international image and for fund-raising can hardly be exaggerated.

IPPF has proved its special competence in the publication of standard works of reference for family planning practitioners, the principal example of which is the frequently revised and up-dated "*Family Planning Handbook for Doctors*". For example, 10,000 copies of the Spanish edition of this were supplied to the government of Mexico, and 5,000 copies to Cuba. These books are universally appreciated for their excellence and accuracy and for the guidance they provide for the conduct of family planning services not only by doctors but by a range of other health professionals.

The "*Medical Bulletin*" and "*Research in Reproduction*" are widely sought after and have steadily growing international readerships. IPPF has been fortunate in having an excellent volunteer Medical Editorial Advisory Board which has not only provided guidance on topics and authors but has co-ordinated the editorial approaches for doctors and research scientists and related these to the publications that are intended to reach the client and the general public.

ANALYSIS OF 1981 ANNUAL REPORTS FROM FPAS

Each year the IPPF Evaluation Department makes an analysis of information provided by grant-receiving Family Planning Associations in their annual reports. In presenting summary information from the analysis of 1981 reports it is not possible to distinguish between the many different characteristics of individual programmes, nor to take account of differences in project size. The value of the summary is to demonstrate trends and shifts of emphasis, to indicate where new ideas may be catching on more rapidly than expected and to provide the basis for long-term study.

Service delivery projects

The general upward trend in numbers of service delivery projects was maintained in 1981 and the proportions of projects concerned with non-clinical distribution or with integrated activities were similar to the 1980 levels. The combination of family planning with other maternal and child health services is strongest in Africa, Middle East and North Africa, and the Indian Ocean Regions of IPPF. More than 630,000 acceptors in FPA programmes were reported to have received their services in an MCH setting. In India the numbers receiving MCH care as well as family planning rose by 10 per cent, while in Tunisia an evaluative study of a rural project in Le Kef showed that family planning acceptance had risen from 13 to 44 per cent between 1978 and 1981 in this congenial setting. More than half the women reached by the project took their children to child welfare sessions as a result of this project.

Integrated approaches

For some FPAs the integrated approach was a major strategy. Bangladesh, India, Indonesia and the Philippines FPAs reported integrated service delivery projects combined with a wide variety of activities, including the integrated family planning, parasite control and nutrition projects sponsored by JOICFP. The Philippines FPA also implemented its own parasite control projects in three chapters.

JOICFP projects were also implemented in Mexico, Brazil and Colombia; in Mexico parasite control was introduced into the Vera Cruz community-based distribution project area.

Projects for women

Projects for women formed roughly one-third of all integrated projects, either as part of IPPF's Planned Parenthood and Women's Development (PPWD) programme or initiated by FPAs. By March 1981, 24 women's development projects initially funded under the PPWD programmes had been taken over by the FPAs and included in their regular work programme/budgets. This represented 51 per cent of ongoing PPWD projects. In Bangladesh and India, women's development components were fully integrated into their work programmes. In 1981, 30 income generating self-help and community development projects for women were reported, half of which were in the Indian Ocean Region. Additionally, four women's development projects with no immediate family planning objectives were reported by FPAs. An evaluative study of the PPWD programme was completed in 1981.

Non-clinical distribution of contraceptives

Non-clinical distribution of contraceptives continued to expand. Ninety projects were reported by 41 Associations. The number of non-clinical projects in Africa, ESEAOR and WHR increased in 1981. A total of 691,655 new acceptors were served, 36 per cent of all new acceptors. Two-thirds of all non-clinical acceptors chose oral contraceptives. This was the most important method in the Western Hemisphere Region, while condoms were most frequently used in the Indian Ocean Region and Ghana had a large spermicides programme.

Regional patterns in the use of retail sales outlets and individual distributors have developed. FPAs in Asia made use of retail sales outlets, vending machines and postal services, sometimes in large and complex schemes. These and FPAs in the Western Hemisphere Region reported extensive use of local people, women and community leaders, many of whom were volunteers they had recruited and trained. The Philippines, Thailand and India also had high levels of community involvement in the distribution of contraceptives; in Thailand groups of refugees were selected and trained as volunteers to give family planning counselling and services to other refugees. The Middle East and North Africa Region used field workers for non-clinical contraceptive distribution.

Youth projects

The analysis revealed the growth and variety of youth projects. In four IPPF regions, about half the information and education projects reported in 1981 involved youth, many of them not aimed solely at young people but part of a larger strategy. Youth activities permeated the Bangladesh and Indian programmes at all levels. In India youth are involved in integrated projects, women's development activities, information and education projects ranging from population studies cells in universities, to youth clubs and training programmes for youth and student leaders. As most Indian states have been slow to implement the government policy on population education, the Family Planning Association of India (FPAI) has adopted a strong pathfinder and catalytic role in the area of population education, particularly through lessons in schools and orientation courses for teacher trainees and teachers. As the government solidifies its population education programme in the formal educational sphere, FPAI intends to gradually shift its emphasis to out-of-school youth.

The number of projects providing contraceptive services to young people or making referrals has been increasing slowly; 18 information and education projects offering contraceptive services or referrals included youth in their target audience.

Broadening the base of FPA activities

The level of activity designed to broaden the base of FPA activities was maintained. Half the Associations in Africa were involved in projects promoting inter-agency co-operation. FPAs were more concerned with general family planning orientation for professional people, e.g. social workers and others who would then include family planning in their work; 21 projects of this type were reported. A further 15 orientation projects were for FPA volunteers and the general public. Sri Lanka, Korea, El Salvador and Nicaragua had campaigns to recruit new members.

Forty monitoring and evaluation projects were carried out in 1981, 70 per cent of them concerned with the implementation and efficiency or effectiveness of programmes, and the remainder with preliminary studies of unmet needs or pretesting. Of the 58 research projects reported, contraceptive methods formed the largest category, followed by studies of sociological factors related to family planning, health, welfare and demographic topics.

Programme costs and income

An Evaluation Department special study on service delivery project acceptor costs derived from the 1980 Annual Reports Analysis served as an initial response to requests from management and donors for more analytical information about programme costs. The variables selected for study were expenditure and acceptors for each separately reported service delivery programme or project, and the income derived from these activities. Comparisons of FPA income and expenditure were made. Regional service delivery costs and income per new acceptor were calculated for both the programme as a whole and for clinical and non-clinical programmes.

Service delivery represented the main area of IPPF funding (44 per cent). Most of this (31 per cent) went on medical and clinical programmes, but although only 13 per cent of total expenditure went on community-based distribution, these programmes recruited over one-third of total IPPF acceptors. The analysis illustrated national, global and regional variations in costs per acceptor. Regional averages of net costs per person served ranged from \$0.90 in IOR and MENAR to \$2.60 in WHR. At global level, costs per person served were fairly low (\$1.90) and suggested a relatively efficient overall operation. Generally, non-clinical programmes were found to represent a more cost-effective means of service delivery.

The analysis also showed that service-related income (contraceptive sales, patient fees, pap smears and other sources) amount to 26 per cent of the global total costs of service delivery. Contraceptive sales alone represented 54 per cent of all service delivery income, and in Africa these sales made up over 98% of the regional total of income derived from service delivery activities. It was also the largest item in service-related income for the Middle East and North Africa Region and the Western Hemisphere Region.

The East, South-East Asia and Oceania Region and the Western Hemisphere Region generated high proportions of income through patient fees (52 per cent and 45 per cent of the regional total respectively), and in the Indian Ocean Region the largest source of income was the Indian government's sterilization compensation, an amount supplied to the FPA over and above the total cost of operations, beds, and other facilities.

The regional and country reviews in this report amplify and explain these trends.

PART 2: THE YEARS AHEAD

Many of the developments described in the review of the last 30 years are a source of real and justifiable pride to the Federation.

The variety of IPPF activities that have been undertaken over the years, many of them unforeseen in 1952, have developed through IPPF's ability, as a voluntary organization, to respond to new challenges.

Nevertheless, it would be rash to claim success in all the endeavours IPPF has undertaken. It may be salutary to touch on some of those areas where there are recognized short-comings;

where IPPF is aware of the need to set still more ambitious targets; where experience has necessitated a new approach.

IPPF's efforts to reach the younger generation is a case in point. A survey published last year by the International Clearing House on Adolescent Fertility pointed out that most fertility-related youth programmes were being carried out by IPPF. Yet the Programme Committee has expressed deep concern that too little is being done to build a "second line leadership" within IPPF itself; a group of vigorous and highly motivated young people into whose hands the future of the Federation can confidently be committed.

The PPWD programmes, recognized within and outside IPPF as one of the Federation's most significant activities reach out to only a very small minority of disadvantaged women. Ways to expand PPWD projects in number and coverage while retaining the essential characteristics of the programme remain to be found.

IPPF was one of the principal actors in bringing about today's consensus that integration is a key to wider acceptance of family planning. Yet IPPF is only slowly coming to grips with the operational implications of this approach, perceiving and tackling some of the difficulties that inter-agency collaboration brings with it in practice, whether at the international, national or local level. Other agencies, however, are not the only partners in integrated rural development. It remains to be seen how well IPPF has succeeded in drawing into its work the men and women in the communities served, so that they become participants in, as well as recipients of, IPPF programmes and projects. More attention has to be paid to the question of devolving responsibility for management of these programmes and projects to the community itself.

IPPF's record in demonstrating different patterns of community family planning services is well-known. Nevertheless, the "difficult to reach" remain, in many countries, unreached by these services. IPPF's commitment to ensuring that the needs of disadvantaged communities are given higher priority, whether by IPPF or others, is clearly stated in the Federation's 1982-4 Three Year Plan. It might be asked, however, if the urgency of this task has been sufficiently reflected in IPPF's achievements so far.

Conversely, there are other areas of activity which may have been over-emphasized. IPPF was not exempt, for example, from placing perhaps exaggerated importance on the production and distribution of communication materials. In conjunction with UNESCO and with UNFPA support, IPPF established in London the International Audio Visual Resource Service, in an effort to increase the availability of audio visual hardware and software. This project has now been terminated but demonstrated that efforts of this nature at the international level may not result in the most effective use of limited resources.

CONTINUING CHALLENGES

As IPPF moves forward into the years ahead, there are two major problems which it will seek to resolve: the lack of political commitment to family planning, without which commitment there is unlikely to be a sufficient resource availability, and the continuing unmet need.

Lack of Political Commitment

It has been argued in the past that once a Family Planning Association has accomplished its fundamental task of persuading its government to assume responsibility for provision of information, education and services, the role of that Association gradually diminishes; it ceases to play a meaningful role in the country. Experience shows that this is not so. The last five years have once more clearly shown that the advocacy role is an everlasting one for an organization like IPPF. This period has witnessed the re-emergence of opposition to family planning, endangering the hard-earned government support to it in many countries. Even in Asia where government programmes are well-established, private sector advocacy for family planning is still essential, as the Indian Ocean Regional Review makes clear.

Opposition to family planning reflects an interesting mix of rationales, motives and ideologies. It is sometimes directed at population policies, sometimes at certain contraceptive methods or abortion. Opposition to family planning may also be part of a broader resistance to social change which appears to upset traditional value systems and may gain strength from religious concerns. Family planning has faced these and other forms of opposition since the early days of the pioneers. A more recent development, however, has been the increasingly organized nature of the opposition forces. In many countries, especially the industrialized ones, some highly vocal groups have been established. Some of these groups are primarily against abortion but they also oppose contraception and create a great deal of confusion in public opinion.

Another powerful influence in this respect has come from what may be broadly called consumer groups. The legitimate safety concerns of the medical profession and dissatisfaction with existing contraceptive technology have been turned into political weapons by opposition groups. Their distortion of facts and emotional exploitation have led to the politicisation of the whole issue. Campaigns directed towards influencing government and parliamentary decisions related to contraception and abortion have made decision-makers cautious, if not timid.

The effects of such campaigns have also gained international dimensions in different ways. First, the politicisation of abortion and contraception in donor countries affects not only domestic family planning services, but also the population assistance programme. The problems encountered in obtaining Congressional support for population assistance in the United States are clear examples. Second, some organized and well-funded opposition forces in developed countries are using all the means they can muster to exert direct influence on decision-makers in developing countries. The deliberate distortion of facts is most unfortunate.

Confronted with arguments about the "risks" of certain methods and the "real motives" of donor countries, governments become hesitant to approve the use of these methods, sometimes disregarding the views of their own medical authorities. A direct result of this attitude is the denial to people of some contraceptive methods which they might have found acceptable for their needs, or even the denial of access to any reliable means of exercising their basic right to plan their families.

Even in the absence of such opposition, the task of constantly informing and educating decision-makers is important, not least because of the new generations of politicians and administrators with whom IPPF has to work. This high turnover of decision-makers is true for both national and local decision-makers and the donor community. The regional reviews included in this report provide significant insights into these problems.

Advocacy has always been one of the major roles of this Federation. The last five years saw a more structured and reinforced approach to accomplishing this role. Many FPAs and the IPPF at regional and international levels began what is called "leadership development" or "leadership education" activities. Efforts to generate and sustain political commitment and resource development activities have an obviously beneficial overlap in intent and in impact. Perhaps the most significant development in organized efforts to enlist the support of policy-makers, be it in terms of political commitment or resources, has been the emergence of the parliamentarians movement. The movement began under IPPF auspices with support from UNFPA; it started with informal visits by donor country parliamentarians to developing countries. It has rapidly grown to the establishment of national, regional and international permanent structures, such as the Asian Parliamentarians Forum and the Global Committee of Parliamentarians on Population and Development.

The importance of reaching the legislators as the main decision-makers in the allocation of resources for national and international programmes cannot be over-emphasised. Where these movements are strongest, population assistance is most frequently on the parliamentary agenda and the attitude of the government most positive.

A very specific action taken during the last year in regard to IPPF's fundamental advocacy task, that is promoting family planning as a human right, was the establishment of a working group to make recommendations to the IPPF on how this task can be carried out even more vigorously. The group will continue its work, mainly through correspondence but meeting when necessary, and its conclusions will make a major input to the Members' Assembly discussions on this subject in 1983.

Continuing Unmet Need

IPPF faces the difficulties caused by uncertain political commitment and insufficient resources against a background of continuing and increasing unmet need. The World Fertility Survey (WFS) has unequivocally confirmed IPPF statements that millions of women are still faced with the risk of unwanted pregnancies. More than 30 per cent of those interviewed in the Survey have openly stated that their last birth was not wanted. Half of the married women who do not want to have any more children are not using effective methods of contraception. And these are only the reflections of the wish to limit family size. There are no conclusive estimates about the scale of the unmet need of those who wish to delay or space the births of their children but are unable to do so because of lack of access to education and services.

The Africa Regional Review provides dramatic evidence of the scale of unmet need and of its consequence for the quality of social and economic life for future generations. 18 of the

32 officially designated Least Developed Countries (LDCs) are in Africa. As the Indian Ocean Regional Review explains, there is a vast unmet need even in countries with relatively vigorous national family planning programmes.

Catching up with the existing unmet need, or the "latent demand" as some prefer to call it, requires a substantial expansion of family planning services. In addition, the need for these services is likely to increase rapidly and dramatically. In the developing countries, more people enter the reproductive age group than those leaving it and the demand for family planning services is bound to increase as a result of educational efforts and of advances in social and economic development.

The WFS analyses have shown that population growth rates could be reduced by up to 40 per cent if all unwanted births could be prevented. In the Bangladesh study, for example, 37.5 per cent of currently-married women said that their last birth was unwanted. If they had been able to prevent these pregnancies, the crude birth rate of the country would have been 25 per 1,000 instead of the current 40 per 1,000 and the natural increase rate would have been 1.3 per cent instead of 2.8.

The WFS has also shown, however, that even if most unwanted and mistimed births could be prevented, targets set by many developing countries to reduce the rate of growth to under one per cent would not be met without changes in family size desires and norms. The average number of children wanted is still as high as 7 in many parts of Africa, although a notable decline is taking place among the younger generation.

The required changes in fertility aspirations and behaviour underscore the importance of education activities, a traditional role for Family Planning Associations. These activities need to be strengthened and, where necessary, modified along the lines mapped out at the International Conference on Family Planning in the 1980s, held in Jakarta in 1981.

IPPF has already moved towards more cost-effective approaches in reaching out to people with education, information and contraceptive services outside the conventional clinical system; and by a much more active collaboration with other organizations, especially at the local level, in order to share mutual strengths and respective networks.

Concern for people's other needs has led IPPF to advocate integrated development approaches. In Jakarta, which was a major reassessment of where family planning stood in the beginning of a new decade, there was a worldwide affirmation of the principle of community participation emphasised in so many IPPF policies. The appropriateness of this approach is nowhere better demonstrated than in Africa, as the Regional Review shows.

GAINING OPERATIONAL STRENGTH

These broad shifts in programme priorities and approaches are reflected in the IPPF 1982-84 Plan which clearly states IPPF's intentions for the Plan period in a better structured format than in previous plans. This new approach to formulating the Plan has helped IPPF keep the

main programme priorities in focus while allowing sufficient flexibility for setting local priorities in accordance with local needs and circumstances.

During the last few years, much effort and energy went into improving the committee structure. It would not have been possible to work effectively towards integration under the guidance of a number of different specialised committees each looking at its own area of expertise without the necessary input from other very closely related programme areas.

The formation of the Programme Committee and the International Medical Advisory Panel has achieved a more effective use of volunteer time and skills. The Programme Committee has enabled IPPF to integrate thoughts as well as actions. The prestige of the IMAP has been a considerable asset in responding to the opposition forces who chose to distort scientific data in order to influence both the decision-makers and public opinion.

FPA's which do not need close monitoring by the IPPF, and which can offer so much of their experience to other FPA's not yet at the same level of development, have responded with enthusiasm to the challenge posed to them, confirming that one of the fundamental aims in establishing a worldwide network for family planning is still valid. Volunteers are taking an active part in this process of technical assistance as well as participating in in-country reviews of work programmes and budgets of other FPA's. Volunteers have also resumed certain operational functions which had been allotted to staff in the 70s.

Progress has been made over the past two years in consolidating and trimming the Secretariat, giving more rapid communication with and between FPA's, thus facilitating volunteer participation in IPPF decision-making and policy formulation. The benefits gained from having the advice of Regional Directors and their colleagues readily accessible for management decisions are demonstrated by improved responses to the needs of the field while minimising the risks of information gaps and misinterpretations. Major decisions are taken with the full knowledge of the conditions and needs at the local level. The new field offices, small units placed in the areas of greatest need, promise to improve management and technical assistance to young member Associations. This restructuring, based on integration, rationalization and decentralization, aims to ensure that the highest possible proportion of available funds will go into actual family planning. Secretariat costs as a proportion of total expenditure continue to decrease: in 1980 27.2%; in 1981 25.2%; and the estimated figures for 1982 and 1983 are 23.2% and 22.8% respectively.

A new system of Planning, Programming, Budgeting and Reporting (PPBR) will be introduced throughout the Federation in 1983. This system has undergone extensive designing and testing, taking into account the experiences gained with the existing system as well as the present and future needs of FPA's. The new system, designed as a basic management tool for the use primarily of Associations themselves, will provide the basis upon which Associations can further develop their management capacity and techniques.

The new system is designed to offer a medium term planning perspective (in the form of a Three-Year Plan) through which Associations will be able to state an assessment of what work they should be doing, and what work they intend to do, over a three-year period. In addition, they will quantify this work and show its financial implications for each of the three planned years. The annual Work Programme/Budget simply expands some of the information presented in the Three-Year Plan and allows for updating of that information nearer to the date of implementation.

The final component of the PPBR system is the Annual Report. This is a mirror image of the Work Programme/Budget, and allows Associations to assess the actual achievements of the year's work against the planned achievements as set out in the Work Programme/Budget. This assessment provides a logical input into the development of the next year of the rolling Three-Year Plan.

CHANGES IN THE FAMILY PLANNING MOVEMENT

The full impact has yet to be felt of the profound changes that have occurred in the family planning movement during the last few years. The client — the user of services — is being listened to as never before. Community participation in the design and conduct of programmes is spreading rapidly. The voluntary sector is growing stronger, increasing its influence and gaining new respect from governments and international agencies. Fertility control is no longer set apart from other human problems; it is a recognized part of the whole fabric of environmental health and the regeneration of the earth's resources.

An important contribution to these changes was the Jakarta Conference, which drew its inspiration from the striking evidence which emerged during the 1970s that for the enhancement of human well-being a variety of development inputs, including the provision of family planning services, are required.

There is now widespread public and official recognition that family planning contributes directly to this objective by lowering fertility, increasing birth intervals, reducing infant mortality and improving maternal and child health. This triggers benefits from other social economic inputs and increases people's, especially women's, participation in development.

The Conference underlined the danger of relaxing commitment to family planning on grounds that birth rates in some countries are already falling. While contraceptive practice rates range from 50 to 80 per cent among the one-third of fertile married women who live in developed countries, the rate is only 20 per cent or less among the two-thirds of fertile married women in developing countries.

More than 100 governments covering 90 per cent of the world's population now have policies under which family planning services can be provided. While this is undoubtedly encouraging, in many cases this is little more than lip service to the duty to provide these services. In many countries with rapid rates of population growth, there remains a conspiracy of silence on this subject and the impact on social and economic development is ignored.

Bali, China, Costa Rica, Northern Thailand and some of the South Indian states have demonstrated that fertility rates can be sharply reduced, even where per capita incomes are low. That there is a large unmet need for family planning has been demonstrated by data from the World Fertility Survey on the dramatic decrease in desired family size. The report in "People" magazine of a grandmother who wanted more than 12 children, a daughter-in-law who wanted six and her daughter-in-law, in turn, who opted for sterilization after three births, only puts in human terms what survey results give us in statistics.

The Jakarta Conference focussed attention on the client, stating:

"User's Perspective: Family planning programmes need to tailor their services and the contraceptive methods they offer to the needs and preferences of the people who use them. Programmes should. . . provide services in ways that are sensitive and responsive to local community values and individual needs.

Community Participation: Family planning programmes must engage communities more actively in both the design and the actual provision of family planning information and services. Only in this way can programmes truly reflect local priorities and be accountable to the people they serve. Family planning programmes should foster community self-reliance and participation."

One major hindrance is male attitudes to the family, to women and to family planning. Ignorance among men, not only in developing countries, is widespread and chauvinism persists in many cultures. Some promising beginnings are being made to reach men through youth movements, places of work, the armed forces and the universities.

Clearly young people of both sexes must be a priority for family planning programmes. Too much effort has been wasted in the past trying to change the attitudes of "the lost generation". Answers must be found to the special needs of young people. The high worldwide incidence of adolescent pregnancy is a symptom of these needs, as is the spread of venereal disease. Such dangers for immature young people flourish in conditions of extreme poverty but are also prevalent in affluent societies, particularly where special groups, such as the handicapped, have been by-passed by otherwise widespread sex education. IPPF must adapt to the changing younger generation and win their participation by capturing their interest in the wider implications of integrated development. In this area much hard work remains to be done.

Fortunately, IPPF's concern for young people coincides with the broadening spectrum of its work. Young people are disinclined to put problems in different pigeon holes. They interrelate what they see around them. This spirit of totality is caught by the resolution on People, Resources and the Environment adopted in October 1981 by the International Union for the Conservation of Nature and Natural Resources (IUCN), which specifically called for the collaboration of IPPF in putting a world strategy for conservation into effect.

Every opportunity is being seized to press home this promising initiative. At an important World Public Hearing on the Environment in London in July many eminent conservationists demanded that population should be included in the World Conservation Strategy and it was particularly significant that IPPF itself was asked to take part. It is equally important to broaden the spectrum of population conferences themselves and to put an end to strictly sectoral approaches to social and economic development.

IPPF sent a strong delegation to the Third Asian and Pacific Population Conference at Colombo, led by prominent international volunteers from several countries of the region. The International Conference on Population, to be held in Mexico in 1984, will be a crucial world event, at which experiences and knowledge gained since Bucharest will be distilled. This is an opportunity to put family planning and the voluntary sector back on the world agenda; the special roles of NGOs were virtually ignored at Bucharest and the revised World Population Plan of Action must state clearly that without people's own participation development efforts will fail, and without the stimulus of people's organizations no amount of governmental and inter-governmental machinery will succeed in enlisting popular support.

RESOURCES

The latest estimates show that international population assistance increased by a mere five per cent in 1981 -- not even sufficient to keep up with inflation.

There are no signs yet of reaching the target set by the Jakarta Conference for donors to allocate at least five per cent of their development assistance to supporting population programmes. At present, only the equivalent of one-fifth of one per cent of the money spent on armaments goes into population activities; an almost imperceptible transfer from the giant to the dwarf would bring incalculable benefits in terms of human well-being and could cut population growth rates by as much as 40 per cent in many developing countries.

A most welcome recent trend is the increasing responsibility assumed by developing country governments to fund their population/family planning programmes. Data collected by the Population Council show that in 15 countries, an average of 67 per cent of total expenditure for family planning was met by the governments themselves and only one-third came as external aid. The proportion of national funding to family planning programmes has been growing steadily in many countries, notably in Indonesia, India, Thailand, Tunisia and Mexico. This is most encouraging. However, the need for increasing external funding is likely to continue for at least another decade or two. In many parts of the world, programmes are only now being established. They are in the very early stages of development, when substantial support from the international community is necessary.

Despite governments' stated willingness to allocate national resources to family planning, their immediate capacity to do so may be limited, particularly in the poorest countries where family planning would have a significant impact on the quality of life. Even programmes which are now well established require substantial investments to improve their outreach and their quality. In order to increase effectiveness and to keep pace with

the increasing number of people in the reproductive age span, allocations to family planning programmes must be increased substantially. And, naturally, these programmes are only one of the many social development activities which demand public funds urgently. IPPF has repeatedly stressed the need for integration.

The question of resources is one to which IPPF has been paying greatly increased attention. IPPF volunteers were asked by the Central Council at its November 1981 meeting to take a more vigorous role in resource development : volunteers and staff were urged to commit themselves to the development of more effective strategies in their future funding approaches to donors; volunteers were urged to proceed with the utmost urgency to expand the donor community; and with staff assistance to make every effort to provide programme information on a continuous basis to all present and potential donors. A resource development workshop met at International Office in February 1982. It brought together volunteers and staff and some successful population programme fund-raisers to develop general strategies to enable FPAs to move towards self-support. Participants identified a number of possible strategies for increasing resources within FPAs and drew up an outline training programme. The resource development programme is now well under way.

THE OUTLOOK

The global economic outlook continues to be grim. The record of development efforts show that, despite enormous strides in some countries, the lot of the poorest has not improved. The 1982 World Bank estimates, which indicate that 1.000 million people are living in absolute poverty, tragically illustrate the scale of the problem. Most of the developing world has entered the third development decade with a very large deficit and the worldwide economic recession and inflation, coupled with unfavourable international trade arrangements, do not allow them to close that deficit. In this kind of environment, it would be naive to expect most developing countries to achieve self-sufficiency in running effective family planning programmes.

Fortunately, IPPF is in a unique position as it looks ahead to 1983 and beyond. The Federation has undoubtedly earned high ratings with the providers of its resources. It cannot rest on these achievements; if it is ever-watchful and self-appraising it will continue to represent the people and be an important vehicle for changes that will promote human well-being, and hopefully help ensure the survival of the planet.

SECRETARIAT ESTABLISHMENT

INTERNATIONAL OFFICE

Secretary General's Office	2
Management Audit Department	5
Evaluation Department	11
Deputy Secretary General's Office	2
Programme Development Department	8
Medical Department	3
Europe Bureau	5
MENA Bureau	4
IOR Bureau	4
Africa Bureau	6
ESEAOR Bureau	4
WHR Bureau	1
Policy Information & International Relations	3
Policy Unit	2
Information & Public Relations	20
Volunteer Relations	4
Management Service & Resource Development	3
Co-ordination, Planning and Training Unit	2
Resource Development Unit	2
Finance Department	20
Personnel & Administration Department	23
Purchasing and Supply Department	8
Sub-total	142

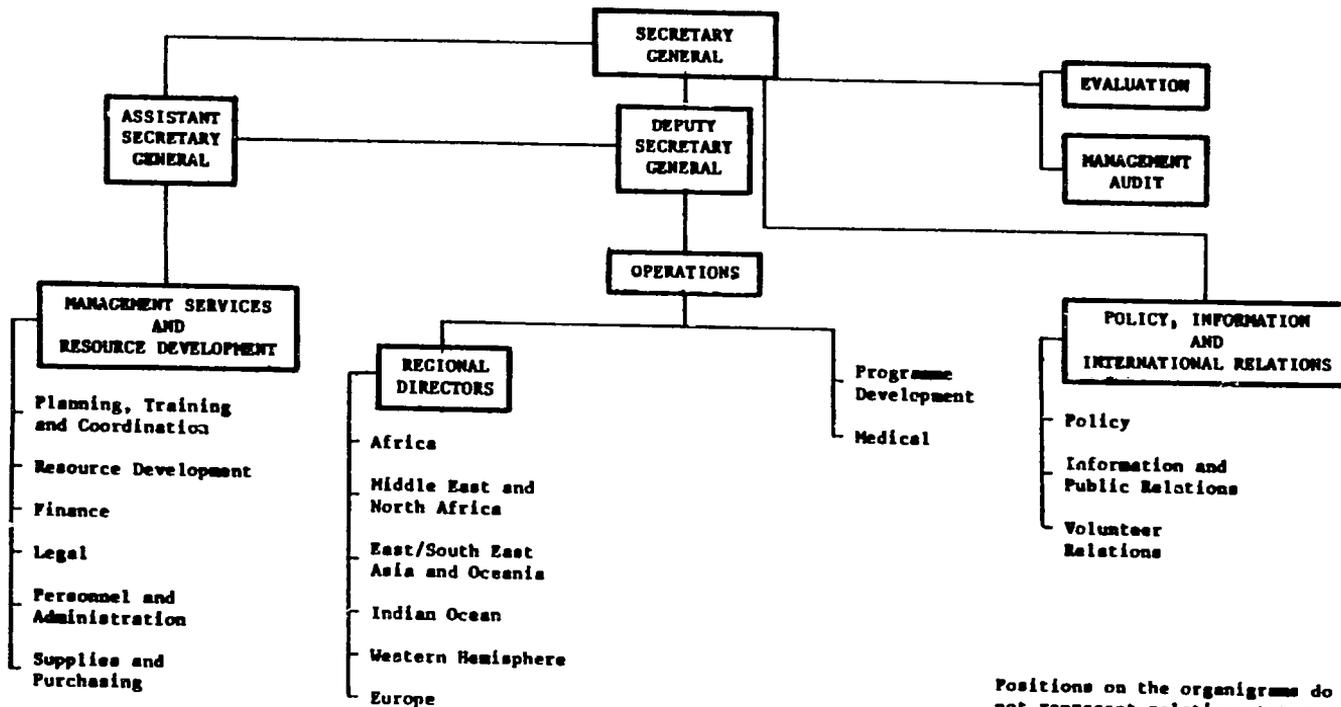
FIELD OFFICES

Dakar Field Office	5
Lome Field Office	10
Nairobi Field Office	11
Mbabane Field Office	5
Another Field Office	5
Kuala Lumpur Field Office	5
Kathmandu Field Office	3
Tunis Field Office	2
Cairo Field Office	2
Amman Field Office	2
Sub-total	50

Western Hemisphere Region	192
	37
TOTAL	229

IPPF SECRETARIAT

ORGANIGRAM OF INTERNATIONAL OFFICE

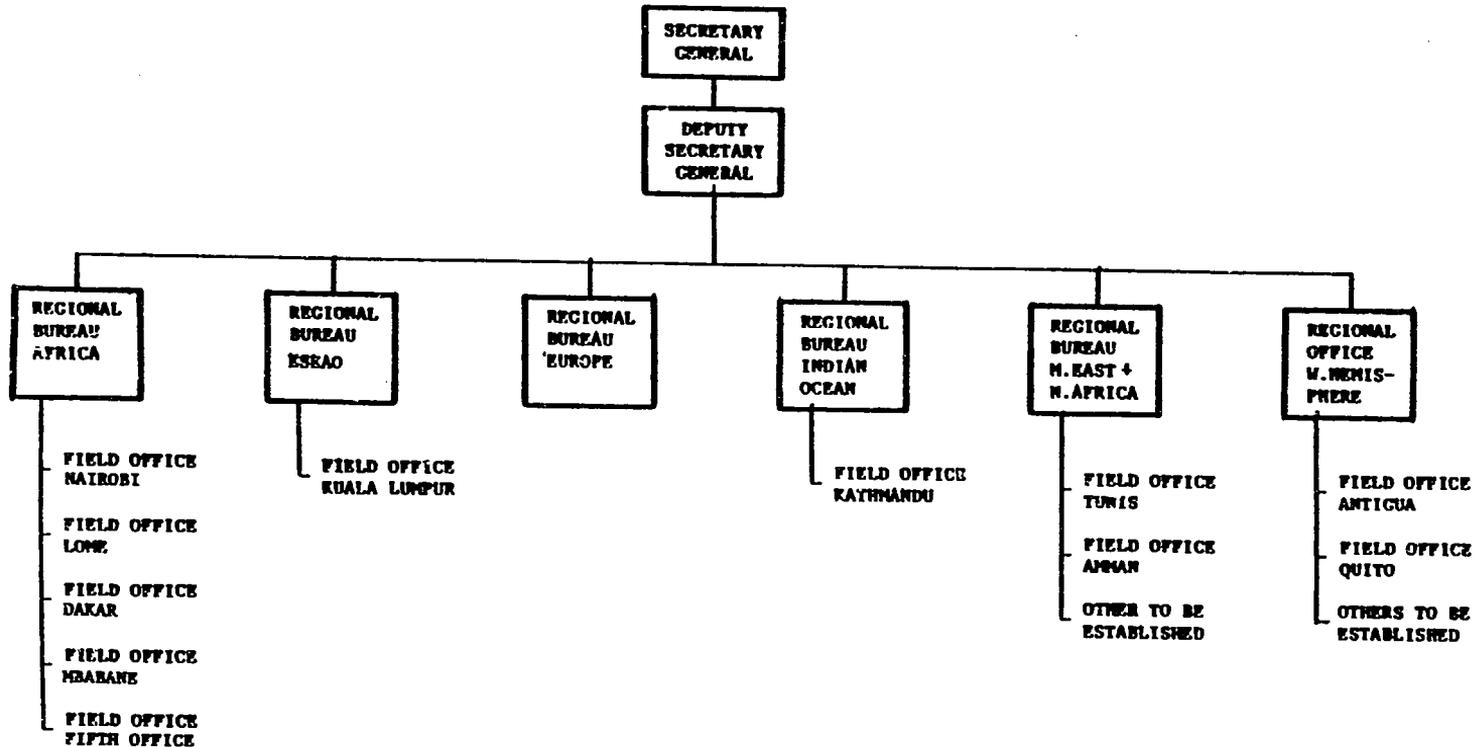


Positions on the organigram do not represent relative status or priority of functions within the International Office

IPPF SECRETARIAT

ORGANIGRAM OF REGIONAL BUREAUX AND FIELD OFFICES

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FAMILY PLANNING ACCEPTOR STATISTICS 1979 - 81

REGION	YEAR	CLINICS	NEW ACCEPTORS	CONTINUING ACCEPTORS	TOTAL ACCEPTORS	
Africa	- Clinical	1979(16)	596(13)	148,679(15)	245,731(15)	394,410
		1980(17)	812(15)	170,722(17)	219,960(16)	390,682
		1981(17)	963(16)	166,905(16)	271,637(16)	438,542
	- Non-clinical	1979(16)		22,756(7)	25,018(7)	47,774
		1980(17)		23,008(7)	24,885(4)	47,893
		1981(17)		25,288(6)	38,739(5)	64,027
Middle East & North Africa	- Clinical	1979(12)	748(12)	166,380(12)	390,274(12)	556,654
		1980(12)	668(12)	187,062(12)	427,408(12)	614,470
		1981(13)	668(13)	166,967(13)	467,516(12)	634,483
	- Non-clinical	1979(5)		24,860(4)	31,521(4)	56,381
		1980(5)		40,519(4)	54,017(4)	94,536
		1981(2)		21,758(2)	17,915(2)	39,673
Indian Ocean	- Clinical	1979(5)	530(5)	209,011(5)	186,630(5)	395,641
		1980(5)	544(5)	167,011(5)	111,990(5)	279,001
		1981(5)	544(5)	202,132(5)	205,511(5)	407,643
	- Non-clinical	1979(5)		196,495(4)	198,423(4)	394,918
		1980(5)		218,205(4)	284,035(4)	502,240
		1981(5)		189,001(4)	185,992(4)	374,993
East, South East Asia & Oceania	- Clinical	1979(12)	566(12)	156,872(12)	311,539(12)	468,411
		1980(13)	458(12)	151,761(13)	254,858(13)	406,619
		1981(11)	820(10)	151,200(11)	252,468(11)	403,668
	- Non-clinical	1979(12)		87,792(9)	206,467(9)	294,259
		1980(11)		28,540(6)	46,273(6)	74,813
		1981(9)		24,996(5)	53,227(5)	78,223
Western Hemisphere	- Clinical	1979(31)	875(26)	617,695(28)	840,158(27)	1,457,853
		1980(30)	1,750(29)	559,185(30)	745,718(28)	1,304,903
		1981(30)	1,578(29)	553,670(30)	877,089(26)	1,430,759
	- Non-clinical	1979(20)		320,759(16)	421,003(9)	741,762
		1980(20)		399,694(16)	677,435(14)	1,077,129
		1981(18)		430,612(13)	726,584(13)	1,157,196
IPPF Total	- Clinical	1979(76)	3,315(68)	1,293,637(72)	1,974,332(71)	3,272,969
		1980(77)	4,232(73)	1,235,741(77)	1,759,934(74)	2,995,675
		1981(76)	4,573(73)	1,240,874(75)	2,074,221(70)	3,315,095
	- Non-clinical	1979(58)		652,662(40)	882,432(33)	1,535,094
		1980(58)		709,966(37)	1,086,645(32)	1,796,611
		1981(51)		691,655(30)	1,022,457(29)	1,714,112
All Services	1979(76)		1,951,299(72)	2,856,764(71)	4,808,063	
	1980(77)		1,945,707(77)	2,846,579(74)	4,792,286	
	1981(76)		1,932,529(75)	3,096,678(70)	5,029,207	

Numbers of FPAs reporting each year are shown in parenthesis.

FINANCIAL REVIEW

1. 1981 ACTUAL INCOME AND EXPENDITURE

IPPF's 1981 Audited Accounts show that expenditure exceeded income resulting in a deficit of \$ 371,000. The approved budget and actual results for 1981 are summarised in the following table:-

	Approved Budget \$ 000	Actual Results \$ 000	Increase + Decrease -- \$ 000
Income	50,557	48,596	- 1,961
Expenditure	50,232	48,967	- 1,265
	325		
Surplus Deficit	325	371	

Actual expenditure was 2.5% below approved budget.

2. 1982 ESTIMATED INCOME AND EXPENDITURE

A comprehensive review of the 1982 approved budget was carried out in early September, and this shows that IPPF will have a deficit of \$ 1,291,000 at the end of 1982. The figures are summarized below:-

	Approved Budget \$ 000	Latest Estimate \$ 000	Increase + Decrease -- \$ 000
Income	50,616	50,315	- 301
Expenditure	51,242	51,606	+ 364
	626		
Surplus Deficit	626	1,291	

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 revised again in November. Current indications are that as a result of exchange 'gains' at Association level, expenditure may be some \$1.5 million less than that shown above.

3. 1983 PROJECTED INCOME AND EXPENDITURE

At its meeting in September 1982, IPPF's International Budget and Finance Committee (B&F) recommended a 1983 budget to the Central Council (meeting in November 1982) as follows:-

	\$ 000
Income	52,225
Expenditure	53,725
Deficit	<u>1,500</u>

During June, IPPF Regions stringently reviewed Work Programme/Budget submissions from Associations around the world and formulated their recommendations to the Secretary General. At the same time volunteers and the Secretariat were canvassing support from donors in order to prepare a reasonable estimate of financial resources that would be available to IPPF in 1983. When the two exercises were brought together in July, it was established that a deficit of over \$ 3 million would be incurred. The Secretary General in close consultation with senior volunteers and secretariat staff therefore had to identify reductions amounting to \$ 2 million in order to present a reasonable budget to the B&F Committee, showing a small projected deficit for the year.

In September, the Budget and Finance Committee reviewed the latest position. In view of the fact that exchange 'gains' at Association level during 1982 were likely to alter the estimated deficit into a surplus, the Committee decided to recommend a deficit of \$ 1.5 million for 1983.

4. WORKING CAPITAL AND CASH FLOW

The following table traces the recent history of movements in the levels of IPPF financial year-end 'Working Capital':-

	Actual 1977 \$ 000	Actual 1978 \$ 000	Actual 1979 \$ 000	Actual 1980 \$ 000	Actual 1981 \$ 000	Latest Estimate 1982 \$ 000	Budget 1983 \$ 000
Income	37,853	40,458	45,923	50,240	48,596	50,315	52,225
Expenditure	<u>38,297</u>	<u>45,336</u>	<u>45,261</u>	<u>48,174</u>	<u>48,967</u>	<u>51,606</u>	<u>53,725</u>
Surplus/ (Deficit)	<u>(444)</u>	<u>(4,878)</u>	<u>662</u>	<u>2,066</u>	<u>(371)</u>	<u>(1,291)</u>	<u>(1,500)</u>
Working Capital 1 January	14,236	13,700	8,876	9,327	11,355	11,471	10,180
ADD Surplus for year			+ 662	+ 2,066			
LESS Deficit for year	- 444	- 4,878			- 371	- 1,291	- 1,500
Other Adjustments	- 92	+ 54	- 211	- 38	+ 487		
Working Capital 31 December	<u>13,700</u>	<u>8,876</u>	<u>9,327</u>	<u>11,355</u>	<u>11,471</u>	<u>10,180</u>	<u>8,680</u>
Working Capital as a %age of following year's expenditure	30.2	19.6	19.4	23.2	22.2	18.9	15.3

Notes to Table

- i Other Adjustments – Relating to movements in Fixed Assets etc. during the financial years in question.
- ii End – 1983 Working Capital percentage assumes that 1984 expenditure will be 5% higher than 1983.

From the table it will be seen that IPPF's Working Capital continues to be below the target level of 25%. However, it is anticipated that the possible 1982 underexpenditure of \$1.5 million will result in a Working Capital level of 22% at end 1982 and 18% at end 1983.

It is important to understand that IPPF's Working Capital is not wholly held in cash, but also in current assets less current liabilities. For the purpose of the above table Working Capital has been calculated as a financial year-end figure. An analysis of the figures at the end of 1979, 1980 and 1981 shows:-

	1979		1980		1981	
	\$ 000	%	\$ 000	%	\$ 000	%
Bank Balances	2,088	15	10,794	73	5,002	34
Cash Grants paid in advance	4,714	33	55	—	218	1
Other Current Assets	<u>7,310</u>	<u>52</u>	<u>3,946</u>	<u>27</u>	<u>9,511</u>	<u>65</u>
Sub Total — Current Assets	14,112	<u>100</u>	14,795	<u>100</u>	14,731	<u>100</u>
Less Current Liabilities	<u>4,785</u>		<u>3,440</u>		<u>3,260</u>	
End of Year Working Capital	<u><u>9,327</u></u>		<u><u>11,355</u></u>		<u><u>11,471</u></u>	

It is also necessary to appreciate that IPPF's cash flow during the year peaks and troughs as income is received from donors and expenditures are paid out. The graph at the end of this review shows the month-end balances actually held in cash by IPPF during 1980, 1981 and 1982.

During 1982, IPPF repeatedly faced cash flow problems. The position was exacerbated by the fact that some donors are now paying their grants to IPPF in instalments. At 31 December 1981 grants due for 1981 but not received at that date amounted to \$9.0 million (1980 — \$3.4 million). The liquidity problem required IPPF, on occasion, to borrow money from our bankers, in order to meet financial obligations to FPAs.

5. RATES OF EXCHANGE

IPPF's budgets and accounts are maintained in US dollars. Since IPPF's International Office is located in London, cash balances are held in both sterling and in US dollars.

Approximately half of IPPF's income is received from donors in US dollars with the other half being committed and remitted in non-dollar currencies.

IPPF's expenditure, however, is mainly committed and incurred in US dollars. Therefore any falls in exchange rates against the US dollar significantly reduce income without having a corresponding effect on expenditure. The impact on expenditure is partially alleviated by the fact that the currencies of the less developed countries tend to fall against the dollar. However, this impact is generally offset by inflation in the countries concerned.

SHIFT OF EMPHASIS IN RESOURCE ALLOCATION

In September 1982, the Budget and Finance Committee reviewed IPPF's implementation of the Shift of Emphasis policy (approved by the Central Council in 1980). The Committee concluded that "the proposed budgets appear to reflect the wishes of the Central Council on the Shift of Emphasis".

In arriving at this conclusion a Working Group of the Committee reviewed the Secretary General's budget recommendations.

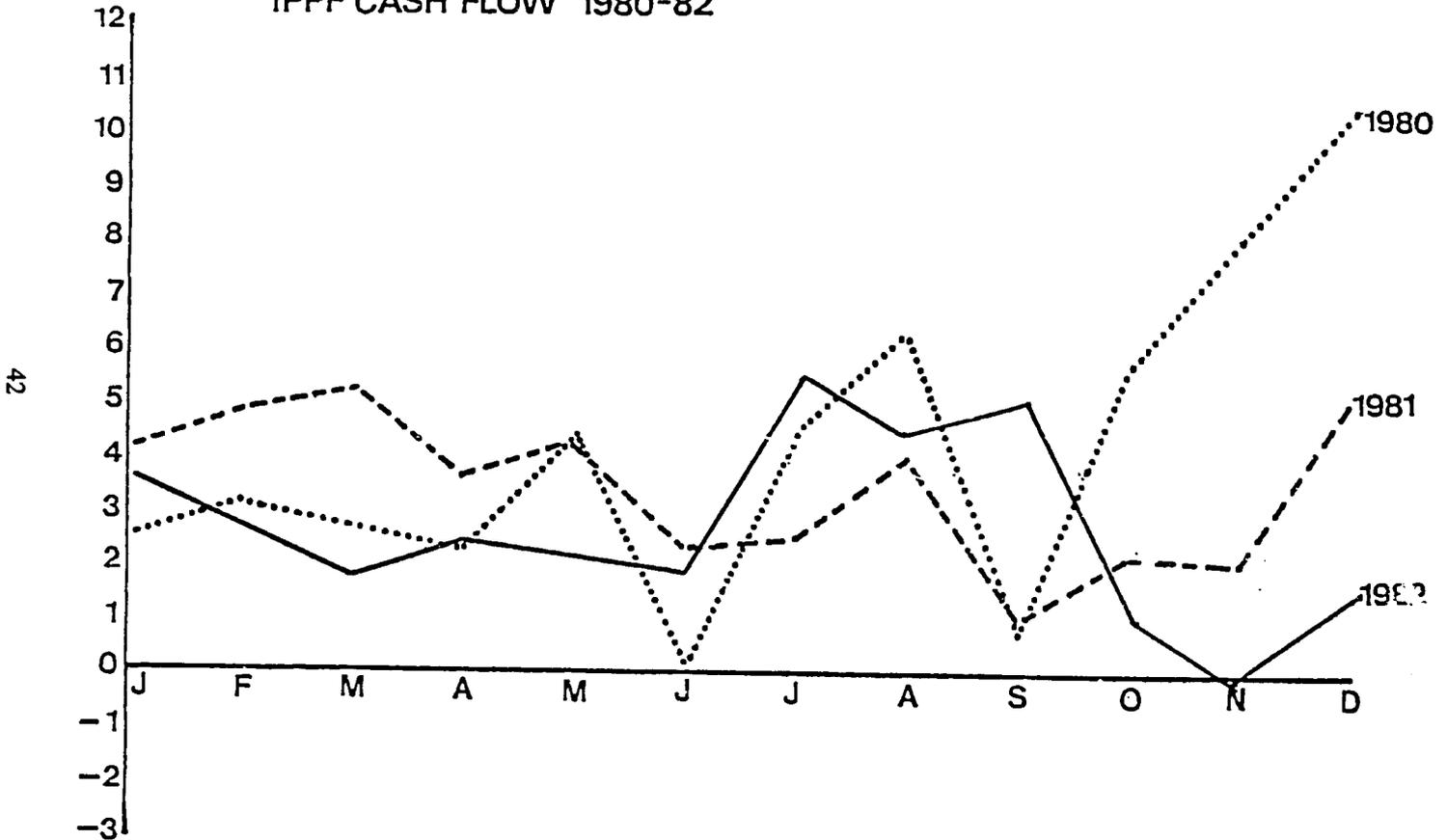
The table below outlines progress made in the implementation of the Shift of Emphasis policy:

Need Index (24=highest need)	Number of Grant- receivers 1983 (1)	Grant Allocations			% Increase Decrease 1981/83 (5)	% of Total IPPF Grant to each Group		
		1981 \$ 000 (2)	1982 \$ 000 (3)	1983 \$ 000 (4)		1981 % (6)	1982 % (7)	1983 % (8)
20 - 24	22	8,099	9,543	10,588	+ 30.7	25.8	28.4	30.9
15 - 19	29	12,680	12,991	13,509	+ 6.5	40.5	38.6	39.4
10 - 14	18	6,552	7,169	6,697	+ 2.2	20.9	21.3	19.5
5 - 9	12	3,050	3,099	2,736	- 10.3	9.7	9.2	8.0
0 - 4	8	973	841	758	- 22.1	3.1	2.5	2.2
TOTALS	89	31,354	33,643	34,288	+ 9.4	100.0	100.0	100.0

The Working Group also noted that "the Shift has proceeded far enough that in years beyond 1983 we run the risk of reducing funding to the 'lowest need' Associations to a level beyond which they could not be expected to remain active". This point will be kept under constant and continuous review when future budget recommendations are made.

