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MADAGASCAR:
POPULATION AND FAMILY HEALTH ASSESSMENT

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TABLE OF CONTENTS

	<u>Page</u>
ABBREVIATIONS.....	i
PURPOSE OF MISSION.....	1
EXECUTIVE SUMMARY.....	2
I. COUNTRY OVERVIEW.....	8
II. AID COUNTRY STRATEGY AND ROLE OF POPULATION/FAMILY HEALTH.....	12
III. GOVERNMENT POLICY ON POPULATION.....	13
IV. DEMOGRAPHIC STATISTICS AND RESEARCH.....	15
V. MINISTRY OF HEALTH: POLICY, STRUCTURE AND ACTIVITIES.....	19
VI. PRIVATE VOLUNTARY ORGANIZATIONS PROVIDING FAMILY PLANNING SERVICES.....	21
VII. AID-SUPPORTED POPULATION/FAMILY PLANNING ACTIVITIES.....	28
VIII. OTHER DONOR ACTIVITIES.....	30
IX. RECOMMENDATIONS.....	32
X. IMPLEMENTATION PLAN.....	37
 ANNEXES	
Annex 1: Persons Contacted	
Annex 2: Site Visits	
Annex 3: Ministry of Health Structure	
Annex 4: Repartition Des Infrastructures Sanitaires Par Province Et Par Categorie De Formation Sanitaire	
Annex 5: Additional Information on Mortality	
Annex 6: Maternal Child Health Program	
Annex 7: GDRM Statement at Mexico City Population Conference, August, 1984	
Annex 8: JHPIEGO Trainees - Madagascar	
Annex 9: Importance Des Nombres de femmes protegees par les firmes pharmaceutiques, la FISA et le FTR, 1979-1982	
Annex 10: IPPF Support to FISA	
Annex 11: USAID Supported Training	
Annex 12: FISA Project Proposal to AID	
Annex 13: JIRAMA: Plan of Activities	

ABBREVIATIONS

AID	(United States) Agency for International Development
AID/ANTAN	AID Antananarivo (Country AID Office)
AVSC	Association for Voluntary Surgical Contraception
BUCEN	U.S. Bureau of the Census
CDSS	Country Development Strategy Statement
CEDPA	Centre for Development and Population Activities
DDD	Demographic Data for Development Project
FHDS	Family Health and Demographic Surveys Project
FISA	Fianakanviana Sambatra (Happy Family), the local Family Planning Association
FTK	Fivondronan NY Tokantrana Kristianaina (Movement for the Promotion of the Family), the local Natural Family Planning Association
GDRM	Government of the Democratic Republic of Madagascar
IFFLP	International Federation for Family Life Promotion
INSRE	Institute of Statistics and Scientific Research
INTRAH	Program for International Training in Health Project
JIRAMA	Water and Electricity Parastatal
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MOH	Ministry of Health
MPCSJP	Ministry of Population, Social Conditions, Youth and Sports
NFP	Natural Family Planning
NGO	Non-Governmental Organization
OSTIE	Organisation Sanitaire Tananarivienne Inter-entreprise
PCS	Population Communication Services Project
PVO	Private Voluntary Organization
RAPID	Resources for Awareness of Population Impact on Development Project
REDSO/ESA	Regional Economic Development Services Organization, East/Southern Africa (AID's Regional Office)
SOLIMA	Major Petroleum Parastatal
UNFPA	United Nations Fund for Population Activities

PURPOSE OF MISSION

Following an absence of nearly ten years, an AID Office was re-established in Madagascar in 1984. The first Country Development Strategy Statement (CDSS) was prepared for FY 1986 and was designed to respond to the country's severe financial difficulties and lagging economic growth. The focus of AID development assistance proposed for Madagascar is in the agricultural sector; balance of payments support and limited assistance in transport is also included. Additionally, given the relationship between population growth and development, the CDSS proposes support for start-up of family planning activities.