US \$'000

IPPF CASH FLOW 1980-82



WORLD INCOME AND EXPENDITURE SUMMARIES 1979 - 1983

	1979	1980	1981	1982	1983
	Actual	Actual	Actual	Latest Estimate	Budget
	\$'000	\$'000	\$'000	\$'000	\$'000
<u>INCOME</u>					
Governments	42,692	46,417	44,860	46,912	49,356
Private Sources	1,754	2,108	1,372	1,460	1,194
Collaborative Projects	<u>1,477</u>	<u>1,715</u>	<u>2,365</u>	<u>1,943</u>	<u>1,675</u>
TOTAL INCOME	<u>45,923</u>	<u>50,240</u>	<u>48,597</u>	<u>50,315</u>	<u>52,225</u>
<u>EXPENDITURE</u>					
Africa	6,986.5	8,012.3	8,210.8	9,379.6	10,109.3
East, S.E. Asia & Oceania	4,337.0	4,061.3	3,831.8	4,712.2	4,747.1
Europe	86.6	64.5	50.0	90.0	115.5
Indian Ocean	4,445.2	4,987.1	5,037.1	5,484.6	6,815.4
Middle East & North Africa	1,816.7	2,154.6	1,833.5	2,373.8	2,732.0
Western Hemisphere	13,343.7	13,452.3	13,311.0	13,510.1	12,772.4
Countries not in IPPF Regions	878.9	562.9	898.5	624.2	714.3
Projects in Collaboration with other Agencies	2,227.9	2,506.4	2,808.8	2,983.2	2,960.3
Secretariat Operations and Projects	12,211.6	13,284.9	11,871.1	11,857.1	11,920.3
Programme Development Fund	-	-	-	1,310.5	2,166.4
Secretariat Rationalisation	292.7	113.2	752.3	750.0	-
Other Budget Items	70.8	330.9	309.0	184.0	659.0
Reserve Fund	-	-	-	-	250.0
Difference in Currency Translation	<u>(87.8)</u>	<u>(187.1)</u>	<u>1,177.7</u>	<u>-</u>	<u>-</u>
Total IPPF Grants	46,610.0	49,363.3	50,091.6	53,259.3	55,962.0
Less: In Kind Commodities	<u>1,349.5</u>	<u>1,188.7</u>	<u>1,123.8</u>	<u>1,653.0</u>	<u>2,237.0</u>
TOTAL EXPENDITURE	<u>45,260.5</u>	<u>48,174.6</u>	<u>48,967.8</u>	<u>51,606.3</u>	<u>53,725.0</u>
Surplus/(Deficit)	662	2,066	(371)	(1,291)	(1,500)

WORLD SUMMARY OF INCOME 1979 - 1983

	1979 Actual \$'000	1980 Actual \$'000	1981 Actual \$'000	1982 Latest Estimate \$'000	1983 Budget \$'000
<u>GOVERNMENTS</u>					
Australia	201	248	314	306	343
Canada	3,100	3,100	3,303	3,557	3,893
Denmark	1,381	1,337	1,277	1,414	1,713
Finland	125	167	147	168	192
Germany, Federal Republic	2,400	3,000	2,396	2,319	2,476
Japan	6,500	7,000	8,000	9,000	9,000
Netherlands	1,377	1,534	1,237	1,270	1,356
New Zealand	259	249	201	185	185
Norway	3,725	3,867	3,356	3,700	3,824
Sweden	7,822	8,766	7,725	8,203	9,494
United Kingdom	4,280	4,660	4,365	4,590	4,680
United States	11,432	12,300	12,263	12,000	12,000
Others	90	189	276	200	200
SUB-TOTAL	<u>42,692</u>	<u>46,417</u>	<u>44,860</u>	<u>46,912</u>	<u>49,356</u>
<u>PRIVATE SOURCES</u>					
Population Crisis Committee Associations:	262	200	-	-	-
Canada	70	81	79	80	84
United Kingdom	132	101	118	45	50
United States	711	592	311	400	400
Interest	344	837	526	560	200
Interest - WHRO	-	-	-	-	60
Sales of Publications etc. and Miscellaneous	235	297	338	375	400
SUB-TOTAL	<u>1,754</u>	<u>2,108</u>	<u>1,372</u>	<u>1,460</u>	<u>1,194</u>
<u>FOR COLLABORATIVE PROJECTS</u>					
UNFPA - For JOICFP	1,025	1,175	1,175	1,175	1,175
P.C.C. Projects	230	270	458	400	400
DANIDA - Calcutta Project	199	199	150	150	-
CIDA	-	-	-	169	-
CRESALC	-	-	582	49	100
Others	23	71	-	-	-
SUB-TOTAL	<u>1,477</u>	<u>1,715</u>	<u>2,365</u>	<u>1,943</u>	<u>1,675</u>
TOTAL INCOME	<u>45,923</u>	<u>50,240</u>	<u>48,597</u>	<u>50,315</u>	<u>52,225</u>

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

<u>WORLD</u>	<u>SUPPLIES PURCHASED BY IPPF</u>				
	<u>ACTUAL EXPENDITURE</u>		<u>1981</u>	<u>ESTIMATED EXPENDITURE 1982</u>	<u>PROJECTED EXPENDITURE 1983</u>
	<u>1979</u>	<u>1980</u>			
Contraceptives	3648.8	3469.4	3290.2	4314.3	4102.0
Medical & Surgical	776.0	442.8	574.0	316.1	438.8
Audio Visual Equipment	191.7	153.2	91.1	127.9	156.5
Office Equipment	305.9	150.9	106.7	136.0	112.4
Transport	667.2	535.3	593.5	471.4	591.1
Insurance, Freight & Storage	-	111.2	-	-	-
Prior Year Adjustment	(136.3)	(28.0)	(206.3)	-	-
TOTAL	5453.3	4834.8	4449.2	5365.7	5400.8

AID SUPPLIES DONATED TO IPPF

Contraceptives	1461.8	1188.7	1123.8	1653.0	2237.0
FULL TOTAL	6915.1	6023.5	5573.0	7018.7	7637.8

WORLD SUMMARY OF EXPENDITURE (BY LOCATIONS)

1981 ACTUAL

	IPPF GRANT			All figures in US\$'000		
	Cash	Comms	Total	Other Income	Dec. (Inc.) of Funds	Total Exp.
Africa	6995.3	1215.5	8210.8	3032.9	(1062.8)	10180.9
East, S.E. Asia and Oceania	3295.9	515.9	3811.8	6361.3	(561.5)	9631.6
Europe	50.0	-	50.0	39.3	(0.9)	88.4
Indian Ocean	4326.3	710.8	5037.1	1353.7	(590.0)	5800.8
Middle East & North Africa	1333.5	300.0	1833.5	950.6	(166.8)	2617.3
Western Hemisphere Countries not in IPPF Regions	11086.7	2224.3	13311.0	15338.6	(711.4)	27938.2
Projects in Collaboration with other Agencies	312.0	586.5	898.5	3.3	24.0	925.8
Secretariat Operations and Projects	2808.8	-	2808.8	-	-	2808.8
Secretariat Rationalisation Expenses	11871.1	-	11871.1	-	-	11871.1
Difference in Currency Translations	752.3	-	752.3	-	-	752.3
Other Budget Items	1177.7	-	1177.7	-	-	1177.7
	309.0	-	309.0	-	-	309.0
TOTAL	44518.6	5573.0	50091.6	27079.7	(3069.4)	74101.9

RECONCILIATION WITH 1981 AUDITED ACCOUNTS

Total IPPF Grants (as above)	50091.6
Less:	
In-Kind Commodities	<u>1123.8</u>
Total Expenditure per audited accounts	<u>48967.8</u>

WORLD SUMMARY OF EXPENDITURES (BY LOCATIONS)

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Africa	7923.4	1456.2	9379.6	2313.9	-	11693.5
East, S.E. Asia and Oceania	3472.1	1240.1	4712.2	7208.5	142.3	12063.0
Europe	90.0	-	90.0	112.0	13.0	215.0
Indian Ocean	4597.7	886.9	5484.6	1298.8	50.0	6833.4
Middle East & North Africa	1963.1	410.7	2373.8	449.5	(6.1)	2817.2
Western Hemisphere Countries not in IPPF Regions	10725.3	2784.8	13510.1	16582.9	69.6	30162.6
Projects in Collaboration with other Agencies	384.2	240.0	624.2	12.0	-	636.2
Secretariat Operations and Projects	2983.2	-	2983.2	-	-	2983.2
Programme Development Fund	11857.1	-	11857.1	-	-	11857.1
Secretariat Rationalisation Expenses	1310.5	-	1310.5	-	-	1310.5
Other Budget Items	750.0	-	750.0	-	-	750.0
	184.0	-	184.0	-	-	184.0
TOTAL	46240.6	7018.7	53259.3	27977.6	268.8	81505.7

WORLD SUMMARY OF EXPENDITURE (BY LOCATIONS)

1983 BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Africa	8478.0	1631.3	10109.3	2418.9	-	12528.2
East, S.E. Asia and Oceania	3599.8	1147.3	4747.1	11324.7	399.6	16471.4
Europe	115.5	-	115.5	114.0	-	229.5
Indian Ocean	5501.5	1313.9	6815.4	1858.8	9.1	8683.3
Middle East & North Africa	2199.5	532.5	2732.0	533.0	(17.9)	3247.1
Western Hemisphere	10058.6	2713.8	12772.4	18217.3	-	30989.7
Countries not in IPPF Regions	415.3	299.0	714.3	15.0	0.9	730.2
Projects in Collaboration with other Agencies	2960.3	-	2960.3	-	-	2960.3
Secretariat Operations and Projects	11920.3	-	11920.3	-	-	11920.3
Programme Development Fund	2166.4	-	2166.4	-	-	2166.4
Other Budget Items	659.0	-	659.0	-	-	659.0
Reserve Fund	250.0	-	250.0	-	-	250.0
TOTAL	48324.2	7637.8	55962.0	34481.7	391.7	90835.4

EXPENDITURE SUMMARY - COUNTRIES NOT IN IPPF REGIONS

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
China	175.0	-	175.0	-	-	175.0
Cuba	106.5	70.0	176.5	-	-	176.5
Israel	102.7	-	102.7	12.0	-	114.7
Vietnam	-	170.0	170.0	-	-	170.0
TOTAL	384.2	240.0	624.2	12.0	-	636.2

EXPENDITURE SUMMARY - COUNTRIES NOT IN IPPF REGIONS

1983 BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
China	270.0	-	270.0	-	-	270.0
Cuba	60.3	79.0	139.3	-	-	139.3
Israel	85.0	-	85.0	15.0	0.9	100.9
Vietnam	-	220.0	220.0	-	-	220.0
TOTAL	415.3	299.0	714.3	15.0	0.9	730.2

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURE BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US \$'000)

COUNTRIES NOT IN REGIONS

SUPPLIES PURCHASED BY IPPF

	ACTUAL EXPENDITURE 1981	ESTIMATED EXPENDITURE 1982	PROJECTED EXPENDITURE 1983
Contraceptives	173.2	138.1	173.0
Medical & Surgical	402.5	93.8	106.0
Audio Visual Equipment	10.3	6.6	20.0
Office Equipment	.5	1.5	—
Transport	—	—	—
Prior Year Adjustment	—	—	—
TOTAL	586.5	240.0	299.0

AID SUPPLIES DONATED TO IPPF

Contraceptives	—	—	—
FULL TOTAL	586.5	240.0	299.0

SUMMARY OF EXPENDITURE (BY FUNCTIONS)

IPPF SECRETARIAT

	1981 Actual	1982 Latest Estimate	1983 Budget
	\$'000	\$'000	\$'000
Management, Evaluation and Audit	827.0	1042.2	1171.6
Programme Development	6701.1	6499.1	5941.6
Policy and International Relations	1364.9	1505.8	1512.6
Resource Development, Finance and Administration	2978.1	2810.0	3294.5
TOTAL	<u>11871.1</u>	<u>11857.1</u>	<u>11920.3</u>

INCOME OF NON-GRANT-RECEIVING ASSOCIATIONS

The summary below gives details of 1981 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	1981 INCOME \$ 000
EUROPE	Austria	72
	Belgium	55
	Denmark	213
	Finland	318
	France	278
	German Federal Republic	393
	Italy	43
	Portugal	63
	Sweden	494
	United Kingdom	2,598
E & SE ASIA & OCEANIA	Australia *	3,150
WESTERN HEMISPHERE	Canada *	348
	United States of America	173,500

* year ending March 31 1982

AUDITORS' REPORT

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION
INTERNATIONAL OFFICE**

31 December 1981

**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 pages 3 to 11 in accordance with approved auditing standards.

In our opinion the 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 1981 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

16 June 1982

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 organisations of the International Planned Parenthood Federation and the 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 the community based distribution of contraceptive programmes.

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.

International Office provides technical assistance and advisory services, both directly and through the regional organisations to family planning associations throughout the world. It grants financial assistance to the regions and associations both in terms of monetary and non-monetary grants.

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 International Office provides, *inter alia*, the following services to regional organisations and 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 service statistics.
3. Promotion of national and local fund raising campaigns, advice and materials supports.
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 and Regional Offices 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. Donations of commodities are not reflected in the financial statements as they are shipped directly to the regions and associations concerned.

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 and on the Community Based Distribution includes administrative expenditure applicable to them.

3. SPECIFIC FUND BALANCES

Specific fund balances represent grants earmarked for specific purposes and funds specifically donated for various projects. Funds specifically donated are refundable to the donor if unexpended on the projects for which they have been donated.

4. FIXED ASSETS

Leasehold property is stated at cost less accumulated depreciation. Provision is made for depreciation on a straight line basis over the period of the relevant lease. The cost of office furniture and equipment is written off on acquisition.

5. CURRENCY TRANSLATION

Balances 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 1981 \$ 1.91 = £1.00 (1980 \$ 2.39)
Income and Expenditure –	At an average rate for the year \$ 2.03 = £1.00 (1980 \$ 2.33)

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION –
INTERNATIONAL OFFICE**

**STATEMENT OF INCOME AND EXPENDITURE AND FUND
BALANCES FOR THE YEAR ENDED 31 DECEMBER 1981**

US DOLLARS 1980	NOTES	US DOLLARS
INCOME		
46,416,692		
974,676	9	44,859,748
1,715,085	10	507,755
1,133,598	8	2,364,456
	11	864,693
50,240,051		48,596,652
EXPENDITURE		
27,402,722	12	27,599,719
6,133,502	13	5,757,643
4,723,568	14	4,449,191
2,292,605	8	2,597,151
213,788		211,613
846,226		706,678
617,455		398,303
301,769		259,455
545,647		357,142
416,267		344,899
1,604,804		1,207,445
2,819,280		2,678,715
–	15	43,895
330,942		116,922
113,164		752,323
(187,128)		1,177,683
–		309,040
48,174,611		48,967,817
2,065,440		(371,165)
BALANCES OF FUND AT 1 JANUARY 1981		
General	11,866,961	
Specific	121,825	
9,923,346		11,988,786
REGIONAL OFFICE FUNDS	16	372,623
BALANCE OF FUND AT 31 DECEMBER 1981		
General	11,355,415	
Specific	634,829	
11,988,786		11,990,244

STATEMENT OF FUNCTIONAL EXPENSES FOR THE YEAR ENDED 31 DECEMBER 1981

OPERATING EXPENSES

	Secretary General's Office	Volunteer Relations	Policy and International Relations	Programme Strategy	Evaluation	Information and Public Relations	Administration and General Services	Total for year ended 31 December	
								1981	1980
Personnel costs	618,700	106,993	157,240	244,300	277,813	547,241	857,104	2,809,391	3,146,128
Cash and project grants	—	—	—	26,500	—	—	2,638	29,138	—
Travel and travel expenses	84,891	277,592	49,679	42,969	55,415	19,119	68,687	598,352	1,038,447
Printing and stationery	—	940	—	—	501	345,798	94,096	441,335	691,935
Occupancy	—	—	—	—	—	—	905,908	905,908	922,562
Commodity grants	—	—	—	—	—	—	81,079	81,079	112,123
Film production and audio visual	—	—	575	—	—	43,693	—	44,268	53,828
19 Consultancy	—	—	2,533	38,959	8,438	46,501	20,034	116,465	277,359
Postage	—	824	—	177	—	108,976	116,716	226,693	332,790
Telephone and telex	—	—	—	—	—	—	107,750	107,750	162,163
Washington Office	—	—	—	—	—	—	73,000	73,000	65,000
Bangkok Office	—	—	39,651	—	—	—	—	39,651	50,288
Legal expenses and audit fees	243	—	1,502	—	1,918	223	72,774	76,660	69,642
Amortisation	—	—	—	—	—	—	18,114	18,114	25,131
Other expenditure	2,844	11,954	8,275	4,237	814	95,894	260,815	384,833	204,052
TOTAL AT									
31 DECEMBER 1981	706,678	398,303	259,455	357,142	344,899	1,207,445	2,678,715	5,952,637	
TOTAL AT									
31 DECEMBER 1980	846,226	617,455	301,769	545,647	416,267	1,604,804	2,819,280		7,151,448

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION –
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1981**

US DOLLARS 1980		US DOLLARS
	1 CASH GRANTS PAID IN ADVANCE TO REGIONS AND ASSOCIATIONS	
–	Africa	63,650
50,000	East and South-East Asia and Oceania	100,000
–	Europe	–
–	Indian Ocean	–
–	Middle-East and North Africa	–
5,000	Western Hemisphere	54,000
55,000		217,650
	2 RECEIVABLE FROM NON-IPPF SOURCES	
–	Sweden	3,607,688
2,000,000	Japan	4,500,000
592,398	Planned Parenthood Federation of America	310,551
487,500	JOICEP	–
14,568	United Nations Fund for Population Activities	–
342,532	Miscellaneous amounts receivable	417,318
–	Danida	150,000
–	FPC of Canada	76,556
3,436,998		9,062,113
	3 RECEIVABLE FROM REGIONAL OFFICES	
90,433	Africa	–
1,581	Europe	4,116
227,875	Western Hemisphere	–
319,889		4,116
	4 RECEIVABLE FROM ASSOCIATIONS	
90,077	Africa	98,885
9,077	East and South-East Asia and Oceania	36,654
10,060	Indian Ocean	15,300
–	Middle-East and North Africa	10,425
44,714	Western Hemisphere	27,369
5,845	Countries not members of IPPF Regions	105
159,773		188,738

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION –
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1981 (continued)**

8 PROJECTS IN COLLABORATION WITH OTHER AGENCIES

	1 January 1981		Income Others	Expenditure	31 December 1981
		IPPF			
Japan/UNFPA	–	895,699	1,174,592	2,070,291	–
PCC (see (ii) below)	121,825	–	458,175	91,388	488,612
Denmark	–	–	150,000	150,000	–
SIDA for CRESLAC	–	–	581,689	435,472	146,217
	121,825	895,699	2,364,456	2,747,151	634,829

- (i) Expenditure comprises \$ 2,597,151 for projects implemented by other operating agencies and \$ 150,000 for projects implemented by the IPPF Secretariat and Family Planning Agencies.
- (ii) \$458,175 includes income of \$ 58,175 expensed in 1980.

US DOLLARS

US DOLLARS

9 GRANTS AND DONATIONS FROM GOVERNMENTAL SOURCES

13,000,000	United States of America	12,000,000
(700,000)	Add (1980 Deduct) : Release of provision for interest payable	262,919
12,300,000		12,262,919
8,766,460	Sweden	7,724,642
7,000,000	Japan	8,000,000
4,660,000	United Kingdom	4,364,500
3,867,363	Norway	3,356,553
3,100,000	Canada	3,302,510
3,000,000	Federal Republic of Germany	2,396,514
1,337,469	Denmark	1,277,211
1,534,326	Netherlands	1,236,560
247,559	Australia	314,304
248,525	New Zealand	201,364
166,667	Finland	147,196
85,000	Ghana (two years' donations received)	170,000
55,117	Nigeria	47,074
9,069	Korea	20,000
10,000	Indonesia	10,000
7,625	Mauritius	6,754
6,274	Tunisia	5,866
5,045	Pakistan	5,082
4,000	Barbados	4,000
2,525	Sudan	2,525
1,026	Thailand	2,000
2,642	Philippines	1,210
–	Sri Lanka	964
46,416,692		44,859,748

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION –
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1981 (continued)**

US DOLLARS 1980			US DOLLARS
	5	PAYABLE TO REGIONAL OFFICES	
		Africa	155,869
–		East and South-East Asia and Oceania	255,381
102,197		Middle-East and North Africa	–
13,635		Western Hemisphere	100,185
–			
115,832			511,435
	6	PAYABLE TO ASSOCIATIONS	
		Africa	50,210
164,428		East and South-East Asia and Oceania	7,000
–		Middle-East and North Africa	–
5,320		Western Hemisphere	4,750
–		Countries not members of IPPF Regions	64,200
169,748			126,160
	7	FIXED ASSETS	
			Net book
		Cost	amount
		Depreciation	
		Short leasehold property	
		Balance 1 January 1981	118,974
		Disposals	(25,609)
		287,207	93,365
		Adjustment arising on currency translation	(18,422)
		229,525	74,943
		Depreciation for year	(18,114)
		–	18,114
		Balance 31 December 1981	56,829
		229,525	172,696

The cost of equipment and office furniture written off on acquisition in 1981 was \$ 12,180 (1980 – \$ 26,501).

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION –
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1981 (continued)**

US DOLLARS 1980		US DOLLARS
	10 GRANTS FROM OTHER SOURCES	
592,398	Planned Parenthood Federation of America	310,551
200,000	Population Crisis Committee	—
100,621	Population Concern (UK FPA)	118,063
81,657	Planned Parenthood Federation of Canada	79,141
974,676		507,755
	11 OTHER INCOME	
837,274	Bank interest	526,196
175,998	Sales of publications and visual aids	122,946
1,111	Membership fees	1,582
119,215	Miscellaneous items	86,503
—	Profit on disposal of lease	127,466
1,133,598		864,693
	12 CASH GRANTS TO ASSOCIATIONS	
6,948,927	Africa	6,995,289
3,254,229	East and South-East Asia and Oceania	3,295,900
64,500	Europe	50,000
4,046,076	Indian Ocean	4,326,330
1,671,715	Middle-East and North Africa	1,533,496
11,226,898	Western Hemisphere	11,086,704
190,377	Countries not members of IPPF Regions	312,000
27,402,722		27,599,719
	13 CASH REMITTANCES TO REGIONAL OFFICES	
1,899,000	Africa	1,609,343
740,000	East and South-East Asia and Oceania	530,000
249,813	Europe	291,000
228,489	Indian Ocean	90,000
658,800	Middle-East and North Africa	725,600
2,357,400	Western Hemisphere	2,491,700
6,133,502		5,757,643

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION –
INTERNATIONAL OFFICE**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER 1981 (continued)**

US DOLLARS 1980		US DOLLARS
	14	COMMODITY GRANTS TO ASSOCIATIONS
934,769	Africa	1,023,295
713,027	East and South-East Asia and Oceania	476,286
839,586	Indian Ocean	405,299
411,730	Middle-East and North Africa	270,870
1,452,529	Western Hemisphere	1,686,934
371,927	Countries not members of IPPF Regions	586,507
4,723,568		4,449,191
	15	REGIONAL BUREAU COSTS
	These are Secretariat costs of the Indian Ocean and Middle East and North Africa Regions from the date their respective offices were transferred to London	
	Indian Ocean	22,390
	Middle East and North Africa	21,505
		43,895
	16	REGIONAL OFFICE FUNDS
	The balance of funds of the Indian Ocean and Middle East and North Africa Regions have been brought into the International Office accounts at the date those offices were transferred to London.	
	Indian Ocean	383,065
	Middle East and North Africa	(10,442)
		372,623

AFRICA REGION

REGIONAL OVERVIEW

GENERAL ENVIRONMENT

Sub-Saharan Africa is, according to a recent UN report, the poorest region on earth, with an average life expectancy of 47 and an infant mortality rate of 150 per 1,000; the outlook for the future is bleak. Without exception, all governments in the region are experiencing severe difficulties in feeding, housing, schooling and in providing medical services for their young populations (approximately 40% of the people of any given country being under 20 years of age); these populations between 1960 and 1979 rose by 63% to total 334m. During the seventies the region had the doubtful distinction of recording the highest rate of population growth in the world of 2.7% annually. According to World Bank estimates, it will continue to grow by 3% per year during the eighties and nineties as a result of improvements in maternal and child health, accompanied by high fertility, phenomena which already exist in Kenya, Nigeria and Zambia. If these factors remain unchanged, forty years from now Nigeria will have a population of 341m, Zaire 95m and Kenya 81m, vivid illustrations of the magnitude of the problem affecting both urban and rural areas. In the last decade the population of African cities grew by 6% p.a., the rapid urbanization resulting from rural migrants seeking greater economic opportunities. This movement will accelerate in the future, particularly where pressure on the land is already acute. Many cities will double their population each decade and, judging from the extreme paucity or total absence of amenities available, the vast majority of future inhabitants will have no access to satisfactory water supplies, sanitation, waste disposal facilities, shelter, transport, schools, health care and job opportunities.

Poverty in the towns will be matched by that in the countryside. In the tropical counties south of the Sahara, the interaction of climate and geography is such that most African soils are delicate, deficient in organic material and, in general, only moderately fertile. Well-watered areas form only about one quarter of the total; elsewhere rains are inadequate and highly irregular, while the absence of frost makes weed and pest control particularly difficult. Most African agricultural systems involve extensive use of land resulting from the practices of shifting cultivation and long fallow periods, with limited use of manure and off-farm inputs. As long as land was abundant the use of such methods provided a steady yield per capita, even with the growth in population. However, land is no longer plentiful on most of the continent: population pressures have existed for many decades in East Africa (Burundi, Kenya and Rwanda), Southern Africa (Lesotho, Swaziland and Zimbabwe) and West Africa (Mauritania and Niger). There are pockets of high density settlement in a few countries such as in South-eastern Nigeria, the Western Highlands of Cameroon the Mossi plateau of Upper Volta and Senegal's northern "groundnut basin". In recent decades very high population growth rates for Sub-Saharan Africa have discouraged production and

economic growth. There is evidence that returns for labour in agriculture are declining: fallow periods are being shortened which reduces the regenerative power of soils; the cassava plant which can be grown on soils too impoverished for other staples has become more widely cultivated at the expense of other more nutritious crops, and disputes between cultivators and pastoral people for fuelwood and grazing are becoming more frequent. In addition, more marginal land has been brought under cultivation, either in zones of lower and uncertain rainfall or on slopes, leading to soil erosion and degradation. The conclusion can be drawn that part of the decrease in agricultural output per capita in the 1970s can be largely explained by population pressure on arable land: in the 1960s agricultural production grew in volume by 2.3% p.a., or roughly at the same rate as population growth; in the 1970s production growth dropped to about 1.3% p.a. while population grew at about 2.7% p.a. Sub-Saharan Africa is the only region in the world where per capita food production has actually declined over the past twenty years, resulting in constantly rising food imports.

There is little hope of most African countries being able to solve their food problems before the end of the century. In 1981 per capita food production declined for the fifteenth time in the past twenty years. More than one half of the population in the region is estimated to have a seriously inadequate diet, and today the average per capita food intake of Africans is 15% below that of ten years ago and 20% lower than at the start of the sixties. Even if the total food currently available in Sub-Saharan Africa were distributed equally and efficiently, there would still not be enough to give everyone an adequate diet. The resultant ever-rising food imports are largely composed of cereals which have trebled over the past 20 years. A recent agro-business study estimates that unless there is a remarkable change in production patterns the 18m tons of food imported in 1981 will have to double by the end of the decade.

The forestry picture is as disturbing as that for agriculture. Population growth among herders has been paralleled by a commensurate increase in their livestock, with the result that savannah woodlands have now been destroyed through overgrazing. Elsewhere the destruction of trees has also had catastrophic results: nearly half the trees which existed at the beginning of the century have been cleared, leaving some 800m hectares of forest, out of the continent's total land area of 2,970m ha. The spread of deserts is on the increase, and forests become increasingly incapable of playing their functional role of maintaining productive watersheds, preventing soil erosion and reducing the risk of flooding. It is also thought that the widespread destruction of forests can effect changes in weather patterns. In Ivory coast forests are being felled at a massive rate in order to make way for new and expanding cocoa and coffee plantations. As a result, the country's entire forest land may disappear within the next twenty-five years. Environmentally, the impact has already been felt in the southern region of the Ivory Coast as well as in neighbouring Upper Volta and Mali where there has been a substantial increase in the severity of drought.

Apart from these alarming ecological consequences there is also the energy aspect to consider: in Africa some 90% of the trees cut down are burnt as fuel, as over 300m

people in rural areas are dependent on firewood. As this becomes increasingly scarce young trees are being stripped well before they have reached maturity, thus aggravating the problem. The extent of the energy crisis facing rural Africa is difficult to gauge because of the lack of reliable statistics. UN figures indicate that at least 25m people in Africa are unable to obtain sufficient fuelwood, and a further 250m people face shortages. In The Gambia fuelwood is so scarce that it takes 360 man-days per year per family to collect. This scarcity inevitably means sharp price increases. In parts of the Sahel it is estimated that fuelwood can cost up to 25% of a family's budget. Many families are now having to go without it altogether; cooked food for them has become a thing of the past, increasing the already high incidence of malnutrition. It has been estimated that Kenya is in danger of having no trees left by 2000 if the present rates of deforestation and inadequate reforestation continue, while Senegal and Cameroon are similarly suffering from high rates of deforestation. In Niger the concentration of population around Niamey has resulted in such a rush for firewood in the surrounding area that the land has now been completely stripped and has turned into a desert for up to 70km around the capital.

In the fields of education and health the Sub-Saharan countries have made extraordinary strides in the past twenty years: tens of thousands now graduate each year from secondary schools and thousands from the universities. The African record is unparalleled as nowhere else has a formal education system been created on so broad a scale in so short a time. The achievements in medical care are no less remarkable. Life expectancy, the most important indicator of general health status, increased from 39 to 47 years, a 21% rise since 1960, while at the same time child death rates fell from 38 to 25 per thousand. The number of medical and nursing personnel per capita doubled, despite very high rates of population growth. Nevertheless, despite these immense achievements, the magnitude of the issue is such that the possibility of Sub-Saharan Africans obtaining access to health and educational facilities is still very low, and will decrease further with inevitable population growth as forecast. The 1978 primary school enrolment ratio was only 63% of the applicable age group for the region as a whole. In about one third of the countries less than 50% of primary age children are in school, and in only six are more than 20% of the relevant age groups in secondary school.

The health gap between Africa and other regions of the world also persists. Life expectancy is still twenty-seven years shorter than in industrialised countries and less than in any other developing region. The probability that a one-year-old child will die before his/her fifth birthday is twenty-five times greater than in the developed world, while the African child death rate is 67% greater than in South Asia and three times higher than in Latin America. It is worth noting that concealed within these health statistics is a major factor which does not afflict rich, industrialised countries: a large number of organisms which endow tropical man (and beast) with a wide variety of extremely unpleasant diseases, which are often of a chronic and very debilitating character. Due to the magnitude and complexity of the problems associated with their control, not only have the reservoirs of infection not been eradicated, but they

have, in some cases, actually been increased, either due to the development of resistance on the part of the organisms or as a result of the man-made creation of suitable habitats, such as dams. For the underprivileged sectors of society in particular, constant re-infection is an everyday hazard, the ill-effects being compounded by already low level of health generated by malnutrition. One corollary of this unhappy situation is that demands unknown to the richer countries are made on the already overburdened and grossly inadequate health services of poverty-stricken African countries.

Recent disturbances, actual and attempted, in several countries have made it clear that poor as they are, countries south of the Sahara may increasingly divert their spending to the military sphere, to the detriment of family planning and other development activities. In addition to the difficulties outlined above, there are also those in the area of finance where the debt that now faces many countries in the region has reached serious proportions. Rising prices for the oil imported, plus the generally lower prices for commodities exported, have meant that countries have had little option but to borrow more during the past few years, sinking deeper into debt. In 1981 nine developing countries had their debts rescheduled, five of them African. Zaire had to reschedule debts of US \$ 680m while Senegal, Liberia and Madagascar reached agreement with their creditors to postpone debt repayments. The debt of Sub-Saharan African countries is rising fast: at the end of 1970 this stood at US \$ 7bn, but grew over five-fold to total US \$ 38bn by the end of 1980. A disturbing feature of the situation is that for a significant number of countries the debt burden now forms a very high percentage of their national income: Togo's debts rose in the seventies from US \$ 40m to US \$ 851m and account for 86% of national income, and the debts of at least eight other African countries now account for over 40% of their national income. The outlook for the future is far from encouraging as, with worldwide interest rates expected to rise, countries will almost certainly have to pay out more to service their debts in the years to come.

STATUS OF ATTITUDES TO POPULATION/FAMILY PLANNING

Despite the increasingly wide variety of evidence that the past rapid growth of population in the countries south of the Sahara has brought about a decline in the quality of life for their peoples and has also had profoundly damaging effects on the environment, it is only now that governments in this part of the world are beginning to pay serious attention to the subjects of family planning and population. Several factors account for their previous reluctance to address themselves to the subject; many countries in the region cover vast geographical areas and decision-makers were often of the opinion that sheer size, irrespective of the land's fertility, was an argument against population growth. Secondly, environmental studies are a relatively recent discipline and the deleterious effects of human activity on the habitat are only now being acknowledged in some quarters, while in others they are to some extent discounted, as certain groups vociferously maintain that it is the imbalance of resource distribution rather than the inability of the planet to support more people which is the real cause of poverty and environmental problems. African decision-makers and opinion-formers were generally not well-informed on population and/or FP/MCH matters and did not see any particular convincing reasons to place either of these high on their list of priorities.

The climate is now changing. This has come about partly because of the failure of some governments to achieve their development plans and partly as a result of natural disasters, chiefly devastating droughts, which have necessitated the large-scale importation of food, thus consuming scarce foreign exchange previously destined for development projects which then had to remain unrealised. Also, censuses have been undertaken in several countries in recent years which have sometimes revealed significantly larger populations and/or higher rates of growth than had been suspected, the effect of which has been to jolt at least two governments (Senegal and Swaziland) into taking the issue of population/FP more seriously than before. Further, arguments in favour of birth-spacing for maternal and child health together with those advocating family size limitation (a subject which until fairly recently was virtually taboo in Africa) are becoming acceptable in some countries. This preparedness of people to give a more sympathetic consideration to these two issues has been generated partly through the improved education of girls and improved government MCH services, and partly as a result of the acute economic pressures analyzed above which have caused many families to rethink their approach to the question of family size. Nevertheless, the reluctance of some couples to have more than three or four children very frequently meets opposition which is particularly strong from older women relatives who employ varied tactics to try and persuade the younger ones to be more prolific.

These changing trends have been given concrete manifestation by an encouraging number of governments, which include Botswana, The Gambia, Ghana, Kenya, Mauritius, Senegal, and the Seychelles and Swaziland, which have declared population policies orientated towards the planning of population growth rates to match their development capacities, and have set up institutions for the management and implementation of FP programmes.

Others, including Ethiopia, Lesotho, Nigeria, Tanzania, Togo, Uganda and Zambia, as well as voicing concern regarding high rates of population growth have also adopted policies to implement FP programmes within their public health services for reasons of health and family welfare, while in August, 1982, President Nyerere called upon the General Council of the Tanzania Parents Organisation to spearhead mass education on the importance of child spacing in the interests of MCH. Over the past two years the Francophone governments of Burundi, Madagascar, Rwanda, Senegal and Cameroon have also expressed concern over population growth rates.

It is apparent that the Francophone countries of the region lag a little behind their Anglophone neighbours in the field of policy formulation regarding population and/or FP. In some cases, for example Zaire, the country is so large and so rich in both agricultural and mineral resources that there is no disquiet regarding overpopulation; however, there is concern at the rate of growth which will place an intolerable strain on the provision of jobs, housing, medical services, etc. Another vast but far less fertile country, Mali, although not dissatisfied with fertility trends, is concerned to reduce the high levels of mortality and morbidity currently prevailing, to which end the government established an FP programme as early as 1971, and now has a Family

Health Division operating within the Ministry of Health. Other Francophone countries lacking a population policy include Benin, Burundi, Rwanda, Togo and Upper Volta. Benin, with UNFPA assistance, has recently established a National Family Welfare Programme, and the government has, largely thanks to the influence of the FPA, accepted the integration of FP into the MCH services. Burundi had its first population census in 1979 and senior government officials have recently been expressing concern regarding the rate of population growth. Neighbouring Rwanda held its first population census in 1978, and in 1981 established ONAPO, their National Population Office, in response to government concern over the ever-growing pressure on land. Progress in Togo has been rather disappointing. Having given its blessing to the establishment of a Family Welfare Association, which has been a member of IPPF since 1977, the government still takes an ambiguous stand on both population and family planning and continues to restrict the delivery of contraceptive services to authorised gynaecologists, irrespective of the methods, which severely limits the provision of services. There are signs that changes are on the way, and it is to be hoped that these will materialise before the year is out.

Although Upper Volta has not formulated a population policy and is of the opinion that current fertility rates and the natural rate of increase are satisfactory, the government is concerned at the high rates of morbidity and mortality and is anxious to improve MCH services as well as favouring the introduction of population education and family life education in schools; in addition the government has established its own FP Department in the Ministry of Economic Planning. Concern with maternal and child health has also recently been manifested by one of the two major Lusophone countries in the region, Mozambique. With a population of about 12m, the concern is not to reduce the birthrate, but to encourage women to space births, to which end in 1981 Mozambique, funded by UNFPA, cautiously launched a US \$ 4.5m family planning programme which provides FP services free of charge to any women requesting them.

All these encouraging developments were given what could perhaps be regarded as a stamp of approval by the 1981 Inter-Parliamentarian Union meeting for African Parliamentarians on Population and Development. Most of the participants came out in favour of family planning and observed that the very large population growth rates were among the major obstacles to development on the continent. They also recommended that FP programmes should be integrated into the overall programmes of family health and, where necessary, that they should be given added prominence through separate programmes.

DEGREE OF FAMILY PLANNING PRACTICE

Disappointment is frequently expressed at the relatively low-level of statistically quantifiable family planning practice in Black Africa. The matter must, however, be considered in context and due recognition given to the difficult circumstances in which FPAs are operating, some of which were outlined above. Several other factors

should not be forgotten: the Sub-Saharan countries are endowed with a multiplicity of languages; the illiteracy rate is very high; the paucity of roads makes it difficult to reach clients in the rural areas where 80% or more of them live; high infant mortality understandably encourages high fertility, and, in all these countries where social security is virtually non-existent, desired family size is often six or above. With the exception of Mali and Senegal almost every Francophone country in the region still has laws prohibiting the dissemination of information about contraception on the statute books; in other countries the distribution and insertion of clinical contraceptives is restricted to doctors, most of whom are only to be found in towns, while in some countries the law brings published information on family life education into the category of "obscene publications". With very few exceptions the laws on abortion are either extremely restrictive or enforce imprisonment for the practitioner as well as the client. The Islamic code, which is adhered to by large numbers of people in the region, while tolerating abortion up to 120 days, prohibits voluntary sterilisation except in cases where, as a result of a hereditary disease, the children would be "afflicted with malicious and incurable diseases", also, this form of contraception remains against the law in many countries in Sub-Saharan Africa. Catholicism is widespread and the hierarchy is now reinforcing its traditional opposition to "unnatural" methods by starting "Natural Family Planning" campaigns which have been reported as getting under way in Kenya, Rwanda and Zambia. Added to these constraints which discourage the practice of family planning there are also factors affecting individual couples which cause women in particular to hesitate. First, and perhaps foremost, is the problem experienced by women the world over of undesirable side-effects. Then there is the feature of many African (and other) societies of the low status of women; not only do their husbands refuse to allow them to participate in decision-making about fertility regulation, but also the status of women is largely reflected in the number of their children, while the standing of the man is correspondingly enhanced if he likewise can boast numerous offspring.

There are, however, many encouraging signs that, even if still comparatively low, the demand for reliable family planning is there and is growing, and, as has been noted above, that it will increasingly get official support. Associations in the region are in general finding that the services they provide are proving insufficient to meet the growing demand, and Benin, Ethiopia and Kenya have expressed their view that this is in no small measure a result of the ever-mounting economic difficulties being experienced by families, inclining them towards a limitation of their family size, while Kenya and Tanzania have reported that population pressure in some regions is becoming a growing concern at grassroots level, a factor which should encourage the acceptance of FP. Proof of demand is not hard to find, one acutely distressing symptom of which is the increasing incidence of clandestine abortion and abandoned newborns, particularly in urban areas. A just perceptible demand for voluntary female sterilisation is also beginning to appear, having been reported by Kenya and Sierra Leone, while Ghana's trail-blazing community-based distribution in the countryside has repaid this dynamic Association with an accelerating demand, which goes a long way to prove that CDB is acceptable in certain African societies, something which a few conservatives in

the movement are still denying. It will be recollected that at the 1980 World Conference of the UN Decade for Women Ghana, Kenya, Lesotho, Rwanda, Uganda, Zaire (among others) co-sponsored Resolution One on Family Planning which called upon governments to take all appropriate measures including legislative ones within the framework of national policies, to provide information, education and means to enable women and men to freely exercise the right to determine their family size, and recommended that contributing governments should set aside an appropriate proportion of their resources for population programmes. Further to this the Associations of Benin, Ethiopia, Mali, Senegal, Upper Volta, Zaire and Zambia all report that they obtain very strong support from the official women's organisations in their country, the Secretariat for Women's Affairs in Zaire having stated that a well-formulated policy on FP is an essential prerequisite for all social development.

ROLES AND RELATIONS WITH GOVERNMENTS

In all countries where Family Planning Associations have been established, relations with their governments are cordial, and, with the growing awareness regarding population dynamics and maternal and child health, it is to be anticipated that they will become even more so. Notable in the Francophone countries for their collaborative relationship with their family welfare associations are the governments of Benin, Mali and Upper Volta. As early as 1971, the Malian government, having accepted family planning as an integral part of the national MCH services, established an FP programme, and in the following year the 1920 law against contraception was modified and people were permitted to use "all contraceptive methods except abortion". In 1978 the government created a Family Health Division within the Ministry of Health and Social Welfare which has the responsibility for co-ordinating all family planning activities in the Republic, and works in close collaboration with the Association Malienne pour la Protection et la Promotion de la Famille (AMPPF) as well as with UNFPA which finances the government programme. Further, very recently, a Memorandum of Understanding was drawn up between AMPPF and the Ministry of Health which assigns the following role to the Association: the provision of information on FP and motivation of the general public to accept and use reliable methods of contraception as an element of family welfare; the provision of contraceptive products to the MoH which in turn will carry out the service delivery aspect of the programme, and assistance in the training of personnel in FP service delivery. Like Mali, neither Benin nor Upper Volta have population policies, but their commitment to MCH and family planning is very high, and is matched by their co-operation with their respective family welfare associations: Benin has very recently established a National Family Welfare programme with UNFPA financial assistance in which the participation of the *Comite National du Benin pour la Promotion de la Famille* is assured, and Upper Volta, which in its Five Year Socio-Economic Development Plan (1977-81) stressed the need to work out an FP policy, collaborates with the Association (AVBEF) through its Family Planning Department established in the Ministry of Economic Planning and has granted duty free facilities to the young AVBEF. It is very much to be hoped that these three associations, two of which have not been without their problems in the past, will not fail to take maximum advantage of the support of their governments. Sub-Saharan

Africa can now claim three Heads of State who have unequivocally demonstrated their support for family planning and for the association in their country by agreeing to become Patron of the FPA, the Heads of State of Kenya and Liberia having been joined by President Shehu Shagari of Nigeria who this year accepted PPFN's invitation to become Grand Patron of the Planned Parenthood Federation of Nigeria, while the Governors of four states in Nigeria (Niger, Imo, Ondo and Bauchi) consented to become Vice-Patron in their respective states. Also in 1982, on the occasion of the tenth anniversary celebrations of the Planned Parenthood Association of Zambia, President Kenneth Kaunda not only sent a personal letter of congratulation to PPAZ but also instructed the Secretary-General of the Party to deputize for him at the celebration.

If the delivery of FP services is to be guaranteed for the future it is imperative that FPAs seize the opportunities presented by such favourable government attitudes to carry out a strategy which should be part and parcel of the planning of every association in the region: that of self-reliance. In recent years, it has become inescapably evident that IPPF's donors are (and will continue to be for the foreseeable future) experiencing very severe constraints, and that if associations are to survive they will have to look to sources other than the Federation for the increased support they need. The record so far is not particularly encouraging, with such revenue as has been raised very largely coming indirectly from IPPF through contraceptive sales.

Ghana has an outstanding record in this regard, raising over 60% of her expenditure in this way, with Madagascar not lagging too far behind. In the past, African governments and other agencies have not been prepared to take population/MCH seriously, and governments have previously regarded such associations as had been formed as being eccentric aberrations whose activities were of no particular interest and so unworthy of funding. But this is now changing and FPAs must not be slow in exploiting all opportunities to the full, whether presented by government or arising from other sources. Encouraging examples are being given by the very new association in Upper Volta, and by two other Francophones, Mali and Zaire, which have all managed to attract a significant amount of non-IPPF support. Among the Anglophones the governments of Ethiopia and Kenya provide extremely encouraging examples by, directly or indirectly, providing assistance to the FPAs of around US \$ 350,000. Among the others, The Gambia is doing well, while Sierra Leone and Nigeria are making valiant efforts which have not been without success, and which are particularly commendable in the case of the Nigerian FPA, given that it is operating in a country whose attitude to population/FP is still only lukewarm; these are examples which some other FPAs, notably Mauritius, would do well to emulate. It is to be hoped that the resource development visits made by the Regional Office in 1981 to Madagascar and Zambia will bear fruit, particularly in Zambia where the FPA's unsatisfactory past performance has long discouraged potential contributors, but whose very dynamic new senior staff have in a remarkably short space of time succeeded in creating a burgeoning respect for PPAZ, a respect which now appears to stand a reasonable chance of being translated into tangible form.

In the current climate the development of self-reliance will become an element of the role of FPAs world-wide. For Black Africa, due to the adherence of new members in the future, the other main features of the role of the large majority of associations will for a long time to come continue to be the pioneering ones of service provision; sensitising opinion-leaders and the general public to the need for family planning, and of persuading governments both to adopt a population policy and to take over responsibility for the provision of family planning services through integrating them into the state maternal and child health structure. Several associations have now successfully carried out this challenging role, and must in consequence think in terms of re-defining the orientation of their activities so that they can exploit to the fullest the "second stage" of development which they are now entering. This process will demand a high degree of flexibility from the FPAs who will inevitably be forced into having to take some very hard decisions, particularly regarding staff redundancies. Such changes will however be foreseeable, and it will thus be possible to plan for them in an orderly fashion some time in advance. This will not be the case for those associations whose countries suddenly receive the large-scale financial attention of international donors wishing to contribute to a vast and rapid expansion of primary health care/family planning facilities, a phenomenon which is becoming a rather prominent feature in countries south of the Sahara, and which will in turn place great strains on FPAs and make enormous demands on their ability to adapt to fluctuating circumstances. Among those associations currently contending with the strong possibility of having to adapt are Nigeria, Senegal, Zambia and Zaire, and it is to be anticipated that their need for technical assistance from the Regional Bureau will increase accordingly. However, exchange of experience on this and other issues will be facilitated through the creation of an innovative piece of machinery, namely The Association of Chief Executives of Africa Region FPAs, which held its inaugural meeting in 1981 and has now finalised a draft constitution, the objectives of which include exchange of experience among associations and the effective expansion of FP services in the region.

VOLUNTARISM

Family planning came to the Africa Region as a result of volunteer efforts, and, as governments increasingly find their resources over-stretched due to the demands of other development activities, it is clear that the movement will continue to depend for its continued success on the invaluable contribution of its volunteers. But ultimately it is hoped that governments will take over the running of the bulk of services, and FPAs are being urged to encourage their governments in this direction. At the local, provincial, national, regional and international level volunteers play an essential role in policy making and in the overall management and delivery of information and services, by giving free of charge their time, skills, knowledge and experience, and, in some cases, additionally donating their own money or other resources, contributions which endow the Federation and its constituent family planning associations with a co-ordinated moral force entirely lacking in more "orthodox" development projects. In addition they not infrequently take on the irreplaceable role of "persistent persuaders", firmly but unaggressively and steadily encouraging people of influence in every strata of society to give their serious attention to the extent to which family

planning can contribute to maternal and child health and thus to overall family welfare and to a planned and structured approach to population growth. It is the volunteers who, when carrying out this persuading role, give IPPF its unique and extraordinary strength and endurance, as, without these indigenous agents working within their own societies for what in Africa is still a highly controversial cause, family planning in the Sub-Saharan countries would probably have long ago gone the way of countless development projects and vanished without trace. It is undeniable that it is due to the commitment and endurance of volunteers, working in partnership with staff, who are without exception nationals of the countries concerned, not only that family planning and welfare associations have taken root in Black Africa but also that, often in the face of tremendous vicissitudes they have, even if withering a little from time to time, continued to survive.

The spirit of voluntarism is indigenous to virtually all African societies, and, with the growing awareness of the wide variety of benefits to be derived from reliable methods of contraception, the family planning movement has in many countries been able to attract increasing numbers of volunteers. It is discouraging to note that although in most countries there is rarely a shortage of volunteers at the national, or "elite" level, in many countries not many candidates come forward from the "grassroots" level, a phenomenon which is probably explained by a number of facts including the heavy workload of the less privileged (particularly women) which does not permit them much, if any, spare time, their involvement in clan welfare activities and their lack of information about family planning matters in general. In the light of this situation a number of associations, notably Ethiopia, The Gambia, Ghana, Kenya, Lesotho, Nigeria and Zambia, have made special efforts to recruit more volunteers to assist with programme implementation,

Once recruited, it will be essential to incorporate training seminars into work programmes so that the newcomers clearly understand what their role should be. Nor will such training be confined to those FPAs taking on new volunteers, as it is very clear that even some of the long-standing ones also require reminders as to the boundaries of their role, which they occasionally either overstep or fail fully to carry out. The conduct of senior volunteers in some FPAs continues to leave much to be desired and must be improved, while in others the excessive caution of some volunteers regarding innovative methods of service delivery has seriously hampered the spread of family planning in a region which is beginning to gain an unfavourable reputation internationally for unacceptably low practice rates.

A PERIOD OF TRANSITION

The past two years have been, and 1983 will continue to be, a period of major transition for the IPPF with the restructuring of the Secretariat, the gradual but steady implementation of the shift of emphasis policy, and the inauguration of the new programme planning, budgeting and reporting (PPBR) system. The first two of these, in effect, even in these difficult times, usher in a period of modest expansion for the

Africa Region, which, from the point of view of the scale of unmet needs and the lack of service delivery facilities places the overwhelming majority of its component countries in the category of the most deprived in the world. The Regional Bureau, which started operating from London in April, 1982, co-ordinates the work of five field offices, three of which were set up this year and are additional to the two well-established ones in Kenya and Togo. Of the new offices one is in Senegal, another in Swaziland and the third, presently housed in the Togo office, is to be established in Cameroon, The Congo or Nigeria. In July of this year the Centre for African Family Studies, in the interests of economy, vacated its previous Nairobi premises and is now sharing those occupied by the Kenya Field Office.

Despite the difficulties caused by the reorganisation of the regional administration the Regional Office managed successfully to carry out almost all of its 1981 work programme, the only major casualty being that expansion work into new countries was not as great as had been planned.

The project on upgrading the communication competence and skills of FPA field personnel resulted in Ghana, Kenya, Lesotho, Mauritius, Nigeria and Sierra Leone developing a large measure of self-sufficiency in this area, and a Planned Parenthood and Women's Development workshop was held in Benin, which served to launch a PPWD programme for the Francophone countries which is being further developed in 1982 and which will continue in 1983. A regional project on male motivation was also inaugurated in 1981, with the idea being introduced to associations through the distribution of relevant material and assisting them with project design. Unfortunately the Law and Planned Parenthood project regarding the publications "What Every Woman Should Know" fell behind schedule due to numerous amendments which had to be made to the drafts; however the training of FPA and other paramedical personnel in service delivery went on as planned. Inter-agency collaboration continued, while on the finance side training was provided to the relevant staff of three Francophone associations. In this connection, a considerable problem which has long manifested itself in the region is the high turnover of financial staff, largely as a result of terms of service which, when compared with those which can be obtained elsewhere, are not attractive. This is a phenomenon not confined to the sphere of finance, but is also apparent in the medical area, and associations have to try and improve terms of service so that they can attract and retain people of the requisite calibre.

The overall picture regarding the performance of Associations during 1981/3 is encouraging, particularly when taking into consideration the difficult socio-economic conditions in which several of them are working. In this regard the Planned Parenthood Association of Ghana must be commended for its remarkable record of full implementation of an innovative programme in recent years, during a period which has witnessed a seriously deteriorating economic situation in the country. In contrast it is disappointing that, given the propitious climate in which the Family Welfare Association of Senegal is operating, with very strong government support for the Association and for all matters pertaining to family welfare, that ASBEF's performance

over the past year and a half has left much to be desired. It is to be hoped that the volunteers will take the necessary steps to resolve certain weaknesses at senior management level to enable the Association to operate from a firm foundation. Similar firmness would also not come amiss in Uganda, where, although socio-economic conditions are difficult and security problems prevail, the official view regarding family planning is extremely encouraging, a climate which FPAU has so far failed fully to exploit; a mini OPE/MA is currently underway to identify problems and solutions. Despite previous indications that the Lesotho Planned Parenthood Association had, after several years, finally resolved its difficulties in relation both to the quality of its senior staff and divisions among the volunteers, it now appears that factionalism among the volunteers is still afflicting the Association, a situation which seriously risks jeopardising the effectiveness of LPPA. In The Gambia and Liberia the volunteers have taken steps to remedy certain weaknesses in their respective Associations, while in Togo efforts continue to be made to ease the severe official restrictions still in force regarding service delivery. Throughout 1981 the Benin Association experienced a period of hiatus after the dismissal of all its senior staff, a period of Regional Office administration and the appointment of new personnel, but it says much for the quality of the new incumbents that programme performance during 1982 has been very satisfactory. The very much larger Association in Tanzania also experienced certain vicissitudes on the staff side in recent years which are currently being sorted out.

Among the Francophones, Madagascar, Mali and Upper Volta are progressing satisfactorily, with the first two steadily implementing the OPE and MA recommendations made for their respective Associations. Zaire continues to perform creditably in a favourable official climate but in an extremely difficult economic one, while Mauritius maintains its good record of programme implementation, which includes the recent introduction of condom vending machines.

Exploratory steps for the inauguration of community-based distribution are being taken by the Planned Parenthood Federation of Nigeria, an Association which is aware that it must undertake a critical assessment of its over-large field-work force, and which, like its Zambian counterpart, is an Association which is doing much to enhance its collaboration with other agencies. Throughout the second half of the 1970s the Planned Parenthood Association of Zambia underwent a number of very serious difficulties pertaining to its senior staff. However, with the appointment of competent officers in 1980, who have the support of dynamic branches, 1981 and 1982 have witnessed good programme implementation. The Family Planning Association of Kenya has a good record for 1981 implementation, but overall programme would benefit from permitting greater involvement on the part of field staff in the development of innovative approaches. Together with FPAK, the neighbouring Family Guidance Association of Ethiopia enjoys a very great degree of government support. FGAE implements with effectiveness a relevant programme, into which innovative elements are being introduced.

Regarding countries which are new to the Region, the mountainous, predominately Catholic and very densely populated countries of Rwanda and Burundi (235 people per km² of arable land) are becoming increasingly concerned about rapid population

growth, estimated at 2.2% per annum. An embryonic FPA has been formed in the latter, and the National Population Office of Rwanda sent an observer to the 1982 Africa Regional Council. In Zimbabwe the long-established FPA, now called the Child Spacing and Fertility Association, is now a parastatal body and has an excellent programme which contains a large CBD component. There has been considerable collaboration between the CSFAZ and the Africa Region throughout 1982, which will be followed in 1983 by the inauguration of a major three-year project in the previously war-torn province of Manicaland, to be funded by IPPF.

Associations in the region have been quick to respond to the ideas in the Federation's 1982/4 Plan, and this, coupled with the acute awareness throughout the region of the problems of young people, has resulted in the drawing up of work programmes for 1983 which are more clearly focussed on innovative ways of meeting needs. Almost without exception associations have youth or youth related projects, and, in a region not hitherto renowned for innovative FP activities, these are increasingly beginning to appear in the form of male motivation and community-based distribution projects, together with those for training traditional birth attendants (TBAs). Kenya is adding innovation to innovation by getting village-based lay educators to become distributors of non-prescriptive contraceptives. All of these activities will contribute to an increase in service delivery which is now becoming essential in a situation where many FPAs are reporting that information and education is so far ahead of service delivery that an increasing number of motivated people are finding themselves without access to a reliable source of supply. In this regard the Regional Programme Review Committee in June recommended that "The Regional Office encourages the FPAs to adopt as a strategy the increased use of community extension workers (e.g. health, education, agriculture, TBAs, etc.) in CBD programmes within the Region", and that "the Law Task Force should assist by reviewing the laws that would prevent or hinder such workers from providing FP services in each of the countries of the Region".

Alongside these new approaches, the Africa Region Associations will be continuing with the more "routine" activities of training medical and paramedical staff; management development seminars; inter-agency collaboration, and undertaking motivational work aimed at decision-makers and opinion-formers. In these activities too the element of innovation will not be lacking as FPAs are increasingly starting to train TBAs in some FP techniques, and to consider using them as distributors for non-prescriptive contraceptives. Regarding IEC activities the time might not yet be ripe in Africa to insist upon the human rights aspect of family planning. It is nevertheless considered that a somewhat more aggressive approach should be adopted and that a deliberate IEC policy emphasising the use of family planning as a means of slowing down population growth is essential.

As regards the Regional Bureau activities, in addition to its major role in assisting associations, one completely new approach inaugurated this year by the Bureau is that of joint nutrition, parasite control and FP projects. Preliminary activities are already under way in Ghana, Tanzania and Zambia, which will be further developed in 1983 and 1984 under the aegis of a medically qualified member of the Bureau staff. In

addition the Bureau will next year be particularly involved in assisting FPAs in the areas of FLE and adolescent fertility management; youth; women's development programmes, particularly in the Francophone countries; community-based distribution; information and publications, and with technical assistance specifically orientated towards the implementation of the new resource allocation and PPBR system. In the light of the intensity of the difficulties being faced in several countries regarding Depo-Provera, the Bureau will be monitoring information from two countries, which will then be analysed and used as a guide for future action. Last, but by no means least, the Bureau will continue its work of expansion by making contacts with the relevant authorities with a view to establishing feasible FP programmes in Guinea, Cameroon and The Congo, while the already very cordial relationship established with the Zimbabwe FPA and with the government authorities will be further built upon.

CENTRE FOR AFRICAN FAMILY STUDIES (CAFS)

As has been noted, the recognition of the need for formal population/family planning policies is growing among governments. However, it has long been evident that the region lacks people who have been well instructed in both the implications of rapid population growth and in the skills necessary for developing, implementing and managing FP programmes, and that there is therefore an urgent need for education and training of various cadres in these matters. It was to meet this need that the Centre for African Family Studies (CAFS) was established in 1976. After a rather difficult initial period the institution, currently with four professional (Anglophone) staff, has been functioning effectively for three years by concentrating on the training of trainers and supervisors and bringing together development practitioners from various disciplines to promote integration along viable lines, by means of seminars, courses and workshops. Technical assistance is also provided direct to FPAs to augment their own training programmes. In July, 1981, CAFS' pursuance of these objectives was endorsed by the Regional Council, while they added that the Centre should in future operate as a separate body within the IPPF, and should integrate Francophone programmes into its activities.

During 1981 and the first half of 1982 CAFS has carried out one Integrated Family Welfare course for twenty participants from thirteen countries and another for twenty-five participants from eleven countries, both of which were for eight weeks and covered the following major topics: population growth and social development; family life education; family planning; communication, motivation and counselling, and, fifthly, administration, management and project development. In November, 1981, a workshop on the production of a family life education textbook was held, involving seventeen participants from seven countries and a variety of relevant disciplines, whose two tasks were to revise the curriculum guidelines on FLE developed in 1979 and to produce an introductory textbook on FLE based on these guidelines. Twelve chapters were written which have been released for limited use by selected institutions for pre-testing prior to final editing and printing at the end of this year or early in 1983. In December CAFS' first Francophone training course was held in Dakar (Senegal) on "The Communication of Family Planning and Population Messages", the twenty-one participants coming from Benin, Madagascar, Mali, Togo, Upper Volta and Zaire.

In 1982 the Centre has implemented its work programme on schedule and has conducted a course in Nairobi on project development for twenty-five participants and a seminar in Lusaka (Zambia) on family welfare and development with twenty participants from Lesotho, Swaziland, Zambia and Zimbabwe. Throughout the period the Information and Documentation Unit serviced the training courses and seminars, as well as both CAFS and Regional Office staff and some outside users.

It is anticipated that two Francophone staff (a Deputy Director and a Programme Officer) will be appointed during 1983, whose main task will be to develop training courses for Francophones as an integral part of CAFS programmes; two of these will be held in 1983, and it is hoped that these will be increased in number in subsequent years. In 1983 CAFS will also assume the responsibility of fund-raising, in which the Board of Directors will be expected to play a major role. Courses will be held on Integrated Family Welfare, FLE and Family Health, Project Development and Management for Francophone West African FPAs, and on Family Planning Communication for three Francophone countries; a seminar on Population and Development for MPs from Kenya, Lesotho, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe will be held in Harare (Zimbabwe) as a follow-up to the 1981 Inter-Parliamentary Union Conference in Nairobi on Population and Development for Parliamentarians in Africa. The family life education textbook will be translated into French and printed. In addition to these projects CAFS will also assume major responsibility for implementing the following activities: a Family Welfare course for social work educators; technical assistance to the Madagascar and Gambian FPAs for an FLE course, and technical assistance to the Lesotho association regarding a communication course.

Regarding the future organisational structure of the Centre, the OPE carried out in May 1981 had recommended that CAFS become a completely autonomous organisation. However, the Regional Council was of the opinion that it should rather be established as a separate legal body within the Africa Region, and a draft constitution to this effect has been approved by the Regional Council and been forwarded to the Central Council for final approval. This proposed constitution will convert the CAFS Board into an Executive Board of Directors, and will give IPPF control over the Centre through its nominations to the Board. Work programmes and budgets will pass through the usual IPPF channels for approval, and funds will be accountable as hitherto.

EXPENDITURE SUMMARY - AFRICA REGION

1981 ACTUAL

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Benin	112.2	33.8	146.0	48.0	28.7	222.7
Ethiopia	507.1	84.5	591.6	36.6	(70.2)	558.0
Gambia	165.8	45.4	211.2	14.3	2.1	227.6
Ghana *	307.4	196.7	504.1	707.0	(193.3)	1017.8
Ivory Coast	-	-	-	-	-	-
Kenya	781.3	124.5	905.8	940.9	(114.6)	1732.1
Lesotho	330.2	28.1	358.3	48.0	(34.7)	371.6
Liberia	372.2	33.3	405.5	57.5	11.1	474.1
Madagascar	243.0	11.4	254.4	160.9	(95.4)	319.9
Mali *	139.0	6.2	145.2	35.8	(20.5)	160.5
Mauritius	171.2	26.8	198.0	98.5	(4.6)	291.9
Nigeria	1043.5	166.1	1209.6	282.3	(192.2)	1299.7
Rwanda *	-	38.6	38.6	-	-	38.6
Senegal	131.8	10.1	141.9	40.0	6.2	188.1
Sierra Leone	287.5	46.6	334.1	80.6	51.2	465.9
Swaziland *	38.6	15.2	53.8	-	-	53.8
Tanzania	775.0	82.7	857.7	107.8	(56.1)	909.4
Togo	191.2	5.0	196.2	82.9	(8.6)	270.5
Uganda	301.6	61.4	363.0	134.4	(190.2)	307.2
Upper Volta *	60.9	18.0	78.9	23.1	18.3	120.3
Zaire	197.6	126.3	323.9	119.4	(26.5)	416.8
Zambia	223.9	54.8	278.7	14.9	(4.8)	288.8
Zimbabwe	-	-	-	-	-	-
CAFS	614.3	-	614.3	-	(168.7)	445.6
TOTAL	6995.3	1215.5	8210.8	3032.9	(1062.8)	10180.9

* Unaudited
figures

EXPENDITURE SUMMARY - AFRICA REGION

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Benin	179.8	57.2	237.0	12.6	-	249.6
Ethiopia	522.4	91.7	614.1	33.0	-	647.1
Gambia	173.7	21.6	195.3	40.6	-	235.9
Ghana	349.4	271.1	620.9	600.5	-	1221.4
Ivory Coast	-	-	-	-	-	-
Kenya	861.9	63.5	925.4	820.4	-	1745.8
Lesotho	367.5	26.9	394.4	29.4	-	423.8
Liberia	393.8	50.0	443.8	58.2	-	502.0
Madagascar	224.8	54.5	279.3	170.5	-	449.8
Mali	140.3	53.9	194.2	8.7	-	202.9
Mauritius	196.4	21.4	217.8	54.3	-	272.1
Nigeria	1303.7	132.5	1436.2	341.1	-	1777.3
Rwanda	-	62.7	62.7	-	-	62.7
Senegal	150.6	33.3	183.9	3.6	-	187.5
Sierra Leone	387.5	38.2	425.7	46.3	-	472.0
Swaziland	26.1	17.3	43.4	-	-	43.4
Tanzania	898.5	54.7	953.2	11.9	-	965.1
Togo	226.4	23.1	249.5	8.5	-	258.0
Uganda	340.2	54.4	394.6	-	-	394.6
Upper Volta	107.2	37.5	144.7	1.8	-	146.5
Zaire	281.9	187.7	469.6	8.0	-	477.6
Zambia	262.1	98.1	360.2	64.5	-	424.7
Zimbabwe	5.0	4.9	9.9	-	-	9.9
CAFS	499.7	-	499.7	-	-	499.7
New Requests	24.1	-	24.1	-	-	24.1
TOTAL	7923.4	1456.2	9379.6	2313.9	-	11693.5

EXPENDITURE SUMMARY - AFRICA REGION

1983 - BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Benin	196.8	51.5	248.3	17.4	-	265.7
Ethiopia	602.5	108.6	711.1	42.2	-	753.3
Gambia	169.4	24.8	194.2	87.5	-	281.7
Ghana	339.8	305.0	644.8	831.5	-	1476.3
Ivory Coast	-	-	-	-	-	-
Kenya	941.7	74.4	1016.1	706.5	-	1722.6
Lesotho	343.4	67.3	410.7	35.6	-	446.3
Liberia	446.4	42.2	488.6	48.6	-	537.2
Madagascar	225.8	78.0	303.8	105.0	-	408.8
Mali	149.4	29.2	178.6	9.2	-	187.8
Mauritius	197.5	7.0	204.5	49.0	-	253.5
Nigeria	1314.7	140.6	1455.3	317.5	-	1772.8
Rwanda	-	25.4	25.4	-	-	25.4
Senegal	158.4	17.4	175.8	-	-	175.8
Sierra Leone	372.2	43.8	416.0	58.7	-	474.7
Swaziland	20.6	4.6	25.2	-	-	25.2
Tanzania	924.6	157.9	1082.5	26.1	-	1108.6
Togo	222.7	15.8	238.5	12.6	-	251.1
Uganda	289.4	81.9	371.3	30.7	-	402.0
Upper Volta	110.9	32.4	143.3	25.2	-	168.5
Zaire	323.6	187.1	510.7	-	-	510.7
Zambia	319.0	136.4	455.4	15.6	-	471.0
Zimbabwe	109.2	-	109.2	-	-	109.2
CAFS	600.0	-	600.0	-	-	600.0
New Requests	100.0	-	100.0	-	-	100.0
TOTAL	8478.0	1631.3	10109.3	2418.9	-	12528.2

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURE BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US \$'000)

AFRICA

SUPPLIES PURCHASED BY IPPF

	ACTUAL EXPENDITURE 1981	ESTIMATED EXPENDITURE 1982	PROJECTED EXPENDITURE 1983
Contraceptives	650.3	848.0	938.6
Medical & Surgical	68.2	33.8	42.9
Audio Visual Equipment	35.9	32.7	32.8
Office Equipment	42.8	41.5	33.1
Transport	242.0	162.4	268.1
Prior Year Adjustment	(15.9)	—	—
TOTAL	1,023.3	1,118.4	1,315.5

AID SUPPLIES DONATED TO IPPF

Contraceptives	1,122	337.8	315.8
FULL TOTAL		1,456.2	1,631.3

ETHIOPIA

FAMILY GUIDANCE ASSOCIATION OF ETHIOPIA (FGAE)

COUNTRY BACKGROUND

General National Environment

Ethiopia, Africa's eighth largest country with the third largest population on the continent (31 million), covers an area of 1,223,600 sq. km. and has a high proportion of women at risk – over 46% of the female population is in the reproductive age group.

The population is predominantly rural, with an estimated 10% only being town dwellers, the greater proportion of whom reside on the temperate high plateaux in the centre of the country. To the east, south-west and the north there are extensive dry zones, verging on desert, which are far more sparsely populated than the highlands. Transport and communications are not easy as the road network is limited, much of it becoming impassable during the two rainy seasons. It is estimated that there are more than seventy distinct languages in Ethiopia (and possibly 250 dialects), with Amharic being the national language. English is spoken by the educated, but is being phased out as the language of administration. In the highlands the predominant religion is Ethiopian Orthodox Christianity (35% of the total population) while a further 35% are Moslem with the remaining 30% adhering to a variety of traditional faiths. Over 80% of the population is employed in agriculture and GNP at \$200 per capita is among the lowest in the world. No significant mineral deposits have so far been discovered and, therefore, the main hope for the future development of the country lies in the agricultural sector.

In 1974, after almost fifty years on the throne Emperor Haile Selassie was deposed and a socialist state was established in what was then a very poor, quasi-feudal and almost wholly illiterate country.

All rural land was nationalised and millions of landless peasants acquired the right of its use, as was, with the exception of owner-occupied houses, urban land and housing. A notable policy of the revolutionary government has been its reliance on mass organisations, especially the Farmers' Association, The Kebele Association (for urban dwellers) and the Revolutionary Ethiopia's Youth Associations (REYA). In 1980 the Revolutionary Ethiopia's Women's Organisation (REWO) was established. These mass organisations each from the centre down to village level, thus providing a most effective channel for reaching the population. As the government supports family planning activities this channel is and will continue to be utilized by FGAE.

General education in Ethiopia is very poor. Until 1978 less than 10 per cent of the population was literate. In this respect one of the most notable achievements of the revolutionary Government has been to reduce the illiteracy rate from 93% to 65% by 1980. Figures for 1976/77 indicate that only about 20% of school-age children were actually enrolled, that a large majority were to be found in urban areas where schools are concentrated, and that approximately 30% of these enrolled were girls.

Government policies are firmly oriented towards improving the lives of the poor and since 1978 urgent reviews of the economic situation have been started. The exercise primarily involves reviews of the major problems which confront Ethiopia. Many issues were stated in the First Year Programme of the National Revolutionary Development Campaign (1979), the major problems and goals of which included:

Food shortages caused by insufficient crops as a result of poor weather conditions and reduced acreage. Limited Government participation in marketing also made food inaccessible to urban dwellers. Crops were destroyed by the fighting and farmers in the war zone were prevented from cultivating the land. Subsistence agriculture was pursued with crude farming techniques, and farmers, beyond producing what their families needed, were reluctant to produce for the market. Even if productivity had increased, inadequate infrastructure, particularly in the form of feeder roads, made the marketing of surplus produce impossible and therefore deterred the monetization process. Consequently, Ethiopia became a net importer of grain. The elimination of the food grain shortage is one of the principal goals of the development campaign, which recognises that in order to feed a population growing at an annual rate of 2.5 per cent, agricultural production must be steadily increased.

Reconstruction and rehabilitation of the war-affected regions, involving the repair and replacement of damaged machinery, bridges, buildings, etc.

The low level of industry activity and production as a result the number of factories destroyed in the war zone, not of over-concentration on the manufacture of consumer goods. Only 10 per cent of the GDP originates from manufacturing.

Limited industrial output. Even if the most labour-intensive techniques are used, expansion will require imports of capital goods. In this connection the shortage of foreign exchange will be a major constraint. Diversification of exports will be necessary to reduce the present dependence on coffee as the source of 75 per cent of Ethiopia's foreign exchange earnings.

Despite the improvements over the past years, inadequate transportation, communication, and port facilities delay the delivery of goods, put the country in debt in terms of foreign exchange and prevent adequate quantities of raw materials from reaching industries on time. The network of roads is limited and telecommunication facilities are scarce.

Shortage of urban housing due to the rapid growth of towns and cities from both the natural increase of population and rural-urban migration. In the next five years, 111,200 houses are to be built. Rapid urbanisation is a feature of Ethiopia life, with the increasing number of illegitimate births, illegal abortions and their complications and abandoned babies being recognised as major problems in urban areas.

The relief and rehabilitation of people and families displaced by natural disasters, especially drought and bad weather. Due to lack of data, the exact size of the target population is not known. However, the Government plans to resettle about 40,000 people yearly.

Insufficient health facilities, despite significant efforts to provide health services. Health is still a major area of concern. The policies and measures to be taken will focus on immunization campaigns, expansion of basic health services and appropriate training of health personnel. By 1990, infant mortality should decrease by 60 per cent and child and maternal mortality by 50 per cent.

Inadequate educational facilities. Besides improvement and increases in the school system (more classrooms, more teachers, higher enrollment), particular attention will be paid to adult education (the literacy campaign).

A general scarcity of human resources, trained and qualified, to cope adequately with the administrative and technological needs of development. Manpower shortages exist in all sectors; to remedy the shortages will be a major challenge for the campaign.

Meanwhile internal unrest resulting from conflicts of varying intensity in the regions of Tigre, Eritrea and in the provinces bordering Somalia have resulted in the enforcement of strict measures, high military expenditure and an ever-growing number of refugees.

Family Planning/Population Policies and Programmes

No census has so far been carried out in Ethiopia, but preparations are in hand for the first, to be undertaken with the assistance of UNFPA. Fragmentary data indicate that in 1978 the population was 31 m; that population density is about 25 per sq. km.; the growth rate is 2.5% p.a. (which means the population will double in 27 years) that 43% of the population is below 15 years of age, and that the infant mortality rate is 155-160 per 1000. Once the results of the census are known a population policy may be formulated. It is hoped that unexploited agricultural land will serve to absorb the rapidly growing population. A full analysis of population factors in relation to development goals is still pending.

After some initial hesitation the Revolutionary Government of Ethiopia in 1974 came out cautiously in support of family planning as a voluntary element in MCH. The government allowed FGAE to train Ministry of Health personnel in family planning and allowed Ministry staff to run family planning clinics under FGAE auspices in government clinics. By 1980 FP was adopted as a component of the government MCH programme (assisted by UNFPA/ UNICEF and other agencies), and has appointed Regional MCH Co-ordinators. The programme represents a shift of emphasis in the priorities of the basic health services towards MCH.

However, it will take some time before the government is in a position to assume responsibility for all contraceptive delivery services, training and supervision, during which period FGAE will still have an important contribution to make in this sphere. (The FGAE budget

is equivalent to about 1% of Ethiopia's total public health expenditure).

The government has placed a high priority on the expansion and improvement of the health services. Extensive training programmes for new personnel and construction programmes are on hand with several million dollars of assistance being contributed by UNFPA, UNICEF, WHO and SIDA in order to upgrade the health infrastructure, which requires considerable strengthening. According to the most commonly quoted estimates hardly one quarter of the population has, in practical terms, access to public health services, which are distributed unevenly, mainly in the urban areas and the Shoa and Eritrea regions.

The pyramidal organisational structure of health facilities is well geared to maximising the availability of scarce resources: at the base are community health agents, a relatively recent introduction into the system, who perform simple first aid, preventive care and health education particularly among farmers' associations, and who act as a link with the health services. Above them are just over one thousand health stations, staffed by a health assistant, at which outreach services are only available if a trained nurse is on duty. Family planning services are only given if that nurse has been FGAE trained.

One hundred or so health centres, with minimum staffing of one nurse, provide most kinds of out-patient services, and on occasions may be equipped with in-patient facilities. Family planning services are only available if the nurse(s) have been FGAE trained. At the apex of the pyramid are approximately 84 hospitals which are relatively adequately staffed. About two hundred Ministry of Health clinics are supervised by FGAE, who also supply the contraceptives.

Apart from the government infrastructure there are health units which are named clinics and are run by companies or missionary societies. They are officially classified as health stations but may in fact be staffed with nurses or health officers. The Association is currently awaiting the training of health assistants so that services can be made available in remote parts of the country.

THE ROLE OF THE ASSOCIATION

FGAE sees its role for the years 1983/85 as being to intensify the promotion of family planning as a basic human right; to promote government commitment to population as one of the factors in development; to expand and improve service delivery; to meet the needs of young people; to create greater awareness among men about their responsibilities for the practice of family planning and to strengthen the voluntary sector in family planning.

In the past it was clear that the role of the Association was to convince the government that family planning was a fundamental need, and then to persuade them to incorporate it as an element of the basic health service structure. Largely due to FGAE's efforts this has now virtually been accomplished. It was suggested by the OPE team of July, 1981, that,

given the change in the country situation from that at the Association's inception, although FGAE should not immediately totally abandon its former role, it should now be thinking in terms of tailoring its activities to encourage popular understanding and support for family planning in the total development perspective at the national level as well as the level of the family; a suggestion which has not been very precisely articulated in the Association's 1983/85 Plan. However, in implementing the Plan FGAE will enjoy a degree of co-operation from government unprecedented in Sub-Sahara Africa: collaboration with the various government mass organisations (Peasants, Farmers, Urban Dwellers, Women's, Youth, Labour Unions, etc.) is assured, while the recent adoption of maternal child health/family planning as a national programme, coupled with the expressed government wish that FGAE should co-operate closely with the newly established National MCH Co-ordinating Office of the Ministry of Health, means that family planning services can now be introduced into almost all health institutions, thus responding to an OPE recommendation as well as to a need manifesting itself throughout the region for the expansion of service delivery to meet the increased grassroots demand for services.

A further excellent channel for all aspects of motivational work which FGAE intends to exploit is the illiteracy eradication campaign. Reading materials on family life education and responsible parenthood and sexuality will be developed for this programme. FGAE intends to proceed with caution in the implementation of the highly sensitive programme area of meeting the needs of young people, and has already begun by establishing a collaborative relationship with the secondary school system, as a result of which family life education/sex education is being incorporated into the school curricula. Seminars and workshops will be held in collaboration with Youth and Women's organisations. Concerning male responsibility the Association will undertake motivational work among the various male dominated organisations in the country in an effort to change attitudes, which responds to an OPE recommendation that FGAE should work through influencing institutions rather than in motivating individuals.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Past Performance

The overall performance of FGAE in 1981 was good, and particularly commendable in view of the continuing difficult socio-economic situation in the country. Of the eleven projects approved from 1981, ten were fully implemented, with one, MCH/FP Training for Health Workers at \$60,358, having the costs reduced by half as a result of collaboration with the Ministry of Health. The only reason that FGAE was unable to implement the "Training Modules Pre-Test" was because the consultant hired to carry it out was unfortunately taken ill and not able to undertake the work.

The FGAE have a record of significant underspending as compared with the Budget. In 1980 and 1981 actual expenditure was 87.3 and 87.2 per cent of Budget respectively. A major factor in this under-expenditure was vacant posts, particularly that of the Medical Director which was vacant for four years before being filled in October 1981. The other significant factor in 1981 was the collaboration with the Ministry of Health in the training

of health workers, referred to above. These factors apart, adherence to and control of the Budget have been good. This represents a marked improvement over previous years following staff changes in the Finance Department.

Generally, FGAE has had a relevant and well-articulated programme which is basically well executed and controlled, in spite of the changes especially in the senior staff during the last few years. The main programme thrusts of the Association are general family planning motivation and the training of family planning practitioners. The former is a diverse programme including field staff, audio-visual activities, printed materials and tentative approaches in family life education. The OPE mission observed that most of these activities are well controlled and planned in advance and that the staff involved were competent and dedicated. However the mission noted that there was no overall strategy for this programme, which gave the impression that the Association was reacting in most instances to existing opportunities rather than actively creating strategically important opportunities. It would appear that the MCH/FP programme will need a consistently and strategically planned motivational support as the public health services have no outreach personnel.

The training programme has been carried out since 1975 and has concentrated on the training of health officers and nurses. This programme was originally financed by Family Planning International Assistance (FPIA) but this support fell away as a consequence of USAID withdrawal from Ethiopia. Since 1979 the programme has been financed by IPPF as part of the general grant to FGAE.

Since it was started the programme has been extremely well managed and relevant courses have been conducted. As a result the programme has established country-wide family planning services and has advanced the timetable for the MCH/FP programme by several years. At the same time it has facilitated greater support for and understanding of family planning in Ethiopia. It is noteworthy that over 75% of the trainees are deployed on provision of family planning services after graduating from FGAE.

MANAGEMENT CAPACITY

Due to local conditions which tend to inhibit the formation of private organisations, FGAE has not been able to organise branches on a country-wide basis, and it has only been through the use of the government health structure that the Association has been able to extend FP services in the country, including to Asmara, the provincial capital of war-torn Eritrea. FGAE is well aware that service delivery is primarily urban oriented (i.e. in towns with a populations of over 2,000) and that only about 20% of the services they provide reach country-dwellers; but it is anticipated that, with the expansion of the government health structure into rural areas this most unsatisfactory imbalance will, by degrees, be rectified.

For many years the number of members of the Association has been regrettably low (less than a dozen), with all of them based in the capital, Addis Ababa. In 1981 steps were taken to improve the situation, and the Executive Board was enlarged to 36 persons,

a long over-due improvement. However, in comparison with some other Associations in the Region this is nevertheless still a very small number of members, and FGAE will not only make a further increase but will also, as recommended by the OPE, at the same time increase institutional membership so that the Annual Assembly will become a forum where representatives from a wide variety of influential groups in society may contribute to the shaping of FGAE's activities.

During 1981 FGAE revised its Constitution (which still has to be presented to the Central Council, through the Africa Regional Council, for ratification) in which no indication is given regarding the powers delegated to the Executive Director. In this connection it is essential that the Board confines itself to dealing with broad considerations and policy decisions, while leaving the executive action to its appointed staff led by the Executive Director, particularly concerning personnel matters and the authorisation of expenditure. These comments apply with equal force to the five proposed Standing Committee which, as constituted, would be direct supervisory bodies over each department of the Association.

On the staff side, FGAE had proposed the post of Head of Training, a position which the OPE felt was justified, providing the Association shifted its emphasis from exclusively training nurses and trained other categories of personnel and also carefully devised an IEC strategy that will consistently support the MCH/FP programme. Both these changes have been accepted by FGAE which is now in the process of implementing them. The post was advertised in May, 1982.

With regard to regional operations FGAE already has three Regional Offices (housed in Ministry of Health buildings) at Asmara, Dessie and Awassa, with a total staff of eight, and the Association had been considering proposals for increasing the number to five with a staff of six at each office, i.e. thirty in all. Since then the Ministry of Health, having approved the inclusion of FP in the health service, has appointed Regional MCH Co-ordinators, which means that FGAE will gradually be withdrawing from the direct supervision of service provision. Nevertheless, the Association still considers it desirable to have one officer at regional level whose responsibilities would be primarily IEC; the total envisaged being six or seven. The OPE team, however, felt that the establishment of further regional offices was not to be recommended for the moment, and that, for an experimental period, existing regional officers should be given firmer guidelines from the centre regarding IEC and should also be provided with transport, and that their performance should then be monitored in order to establish their effectiveness when supplied with this additional support.

In the past FGAE has suffered from a high staff turnover which somewhat affected its overall programme implementation. During 1980 the posts of Chief Executive and the Head of IEC and Finance were all filled through internal promotions, and vacant supervisory posts were also filled. The post of Medical Director which had for far too long been vacant (over 4 years) was filled externally in 1981, and the post of Head of Training was advertised in May, 1982; in the same month candidates were interviewed for the post of Director of IEC. Recognising the need for staff training to enable them

better to carry out their increased responsibilities the Regional Office arranged for the Training Officer to attend an appropriate course at the Centre for African Family Studies, and the Head of Finance and the Store-keeper participated in relevant training courses organised in Togo.

The quality of the new incumbents has been favourably reflected in the improved programme and financial reports.

It should be noted that recruiting new staff is made difficult by the fact that it must be done through the Ministry of Labour and Social Services. Direct advertising is permitted only if the Ministry is unable to find applicants. One effect of this system is that such applicants as do materialise are frequently of low-quality. The whole process also takes a considerable amount of time. Nevertheless FGAE has been lucky in getting the staff of the calibre it has.

PROPOSED 1983 WORK PROGRAMME/BUDGET

FGAE submitted a well-composed work Programme and Budget, covering eleven projects, two of which were new. The projects corresponded with the Association's Three Year Plan and, with one exception, that on infertility, responded to a number of recommendations made by the OPE. Of the four IEC projects the "Production of Motivational Materials", the "Production of Audio-Visual Materials and Teaching Aids" and the "Family Life Education Seminar for 100 Education Officers" were all on-going, while the "Seminar on Male Motivation" was new. Two training projects were proposed, that for the training in family planning of 48 Health Officers and Nurses being on-going; the new one being "Training in Concepts of Population and Family Planning for 25 Agricultural Extension Workers and 24 Social Workers". Four projects consisted of the reprinting of clinical records and follow-up books, the expansion of services into a further nine government clinics, an infertility and family planning referral service, and a guidance and counselling service. The seventh project was for up-grading the skills and competence of staff.

The future outlook for FGAE would appear to be very challenging. The Association has most successfully carried out its first pioneering role of convincing the authorities that family planning is a fundamental need for the welfare of Ethiopians, and of persuading the relevant government ministries to incorporate it as an element in the basic health structure. In view of the great degree of official support enjoyed by FGAE it would appear that the Association should not encounter insurmountable obstacles in formulating and implementing a second pioneering role, which, it was suggested by the OPE team, could most usefully be concerned with the generation of popular understanding and support for family planning in the total development perspective at the national level as well as at the level of the family. In order to realise this or a similar role FGAE must not shirk carrying out innovative strategies, particularly in the areas of expanding and improving services and in that of research and evaluation, such as, for example, experimenting with the use of the injectables and with CBD projects (about which there are great reservations in Ethiopia), and setting up small-scale research projects on controversial

issues such as adolescent sexual behaviour, abortion and sexually transmitted diseases.

It is encouraging to note from the 1983/5 Plan that the Association means to move into the innovative areas of meeting the needs of young people and of the promotion of male responsibility, and, further, to learn that a collaborative relationship with the secondary school system is already in hand, as a result of which FLE/sex education is being incorporated into the school curricula. As a complement to this FGAE intends to undertake a series of studies on the incidence of illegal abortion, deserted children, out-of-wedlock pregnancies and female high-school drop-outs due to pregnancies, and to use the information thus obtained to persuade policy makers that there is a clear need to provide services specifically designed for young people.

ALTERNATIVE FUNDING

The Government and the FGAE work closely together with the Government making a substantial input to family planning work through the provision of clinic services and personnel. Duty exemption, not normally accorded to non-governmental organisations in Ethiopia, also represents a substantial hidden input. The FGAE estimates the value of these inputs at \$388,000.

Cash income is less easy to come by in Ethiopia, with contraceptive sales income of \$40,000 being the only significant item of non-IPPF income in the 1983 budget. This source is also likely to decrease in future as there are indications that UNFPA will shortly be supplying contraceptives for the MCH/FP programmes. Fund raising is difficult in Ethiopia as any such activities have to be approved by the authorities. The Association expects to realise a total cash income of \$42,200 from local sources, 7% of the total 1983 estimated expenditure of \$602,500.

SIERRA LEONE

PLANNED PARENTHOOD ASSOCIATION OF SIERRA LEONE (PPASL)

COUNTRY BACKGROUND

General National Environment

Sierra Leone is situated on the bulge of the West Coast of Africa, between the latitudes 7° and 10° North and longitudes 10° and 13° West. It shares a common border with the Republic of Guinea on the North East, North and North West and with Liberia on the South West. On the South Eastern border is the Atlantic.

The country covers an area of 73,326 sq. km. From the coast, the Northern portion extends inland into low-lying tidal swampland which provides some of the finest rice growing land in the country. The North-Eastern quadrant of the country is a plateau approximately 3,000 feet high with mountain peaks rising to a height of over 6,000 feet in the Loma Mountains and Tingi Hills area.

Sierra Leone became independent from Britain in 1961 and became a Republic under a one-party system of government in 1971. Administratively the country is divided into three Provinces and the Western Area (which includes Freetown, the capital and principal port). There are at least 18 principal ethnic groupings with the Mende and Temne accounting for approximately 60% of the population. The majority of the people follow the Moslem faith (the Temne who live in the North) and the rest are predominantly Christians (mostly Mende living in the South). English is the official language but there is also a local lingua franca, the Krio.

Like many developing countries, Sierra Leone has a dual economy. The non-monetised sector consists largely of subsistence agriculture which accounts for over 70% of the labour force and which contributes 32% of the total gross domestic product (GDP). The monetised sector is dominated by the mining industry, diamond and bauxite being the predominant minerals and contributing approximately 16% of total GDP. This industry accounts for only 5% of the labour force.

The total population of Sierra Leone is currently estimated at 3.6 million giving a population density of about 31 inhabitants per sq. km. The population is predominantly rural with only about 15% estimated to be living in the urban areas. As in most other African countries, the population is best described as rural poor with a large majority engaged in subsistence farming.

With crude birth and death rates estimated at 46 and 19 per cent per annum respectively, the population is presently estimated to be growing at about 2.7 per cent per annum with the result that the population is very young. 43% of the total population is under 15 years of age but only 3% above the age of 65, indicating among other things a very high dependency ratio. Infant mortality rates range between 221 and 225 per 1000 live births and life expectancy estimated at 44 and 47 for males and females respectively. About

830,000 females are estimated to be in the reproductive age group (15-49), but the proportion of these women presently utilising effective contraceptive methods is known to be significantly low.

General health facilities in the country are still limited and are overwhelmingly curative-oriented and urban-based. The present MCH services alone, for example, are inadequate to meet existing demands as reflected in the fact that only 30% of the total annual births are delivered by trained Ministry of Health personnel in existing health facilities. The doctor/patient ratio is around 1:13,000.

Although Sierra Leone is known to have been exposed to Western education long before any other country in Black Africa, the literacy rate is very low, estimated at only 12%. In 1979, total enrolment in the 1100 primary schools was 220,000. There were 129 secondary schools with a total enrolment of 50,500 students. The six teacher training colleges had 1,656 students, just about the same number of students as at the only university in the country.

Family Planning/Population Policies and Programmes

PPASL was established in 1959 at a time when FP knowledge was extremely limited and services almost non-existent. From its inception to the present day, it has remained the principal advocate for family planning programmes and the main provider of family planning education and services. Although in its earlier days the Association's activities were confined to the capital city of Freetown, between 1970-71 it expanded its activities to the provincial and district towns. In the following years education and service delivery were further expanded by using Ministry of Health and private clinics and employing field-workers now designated as welfare workers (WW) essentially in the urban areas where 15% of the total population reside.

It was not until around 1973 that the Government indicated any recognition of the population problem in Sierra Leone or any interest in the development of a national population policy and family planning service programme. Recognition of the effects of rapid population growth on the nation's socio-economic development was first made public in the Government's 1974-79 plan, wherein it was stated that:

“It is generally recognised that a population expanding too rapidly aggravates many economic and social problems. The increase in demand for food, clothing, housing, sanitation and drinking water as well as education, medical care and other social services is largely determined by the growth rate of population. If the population growth is accelerating too rapidly, the increase in income and consumption per head will, other things being equal, slow down.

Moreover, the increase in national consumption caused by rapid population growth tends to reduce the share of the national product available for investment in physical and human capital for the

development of the country. According to available estimates, population growth in Sierra Leone has been considerably accelerated during the last 10 years, and this acceleration is expected to continue in the foreseeable future”.

As the corner-stone for support of a national policy and service programme, the plan provided for:

- continued Government support of PPASL's FP activities;
- a crucial role for MOH in the national FP programme;
- a Government grant allocation for population activities;
- the establishment of a National Population Council with representatives from Government Ministries, the University and other organisations;
- the provision of FP services, mainly in the form of child-spacing, within the MCH programme.

The Government's commitment to implementation of its Plan is most visibly reflected in the several actions which it has taken in recent years:

The Government has established a Population Planning Section in the Central Planning Unit of Ministry of Development and Economic Planning responsible for coordination of all population and FP activities in the country. As part of its activities a national level seminar on population issues was organised.

The establishment of the National Population Planning Unit and legislative action on the proposal is expected soon.

The Ministry of Health has, under a UNFPA grant, initiated a pilot project on integrated MCH-FP services to develop suitable approaches and train MOH personnel. The project is expected to cover other districts from 1982.

Since 1976 the Ministry of Education has been engaged in development of a curriculum for population education and training of teachers. These activities are supported by a grant from the UNFPA.

The Ministry of Social Welfare is promoting family life education for young people both in school and out of school through its various projects.

The Government has exempted PPASL's import of commodities from duties, given financial grants to the PPASL, collaborated with it to provide FP service through the MOH service units and included a representative of the Association on all committees dealing with population and FP.

Thus, while some considerable progress has been made toward the development of a national population policy and programme, the pace of such progress has been much slower than anticipated. At present no formal population policy has as yet been promulgated, nor is it likely that integrated MCH-FP services will be available nationwide in the next few years. There are indications that while there is growing support among political leaders and Government officials for a national population policy and programme, the cultural and political sensitivities surrounding FP have resulted in:

- a) a slow and cautious low profile approach by the Government;
- b) limited public exposure of the Government's plans and intentions;
- c) continuing pockets of resistance in some political and religious circles.

There are also difficulties in developing the existing health infrastructure to the point where it is in a position to adequately discharge its additional responsibilities connected with the provision of integrated MCH-FP services. However, it is expected that during the legislative discussions on the formation of the National Population Council, a national population policy will crystallise.

Outside the confines of governmental action, the Association is actively supported by professional groups and a number of agencies engaged in population and family planning activities in the country – the Home Economics Association of Sierra Leone which has undertaken a number of Family Life Education projects with FPIA assistance; the U.N.F.P.A., the International Development Research Centre (IDRC) which funds a research project to determine fertility levels in the country and the International Federation for Family Life Promotion.

With regard to traditional and religious support, the Association has broken much ground in the urban areas particularly in the Western area where a substantial number of the population is protestant. By contrast, much remains to be done in respect of gaining the firm and effective support of traditional leaders (paramount chiefs, tribal headmen etc.) who are mostly rural-based.

THE ROLE OF THE ASSOCIATION

In its 3-Year Plan for the Period 1983-85, the PPASL has mapped out a number of strategies geared towards the achievement of its objectives stated in its constitution. The Association sees its major role in the plan period as

- (i) Intensification of its information and education campaign in order to get policy makers and hence government to continue to develop concrete and favourable policies in the area of family planning;

- (ii) Continuation of training for government and FPA personnel in order to ensure a better and more efficient system of integration and service delivery to the population;
- (iii) Making these services actually available;
- (iv) Undertaking activities to ensure the full development of resources, both human and material, within the association.

The OPE mission in 1981 observed that the PPASL has continued to place most of its emphasis on family planning education and service delivery in the urban centres. In 1981, 70% of the Association's budget was allocated to these areas. Its educational activities have mainly been focussed on inter-personal contacts, while its service delivery programme can be characterised as a traditional clinic-based approach. Because both of these are labour-intensive, they are necessarily limited in the extent to which they can effect widespread population coverage or be extended into the rural areas. Despite their limited outreach, however, the Government has both recognised and supported the Association's pioneering activities in these areas as meeting at least part of the population's need for FP education and modern means of birth spacing. The mission commended the Association's decision to place high priority on these important areas despite their limited coverage since the Association remains the only national organisation engaged in providing such services. It was observed that if PPASL were to stop functioning today there would be practically no immediate service alternative for most of the estimated two percent of the eligible couples who are now practising contraception. Nor would FP educational efforts be likely to continue on even a limited scale. Such circumstances clearly point out the importance of the present roles of the Association in service provision and demand creation.

Nonetheless, the Mission considered that it is time that PPASL should devote some attention to the balance between its educational and service delivery activities and review its past practice of concentrating its attention on the urban areas. While some educational activities are carried out in the rural areas, all but one of the service units are currently located in urban or suburban areas. Thus, while only a small number of couples can now be served, demand for services may well be in excess of this number.

It must be noted that if the education programme is to maintain credibility, service delivery must keep pace with it. Therefore, while the need for continuation of education and service delivery is appreciated, the present priorities in education and service delivery will be reviewed and a proper balance struck between the two by adopting appropriate strategies. This determination of relative priority of education and service delivery programmes in turn will have implications for the utilization of the fieldworkers, who for so long have been engaged in community education work through inter-personal contracts.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Past Performance

According to the report of the Management Audit exercise carried out on the PPASL in September 1981, the Association has over the past five or six years expanded from an essentially capital-based organisation to one which is represented nationwide. This expansion has not been without management and logistic problems, but in spite of these constraints, programme implementation in 1981 was carried out according to schedule. All approved projects in 1981 were successfully implemented. Interagency collaboration was given high priority and volunteer involvement in project development and implementation was reportedly high.

In 1978, PPASL undertook a review of its role and activities in the growing family planning movement and agreed on the need to devote more attention to its information and education work. This is reflected in its Three-Year Plan for the 1978-80 period, wherein the Association underscored the need to implement a broad based I & E programme which would not only lend additional support to its service delivery activities but would form an integral part of Sierra Leone's social and economic development programme. It was also hoped that PPASL's expanded I & E programme would stimulate the Government to initiate its own family planning programme on a national scale.

Since 1978, PPASL's education and motivation programmes have gradually expanded and diversified. Primary responsibility for implementation of these programmes lies with the welfare workers variously stationed throughout PPASL's eight branches. During 1979-80, several projects were implemented, with varying degrees of success, in five major areas:

- a. Family Life Education
- b. Audio-Visual Communication for Family Planning,
- c. Planned Parenthood and Women's Development
- d. Motivation of Opinion Leaders,
- e. Integrated Population and Development Programmes.

The 1981 work programme of PPASL contained a total of eight projects, four of which were classified under the heading of IEC. They were

- a. Dissemination of Family Life Education in Urban, Peri-urban and Rural Areas.
- b. Dissemination of Family Planning Information and Education to Locally Interested and Influential Persons.
- c. Cassell Farm Project.
- d. Makari and Pindegumahun Rural Development Project.

Overall, PPASL's IEC programmes, both past, current and planned, are appropriate in the national context and consistent with IPPF's guidelines for IEC work. Three of IPPF's nine major policy statements, which were drawn up as a result of the Forward Look Study of 1976, stress the need for all FPAs to advocate family planning as a basic human right, integrate family planning into other socio-economic development programmes and meet the needs of young people, especially adolescents.

The service delivery programme of PPASL can be characterised as a traditional clinical approach. Since 1966, when its first clinic was established in the capital city of Freetown, clinical service delivery has remained the Association's primary area of activity.

In its desire to expand the family planning service network to the other provinces while at the same time avoiding the high costs of opening new clinics, PPASL adopted the commendable procedure of making use of existing private and later Government (MOH) clinics. By the end of 1977, PPASL had opened and was operating seven of its own clinics throughout the country. Additionally, it was providing staff, financial and commodity support to five private and two MOH clinics. Between 1978 and 1981, four private clinics and nine MOH clinics were added to the service network, thus totalling 27 clinics distributed as follows throughout Sierra Leone.

- Western Area: 9
- Eastern Province: 5
- Southern Province: 6
- Northern Province: 7

All but one of the clinics are located in urban areas. The one rural clinic to which PPASL provides support is privately owned and was added to the Association's service network in 1980.

The clinics offer a variety of services and contraceptive methods. The former include infertility services, pregnancy testing and MCH care. Contraceptives offered included orals, injectables, condoms, IUDs and spermicides. Female sterilization is also available (on referral to government facilities) but there has been little demand for this service. At present, orals constitute the most popular method among family planning acceptors, both new and continuing.

MANAGEMENT CAPACITY

Even though PPASL has been operating satisfactorily, there is room for improvement in the operational structure. Currently the Association has its headquarters in Freetown. There are also eight branches. An IPPF Management Audit Report suggests that roles and functions of these branches as well as relationships between branch and national committees are poorly, if at all, defined. The Association has reported that it is taking steps to improve the situation.

With the appointment of a new Executive Secretary, in 1979, there has been a considerable improvement in the administration of the PPASL and in the management of its programmes. Despite the absence of a clear-cut definition of roles, the chain of command has been satisfactory. Documents submitted by the Association have improved both in quality and in content.

There is the need to strengthen the finance function within the Association despite the progress made since the appointment of a new Finance Officer. The latter will need some training in the IPPF system of financial reporting and procedures.

There is need for streamlining volunteer/staff relations as well as defining clear-cut guidelines and constitutional provisions for branch structures in order to eliminate the relative ineffectiveness of the branch committees in programme development.

PPASL has taken great strides regarding its compliance with the terms and conditions of grant.

PROPOSED 1983 WORK PROGRAMME/BUDGET

PPASL proposed a total of eleven projects in its 1983 Work Programme/Budget for IPPF funding – five on IEC, one on M & C, three on training, one on evaluation and one on resource development.

The main thrust of the whole programme is motivation and advocacy for family planning. There will be four projects aimed at increasing family life education among the youth of Sierra Leone. One will try to bring together teachers of Primary Teachers Colleges to discuss and draw up a programme for integrating family life education into the school curriculum of these colleges. The second aims at introducing family life education through integrated rural development projects. The third envisages the production of educational materials with emphasis on family life education whilst the fourth aims at promoting the subject through youth clubs.

Another major project aims at promoting family planning as a basic human right through contacts with influential people at all levels of the society.

An on-going project envisages the extension of family planning service delivery facilities to five rural areas in view of the mounting demand consequent upon PPASL IEC activities.

PPASL will also carry out three two-day management development seminars in branch offices to improve staff and volunteer relationships at grass-root level and ensure a wider dissemination of the knowledge of the management systems of the IPPF and PPASL, as well as their policies and activities. PPASL will also up-grade the skills and competence of the middle level staff of the Association in planning, administration, interacting and cooperation as well as reporting, clinical service delivery and evaluation.

Attention will be paid to the establishment and strengthening of branches. Activities include holding formal discussions with senior volunteers about roles, recruitment of new members, committee structure, fund-raising activities and the formulation of activities and branch constitutions.