In order to design population and family planning activities to be responsive to the cultural context, the policies of the Government of the Democratic Republic of Madagascar (GDRM) and the country's needs, it was agreed between AID and GDRM officials that a Population/Family Health Assessment should be conducted to review population and family activities and make general recommendations for improvements including the type of AID population assistance that should be provided. Therefore, in May, 1985, a team consisting of a Demographer/Population Policy Expert and a Public Health Physician specializing in family planning came to Madagascar to conduct the assessment. The REDSO/ESA Population Officer provided overall guidance, participated in discussions with GDRM officials and assisted with report writing and recommendations. During their three week stay in Madagascar, the team met with directors and technical personnel in ministries and other agencies concerned with population and family health. In addition, field visits were made to health centers in the provinces of Antananarivo and Tamatave.

Based on their findings, the team prepared a preliminary report describing the current situation and recommending areas in which assistance should be provided. This draft report was circulated to GDRM ministries for review and a follow-up visit was made to Madagascar in September, 1985. During this visit, the Demographer/Population expert and REDSO/ESA Population Officer reviewed the report with GDRM officials, prioritized recommendations and developed a plan for AID population support.

EXECUTIVE SUMMARY

Madagascar is an island nation characteristic of many developing countries: a predominantly agricultural based economy, low per capita income, high rates of illiteracy, low life expectancy due in part to high infant mortality and high fertility. The country's population of approximately 9 million is growing at a rate of 2.8% annually, which means the population will double in less than 25 years. Agricultural production is not keeping pace with this population growth rate. Food imports--and, consequently, foreign debt--are increasing. Demographic pressure is felt particularly in the capital where inadequate infrastructures as well as poverty are especially visible.

Despite this situation, the GDRM has articulated no official population policy even though an Office of Population has existed since 1973 and is presently situated within the Ministry of Population, Social Conditions, Youth and Sports. This Ministry conducts some small-scale socio-demographic research and also includes a Bureau of Women's Affairs (Direction de la Condition Feminine) which carries out activities seeking to promote the role of women in development. Collaboration between the Office of Population and the General Directorate of Planning is minimal, and demographic factors have thus far not been systematically incorporated into sectoral planning. However, the Director of Planning has stated that it is now necessary to reconsider the importance of population factors, and suggested to the team that a seminar on Population and Development be held. His views, however, reflect the general tendency throughout the government to view "demographic problems" as being primarily related to distribution of the population and allocation of resources.

In the absence of an official population policy, the GDRM's position must be inferred from other policies and statements, and from its actions. For example, it is significant that the GDRM has stated the reduction of maternal and infant mortality and morbidity as an explicit goal in the health sector. Moreover, at the 1984 World Conference on Population, the GDRM stated that they recognized "the difficulty of breaking the vicious circle of under-development--high fertility--rapid demographic growth--under development." However they went on to say, that it may be more appropriate to seek the solution through promoting economic growth rather than limiting fertility.

Nonetheless, the GDRM's actions have long reflected an attitude of acceptance and support for family planning. Although the French law of 1920 forbidding the sale and use of contraceptives has not been rescinded, it is not enforced. Contraceptives are sold on prescription in private pharmacies. The private family planning association, FISA (an IPPF affiliate) is officially recognized as a non-governmental organization (NGO) which provides clinical

contraceptive services throughout the country. The public health system provides no family planning services however, "individual counseling" is given. According to MOH statistics for the first six months of 1984, one-third of the women who visited health facilities received such counseling. Also at the request of public health physicians, FISA now provides contraceptive services in 40 MOH facilities. The GDRM has approved the participation of 35 medical and para-medical personnel in JHPIEGO training courses (in the U.S. and at African regional training sites) as well as installation of laparoscopic equipment in eight medical facilities.

Several other organizations provide child-spacing services. For example, an active family planning program exists within the medical centre in Antananarivo servicing the personnel of JIRAMA, the water and electricity parastatal. OSTIE, a participatory medical care program for employees of private enterprises has also provided some contraceptives for the past two years and is currently establishing family planning in a newly-opened clinic in the capital. Madagascar's major petroleum company, SOLIMA, has likewise initiated provision of family planning services in its clinic in Antananarivo. FTK, another recognized NGO, provides natural family planning education and within the army's health system, child-spacing is also promoted.