PPASL will continue with the evaluation of family planning training courses scheduled to start in 1982. Two hundred nurses, midwives and community health nurses are to be involved in the exercise in 1983.

PPASL will also develop local resources so as to generate income to supplement funds from IPPF in support of the Association's activities.

On the whole, PPASL performance has considerably improved in spite of some management and logistic problems. There is every indication, for instance, that the Association's activities have achieved a large measure of success particularly in the Western area where the country's capital, Freetown, is situated. However, considerable efforts at effective motivational work in the three remaining areas (Northern, Southern and Eastern Province) still need to be developed, especially among the male target groups of Mendes, Lokkos and Konos which are important representative tribal groups of those provinces.

PPASL is likely to be actively involved in the work of the proposed National Population Council and it is necessary for the Association to recast its role within the new context likely to result from the establishment of this Council. This new role will take into account the terms of reference and activities to be attributed to the Council with a view to either eliminating or at least minimising duplication of efforts and unnecessary spread and ineffective use of resources.

If, as expected, the Council advises the Government to gradually assume responsibility for family planning service delivery, the PPASL programme, which at present is clinic-oriented, will have to focus more on education, motivation and training.

PPASL will also have to review its strategy of the fieldwork programme. At the moment this aspect of the Association's activities is heavily concentrated on home visits and PPASL will study the possibilities for greater diversification in order to maximise resources and improve operational efficiency.

For the foreseeable future, there will always be a need to continue educating the Sierra Leone public-at-large about the demographic trends in the country, the relationship between population growth on the one hand and socio-economic development on the other, and the role of family planning in upgrading the quality of life for individual citizens and their families. Therefore, PPASL will prepare itself to provide such education through any and all appropriate channels. Radio and television talks, participation in trade fairs and agricultural shows, drama and the press are some examples. Film units located in PPASL branches might help to make this medium more immediately accessible. Various publicity campaigns, well planned and undertaken at branch level, may also

serve to captivate large numbers of opinion leaders, politicians and religious leaders. The national base of support for family planning will further be broadened by seeking volunteer help in the preparation and propagation of family planning messages.

ALTERNATIVE FUNDING

The Association expects to realise from local sources an income equivalent to approximately 17% (\$62,000) of the total expenditure of \$372,200. \$17,400 of this local income represents a grant from the Government of Sierra Leone. The indications are that in the near future the Government will increase the yearly subvention. Sale proceeds of contraceptives have increased and the Association's achievements at fund raising have taken a sharp upward trend, which is very encouraging.

EAST AND SOUTH EAST ASIA AND OCEANIA REGION

REGIONAL OVERVIEW

REGIONAL BACKGROUND

The ESEAOR is a double region, with three member FPAs in East Asia (Japan, Hong Kong and South Korea), five in South East Asia (Indonesia, Malaysia, Philippines, Singapore and Thailand) and, in the widely scattered island countries in the vast South Pacific or Oceanic area, three member FPAs (Australia, Fiji and New Zealand). There are also four small grant-receiving FPAs (Papua New Guinea, Solomons, Tonga and Western Samoa). The estimated combined population of these countries is 435 million.

There are wide variations in the stage of development of population/family planning programmes among the eleven full member FPAs in ESEAOR. Hong Kong, Japan, South Korea, Singapore, Australia, New Zealand and Fiji are countries with well developed national programmes and very little and only occasional, if any, technical assistance is required from the Secretariat. Only three FPAs in these seven countries receive varying amounts of grants from IPPF.

The UN report on the State of the World Population 1981, which draws heavily on the data prepared over 10 years by its World Fertility Survey, predicted that it will be nearly 125 years before Southern and Eastern Asia's population achieves zero growth. This is despite some landmark successes in family planning in the Region. The world population as a whole will take 130 years to level off its population growth, by which time there will be 10 billion people, two and a half times the present number.

The report links the decline in birth rates to factors such as improved education, employment opportunities and generally rising standards of living, all of which encourage family planning. Within the past decade the number of women within the reproductive age group who are using modern contraceptive methods has increased from 14% to 48% in Thailand and 9% to 25% in Malaysia. In South Korea almost all women of reproductive age know at least one birth control method and 86% have access to contraceptives. The persistent KAP gap in a number of developing countries in the Region may be largely due to inadequate availability and accessibility of FP services to couples who want to control their fertility.

Rapid urbanization in most cities and big towns in member countries remains a severe problem with far-reaching economic and social consequences. Rural incomes still lag behind urban wages.

The green revolution and land reform calculated to encourage people to stay in the rural areas have very little impact and are described as mainly cosmetic. There seems to be a tendency to treat population decentralization in isolation; the focus on symptoms rather than root causes; the formulation of policies without adequate supporting data and, above all, the lack of political commitment at high levels.

Countries making significant strides towards socio-economic self-reliance are those with the most successful population programmes, as in Indonesia and Korea. Governments in countries like Japan, Hong Kong and Singapore with strong political will and committing substantial domestic resources to population projects, with international assistance having only a supplementary function, generally achieve their population goals.

THE ROLE OF THE ASSOCIATIONS

Overall performance of member FPAs in the Region for 1981 was generally satisfactory, despite some organizational problems in a number of associations. The rapid turnover of senior staff in some FPAs meant the loss of experienced personnel and the urgency of training their replacements. The Regional Office provided significant input in their training.

Grant-receiving FPAs in ESEAOR spent more than US\$10 million for family planning programmes. Only 35% of this amount was provided by IPPF, and 65% was from local income and other non-IPPF sources.

The preliminary survey conducted by the Regional Office on the extent that the six Action Areas of the IPPF Three Year Plan (1982-84) were implemented by FPAs in ESEAOR indicated that most FPAs placed much emphasis on Action Area 3: Expanding and Improving Family Planning Services (32%). This was followed by Action Area 4: Meeting the Needs of Young people (21%) and by Action Area 6: Strengthening the Role of the Voluntary Sector in Family Planning (20%). More resources of the FPAs were allocated to projects and activities reflecting these three action areas than the others. Medical and clinical activities continue to improve and expand, and more efforts are being made towards self-reliance using clinic fees and other income from medical services. IEC projects remain a strong programme thrust of most FPAs, compatible with their Roles. It should also be noted that, based on the individual FPA needs and priorities and in the context of the local environment, FPAs have also initiated their own action areas which are additional to the six Action Areas of the IPPF Plan. Two such Action Areas are Resource Development and Improvement in the Status of Women.

PROGRAMME AREAS OF THE ASSOCIATIONS

There have been no major programme shifts in the Region in the last 4-5 years. However, there have been changes in operational strategies in almost all the major FPAs. Projects have become more comprehensive and more integrated. There is less compartmentalisation such as training, evaluation, etc. Most of the FPAs carry out "core" programmes which may be medical or IEC, supported by other activities such as training and evaluation.

The two main programme areas of the Region are improvements in the availability and accessibility of contraceptive services, and more target-oriented IEC programmes. The contraceptive services programme through static clinics has been increasing significantly in FPAs in Korea, Malaysia, Philippines and Thailand. This expansion has created some concern in the IPPF as the general world trend has been for FPAs to move away from

increasing services offered by clinics to other methods. However, the expansion of clinical services has catered for the increasing demands for such services, unmet by the local government. Nevertheless, unless this new trend is mandated by agreement between the government and the FPA, as one of the executing agencies of the national programme, this trend towards further expansion of clinic services in the delivery of family planning services needs to be carefully examined in terms of the FPA role and priority objectives.

It is to be regretted that the CBD programme did not pick up at the rate envisaged. Some FPAs gave up this type of programme because of government take-over of such strategies, and the involvement of other organizations in these activities. Others find this project more difficult to manage in comparison with the traditional clinic services.

FP programmes in the eighties will demonstrate increasing involvement of trained community leaders and rural village volunteers. The ESEAOR programme thrust parallels the ESCAP countries in this trend and emphasis. The integration of FP into community development activities is increasingly becoming acceptable and popular. This new strategy fits well with IPPF's Action Area 2 on "Increasing Commitment to Population as a Crucial Factor in Development" and greatly enhances the focus on the other equally important action areas of this IPPF 3 Year Plan 1982-1984.

FPAs are also stressing the importance of development projects for women to enhance their status and their involvement in community development, as well as their increasing participation in FP. All major FPAs have allocated considerable effort and resources in this field.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY OF THE ASSOCIATIONS

One of the healthy signs in the Region is the fact that administrative and general services (AGS) costs have been held for about the last 2 years at the same level, in spite of inflation in the Region. For example, the FPA AGS cost in 1979 was US\$1.7 million; in 1981, the approved budget for this item was also US\$1.7 million. This means a decrease in percentage terms, as the overall expenditure has risen. The main reason for this improvement is that most of the large FPAs in the Region have reorganized their organizational structures so that they are more relevant to their role and priority goals in the context of the national programme. Possibly influenced by the restructuring of the Secretariat, mindful of the levelling of IPPF funding, several FPAs have recently undergone rationalization of their programmes and structure to ensure more cost-effective operations with reduced staff. Programmes are now receiving a large proportion of the resources of FPAs. The operational strategies have also improved.

The proportion of IPPF grants to FPAs compared with other sources of income actually decreased from 52% in 1977 to 38% in 1980, and was down to 35% in 1981. Income other than cash grants from IPPF has steadily increased. It was 48% of the FPA's total expenditure in 1977, and 62% in 1980 and expected to be 66% in 1981. The Region's share of the total international IPPF Budget has remained constant at 12% from 1980-1982.

FPA's have generally welcomed IPPF OPE/MA missions and their recommendations. The use and benefits of OPE/MA findings and recommendations are now fully appreciated. The follow-up, technical assistance and monitoring of the plans of action of FPA's in carrying out the recommendations were undertaken periodically by the Field Office. As a result of these missions, the FPA's concentrated on streamlining areas such as FPA role development, programme priorities, essential changes in the organizational structure, staff development, improvement in operational strategies, and evaluation activities. It is evident that FPA's are now on a strong administrative footing with greater capacity for resource absorption and utilization.

SECRETARIAT SERVICES

As from August 1982, the Regional Office has become the Regional Bureau located in the International Office in London; a Field Office will function from Kuala Lumpur. Secretariat services are varied and will continue to be provided to Associations on a need basis. Major services aim to enhance Associations' capacity and processes for programme development and implementation. The Secretariat assists the Associations in upgrading the knowledge and skills of their staff for greater overall effectiveness and efficiency.

Particular attention has been paid to evaluation, in which FPA's have been well trained. In 1981 all the major FPA's were given intensive field training in evaluation and project implementation. As a result evaluation activities in the Region have expanded and evaluation, now considered an integral part of project planning and implementation, is assisting FPA's in achieving more benefits from their limited resources.

Other Secretariat services assist Associations in resource development and enhancing volunteer productivity.

Member FPA's in the Region were informed of the changes in the Secretariat reorganization and its implications to FPA's in terms of the emerging working relationship between the Secretariat and the FPA's, the application of the new PPBR system, the functions of the ESEAO Regional Bureau in London and the Field Office in Kuala Lumpur.

EXPENDITURE SUMMARY - EAST & SOUTH EAST ASIA & OCEANIA

1981 ACTUAL

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Hong Kong	156.0	63.2	219.2	1374.7	(55.4)	1538.1
Indonesia	573.3	87.6	660.9	733.2	22.7	1416.8
Korea - South	1158.0	40.2	1198.2	3260.5	(387.0)	4071.7
Malaysia *	279.2	91.9	371.1	130.8	(8.5)	493.4
Papua New Guinea	34.0	-	34.0	16.7	1.5	52.2
Philippines	612.0	72.0	684.0	161.2	(53.9)	791.3
Sabah	-	50.6	50.6	236.5	(18.9)	268.2
Sarawak	-	74.0	74.0	300.9	(50.1)	324.8
Samoa	-	-	-	-	-	-
Singapore	62.0	0.5	62.5	16.3	(3.3)	75.5
Solomon Islands	30.2	5.4	35.6	0.3	2.0	37.9
Thailand	373.2	42.3	415.5	129.6	(10.7)	534.4
Thailand CBD	-	-	-	-	-	-
Thailand - McCormick Hospital	-	-	-	-	-	-
Tonga	17.0	8.2	25.2	0.6	0.5	26.3
Vanuatu *	1.0	-	1.0	-	-	1.0
	3295.9	535.9	3831.8	6361.3	(561.5)	9631.6

* Unaudited
figures

EXPENDITURE SUMMARY - EAST & SOUTH EAST ASIA & OCEANIA REGION

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Hong Kong	160.0	84.7	244.7	1410.4	60.6	1715.7
Indonesia	668.7	24.5	693.2	1220.7	(32.7)	1881.2
Korea - South	1110.2	42.9	1153.1	3421.5	0.3	4574.9
Malaysia	334.0	144.4	478.4	183.3	(15.3)	646.4
Papua New Guinea	68.0	21.5	89.5	12.0	-	101.5
Philippines	644.3	115.2	759.5	299.1	(40.0)	1028.6
Sabah	-	63.4	63.4	178.6	61.4	303.4
Sarawak	-	94.3	94.3	221.3	78.0	393.6
Samoa	-	-	-	-	-	-
Singapore	54.0	6.4	60.4	15.0	12.4	87.8
Solomon Islands	33.0	0.2	33.2	4.5	(0.1)	37.6
Thailand	251.6	368.1	619.7	240.4	8.0	868.1
Thailand - CBD	-	100.0	100.0	-	-	100.0
Thailand -	-	-	-	-	-	-
McCormick Hospital	36.8	164.1	200.9	-	-	200.9
Tonga	25.0	10.4	35.4	1.7	(0.3)	36.8
Tuvalu	-	-	-	-	-	-
New Requests	86.5	-	86.5	-	-	86.5
TOTAL	3472.1	1240.1	4712.2	7208.5	142.3	12063.0

EXPENDITURE SUMMARY - EAST & SOUTH EAST ASIA & OCEANIA REGION

1983 BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Hong Kong	158.0	66.9	224.9	1726.9	10.0	1961.8
Indonesia	805.0	65.5	870.5	1269.6	34.2	2174.3
Korea - South	1012.6	54.4	1067.0	7046.7	194.1	8307.8
Malaysia	344.0	155.0	499.0	227.0	63.9	789.9
Papua New Guinea	79.2	11.7	90.9	13.5	-	104.4
Philippines	675.0	220.7	895.7	255.0	28.0	1178.7
Jabah	-	60.5	60.5	310.6	(0.2)	370.9
Sarawak	-	145.1	145.1	236.8	62.5	444.4
Samoa	-	-	-	-	-	-
Singapore	52.0	3.0	55.0	14.0	27.1	96.1
Solomon Islands	38.0	10.1	48.1	2.3	-	50.4
Thailand	301.4	348.1	649.5	222.0	-	871.5
Thailand - CBD	-	-	-	-	-	-
Thailand - McCormick Hospital	-	-	-	-	-	-
Tonga	34.6	6.3	40.9	0.3	-	41.2
Vanuatu	-	-	-	-	-	-
New Requests	100.0	-	100.0	-	-	100.0
TOTAL	3599.8	1147.3	4747.1	11324.7	419.6	16491.4

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

ESEAO

SUPPLIES PURCHASED BY IPPF

	ACTUAL EXPENDITURE 1981	ESTIMATED EXPENDITURE 1982	PROJECTED EXPENDITURE 1983
Contraceptive	297.3	840.3	733.0
Medical & Surgical	29.6	110.3	102.1
Audio Visual Equipment	10.1	27.0	19.2
Office Equipment	14.3	25.6	31.3
Transport	178.4	62.9	101.6
Prior Year Adjustment	(53.4)	—	—
TOTAL	476.3	1,066.1	987.2

AID SUPPLIES DONATED TO IPPF

Contraceptives	59.6	174.0	160.1
FULL TOTAL	535.9	1,240.1	1,147.3

HONG KONG

THE FAMILY PLANNING ASSOCIATION OF HONG KONG (FPAHK)

COUNTRY BACKGROUND

Geographical Setting

Hong Kong is a British Crown Colony consisting of the Hong Kong Island, the Peninsular Kowloon and the New Territories, and 236 small islands. The total area is approximately 1,100 sq kilometres with an overall industry density per sq kilometre of 4,760, the highest in the world.

Demographic Situation and Trends

The population of Hong Kong is about 5.2 million, of whom 98% are Chinese. Of this population, 24% is below the age of 15. The crude birth rate is 16.9/1000, while the crude death rate is 4.8/1000, giving a natural rate of population of 12.1/1000. The growth of population in recent years was mainly due to the influx of legal and illegal immigrants from China, and the Vietnamese refugees. It was estimated that due to illegal immigration the population grew by half a million in the last three years.

Socio-Economic Status/Indicators

In 1981 the total workforce was 2.1 million people, with 28.7% engaged in commerce and services, 41.5% in manufacturing, 3.9% in construction and 6.1% in government and public utilities. The dependency ratio has decreased in the last decade from 674 to 457 per 1,000. The overall median household income has increased to HK\$2,955 in 1981 and the GNP per capita is US\$4,695. The government provides nine years free and compulsory education for children up to the age of 15. The proportion of those with secondary or post secondary education increased from 28.5% in 1971 to 42% in 1981.

The government has a good comprehensive maternal and child health care programme, thus bringing down the Infant Mortality Rate to 12 per 1,000 and general death rate to 5 per 1,000. Life expectancy at birth is estimated at 73 years.

Unmet Needs in Family Planning

In a 1982 KAP Survey it was reported that 89.7% of respondents have experienced contraception, and 72.2% of the married women in the reproductive age were using some method. Efforts have been made by the Hong Kong Family Planning Association to meet the needs of the Chinese and Vietnamese refugees. In a survey conducted recently, 54.6% of the Chinese refugees are current contraceptive users, compared with the 72.2% of local contraceptive users. It is estimated that over half a million refugees from China arrived during the last four years, and there are 12,000 Vietnamese refugees staying in Hong Kong.

Although FP practice looks high, about 40% are using less effective methods. Therefore there still exists a need to intensify FP IEC and service programmes. This is especially so at

present, as there are sectors which government services cannot reach on account of geographical coverage or time constraints; government clinics only open in day time, which makes it difficult for working people to obtain services. Consequently some FPA clinics are open at night and are located in areas where there are no or very little government services. The public attitude to family planning is favourable. In a 1982 KAP Survey, the respondents against its use only represented 2% of the sample.

Government Family Planning Policy and Programmes

The Government Family Health Service operates 41 centres and family planning is an important component of the services provided.

Until 1974 the FPAHK had the sole responsibility for providing family planning services. In that year, upon the Association's urging, the government took over the running of half of its clinics. The government now runs family planning clinics in its Family Health Centres throughout the territory as part of a comprehensive mother and child health care programme.

There is no official population policy in Hong Kong.

Constraints for Family Planning

Hong Kong receives 150 legal immigrants from China daily. This does not take into account the number of illegal immigrants coming across the border into Hong Kong. In the past three years, over half a million immigrants have arrived. There are 12,000 Vietnamese refugees in Hong Kong awaiting resettlement overseas. These are placing heavy demands on FP services.

Even in 1982, there are still 30% of total births being of third or higher parity order. The primary cause for this is the lingering preference for boys. Secondly, though men do not object to their wives using contraceptives, the general attitude is still that birth control is the women's business.

Factors which help the promotion of Family Planning

The main factor which helps the promotion of family planning and the decline in fertility is the economic and social change that Hong Kong has undergone in the past two decades. Those changes helped to develop the growth of individual aspirations and to create new pressures on reproductive behaviour.

Couples took a more positive attitude towards limiting family size. People's aspirations for improved standards of living and the high cost of raising children make a large family too expensive. Late marriages, improvements in education and job opportunities for women have also contributed to the decline in the birth rate.

THE ROLE OF THE ASSOCIATION

The FPAHK, with the full support and cooperation of the government, plays a supplementary and complementary role in providing specialty and IEC services and running family planning clinics in areas not served by government. Because of its policy of not duplicating services

offered by government, the Association is placing increasing emphasis on specialty and IEC services specialty services include sub-fertility investigation and treatment of sterilization, artificial insemination by donor service, vasectomy, termination of pregnancy, clinics for the mentally handicapped and the deaf, a youth advisory service, and special counselling and service for rape victims.

Relevance of FPAHK Role in National Context

The Association's role is clearly stated and reflects the desire of the Association to meet the needs of specific target groups. The Association is the only organization that is directly involved in population/family planning activities in the colony and as such, the government provides substantial assistance – financial and otherwise. The good government – FPA relationship is also seen in the relationship between the FPA and other NGOs. Many FPA volunteers and staff sit on committees of other social organizations, thus improving the working relationships with these NGOs.

Objectives of FPAHK

The main objectives are:

- 1) To provide IEC back-up services for the FP programmes as a whole.
- 2) To provide medical/clinical services thus complementing those provided by the government.
- 3) To advocate the formulation of a government population/FP policy, thus accelerating the development of FP programmes.
- 4) To make the FPA a resource and possibly a Training Centre on matters related to population/FP.

FPA's Relationship with Other Agencies

Some joint projects were recently conducted with five other agencies, including the Chinese Manufacturers Association and the International Labour Organization. The production of six FLE-TV programmes was undertaken with the Education Television Department; a workshop was held with police personnel to increase understanding in helping rape victims; and an FLE workshop was carried out with the Education Department Advisory Inspectorate.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Past Performance

In 1981, HKFPA planned and implemented 16 field projects as follows:

- Information, Education and Communication Projects
 - International Year for Disabled Persons
 - Parenthood Education Programme

- Three Year Family Life Education Course at the Secondary Level
- Adolescent Service
- Audio-visual and Promotional Design
- Development of Resource Centre
- Campaign and Mass Media Promotion

Medical and Clinical Projects

- Surgical Services
- Sub-fertility/Artificial Insemination
- Comprehensive Family Planning Service
- Women's Health Promotion and Service

Community Based Distribution Projects

- Community Integration
- Comprehensive Vietnamese Refugees Project

Training

- FP Training for FP workers

Evaluation Projects

- Study of Termination of Pregnancy Project
- Family Life Education Survey

In 1982, sixteen field projects have been planned as follows:

Information, Education and Communication Projects

- Family Life and Sex Education Resource Centre
- Three Year Family Life Education Course for Secondary Level
- Adolescent Sexuality Programme
- Campaign and Mass Media Promotion
- Audio-visual production
- Counselling Services
- Comprehensive Vietnamese Refugee Project

Medical and Clinical Projects

- Women's Health Service
- Surgical Services
- Birth Control Services

- Sub-fertility/Artificial Insemination

Community Based Distribution Project

- Community Integration

Training Projects

- Family Life and Sex Education Development Training
- Counselling Training Programme

Evaluation Projects

- Fertility Survey of Chinese Immigrants
- KAP Survey 1982

Pioneering Activities in 1981

The Association believes that every one should have access to family planning, even the minority group such as the mentally handicapped, the deaf, the Vietnamese refugees and the legal and illegal immigrants from China.

The Association's Deaf Clinic was started in February 1982. Pre-marital check-up examinations are offered; there were 8,128 clients making a total of 15,434 visits, with an increase of 2.2% in new cases.

Since the Vietnamese project started in 1979, FPA fieldworkers motivated 60,000 people to practise family planning and 6,900 have become acceptors. As many of the recent arrivals from China settle in temporary housing areas run by the government, the FPA has established six women's clubs, which also act as community based depots in these places.

The youth advisory service which started 5 years ago is now firmly rooted. In 1981, 2,997 interviews were conducted, with an average of 120 new cases per month.

Collaborative Activities

The "Population and FLE Programmes for Employers in Hong Kong" conducted jointly by the Chinese Manufacturers' Association of Hong Kong (with 2,400 members) and the Association is now in its second year. During the past year the FPA took part in seminars to introduce its services to employers. In-plant programmes on family planning were conducted for staff of a number of companies.

With the assistance of the Hong Kong Association of the Blind, pamphlets on "Birth Control Methods", "Vasectomy" and "Female Sterilization" were translated and printed in Braille. 500 copies of each subject were produced for free distribution to the blind people. A family planning seminar for the Blind was held at the Hong Kong Association of the Blind Centre in Oi Man Estate.

Infertility

A milestone was reached for the Association's Medical service when the first semen bank in Hong Kong was established in July 1981 at the Association's Ma Tau Chung Clinic. The Association can now help childless couples affected by male infertility when azoospermia is the most common cause. The long waiting list indicates a great demand for this service. The Association has long been recognized as an organization wellknown for its provision of family planning services. The provision of artificial insemination by donor services shows that the Association does not only provide birth control but advocates happy planned families.

Demand Creating Activities

As the attendance to the male clinic was low a "Family Planning – Male Responsibility" campaign was launched. A new 30-second TV spot was produced and shown. Posters were printed and other promotional items included stickers, "Men Only" match boxes and condom envelopes that give information on the male clinics.

Demonstrative Activities

In conjunction with the Hong Kong Society for the Deaf, a Family Planning occasion for the Deaf was attended by 740 deaf people and their families. An exhibition introduced sex education, marriage preparation, birth control methods, family planning youth advisory services, models of the developing stages of foetus, services of the Association and the Hong Kong Society for the Deaf. Family Planning consultation and free medical check-ups were offered, together with the showing of a new 8-minute "Birth Control in Sign Language" video programme and family planning films.

Contraceptive Delivery

The Association has five women's clubs and two more new ones will soon be established in temporary housing areas of the New Territories. The residents there are mostly immigrants who have recently arrived from China and their families are large, numbering 6-10 to a household. These estates are far away from urban areas and contraceptives are not so readily available. Before the clubhouse is built, the Association's workers conduct door-to-door visits in the area to find out the family planning practising rate, to soft-sell family planning to potential acceptors and to recruit club members. The fieldworkers who are stationed daily at the clubhouse act as agents to sell oral contraceptives or condoms to members of the women's clubs. The Association helps members to maintain their birth control practice, and to promote sterilization among those who have already completed their family size. There is a medical adviser in the club house once a fortnight to carry out examination and to answer any queries on birth control.

Management Capacity

There are two divisions, the IEC and Medical, which carry out the FPA's programmes. The functions of Evaluation, CBD and Training come under the IEC Division.

The volunteers provide firm and valuable leadership and policy direction. There are seven different kinds of sub-committees with some 74 members who guide the Association's business. In addition, some of them act as Honorary Consultants to the Association.

While volunteers as policy makers perform an excellent function, there are indications that the Association can have more volunteer involvement at the implementation level – thus making it a really broad-based organization while at the same time saving costs in running projects.

The Management Audit (MA) conducted in mid 1981 stated the HKFPA had “well developed and practised systems and procedures for the use and control of its resources”. It also stated that “its programmes and projects appear well aimed, planned and executed”. On the whole it is a well-managed Association with adequate leadership from the volunteers, and supervision and direction from the senior staff. It is one of the leading Associations in the Region both in terms of management and productivity.

The staff are of good calibre and are a prime reason for the FPA's efficiency. Staff turn-over is low. Administrative costs have been maintained at 11% of total costs.

The government's annual funding to the Association is approximately 40% of its total income. Other local donors, which include the Community Chest of Hong Kong and the Hong Kong Jockey Club, contribute 8% of the income. The FPA clinic services raise 36% of the total income. IPPF support the FPA programme in cash and in commodity grant. The cash grant has recently dropped to below 10%. The balance of funds are generated through membership and other fees.

The FPA also receives substantial amount of in-kind donation from the mass media sector. For example, its jingles and motivational films often appear on the TV channels, and broadcasting over the radio is cost free. Its articles, feature columns, activities such as exhibitions, displays, press conferences, annual general meetings are widely reported in the mass media. The underground railway corporation allows the Association to use its billboards at every station, free of charge, to advertise family planning.

The present trends shows that local income generation will increase. More income will be derived from new specialty services, the new preventive health care service, fees from workshops and seminars and the sale of the Association's own production of audio-visual materials, such as slides, and their accompanying explanatory booklets.

There is every indication that the government will continue giving the present level of funding.

The Association has been moving towards its goal to be financially self-sufficient and self-reliant, as indicated by its smaller budget requests to donors in recent years despite expansion of its services.

THAILAND

PLANNED PARENTHOOD ASSOCIATION OF THAILAND (PPAT)

COUNTRY BACKGROUND

Geographical Setting

Thailand is an agricultural country situated in the Indochina Peninsula, Southeast Asia. Its national boundaries cover a total area of about 541,000 square kilometres, divided into 4 geographical Regions; the Central, Northern, Northeastern and Southern Regions. Bangkok Metropolis, the capital of Thailand, is located in the Central region, and is the administrative, economic and cultural centre of the country.

Local administration is effected by dividing the country into administrative areas with the Province as the largest administrative unit. Lesser in size to the Provinces are the districts, tambons, and villages respectively.

Demographic Situation and Trends

Since 1960 and particularly in the 70's, Thailand's national population growth rate has been decreasing. In the early sixties the birth rate was as high as 35-40/1000. The substantial decrease in the national population growth rate can be attributed to foresight in recognizing the serious long range drawbacks of rapid population growth. The country-wide campaign aimed at encouraging people to accept and practise family planning significantly contributed to the decrease.

Initially, the birth rate of the urban population began to decrease as the socio-economic characteristics of the urban setting favoured small families. Besides, family planning services were also more accessible in urban areas. The birth rate of the rural population started to decrease following the shift in government emphasis to control the rapid population growth rate in rural areas during the implementation of the Third National Economic and Social Development Plan (1972-1976). In this Plan, the Government aimed to reduce the national population growth rate from 3.0 per cent to 2.5 per cent by the end of the implementation period. In the Fourth National Economic and Social Development Plan (1977-1981), the target was further reduced to 2.1 per cent. According to the report of the Thai-American Evaluation team submitted to the Government at the end of 1978, the population growth rate at the time was estimated to be between 2.0 and 2.3 per cent; this means that, providing that this estimated is accurate, the target of the Fourth Plan might have, in fact, already been achieved by 1979.

Rural-urban migration has led to rapid population growth in towns. The existing high population growth in the rural areas coupled with the increasing difficulty in obtaining farm land, and growing poverty has resulted in large numbers of the rural population migrating into urban areas. The proportion of the population residing in urban areas has increased from 10 per cent 1947 to around 17 per cent in 1976. The Bangkok Metropolitan area accounts for nearly one-tenth of the country's total population.

In 1981, which is one year after the 8th population census was conducted, the birth rate was 28.4/1000 while the death rate was 7.7/1000; this means a population growth rate of 2.07 per cent, significantly lower than the target set in the Fourth Plan. In view of this success, the Thai Government set a lower target, a growth rate of 1.5 per cent, by the end of the Fifth Plan period (1982-1986). To achieve this target the Government needs large amounts of resources and must undertake several approaches and strategies. In its endeavour, the Government will have to solicit assistance from family planning agencies in the private sector.

The country's population in 1981 was 47.5 million. Thailand has a population density of around 88/sq km. It has a young population structure -- 40% are under the age of 15. Women between the ages of 15-49 represent around 25% of the whole population.

Socio-Economic Status/Indicators

The period prior to and during the current fertility decline in Thailand was also one of sound development, economic growth and social change, which undoubtedly exercised a positive influence on fertility rates.

Socio-economic indicators all point to increasing development. Literacy among adults is becoming universal. The proportion of the labour force engaged in agriculture is decreasing. Geographical mobility and the per cent living in urban areas are on the rise. Rapid change is occurring in the areas of communication and transportation while a greater proportion of the population is being reached by mass media. Life expectancy is rising while infant mortality is declining.

Thailand is still mainly an agricultural country and in fact only 17% of its population live in urban areas. It has a total work force of about 21.7 m people: 15.8 in commerce and services; 6.7% in manufacturing; 73.8% in agriculture and fishing; 2.3% government and public authorities and 1.4% in construction. The GNP per capita is \$490.

The government spent in 1981 approximately one-fourth of its total national budget on national security affairs, and one-fifth each on economic and educational development. The budget for public health activities is relatively low. The government, therefore, cannot supply enough medical service including sanitation, nutrition, environmental development to the public.

The status of women needs special mention. The analysis of the level of education of women who live in the rural and urban area indicates that the educational opportunities of the rural women are very much fewer than for urban females. One way to solve these problems is to develop out-of-school educational systems to provide training on development activities, income generating skills such as vocational training, and education in MCH, Sanitation, Family Planning, Health and Nutrition. At present the out-of-school education programme conducted by the government and private agencies must be up-graded and improved, but such progress is hampered by the lack of research and information on the needs of the women, skill of trainers and support from interest groups.

Unmet Needs in Family Planning

The most important targets in need of Family Planning services are those living in remote, poverty-stricken and rural areas. They generally want a large number of children to help earn income for the family. Evaluation findings based on data from the "Survey of Fertility in Thailand (SOFT): 1975" which is part of the World Fertility Survey (1975) revealed that 90 per cent of currently married women have an unmet need for contraception. The unmet need is highest among women 35-44 years of age who have little education and live in rural areas. Working women and those living in the northeast also have somewhat higher levels of unmet needs than others.

The findings of the 1981 Contraceptive Prevalence Survey were that the proportion of the unmet need in family planning is highest in the rural areas and lowest in Bangkok Metropolis. In terms of region, it was found that the southern region had the highest proportion of women at risk, followed by the northeast.

Government Family Planning Policy and Programme

In the Fifth National Economic and Social Development Plan (1982-1986) the Government stated its population policy as follows:

- a decrease in the population growth rate
- the improvement of population distribution and human settlement.
- an increase in the quality of the population.

Targets in the implementation of the national population policy have been set as follows:

Reduce the population growth rate to approximately 1.5 per cent by the end of the implementation period of this Plan (1986).

Improve population distribution and human settlements.

Improve population quality.

Targets for Family Planning acceptors have been set for each year as follows:

Annual targets of New Acceptors

Fifth Plan Period

Year	All Methods
1982	795,561
1983	847,131
1984	926,086
1985	982,021
1986	1,042,535
Total	4,593,334

The Success and Failure of Family Planning in Thailand

In March 1970, the Royal Thai Government announced the national population policy to support voluntary family planning, and the National Family Planning Programme (NFPP) administered by the Ministry of Public Health (MOPH) was incorporated in the Third Development Plan (1972-1976) of the National Economic and Social Development Board.

In view of the considerable success in reducing its population growth rate, the Fifth National Economic and Social Development Plan has set the target for a further decrease to 1.5 per cent by the end of 1986. This target decrease in the population growth rate is feasible considering the close and effective collaboration between government and private agencies under the National Family Planning Programme (NFPP), as well as the fact that in 1981 up to 98 per cent of the women in reproductive age groups had some knowledge of contraception.

Policies and Programmes of Other Agencies

In addition to the National Family Planning Programme (NFPP) and PPAT, three other private agencies also provide Family Planning services and contribute towards the achievement of the demographic targets especially with regard to family planning acceptance.

The three Family Planning agencies are:

(a) **The Association for Strengthening Information on National Family Planning Programme (ASIN)**

This association supports the work of the NFPP in terms of disseminating family planning knowledge and information and promoting family planning acceptance in an effort to encourage the population at all levels to have knowledge and awareness of the benefits of practising family planning. Dissemination of family planning knowledge and information is done by utilizing all forms of mass media: radio, television and the press.

(b) **The Thai Association for Voluntary Sterilization (TAVS)**

This association provides or stimulates the production of adequate and effective education-motivation and clinical services on voluntary sterilization throughout the country.

(c) **The Population and Community Development Association (PDA)**

This association provides access to safe, economical and convenient family planning information and services, and also promotes local participation in community development, by encouraging community members to take the initiative.

PDA has the following areas of operation:

- Community-Based Family Planning Services
- Community-Based Appropriate Technology and Development Services
- Community-Based Emergency Relief Services
- Asian Centre for Population and Community Development

Public Climate/Attitude for Family Planning

The Government and private agencies involved in Family Planning work have played a significant role in promoting awareness of family planning and motivating people to accept family planning services, as well as pointing out the detrimental effects of rapid population growth to national socio-economic development.

The Parliament has considered a proposed bill to amend the abortion law which would allow a more liberal legal stance towards abortion. Despite the fact that this proposed amendment was passed by the House of Representatives but later rejected by the Senate, the publicity both for and against the amendment greatly aroused public awareness and interest in family planning and contraception as an alternative to abortion. In addition, training, seminars and symposiums on the subject of family planning also received extensive and positive media coverage. Moreover, the private sector, especially the various private organizations, has become more active in family planning work. In addition to the four organizations directly involved in family planning, other private agencies which have helped to promote family planning and provide material as well as financial assistance to family planning work include the Professional Radio and Television Programme Producers Club and the Thai Executive Relations Association.

Constraints for Family Planning

The main constraints for Family Planning in Thailand are the negative rumours concerning family planning in the remote rural areas. There is also the problem of unmet needs in family planning service delivery especially in sensitive areas, where communist insurgents operate. In addition, Thailand suffers from the shortage of medical personnel in the rural areas, as well as insufficient information dissemination which hampers family planning motivation.

Moreover, there are still doubts as to whether family planning is allowed according to the Islamic religion. This greatly impedes family planning acceptance and sometimes even provokes antagonistic feelings about family planning in the South.

Factors which help the Promotion of Family Planning

The success of family planning in Thailand can be attributed to the following:

- The Thai Government announced the national population policy for the first time in March 1970, aimed at reducing the population growth rate.
- The Government established the National Family Planning Programme to be operated under the Ministry of Public Health, with emphasis on family planning as part of family health care.
- Educational institutions and research agencies conducted research, studies and surveys in the fields of medicine, sociology and demography.
- The work of the private sector.
- The general public has become increasingly involved in promoting family planning work either by making contributions in cash and commodities, or by carrying out public relations operations.

- Generally, the public climate is favourable and the community at grassroot level has shown enthusiasm for taking initiative in family planning work.

THE ROLE OF THE ASSOCIATION

PPAT is a private organization whose work is aimed at disseminating FP knowledge and information, motivating people to practise family planning, and providing FP services to the selected target groups especially those living in remote rural areas. PPAT's target areas are the impoverished rural areas in the northeastern and southern Provinces where the birth rate is still high and FP acceptance low. In addition, PPAT's operations also concentrate on the low income groups in urban areas, both Bangkok Metropolis and in the provinces.

PPAT has set its role as follows:

1. To support the government's population policy and the National Family Planning Programme in their effort to achieve a manageable level of population.
2. To complement and supplement the efforts initiated by the government and other participating agencies in promoting family planning as a basic human right and insuring that all people have access to FP information and services.
3. To seek appropriate measures which will further improve the overall programme and organizational performance of the Association, in order to carry out its tasks effectively and more economically.
4. To strengthen the advocacy role of the Association in obtaining government and private sector commitment and resources for FP, and to support necessary reforms which will further promote the adoption of FP as a way of life.
5. To develop a resource development programme.

Relevance of PPAT Role in National Context

The Association's role has not changed for the last few years and is appropriate in the national environment. In addition directly supporting the Government's population policy and the National Family Planning Programme, PPAT also concentrates its efforts in setting up additional strategies to meet developmental needs of specific target groups and in stimulating other agencies to participate in FP activities more vigorously. PPAT is very much aware of the importance of sex education and has organized seminars on this subject for education administrators and provided training in sex education to resource persons, as well as enlisted the co-operation and assistance of the mass media sector in disseminating sex education information.

PPAT recognizes that the youth of today will become the main force to guide the nation in future development. Providing proper knowledge, information and guidance to youth will help to ensure that they will grow up to be mature and responsible adults. Therefore, PPAT has established a youth counselling centre, which provides vocational training, orientation and recreation activities.

Another target group which PPAT caters to is women. In Thailand, women constitute approximately half of the total population. Accordingly, PPAT has devised a women's development project, implemented in the northeastern provinces. In this project, housewives receive training in FP motivation and service distribution, maternal and child health care, community development, vocational skills, etc. This project has enabled women in these areas to become increasingly active in the development of their family and their community especially in terms of elevating the family's living standards and enhancing the status of women.

Besides being able to closely collaborate with relevant government agencies and the other three private FP associations mentioned earlier, PPAT has also been successful in encouraging other private agencies to play a more active role in promoting family planning. In its endeavours, PPAT has received co-operation from the mass media, other voluntary organizations (e.g. Women's Culture Club, National Women's Council, Woman Lawyers Association, etc.), as well as from private companies and commercial enterprises.

It is difficult to ascertain PPAT's contribution to the national programme as there is no information to indicate the performance of individual organizations. However, PPAT's work and contribution to the national FP programme is recognised by the Government. With the introduction of the new IPPF PPBR system in 1983, PPAT's role will be thoroughly re-examined so that the new role will be based on assessed unmet FP needs.

Objectives of PPAT

In accordance with the Fifth National Economic and Social Development Plan (1982-1986) and the stated role of PPAT, PPAT's main objectives are:

1. To take a leadership and pioneering role in FP in the rural community in the southern provinces, refugee camps, and other areas assigned by the Government.
2. To consolidate, strengthen and expand the comprehensive and integrated PPWD/CBD/youth types of projects in Bangkok Metropolis and the northeastern region of Thailand where FP is recognised as an important component of development.
3. To develop projects integrating FP with primary health care, nutrition and community health development as demonstration projects on the vital relationship of population and development.
4. To concentrate efforts in developing pilot projects on women (PPWD) and out-of-school youths and their involvement in development, men's responsibility in family planning and approaches towards self-reliance.
5. To further strengthen the Association's collaboration with the government and NGOs in the field of population and family planning.
6. To recruit and train more volunteers to stimulate their involvement at national and field levels and to develop broad base community support.
7. To develop IEC supportive material and instructional media in response to the unmet family planning need.

8. To develop and implement volunteer and staff development programmes.

Relationship with other Agencies

PPAT is one of the organizations represented in the Sub-Committee on Co-ordination of Private Sector Groups under the National Family Planning Co-ordination Committee. In addition to the joint co-operation and inter-agency coordination of PPAT and other relevant agencies under the National Family Planning Programme, PPAT also collaborates with both government and private agencies in the implementation of the Association's projects and programmes.

Currently, PPAT enjoys a good image in Thailand; both government and international agencies give it increasing recognition.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

In 1981, PPAT implemented 12 field projects:

Information, Education and Communication projects

- Family Life Education and Counselling for Youth
- Mass Communication and Public Relations
- Legal Reforms to Promote Family Planning

Community Based Distribution projects

- The Refugees Project in Northeast
- Family Health and Welfare for Muslim Community in Southern Thailand
- Family Development for Rural Housewives in Ubol Province
- FP and Health Services in Saraburi Province
- FP in the Industrial Community
- FP in the Housing Community of the National Housing Authority in Bangkok Metropolis
- FP services in Cooperation with Private Medical Clinics Training project
- Training for Trainers in Sex Education

Resource Development project

- Fund Raising

In 1982 the PPAT programme was on the same basis as in 1981 with the same mix of projects.

The main change in 1982 was the establishment of a Medical Clinic for both service and income generation.

IEC and Motivation

PPAT's Mass Communication and Public Relations programme is the only private organization which covers continuous IEC and motivation in a frequent and systematic way, utilizing up-to-date data and information from various researches and studies. Particular emphasis is given to "how" people can be motivated to accept FP services and attain a better quality of life.

PPAT has regularly monitored and evaluated the achievements of the Mass Communication and Public Relations programme. Success is evident in the feed-back from viewers and listeners combined with the pledge made by radio and television stations to continue to donate free air-time to PPAT.

At present, PPAT is endeavouring to develop its IEC Centre to provide various types of instructional media services pertaining to FP, FLE and sex education to the general public and both in-school and out-of-school youth.

FP Contraceptive Services

PPAT is fully aware from past experience that providing IEC and FP motivation without efficient FP service delivery cannot meet the population's family planning needs and demands. PPAT's FP & Health Services for Saraburi Province Projects, which utilized CBD approaches, was highly successful and is considered as a model. PPAT's Community Integrated Development Approach (CIDA) Project initiated in Ubon Ratchathani Province in the northeastern Region has also been highly commended by both local governors and central administrative units, namely the Ministry of Interior and the Ministry of Public Health. The highlight of this project is that it integrates family planning with development components undertaken by the provincial authorities which stress health, nutrition, maternal and child health care, environmental sanitation, out-of-school education, vocational training, home management, etc. In addition to this, the CIDA Project also includes efficient mobilization of available local resources from the government and private sectors as well as from community members. This has resulted in a high level of community participation and stimulated provincial and district governors to become more actively involved and responsible. Even though PPAT will withdraw itself from this project in 1983, the province has already included the project in their own work programme. Nevertheless, for the first 2-3 years, PPAT may still have to support this project in terms of contraceptive supplies.

PPAT has also had considerable success in providing FP services to refugees. PPAT has been able to reduce the birth rate in the Surin Refugee Holding Camp from 71.9/1000 in 1979 to only 19.2/1000 in 1981. PPAT was the first organization in Thailand to initiate projects to provide FP services to refugees and tried to serve as a model in carrying out FP work for other relevant agencies. However, due to limited funding coupled with the fact that another agency was prepared to take over this work, PPAT withdrew itself from this services. Later PPAT received requests from the Ministry of Public Health and the Ministry of Interior to resume FP service delivery in another refugee holding camp, in

Nong Khai Province, and PPAT took up the challenge again. At present, it is the Government's policy to close down refugee holding camps, leaving only two camps in operation. The Government has especially requested that PPAT collaborate with the MOPH in providing FP services at the two camps.

The Contraceptive Delivery Service for Urban Low Income People Project is another example of a successful project. This project is based on the commendable cooperation from community pharmacists, private medical clinics as well as owners and managers of industrial factories. The work carried out by these volunteer groups, acting as FP motivators and distributors, complements and supplements government efforts in providing medical treatment and promoting family planning.

Clinical and Counselling Services

In 1981, PPAT provided counselling services to youth, adolescents and the general public at its Counselling Centre in Bangkok, totalling a number of 9,703 persons, 50 per cent higher than the total number of recipients for 1980. One of the main reasons for this increase is the provision of satisfactory services. PPAT's volunteers who are qualified medical practitioners also provided FP clinical services at this Counselling Centre which enabled those who came from counselling to receive special FP clinical services on request.

The PPAT Board took into consideration the need to provide FP clinical services to the population in the low and middle-low income groups, combined with the fact that establishing a separate medical clinic would facilitate the counselling services at the Centre and help raise supporting funds for the Association. Two of PPAT's Board members jointly donated the sum of \$28,000 to purchase a shop-house building to house PPAT's management capacity.

PPAT's volunteer organizational structure is headed by the PPAT Board comprising a total of 13 members who set the Association's policies and oversee the overall performance. PPAT has 7 Advisory Committees, including Medical, Fund Raising, Technical and Programme Development, with members who are experts in their fields.

PPAT's staff structure has 3 Divisions, viz. Operations Division, Programme Development and Evaluation Division, and Production and Communication Division.

Operations and Management System

The PPAT Board is responsible for policy formulation, with the assistance of the 7 Advisory Committees and the staff. Policies are executed by the staff, and the general management style is participatory.

Generally, PPAT has been responsive to recommendations made by the IPPF Secretariat. The plans of Action arising from the OPE and MA recommendations have been acted upon and are now being monitored by Field Office. On account of secretariat guidelines and explanations, there is now a clear distinction between staff and volunteer rights and responsibilities.

PPAT has requested more technical assistance from the Regional Bureau for staff development in areas like Evaluation, Programme Development and Record Keeping.

PROPOSED 1983 WORK PROGRAMME/BUDGET

PPAT has used the Government's Population Plan (1982-1986) as a guideline in formulating its own 1983 WP/B which concentrates primarily on providing FP knowledge and services to cover remote rural areas. Seeing that youth constitute approximately half of the total population, PPAT will give special emphasis to youth development projects during 1983-1985. These youth projects will concentrate on imparting knowledge, enabling young people to take the initiative in constructively contributing to society, forming groups to carry out activities in community development, etc.

PPAT's women's development project, which integrated FP components into other aspects of development and was implemented in Ubon Ratchathani Province, has achieved great success; so much so other northeastern provinces have requested PPAT to implement similar projects in their provinces. Therefore, in 1983 PPAT plans to extend this project in other northeastern provinces starting with Nakhon Phanom. By then, the project operation in Ubon Ratchathani will have been transferred to the provincial authorities.

With regard to the urban population groups, PPAT not only provide FP clinical services at PPAT's medical clinic in Bangkok Metropolis, but also provides contraceptive delivery services through project volunteers, private medical clinics and community pharmacists groups.

In 1983, PPAT will execute 10 projects as under:

Medical and Clinical project

- PPAT's Medical Clinic

Information, Educational and Communication projects

- Urban Adolescent Development Project
- IEC Resources Development Centre

Community Based Distribution projects

- Family Health & Welfare for Rural Community in Southern Provinces
- Community Integrated Development for Rural Housewives in Northeastern Provinces
- Contraceptives Delivery Services for the Urban Low Income People
- Refugee Project

Training Projects

- Family Life Education Promotion Project
- PPAT's Staff Development

Resource Development project

– Fund Raising

PPAT has proposed a 1983 budget of US\$632,400:

IEC	US\$168,100
MC	34,500
CBD	115,100
TR	28,200
EV	37,900
AGS	248,600
Total	632,400

PPAT has asked for more commodity assistance, especially contraceptive supplies. PPAT's projects are mainly concentrating on community-based distribution. PPAT's Medical Clinic, which provides FP clinical services as well as general medical services, also needs medical equipment. Moreover, in 1983 PPAT will need additional audio visual equipment for its IEC Resource Centre so as to ensure effective and efficient production of IEC supportive material and instructional media.

ALTERNATIVE FUNDING

PPAT had not previously had much success generating funds on its own or from other agencies, and in 1982 therefore decided to go on a commercial programme for distribution of contraceptives in Bangkok and embarked on a clinical project as a means of fund raising. The results are yet to be seen but there are grounds for optimism.

EUROPE REGION

REGIONAL OVERVIEW

While most European governments have become increasingly aware of their obligations to recognise and meet their population's growing needs for fertility regulation services, the continuing fall in birth rates presents a very real danger that some pronatalist governments might seek to restrict access to family planning facilities. In the face of an economic recession and increasing cuts in government expenditure on planned parenthood services, European Planned Parenthood Associations have continued their information and education work at various levels, to counteract government beliefs that readily available fertility regulation services result in a declining birth rate, and to encourage use of such services among vulnerable groups in society.

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 PPAs 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 consumer access to fertility regulation and services; the human right to planned parenthood, theoretically and in its implementation; migrants and planned parenthood; and adolescent services.

MEMBER COUNTRIES

Austria – Osterreichische Gesellschaft fur Familienplanung (OGF)

The Minister of Health has not expressed any interest in family planning. The incidence of adolescent pregnancy is increasing and there has been no improvement in the abortion situation; there is still no routine registration of hospital operations. OGF continues to collaborate with the government in designing courses for family planning unit personnel, lecturing and organising discussion groups, and in writing and editing state-produced material. OGF pressure group activities to improve the standard of contraceptives led to a Ministry of Health-funded study on the quality of condoms sold in Austria. In addition, OGF acts as a consultant and research body on activities relating to sex education and abortion.

Belgium – Federation Belge pour le Planning Familiale et l'Education Sexuelle (FBPFES) Belgische Federatie voor Gezinsplanning en Seksuele Opvoeding (BFGSO)

The atmosphere in which the centres operate has not improved, and the institutional crisis affecting Belgium has given risk to a political instability which deeply affects the Federation's work. The abortion situation drastically worsened but, in spite of a repressive climate, the non-hospital centres continue to perform illegal abortions. The Federation

continues its training, documentation and information activities, and through these is becoming more known to the public. Its areas of interest encompass youth, immigrants, artificial insemination by donor, and the use of audio-visual material in sex education. The Federation intends to intensify its efforts in these areas.

Bulgaria – Family Development Council (FDC)

Induced abortion and coitus interruptus remain the most widely practised methods of fertility regulation. The abortion rate is increasing and 1981 saw the lowest ever birth rate. A new law to liberalise abortion will be discussed in 1982. The national study on infertility is now in its final stages and the FDC is also preparing a legal document for the introduction of sterilisation on medical grounds. In addition to these major tasks the FDC continued to coordinate state and social welfare activities with adolescents and young families, expand its sex education and public information work, and help in the organisation of state production of the IUD.

Denmark – Foreningen for Familieplanlægning (FF)

A shortage in the supply of diaphragms unfortunately came when interest in barrier methods seemed to be increasing, and FF was inundated with requests for help from pharmacists and physicians. FF feels that adolescents' needs in particular remain unmet, and will organise a Workshop on Adolescence with participants from all over Europe. While this remains the Association's major task, it is also working on the production of a newsletter for physicians on contraception and planned parenthood, and a film for primary school sex education use. FF is particularly interested in extending cooperation with developing countries to encompass family life education.

Finland – Vaestoliitto

Following the pattern of the last decade, the birth rate is still below replacement level and the government is concerned about depopulation. Vaestoliitto's main aim in the last year has been to improve family living conditions by influencing social policy; in 1980 the Association concentrated on the issue of housing for young families, and published a book stressing the importance of housing policy to family welfare. In addition to other family policy-related research, Vaestoliitto continues its clinical research which it hopes will lead to the use of two new methods of contraception, IUDs and vaginal rings releasing steroids. Vaestoliitto has designated the 1980s as the 'Decade of the Father' as part of a campaign to emphasise the male role in family life.

France – Mouvement Français pour le Planning Familial (MFPF)

Provisions for contraception and abortion remain inadequate and government family planning policy clearly indicates its pronatalist attitudes: a grant for the birth of a third child, and restrictive legislation stemming from its interpretation of the 1979 Abortion Law. Access to contraception is not facilitated, and minors in particular experience difficulties in obtaining supplies. MFPF is largely involved in pressure group activities to establish hospital abortion services, to demand free contraception for minors, to

improve access to family planning facilities and to support physicians prosecuted under the abortion law. The Association also continues its fight for abortion on demand, its work with women's groups, and its educational activities.

Federal Republic of Germany – Pro Familia, Deutsche Gesellschaft für Sexualberatung und Familienplanung eV.

The overall economic crisis has affected Pro Familia through reductions in funding. Pro Familia has attained a high political profile through press statements against the cuts in public services. A new centre for integrated family planning services including abortion was opened – it will be the second Pro Familia centre to perform abortions. The project on family planning counselling for Turkish migrant women in Berlin has been concluded, and a new training programme for migrant work is still to be evaluated. Pro Familia has launched a new periodical 'Sexualpädagogik und Familienplanung', the first of its kind in German. Pro Familia continued to work to enlarge its services to meet the needs of groups such as adolescents, migrants, men, the elderly and the handicapped.

German Democratic Republic – Ehe und Familie (EFA)

The planned parenthood situation is positive, governmental institutions and the EFA jointly working to realise the individual right to family planning through the availability of contraceptive counselling and the desired method, free-of-charge. The Association's current activities include training courses for psychotherapists and counsellors and, together with other health bodies, working towards the improvement of medical and public health care. A one-week international symposium on infertility was held, and the EFA annual meeting was devoted to 'Sexuality and the Handicapped'. In 1982 EFA will host the Third Seminar of Socialist Countries on 'Preparation for Marriage and Family, the Sexual Behaviour of Young People'.

Hungary – Hungarian Scientific Society for Family and Women's Welfare (HSSFWW)

The birth rate in Hungary has continued to decline. The range of available oral contraceptives increased and artificial insemination by donor has now been legally introduced. The Society continued its work related to preparation for family life, and organised a conference for physicians and teachers in this sphere. The Society participated in a national symposium on population policy and took an official stand-point on voluntary sterilisation, which it hopes will encourage the Ministry of Health to actively promote sterilisation. HSSFWW also organised a scientific conference on 'Demography, social and health aspects of illegitimate births'.

Ireland -- Irish Family Planning Association (IFPA)

1981 saw the birth of a public campaign to draft into the Irish Constitution an amendment guaranteeing the absolute right to life of the foetus from the moment of conception. Although abortion is still completely prohibited and thousands of Irish women undergo abortion abroad each year, the major political parties have accepted

this amendment which will be debated in the Irish parliament in late 1982. Meanwhile, the IFPA continues its work for disabled people, and courses in sex education skills and techniques for teachers, youth workers, probation and welfare officers, and plans to introduce new courses to meet the unprecedented demand for sex education.

Italy – Unione Italiana Centri Educazione Matrimoniale e Prematrimoniale (UICEMP)

For the first time ever there has been a decrease in the population growth rate, which is cited by the mass media with increasing alarm. There has also been a decrease in the use of all contraceptive methods. Two laws on voluntary sterilisation were presented, and the women's movements are pressing for a discussion of a law on rape. The public clinic situation is good in the north and centre, but clinics are few or non-existent in the south and islands. UICEMP concentrates on training courses and public information and in 1981 produced some new leaflets which will also be used in the public clinics. The Association is hampered by financial constraints and the need for more funding outside IPPF. Collaboration continues with WHO Europe on the adolescents' sex education project, and the MENA Region.

Luxembourg – Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle (MLPFES)

Since 1979 the economic and political situation has been unfavourable for family planning, and government subsidies to MLPFES have not increased. The 1978 law on abortion and sex education is still not being implemented. The Association continued with its information and education activities and clinic services, and maintained mass media prominence through an hour-long programme every three weeks on the national broadcasting network. MLPFES will intensify its activities to include sex education in teachers' curricula, and intends to provide a new slide series for primary schools.

Netherlands – Rutgers Stichting (RS)

Abortion remains legally restricted but is still widely available. It is very much a topic of public interest, particularly as the abortion rate is rising among Dutch women. In 1981 RS celebrated the centenary of the first organised family planning movement in the Netherlands but, despite this long tradition, RS is suffering greatly from government cuts in funding. RS still manages to maintain its clinic and psychosexual counselling services, information and education activities and training in multi-disciplinary cooperation; it is hoped to establish more general bureaux with diverse approaches to serve clients such as adolescents and young immigrants.

Norway – Norsk Forening for Familieplanlegging (NFF)

The state Social Affairs Department produced a report on the status of sex education and concluded that the quality and quantity of sex education is inadequate and varies widely. Hence NFF intends to intensify its activities for young people still at school. The Association's main objectives are to help those groups which have limited access to contraceptive information and services, such as handicapped people and adolescents,

who cannot get assistance through MCH institutions.

Poland – Towarzystwo Rozwoju Rodziny (TRR)

The TRR celebrated its 25th anniversary in the face of the most severe difficulties it has ever experienced. With the political upheaval of the last two years, TRR teetered on the brink of dissolution with a decline in membership and the closure of six clinics. To save the situation, TRR has gone into the commercial production of a new IUD, spermicides, and baby-care and general hygiene products. In spite of the critical climate, the Association continued with its clinic and counselling services, training for counsellors, and lectures in sexology, sex education and family planning.

Portugal – Associacao para o Planeamento da Familia (APF)

The Roman Catholic church increased its attacks on abortion and family planning; abortion is still illegal and family planning services are only available through the Health Department. The high rate of adolescent motherhood led to a directive from the Ministry of Health in August 1981, banning under-18s from attending clinics without parental consent. In spite of financial problems, the Association is active in a large number of areas and especially with information and education work with adolescents. APF has established four new branches and enlarged its community work in urban and rural areas. In 1980, APF opened a documentation centre for public use, and distributed audio-visual material funded by the UNFPA and produced by the Comissao da Condicao Feminina. IPPF grant assistance remains APF's main source of income and APF has requested further help for 1983.

Sweden – Riksförbundet för Sexuell Upplysning (RFSU)

There are no noticeable obstacles to family planning in Sweden; when the government approved new abortion legislation it was decided to devote greater resources to preventive methods, and a new system is now operating whereby family planning services are integrated with MCH services. 70% of all contraceptive services are provided by RFSU-trained midwives, and training remains prominent in the Association's activities. In 1981 RFSU produced a new periodical 'Ottar' and continued its successful summer camps for men, women, and children. RFSU will hold a Workshop on Rape in 1983 which will enable a European-wide exchange of ideas and experiences, and will disseminate the results of RFSU's past research on rape and sexual assault victims.

Turkey – Türkiye Aile Planlamasi Dernegi (TAPD)

The climate became even more favourable towards family planning with the new government giving priority to population issues. Proposals for legislation on abortion and sterilisation are still being considered. The Association introduced sex education programmes into several factories. TAPD sent educational teams to visit villages and underprivileged areas, and organised training courses for different sectors of the community. TAPD has requested IPPF assistance in 1983 and hopes to be able to enlarge the existing information machinery to meet the needs of certain target groups.

United Kingdom – Family Planning Association (FPA)

In 1981 three traditionally controversial areas continued to be prominent: sex education, abortion, and the provision of contraception to adolescents. The FPA's work included information and education activities, the production of the bulletin 'Family Planning Today', and the initiation of a project designed to disseminate family planning information through pharmacists. The FPA also continued to offer a wide variety of courses. Its targets for the next few years will focus attention on creating male awareness, increasing parental awareness of the need for sex education, the training of health personnel in sex problems, mass media publicity campaigns, and various research projects.

The FPA's fund raising organisation, Population Concern, has continued its successful endeavours to raise funds for population education and projects carried out by the FPA in the United Kingdom, and also for a variety of projects executed by other IPPF member FPAs in developing countries.

Yugoslavia – Family Planning Council of Yugoslavia (FPCY)

The Association's activities are directed towards the inclusion and promotion of family planning work within the framework of the public services. To this end, FPCY is particularly involved with preparation for family life education and the realisation of planned parenthood as a basic human right. Together with the UNFPA, FPCY is engaged in research projects in the fields of demography, social policy, medicine, and education. In 1981 FPCY held two meetings on the roles of the social worker and the trade unions in the humanisation of relations between the sexes, and the right to freely decide on childbirth, of which the conference proceedings will be published.

SELECTED NON-MEMBER COUNTRIES

Czechoslovakia

The Czechoslovak demographic situation has always been of great interest to the government; although a pronatalist population policy encourage a rise in fertility in the 1970s, 1981 continued the decline in birth rate and population growth seen in 1980. In late 1980 the abortion law was amended to permit free abortion when pregnancy occurs with an IUD in place or if oral contraception is used. In 1981, artificial insemination by donor was legally regulated. Planned parenthood activities over the last year have focused mainly on exploring ways of making parenthood education more effective through a survey of teaching methods.

Malta

Since the introduction of three family welfare clinics in May 1981, two staff members have travelled to the United Kingdom to undergo training, and it is hoped to continue to send staff. A trained counsellor from the United Kingdom will visit Malta to identify a

programme for local training and select counsellors to go abroad to receive specialist training. Malta is still without a voluntary PPA but a voluntary organisation has been created within the family welfare services network, and it is hoped that the voluntary aspect of family planning services will be expanded.

Spain

Contraception was finally legalised in October 1978, opening the doors for private doctors and family planning groups to provide a service. Abortion and sterilisation remain illegal but, in comparison to the previously stagnant situation, family planning in Spain is growing quickly. There are now approximately 150 centres of which about 60 are on the municipal level and have been created within the last two years. The government, despite initial statements of intent to set up family planning clinics, has taken little action in this area. Volunteers and women's movements are working towards a united interregional family planning movement.

EXPENDITURE SUMMARY - EUROPE REGION

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Italy	20.0	-	20.0	1.5	11.0	32.5
Portugal	20.0	-	20.0	42.7	(0.1)	62.6
Spain	-	-	-	-	-	-
Turkey	10.0	-	10.0	67.8	2.1	79.9
New Requests	40.0	-	40.0	-	-	40.0
TOTAL	90.0	-	90.0	112.0	13.0	215.0

EXPENDITURE SUMMARY - EUROPE REGION

1983 BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Italy	43.0	-	43.0	33.0	-	76.0
Portugal	27.5	-	27.5	38.0	-	65.5
Spain	-	-	-	-	-	-
Turkey	30.0	-	30.0	43.0	-	73.0
New Requests	15.0	-	15.0	-	-	15.0
TOTAL	115.5	-	115.5	114.0	-	229.5

INDIAN OCEAN REGION

REGIONAL OVERVIEW

CHARACTERISTICS OF THE REGION

The Region accounts for 30% of the total IPPF population and 42% of IPPF's grant-receiving world (excluding China). A substantial portion of this population lives in abject poverty. Infant mortality is high, literacy low, and the difficulties of delivering even basic health care services – let alone family planning – are enormous, considering that the bulk of this population lives in rural areas which are not easily accessible: in all countries over 70% of the population is rural; in Nepal 95%. There is little hope of governments being able to make any significant impact on such populations without the support of the people themselves, and without organised voluntary community effort from within and financial and technical support from outside. The FPAs have an important role to play in demonstrating how these communities can be organised to help themselves.

About 40% of this population is under the age of 15. This has major implications for the future, to which the FPAs are very much alive.

The population continues to expand at the rate of about 2% or more, with Pakistan registering a high of about 2.9%. Birth rates are high, ranging from 33 to 42. So are the death rates at 13–19. These figures do not apply to Sri Lanka which does not share many of the characteristics of the region. As has been demonstrated in this country, a declining birth rate (which has fallen to 27.6) does not necessarily have an impact on the rate of growth. Improved health services must also bring down the death rate, which in Sri Lanka is now 6.1. It means that Sri Lanka's rate of natural increase at 2.15% is no different from that of its neighbours.

In countries which are predominantly rural the effects by way of pressure of population on the limited extents of arable land are felt immediately. In Bangladesh the average farm size declined from 3.5 acres to 2.8 acres, while rural landlessness increased from 17.2% to 37.6%, over a period of 15 years from 1960. The story is the same in the other countries. In Bombay the migration to towns with all its attendant miseries will continue. 300 families move in each day to swell that city's population. The pressures on the social and political fabric will also continue, whether from the landless rural population or the urban slum dwellers.

In Nepal the situation is further complicated by migration across the frontiers and into the Terai plains, over which there is little control. The overall rate of population increase in Nepal is estimated at 2.3%. In the Terai plains the rate is over 4%. In the hilly and arid regions, where infant mortality takes a heavy toll, it is 1.3% and 1.8% respectively.

Against this background it is no surprise that all governments are firmly committed to family planning. But given the complex problems governments face in the delivery of services and the many obstacles ranging from illiteracy to ethnic fears, religious beliefs, social pressures and

cultural norms, it is equally not a matter of surprise that their commitment has not been matched by the results. Targets in national plans are not being achieved, even to a modest extent. Successive plans have had to revise these targets, but judging from past experience, they may still seem too ambitious. In India the Sixth Five Year Plan aims at increasing the number of protected couples from the present 24.5 million to 43.5 million. In Nepal the Fifth Plan (1975–80) aimed at reducing the birth rate to 38 per thousand. The latest estimate is 43; this is hardly surprising since in 1976 only 22% of the World Fertility Survey sample had heard of any method of contraception and only 4% had ever practised any method. The Government of Bangladesh has set a target limit to its population of 121 million by the year 2000. This implies a net reproduction rate of 1 by 1985 against a current gross rate of 3.5. This will be difficult to attain. Pakistan has reached its moment of decision. After the failure of several plans, in which one strategy after another was tried and abandoned, and following nearly two years of inaction during which population policy options were examined within the framework of Islamic Law, the Family Welfare Plan has been formulated. It features many of the strategies tested and tried by the FPA, which has been made an active partner in both planning and implementation. Now the time for action has come. The government will need all the support that its own NGOs and the international community can give it.

All countries of the Region contain a multiplicity of religious ethnic and linguistic groups. Their fears and prejudices are easily exploited for political ends. The government of the day skates on thin ice when it advocates family planning. The growing Parliamentarians Movement is therefore of special significance for the region. It can help to raise the subject out of the cock-pit of party politics. The Indian Parliamentarians Group has given a splendid lead, which is not only helping to heal the old wounds of that nation, but can influence the rest of the Region. The FPA of India has been an important influence in this. Its president was official adviser to the Indian parliamentary delegation to the Beijing Conference in 1981 as well as being co-chairman of one of the Commissions set up at a conference of the Indian Association of Parliamentarians on Population and Development. Some of the far reaching recommendations made at this Conference are detailed in a section that follows. In Sri Lanka a Parliamentary Committee on Population with representation from all political parties in Parliament began its activities in March. It expects to have regular sittings, to which the public will be invited.

THE ROLE OF THE FPAS

All FPAS see one of their roles as demonstrating effective strategies to government. The most important facet of this role, given the characteristics of the Region, is the testing of strategies for mobilising the community to help itself in the provision of information, education and services. If the community is to be genuinely involved, its own perceptions of its priorities must be respected. And the effort must be directed to meeting its needs as a totality. The isolation of any one need such as family planning will not evoke an enthusiastic response. This immediately opens up the whole field of integrated community development – one that is too vast for any single NGO to tackle. The FPAs play an important role in bringing together various agencies concerned with separate facets of community development; in

stimulating and articulating the demands for services that government agencies are expected to provide; and in revitalising or creating village level institutions which can gradually take over these responsibilities from the FPA.

The FPA India has demonstrated a number of excellent community participation programmes with the community assuming an increasing degree of self-reliance. The Family Welfare Plan of the Government of Pakistan is firmly grounded on the experience of the FPA. The models it demonstrated have been incorporated into the national plan. The FPA of Sri Lanka is demonstrating how an infra-structure based on village volunteers can be used to cover the entire country, delivering education and services in family health with very little financial resources. In Bangladesh women's programmes have been organised; a community participation programme with a strong research element is in the planning stage. Males are being approached through occupation-based organisations. All these must have a demonstration effect. Another example, in a different field, comes from Nepal. The FPA Nepal has set up a repair and maintenance centre in collaboration with another donor for maintaining laparoscopes, other instruments used in endoscopic sterilisation, projectors, and generators. All such equipment received into the country as donations have been inventorised. Both a regular and emergency repair service is provided. This, as may be imagined, fills an acute need in a country like Nepal. Now that the service has been established it will be handed over to the government.

The FPAs have a long history of paving the way for the government into sensitive areas. One such area of current importance is youth. With the problem as it manifests itself in this region it is possible to conclude that the present is as good as lost. The only hope is to save the future – a future that will be determined by the 40% of population presently under the age of 15. In India the FPA pioneered population education until the government adopted such a programme. The government now relies on the experience and expertise of the FPA in the execution of the National Programme. But, in other countries, governments are reluctant to enter an area that is still sensitive. The FPAs will continue to take their own initiatives until the subject is sufficiently de-sensitised for governments to enter the field. In Sri Lanka the subject was taboo as far as the Ministry of Education was concerned until the FPA's efforts bore fruit this year when that Ministry agreed to the FPA conducting population education classes in schools throughout the country. The "study your village" projects which they have pioneered in schools will bring home to the younger generation the immediate realities of population and environmental problems. The FPA will now undoubtedly be able to demonstrate to government how it can undertake this responsibility itself without fear. In Pakistan youth programmes are dependent almost solely on the FPA who has to approach this activity with discretion. In Bangladesh and Nepal it will be up to the FPAs to show the way. A large proportion of the youth are out of school. They can be reached only through local community institutions. The experience and skills developed by the FPAs in working with local community groups clearly marks them out for such a role in relation to out of school youth.

Some of the FPAs of the region existed before the Federation was formed. Many of them were active before their governments adopted a family planning programme. The youngest of them

the FPA of Nepal, is 23 years old. They have a wealth of experience and expertise, which they are called upon to use in the training of family planning workers and decision makers at various levels. Planners and administrators, teachers, doctors, paramedics, field workers, traditional birth attendants, and indigenous medical practitioners are some of the groups that rely on the FPAs for orientation and training. The experience gathered by the FPAs has been of a highly experimental and innovative sort, and the contribution they can make to training within the national context is unique.

All FPAs began with providing clinical services. The expertise they have gained in this field is still used for the training of doctors and other medical personnel of government, although they continue to withdraw from clinical services as such, wherever possible. The FPA of India is giving up all Urban Family Welfare Centres except those funded by the government. It continues to run the Comprehensive Model Family Planning Centres where standards are set and training provided. The FPA of Pakistan has been asked to carry out the Reproductive Health Project of the government through 11 static units and an extension service, funded by government, as an important element of the national plan. The FPA of Sri Lanka, which once ran a network of clinics all over the island, withdrew from the last of these last year. It will continue to run the clinic at its headquarters as a model. Government and private doctors are trained here in techniques of sterilisation. It will also experiment with another clinic at which fees will be recovered in order to make the clinic self-sufficient.

The professional expertise of the FPAs also makes them an obvious choice for the role of co-ordinating the activities of the NGOs sector when governments reach the stage of recognising the need for this. Most of them attempt to do so on an ad-hoc and informal basis whenever they see the opportunity. In Pakistan this responsibility has been formally placed on the FPA, as part of the national plan. This is a key role. It entails selecting viable NGOs; drawing up programmes with them; recommending financial assistance; channelling funds; and monitoring and evaluating their programmes.

The role of the FPA Pakistan has developed into one of close partnership with the government so much so that it has had to turn down requests by government to act as its agent in setting up an organisation for the social marketing of contraceptives and for the production of copies of its family planning magazine for distribution under the national programme. The tasks it has already accepted in the national programme will stretch it to capacity.

Influencing special groups of professionals and other opinion leaders is another of the roles common to the FPAs of the Region. Some of them are "sensitive" groups that an NGO is in a better position to tackle than the government. In Pakistan, although the national plan is now a reality, there are still religious and community leaders whose support must be won over, particularly in the prevailing atmosphere of an Islamic revival. The FPA of Bangladesh has directed its efforts particularly to religious leaders. In Nepal the FPA has taken a number of initiatives with local village councils. Private medical practitioners, journalists and broadcasters and indigenous medical practitioners are some of the other groups that the FPAs concentrate on, in order to create a climate of opinion favourable to the national programme and to enlist support for it.

RELATIONSHIPS WITH GOVERNMENT

Having at various stages played the role of critic, advocate or watchdog of human rights in relation to government programmes, or the lack of them, all the FPAs and governments in the Region are now moving towards a more mature partnership with each other. In Pakistan, as noted earlier, this has extended from the level of policy and planning to programme implementation with the FPA being assigned specific responsibilities in the national programme. All FPAs are represented on various national population planning or co-ordinating bodies of the government. The partnership does not stop there. Other FPAs enjoy a similar close relationship with their government to that in India described already.

The Executive Vice-President of the FPA, Pakistan, is Adviser to the President on population. The FPA of Sri Lanka is a member of the steering committee set up by the government for the third Asian and Pacific Population Conference in Colombo. Its Executive Director will be a member of the official government delegation to that conference. It is likely that this will also be the case with delegations from some of the other countries as well.

Collaboration with governmental agencies at the field level is equally important but less predictable as much depends on personalities. But FPAs have had many successes, even if they have also encountered some disappointments.

PROGRAMME REVIEW

Given the characteristics of the population of the region as described earlier, voluntary community effort based on self-reliance is the key to success. Each FPA has adopted its own individual approaches dictated by local needs. The excellent community development projects in India and the rural volunteer structure spread across the country for the delivery of family health services in Sri Lanka are described in detail in the sections that follow. Their experience has been most rewarding. In Pakistan the Rural Family Welfare Centres have been the backbone of this strategy. Over the years the activities of these centres have been integrated with other community development activities. These are planned and managed by local management committees, and cover a wide range of activities from literacy classes, primary health and nutrition to the construction of small irrigation dams and channels. One important feature of the effort to involve the local community in Pakistan has been the evolution of the concept of the "Work Unit", which in many ways provides a more effective alternative to the conventional branch structure. It eliminates what can often turn out to be another hierarchical level in the organisational structure, with its own demands for administration and overheads, and goes direct to the people.

Perhaps the most striking feature of these programmes has been the growing degree of self-reliance and mutual self-help on the part of local communities. They live in poverty, yet they contribute not only their time and energy but their money as well. There are many examples: a road costing Rs. 150,000, and a muni-dam that will irrigate 16,000 acres in Pakistan; 52% of the costs of training programmes under one project in India and 91% of the costs of

educational activities in the same project; 53% of the costs of developmental activities last year in Sri Lanka with even more expected this year. If the cost of voluntary labour is added to these monetary contributions, the degree of self-reliance is truly significant. Trusts and societies are being formed in India, to enable the community to take on the full responsibility for these activities before long, so that the FPA can withdraw from them. In Sri Lanka the FPA has already withdrawn from a number of project areas while continuing to provide refresher courses for the core group of volunteers left behind. They are being institutionalised in the form of Family Planning Welfare Societies, which will be expected to function as viable units. The first two were established this year. A network of such village societies across the country, federated to form a national apex body and dependent on the FPA only for technical advice is a vision implicit in this approach and must be pursued.

In societies where ethnic and religious fears lie uneasily below the surface, compounded by suspicion of the "stranger's medicine", measures promoted by the community itself inspire greater confidence than anything advocated by an outside agency. There is therefore more than one reason why the testing of these strategies is the biggest single contribution the FPAs can make.

Population education is the next programme priority. The achievements of the FPA India are detailed in the report on that country. In Pakistan the FPA is advisedly cautious, but not inactive. Last year 5,000 male and female students, both in and out of school were instructed by FPA volunteers. Youth volunteers organised population cells to reach their out-of-school peers. They combine population education with development activities, and health care. Free medical services, a blood bank and "eye camps" are examples of services provided by students to neighbouring communities over the last year.

The gap in Sri Lanka seems as though it will be filled at last. Early this year a reluctant Ministry of Education finally allowed the FPA to conduct classes in schools. Five Administrative Districts will be covered in 1982. In the few months since this permission was received, programmes have been conducted in 15 schools. Nepal and Bangladesh needs to make more headway. The experience of their neighbour India can prove of immense benefit to them. The region has arranged for an exchange programme to enable the training during 1982 of staff and volunteers, who will be placed for short periods in projects of the FPA India.

In a society largely male dominated, male involvement is important. It is here that the programmes remain weak. Up to now the programmes have concentrated on industrial labour. The co-operation of management and trade unions has been forthcoming. But the results have not been too encouraging from the point of view of cost-effectiveness. The Evaluation Department of the International Office will undertake an evaluation of all industrial programmes in the region in 1983. The lessons that may be learnt will be shared throughout the region, and clearer decisions made for the future. A different approach has been to contact various organised occupational groupings. This seems to hold more promise, though it is too early to draw any conclusions. The FPA Pakistan has over the last year worked with such organisations as the Lahore Party Decorators Association, the Taxi Rickshaw Drivers Association, the Hair Dressers' Association and the All-Pakistan Cigarette

and Pan Farosh Union. The Bangladesh FPA also continued with a similar project over the last year. The objective of these programmes, as defined by the Regional Council, is not merely the motivation of males to accept or promote a male method, but where appropriate to accept their responsibility in sharing and supporting the decisions of their female partners. Both are important. In 1980 45% of all acceptors in "clinical programmes" sought sterilisation. Two thirds of them were women.

All FPAs carry out programmes for women's development in one form or another. Such activities as literacy classes and training in household skills have presented no problems. But the creation of income-generating activities for women carry the inevitable problem of marketing the products. Where these activities have been wisely chosen, they have been successful. But the problems are complex. A noteworthy trend over the last year has been the progressive integration of these activities into the general community development programmes.

All FPAs continue to promote family planning through the media. In societies which are largely illiterate, the ubiquitous transistor radio has proved very effective. So has the popular cinema. Television may make a bigger impact if its reach can be expanded through community viewing. But this has yet to prove itself. In the last year more than one FPA has made an effort to relate its audio-visual productions and media promotion more directly to specific project needs. But much more remains to be done along these lines.

INDICATIONS FOR THE FUTURE

The present trends indicate that increasingly governments will look at the FPAs as genuine partners in the National Programme. This process can be greatly hastened by the establishment of close working relationship in the field.

Community Development programmes truly managed and supported by the community itself are the key to the future. There is more than one approach and the FPAs will continue to test them. Self-reliance is increasing. If this trend continues, it may transform family planning into a genuine people's movement. It is unlikely that governments can emulate these examples in the immediate future. They start with the disadvantage of carrying less credibility than an NGO. The bureaucracy must find more flexibility if it is to work in partnership with the people. The danger of such movements and institutions being politicised is ever present. If that is allowed to happen, it will signal the end.

Population Education is gaining ground and must play an increasingly prominent part in FPA programmes, though this responsibility should be assumed by the government sooner rather than later. Out of school youth, however, must continue to be served by the FPAs, and will increasingly become an integral part of their general community development programmes.

The search for new ways of reaching people will go on. It requires imagination more than anything else. Next year the FPA Pakistan will initiate a project for using postal agency

personnel to motivate those with whom they come into contact – not only in the course of transacting normal business, but also those who come to them to have their letters read and explained or replies written. The hawkers and quacks who held their audience spellbound in the fairs and market-places of Bangladesh have suddenly found themselves out of business as a result of the tightening-up of government regulations. The FPA Bangladesh will make a start next year in using the persuasive skills of these hawkers to promote family planning and to distribute contraceptives. The continuing experiments in Sri Lanka will show over the next two years how far one can go towards making a contraceptive retail sales programme self-sufficient. The Depo-Provera Programme already generates its own funds.

The preference for Depo-Provera in many countries is a trend that will continue to grow. The FPAs, right down to the level of their village workers, must be fully armed with the facts, in order to meet the predictable controversies that will arise from time to time.

The use of commercial networks variously termed “Contraceptive Retail Sales” or “Social Marketing Projects” for distributing the pill and the condom will expand within the region, whether under aegis of governments or NGOs. It is important that the experience already available is widely disseminated. The FPA Sri Lanka has been requested to make a contribution to the discussions being organized in India on the same subject, and to provide an orientation for the new manager of the Contraceptive Retail Sales project in Nepal. Such a sharing of experience augurs well for the future.

EXPENDITURE SUMMARY - INDIAN OCEAN REGION

1981 ACTUAL

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Bangladesh	466.8	121.6	588.4	122.8	(5.5)	705.7
India	2555.9	49.5	2605.4	642.0	(586.5)	2660.9
Iran	-	-	-	-	-	-
Nepal	180.0	31.9	211.9	278.9	(2.3)	488.5
Pakistan	882.9	51.9	934.8	112.0	7.2	1054.0
Sri Lanka	240.7	455.9	696.6	198.0	(2.9)	891.7
TOTAL	4326.3	710.8	5037.1	1353.7	(590.0)	5800.8

EXPENDITURE SUMMARY - INDIAN OCEAN REGION

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Bangladesh	550.2	109.5	659.7	11.1	7.1	677.9
India	2563.2	219.4	2782.6	369.5	29.0	3151.1
Iran	-	-	-	-	-	-
Nepal	251.9	95.9	347.8	381.3	2.5	731.6
Pakistan	983.7	123.7	1107.4	330.0	11.4	1448.8
Sri Lanka	248.7	338.4	587.1	206.9	-	794.0
TOTAL	4597.7	886.9	5484.6	1298.8	50.0	6833.4

EXPENDITURE SUMMARY - INDIAN OCEAN REGION

1983 BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dcc. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Bangladesh	683.2	265.5	948.7	138.1	-	1086.8
India	2942.2	125.9	3068.1	549.0	-	3617.1
Iran	-	-	-	-	-	-
Nepal	402.7	158.0	560.7	369.8	-	930.5
Pakistan	1089.7	108.0	1197.7	572.5	0.1	1770.3
Sri Lanka	308.7	656.5	965.2	229.4	9.0	1203.6
New Requests	75.0	-	75.0	-	-	75.0
TOTAL	5501.5	1313.9	6815.4	1858.8	9.1	8683.3

ANNUAL PROGRAMME COMPONENT REPORTING
EXPENDITURE BY MAJOR COMMODITY COMPONENTS

(ALL COSTS SHOWN IN US \$'000)

IOR

SUPPLIES PURCHASED BY IPPF

	ACTUAL EXPENDITURE 1981	ESTIMATED EXPENDITURE 1982	PROJECTED EXPENDITURE 1983
Contraceptives	368.7	529.7	426.0
Medical & Surgical	11.1	2.7	33.0
Audio Visual Equipment	5.5	18.6	30.9
Office Equipment	3.4	21.3	14.4
Transport	37.4	83.3	98.1
Prior Year Adjustment	(20.8)	—	—
TOTAL	405.3	655.6	602.4

AID SUPPLIES DONATED TO IPPF

Contraceptives	305.5	231.3	711.5
FULL TOTAL	710.8	886.9	1,313.9

INDIA

THE FAMILY PLANNING ASSOCIATION OF INDIA (FPAI)

COUNTRY BACKGROUND

According to the Census conducted in February 1981, the population of India is 683.81 million. During the ten years 1971 to 1981 the population had increased by 24.75%. During the immediately preceding ten-years period 1961 to 1971 the increase was only marginally higher – 24.80%. The estimated crude birth rate for 1978 was 33.3 and the crude death rate 14.2, implying an annual rate of growth 2.09%. The compound rate of growth during the period 1971 to 1981 based on the Census determination of population was 2.23%. The marital fertility rate in 1978 was 5.6. in rural areas and 4.7 in urban areas.

The per capita income in 1979 – 80 was estimated at \$153. The World Bank estimated that in 1978 economic growth was ahead of population growth in the three preceding years. Progress has been made in the building up of grain stocks, in the development of irrigation, oil and natural gas, and in the iron and steel industries.

The 1981 Census however came as a shock, revealing as it did a higher population level than had earlier been estimated. This has resulted in efforts to revitalise the family planning programme. The Prime Minister has asked the Chief Ministers of all States to provide improved family planning services. She has stated that the task cannot be left to the Ministries of Health and Family Welfare; all sectors of society and all development departments of the Government should be involved. The Sixth Five-Year Plan calls for an increase from the present level of 24.5 million protected couples to 43.5 million. Monitoring and decisions on practical problems will be entrusted to a Cabinet Committee.

The Indian Parliamentary Group has formed itself into the Indian Association of Parliamentarians on Problems of Population and Development. Leading figures from Government and Opposition political parties have come together to make this a national issue rather than a political one, and to try to remove it from the battleground of party politics. The Delhi Declaration, made at the first National Conference of Parliamentarians, and the Reports and Recommendations of three Commissions set up by the Conference, are important landmarks in the Parliamentarians Movement. They included such far-reaching reforms as an amendment to the Election Law to make it an offence for any candidate to campaign for votes during elections by voicing opposition to family planning measures.

The President of the FPA India has played an important role in this, as an advisor to the Indian Parliamentary delegation to the Beijing Conference and Co-Chairman of one of the three Commissions of the National Conference of Parliamentarians.

Primary Health Care in the rural areas is provided by the Primary Health Centres each serving a population of about 100,000. A centre is staffed by 3 doctors, one of whom

is responsible for maternal and child health and family planning. Sub-centres, staffed by an Auxiliary Nurse-Midwife (ANM), serve a population of about 10,000. The number of ANMs will be increased so as to provide one for every population of 5,000. Their work is supervised by Lady Health Visitors. At the village level are the traditional birth attendants (Dais) who deliver 80% of births. Since 1977 village-level workers have also been introduced to provide primary health care services. Urban Family Welfare Planning Centres serve a population of about 50,000 in the urban areas. A Medical Officer assisted by Lady Health Visitors, Auxiliary Nurse-Midwives and Family Welfare Field Workers staff these centres. They are managed by urban corporations or through the agency of NGOs, including the FPA. These urban and rural organisations achieved a very high level of performance in the years immediately before the change of Government in 1978, when the programme received a severe set-back from which it is now slowly recovering.

The Government recognizes the importance of population education. In 1970 a Population Education Unit was established in the National Council of Education, Research and Training (NCERT) to promote population education in the States. Most State Governments were not enthusiastic. In 1980 a national project funded by UNFPA was launched by NCERT to ensure the implementation of population education in schools all over the country within a period of five years.

The Effective Protection Prevalence (the percentage of eligible couples protected taking into account the use-effectiveness of the method) increased from 4.2. in 1967 to 23.6 in March, 1982. Of these, 87.3 per cent had been sterilised.

THE ROLE OF THE ASSOCIATION

The FPAI's goals during the Plan period are briefly described as follows:

Promoting voluntary family planning as a way of life in the interests of the family, community and the nation.

Assisting in achieving the national goal of a birth rate of 30 per thousand by 1984.

Maintaining and developing the role of volunteer agencies.

The role of the FPAI has been defined as:

Promoting the National Population Policy by complementing and supplementing the national family welfare programme in its various aspects, with emphasis on rural areas, population education, training of extension (village-level) workers and the delivery of services in an integrated manner.

Developing new approaches and strategies and evolving models for integrating family planning with other developmental activities, which other agencies, including Government, might adopt.

Testing and developing new strategies for community participation in rural programmes.

Identifying and articulating the need for specific measures for family welfare.

With a population of over 680 million, 80% of whom live in rural areas not easily reached through existing institutions and infrastructures, community participation is the key to success. Genuine community participation implies a recognition of the totality of the needs of the community. Integrated programmes therefore must go hand in hand with community participation programmes.

The testing of strategies for true community participation in integrated programmes is of the utmost importance. At the same time disadvantaged groups in urban areas and special groups, such as women youth and tribal people, cannot be neglected. With over 40% of the population under the age of 15, population education is of crucial importance for the future. The size of the population also implies that strategies for service delivery have to be constantly improved. The magnitude of the problem demands a sense of urgency in the pursuit of demographic goals. At the same time family planning has to be maintained as a human right practised out of free choice.

The role of the FPAI and its main programme thrusts reflect these priorities. Particular mention must be made of the remarkable models of community participation, the involvement of village institutions, and collaboration with other local agencies in integrated projects which are being tried out in a number of areas. They should in the course of time illustrate to Government and other agencies the most effective strategies for reaching the rural population.

The OPE has confirmed the validity of the FPA's role and its main programme thrusts.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Past Performance:

The activities of the last few years have constituted a steady development and testing of strategies and approaches which have matured into the main programme thrusts as now reflected in the 1983 Programme. They are directed to well defined priorities. The early efforts with integrated community development through community participation were represented by the Karnataka Project through which the FPAI has learned many useful lessons. Covering a population of 300,000 it sought to achieve community participation by setting up or revitalising village institutions. In the year ending March 1981 over 128 institutions, including 44 youth clubs and 51 women's clubs, were established, bringing the number of community institutions through which the project operates to a total of 412. Some idea of the range and scope of its activities may be gathered from the fact that 2834 family planning and 7,134 population education events were arranged, involving 360,000 persons. Over 88,000 person-to-person contacts for family planning and counselling were made. 3,640 new acceptors resulted from these activities. The project surpassed its sterilisation targets in four of the six areas covered by it. These targets are set by the Government. It continued to maintain its high performance in respect of other methods.

The validity of this approach is demonstrated by the fact that not only have a large number of community institutions been set up or revitalised to carry out the project activities, but they are now becoming increasingly self-reliant. Not only do they now organise activities with a high degree of commitment, but despite the poverty of these rural populations they even make a financial contribution. Last year this amounted to 74% (91% for the year to December 1981) of the expenses incurred on educational activities. The community also contributed 52% of the expenditure for 67 training programmes for community leaders.

An important element of the project is the development of village leadership from implementing FP/MCH programmes. For the year to March 1981, orientation courses were held for 546 village leaders, both men and women, representing 247 local institutions in 213 villages. Short-term courses for medical, para-medical and field staff were also arranged. Trained doctors in local institutions run 72 depots for the distribution of condoms and 86 for the distribution of the Pill.

The Varanasi Project, though rooted in this experience, represents an interesting variation. Here the FPA works in collaboration with the Department of Preventive Health and Social Medicine of the Benares University. Covering a population of 400,000 it will be extended in a phased manner to cover the entire district of 2.8 million rural people. The Primary Health Centres of Government have cooperated effectively with the project.

Three categories of extension workers are used -- traditional healers (Samyojaks), community health workers and auxiliary nurses. Last year, 314 Samyojaks were trained in family planning work which included the screening of potential pill acceptors, distribution of condoms and referrals for IUD and sterilisation. This is combined with primary health care and the promotion of primary health concepts within the community. These workers distribute oral rehydration packets to combat diarrhoea, a major cause of infant mortality, chlorine tablets for the purification of water, and drugs for ring-worm infection. They are also provided with hygienic disposable delivery kits. Nutritional food supplements are provided for children. These items are sold at cost price to the Samyojak. Families are trained to prepare the oral rehydration packets themselves. 492 families were trained in this and 178 adopted them for regular use. These Samyojaks provided counselling to 40,000 persons, recruited 3,300 acceptors for the condom and 2,800 for the Pill. 44 persons were referred for sterilisation. The FPAI and national programmes are closely coordinated as is the reporting of achievements to the Government. The project exceeds all its targets for the reporting year and contributed to one of its three areas exceeding the State's family planning acceptance level.

The project has demonstrated that continuity rates can be well maintained as a result of using traditional healers; drop-out rates during the first year were 7% for the Pill and 2.3% for the condom. The reason for this is that Samyojaks maintain a door-to-door follow-up service. Another significant finding is that Samyojaks can be trained to efficiently screen potential pill users; only 1.7% of the women screened by them were rejected at the final screening at the clinics.

Social and developmental activities are another important component of this project. Women are trained in various skills which help to supplement the family income. Some of the villages run adult education classes and also provide primary education for children. Again, as in Karnataka, the community is increasingly taking on the responsibility, including financial responsibility, for these activities. Development activities are being increasingly funded by Trusts or Societies which have been set up by village leaders. The original investment in these activities is being steadily recovered. All this is a remarkable achievement for a project which is a little over one year old.

Just as the Varanasi Project represented a variation on the earlier experience of the Karnataka Project, other projects following the same lines whose validity had been amply demonstrated have been started in other areas but with variations to suit local conditions. In Allahabad, family planning and extension services are integrated, in collaboration with the Agricultural University. In Bhanaskantha, 16 youth and women's clubs had been established by March 1981, so that 28 villages, or 47% of the project area, were covered by women's clubs, and 49 villages, or 83% of the project area, had at least one youth club. The achievements in many of these project areas are monitored by comparison with control areas where the normal pattern of motivation and delivery of services are provided. The results have time and again demonstrated their validity. In the Malur Project local community leaders have, through their own efforts, constructed community halls in 5 villages and initiated development schemes in 12 villages as part of their contribution to the integrated approach to family planning. School attendance has been raised from 10% to 30% in almost all the schools in the area. Although only 255 educational, health and development activities were scheduled for the year, 689 activities were in fact organised, of which nearly 70% were at the initiative of the community and conducted by the community. The community itself met voluntarily 67% of the project expenditure. These activities are carried out with the assistance of a total of 417 youth clubs and 29 women's clubs located in 134 of 334 villages covered by the project. The FPA provides an important contribution by way of training programmes, which includes training of traditional birth attendants. These training activities which began five years ago have now resulted in raising the number of deliveries conducted by trained birth attendants, from 8% in the period 1966-67 to 27% in the last year. The training they receive includes family planning and family welfare. The coverage of eligible couples in the project area has increased from 10% in 1976, the year in which the project started, to 57% in 1981.

The Calcutta Project covers the urban areas as well as the adjoining rural areas. Information and services are provided. Special activities within the project area include industrial programmes and population education programmes. The project registered a 20% increase in acceptors last year, while sterilisation increased by 47%. The MCH components of the project provided medical, immunisation and prophylactic services to 20,000 women and children. Population education programmes for youth in-school and out-of-school continued. 15,000 school children and 1,200 college students were reached. The project also continued last year to train teachers in population and family life education. Other rural projects, such as the Wada Project, covered the very backward sections of the

population, namely tribal groups in the hilly areas of Maharashtra. This project which was started in 1980 had in 1981 established 27 new youth and women's clubs and activated 24 others to initiate and carry out educational, social and developmental activities. These organisations have been responsible for starting 6 child welfare centres, 5 of which are run by contributions from the community itself. Adult literacy classes are conducted and training provided in various development activities.

The population education programme is one of the keys to the future. The Association has developed a high degree of expertise in this field and the Government looks to it for technical support. The FPA sponsors population education cells in 6 Universities. The cells have set up population education clubs through which community programmes are conducted. Last year special attention was paid to family life and sex education. Some of the activities of the student cells include the organisation of a Seminar for the purpose of providing education in family planning to the University faculty staff, and to gain their support for the programme of the University cells. The population education programmes for teachers and teachers trainees has become particularly relevant since the inauguration of the national population education project in April 1980. Over 16,800 teachers and teacher-trainees attended sessions organised by the FPA throughout the country. In the schools population education programmes of the FPA covered 241,000 students in 796 primary, middle and high schools. At the college level, seminars, lectures and discussions have been organised for under-graduate, graduate and post-graduate students. A total of 40,472 students were covered in 143 institutions. Many of them have set up their own population education clubs. The programme for out-of-school youth last year covered nearly 98,000 between the ages of 16 and 25 in urban areas and 95,000 in rural areas. Population education modules have been developed for out-of-school groups and most of the programmes are run by the FPAI Branches through youth clubs. Recently, the 20 youth clubs in the Punjab Branch decided to form a Family Welfare Committee for motivating and educating eligible couples in their villages.

Planned Parenthood and Women's Development was promoted through 145 women's clubs which conducted short-term courses, provided leadership training and developed income-generating skills with a view to making these groups self-sufficient. Most of the members were family planning acceptors at FPAI clinics. They work as promoters of family planning and family welfare with their friends and neighbours. 1,447 new acceptors were recruited by them last year, which is a three-fold increase over the previous year's performance. 445 of these recruited by Mother Club members accepted sterilisation, 355 IUD and 650 accepted other spacing methods. Adult literacy classes are also conducted through these clubs.

The Association also runs a large clinical programme through its Comprehensive Model Family Planning Clinics, which serve as models for the safe delivery of services and as training centres. Many of the cost elements are reimbursed by the Government. The clinics also provide the necessary back-up for mobile units and for the urban clinics and other non-clinical programmes of the Association. Last year they registered a 37% increase

in acceptors. Male and female sterilisations rose by 50% and IUDs by 30% in the urban areas.

The FPAI operates 52 urban family welfare clinics which are run on Government grants. The FPA has made its own input by way of training doctors at these clinics so that now they can perform sterilisations promptly on request instead of referring clients elsewhere.

50 mobile education-cum-service units operated in Calcutta and other branch areas; they provided regular services to urban and peri-urban groups and referred others to the nearest clinic. The service delivery programme continues to be of great importance, particularly since the demand for sterilisation is high. Out of a total of 132,000 acceptors, 45,000 were for sterilisation, 23,000 for IUDs and the balance for other methods.

Management Capacity

The calibre of the professional staff of the Association has been steadily upgraded over the last few years and the Association is now fully capable of coping with further expansion. An elaborate reporting system has been instituted to receive and process the vast volume of information flowing from its projects and its 42 branches. However, this information has not been systematically evaluated and used as a guide to management in the development of new strategies. Following on the comments of the recent OPE this weakness has been rectified by the appointment of a fully qualified Director of Evaluation. The organisation structure is adequate to support the needs of the programme. Experienced and dedicated volunteers provide careful guidance and supervision and the Association has an excellent record of very careful and conscientious control over its funds.

PROPOSED 1983 WORK PROGRAMME/BUDGET

The total budget for 1983, as compared with 1982, is made up as follows:-

	1982	1983
	\$'000	\$'000
Total estimated expenditure	2,932.7	3,491.2
Income other than IPPF	369.5	549.0
IPPF Grant	2,563.2	2,942.0

The allocation of resources in the budget represents the right priorities in relation to the needs of the country and the FPAI's role. The significant increases over the last year are directed largely to the integrated community projects whose activities will be expanded, while new projects will be started in new areas. A new community-based distribution project is being planned which is a variation of the approach adopted in the earlier project at Varanasi; together they account for an increase of \$240,000 in the budget for 1983.

MCH activities will be started in 4 new branches and new activities initiated. In 1983 the urban family planning centres run by the FPA will be given up as this activity must increasingly become a responsibility of the Government. The FPA, however, will continue to run the centres funded by the Government. There are other important projects which represent a very small cost, but may demonstrate important strategies in the future, e.g. an orientation course for medical practitioners, an orientation course for para-medics, seminars for indigenous medical practitioners, a seminar for pharmacists, seminars for nurses; a seminar on the important subject of people's involvement in family planning will help to develop further the remarkable experience that the FPA has gained in this area in the last few years.

Competent professional staff have now been appointed to the Evaluation Department and two important surveys will be carried out in 1983.

The cultural and other obstacles to male involvement are great and this represents the weakest part of the FPAI's programme. The main strategy for male involvement has been through the Industrial projects which have male workers. They are run with the cooperation of the management and labour but have been beset by many difficulties caused by strikes and long periods of power failures which disrupted work in factories. The cost-effectiveness of these projects to which these factors have been a contributory cause, is now in question. The Evaluation Department will undertake a special evaluation of all Industrial Projects in the region.

ALTERNATIVE FUNDING

The income from other sources goes up from \$369.5 thousand in 1982 to an estimated \$549.0 thousand in 1983. This is 15.6% of the total estimated expenditure for 1983 of \$3, 491,200. Despite the poverty in which the vast mass of the population lives, there has been a remarkable increase in local contributions which are not reflected in these figures. The contributions, made both in money and in terms of voluntary effort, by local communities towards the integrated rural projects have been referred to earlier. They represent a commendable attempt at self-reliance by the local community, and as this trend progresses it should enable the FPA to reduce the volume of its financial support to the older projects and divert its resources elsewhere.

SRI LANKA

THE FAMILY PLANNING ASSOCIATION OF SRI LANKA (FPASL)

COUNTRY BACKGROUND

The population according to the Census of March 17, 1981 was 14.86 million. The data has not been fully processed, but the latest published figures show that the crude birth rate has declined from 30.4 in 1971 to 27.6 in 1980. At the same time, the death rate has declined from 7.7 in 1971 to 6.1 in 1980. The current rate of natural increase is 2.15%.

The rate of growth between 1971 and 1981 has been 1.7%. The difference is accounted for by migration. There is, however, no room for complacency. The massive emigration of skilled labour to the Middle East over the last four years is of a temporary nature for short-term employment. About 78% of the population is rural and nearly 40% below the age of 15.

The economy is agricultural and cultivable land area is limited. The pressure of population on the land has resulted in the fragmentation of agricultural holdings. 67% of these holdings are now less than 1 acre and 44% less than $\frac{1}{2}$ acre.