In spite of the above, the availability of contraceptive services remains extremely limited and contraceptive prevalence in 1982 was estimated at 1% of women aged 15-49. Anecdotal information (no KAP or similar empirical studies are yet available) suggests that the unmet demand for contraception goes far beyond this figure. Further indications of unmet demand are high rates of abortion, and growing numbers of abandoned children. In addition, increasing numbers of medical personnel are requesting assistance from FISA to integrate family planning services into their MCH programs.

Yet a number of obstacles impede accessibility to contraceptive services and hamper expansion of family planning programs. Malagasy culture has always favored large families and the influence of the Catholic Church is strong. The number of medical centres providing family planning services is limited and in some cases, eligibility criteria are numerous and strict. There is lack of knowledge about modern contraceptives and misconceptions concerning their usage and effects are widespread. There is a lack of data on fertility, knowledge and use of contraception which is essential to sound program development. While the lack of an explicit population policy need not present an insurmountable obstacle, it appears to cause reluctance among certain groups to promote family planning. Finally, the collaboration and

communication between the Office of Population and Ministry of Health has not been the most favorable for the development of effective programs in either area, however, the recent naming of a physician to the position of Director of Population may facilitate closer collaboration.

In the area of MCH information, education and communication (IEC), not much has been done primarily due to limitations of personnel and material resources. Responsibility for health education is delegated to the Maternal/Child Health Service (MCHS) of the Ministry of Health and they do not have a written strategy or work plan for IEC activities. In the field, Health Agents give educational talks in health facilities, however, this is also limited due to lack of teaching aids and audio-visual equipment especially outside the capital. At the national level, the primary activity is a daily five-minute health broadcast on national radio. Beyond this, lack of trained personnel and resources restrict activity to the occasional production of posters and some brochures.

Limited resources have also been a constraint in the areas of health and demographic statistics and research. A recent assessment of local statistical capabilities was carried by the U.S. Bureau of the Census (BUCEN). As indicated in the report, the major national level statistical capability is situated within the Ministry of Agriculture Production and Reform (MPARA) and the National Institute of Statistics and Economic Research (INSRE). The former, with a staff of forty professionals, conducts an annual agricultural survey which provides baseline data for planning purposes. In addition, several special surveys have been conducted by MPARA. Currently, its major activity is a comprehensive sample census of agriculture being carried out with FAO assistance. Problems have been encountered with data collection and data processing due in part to MPARA's limited data processing capability.

INSRE is situated within the Ministry of Finance and Economic Development and was the executing agency for the 1975 general population census. Analysis of these data is still going on, due to limited data processing capability. In addition to the census analysis, INSRE's staff of fifteen statisticians and one demographer are also beginning to process data from a 1978 household income and expenditure survey. Other small-scale data collection activities include an annual industrial survey and a monthly price survey. At the same time, INSRE is responsible for maintaining the country's civil registration system, although as the BUCEN report points out, "they lack the resources necessary to do so." The GDRM has not made an official decision.

regarding whether or not a population census will be carried out in the near future. If it is decided to do so, INSRE will likely be responsible for implementation however, its capability in personnel and data processing may present constraints to successfully carrying out this task.

The collection of health statistics is hampered by similar limitations. The MOH's statistical system was restructured in 1983 with the assistance of UNFPA. The Health and Demographic Statistics Service (SSSD) is responsible for operation of the system which is based upon two types of data collection: monthly registration by each health facility of the health status of the population served and types of treatments provided. A second type of data collection (designed under the UNFPA-financed project) involves maintenance of demographic record books for a sample of 12,000 villages. This activity, which has begun only recently, will potentially provide much useful demographic data. As of September, 1985, one summary report (for the first half of 1984) had been published.

For a number of years UNFPA has been the major provider of assistance to Madagascar in the area of population/family planning, and through 1985, provided aid totalling \$2.4 million. The major activities supported have been in demographic data and health statistics collection population education and assistance to the local family planning association. Due to various budgetary and in-country difficulties, UNFPA assistance to Madagascar has consistently fallen below its potential. However, UNFPA has expressed a strong interest in continuing and expanding support and co-ordinating future efforts with AID-sponsored activities.

Even though there was no AID office in Madagascar, AID has provided some population assistance through centrally-funded projects within the past few years. These have included JHPIEGO (training in reproductive health), CEDPA (training in family planning program administration), IFFLP (support for natural family planning), Pathfinder Fund (contraceptives) and AVSC (installation of laparoscopic equipment).

Taking into account the constraints identified above, and based upon the assessment of the current status of population and family planning in Madagascar, the team has made a series of recommendations. While it is felt that the activities proposed are appropriate and feasible, the need to proceed cautiously in their implementation cannot be overemphasized. The re-establishment of relations with the United States is symbolic of what may be a gradual political re-orientation on the part of the government. In the early stages of the new relationship, activities undertaken by AID are likely to be closely scrutinized both by GDRM officials and

by other governments having a political interest in the course of the country's development. Particularly in an area as sensitive as population, extreme care must be taken in design and implementation of assistance programs.

The recommendations which follow outline a general strategy for the initiation of population activities in the short term. In some of these areas, AID assistance is feasible; in others, it is proposed that assistance be sought from other sources, particularly UNFPA. Another major consideration in identifying areas for AID assistance was AID/Antananarivo's limited management capability which eliminates the possibility of a bi-lateral population program. Given this situation, assistance will be provided through a number of AID-financed cooperating agencies specialized in various areas. Their activities in-country will require minimal support from the AID mission. In addition, periodic visits by the REDSO/ESA Population Officer will assist USAID in monitoring these activities.

The following recommendations are listed in order of priority as specified by the GDRM. Following the discussion of each activity area, the likely source of funding (AID co-operating agency, UNFPA, etc.) is indicated in parentheses.

1. Strengthening Family Health Service Delivery within the MOH. Assistance should be provided both in orientation and in upgrading clinical skills of MOH personnel in reproductive health and family planning. Activities should be designed to increase awareness of health leaders, health planners, and administrators, to the health implications of current fertility patterns and the importance of child-spacing. A series of three to four day national and regional seminars on these issues should be held for MOH and other personnel responsible for the planning or delivery of health services. (INTRAH, JHPIEGO).

It is also recommended that service delivery personnel (physician, nurses, midwives and others) be taught to provide child-spacing information and services including other important reproductive health skills such as treatment of infertility and sexually-transmissible diseases. A core training team (8 - 10 trainers) should be trained and made responsible for conducting a series of short in-country training courses for these service delivery personnel. (UNFPA, INTRAH).

As a complement to this, delivery of health services should be strengthened through the provision of needed equipment, supplies, automation of the health statistics system, and other material support. (UNFPA).

2. Population Policy. There is a need to increase awareness and understanding among policymakers and planners of the relationship between population factors and development.

Recognizing this need, the GDRM has expressed a strong interest in holding a national seminar on Population and Development. It was suggested by the Director General of Planning that such a seminar should be organized to coincide with the preparation of the next five-year development plan, which will begin in 1987. (Futures Group through RAPID II).

Assistance should also be given to assist in the incorporation of demographic variable into development planning. Creation of the institutional structure necessary to do this within the Directorate General of Planning is recommended. (UNFPA). Additionally, short-term training of planners (BUCEN, INPLAN, DDD) and financing of small-scale studies in related areas (Futures Group, DDD, UNFPA) are recommended.

3. Demographic Statistics and Research. If program expansion in population and family health is to occur, it is essential to obtain baseline data for purposes of planning and evaluation. A survey should be designed and executed to obtain data on fertility, infant mortality, contraceptive prevalence, knowledge and attitudes regarding contraception, data sources for health information, and other key variables. (UNFPA, FHDS, Westinghouse).

In addition, it is recommended that small-scale studies in areas related to population and family health be conducted within the Office of Population, the University of Madagascar or other research institutions. (Futures Group through RAPID II, DDD).

When the GDRM has made a determination regarding the next general population census, appropriate support should be provided. This would include hardware and general support for census execution (UNFPA) as well as short-term technical assistance in specialized areas, training of personnel and provision of software. (BUCEN).