Whilst the peasant sector provides the bulk of the staple domestic food supply, the organised plantation sector produces export crops which account for 50% of the export earnings.

Per capita income in 1981 was \$265. Unemployment stands at 20% of the work force. With the work force increasing at 2.6%, a high rate of growth of the national product will have to be achieved if living standards are to be maintained. The overall literacy rate is 86.5%.

The Government is firmly committed to a population policy. The national programme is implemented by the Family Health Bureau through the medical and para-medical staff of the Ministry of Health. The field motivator is the Public Health Midwife (PHM). Each of the 2,178 PHMs cover a population ranging from 2000 to 8000. They are supervised by the Public Health Nurses and the Medical Officers. The latter provide contraceptive services (Pill, IUD) through 500 clinics, or refer clients to the provincial base of district hospitals for sterilisations. The health infrastructure is good. There are 285 hospital beds for every 100,000 persons and 75% of all deliveries take place in institutions. In addition to 2,800 allopathic doctors there are about 11,000 indigenous medical practitioners (ayurvedics). They are being trained in family planning methods.

According to the Sri Lanka Fertility Survey, 1975, the average completed family size for ever-married women was 5.94. Yet 50% of the women in the Survey with two children and 73% of those with three children did not want any more.

Among the women with 0, 1 or 2 children, the average desired family size was 2.5 children. 91% of the women were aware of modern contraceptive methods but only 43% of the women

had ever used any method. The Survey concluded that the prospects for a successful programme are high because the data indicated that the values and motivations of the women are consistent with family planning.

ROLE OF THE ASSOCIATION

The role of the Association as stated in its 3 Year Plan (1983 – 1985) is as follows:

Complementing the national programme;

Undertaking innovative activities consistent with its pioneering role;

Mobilising new and heretofore untapped human and financial resources;

Advocating change and improvement in the promotion and provision of family planning services;

Within this framework it will focus on the following priorities:—

Community-based rural programmes;

Youth and Population Education;

A medical and clinical service research programme;

Distribution of contraceptives through its Commercial Retail Sales programme and Community-Based Distribution programme.

The role of the FPA is well defined in relation to the needs of the country and the national programme. With the Government providing contraceptive services through a health infrastructure, the FPA has given up its clinics over the years. The remaining few were handed over last year, and only one remains at its Headquarters. This provides training services in addition to its standard-setting role.

With a rural population of 78%, among whom family planning awareness is high but practice relatively low, the real challenge is to take family planning services to the door-step of the rural peoples. The FPA can develop and demonstrate strategies for doing so to Government and other agencies.

Community participation in integrated community development programmes, based on self-reliance, is possibly the most effective way of achieving this.

Part of such a strategy includes making contraceptives easily accessible. The FPA does this through its commercial and its community based distribution programmes.

With the experience and expertise it has gained over the years, it has an important role to play in providing training, as a supplement to the national programme.

With nearly 40% of the population under the age of 15, population education is of vital importance for the future. This is the weakest area of the national programme. The Government

is hesitant to enter into what it sees as a sensitive and controversial area. The FPA must fill this gap.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Past Performance:

In the context described above, the most significant development in the last few years has been the evolution of the Rural Programme. District Committees composed of rural volunteers guide the activities of village volunteer committees. Government officials participate at both levels and the collaboration of local community institutions is obtained. Volunteers from the community promote family planning integrated with other community education and developmental activities. The project was extended to 11 more Districts during the year and now covers all of the 24 administrative districts into which the island is divided. A total of 115 new villages were covered through the district organisation.

A distinctive feature is FPASL's rural programme which is run by volunteers from the rural community itself. The Association estimates that it now has a force of 4,000 volunteers, over 3,000 of whom have been trained. The training of all volunteers includes improving their skills in carrying out simple base-line surveys and interpersonal communication, apart from family planning knowledge. Of the 83 development activities planned, 66 were completed during the year. 53% of their financial costs were contributed by the community itself, representing some progress towards the goal of self-reliance. The FPA estimates that volunteers contributed over 100,000 man-hours of voluntary effort. Volunteers from different areas were given a refresher training through four three-day programmes. The FPA hopes that in the course of time it will be able to withdraw on a larger scale, leaving behind a trained and motivated group within each community to continue the work. Statistics which are available only for 15 of the districts show that these rural volunteers motivated 4,700 couples out of 12,000 eligible couples identified in the villages to accept a modern method of contraception. Referrals were also made to nearby clinics for those desiring surgical contraception. This strategy has another significant aspect. The country is multi-racial, multi-lingual and multi-religious. Programmes run by the Government or through agencies often have their motives distrusted. Community-based efforts carry greater credibility and are therefore possibly the best approach in such a situation. As at the end of 1981 the total coverage of this programme was 170 villages with a population of 138,000, or 24,000 families.

Two special programmes are aimed at the industrial labour force and the plantation labour force in the rural areas. The latter form a distinct community separate from the community of the villages around it. These groups are exposed to a short motivation programme, after which contraceptive services, including sterilisation through mobile clinics, are provided. Motivational programmes in 20 plantations resulted in 134 male sterilisations performed through a mobile clinic. In the industrial sector only motivational programmes are conducted as the services are readily available nearby through Government clinics. In addition, special vasectomy programmes conducted in different areas resulted in 885 sterilisations during the year. When the Government introduced an incentive scheme, there was a ready response and

therefore activities in the industrial sector were suspended in the first half of 1981. However, when the incentive was reduced the response diminished and the motivation programme was resumed in the industrial sector in the second half of the year. 4 Seminars were conducted for opinion leaders on the plantations and 74 of them were given information on family planning and motivated to promote these activities among their work force.

The 1981 Census revealed that acceptance of family planning in certain areas was particularly low. The FPA responded with 27 adult education and community leaders programmes in those areas. 900 community leaders were for the first time exposed to family planning.

Given that nearly 40% of the population is below the age of 15 and population education a neglected area of the national programme, this activity is of the utmost importance in the FPA programme. The FPA has been successful in gaining the cooperation of the National Youth Service Council (which in the past has been hesitant) in order to carry out a youth and population education programme. Leadership training programmes with a strong population education element were conducted for the District Committees of the National Youth Council. They covered 13 districts and involved 1,500 youth leaders from the NYC. An environmental education programme for teachers was carried out by the youth themselves. These were run in 5 teacher training colleges and covered 600 teacher trainees who are now carrying out special activities with students in their respective areas. 35 youth were selected from different parts of the country for a three-day programme for the purpose of enabling the FPA to set up a resource panel of young people who could support the rural education programme in their respective areas.

One noteworthy activity was a special workshop conducted by youth in 10 administrative districts for 40 newly appointed Grama Sevakas (multi-purpose Government officials, each of whom cover a group of villages and are the chief representative of the Government in that area). The workshop was chaired by the Deputy Minister of Local Government. Vocational training was provided by youth groups for their peers who were taught income-generating skills. The funds for this activity were found by the youth themselves. 122 young people underwent such training.

The Headquarters clinic, which is the only clinic run by the FPA, helps to set standards for the safe and effective delivery of contraceptive services and provides valuable training both to Government and private doctors. The Government has made a request to the FPA to provide training particularly in minisporotomy under local anaesthesia; this will greatly help the national programme by easing the pressure on facilities for female sterilisation. Government doctors and others are also trained in performing vasectomy. The clinic also provides a centre for research. Studies involving Depo-Provera and IUD users have been carried out and the reports completed in the course of last year. Though it is not therefore the primary aim of the FPA to provide clinical services, the clinic served 36,600 new acceptors during the year, which was 47% above the target. 6,600 of them were for sterilisations.

73% of new acceptors of temporary methods chose the injectables and, in spite of the recent substantial price increase, there was only a very slight drop in demand. This service is operated

through over 100 private medical practitioners and the full cost of the programme is recovered. In all, the FPA performed 5,500 vasectomies and 1,100 tubectomies. The vasectomies accounted for 19.8% of the total number of 27,800 performed under the national programme during the year. These figures do not include the services provided under the Contraceptive Retail Sales programme where acceptors cannot be identified.

The Contraceptive Retail Sales programme, which forms a substantial part of the FPA's activities, has continued successfully through 1981. But the time has come to reorientate it. The FPA has experimented with a variation to the programme with financial support from the Columbia University. The operations of the commercial agent were restricted to one half of the island while the FPA operated through local agents who serve a retail network in the other half of the island. The objective was to make a deeper penetration into the rural areas. During the year the total number of outlets increased from 1,000 to 2,350. The sales through agents managed directly by the FPA increased to 2.9 million condoms as against 3.9 million achieved by the commercial agent. These figures do not lend themselves to an acceptor count, but the FPA estimates that the project afforded 115,000 couple years of protection during 1980. It is essential that this project becomes increasingly self-sufficient. Last year the FPA increased the price of the brand of condoms sold under the project (Preethi) by 100%. The price of the orals (Mithuri), which are also distributed through this network though only available on a doctor's prescription, was increased by more than double. At the same time the FPA is experimenting with other products which can be sold under the brand names "Preethi" and "Mithuri" since a large investment has been made in promoting their brand image. These efforts should reduce the amount by which the cost of products currently used are now subsidised by IPPF. New brands have also been introduced into the market last year through this programme and on some of them the FPA recovers its full cost plus a small profit. A start was also made towards integrating the community-based distribution programme as a component of the Rural programme.

The oral contraceptive recorded high sales during the year. "Mithuri" recorded an increase of 7,000 cycles per month on average while a different product introduced under the same brand name but in a different package recorded an increase of 2,000 cycles per month of the average. The major problem encountered by this project last year was the paucity of staff. The FPA lost some of its best marketing staff who found more lucrative employment elsewhere as a result of the recent surge of economic activity in the country.

A new marital counselling service was started in the middle of last year under the guidance of the Professor of Psychiatry from the Faculty in the University of Colombo.

Management Capacity

Perhaps the most important development in the last few years has been the change in the character of the policy-making bodies of the FPA. There is now direct representation from the grass roots through the volunteer level Action Committees and the District Action Committees in the National Council. The development of programmes also now starts at the district

level. The Constitution of the FPA was amended last year to give greater effect to these welcome developments. The FPA is also assisted by volunteers who have high degrees of professional expertise in various fields and a highly competent staff. The OPE conducted last year noted that administrative procedures were well implemented but insufficiently co-ordinated. Financial matters are especially well handled and there is a sophisticated awareness of the benefits of cost-accounting. The OPE team recommended certain improvements to strengthen co-ordination and to reduce the span of control of the Executive Director. Most of these recommendations have been accepted and are being implemented. Overall performance in planning, programming and implementation has been good.

In 1980 expenditure exceeded the budget by 17.6%, the additional funds being obtained from sources other than IPPF. Although it has the capacity to expand its activities and absorb more funds, such additional funds will have to be sought from other sources.

PROPOSED 1983 WORK PROGRAMME/BUDGET

The main thrust of the programme is substantially the same as in 1982. The increase in expenditure represents the right priorities, having regard to the FPA's role in the context of the national programme. The Rural Programme will be extended to cover a further 145 villages in 1983, bringing the total to 200. In accordance with the recommendations of the OPE the PPWD Programme will be integrated into the other activities of the Rural Programme in 1983. The rural volunteer involvement is an important supplement to this programme. It is expected that this project will cover 5,000 volunteers distributed throughout 24 districts. The bulk of the expenditure under this project will go towards meeting the travelling expenses of village-level volunteers who will act as distributors of contraceptives. This is in keeping with the OPE recommendation that the commercial retail sales project should be complemented by an increasingly strong CBD component. The other main item of expenditure on this project will be the training of volunteer leaders. In 1981, 305 volunteers were exposed to refresher courses in areas from where the FPA had withdrawn in accordance with the policy of moving into new areas leaving behind local groups to continue on their own. In 1983 it is planned to provide refresher courses and motivational reinforcement to a further 5,000 such volunteers. These activities represent the most significant programme thrust of the FPA. It is a comparatively recent development. While enlisting community support and increasing self-reliance for integrated rural projects with a strong family planning component, they will, if successful, in the long term change the character of the FPA into a People's Movement.

The other bit increase in expenditure goes to providing motivational activities and organising outlets for the sale of contraceptives in the planning and industrial sectors. The project will be carried out in co-operation with the Government District Development Councils and the support of local community institutions. The plantation work force in particular is a highly disadvantaged group, both socially and economically. In both the plantation and industrial sectors the active participation of management is essential and has been obtained in the past. The project includes workshops for management in both sectors and for field officers and

supervisors of labour gangs, as well as motivational programmes for the workers themselves. The project plans to cover 20,000 plantation workers, 15,000 industrial workers, 20,000 of the population in village areas adjacent to the plantations, and 1,000 community leaders. There will also be more intensive activity in the Youth projects. As against 520 youth who participated in the 1981 programme, in 1983 it is expected to involve 100 youth members of the FPA and 2,000 rural youth. In view of the weakness of the Government programme in relation to youth, this project is an important supplement to the national programme. Two new projects are a clinic in a provincial capital, and community-based rural contraceptive distribution, which has been referred to earlier. The new clinic will provide all contraceptive services other than sterilisation. This is an interesting experiment because clients will be required to pay for these services. It will show from how far down the socio-economic scale will come the clients who are prepared to pay for quality services. If the experiment proves a success it will open the way to self-sufficient clinical activities.

The community-based distribution project is in line with the OPE recommendation and will be tried out in areas where the rural volunteers have already been motivated. The distributors will receive a small commission on their sales as an incentive. They will be supplied from central distribution units which will also directly serve the population in the immediate vicinity. The community agents will carry basic first-aid boxes and will make house-to-house visits. They will provide basic advice on MCH.

Together, these projects are a significant effort to meet the needs highlighted by the Sri Lanka Fertility Survey which showed an awareness of 91% as against an effective protection prevalence rate of 43%. Male involvement is relatively satisfactory. Service statistics show 5,500 acceptors for male sterilisation and 1,092 acceptors for female sterilisation in 1981.

ALTERNATIVE FUNDING

The Association will generate an estimated income of \$ 182,360 from the sales of contraceptives under its CRS and CBD programmes. Columbia University will make a grant of \$ 23,600 towards the costs of this project. It is difficult to raise local funds direct, but the contribution of the rural volunteers mobilised under the Rural Programmes in terms of free services and, to a smaller extent, in cash, is not insignificant.

The total estimated expenditure for 1983 is \$ 764,100, of which income from local sources is \$ 205,857 (26.9%).

MIDDLE EAST AND NORTH AFRICA REGION

REGIONAL OVERVIEW

THE RECENT DEVELOPMENT OF MENA FPAs

Throughout 1982, there has been an effort among many FPAs in the Region to improve their management capacity, and achieve their programme. During the last two years, the FPAs of Bahrain, Morocco, Sudan, Syria and Yemen have recruited qualified executive officers to improve implementation of the programme and decisions taken by the FPAs' Boards. As a result, the reporting capability of these FPAs has tremendously increased, contributing to improvement in attracting funds from IPPF and outside donors.

Some FPAs have begun a process of decentralizing programme implementation to their branches, thus increasing grass-roots involvement. This development is particularly evident in the FPAs of Sudan, Morocco, Egypt and Jordan, who are establishing and strengthening their volunteer structure at the branch level and recruiting Programme Officers at the provincial level.

Despite the difficult situations faced by FPAs in Jordan West, Lebanon and Afghanistan, the FPAs of these countries are achieving excellent results. The Government of Afghanistan is fully cooperative with the Afghanistan FPA; the Lebanon FPA enjoys the respect of the Lebanese people, press and Government for its dynamic and pioneer work in Lebanon.

Operating in an environment of Muslim and Arab societies, the FPAs of the Region are fully aware of the constraints and opposition they encounter in their endeavour to promote family planning. Emphasis has been placed on overcoming these obstacles. The environmental situation in these societies may be considered as threefold:

- a. The threats, as they are seen in the Region, of atheist socialism, "satanic" capitalism and Israel are already leading to calls to increase the number of members of the Umma (community).
- b. The rapid social changes evidenced by growing education of women, co-education, postponement of the previously early age of marriage, teenage pregnancy (especially in North Africa), liberation of women from the fear of pregnancy, all may lead, and are already leading in some areas, to people associating Family Planning Associations with the "decadent" and "imported" values of the "North".
- c. Some of the elements mentioned above, which have resulted in a greater freedom for women, are leading several conservative forces to oppose FPA involvement in women's development programmes, especially when these programmes include requests for revising some legal provisions which are obstacles to women's development and improvement of their status.

Nevertheless family planning is becoming more and more accepted by the population in the Middle East and North African countries, illustrated especially by the growing number of

satisfied acceptors. As family planning is considered as an integral part of community development, the openness of Arab communities vis-a-vis the acceptance of the philosophy of family planning becomes more apparent. The FPAs in countries such as Afghanistan, Egypt, Lebanon, Morocco, Sudan and Tunisia undertook a few projects which allowed family planning to be considered in the context of community development, and therefore gain more acceptability by the population.

THE SECRETARIAT REORGANIZATION IN MENA

In addition to the cost savings, the MENA Region has seen two additional advantages in the Secretariat reorganization.

- a. The Region has been able to attract and recruit good staff for the Regional Bureau.
- b. The transfer to the International Office has meant that there is a greater attention paid to the FPA perspective at the international volunteer and executive level.

THE MENA SECRETARIAT ACTIVITIES DURING THE LAST TWELVE MONTHS

The MENA Bureau was established during the latter part of 1981, and three new staff took up their London posts in the spring of 1982, while the Programme Officer opened the Amman Office in July 1982.

As a result, it was not possible to provide all the assistance requested by FPAs during the last part of 1981 and the first part of 1982 beyond the usual financial and administrative assistance.

Key activities were carried out by the MENA Secretariat. Amongst them were the participation in the preparatory phase of the Muslim Scholars Conference on Population and Development, which is scheduled to take place in Indonesia in 1983, several work sessions with a number of FPAs pertaining to the implementation of OPE/MA recommendations and the upgrading of the management capacity, the organization of the First Arab Symposium on Responsible Parenthood and, most importantly, the organizing and the establishment of a Family Planning Association in the People's Republic of Yemen.

THE REGION'S PERSPECTIVE FOR THE FUTURE

During the next eighteen months, the FPAs of the MENA Region will concentrate on the following tasks:

1. Continue efforts to upgrade FPA efficiency and effectiveness
2. Re-assess constantly their roles in accordance with the changing situation of their countries
3. Launch innovative programmes in family planning
4. Adjust FPA activities to emphasize the importance of public and leadership education of their societies, by using more appropriate audio-visual materials, printed and other media.

Upgrading FPAs' Effectiveness

MENA for a long time found it difficult to find the funds to hire the right type of staff. The situation is changing and a number of FPAs have been provided with adequate funds over the past two years to attract good Executive Directors. Furthermore, some FPAs were encouraged to recruit Programme Officers at the provincial level. The other FPAs which have not yet followed this trend will be urged to do so in the near future.

In order to give these new recruits adequate training so that they can fulfil their tasks, the Regional Bureau will organize two workshops during the last quarter of this year. The first workshop is intended for the new Executive Directors, while the second will be devoted to the Communication Officers.

In addition, in order to introduce the new system of planning, programming, budgeting and reporting (PPBR), several training sessions will be organized from September to December, either at the Association level, or at the level of a small group of Associations. These training sessions will regroup both the volunteers and the senior staff.

FPAs' Re-assessment of their Role

As a result of the OPE/MA recommendations and in light of their own re-assessment of the situation, a large number of MENA FPAs will in 1983 introduce a shift of emphasis in their role and activities in order to make their programme more pertinent to the developing situations in their respective countries. For instance, new developments are taking place in Tunisia leading to a review of its role and strategies along the lines proposed by the Evaluation Mission. The discussions which took place between MENA Bureau and the FPA in January and in March 1982 on this subject are to be continued. Egypt is another example where a new approach is being followed to allot all IPPF funding for the FPA to its branches. This has been done in the context of the decision by the Egyptian FPA, following a self-assessment, to decentralize and give more responsibility to its branches, with the aim of becoming more efficient in the area of service delivery. Other examples include Sudan, which has embarked upon a more active programme in the provinces, and Syria which has undertaken an in-depth analysis of its educational activities.

Launching Innovative Programmes in Family Planning

Community development projects first adopted by a small number of FPAs in the Region are now being undertaken by other FPAs; the future trend will be for almost all the FPAs to focus on providing family planning services within a community development framework. Operating outside the classic FPA framework constitutes a new avenue for family planning; this new approach, established by the FPAs, can therefore be considered as an example to be followed in the future by national governmental programmes. Amongst the programmes which have to be spread throughout all FPAs in the future are: Planned Parenthood and Women's Development (PPWD) programmes, Youth programmes and Parasite Control and Family Planning programmes.

Audio-Visual Material in Arabic for I.E.C. Activities

The effort in this area will be threefold. Initially, the FPAs will undertake an analysis of the material they have been using, select what is relevant and appropriate and make suggestions to the Regional Bureau on the materials for which they would like to have assistance.

Secondly, at the Regional Council level, a task force composed of two volunteers and some professionals will analyse the situation, and propose a sound strategy for Arabic production.

Finally, the Bureau will determine the priorities on the basis of this information and produce and distribute the materials for the FPAs.

The lack of audio-visual materials in Arabic inhibits and stultifies the FPAs in their educational activities. Until now they have had to work with material produced for Western countries which has been adapted, not always successfully, to Arab societies.

THE REGION IN TRANSITION

There are presently thirteen FPAs in the MENA Region and the fourteenth is in the process of being established. When a number of these Associations started in the early 1960s, Family Planning was completely unknown in these countries. There were practically no government family planning programmes even though the first signs of demographic growth were taking place. The governments were, at that time, unaware of problems which result from population growth and did not have a clear view of the long term benefits of family planning programmes. In that context, FPAs have played a very strong, vanguard role which has subsequently enabled governments to adopt the idea of family planning and to make use of the FPAs' initiative and experience. During the period prior to the governments' adoption of family planning, the Associations had to face from the very first controversial reactions generated by the new topic called "family planning".

Now that most of the governments in those countries have been sensitized to the importance of family planning and its eventual impact on the socio-economic development of the society, a majority of them have integrated family planning as a component of their developmental effort. The FPAs, in consonance with their role, are launching new projects to try to make family planning programmes more effective. New approaches in the implementation of family planning within an integrated socio-economic and health framework are being tested by FPAs. Most of these have already shown first signs of success, and have stimulated some governments to contemplate adopting these approaches in their official programmes, while leading others, not yet convinced enough to start an official policy on family planning, to re-assess their official positions vis-a-vis family planning.

The family planning situation with the countries of the MENA Region is fully described below:

Afghanistan

There will be an attempt to evaluate all family planning activities as they are implemented in Information and Education as well as in the delivery of medical services. The main

objective of this evaluation is to assess whether these activities correspond to the family planning needs of the population. It has been brought to the Association's attention that an effort should be made to move away from medical/clinical activities as a consequence of the government's greater commitment in this area, and to focus on Information and Education, Evaluation and Training. The government's decision to provide family planning services stems from its concern over health problems and the continuing rise in the level of morbidity and mortality, especially infant and maternal mortality. However, the government of Afghanistan has not yet formulated a comprehensive population policy and therefore has not incorporated in its development plans objectives and measures to act directly upon demographic behaviour.

The Family Guides (community education & field workers) continue to play a vital role in the family planning activities of the Association.

Bahrain

As a member of the Advisory Committee of Social Affairs (Ministry of Labour and Social Affairs) which groups together all welfare non-governmental organizations, i.e. The Red Crescent, the Women's Union and the Child Care Society, the Association will continue to participate actively in promoting comprehensive Maternal and Child Health programmes and providing family planning information and facilities to all who are interested. In this context, the Association has been using the local press as the main means to channel family planning information, and to facilitate its acceptance by the public at large. An attempt will be made to capture and enlist the commitment and support of Community Leaders to become family planning advocates. This is important for the environment in which family planning operates, especially given the hesitant stance taken by the government in this respect.

Cyprus

In accordance with the specific needs of the country, and in response to an emerging problem of teenage pregnancies, the Cyprus FPA has been conducting seminars and youth meetings to discuss and debate issues dealing with Family Life and Sex Education. The Association will make a special effort in the near future to involve the Ministry of Education in this matter with a view to eventually integrating Family Life Education into the high schools' curricula. Previous contacts with the schools' headmasters and a number of seminars held at the elementary school level have had successful results and as a consequence, these headmasters have reacted with enthusiasm towards the FPA's family life curriculum for parents and pupils.

At the medical/clinical service delivery level, the Nicosia and Limassol clinics, two of the only three centres of the Cyprus FPA, will be further equipped to meet the increasing demand for IUDs. The Larnaca Centre will also be upgraded and equipped with the aim of providing clinical services in the future.

Egypt

The recruitment of Cluster Co-ordinators for the Association's 22 branches, undertaken to improve coordination between the branch associations and the central office for these branches, will be the highlight of EFPA's future activities.

In terms of programme activities, Family Planning projects, integrated with major elements of women's skill development, income generation and day-care services, will be carried out in 1983. However, given the modest financial and human resources available at branch level, it may not be possible to achieve total implementation of these projects. The branches' main objective will be to promote family planning in their society. In May 1982, the EFPA submitted a project proposal to USAID/Egypt. The project envisaged will involve setting up five model centres and upgrading FP clinics in the vicinity of their locations. The centres, located in five governorates in Upper Egypt and the Delta Area, will provide family planning and primary health care services with an emphasis on preventative medicine and health and nutrition education.

Iraq

Contributing to the good health of the mother and child continues to be the FPA's main objective. In this respect, the Association considers it important to obtain the support of both the influential and politically powerful Women's Federation, and the Medical Profession. To maintain and improve good relations and to increase co-operation with the Iraqi Women's Federation (GIWF), the Iraq FPA will incorporate in 1983 family planning services in any new medical centres run by GIWF which will be opened in other governorates. This effort to step up the support to the General Federation of Iraqi Women in FP service delivery is considered within the framework of the attempt of the IFPA to reach the objective of a figure of 30% of women attending the GIWF centres using FP services. The Iraq FPA emphasises the need to continue this project until 1984 in case the GIWF decides to expand its activities. Contraceptive delivery and the organisation of training seminars constitute the major part of the FPA support to the GIWF health centres.

Cooperation with the Anti-TE Society will be carried on during 1982-84, as it is a clear demonstration of integrating medical and social services with FP services in a social centre, run by the Society located in a heavily populated area of Baghdad and inhabited by low-income groups.

Jordan East

Over the next two years, Jordan (East) FPA plans to establish a "programmatic capability" by recruiting three regional programme officers at the branch level and a central programme coordinator responsible for training, information and general programme development. The continuous assistance of this professionally qualified staff will reinforce the already existing dedication of the Association's volunteers and will contribute to achieving better results.

In addition, the Association will endeavour to strengthen its current on-going projects rather than seek a horizontal expansion of its activities.

Jordan West

Greater male participation will be a predominant element in the future activities of Jordan (West) FPA in an effort to increase understanding amongst men on the value of family planning as a contribution to personal, family and community well-being, and to promote husband-wife communication and shared responsibility for family planning. The primary targets will be male opinion leaders, decision makers and health educators, the latter providing the link with villages in remote areas.

In addition, the Association plans to contribute to the launching of a Rural Development Project in collaboration with the Bir Zeit Women's Society, OXFAM, and Bir Zeit University. This University has already opened clinics in surrounding villages with the help of the residents, in which mother and child care is being provided by health educators trained at the Bir Zeit Women Society Centres.

Lebanon

The Lebanese Family Planning Association still maintains a pioneering role amongst the NGOs in Lebanon, and it was at the instigation of the LFPA that the NGOs Board for the purpose of coordinating all community development and social agencies came into being. In Tripoli, an active number of NGOs ensures a wide accessibility of social services to the northern part of Lebanon, while the activities of the NGOs in the Bikaa have been very limited. As a result of this imbalance existing between the two regions, LFPA will focus more attention, in the future, on the Bikaa region.

In its efforts to put pressure on the government to introduce a policy favourable to family planning, the LFPA intends to implement an official Declaration of the National Population Council through contacts with key people and officials at the university as well as the government level. However, the civil strife taking place in Lebanon means that it is impossible to predict to what extent the Association will be able to implement its activities in the future.

Morocco

One of the MFPA's objectives for 1983 is to increase the volunteer commitment. It intends to do this by bridging the gap between the Association's executive members at the Central level and the volunteer body.

Following the remarkable expansion of the Community-Based Distribution programme, the MFPA is considering an evaluation of the programme to ensure that its impact remains within the perspectives of the original objectives.

The USAID funded Audio-Visual studio is scheduled to become operational by 1983. This could well mean that the Moroccan Family Planning Association will be the only FPA in the region capable of producing its own audio-visual material.

Sudan

The decentralisation process has been set in motion in 1982 and the branches are being reinforced by the appointment of a coordinator for each branch. As the government has been assuming more and more responsibility for the provision of medical services, some of the Association's clinics have been handed over to the government. Emphasis will, in the future, be placed on I.E.C. and training. The introduction of Family Life Education into the school curricula will be the topic of a seminar planned for 1983.

With regard to the overall activities, particular attention will be focused on the northern part of the country since this region does not have a family planning branch.

Syria

Since 1981 the number of contraceptive users attending the Association's ten clinics has steadily increased and this has resulted in a need for further medical and paramedical training. These programmes aim at improving the skills of those who provide services in the clinics so that family planning services are upgraded and at the same time more health personnel, such as resident doctors and midwives, are trained so that future needs can be met.

Over the past two years, the Syrian FPA has witnessed a very high drop-out in the number of pill users and therefore intends to deal with this problem commencing in 1983. In this respect, it will first review its approach vis-a-vis the implementation of IEC activities, concerning itself chiefly with problems pertaining to misinformation about family planning in general, and contraceptive use in particular.

Tunisia

The National Office for Family Planning and Population, the governmental body officially in charge of the family planning programme in the country, has been experiencing some difficulty in re-generating the family planning programme. This has, of course, offset the benefits of the socio-economic plan put forward by the government in which the demographic component plays an important role.

In line with its role as a supporting agency to the official programme, the Association has established a study committee whose task will be to review the present situation and make recommendations on the appropriate contribution of the Association in order to revive the family planning programme.

During 1983, the Association will strive to integrate family planning activities with the community development programmes.

Yemen Arab Republic

The family planning services will continue to be provided within the Ministry of Health's major hospitals as well as the basic health/primary health centres. However, because of a need to undertake information and counselling activities in an environment removed from the

overcrowded hospitals and health centres, the Association intends to open a comprehensive clinic to be a model centre for the provision of family planning services. The implementation of this clinic and its development into a comprehensive clinic is envisaged over a three-year period. It may start as an out-patient clinic for the first two years and extended thereafter to an in-patient clinic and, eventually, a training centre for medical and paramedical personnel.

In the area of inter-assistance amongst the FPAs of the Region, the Moroccan FPA sent a member of its staff to help the Yemen FPA carry out an assessment of the present situation and outline its programme activities for the future.

People's Democratic Republic of Yemen

On becoming a new member of the Region in 1983, the PDRY Family Planning Association will consider its first year's activities as experimental and prospective. At the outset of family planning activities, the Yemen PDR FPA will establish close cooperation with the Voluntary Social Defence Committees since they represent the body in charge of all socio-economic development at the local level. Furthermore, the Social Defence Committee Department, which, at a higher level, will be the link between the FPA and the State, operates with the same voluntary nature as the FPA.

The representative of the future PDRY FPA, who attended the 1982 Regional Council meeting and who had a number of informal working sessions with the MENA staff, is a member of the Women's Union in her country and is expected to play an important role in the future as a member of the FPA.

EXPENDITURE SUMMARY - MIDDLE EAST & NORTH AFRICA REGION

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (Inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Afghanistan	190.8	119.2	310.0	0.9	10.2	321.1
Bahrain	24.0	5.6	29.6	3.9	-	33.5
Cyprus	40.0	2.0	42.0	13.4	-	55.4
Egypt	185.1	53.9	239.0	279.7	(0.1)	518.6
Egypt - CBD	-	-	-	-	-	-
Iraq	47.0	61.9	108.9	7.1	-	116.0
Jordan - East	97.7	9.8	107.5	28.7	1.3	137.5
Jordan - West	116.0	2.7	118.7	15.2	-	133.9
Lebanon	261.5	30.6	292.4	28.6	(1.8)	319.2
Morocco	283.6	82.0	365.6	39.9	9.4	414.9
Sudan	156.1	-	158.1	8.0	1.9	168.0
Syria	104.0	10.9	114.9	2.3	-	117.2
Tunisia	172.0	8.0	180.0	21.1	8.0	209.1
Yemen A.S.	133.0	24.1	157.1	0.7	(35.0)	122.8
Yemen P.D.R.	-	-	-	-	-	-
New Requests	150.0	-	150.0	-	-	150.0
TOTAL	1963.1	410.7	2373.8	449.5	(6.1)	2817.2

EXPENDITURE SUMMARY -MIDDLE EAST & NORTH AFRICA REGION

1983 BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Afghanistan	215.5	141.4	356.9	1.2	-	358.1
Bahrain	30.0	8.3	38.3	15.0	-	53.3
Cyprus	30.0	2.6	32.6	19.7	-	52.3
Egypt	210.0	53.9	263.9	279.7	-	543.6
Egypt - CBD	-	-	-	-	-	-
Iraq	63.0	36.4	99.4	8.6	-	108.0
Jordan - East	97.0	4.7	101.7	29.0	-	130.7
Jordan - West	120.0	0.9	120.9	16.1	-	137.0
Lebanon	300.0	37.1	337.1	41.8	-	378.9
Morocco	306.0	101.4	407.4	61.1	-	468.5
Sudan	185.0	21.4	206.4	17.1	-	223.5
Syria	135.0	37.4	172.4	22.1	(17.9)	176.6
Tunisia	172.0	8.0	180.0	20.0	-	200.0
Yemen P.R.	180.0	22.2	202.2	1.6	-	203.8
Yemen P.D.R.	56.0	56.8	112.8	-	-	112.8
New Requests	100.0	-	100.0	-	-	100.0
TOTAL	2199.5	532.5	2732.0	533.0	(17.9)	3247.1

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

MENA

SUPPLIES PURCHASED BY IPPF

	ACTUAL EXPENDITURE 1981	ESTIMATED EXPENDITURE 1982	PROJECTED EXPENDITURE 1983
Contraceptives	170.2	249.2	372.8
Medical & Surgical	20.3	25.0	48.9
Audio Visual Equipment	14.2	10.4	13.6
Office Equipment	16.7	16.8	12.7
Transport	67.1	74.9	47.3
Prior Year Adjustment	(17.6)	—	—
TOTAL	270.9	376.3	495.3

AID SUPPLIES DONATED TO IPPF

Contraceptives	29.1	34.4	37.2
FULL TOTAL	300.0	410.7	532.5

SUDAN

SUDAN FAMILY PLANNING ASSOCIATION (SFPA)

COUNTRY BACKGROUND

Population/Family Planning Policies and Programmes

Sudan, the largest country in Africa, covers an area of 2,505,813 square kilometers, and has a population estimated in mid 1981 at 19.6 million with a national rate increase of 3.1%. Sudan's most pressing problems in the population field are the magnitude of internal migration and the high rate of population growth. However, although it does not have an explicit Population Policy, particularly as there is a lack of manpower and no pressure on resources, it does recognize the need to know more about the population dynamics of the country and is in favour of family planning for health reasons.

Many key people in the country are very concerned about the difficulty of effective planning, caused by the lack of sufficient and reliable data about the population. There are several opinions favouring, first, a national consensus on population goals and eventually efforts to accomplish an explicit population policy. Indeed, in its memorandum to the UNFPA Mission on Needs Assessment for Population Assistance, the Ministry of National Planning stated: "the need for training and research in the general area of population as related to development with a view to identifying the ingredients of a sound population policy for this country." The Ministry wants to develop a Manpower and Population Section. In addition, the Universities of Gezira and Juba plan to provide training and opportunities for research into population problems with emphasis on problem solving, especially in rural areas where about 80% of the population lives. The Economic and Social Research Council plans to extend its work in the population area and the Sudan National Population Committee is also planning a number of activities, including a second National Population Conference (with the theme of "Development and Population") and a number of workshops, seminars and publications.

On the basis of these efforts, the UNFPA plans to assist the country in the areas of data collection and analysis in population dynamics and policy formulation as well as in the areas of MCH/FP and I.E.C. In addition, with assistance from UNICEF, MCH and eventually FP services are to be provided through the basic outlets of the Primary Health Care systems. This programme includes training of primary health care workers and traditional birth attendants. The National Council for Social Welfare has a programme for the delivery of comprehensive social services through 18 provincial centres with rural outreach. These services include FP information and medical services.

The Sudanese Family Planning Association enjoys a respected status with the local authorities, and the mass media are available to the FPA at no cost. Other dynamic bodies in the field of Family Planning are the Sudan Fertility Control Association and the Faculty of Medicine at the University of Khartoum.

Contraceptives are now available to the people in the market. SFPA was the only agency providing services through 30 government centres until 1975 when the government established an MCH/FP programme with WHO. Now, in addition to the FPA clinics, FP services are provided through health centres within the framework of the WHO programme. This programme, initiated in Omdurman and Khartoum, is to spread to rural areas in its current phase.

Demographic and Socio-Economic Profile

There have been two censuses, one in 1955/56 and the other in 1973, but the results have only been estimates.

It is estimated that 44% of the population is under 15. Approximately 80% of the population is rural, varying from 96.3% in Upper Nile Province to 25.9% in rural Khartoum province. Average density is 7 inhabitants per square kilometer, varying from 56 per square kilometer in Khartoum to 3.2 per square kilometer in Upper Nile. It is estimated that up to 40% of the population is on the move every year.

Population growth rate varies considerably from province to province. In the past, Khartoum had the highest growth rate at 4.85% a year, followed by the three central provinces of Gezira, Blue Nile and White Nile at 3.5% a year, and the two eastern provinces of Kainala and Red Sea at 3.1% a year. The crude birth rate as estimated in 1981 is 48 per thousand and the crude death rate is 18 per thousand. The total fertility rate is 6.6 per woman.

Agriculture constitutes the principal sector of the economy and employs about 65% of the active population. With modern irrigation schemes, more than 90% of irrigated land is concentrated in Gezira/Blue Nile, hence the concentration of population in these areas and the spread of waterborne diseases. Per Capita GDP is estimated at \$370.

The literacy rate is low with only 19% of adults able to read and write. School enrolment is low for both sexes, estimated at 40% of those of school age.

Infant mortality is estimated at 140 per thousand and maternal mortality at 200 per 100,000 live births. Life expectancy at birth is 45.5 years for males and 47.5 for females. The major health problems are communicable endemic and epidemic diseases, poor nutritional status and poor environmental sanitation. The Government is making a major effort to counter these problems by the development of an extensive Primary Health Care network which aims to provide a basic care unit for every 4,000 inhabitants. Currently there are 9 hospital beds per 10,000 population, 0.8 physicians, 6.7 nurses and 10.2 nurses and midwives.

Physicians are concentrated in the cities, and many people in the remote areas, particularly in the South, have to rely upon medical officers, nursing or other semi-professional health personnel or must have recourse to folk medicine.

The Southern Region has a particular scarcity of health resources. There are 26 hospitals, 6 health centres, 137 dispensaries. In this region, the total number of practicing physicians is

only 49 (one doctor for nearly 70,000 people).

THE ROLE OF THE ASSOCIATION

The Sudan Family Planning Association (SFPA) was established in 1965 and its objectives are to provide family planning services to the largest possible proportion of Sudanese women and men, and to spread information about maternal and child health and the benefits of family planning for the health of the families.

It has defined its role as follows:

- To generate support for a family planning policy.
- To continue the provision of Family Planning Education, Clinical and Training services.
- To reach the rural areas and adopt an integrated approach in all aspects of Family Planning.
- To develop coordination between voluntary activities and existing and/or tentative projects of government agencies in the Family Planning field which will design programmes to complement the work of the FPA.

As the largest agency responsible for family planning and given the unlikelihood of a deployment of a country-wide government Family Planning programme, the SFPA undertakes a major proportion of all Family Planning activities, complemented by the projects of international agencies. No significant changes can be foreseen in the future attitude of the government.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Past Performance

Formed by a group of humanists who were well aware of the eventual repercussions of unspaced pregnancies on the health of the mother and child, the Sudan Family Planning Association's main concern was to overcome the hazards of excessive fertility by providing for the parents ways of spacing their offspring and consequently lowering the foetal, child and maternal mortality and morbidity, improving the quality of life and raising the status of women. For this reason, a decision was made to integrate family planning activities in the available MCH services and offer FP in the government health centres with the permission of the Ministry of Health.

Although the FPA began its activities in the mid 1960's, it encountered financial problems due to lack of funds. After a slow start marked by a concerted effort in the area of motivation and education, the Sudan Family Planning Association gained recognition soon after being accepted as a member of the IPPF in 1969. It was then given grants for establishing the Central Office, appointing staff and was provided with commodities including contraceptives.

As time went on, the Association's activities increased with more clinics opened in the capital and seven branches situated in the provinces operating on the same principles as the central Association. Presently, 27 clinics altogether are serving the country's needs.

As awareness and interest in FP increased, the SFPA enlarged its scope of work to include the socio-economic and demographic aspects of the programme. Contacts were made for joint collaboration with the Ministry of Health MCH/FP Programme, Khartoum University, Department of Social Affairs, Department of Statistics, Department of Information, Ministry of Education and Guidance, Youth Council and Womens Union.

Through the efforts of the SFPA, there is a more clear-cut indication today that an official population policy is imminent in Sudan. The relations between the government and the Association are very cordial and the support of the latter is reflected in allowing the import of contraceptives and commodities exempt from tax, as well as in giving the Association full access to the mass media and the use of government personnel in the provision of family planning services.

Having created an awareness and a favourable attitude of the public towards FP, SFPA's main impetus is that the message of FP reaches every couple as a declared human right and in particular those who need it most in the rural areas. While realizing its limited scope and resources to cope with the increasing demands for family planning in the vast and widely spread country, the Association is eagerly expecting a national family planning programme to cover the whole country, in conjunction with the voluntary effort.

Activities

Information/Publication Activities

Sudan Family Planning Association presents from time to time radio and TV cultural programmes. It also sometimes executes long-range informational programmes, such as "Managii Extension Informational Programme".

The Association has published many books and booklets in Arabic on family planning for doctors and para-medicals on religious attitudes and on social and demographic aspects, and a monthly bulletin that covers the Association's news and activities. Conferences, seminars and workshops are held on the various international occasions related to population and FP. Yearly seminars are held in relation to various topics of local concern. The results of these conferences and workshops are published and disseminated widely.

Training

SFPA carries out FP Training for medical and paramedical and social workers who are working in the clinics. Also the Association arranged the inclusion of FP in the curriculum of the Nursing College. It also participates in the training of the MOH/WHO/MCH/FP Programme.

Periodical FP lectures, demonstration, and film shows are offered to the departments of

Home Economics and Nutrition of the Ministry of Education, Faculty of Education, University of Khartoum and the Ahfad Girls College, with special emphasis on spacing and breast feeding. Ad hoc training is also given on request to trainers of youth, social workers and the Public Corporation for Workers Education.

Projects

The Association has executed and is executing major projects such as:

- a. The Pathfinder fund project for up-grading the standard of Family Planning Services in Sudan
- b. The Keraba project (Nutrition and Family Planning)
- c. The Managil mass media project

1981 Activities

1981 witnessed the offering of family planning services for the first time to Eritrean Refugee Camps. The President of the SFPA has been re-elected as a member of the National Committee for Population, and the Executive Committee was enlarged by co-opting members from different ministries. The IEC and medical activities are going on smoothly and there is an indication that more family planning acceptors have been recruited in 1981 than previously. In IEC the SFPA has achieved a number of educational activities in family planning through the national mass media. As for the medical aspect, SFPA continues to provide services through most of the 27 government MCH clinics in a satisfactory manner.

Management Capacity

The 1981 OPE/MA team, which visited SFPA, recommended that the country be divided into six regions and that 6 regional coordinators be established. The 1981 Budget was revised in July 1981 to provide funds for this restructuring. However, the FPA took some time to implement this recommendation.

Since the recruitment in 1981 of a new Executive Director, the performance of the FPA has improved. However, the financial budgeting and reporting is weak and will be strengthened by future training in the new PPER and special training for the Executive Directors of the Region, planned for 1983.

PROPOSED 1983 WORK PROGRAMME/BUDGET

The SFPA will continue operating 10 clinics in Khartoum, and 8 clinics for the Wad Madani branch, and 9 other clinics scattered all over Sudan. It will endeavour to upgrade the quality of services provided for family planning clients and render family services in Eritrean refugee camps where there are qualified medical paramedical personnel. The SFPA provides free contraceptives supplies. The FPA will improve the accuracy of clinical reports to enable it to follow-up on drop-outs, and measure progress in meeting family planning needs for the population

During 1983, particular emphasis will be given to the northern region as it is the only region in the country where there is not a family planning branch. The SFPA plans to conduct information activities as extensively as possible and when awareness is created, services are to be offered through the available health centres by medical and paramedical staff. This project will continue for a full year. During the first 2 months, training activities for paramedical staff, as well as a mass-media campaign to create awareness amongst the population, will take place. Around the beginning of March 1983, services will be offered in selected health centres in Shundi, Atbasa and El Damer where women at risk were estimated at approximately half a million. The Women's Union as well as the local TV station and the regional representative of the Ministry of Health, are expected to contribute to this project. The Executive Director, Field Officer and two members of the Programme Committee will be responsible for the implementation and monitoring of this project.

A workshop is planned to be held in Khartoum and representatives from Khartoum and the branches will be gathered for 2 days, to study the issue of upgrading the services provided in the FPA clinics.

A seminar will be held to discuss the introduction of Family Life Education into the school curricula. Emphasis will be placed on Family Life Education within the context of the Sudanese culture. These activities will be implemented on condition that they will be reviewed on the basis of the OPE recommendation which took place in December 1980. Out of the 14 recommendations in this OPE, half of them were either implemented or are in the process of being implemented. One of the most important achievements was the appointment in July 1982 of 5 programme officers for the branches. This is insufficient, and there is still much to be done by the SFPA to strengthen its activities and to introduce radical changes in its structure.

ALTERNATIVE FUNDING

The Sudan FPA realised a local income of \$3,785, mainly from sales of contraceptives. From 1983 the Sudan FPA will be involved in a joint UNICEF/WHO nutrition support project, as Sudan has been chosen with Mali and Tanzania for this type of project which will involve direct cooperation between UNICEF/WHO and local non-government agencies in these three countries. It is hoped that the Sudan FPA will eventually integrate a family planning component into this project. The amount of funding to these countries is not yet known. Other potential sources of funding for the Sudan FPA are few, both from local government and from other agencies, in spite of the fact that Sudan is ranked as one of the neediest countries in the IPPF Shift of Emphasis classification.

YEMEN ARAB REPUBLIC

YEMEN FAMILY PLANNING ASSOCIATION (YFPA)

COUNTRY BACKGROUND

Family Planning/Population Programmes and Policies

The Yemen Arab Republic, located in the south-western corner of the Arabian Peninsula, and covering some 200,000 square kilometers, has a population estimated in mid 1981 at 5.4 million with a rate of natural increase of 2.3%. Because of severe developmental constraints as well as scarcity of demographic information, little progress has been made in the formulation of a comprehensive population policy in Yemen. However, the government has singled out certain population issues for highest priority, viz mortality and morbidity, spatial distribution of population, and international migration. With respect to fertility and natural increase, it has adopted a policy of non-intervention for the immediate future. The government considers poor health and high mortality to be the most serious demographic problem of the country at the present time. Yemen's representative at the U.N. World Population Conference at Bucharest in 1974 indicated that neither the size of the population nor the rate of population growth were viewed as problematic. However, he added that "in spite of the fact that population growth is not a serious problem at the present time, the authorities have started the necessary preparations regarding family planning as a safeguard against population growth in the future; also as a necessity for a future population policy that will aim at improving the status of the family". Also, in its reply to the U.N. Third Population Inquiry of 1976, the government noted that due to the lack of information, it did not have a view on whether adjustment of economic and social factors, or of demographic factors, or both was the most appropriate response to the perceived problems related to population growth. More recent indications based on the Population Policy Data Bank of the U.N. show few changes in Yemen's population policies. In brief, morbidity, mortality and emigration continue to be the central population concerns of the government, while the levels of fertility and natural increase are seen as neither too low nor too high.

In the Yemen Arab Republic, children are still considered to be assets and security for old age and a large family as insurance against the high infant and child mortality. Despite this, however, people are beginning to turn to contraception. Family planning is provided within the MCH family health service in the form of advice and counselling on spacing as well as family health education. Contraceptive services are provided when required in rural and urban health centres, and the methods available depend on the training of the staff. There is an effort to follow-up on the acceptors but the machinery used for this is inadequate. There are no laws or regulations restricting imports, sale or use of contraceptives which are distributed through pharmacies and drug stores. The FPA, as well as the government centres, provides contraceptives free of charge. Private physicians also provide family planning services with minimal charges and on a limited scale.

Few research studies have measured the magnitude of utilisation of family planning and related values and attitudes. IEC components of the family planning programme are limited in both schools and mass media. These components are mostly in the area of health and family life education.

The Yemen FPA enjoys an excellent relationship with the Ministry of Health and is providing most of the Family Planning services and contraceptives in the country. This was officially delegated by the Ministry of Health to the FPA.

In Sana'a, the FPA operates two clinics in the grounds of two major hospitals run by the government (Revolutionary and Republican Hospitals). Two other clinics are at the MCH Centre in down-town Taiz and at the Arof Hospital in Hodeida. The YFPA also gives supplies to 11 smaller clinics/health centres. Although the government has no formal policy regarding the provision of family planning services, there is a tacit approval and a de facto recognition of the legitimacy of the need for Family Planning despite the lukewarm opposition of some community leaders who are aware of the shortage of manpower in the country. The Yemen FPA has a good working relationship with Welfare (Save the Children Fund) and foreign MCH missions, which get their contraceptive supplies from the FPA. In 1979, the Pathfinder Fund provided the Yemen FPA with funds to conduct a survey on knowledge, attitude and practice of contraception in Yemen (\$15,000).

Early in 1980, the Ministry of Health established a Maternal and Child Health Council in which the Yemen FPA is a full member. In Yemen male and female sterilizations are practised and men prefer to have a vasectomy rather than taking their wives to be examined by a male doctor.

Demographic and Socio-Economic Indicators

The economy of Yemen is heavily dependent on agriculture. The agricultural sector, which is predominantly of a subsistence nature, depends heavily on erratic rain fall, accounts for over two-thirds of the gross domestic product, employs about 90 per cent of the work force, and generates virtually all exports. Per capita GNP in 1981 was \$420. The Government's future development Plan is mainly designed to develop the country's human and natural resources and to improve the standard of living of the people, giving priority to their basic needs, food, health services, education, water and other community services. The registration of births and deaths is virtually non-existent in Yemen. 81% of the residents live in five of the ten governorates in Yemen, namely Sana'a, Ibb, Dhamar, Taiz and Hodeida. Most of the population lives in rural areas and small towns. Only 10% of the population is urban. Over 1/2 of the urban population is concentrated in the three main cities: Sana'a, Hodeida and Taiz. The density in 1975 was approximately 23 inhabitants per square Km.

One of the features of the Yemeni age structure is the youthfulness of the population (45% under 15 years of age). A second important characteristic of the Yemeni age/sex structure is the deficiency of males in the age groups for 15-19 to 55-59 which is due to the large number of migrant male workers abroad.

The government is currently carrying out the first national fertility survey ever conducted in Yemen, in co-operation with the World Fertility Survey Programme. Calculations based on the survey of Sana'a City yield an infant mortality rate close to 210 per thousand, which implies an expectancy of life at birth of around 39 years for females and 37.6 years for males. The crude death rate in 1975 is believed to be 25 per 1,000.

All these figures indicate that the level of mortality is among the highest in the region. Socio-economic indicators are consistent with those of a population with a very low level of living. For example, running water inside homes is virtually non-existent and about one out of five households live in huts, tents and caves.

As a result of the limited domestic economic opportunities relative to those in neighbouring oil rich countries, Yemen has been and continues to be a major supplier of labour to Saudi Arabia and other Gulf states. In addition to the massive emigration of unskilled workers, the emigration of educated Yemeni is increasing rapidly in response to the substantially higher incomes and opportunities abroad. Various estimates put the number of Yemeni abroad at 1.25 million, with 19.5% of the total migrant population representing dependent children and parents.

75% of males aged 15 years and over and 98% of females of the same ages were illiterate (1975). In the same year, only 43% of males and 6% of females eligible for primary school were enrolled. The most recent development plan has stressed the construction of hospitals, dispensaries and health centres, particularly in rural areas, and improvements in water supply and sanitation. In 1976, there were 17,200 inhabitants per physician and 1,400 inhabitants per hospital bed.

Although the remittances received from the emigrants were an important contribution to the country's well-being, the absence of approximately 37 per cent of the labour force seriously concerns the government.

The women at risk are estimated at over 1 million of the total population. The birth rate is 48 per thousand and the total fertility rate is 6.8 per women.

THE ROLE OF THE ASSOCIATION

In its 1982-84 three year plan, the YFPA described the following role:

1. Sensitizing, informing and educating the population about the advantages of family planning as a fundamental human right and a contributing factor to the progress of development.
2. Providing services (Maternal and Child Health as well as family planning) for the disadvantaged population who will benefit the most from these services.
3. Responding to the needs of youth, especially young married couples since early marriage is frequent in Yemen.

4. Reinforcing the role of the volunteers in the field of family planning and resource development.

This role is the result of the experience gained in meeting a fraction of the FP needs of the country. The YFPA activities could reach the rural areas not covered by the foreign MCH missions. As an agent for social change, the YFPA is playing a role consonant with the felt needs of the country in the field of family planning, contributing to the welfare of the population assisted by the Government, (Ministry of Health, Ministry of Information) the Women's Association and International agencies (Pathfinder, UNFPA, IPAUS).

The efforts of the YFPA, which started in December 1976, are also geared to support Government clinics and to provide these centres with contraceptives, information, motivation and training abroad. Although its resources are limited, the YFPA's potential is large, provided it obtains sufficient resources, both financial and manpower.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Past Performance

As the only structure providing family planning services in the country, the Yemen FPA has carried out its FP service delivery programme in four clinics (two in Sana'a, Taiz and Hodeida) and has given assistance to the foreign MCH missions Centres which have taken up the responsibility of family planning. The assistance is in the form of contraceptives and FP medical supplies and equipment.

During 1981, 3,962 new acceptors and 5,969 continuing acceptors, resulting in a total of 9,931 acceptors were served by FPA's clinics.

Since its establishment in 1976, the YFPA has been suffering from several problems:

- Narrow volunteer base: most of the elite hold two or three jobs and, therefore, time for volunteer work is necessarily restricted.
- Lack of management capacity: until now, the FPA has been unsuccessful in finding full-time, qualified personnel.
- Lack of funds: although IPPF's Regional Bureau was eager to develop the Yemen FPA, it had not fully grasped the problems represented by the almost total absence of qualified staff, and by the excessively high level of salaries needed to attract even semi-qualified staff.

In sum, there has been a lack of resources and of trained personnel.

The situation of the FPA is changing. IPPF's increasing interest in helping the FPA to solve their basic problems has resulted in a renewed enthusiasm and motivation among the volunteers. Furthermore, increased IPPF funding has allowed the FPA to hire a full-time qualified Executive Director, while a Pathfinder grant has allowed the FPA to recruit a qualified Programme Officer from Lebanon.

These developments now need to be strengthened by increasing funding to enable the FPA to recruit qualified officers and transform their contraceptive distribution programme into a full programme, integrating communications and services.

A number of recommendations have been discussed by the FPA and IPPF, and agreed. These include:

Communications

In order to implement its policy in the reinforcement of its staff, the Association is planning to recruit an Information and Education Officer during 1982. The Officer, with the help of volunteers and the Executive Director, will prepare radio programmes (twice a month), a TV programme and a press article (once a month). Moroccan and Lebanon FPAs will assist Yemen FPA in designing information and Education material.

Medical Activities

A fee-system will be introduced for acceptors, so that local resources can be increased and women's awareness of their problems strengthened. YFPA will make an effort to transform its relationship with Foreign Mission Centres and other FP centres by adopting a comprehensive approach to Family Planning to include information and training and, in this way, will move away from being seen as merely a distributor of contraceptives. Accordingly, the FPA will inform all centres of the recruitment of the new Executive Director and the new Programme Officer. The FPA will request all Foreign Mission Centres to designate one person to be responsible for dealing with the FPA.

Management Capacity

The volunteer input from outside the capital, Sana'a, is very limited, almost non-existent, and there is much to be done to widen the volunteer base and contribution.

The FPA performance has been greatly enhanced by the 3 months assistance given by a Moroccan FPA staff member, the recruitment of a full-time Executive Director, and the recruitment of a programme officer funded by Pathfinder. As a result, a revised Budget for the Yemen FPA was approved for 1982 to allow the FPA to undertake a larger number of projects and activities.

The FPA compliance with the Terms and Conditions of Grant has considerably improved and reports are submitted on time. The accuracy of the reporting still needs to be improved through the training of the new Executive Director. The Moroccan FPA staff re-organised the FPA administration and developed the internal organisation chart which was adopted by the Executive Committee and applied in the YFPA's day-to-day management.

The FPA staff and volunteers will be trained in the new PPBR system and this will not only improve their budgeting and reporting procedures but will also help them in presenting new ideas and projects for the future.

PROPOSED 1983 WORK PROGRAMME AND BUDGET

The Family Planning Association of the Yemen Arab Republic will continue throughout 1983 to provide family planning services integrated within the Ministry of Health's major hospitals in Sana'a, Taiz, Hodeidah, Dammar, Saada and Jibla, as well as the basic health services/primary health centres.

The Yemen FPA intends to open a comprehensive clinic that would be established as a model centre for the provision of family planning services. But, on the basis of the FPA management capacity on the one hand, and the degree of adoption of family planning in the country on the other hand, this comprehensive clinic project may be over-ambitious. A review of this project is planned with the objective of making it more realistic with regard to the situation over a three year period. It could start as an out-patient clinic for the first two years; during 1985 it might be extended to an in-patient clinic and eventually a training centre for medical and paramedical personnel. This plan will, of course be reviewed each year.

Nevertheless, the need to open a FPA clinic stems from the fact that family planning activities have been established to a certain degree in some hospitals where education and counselling on family planning methods can only be done in a very limited manner, due to limited facilities in these hospitals. By establishing its own clinic, the YFPA hopes to strengthen its credibility and to build confidence amongst family planning users.

YFPA, being the only structure with nation-wide responsibility for family planning services, plans to introduce family planning I & E activities and services in the Women's Association centres. The YFPA will endeavour to develop IEC activities in 1983 through the production of radio and TV programmes and the publication of a four-monthly bulletin as well as press articles in the local newspapers. Within the IEC programme, a family planning and women's development project is also planned for 1983.

The training project for nurses working in MCH activities of UNFPA and the introduction of FP activities in its centres was supported as UNFPA could provide the funds and the YFPA could contribute expertise, technical assistance and IPPF medical training publications. As for the project aiming at introducing FP into the curricula of the Health Manpower Institute, it has been recommended as a no-cost activity, as the YFPA will be contributing publications and resource persons. Finally, as the National Development Cooperative Organisation in Yemen asks for a cash contribution from the YFPA to introduce FP services in its clinics, the recommendation is for the YFPA not to fund this organisation and rather to provide contraceptive supplies, basic FP medical equipment and publications.

The I & E activities are very limited but the I & E Officer Workshop, which will be organised by the Regional Bureau and scheduled to take place in the Fourth Quarter of 1982, will help the I & E Officer of the YFPA to develop his communication skills.

ALTERNATIVE FUNDING

The FPA did not try to raise local income because of the unfavourable political climate for family planning. However, the FPA succeeded in getting funds for a Programme Officer and a subordinate from its Pathfinder Fund. The project is initially scheduled for three years starting in January 1981 and renewable depending on performance every year. IPAUS is funding the FPA activities in voluntary sterilization. There are no projects for government funding or in-kind donations and the FPA has to rely solely on IPPF funding. Yemen is considered one of the neediest countries in the IPPF Shift of Emphasis classification.

WESTERN HEMISPHERE REGION

REGIONAL OVERVIEW

During 1981 the Western Hemisphere Region continued to concentrate on three main lines of activity: Resource Development, Leadership Education, and New Programme Directions.

RESOURCE DEVELOPMENT

1981 was the year that IPPF grant support to Western Hemisphere FPAs began to decline rapidly in real terms. In previous years even if IPPF grants did not keep up with Regional inflation, at least the loss of purchasing power was moderated by nominal dollar increases. The dollar increases stopped altogether in 1981, so the Associations were exposed to the full effects of inflation, which in most cases lowered the purchasing power of their IPPF grant to 80-90% of what it had been in 1980.

FPAs and the Region did not sit back and passively accept this loss of purchasing power. On the contrary, they demonstrated that supplementary support remains available at the national and regional levels, and that there are still donors keenly interested in expanding their support for FPAs.

Several grants were obtained to support specific projects of importance to the Region. These included a grant from US AID of \$970,000 to support a comprehensive three-year programme of Leadership Education. Under the terms of this leadership education grant, five countries have been designated for priority attention through sub-grants that will strengthen FPA programmes to inform and educate national leaders. It is hoped that the results of this initiative will be of value to the whole Federation.

Another grant from US AID, of \$2.9M to be expended over four years, will enable the Region to strengthen the programmes of the Ecuadorian Association and two other Ecuadorian private organizations. This programme will increase clinical services, establish a population information system to reach leadership groups, and provide in-clinic and community education and promotion.

A 3-year grant of \$495,000 was received by the Association in Guyana. These funds will strengthen the Association's institutional capacity, will be used to train health personnel, teachers, community leaders and youth educators to provide family life education, and will strengthen the Association's outreach efforts directed toward adolescents.

As evident from the above, the Regional Office is being called on to serve as executing agency for grants made to Associations or to groups of Associations in the Region.

A previous 3-year grant of \$977,000 from US AID to expand the activities of the Caribbean Family Planning Affiliation put that organization on a firm footing, enabling it to carry out a comprehensive programme of management and technical assistance to

benefit its 18 members. In 1981, the CFPA became fully staffed with specialists competent to carry out its programmes. It established its headquarters office on the island of Antigua.

An important Caribbean workshop on resource development was conducted in Aruba in October, 1981. Subsequently, the CFPA Board, in collaboration with the Regional Office, organized a campaign to build up a Caribbean Program Development Fund.

Other resource development workshops were carried out in New York for the training of Regional staff and volunteers. As a result of WHR training efforts, a manual on resource development was produced and submitted to Central Office for eventual utilization in other Regions.

The definition of resource development includes strengthening institutional links with organizations that could complement IPPF efforts. Special emphasis has been placed on improving working relationships with UNICEF, the Inter-American Development Bank, USAID, the University of Chicago and Columbia University, and the U.N. Economic Commission for Latin America, located in Santiago, Chile.

LEADERSHIP EDUCATION

For the past three years, the Region has been seeking to strengthen its ties with political leaders and to improve its relations with the Catholic Church. For the third year in a row, the Regional Council at a meeting in Washington U.S.A. heard addresses by distinguished members of the Latin American clergy. In the political sphere, the 1981 Regional Council meeting carried the Region's ties with parliamentarians to a new level. Appearing as special guests of the Council were more than 20 parliamentarians from five Latin American and two Caribbean countries, all of whom had an opportunity to meet their North American counterparts.

A special panel on "Population and Development" was chaired by the Secretary of Planning of the State of Sao Paulo, Brazil, and featured as panelists a senator from Colombia and the Vice-President of Peru.

The Council was also addressed by the Chairman of the Foreign Relations Committee of the United States Senate; by the Administrator of USAID; by the former Secretary General of the IPPF and by the Director of Coordination for Mexico's comprehensive national family planning programme.

Before concluding the meeting the members of the Regional Council and their guests, priests and parliamentarians alike, signed the Washington Declaration on Population and Development, a document which was subsequently distributed throughout the Western Hemisphere and beyond. Among its provisions, the Washington Declaration called for the "broadest possible" provision of family planning information and services, the inclusion of family life and population education in schools, and the establishment within each country of "a high level government committee or office to coordinate different

population activities in accordance with the process of national development”.

The Regional Council meeting of 1981 was an important event organized on a regional basis, and the various events received ample coverage by press, radio and television: their repercussions continued throughout the year.

The participation of Regional staff in the organization of the upcoming Conference of Western Hemisphere Parliamentarians on Population and Development has afforded the IPPF the opportunity of reaching higher levels of decision-making than have been possible in the past. The Parliamentarians' Conference has also allowed the Regional Office to develop a continuous and fruitful relationship with other organizations working in the field such as the Population Reference Bureau, the Pathfinder Fund, Development Associates, The University of Chicago, and others.

NEW PROGRAMME DIRECTIONS

The Associations in the Western Hemisphere continued their regular programme in 1981. At the same time, emphasis was placed on several new programme directions.

The social marketing of contraceptives is a method of distribution pioneered by the Colombian Association, which places supplies in retail outlets throughout the country. Although these contraceptives are offered to the public at well below the regular market price, the programme is self-supporting, returning to the Association a small profit for the support of other programmes. Marketing programmes are being developed by many other FPAs, including those of Barbados, Brazil, El Salvador, Guatemala, Panama, and Trinidad.

Outreach Programmes directed towards adolescents are receiving special emphasis by the CFPA and by a number of Associations in the Caribbean, where unwanted teenage pregnancy is a particular problem. Several Associations have set up youth centers and are experimenting with the training of youth leaders, as well as with special information programmes directed toward young people. These activities have also been adopted by some of the Latin American Associations. As a follow-up to the Region's recent campaign to promote sex education in Latin America, the Ministry of Education of Guatemala ordered 1,000 copies of textbooks prepared in the Regional Office for distribution to school teachers in that country.

Community programmes are taking new forms in the Western Hemisphere. Of particular interest are the programmes developed in collaboration with the Japanese Organization for International Cooperation in Family Planning (JOICFP). These programmes, integrating nutrition and parasite control with family planning, have been established in Colombia, Mexico and Brazil. Integration is “meant to serve as a catalyst for community development”.

The August 1981 meeting of CAPRI II, the Second American Conference on Integrated Programs, was held in Mexico under the joint sponsorship of JOICFP

and the Mexican Association. Its 70 participants came from throughout Latin America; also present were the Medical Director of the Africa Region, and the Director of the six-year old integrated programme in Indonesia. Integrated programmes of this type have also been developed by the Associations in Dominican Republic, Paraguay and Peru, and funds are now being sought so that these additional programmes can be implemented.

Information, Education and Communication activities concentrated on ways and means of reaching the mass media. Workshops were held in Peru on mechanisms to establish effective relationships with the printed media, and in the Dominican Republic to examine different techniques of communication through radio and television.

The development of new programme directions in the Western Hemisphere Region will undoubtedly require ingenuity and perseverance, both by staff and volunteers. Some of the positive effects of these efforts are beginning to be seen, but it must be recognized that a start has only been made in uncovering the many challenges and opportunities that lie ahead.

The work of the Guatemala Association and the Caribbean Family Planning Affiliation "CFPA" is covered in depth later in this report. Summaries follow of major new developments in other member Associations of the WHR including the grant-receiving members of the CFPA.

Anguilla

The Anguilla Family Planning Association is one of the newest members of the Caribbean Family Planning Affiliation. The Association was established in March 1980 and plays an important supportive role to the Government's national family planning programme. The focus of the Association's work is on information and education. A special emphasis will be put on family life education in schools in 1982 and 1983. The Association's Secretary was elected CFPA President in May 1982.

Antigua

The Association has received Government's permission to conduct family life education programmes in selected schools. This is a significant breakthrough, given the Association's energetic efforts in the past to obtain such approval. Nevertheless, the government continues to resist inclusion of family planning as part of the national health care services. Discussion between USAID (Barbados) and Government on financial aid for family planning services may lead to a change of heart. The FPA's CBD programme seems to have reached a plateau and there was a significant decrease in the use of injectables. A 1981 Contraceptive Prevalence Survey indicated high knowledge levels and current use.

Argentina

During 1981, the Argentine Government changed twice, still remaining in military hands. Early 1982 was marked by increased domestic opposition to the military government. In early April the government seized the Malvinas/Falkland Islands and a two-month war ensued between Argentina and Great Britain. The effect of this conflict on Argentina has been a further worsening of the economic situation, successive devaluations of the peso, projections of up to a 500% inflation rate by the end of the year, and the forced resignation of the government. There is no indication that the new government will change its pro-natalist, anti-family planning stance. Because of this, the FPA is increasing its efforts to reach leadership groups via training professionals, using the mass media, developing integrated programmes with provincial and municipal governments and with private agencies. In reaching out to the most needy areas of the country, the Association has found volunteers and local officials willing to develop integrated projects in health, education and community development. The FPA has also increased its local fund-raising programme, selling educational materials and contraceptives, and will open its own clinic in late 1982, with an eye to making it self-supporting within a year and money-making thereafter. Rural doctors have been trained by the FPA, and are distributing contraceptives. The FPA is also trying to neutralize Church opposition through meetings, publications aimed at Church leaders, and promotion of the Billings methods. The FPA hopes to carry out an MCH-Contraceptive Prevalence Survey in 1983.

Aruba

In 1981, the Association continued to implement what has proven to be a successful strategy involving cooperation with the Government, which provides funds, and with private physicians, who provide family planning services. The Association's programmes are centred on communications and motivation, with special efforts aimed at reaching young people in school.

Barbados

The Barbados FPA continues to implement effectively its mix of education and service delivery programmes, Government has introduced family planning services in three polyclinics and still provides substantial support to the FPA's work. A Contraceptive Prevalence Survey was completed in 1981. The Association has begun a major community education programme. There are plans to introduce a Commercial Retail Sales Project in 1983, with USAID funding. National discussions continue on abortion law reform, and a bill to legalize abortion is now before the Barbados Parliament.

Bolivia

The adverse climate for family planning, the political uncertainty resulting from frequent changes in the national government, and nationalistic campaigns that have sporadically attacked international assistance to family planning have all contributed to the difficulties the FPA faces in carrying out its institutional goals.

Despite these unfavourable conditions during 1981, the Association successfully implemented an ambitious Information and Education Programme. The activities included talks, forums, group discussions, film shows, and workshops directed to blue collar workers, civil servants, the lower ranks of the armed forces, labor leaders, and legislators.

The implementation of the medical and clinical programme continued, in 1981, through the cooperation established with community groups and labor unions, and included distribution of information and contraceptives through a national network of cooperating physicians and professional organizations, the opening of a new clinic in Oruro with a local bus drivers' union and, for the first time, direct FPA services.

Brazil

The momentum in favor of a federal family planning programme seems to be shifting from the executive branch – where there is still little enthusiasm for the political controversy that announcement of an effective federal program would generate – to the legislative branch, where the growing strength of the Brazilian Parliamentary Group for the Study of Population and Development offers many opportunities for long-term progress. The December Conference of Western Hemisphere Parliamentarians on Population and Development, to be held in Brasilia, should accelerate this trend.

The present political situation is dominated by the forthcoming November election, which could substantially alter the political landscape at the state level and in the federal Congress, but family planning has not yet emerged as a divisive issue in election campaigns. The continued lack of definition at the federal level confirms the wisdom of BEMFAM's concentration on collaborative programmes with state and local governments, whose autonomy seems to be growing. This trend, combined with more cost-effective methods of running large-scale CBD programmes, suggests that policy definition and programme support at the federal level may be less important than was once thought. While still pressing for federal action, BEMFAM is simultaneously demonstrating that large-scale service programmes in Brazil are possible even without explicit federal support.

The Association has just moved into new, more spacious quarters, and will consolidate its Rio de Janeiro staff from seven locations into one.

Canada

The Planned Parenthood Federation of Canada (PPFC) is celebrating its 50th anniversary this year with major fundraising and public relations campaigns. These events will help fulfil the three major programme priority areas recently established by the Federation: fundraising, advocacy, and communications links. PPFC continues to face a difficult financial situation, in large part due to federal government cutbacks in programme support for the provincial and local affiliates. Although most provincial governments have accepted some responsibility for family planning services, others (for example, Newfoundland and Prince Edward Island) have failed to do so. Few provinces that do provide funds

have supported the affiliates at the same level as the federal government had done. As a result, several affiliates have been forced to close their provincial offices and Prince Edward Island, the smallest Canadian province, was forced to close all its programmes. Because of this situation, PPFC has gone from an organization with more than 70 affiliates a few years ago to one with 50 now, none of them receiving grants from PPFC.

A major reorganization of the national office has taken place, in line with the new programme priorities. PPFC's volunteer structure has also been changed to reflect the new directions, with changes in the Board of Directors, formation of an Executive Committee, and working committees on fundraising, advocacy and communications, and special projects.

Resource Development. PPFC has developed a case statement for support which describes the Federation's work over the past fifty years and explains why it needs and deserves continued support. The November Executive Committee meeting will be held in Toronto in order to take advantage of that city's locale as corporate headquarters for major Canadian industries and foundations. In late 1981, PPFC conducted a direct mail campaign which made the Federation more known and raised some funds. PPFC is seeking not only cash donations, but in-kind contributions at the national, provincial and local levels. These include equipment and supplies, and volunteer and mass media time. In 1981, 93 radio stations donated C\$106,086 worth of free air time to public service spot announcements prepared by the Federation to reach a teenage audience. PPFC has joined the coalition of Voluntary Organizations, a group proposing tax laws which would give the public more incentives to contribute to charitable organizations.

Advocacy. Faced with serious threats to family planning programmes and principles in Canada, PPFC is working to make the organization and its goals better known through a variety of means, including the PPFC journal, media presentations, and publicity related to the Federation's 50th anniversary. A letter-writing campaign to Members of Parliament is planned to follow national Planned Parenthood Week in October, 1982. PPFC is advocating the first National Fertility Survey, to be utilized in planning future programmes and demonstrating family planning needs nationwide. The Federation is also joining with other organizations (such as the Canadian Medical Association and the Home Economics Association) to promote joint goals and share education programs in the schools.

Communications Links. PPFC has initiated a quarterly journal, an expanded version of the organization's former newsletter. It disseminates information on family planning via a coordinated effort with affiliates. It has also published materials especially aimed at teenagers, including a well-received pamphlet, "Because it Can Happen to You". Capitalizing on the PPFC's 50th Anniversary, the Federation has published brochures and posters. PPFC has an "ombudsman" working on affiliate relations and special projects, the latter including a large public conference in 1983, projects with the native peoples of Canada, and peer counseling.

Each PPFC affiliate chooses whatever activities are best suited to its community's needs. As a result, a great variety of programmes are conducted throughout the nation, with information, counselling services, and educational programmes in the forefront.

"Right-to-life" groups continue to oppose abortion, family planning and sex education. Their attacks are aimed specifically at PPFC, which does not run any abortion clinics but nevertheless seems to be publicly identified with abortion. In 1981, statistics showed a levelling-off of abortion numbers in Canada. PPFC fears this may be due to decreased availability of abortion services in Canada and an increase in the number of Canadians going to the United States to obtain abortions.

Chile

The health system, once highly socialized, is being gradually absorbed by the private sector, but the rhythm of the decentralising process has slowed down as Chile's once blossoming economy has visibly withered in the last 12 months. Growth is now expected to be either nil or negative in 1982.

After three years of frozen exchange rates the government at long last abandoned on June 1982 its ill-fated rigid monetarist policy and adjusted the overvalued peso by 20%; simultaneously the system of monthly mini-devaluations was introduced. Unfortunately APROFA's benefits will be of a transitory nature only as an accelerated rate of inflation will all too soon wipe out the effects of devaluation.

Nevertheless, the FPA continues to provide an impressive volume of family planning services through agreements with the Ministry of Health and private agencies like the Red Cross. The Association also excels in the quality of its management.

Colombia

The Colombia Association, PROFAMILIA, has made an outstanding recovery from its financial difficulties of 1980-1981, thanks to increased support from a variety of donors and considerable success in generating more income from contraceptive sales, patient fees, and local donations (cash and in-kind). PROFAMILIA has registered record-breaking statistics in the first semester of 1982 in its clinic, CBD, and contraceptive marketing programmes. In the past year, the Association has also had the strongest collaboration ever with the government family planning programme, especially in providing voluntary sterilizations. As shown by the 1980 Contraceptive Prevalence Survey, PROFAMILIA's service delivery programs have been instrumental in providing contraceptives to a large portion of the Colombian population, thus contributing significantly to the declining birth rate.

PROFAMILIA has been a regional pioneer in developing programmes which others said could not be done in Latin America. Through its success, the FPA has influenced many to adapt similar programmes to other nation's needs. The FPA's activities which have proven influential include the use of radio, voluntary sterilization, CBD, the use of paramedical

personnel in service delivery, local fund raising, and commercial distribution. PROFAMILIA continues to experiment, always seeking the most cost-effective way to run its programs. Association, governments and other throughout the Region have turned to PROFAMILIA for technical assistance and training in these areas, as well as in clinical service delivery.

The Association concentrates ever more on difficult unmet needs, including: community programmes for urban marginal and rural areas; programmes for hard-to-reach areas, especially those of the Atlantic and Pacific coasts and the National Territories; and reaching leadership groups. PROFAMILIA demonstrates the feasibility of offering not only high quality services but also in high volume, while at the same time receiving only 27.5% of its support from IPPF. Like PPFA in the United States, PROFAMILIA forces a reconsideration of conventional wisdom that large-scale service programmes cannot be sustained by a private FPA.

Costa Rica

Five years ago Costa Rica had a cooperative family planning programme in which the Government delivered the services and the Association provided information, training and supplies. The programme was very successful, both in reaching the people and in reducing a rate of population growth that at one time was the highest in the Western Hemisphere. Success was followed by an adverse reaction; from 1978 to 1982 the national government opposed family planning. Although this did not prevent the Ministry of Health from continuing to deliver family planning services, it did cut off certain avenues of international funding. This hampered the programme of the Association, which had to retrench in the hopes that the situation would improve in the future. The Association pursued a long-term policy of seeking innovative ways of bringing the family planning message to rural audiences. With the change of administration in May 1982 the situation has improved radically, giving the FPA an opportunity to rebuild its cooperation with a new government that openly supports family planning.

Curacao

With services provided through the national health system, the Association concentrates on information and education by agreement with a Government that provides the bulk of its financing. The Association in Curacao also acts as executing agent for government grants to the other islands of the Netherlands Antilles. It operates two model clinics in which services are provided. The arrangement has proved highly successful. The Association's programme has had an impact on all elements of the national population.

Dominica

A measure of political stability was achieved in Dominica this past year. The FPA stabilized its management system and established a more prominent national image. A new Executive Director has been appointed and a new President elected. The FPA seems on the verge of becoming a major force for family planning and family life education programmes. A study of teenage pregnancy funded through the USAID/IPPF-WHR/

CFPA Grant was completed. A USAID-funded Contraceptive Prevalence Survey was also finished; it indicated high levels of knowledge and contraceptive usage. The FPA plans to focus its efforts on the teenage pregnancy problem in 1982 and 1983.

Dominican Republic

The overall programme performance of the Association was highly satisfactory in 1981. Despite financial limitations imposed by the Federation, this FPA was able to expand its programme mainly through: a contract granted by the Ministry of Agriculture to provide family life education for rural women; the creation of a Center for studies in Population and Development; a dramatic increase (57%) in the number of press releases and news items published by the national newspapers. The celebration of the Association's fifteenth anniversary received widespread coverage. Thus the FPA consolidated and confirmed its image as one of the leading private non-profit organizations in the country.

As in recent years, the Association continued to play a major role in reaching vulnerable groups such as the urban poor, adolescents, peasant women, and others who are not covered by public programmes.

The FPA has designed a strategy to reach opinion leaders and decision makers in order to ensure that future government plans recognize population as a key factor in the socio-economic development of the country.

Ecuador

Although Ecuador's 1979 Constitution contains a clause advocating responsible parenthood, the Government has refrained from taking vigorous action. Family planning services are provided in government health facilities to those who ask for them. The Association has increased its cooperation with various government entities, including the Ministry of Health and the Armed Forces. The FPA has greatly widened its scope by expanding its CBD project to five coastal provinces, opening an office in Quito to deal with leadership education, I & E, and administrative matters, and is planning a commercial distribution of contraceptives programme to begin later in 1982.

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. As government services become more widespread, the FPA has assumed new programme roles, including CBD, sterilization, the use of private doctors and midwives in strengthening service delivery, post-partum services in maternity hospitals, and more emphasis on reaching youth and marginal populations. The FPA is also training pharmacists who will form the base for the commercial distribution programme.

USAID considers Ecuador a priority country, and during 1981-82 signed major grant agreements to support both private and public family planning efforts. IPPF/WHO is the executing agency for the \$2,922,000, 4-year Cooperative Agreement with USAID/Ecuador for three private Ecuadorean Associations: IPPF affiliate APROFE (to support

existing clinics in Quito, Guayaquil and Cuenca, starting in late 1983); CEMOPLAF (to open three new clinics in the Guasmo area of Guayaquil, Esmeraldas and Tulcan); and CEPAR (for information, education, training and research activities). This grant, which began in October, 1981, has enabled the WHR to open a field office in Quito, with a staff of two (the Project Coordinator and his Assistant).

El Salvador

The on-going civil war is still creating serious problems for the FPA. No projects, however, have had to be cancelled. On the contrary, the ADS has been able to successfully extend some of its projects to all rural areas.

Six months after the tragic death of the last Executive Director, a new Executive Director was appointed. This fact has increased the general effectiveness of the Association, reduced the turnover among the staff, and restored FPA morale.

The government recently elected does not seem to be opposed to family planning. There are clear indications that family planning programmes promoted by the Ministry of Health and the Salvadorean Institute of Social Security will continue. The AID Mission, AVS, DA and IPPF are the only international donor agencies that still support the projects of the ADS.

Grenada

The People's Revolutionary Government of Grenada has expressed an interest in integrating family planning into its health services. Discussions between the FPA and Government have been held on this matter but no firm action has been taken. Government's concern over the side-effects of Depo-Provera has led to a cessation of its use by the FPA, pending further inquiries. A major adolescent pregnancy study was conducted in 1981 which recommended important changes in the FPA's I & E work.

The Association continues to be the primary agency for family planning information and services. A USAID-funded CBD Project seems most successful, and the Association continues to provide clinical services through its own facilities and some government health centres.

Guyana

The FPA successfully negotiated a 3-year grant from the Guyana USAID Mission in the amount of \$495,000. The grant will enable the FPA to expand its family planning and family life education programmes. In 1981 the FPA facilitated the provision of family planning services in 63 government health centres (100% more than in 1980). In addition, the FPA provided an informal contraceptive service at its headquarters. These achievements need to be seen in the context of the government's ambivalent position on family planning. The Association has moved into new headquarters. The family planning future in Guyana seems most promising.

Honduras

The transition to a civilian government and unrest in neighboring Central American countries were the two major factors affecting Honduras in 1981. The most dramatic issues in Honduras remain the absolute level of poverty and the enormous unmet needs.

In 1981, the FPA had a good record of programme implementation. The IEC department implemented 6 projects, including seminars on family life orientation, sex education courses and the preparation of over 185,000 copies of a variety of printed materials.

The Association continued to offer family planning services in its two clinics, implemented an ambitious programme of male and female sterilization, and continued its successful CBD programme, now expanded to the whole country.

It should be noted that the Association has established a good relationship with the Social Security Administration in Honduras, and helped in the installation of a family planning clinic in 1981. The Social Security Administration not only has accepted total responsibility for the functioning of the clinic, but also wants to receive further assistance from ASHONPLAFA in order to expand its family planning services.

Jamaica

The new Jamaican Government gave special emphasis to family planning in 1981 and took steps to formulate a Population Policy. The socio-economic situation looked more hopeful but will require massive external inputs. USAID (Jamaica) committed itself to continued funding of the national family planning programme, including substantial support for the youth and outreach projects carried out by the FPA. The Association continues to provide sterilization and other clinical services through its two clinics. Its CBD and Outreach Projects serve an important role in meeting unmet needs in rural areas.

Mexico

The largest Spanish-speaking country in the world has developed the most comprehensive family planning programme in the Hemisphere, one that has apparently met ambitious targets so far. Within that context, the Association is testing ways of playing an efficient, complementary role. This has involved its withdrawal from some clinics, which it has handed over to other institutions by means of written agreements. It has also meant an expansion of community-based services, most notably in cooperation with the state government of Veracruz. Community services, including those provided from a railroad car in two Northern states, are moving into other rural districts. Information campaigns include person-to-person contact and the production of pamphlets and film shows. In addition the FPA is trying to concentrate efforts in those states with the greatest need for services and information.

Montserrat

The government maintains a tradition of active support of Association's work but was forced by public opinion to withdraw proposed legislation for the liberalization of the abortion law. The Association continues to function efficiently and with significant national impact. The Association's single clinic serves the entire island. There are plans to add a special youth project and a CBD Programme with USAID funding in 1983.

Nicaragua

The Association has achieved good relations with the new revolutionary government, having signed an agreement with the Ministry of Health. The Government has announced its intention to develop a national programme of family planning services to be delivered "without pressures". Meanwhile, the Association continues to provide services in its model clinic in the capital city. It is also conducting a community-based programme via rural midwives and concentrating on advancing family life education in and out of schools.

Panama

The FPA has consolidated its administrative and programmatic activities in San Miguelito on the outskirts of Panama City, with education and adolescent centre programmes now housed in a new building constructed with locally-raised and CIDA monies. The FPA's success in raising new funds both nationally and internationally has enabled it to expand its programme to include a large clinic, increased information and education activities (for adolescents, parents, labor union leaders and teachers), and to hire a full-time programmer/evaluator. New funds are being sought for a printing training programme for adolescents, a vasectomy project, a women's development project, and for a clinical laboratory. Although there is no official population policy in Panama, several government entities are involved in family planning and related activities, including the Ministry of Health and the Social Security system. The FPA has developed new working relationships with two universities as well as with the Workers Confederation of the Republic of Panama, and the National Anti-Cancer Association.

Paraguay

Attacks on family planning have subsided in Paraguay, after resulting in suspension of the Government's programme. The Association, the only organization still providing subsidized family planning services, must still struggle to survive in a generally hostile environment. The Association is continuing its service activities, trying to concentrate efforts in rural areas and work with low income sectors of the population.

Peru

In 1979 a new Association (INPPARES) began to function, after the original FPA had been closed down five years previously. The situation has progressively improved since then, with the new civilian regime stating that a high rate of population growth is an impediment to national development. The Association, which at first limited its activities to information, has since expanded into services via a network of cooperating physicians and through several strategically located MCH centers.

In order to promote a positive public image, INPPARES participated in various formal and informal meetings on population and development, family planning, and sex education in 1981. These activities were important in strengthening relations with the public sector and other private organizations active in the health and population field. INPPARES also carried out activities with a large number of local governments and with six universities.

Puerto Rico

The family planning movement in Puerto Rico dates back to 1945, when a Forum was held to discuss population growth and socio-economic development. The forum group, which later adopted the FPA's current name (APPBF) and statutes, was not only responsible for developing interest in family planning at both private and public levels, but was actively involved in the international family planning movement. As a matter of fact, the APPBF was among the 12 founders of the IPPF in 1952, and despite the uniqueness of Puerto Rico's political association with the United States, the FPA has chosen to retain its legal programme independence. Hence, their choice to remain a full member of the IPPF. This discussion has proven to be politically sound as well as culturally convenient, since a direct affiliation of APPBF with the FPA of the United States could have been interpreted as inconsistent with the grass roots nature of the family planning movement in Puerto Rico.

Largely because of the accomplishments of the Puerto Rican FPA, the island has succeeded in reducing its crude birth rate considerably in the last 18 years, from 35.2 to 21.5 per 1,000. Fertility has been reduced especially among women over 30 years of age. It must be noted, however, that of the population of 3.9 million, 36% are under 15. Furthermore, with the exception of Barbados, Puerto Rico has the highest population density (388 per sq. kilometer) in the Caribbean.

This success story and the future of family planning in Puerto Rico are in serious danger. In 1981, reductions in the U.S. Federal Budget have affected assistance to U.S. dependencies as well as to the 50 States. The Government of Puerto Rico, and the Health Department in particular, are going through a serious economic crisis which has adversely affected the island's Family Planning Programme and the FPA. The demand for these services is on the rise while the resources to meet that demand are in sharp decline. The Government Health Centers do not have enough medical or para-medical staff to offer the services needed. Contraceptives are scarce or are simply not available at many locations. Voluntary sterilization services have been cut back in the most important cities and completely eliminated in most of the smaller towns.

In order to cope with the crisis, the FPA has concentrated all operations on the second floor of its headquarters, has put into practice cost-saving measures, and continues with the implementation of its financially crippled programme. Staff morale is high despite difficulties and the main task now is the revision of the FPA's structure, its programme strategy, and long range planning.

St. Kitts-Nevis

The Government carries out a national programme involving service delivery in 13 health centres and family life education incorporated into the public school curriculum. The Association complements the national programme by operating a model clinic and conducting a pilot programme of community services. The Association's main thrust is an information programme carried out in support of government services. In 1982, this programme will place a special emphasis on motivating sexually active youth to use family planning facilities. A USAID-funded CBD programme was started in 1981.

St. Lucia

The Association's programme of medical services, community-based activities and vigorous island-wide information campaigns was developed in perhaps the most conservative of all the islands in the Caribbean. Fourteen years of efforts have resulted in a government commitment to establish family planning within the official maternal-child health programme. With USAID funding, the Government will provide family planning services in its health clinics beginning in 1983.

St. Vincent

The Association continues to play primarily an I & E role, focussing on the needs of teenagers. The Government provides family planning services through its health system and, with USAID funding, plans to expand these services in 1983. A CBD Project together with a Youth Clinic and a Youth Outreach Programme are also due to be implemented in 1983.

Surinam

In spite of a prevailing pronatalist policy, the Ministries of Health, Social Affairs and Education continue to collaborate with the Association in the development of its information and service activities. A change of Government in 1980 produced a situation more favourable to family planning. With financial assistance from the Government of the Netherlands, the Association was able to acquire a new headquarters building. From here, it directs clinical activities in the capital and in an outlying community, administers a community-based program involving eleven contract doctors and one hospital as rural distribution points, carries out an information programme with national coverage, and conducts a varied training programme.

The FPA has clearly established a national presence in Surinam. Its 1981 Congress on Contraceptive Technology drew wide participation including government officials and staff. The Government has introduced a National Health Plan for civil service employees in which contraceptives are available free of charge. A new Executive Director has been appointed; the former Executive Director now serves as Surinam's Secretary for External Affairs.

Trinidad and Tobago

As part of the National Family Planning Programme, the FPA's work is recognized and supported by the government. Relations with the media have been strengthened and this is expected to translate into positive results in the following years. In 1981 the FPA consolidated its managerial structure and made a number of vigorous attempts at fund-raising and at increasing government and voluntary support for its activities.

The Association's projects in the areas of clinical and CBD services, and information and education proceeded well with new efforts aimed at strengthening the FPA's staff capabilities.

Uruguay

The oldest Association in Latin America has shown slow but steady progress in attracting collaboration from government agencies. The Government of Uruguay has maintained a pro-natalist stance at international meetings, but has never interfered with the provision of family planning services within its clinics by the Association. The FPA has sought out projects integrated with Ministry of Health programmes, thereby gaining tacit recognition of family planning as an integral part of preventive health. An agreement was signed in 1980 with the State Railroads Administration (AFE), incorporating a family planning clinic into AFE's medical services, and the Association has just signed another agreement with the Air Force whereby family planning is included in all its dependencies, with the FPA providing technical assistance, contraceptives and training. The FPA also has the possibility of conducting a Contraceptive Prevalence Survey in collaboration with the Ministry of Health, if funding can be found.

The Association has been successful in developing new projects, including the Youth Multipliers Projects, which involved young people in the Association's activities, and the family health project in Southwestern Uruguay which integrated family planning with primary health care and education. Funding continues to be a problem, and as a result, the FPA had to suspend the youth Multipliers Project in mid-1980 until new funding could be obtained in 1981. Despite the success of the family health project, the FPA has had to cancel it in 1982, also because of lack of funds.

The Uruguayan FPA continues to be a WHR leader in sex education, and has trained a number of professionals and provided technical assistance to other FPAs. The Association is the only entity in the Region developing special materials for the blind which are used throughout the Spanish-speaking world. The FPA is experimenting with new techniques for reaching specific, target groups (e.g., rural and marginal poor, adolescents and the disabled), and has started a CBD programme which was applauded by the Uruguayan President in a meeting with the FPA's Executive Director. As a result of that meeting, the government has agreed to provide incentives for inter-institutional coordination, and to carry out research on Maternal and Child Health.

United States of America

During its entire sixty-six year history Planned Parenthood Federation of America (PPFA) has focussed its resources and energies on two primary demands. The effort required to meet the growing demand for reproductive health care was, by necessity, matched by an unceasing struggle to promote and preserve reproductive rights.

Preservation of Rights. The Public Impact Programme, implemented in 1979, is a blueprint for social and legislative action on behalf of reproductive rights and individual freedom. Its strategies were revised in response to the 1980 election victories of many ultra-conservative candidates. The Public Impact Programme served as a mechanism for speaking out against those who threatened to eliminate personal choice and impose one standard of morality on all Americans. The reauthorization of Title X of the Public Health Service Act was a major victory for PPFA.

Patient Services. Each of the 188 PPFA affiliates exists to serve the family planning needs of its community. Four of these affiliates devote all their efforts to providing education and information. The remaining 184 affiliates offer a wider range of medical services in addition to educational programmes.

In 1981, PPFA provided contraceptive services to 1.3 million women compared to 1.2 million in 1980. More than 450,000 who turned to PPFA last year were 19 years of age or younger.

National Headquarters Activities. The national office provided guidance, support, and technical assistance to PPFA affiliates in all areas of service delivery. To ensure the highest levels of patient care, the Federation regularly promulgates and updates medical standards and guidelines, and has developed a Patient Care Audit System. Technical assistance on management training, programme planning and population education was also provided.

The Alan Guttmacher Institute (AGI). With offices in New York City and Washington D.C. AGI is an independent corporation for research, policy analysis, and public education in family planning and population, and a special affiliate of PPFA. Among AGI's important undertakings in 1981 were an analysis of the impact of family planning clinic programmes on adolescent pregnancy; a study of the costs and benefits of government expenditures for family planning programmes, research to determine the clinic and community factors affecting the successful delivery of services to adolescents; and a review of how federal block grants to the states in the past failed as a mechanism to deliver family planning and other health and welfare services.

EXPENDITURE SUMMARY - WESTERN HEMISPHERE REGION

1981 ACTUAL

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Anguilla	-	-	-	-	-	-
Antigua	51.0	8.3	59.3	8.0	(7.3)	60.0
Argentina	182.3	12.4	194.7	69.1	(17.1)	246.7
Aruba	8.2	3.2	11.4	64.8	-	76.2
Barbados	91.6	12.6	104.2	344.1	(30.2)	418.1
Bolivia	113.1	4.4	117.5	16.9	(1.5)	132.9
Brazil	2776.6	774.1	3550.7	3217.3	(199.5)	6565.5
Caribbean	80.9	-	80.9	136.4	0.5	218.1
Chile	744.5	250.4	994.9	130.8	170.3	1296.0
Colombia	1937.0	583.2	2520.2	4560.9	(26.9)	7054.2
Costa Rica	339.2	155.1	494.3	273.5	(122.3)	645.5
Curacao	9.7	6.9	16.6	121.1	9.0	146.7
Dominica	25.8	7.4	33.2	0.1	(1.0)	32.3
Dominican Republic	309.6	24.1	333.7	426.5	28.7	788.9
Ecuador	303.3	26.7	330.0	101.0	(60.9)	370.1
El Salvador	415.1	6.0	421.1	1023.6	(2.5)	1442.2
Grenada	66.9	27.9	94.8	57.1	(6.4)	145.5
Guatemala	385.4	26.2	411.6	1337.5	(60.3)	1688.8
Guyana	23.0	8.1	31.1	8.0	(4.2)	34.9
Haiti	-	-	-	-	-	-
Honduras	269.6	15.5	285.1	995.3	(91.3)	1189.1
Jamaica	62.5	15.1	77.6	137.2	(17.4)	197.4
Mexico	1321.3	7.8	1329.1	763.6	(185.1)	1908.9
Montserrat	26.3	7.9	34.2	5.8	0.2	40.2
Nicaragua	222.5	4.8	227.3	299.8	(57.6)	469.5
Panama	132.4	16.1	148.5	63.2	29.8	241.5
Paraguay	383.5	113.0	496.5	128.4	(53.1)	571.8
Peru	229.4	3.4	232.8	12.2	1.2	246.2
Puerto Rico *	15.0	9.6	24.6	525.8	(0.4)	550.0
St. Kitts	36.1	9.3	45.4	4.2	5.1	54.7
St. Lucia	61.8	13.1	74.9	27.4	2.1	104.4
St. Vincent	28.0	2.2	30.2	1.2	3.1	34.5
Surinam	80.6	8.7	89.3	68.7	1.5	159.5
Trinidad & Tobago	191.7	38.0	229.7	343.6	4.3	577.6
Uruguay	162.8	22.8	185.6	65.5	(19.5)	231.6
TOTAL	11086.7	2224.3	13311.0	15338.6	(711.4)	27938.2

* Unaudited
figures

EXPENDITURE SUMMARY - WESTERN HEMISPHERE REGION

1982 LATEST ESTIMATE

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Anguilla	-	-	-	-	-	-
Antigua	48.0	5.3	53.3	9.5	(7.0)	55.8
Argentina	159.7	23.5	183.2	36.2	19.6	239.0
Aruba	6.5	4.9	11.7	60.5	1.4	73.6
Barbados	81.7	23.5	105.2	234.0	3.8	343.0
Bolivia	113.2	19.7	132.9	29.1	8.0	170.0
Brazil	2571.1	837.0	3408.1	2728.5	(94.7)	6041.9
Caribbean	78.5	-	78.5	281.5	-	360.3
Chile	854.4	449.6	1304.0	75.0	(9.5)	1369.5
Colombia	1412.9	535.0	2347.9	4634.7	-	6982.6
Costa Rica	324.2	169.1	493.3	119.6	-	612.9
Curacao	9.7	9.2	18.9	139.5	0.3	159.0
Dominica	22.9	7.1	30.0	-	4.0	34.0
Dominican Republic	317.6	26.8	344.4	734.7	19.0	1098.1
Ecuador	285.1	74.5	359.6	322.2	34.9	716.7
El Salvador	482.2	16.0	498.2	1927.5	-	2425.7
Grenada	56.4	41.2	97.6	72.6	5.8	176.0
Guatemala	403.4	19.1	422.5	983.0	121.2	1526.7
Guyana	23.8	8.0	31.8	0.3	2.1	34.2
Haiti	-	-	-	-	-	-
Honduras	299.7	22.1	321.8	889.9	-	1211.7
Jamaica	43.7	39.7	83.4	140.7	11.4	235.5
Mexico	1256.1	40.9	1297.0	1750.6	(113.9)	2933.7
Montserrat	26.0	1.4	27.4	7.2	4.8	39.4
Nicaragua	188.9	170.5	359.4	227.9	-	587.3
Panama	137.3	9.5	146.8	118.8	11.7	277.3
Paraguay	318.3	62.6	380.9	242.6	33.6	657.1
Peru	233.2	79.4	312.6	45.0	21.8	379.4
Puerto Rico	21.7	4.5	26.2	331.2	15.0	372.4
St. Kitts	37.1	6.1	43.2	16.8	3.4	63.4
St. Lucia	52.4	16.4	68.8	16.3	(2.7)	82.4
St. Vincent	27.3	-	27.3	2.7	-	30.0
Surinam	84.0	15.9	99.9	59.6	(1.9)	157.6
Trinidad & Tobago	188.7	18.0	206.7	290.6	(3.2)	494.1
Uruguay	159.3	28.3	187.6	54.0	(19.3)	222.3
TOTAL	10725.3	2784.8	13510.1	16582.9	69.6	30162.6

EXPENDITURE SUMMARY - WESTERN HEMISPHERE REGION

1983 BUDGET

All figures in US\$'000

	IPPF GRANT			Other Income	Dec. (inc.) of Funds	Total Exp.
	Cash	Comms	Total			
Anguilla	4.5	0.4	4.9	-	-	4.9
Antigua	53.3	2.9	56.2	1.5	-	57.7
Argentina	144.5	11.4	155.9	182.2	-	338.1
Aruba	9.1	3.0	12.1	63.7	-	75.8
Barbados	85.2	11.9	97.1	226.4	-	323.5
Bolivia	123.0	40.8	163.8	39.6	-	203.4
Brazil	2197.0	600.0	2797.0	2729.0	-	5526.0
Caribbean	82.4	-	82.4	109.2	-	191.6
Chile	701.5	424.7	1126.2	104.8	-	1231.0
Colombia	1594.9	521.0	2115.9	4814.0	-	6929.9
Costa Rica	291.4	398.7	690.1	187.0	-	877.1
Curacao	12.0	4.9	16.9	139.8	-	156.7
Dominica	28.3	2.9	31.2	0.8	-	32.0
Dominican Republic	337.9	60.2	398.1	589.1	-	987.2
Ecuador	303.8	101.0	404.8	588.4	-	993.2
El Salvador	485.9	54.5	540.4	2553.2	-	3093.6
Grenada	67.8	23.5	91.3	62.8	-	154.1
Guatemala	439.1	21.1	460.2	1451.2	-	1911.4
Guyana	35.0	33.2	68.2	43.2	-	111.4
Haiti	-	-	-	-	-	-
Honduras	329.4	29.7	359.1	861.0	-	1220.1
Jamaica	60.9	24.0	84.9	136.3	-	221.2
Mexico	1112.5	33.9	1146.4	594.5	-	1740.9
Montserrat	27.2	1.0	28.2	67.4	-	95.6
Nicaragua	245.0	9.8	254.8	396.9	-	651.7
Panama	129.2	1.8	131.0	174.8	-	305.8
Paraguay	337.4	63.1	400.5	342.7	-	743.2
Peru	245.4	98.5	343.9	120.8	-	464.7
Puerto Rico	11.5	25.0	36.5	595.1	-	631.6
St. Kitts	41.0	5.1	46.1	24.3	-	70.4
St. Lucia	60.3	12.6	72.9	34.8	-	107.7
St. Vincent	29.8	-	29.8	-	-	29.8
Surinam	94.0	19.5	113.5	81.0	-	194.5
Trinidad & Tobago	181.0	51.9	232.9	864.8	-	1097.7
Uruguay	157.4	21.8	179.2	37.0	-	216.2
TOTAL	10058.6	2713.8	12772.4	18217.3	-	30989.7

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

WHR

SUPPLIES PURCHASED BY IPPF

	ACTUAL EXPENDITURE 1981	ESTIMATED EXPENDITURE 1982	PROJECTED EXPENDITURE 1983
Contraceptives	1,630.5	1,709.0	1,458.6
Medical & Surgical	42.3	50.5	105.9
Audio Visual Equipment	15.1	32.6	40.0
Office Equipment	29.0	29.3	20.9
Transport	68.6	87.9	76.0
Prior Year Adjustment	(98.6)	—	—
TOTAL	1,686.9	1,909.3	1,701.4

AID SUPPLIES DONATED TO IPPF

Contraceptives	537.4	875.5	1,012.4
FULL TOTAL	2,224.3	2,784.8	2,713.8

CARIBBEAN

CARIBBEAN FAMILY PLANNING AFFILIATION (CFPA)

COUNTRY SITUATION

The CFPA membership comprises 18 FPAs in Anguilla, Antigua, Aruba, British Virgin Islands, Bermuda, Curacao, Dominica, Grenada, Guadeloupe, Guyana, Martinique, Montserrat, St. Kitts-Nevis, St. Lucia, St. Maarten, St. Vincent, Surinam, and the U.S. Virgin Islands. In the context of this membership, the CFPA "country situation" is more appropriately the situation of the Caribbean sub-region.

a. Family Planning/Population policies and Programmes:

In the Caribbean region as a whole, the CFPA is the only regional organization working in family planning. The Health Division of the Caribbean Community (CARICOM) Secretariat has begun emphasizing the case for primary health care and family planning. For the first time, the CARICOM Council of Health Ministers gave special attention to family planning needs at its July 1981 meeting and acknowledged the need to collaborate with the CFPA.

Family planning services are available in all Caribbean countries through the private sector (doctors, drugstores and family planning associations) and some government health services.

Governments in the Caribbean are in the main supportive of family planning programmes. All of the countries have some sort of national family planning programme, in which the government or the private family planning Association, or sometimes both together, manage the delivery of family planning services. Even in Guyana, which espouses a basic pronatalist position, family planning is being integrated into family health services for purposes of child spacing. In fact, government-run programmes in the Caribbean generally integrate family planning into maternal and child health services. Many such programmes have been funded by UNFPA and are likely to receive continued funding from USAID after the cessation of UNFPA funds.

CFPA members have historically been the lead agencies in family planning in their respective countries, working with limited resources and often in not very supportive environments. Even though Caribbean governments have increasingly assumed the responsibility for the provision of family planning services, local family planning associations (FPAs) remain the key agencies for information and education, for taking the initiative in new and sensitive programme areas, and for filling gaps in service delivery. With the recent withdrawal of UNFPA funds from the Caribbean, the function of CFPA members may have to be expanded.

b. Socio-economic conditions.

The Caribbean region represented by the CFPA reflects a variety of demographic situations. There are two mainland countries – Guyana and Surinam – with large land areas and small populations. In addition, there are island countries of varied sizes, population densities, emigration rates and other demographic variables associated with development. As would be expected, these conditions have resulted in different population policies and programmes, ranging from pro-natal to anti-natal, further complicating the emergence of regional strategies in population.

Within the CFPA sub-region, some 98 percent of the land area is in the mainland countries, having about 40 percent of the population of the CFPA area. Surinam has a population density of 3 persons per Km², while Guyana has 4. In contrast, the CFPA islands, with 2 percent of the land area, have about 60 percent of the population. Population densities on the islands range from 101 to 279 persons per Km². Because of their volcanic origins, the islands are generally mountainous, and have limited arable land, which tends to concentrate their populations still further. Thus, in terms of habitable area, they are often among the densest populations on earth.

While the CFPA population is currently growing at about 1.4% per annum, the rate of natural increase has been about 2.4 percent. The difference results from a rather high rate of out-migration. In addition, averages often convey a false picture of the actual growth situation. For example, Surinam's rate of natural increase is 3.5 percent a year, while the average net increase of several islands is under 1 percent.

Three factors suggest that the rate of population growth in the CFPA community may increase in the years ahead. First, there is evidence that the rate of out-migration will continue to fall as opportunities to leave the area become more restricted. Secondly, due in part to a large number of births and lower out-migration rates during the 1950s, the current population is predominantly young: 46 percent are under 15 years of age. This wave of greater numbers coming into child-bearing-age may swell the number of births. And thirdly, at least in Surinam and Guyana, a pro-natalist government policy may encourage more rapid population growth in the years ahead, although both governments acknowledge the need for family planning for maternal and child health reasons.

The interdependence of population and development variables is much in evidence. High dependency ratios generate continued pressure on housing, child care, health, and education services. Rapid urbanization is causing the usual problems relating to housing, sanitation, transportation, social welfare and the environment. Employment generation, income distribution, social security savings and investment are affected by various aspects of demographic change. Unemployment is estimated in some areas at 25 percent. Both the external and internal migration trends are having a notable effect on development. The combination of these factors points to the continued need to balance population and development capacity.

CFPA member countries represent some of the poorest in the Western Hemisphere. The per capita GNP of the English-speaking countries, excluding the U.S. Virgin Islands, ranges from \$410 to \$1,070. The U.S. Virgin Islands have a GNP per capita of \$5,580. The Netherland Antilles (Aruba and Curacao) have a GNP per capita of \$3,540, Surinam has \$2,360, and the French Departments (Martinique and Guadeloupe) have an average of \$3,900. Several of the Eastern Caribbean countries have single-crop economies entirely dependent on prices obtained in external markets. Poverty and endemic unemployment remain the common characteristics of most of these countries.

THE ROLE OF THE ASSOCIATION

The principal role of the CFPA is to represent the collective interest and help meet the collective needs of its members.

The representative function of the CFPA within the IPPF is carried out by two elected representatives to the WHR Regional Council. At present 2 members of the WHR Board of Directors are also from CFPA countries.

In addition, the CFPA provides a forum for the FPAs to share ideas and experiences, consolidate their needs, and, where appropriate, develop programmes on a regional basis. It also unites the FPAs into a single body before the international donor community.

The Constitution of the CFPA details the objectives of the Affiliation as follows:

- (a) the encouragement of family planning and responsible parenthood in the Caribbean area;
- (b) the strengthening of member organisations;
- (c) representing member organisations on appropriate international organisations;
- (d) providing technical assistance to member organisations;
- (e) developing and implementing programmes in responsible parenthood, family planning and related areas on its own and in collaboration with other organisations;
- (f) conducting and stimulating research into human fertility and its consequences and publicising the findings of such research;
- (g) securing funding for its own and its member organisations' programmes;
- (h) implementing such local, sub-regional and regional activities as will further the above objectives.

The CFPA cannot easily be compared to any single FPA in the region. Its role is collectively determined by the member associations.

The CFPA's representational role is its *raison d'être*. Beyond this, however, lies considerable potential for resource development, as demonstrated by the USAID Grant for the CFPA. Given the financial limitations facing the IPPF, the future growth and development of Caribbean FPAs (like all FPAs in the WHR) must depend increasingly on their ability to attract support from non-IPPF sources. The CFPA serves as a powerful instrument to advance the interests of its members by helping to develop multi-FPA projects in the Caribbean and finding donors willing to support them.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

In 1981, the CFPA Secretariat established its Operational Systems and, for the most part, effectively implemented its planned WP/B. There were difficulties in the print and audio-visual production areas but the Secretariat was able to respond to most requests for commodities, technical assistance, I & E materials and exchange of personnel. The CFPA also provided financial support to several new projects in Guyana, Grenada, St. Lucia, St. Kitts-Nevis and Antigua. The following excerpt from the 1981 Annual Report gives a useful summary:

“Any retrospective view of the CFPA must, of necessity, include an assessment that 1981 was a year of decision, a turning point in the history and the direction of the regional organisation.

Apart from introducing a new constitution last June, opening its headquarters in Antigua and expanding its membership to 16 by the addition of Anguilla, the Affiliation took some significant strides forward during the year.

By the end of 1981, the CFPA, operating in a region which experienced a decline in its economic well-being and was buffeted by strong headwinds created by international economic recessionary conditions, had emerged as one of the largest assistance agencies for the implementation of population related programmes in the Caribbean. It contributed more than EC\$250,000 (approximately US\$100,000) in technical assistance, small grants, equipment and commodities to affiliated national associations. Few agencies operating in the Caribbean provided more help to family planning and population programmes during the year. By providing such assistance, the CFPA reinforced the basis for its existence, not merely on a need for regional cooperation at a time of growing nationalism, but by being able to extend a helping hand to affiliates when the need was the greatest.

That “coming of age” was not accomplished on the strength of the CFPA's resources alone. Rather, it reflected a prudent and effective use of the financial assistance made available to the organisation.

A three-year grant from USAID is being used to implement an information and education (I & E) programme.

Studies have suggested that most people – more than 90 percent of the population – in St. Kitts-Nevis, Antigua, St. Lucia, Grenada and Dominica, have become aware of family planning methods and delivery systems. However, they appear, to be reluctant to put them into practice. CFPA is therefore using the funds of the grant to help motivate them to act on the information they already have. CFPA has developed a media mix – publications, radio drama, radio magazine, audio-visual production systems and public information activities – and the results are expected to be significant. Already, the CFPA publications, the Bulletin and Open File, have made their appearance throughout the Caribbean. Three issues of the CFPA Bulletin were distributed in 1981 and four of Open File reached readers.

Production of the Caribbean radio drama series is nearing completion and the series plus the CFPA radio magazine will be aired on Caribbean radio stations in 1982.

Apart from these activities, CFPA's programme of action spanned a range of regional, national and neighbourhood efforts, using a variety of techniques to increase the public's awareness of family planning issues and methods as well as to encourage action on the part of individuals.

Of particular significance was the approach to the problem of adolescent fertility. Early childbearing has emerged as a serious problem in the Caribbean.

CFPA felt that in order to deal more effectively with the alarming levels of teenage pregnancy, it must first pinpoint its causes. Thus, two research studies, the first carried out in Grenada and the second in Dominica, were commissioned by the CFPA and IPPF. They were completed towards the end of 1981 and the basic finding was that the levels of teenage pregnancy were attributable to a lack of knowledge of the precise relationship between sex and pregnancy. In short, ignorance of the body and the way it works. The findings and a set of recommendations have been distributed to FPAs around the Caribbean and should prove to be an invaluable tool in programme development efforts.

Communication and the utilisation of the systems of mass communication constituted another area which received special attention by the CFPA. Communication, the carrier of social process, is vital to the promotion of family planning as a basic right, a fact reflected in our information and education projects. So, in addition to providing FPAs with audio-visual equipment and the expertise of media specialists, the CFPA organised a regional communications strategy planning workshop last October. The five-day workshop, attended by representatives of 14 CFPA associations and two from Trinidad and Tobago and Barbados, focused on communications theory, programme development and strategy formulation.

The Information and Education officers, taking part in what was essentially a short training course in communications practice, were each provided with a manual for use on their return home.

The CFPA Executive Committee approved small grants to six national associations to help finance specific projects, totaling US\$17,425. Guyana received the largest sum, US\$7,500 for a primary health care scheme in a rural village. Surinam, Grenada, St. Thomas (U.S. Virgin Islands). Curacao and St. Kitts-Nevis all received financial help.

Training, Family Counselling:

The CFPA organised three national workshops in St. Lucia, Dominica and Antigua. The focus was on communication and counselling skills in family planning and family life education. The three workshops were attended by nearly 100 people drawn from various agencies in the respective countries including the Ministries of Education, Health and Community Development, the family planning associations and youth organisations.

The Regional Committee on Family Life and Sex Education for Latin America and the Caribbean (CRESALC), the CFPA and the Antigua Government worked together in organising a Regional workshop on Family Life Education. Thirteen countries and twelve regional and international agencies were represented.

Project Advisory Committee:

Established to provide the CFPA with an independent programme review mechanism, the advisory committee held its first meeting in May 1981. The organisations represented on the Committee included the Caricom Secretariat, the Pan American Health Organisation, the University of the West Indies, the University of Guyana, the Development Agency of the Caribbean Conference of Churches (CADEC), the University of Surinam and the United Nations Fund for Population Activities.

In addition to advising on programmes and future plans, the advisory committee extends the link the Affiliation has established with important regional and national institutions.

Technical Assistance and Technical Cooperation:

The following represents a sampling of the requests for help from FPAs which received prompt and positive attention from the CFPA.

In Grenada, a consultant spent nearly two weeks in St. George's assisting the FPA in the lay-out and editing of its youth magazine. He also assisted the association by giving advice on radio production, newspaper advertising and the designing of leaflets on condoms and foaming tablets for the Community Based Distribution (CBD) Programme.

In Dominica, a consultant's research work on adolescent fertility was combined with an evaluation of the FPA's programme. The St. Kitts-Nevis CBD Coordinator went to Grenada on a familiarisation trip organised by CFPA.

Other examples of technical assistance:

Printing of promotion material for a public awareness campaign in Grenada.

A familiarisation trip to Barbados for the newly appointed Executive Director of the Dominica FPA, who reviewed the Association's programme of activities and organisational structure.

An exchange of information for Surinam by the Director of Information and Education of the Guyana FPA."

The CFPA's 1982 Work Programme is being implemented as planned. The new Secretariat is now firmly established in Antigua and the CFPA programme is being conducted with a large measure of efficiency. Some staff changes have taken place without unduly affecting programme implementation.

The basic programme activities for 1982 are essentially a continuation of the 1981 programme areas with a major emphasis on production of a wide range of audio-visual materials for use by member FPAs.

Approximately 100,000 pieces of print materials were produced, three (3) video productions were done, 100 fieldworker kits were assembled, and 25,000 family planning shopping bags have been distributed.

Member FPAs continue to benefit from technical assistance and technical cooperation visits coordinated by the CFPA.

It is clear that in 1982 the CFPA has begun a consolidation of its services in the Caribbean and is establishing itself as a major development agency in the region.

Management Capacity

The CFPA has now consolidated its administrative arrangements. The President is now provided with support services in Anguilla, with the new CFPA Secretariat established in Antigua for implementation of the USAID grant and other CFPA activities. Volunteers take an active role in monitoring the CFPA programme.

The quality and operation of the CFPA's management system in the past have been inadequate, but with the newly re-organized and revitalized CFPA, considerable managerial improvement is evident.

1983 WORK PROGRAMME/BUDGET

The core projects of the proposed CFPA 1983 Work Programme Budget are funded by USAID, through IPPF.

The proposed projects are as follows:

CFPA Regional Information and Education Programme

This project consists of a series of sub-projects as follows:

CFPA Publications

The following activities are envisaged: the publication and distribution of a CFPA newsletter which will allow CFPA members to share information about their respective activities and be informed about the ongoing work of CFPA and other family life education and population-related programmes; the publication of a series of newspaper articles on family planning, population and development, for use by regional print media.

CFPA Radio Productions

This project will involve the production and broadcast of sixteen weekly regional magazine radio programmes as a pilot effort to draw regional attention to population-related issues in the Caribbean.

CFPA Audio-Visual Materials Production System

This project will facilitate the production of a range of audio-visual materials at the specific requests of individual FPAs. In addition, the system will make available to FPAs pre-packaged slide/sound sets on family planning for use by field staff, plus similar video-cassette materials.

Communication, Family Planning Life Education

This project involves the sponsorship of in-country workshops for field staff and other in communication, family planning, family life education and primary health care. Each FPA will have the opportunity of having its staff trained on-site in these areas.

CFPA Technical Assistance Common Services

This project will allow CFPA members to draw on funds and a resource pool for technical assistance in such areas as Evaluation, Management, Medical/Clinical, Training, and Information and Education.

CFPA Technical Cooperation Project

This will enable FPA personnel to visit other FPAs and share experiences or learn from each other, particularly with respect to pilot projects.

CFPA Pilot Programme

This will enable the CFPA, in collaboration with member FPAs, to implement small pilot demonstration projects reflecting the priority Action Areas of the 1982-1984 IPPF Three Year Plan particularly with reference to meeting the needs of young people, increasing commitment to population as a crucial factor in development, and emphasizing male responsibility and the role of the voluntary sector.

ALTERNATIVE FUNDING

In 1980, the CFPA, in collaboration with IPPF successfully negotiated with USAID/ Barbados, for an Operational Program Grant (OPG) of approximately US\$1 million over three years. The IPPF support of the CFPA supplements this grant and, from USAID's view, is seen as necessary counterpart funding to the CFPA. Although the CFPA has been able to obtain funding from AID for approximately 70% of the Association's WP/B, it is also important that IPPF retain a funding input in the CFPA so as to facilitate an appropriate relationship between CFPA's interests, the interests of the individual member Associations, and AID's development and political interests in the Caribbean.

CONCLUSION

In mid-1982 the USAID Mission in Barbados requested an independent mid-term evaluation of the CFPA. The evaluation concluded that the implementation of the CFPA/USAID Project is on target, and that the CFPA Secretariat has established adequate operational systems for the various project components.

The evaluation noted that the CFPA and its member associations have a very important role to play in the I & E field – in both the private and public sectors, and the services and activities contained in the USAID-funded project will enable them to make a significant contribution to family planning in the Caribbean.

GUATEMALA

ASOCIACION PRO-BIENESTAR DE LA FAMILIA DE GUATEMALA (APROFAM)

COUNTRY SITUATION

a. Political Situation

During 1981 and early 1982, Guatemala was plagued by increasing violence perpetrated by both the left and the right, as well as marked corruption on the part of the government. The socio-political atmosphere led to tremendous insecurity throughout the country, especially in rural areas, and contributed to an increasingly difficult economic climate epitomized by the flight of capital to other countries, growing inflation, and a considerable increase in the cost of living. Elections were held in March, 1982, with the government candidate declared the winner. Amid widespread charges of fraud, a group of young officers conducted a coup in late March, and a new military junta took office, pledging to stop the violence and corruption so rampant under the previous regime. The Constitution is suspended, and the country's rule is based on Law Decrees issued by the President (currently General Efraín Ríos Montt) in consultation with his Ministers. Congress plays no role in this. Elections have been postponed until 1985. The President appoints the governors of Guatemala's 22 departments.

At the present time, the government appears to have made some inroads in decreasing the levels of violence (especially in Guatemala City and environs) and in bringing technically qualified people into the government. It remains to be seen whether these improvements will be permanent. In the meantime, President Ríos Montt is trying to revamp the country's political system by creating a middle ground between the authoritarian military groups and the democratic movements that have alternately dominated the country's politics over the last three decades. Ríos has declared a nationwide state of war, a get-tough solution intended to appease the military and retain its support.

Traditional politicians are barred from political action, but are allowed to participate in a council of state as advisers to the executive. Party politics are postponed for two years, an interval designed to break up the old-line parties and establish new power blocks that better represent the populace. The council of state includes representatives of all political and economic facets of Guatemalan society. Ríos's other strength is evenhanded negotiation of guerrilla demands, but rejection of their Marxist ideology.

The new government shows favorable attitudes toward population and family planning. For example, the new Minister of Health has requested assistance with training in voluntary sterilization.

b. Geographical Situation

Guatemala's 22 departments can be characterized as falling into six geographical areas:
(1) The Western/Central highlands with high population density (169 person per Km²)

composed primarily of Indian groups depending on subsistence farming; with 26% of Guatemala's area, the highlands have 60% of its population; (2) the Southern coast, with a tropical climate and plantation agriculture for export – primarily coffee, cotton and sugar, all worked by migrant labor; (3) the metropolitan area of Guatemala City and its surroundings; 70% of Guatemala's industry is located here; (4) the Eastern arid area with a largely non-Indian population, and commercial agriculture as the predominant source of income; (5) the Atlantic coast area, with commercial activity centered in Puerto Barrios; and (6) the jungle area of the Peten which, though it occupies approximately a third of Guatemala's area, has less than one per cent of its population.

c. Cultural Situation

Guatemala's population is composed of two ethnic groups that are economically, culturally and linguistically distinct. The indigenous people (or Indians) account for about 44% of the population. They are descendents of the ancient Maya who have not adopted Western practices and values. Most live in the Western and Central Highlands. They speak one of the 22 indigenous languages of the sub-groups of Mam, Quiche, Cakchiquel, and Kekchi, although some men (and to a lesser extent women) are conversant in Spanish. Their main source of income is from agriculture, either as day labourers or subsistence farmers, with some supplementing their farm income by migrant labour and producing and marketing handicrafts. No formal class structure exists within the Indian community, although gradations of wealth exist. Social rank is a product of age and prestige, the latter often acquired through contributions of both time and money to the *cofradia* (religious brotherhood) system, or from performing a valued community role such as a shaman or midwife.

The second group is the "ladinos" (approximately 56% of the population), those who adopt Western life styles or have European ancestry. Spanish is either their first or their principal language although they may, in some cases, continue to speak an Indian language. Ladinos possess cultural norms and values distinct from the Indians: the nuclear family as opposed to the extended family as the basic social unit; a class consciousness and quest for upward mobility; determination of social status on the basis of acquired wealth; a secular brand of Roman Catholicism in which overt practice of religion is more expected of women than of men, and an ideology which emphasizes the welfare of the individual over that of the group.

Ladinos tend to participate in political activities while traditionally the Indian population has been apolitical, making a political stand only when land ownership was imperilled. However, as better information becomes available to Indian communities and consciousness is awakened, Indians are becoming more politically active.

There are also some blacks and people of Chinese ancestry in Guatemala.

d. Economic Situation

Guatemala's once robust economy is suffering the effects of domestic and regional political troubles. Indicators point to depressed growth, rising unemployment and a deteriorating balance of payments position. The gross domestic product in Guatemala was estimated to have grown by 3.3% in 1980, but only 1.502% in 1981. Projections are for even less in 1982. The scant advance is due primarily to lack of investment because of the increased capital flight, credit scarcity, a drop in tourist revenue, and the poor political climate. Languishing production of Guatemala's two primary exports – coffee and cotton – due largely to lower international prices and local guerrilla activity, resulted in a 22% fall off in 1981 exports earnings. Inflation continues to grow. In 1980 it was 10.7%; in 1981 it was between 11 and 15%; and in 1982 it is estimated to be about 20%.

e. Demographic Situation

Guatemala has a population estimated at 7,704,000. About 44% of the population is under age 15, leading to a dependency ratio of 88.5. The population is primarily rural (61.1%).

Guatemala's population has increased rapidly over the last century-and-a-half, with projections that it will double in the next 24 years. The chart below gives an idea of the tremendous increase registered between 1825 and 1982, with projections to the year 2000.

ESTIMATED POPULATION OF GUATEMALA BETWEEN 1825 AND 1982

(WITH PROJECTIONS TO THE YEAR 2000)

1825	1850	1900	1950	1982	2000
500,000	850,000	1,425,000	2,890,000	7,704,000	14,000,000

These population figures reflect a high population growth rate in Guatemala over recent years, as shown below.

% POPULATION GROWTH RATE IN GUATEMALA BETWEEN 1950

AND THE PRESENT, WITH PROJECTIONS TO THE YEAR 2000

1950-55	1955-60	1960-65	1965-70	1970-75	1975-80	1980-85	1985-90	1990-95	1995-2000
2.89	2.94	3.04	2.96	3.08	3.03	2.92	2.82	2.76	2.74

While the population growth rate is expected to decrease somewhat in the future, it will do so very slowly, because of the young age of the population.

Abortion is illegal in Guatemala. Nonetheless, Guatemala has a high rate of induced abortions. From 1965 to 1972, one patient was hospitalized for complications following an induced abortion for every six obstetric deliveries. Incomplete abortions account for 50% of the maternal deaths in Guatemala. The maternal mortality rate is currently 2.2 per 1000.

Rural to urban migration is causing a major population shift in Guatemala, with an estimated 35% of the population considered urban in 1975 and 40% in 1980. At these rates, it will reach 51% in 2000. With the rural violence, this movement has probably intensified in the 1980-82 period. Seasonal migration among agricultural workers and their families is also a long-established pattern in Guatemala.

Overall population density in Guatemala is 59.7 inhabitants per Km², or 142.9 inhabitants per Km² of arable land. Population density is estimated to be increasing at a rate of 1.7 persons per Km² per year.

f. Social Situation

The literacy rate of Guatemala has improved significantly over the past thirty years – from 28.1% in 1950 to 45.4% in 1973 and 47% at present. These figures are quite different, however, for the different population groups. Only about 32% of indigenous males and 13 per cent of indigenous females are literate. According to the 1973 census, only 48% of the population aged seven to fourteen years attended school, despite the fact that attendance is obligatory at these ages. In rural areas, only 35 per cent of the children this age had the chance to attend. This is primarily because of insufficient classroom space. Just to maintain these percentages would require more than doubling the number of both elementary and secondary school teachers if the population growth rate were to remain stable until 2000.

Infant mortality is estimated to be 70.2 per 1000, though under-reporting of infant deaths is believed to be substantial. Children under the age of five account for half of the deaths registered in Guatemala. Differential rates exist for urban and rural areas, with rates for the latter estimated to be as high as 160 per thousand live births. There is a high correlation between large family size and the prevalence of infectious disease and malnutrition, which contribute to the infant mortality rates.

Malnutrition is one of the most serious problems in Guatemala. A total of 81.4 per cent of the population under five years of age is malnourished. There is an acute need for greater food production to eliminate the existing deficit and to provide the minimum nutritional requirements. The cultivation of new land does not represent a viable solution, since the best land is already being cultivated, and estimates are that by the end of this century the available land will be used. More intensive use of the land through improved technology is also impractical for most of Guatemala since it does not lend itself to the small-scale farming on which a large proportion of the Guatemalan population depends.

To date, the delivery of health services has been dominated by male Ladino physicians, with whom Indian women are reluctant to discuss family planning matters. Indigenous

females are socialized to extreme modesty from an early age and resist gynaecological examinations.

At the end of 1975, it was estimated that Guatemala had a considerable housing deficit. The February 1976 earthquake destroyed over 200,000 housing units, which increased the housing deficit to almost 900,000 dwellings. Taking into consideration the current rate of construction, as well as the current rate of population growth, it is estimated that the housing deficit will have increased to almost two million dwellings within twenty-five years.

Unemployment and underemployment rates are very high in Guatemala, and with the increasingly difficult politico-economic problems, they can be expected to worsen in the near future. Between 1966 and 1977, Guatemala's labor force grew at an average annual rate of 2.8%. Employment in agriculture, the sector which employs 57 per cent of the labour force, has been growing at only 0.3 percent per annum.

FAMILY PLANNING/POPULATION POLICIES AND PROGRAMS

Despite the political difficulties mentioned above and the lack of an official policy on population and/or family planning, several government and private agencies have continued to conduct family planning programmes and/or support them. The Ministry of Public Health offers family planning to those who request it, and is slowly taking over the logistical support project heretofore carried out by the FPA. The Ministry of Education has collaborated with APROFAM in its Adolescent Center and other youth programmes, and has accepted the IPPF/WHR sex education manual for use in its national sex education programme. Professional, business and rural community groups have all cooperated with the FPA, though the political situation has inhibited some activities during the past year. Among those offering special support to the FPA are: the National Cooperative Institute, the Guatemalan Literacy Movement (MOGAL), the Guatemala City Municipality, and the Cotton and Coffee Growers Federations.

History of Family Planning Activities

The IPPF affiliate, the Association Pro-Bienestar de la Familia (APROFAM), initiated activities in January 1965 by opening a clinic in Guatemala City. Several stages of programme development followed. The first stage, beginning in 1965 and lasting about two years, consisted of ascertaining acceptability of family planning clinics and providing services at various locations in the capital. The second stage began in 1967 by expanding services to other urban areas outside the capital, with the intention of creating an interest and awareness among government officials of the need for family planning. An agreement was reached with the Ministry of Public Health stipulating that APROFAM would take the responsibility for providing family planning services in 20 government health centres outside Guatemala City. Based on the positive experience of this two year trial period, the Ministry decided to initiate an official family planning programme which marks the beginning of stage three.

The third stage, beginning in 1969, corresponds to the Ministry of Public Health's creation of the Division of Maternal, Infant and Family Health, and the Department of Child Protection and Family Orientation within this division, to be responsible for family planning programmes for the general public. Again, agreement was reached in 1970 with APROFAM to develop a national family planning programme. According to the agreement, APROFAM would provide services in Guatemala City while the Ministry of Public Health would take responsibility for areas outside the capital. To avoid duplication of efforts in information and education, a joint Office of Information was established between the two institutions.

The Ministry underwent several administrative reorganizations which prevented expansion of coverage for family planning programmes. Furthermore, serious problems arose in adequately supplying these health centres. Consequently, as of 1976, APROFAM was given two new responsibilities: direct distribution of contraceptive supplies to Ministry of Public Health centres throughout the country, and complete responsibility for information, education and communications programmes at the national level.

Starting in 1970, the Ministry hired auxiliary nurses assigned to rural health posts. They received training from APROFAM in family planning, as did almost all clinic personnel. The Ministry of Public Health's implementation of the family planning programme in rural clinics proceeded more slowly than had been anticipated.

All seemed to be going well until June 1979 when the Minister of Public Health directed all Ministry clinics not to engage in family planning activities. Through pressure from friends of family planning (including APROFAM's staff and volunteers), family planning service delivery was soon re-authorized in all health clinics where a physician was present. The Minister's reconsideration of his decision was reinforced by the reactions of his own medical directors in the field who had been forced to deal with large numbers of rural people insisting that clinics continue to provide family planning services, and by protests from large plantation owners, peasant organizations, the Chamber of Commerce, women's groups, newspaper reporters and others who appealed directly to the President. Most of these people were mobilized through APROFAM's efforts.

The fourth and current phase of APROFAM's programmes began in June, 1976 with the initiation of a direct distribution programme in charge of distributing adequate contraceptive supplies and education materials to all health centres. When started, only 125 of the 580 health centres offered family planning services and supplies. By 1978-79, virtually all the centres were covered. With the coverage of health centres estimated to be 83% at the end of 1979, APROFAM acquired a new role of informing and educating the rural population so that these people could make informed decisions about family planning. Since that time, APROFAM has initiated a number of innovative programmes to reach the marginal populations in both rural and urban areas, including community-based distribution (CBD) which began in 1975, an adolescent centre in Guatemala City (El Camino), the use of radio spots in Spanish and Indian languages, integrated health, nutrition, and family planning programmes utilizing Indian promoters in indigenous areas.

The Contraceptive Prevalence Survey conducted in 1978 in Guatemala showed a low contraceptive usage rate of less than 4% for the rural indigenous groups, as compared to approximately 20% for the non-indigenous rural population. In Guatemala City, 41% of potential users are contracepting. A new CPS is planned for late 1982. Guatemala currently has an estimated crude birth rate of 38.4 and a 2.9% annual rate of natural increase. The total fertility rate at present is 5.7.

Opposition to family planning has been centred at the University of San Carlos in Guatemala City. The Faculties of Medicine and Economics have been foci of opposition over the years, on the basis that it is imposed on people by outside interests and that it is a substitute for more sweeping social and economic reforms such as distribution of land and income to the needy. The Roman Catholic Church of Guatemala is conservative, but has not recently made many specific protests against family planning. The Protestant religion espoused by Gen. Rios Montt is rapidly gaining converts in Guatemala, with most following fundamentalist beliefs. They have not opposed family planning.

THE ROLE OF THE ASSOCIATION

APROFAM's three year plan defines its role as follows:

- a. To maintain its image as a public service institution dedicated to family planning and responsible parenthood with the ability to increase commitment to population as a crucial factor in development;
- b. To influence national decision-makers to define and implement a population policy; and
- c. To support family planning programmes in collaboration with both public and private organizations.

From its modest beginnings in 1965 when APROFAM registered 1,700 acceptors, the Association has had considerable impact on the usage of family planning in Guatemala. From 1975 to 1981, APROFAM registered 70,068 new acceptors in its clinic programme, 68,318 in its CBD program, carried out 32,191 female and 5,491 male sterilizations, and registered by 1981 420,607 total acceptors in its programmes.

PROGRAMME PERFORMANCE AND MANAGEMENT CAPACITY

Programme Performance

In 1981 the FPA continued to be regional leader in family planning. It recorded the highest number of male sterilizations in Latin America, and succeeded in reaching a sizeable number of acceptors through its efficient clinical and CBD programmes, as well as through recruiting and training private doctors. The FPA is pioneering youth programmes, training, and evaluation techniques as well as showing the way for reaching indigenous groups with special I & E materials and programmes in their own languages. The FPA has also been most successful in obtaining considerable assistance for a variety of programmes from individuals and institutions, with professional time, monetary, and in-kind contributions. In 1981, 76% of the FPA's income was from non-IPPF sources; 10% of its income was from local sources.

In 1982, APROFAM continues the same types of programmes, with special emphasis in its efficient clinical programmes, cost-effective CBD projects, and on reaching specific target groups such as adolescents and indigenous groups. Strong support is provided by the I & E campaigns, and the training and evaluation units. The technical assistance and logistical support project is slowly being turned over to the Ministry of Public Health. The FPA is exploring the possibility of initiating a commercial distribution programme.

Management Capacity

The FPA has a strong group of volunteers who represent a variety of professions and effectively establish policies for the staff to carry out. The violence in the country has affected the FPA's abilities to carry out the decentralization plan and, as a result, the FPA is now exploring new ways to supervise programmes outside Guatemala City more effectively.

The FPA has a highly qualified, adequately trained and dedicated group of project directors who have had more than satisfactory results in increasing international donor support because of the quality of their projects. The FPA is considering automation of budgets, reporting, and service statistics analysis. The interchange of information between programme and accounting continues to improve.

PROPOSED 1983 WORK PROGRAMME/BUDGET

Information and Education: Within this category there will be 5 projects:

- a. The Communications Campaign will utilize radio, press, posters, pamphlets, a mail campaign aimed at 1500 opinion leaders in the interior of the country, and a telephone "hotline" in Guatemala City; the campaign aims at reaching indigenous people (in 3 different languages), adolescents, and the CBD target population. This project is funded by the USAID Mission in Guatemala.
- b. The Family Life Education Project will offer educational activities for organized groups throughout the country (industry, parents, professionals, students), and will reach approximately 28,000 people with information about responsible parenthood, family life, and family planning;
- c. The Youth Education Programme will train about 1400 youth multipliers in 10 Departments (states) of Guatemala to conduct courses, seminars, and other educational activities for approximately 8,200 people;
- d. Family Planning Promotion in the Highlands. 5 indigenous couples will work in 5 municipalities of the Quiche and Cackchiquel-speaking areas; via home visits, interviews, and work with local authorities, they will promote primary health care and family planning. This project is funded by USAID/Guatemala;
- e. The Documentation Center will continue to offer library and AV services to professionals and students from its facility in Guatemala City; periodically it will publish a bibliographic bulletin.

Medical/Clinical

- a. 4 clinics will offer basic family planning services to 15,000 new and 60,000 follow-up acceptors during 1983; the clinics will also serve as back-up and re-supply points for all FPA programmes, but especially for the urban CBD programme; the clinics also offer training for medical and paramedical personnel, including medical students; costs are to be financed by IPPF and clinic income from patient fees;
- b. 10,000 male and female sterilizations are projected via the voluntary sterilization programme in 20 strategically-located areas of the country, including the FPA's clinics as well as mobile units which travel to selected areas to cover the demand for these procedures; 25 doctors and nurses will be trained in sterilization techniques; IPAVS supports this project;
- c. More than 400 private physicians will continue to distribute FPA-provided contraceptives at low cost to their patients; 100 doctors will be trained in IUD insertion, and 50 will be trained in male and female sterilization techniques; Pathfinder funds this project;
- d. The "El Camino" Adolescent Center in Guatemala City will continue to offer integrated health, family planning, psychological, social, as well as job training and recreational services to adolescents aged 11 to 19; the Center aims at preventing unwanted adolescent pregnancy, venereal disease, and at providing complementary services to the target population; this project is also funded by the Pathfinder Fund, with a considerable additional input of donated professional services and in-kind contributions.

Community-Based Distribution

APROFAM will have 800 distribution posts offering family planning methods to 18,000 new acceptors during 1983. The projects include:

- a. The Metropolitan programme in the slum area of Guatemala City and rural environs, funded by USAID/Guatemala.
- b. The FECOAR projects (in collaboration with the Federation of Regional Agricultural Cooperatives) which works in 6 Departments (states), with a primarily indigenous population; this is also funded by USAID/Guatemala;
- c. The Campesino Leagues project, in two Departments with a large migrant labor population (both indigenous and ladino), also funded by USAID/Guatemala; this project will absorb some of the CBD posts from the sugar growers' programme;
- d. The Coffee Growers project in Santa Rosa Department, funded through 1982 by FPIA, with the majority of 1983 funding expected from the Coffee Growers themselves;
- e. The Chiquimulja project in collaboration with a cooperative in Chiquimula Department, with funding from USAID/Guatemala;

- f. The Tactic project in Alta Verapaz Department, 95% indigenous, with funding from World Neighbors;
- g. The Mother's Clubs project in 8 Departments and the capital, wherein women form clubs to promote family planning and also develop money-saving and money-earning projects such as baking, masonry, etc.; this project is also funded by USAID/Guatemala.

Training

APROFAM's Training Unit will continue to offer regular courses, seminars and workshops for final year medical students, fieldworkers, medical and paramedical personnel, CBD staff and distributors of the FPA and other development agencies (both Guatemalan and from other countries). Emphasis will be on training trainers, supervisors, and other in sex education, family planning, training and participatory techniques. Funding will be provided by Development Associates, USAID/Guatemala, and IPPF.

Evaluation

The FPA's Evaluation Unit will continue to motivate leaders (government and private) to: (i) collaborate as volunteers with family planning programs; (ii) assist in establishing a national population policy in Guatemala; and (iii) obtain cash and in-kind contributions.

ALTERNATE FUNDING

APROFAM has demonstrated success in obtaining funds from a wide variety of international donors, including USAID/Guatemala, IPAVS, FPIA, Development Associates, Pathfinder Fund, and World Neighbors. Since 1978, more than 75% of APROFAM's income has been generated from non-IPPF sources – 68.3% from other international sources, and 7.9% from Guatemalan sources.

CONCLUSION

Guatemala is a high priority country faced with a difficult socio-politico-economic situation. Despite the violence and other problems within the country, the FPA has been able to carry out most of its programs with success. The proposed programme is an extension of projects that the Association has successfully implemented in past years. The IPPF grant, by supplementing non-IPPF project grants, will support I & E activities, Clinical Services, the Training Unit, Evaluation and Research activities, and Administration.

APROFAM's 1983 programme, with its emphasis on reaching rural groups, youth, women and men with integrated programs, voluntary sterilization, and community-based distribution, is fully consistent with IPPF plans and policies.

APROFAM's Training Unit has been assisting other FPAs in the Region with training programmes. Its Evaluation Unit has been a leader in developing new evaluation strategies for Central America which may later be applied elsewhere. Its CBD and adolescent programmes may also serve as useful models for similar projects in other Latin American countries.

MEMBER ASSOCIATIONS OF IPPF

COUNTRY	ASSOCIATION	REGION
Afghanistan	Afghan Family Guidance Association, PO Box 545, Kabul.	M.E.N.A.
Argentina	Asociacion Argentina de Proteccion Familiar (AAPF), Aguero 1568 – (1425), Buenos Aires.	W.H.
Australia	The Australian Federation of Family Planning Associations, 70 George Street, Sydney, NSW 2000.	E.S.E.A.O.
Austria	Osterreichische Gesellschaft fur Familienplanung, Universitatsfrauenklinik 11, Spitalgasse 23, A-1090 Wien.	EUROPE
Bahrain	Bahrain Family Planning Association, PO Box 20326, Manama.	M.E.N.A.
Bangladesh	Family Planning Association of Bangladesh, 2 Naya Paltan, Dacca-2.	I.O.
Barbados	Barbados Family Planning Association (BFPA), Bay Street, Bridgetown.	W.H.
Belgium	Federation Belge pour le Planning Familial et l'Education Sexuelle, 51 rue du Trone, 1050 Bruxelles.	EUROPE

COUNTRY	ASSOCIATION	REGION
Benin, People's Republic of	Comite 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 380, Hamilton.	W.H.
Bolivia	Centro de Orientacion Familiar (COF), Edificio Guadalquivir, Oficina No. 106, Primer Piso, Mezzanine, Avenida 20 de Octubre, esq. Rosendo Gutierrez, Casilla Expresa 7522, La Paz.	W.H.
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 Estacao do Riachuelo, Rio de Janeiro RJ.	W.H.
Bulgaria	Family Development Council of Bulgaria, Institute of Obstetrics and Gynecology, Medical Academy, Sdrave 2, Sofia 1341.	EUROPE
Canada	Planned Parenthood Federation of Canada (PPFC), 151 Slater Street, Suite 200, Ottawa, Ont. K1P 5H3.	W.H.

COUNTRY	ASSOCIATION	REGION
Caribbean	Caribbean Family Planning Affiliation. PO Box 419, St. Mary's Street, St. John's, Antigua.	W.H.
Chile	Asociacion Chilena de Proteccion de la Familia, Casilla 16504, Correo 9 – Providencia, Santiago de Chile.	W.H.
China, People's Republic of	China Family Planning Association, Xi Zhi Men, 2 Nan Shun Cheng, Beijing.	
Colombia	Asociacion Pro-Bienestar de la Familia Colombiana (PROFAMILIA), Calle 34, No. 14–52, Bogota.	W.H.
Costa Rica	Asociacion Demografica Costarricense, Apartado Postal No. 10203, Calles 18 y 20, Avenida Central, Casa No. 1811, San Jose.	W.H.
Cuba	Sociedad Cientifica Cubana para el Desarrollo de la Familia (SOCUDEF), Calle 4 No. 407 (entre 17 y 19), Vedado, La Habana.	W.H.
Cyprus	Family Planning Association of Cyprus, 25 Bouboulinas Street, Nicosia.	M.E.N.A.
Denmark	Foreningen for Familieplanlaegning, Aurehøjvej 2, 2900 Hellerup.	EUROPE

COUNTRY	ASSOCIATION	REGION
Dominican Republic	Asociacion Dominicana Pro-Bienestar de la Familia, Inc., Apartado Postal 1053, Calle Socorro Sanchez No. 64, Zona Postal 1, Santo Domingo, D.N.	W.H.
Ecuador	Asociacion Pro-Bienestar de la Familia Ecuatoriana, Apartado Postal 5954, Noguchi 1516, Guayaquil.	W.H.
Egypt, Arab Republic of	Egyptian Family Planning Association, 5 Talaat Harb Street, Cairo.	M.E.N.A.
El Salvador	Asociacion Demografica Salvadorena, Apartado Postal 06 1338, La Calle Pte. 1214, San Salvador.	W.H.
Ethiopia	Family Guidance Association of Ethiopia, PO Box 5716, Addis Ababa.	AFRICA
Fiji	Family Planning Association of Fiji, Inc. PO Box 619, Suva.	E.S.E.A.O.
Finland	Vaestoliitto, Kalevankatu 16, 00100 Helsinki 10.	EUROPE
France	Mouvement Francais pour le Planning Familial, 94 Blvd. Massena, 75643 Paris, Cedex 13.	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	Asociacion Pro-Bienestar de la Familia de Guatemala (APROFAM), 9a Calle 0-57, Zona 1, Apartado Postal 1004, Ciudad de Guatemala.	W.H.
Honduras	Asociacion Hondurena de Planificacion de la Familia, Apartado Postal 625, Avenida Principal, entre: Colonias Alameda-Ruben Dario, Tegucigalpa, D.C.	W.H.
Hong Kong	Family Planning Association of Hong Kong, 186-192 Lockhart Road Ground, 1st, 2nd & 3rd Floors, Hong Kong.	E.S.E.A.O.
Hungary	Hungarian Scientific Society for Family and Women's Welfare, Buday Laszlo u. 1-3, 1024 Budapest.	EUROPE
India	Family Planning Association of India, Bajaj Bhavan, Nariman Point, Bombay 400 021.	I.O.

COUNTRY	ASSOCIATION	REGION
Indonesia	The Indonesian Planned Parenthood Association, PO Box 18 KBY, Jalan Hang Jebat III/F.3, Kebrayoran Baru, Jakarta Selatan.	E.S.E.A.O.
Iran	The Family Planning Association of Iran, PO Box 2851, Tehran.	I.O.
Iraq	The Iraqi Family Planning Association, PO Box 6028, Maari Street, Mansour City, Baghdad.	M.E.N.A.
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.	W.H.
Japan	Family Planning Federation of Japan, Inc., Hoken Kaikan Bekkan, 1-1, Sadohara-Cho, Ichigaya, Shinjuku-ku Tokyo.	E.S.E.A.O.

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>	M.E.N.A.
	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.	E.S.E.A.O.
Lebanon	Lebanon Family Planning Association, PO Box 118240, Corniche Mazraa, Al Maskan Building, Beirut.	M.E.N.A.
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	Fianakaviana Sambatra, BP 703, Tananarive.	AFRICA

COUNTRY	ASSOCIATION	REGION
Malaysia	Federation of Family Planning Associations, Malaysia, 81A Jalan SS 15/5A, Subang Jaya, Selangor.	E.S.E.A.O.
Mali	Association Malienne pour la Protection et la Promotion de la Famille, BP 105, Bamako.	AFRICA
Mauritius	The Mauritius Family Planning Association 30 Desforges Street, Port Louis.	AFRICA
Mexico	Fundacion para Estudios de la Poblacion, A.C., Calle Juarez 208, Tlalpan, Mexico 22 DF.	W.H.
Morocco	L'Association Marocaine de Planification Familiale, PO Box 1217 RP, 6 Ibn El-Cadi, Quartier des Orangers Rabat.	M.E.N.A.
Nepal	Family Planning Association of Nepal, PO Box 486, Katmandu.	I.O.
Netherlands	Rutgers Stichting, Correspondence: Postbus 17430, 2502 CK, s Gravenhage. Street Address: Grott Hertoginnelaan 201, 2517 ES, s Gravenhage.	EUROPE

COUNTRY	ASSOCIATION	REGION
New Zealand	The New Zealand Family Planning Association Inc., Correspondence: PO Box 6820, Newton, Auckland, 1. Street Address: 218 Karangahape Road, Auckland 1.	E.S.E.A.O.
Nicaragua	Asociacion Demografica Nicaraguense, Apartado Postal 4220, Iglesia del Carmen 1 Cuadra al Norte ½ al Oeste, Managua.	W.H.
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, Lahore.	I.O.
Panama	Asociacion Panamena para el Planeamiento del la Familia, Apartado Postal 4637, Edificio Multifamiliar No. 2a, Panama 5.	W.H.
Paraguay	Centro Paraguayo de Estudios de Poblacion, Edificio "El Dorado" 8º piso, Juan E. O'Leary y Manduvira, Asuncion.	W.H.

COUNTRY	ASSOCIATION	REGION
Peru	Instituto Peruano de Paternidad Responsable (INPPARES), Intisuyo 371, Urb. Maranga, San Miguel, Lima.	W.H.
Philippines	Family Planning Organization of the Philippines, Inc., Correspondence: PO Box 1279, Manila. Street Address: 50 Dona M. Hemady Street, Quezon City.	E.S.E.A.O.
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	Asociacion Puertorriquena Pro-Bienestar de la Familia, Apartado Postal 2221, Calle Padre las Casas No. 117, El Vedado, Hato Rey, Puerto Rico 00919.	W.H.
Senegal	Association Senegalaise pour le Bien-Etre Familial, BP 6084, Dakar.	AFRICA
Sierre 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, 11 Penang Lane (Room 4D), Singapore 9.	E.S.E.A.O.
South Africa	Family Planning Association of South Africa, 412 York House, 46 Kerk Street, Johannesburg 2001.	
Sri Lanka	Family Planning Association of Sri Lanka, PO Box 365, 37/27 Bullers Lane, Colombo 7.	I.O.
Sudan	Sudan Family Planning Association, PO Box 170, Khartoum.	AFRICA
Swaziland	Ministry of Health, PO Box 5, Mbabane.	AFRICA
Sweden	Riksförbundet for 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.	M.E.N.A.
Tanzania	UMATI (Uzazi Na Malezi Bora Tanzania), PO Box 1372, Dar es Salaam.	AFRICA
Thailand	Planned Parenthood Association of Thailand, No. 8 Soi Dai Dee Vibhanadi-Yao, Bangkhen, Bangkok 9.	E.S.E.A.O.

COUNTRY	ASSOCIATION	REGION
Togo	Association Togolaise pour le Bien-Etre Familial, BP 4056, Lome.	AFRICA
Trinidad & Tobago	Family Planning Association of Trinidad & Tobago, 141 Henry Street, Port of Spain.	W.H.
Tunisia	Association Tunisienne du Planning Familial, 6 rue Amine Er-Raihani, 1605 El Omrane, Tunis.	M.E.N.A.
Turkey	Turkiye Aile Planlamasi Dernegi, Atac Sokak No. 73/3 Ankara.	EUROPE
Uganda	Family Planning Association of Uganda, PO Box 30030, Kampala.	AFRICA
United Kingdom	Family Planning Association of the UK, 27-35 Mortimer Street, London, W1N 7RJ.	EUROPE
United States	Planned Parenthood Federation of America, Inc., (PPFA), 810 Seventh Avenue, New York, NY 10019.	W.H.
Uruguay	Asociacion Uruguay de Planificacion Familiar e Investigaciones Reproduccion Humana, (AUPFIRH), Correspondence: Casilla de Correo No. 10.634, Distrito 1, Montevideo. Street Address: Avenida Luis P. Ponce 1574, Montevideo.	W.H.

COUNTRY	ASSOCIATION	REGION
Yemen Arab	Yemen Family Planning Association, PO Box 795, Al Tahreer Square, Near Arab Bank, San'a.	M.E.N.A.
Yugoslavia	Family Planning Council of Yugoslavia Bulevar Lenjina 6, 11070 Belgrade.	EUROPE
Zaire	Comite National des Naissances Desirables BP 15.313 Kinshasa.	AFRICA
Zambia	Planned Parenthood Association of Zambia, PO Box 32221, Lusaka,	AFRICA

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