4. Support to Existing Private and Parastatal Organizations. Assistance should be continued and expanded to the several private organizations interested in providing child-spacing services through their health care delivery systems. The needs of FISA, JIRAMA, OSTIE, and SOLIMA should be reviewed and three to four small-scale support activities planned per year for these organizations. Such activities could potentially include commodities, equipment and supplies, training, IEC materials and general support. (FPPIA, Pathfinder Fund).

Current AVSC-supported activities should continue but be broadened in scope to include a full range of contraceptive information and services. (AVSC). Support should also be provided to FTK, the local natural family planning organization to train NFP trainers, conduct seminars, and sponsor participants to attend regional and international conferences. (IFFLP).

5. Information, Education and Communication. If the MOH is interested in expanding its family health service programme to include the introduction of child-spacing, a strong national family health IEC programme should be developed. It is recommended that a preliminary evaluation of current IEC capability and needs be carried out (PCS). Based on the results of this assessment, and using the findings of the national baseline survey described above, a national IEC strategy should be developed. Assistance should include short-term technical assistance in specialized areas (message development and testing, development of media plan) and training in IEC skills for appropriate MOH personnel (PCS). Support should also be provided for the implementation of the national IEC programme, once it is developed (UNFPA).

For the activities to be financed by AID cooperating agencies, initial visits will be planned by representatives of the various agencies to begin discussions and initiate assistance in the recommended areas described above. A proposed time table for these visits appears in the Recommendation Section of the report.

Monitoring of the AID population activities will be carried out through quarterly visits by the REDSO/BSA Population Officer in collaboration with the local AID Representative. As this population strategy is focused on short term needs, depending upon strategy or policy changes made by government, the report and recommendations should be periodically updated to reflect current population and family health program assistance needs for the country.

I. COUNTRY OVERVIEW

Madagascar is an island nation situated off the eastern coast of Africa at the edge of the Indian Ocean. The fourth largest island in the world, Madagascar has a land area of 590,000 square kilometres across which the population of nearly 9 million inhabitants is unevenly distributed. Perhaps the most striking physical characteristic of Madagascar is its geographic diversity. A rugged country, it includes mountainous regions, highlands and semi-desert areas traversed by numerous rivers. Climatic differences correspond to these geographical variations. Seasons occur at different periods in the North and in the South, for example, and annual rainfall varies from up to 2,000 mm. in the tropical east coast region to as low as 400 mm. in the arid southern region. Communication and movement among regions is rendered difficult by the combination of rugged terrain and inadequate infrastructure. Although there are 50,000 kilometres of road, about 80% are unpaved feeder roads and tracks and are often unpassable during rainy seasons.

Madagascar's ethnic and cultural characteristics are as diverse as its geography. The country's inhabitants are descendants of migrants who have come to Madagascar over the centuries from Indonesia, Malaysia, Polynesia, the Arab countries, China, India, and the African continent. The Malagasy culture of today reflects the influence of these peoples as well as those of the European countries which colonized Madagascar during the nineteenth century. The Malagasy language, which is one common bond uniting the country, also shows these multiple influences, although it is most similar to those of Indonesian derivation. A diversity of religions exist, with nearly half the population pronouncing themselves Christians. These are divided approximately evenly between Protestants and Catholics. Only about 5% of the population adhere to the Islamic faith, and the remainder of the population practice traditional religions.

Madagascar remains a primarily rural country with agriculture being the main activity of the 86% of the population living in rural areas. Agriculture has been at the center of the domestic and export sectors, and stagnation of production is one (although not the sole) factor leading to the deterioration of the country's economy over the past decade. In spite of the consequent worsening of the conditions of life in the rural areas, migration to urban centres has been relatively slow compared to other developing countries. Only the capital has experienced growth much higher than the national average, with the rate for Antananarivo estimated at 5% per year. As in most such situations, a deterioration of the quality of life in the capital has been inevitable. Insufficient urban infrastructure and increasing consumer prices for food and other essentials are having an impact on the health status of the inhabitants of the country's capital.

As seen above, Madagascar has some characteristics which set it apart from other developing countries, however in other areas it is quite similar. Perhaps most notable are the continuation of high fertility and the closely related poor health status of the population. As shown in Table I, Madagascar's rate of natural increase is estimated at 2.8% annually, with a total fertility rate of 6.4. The poor health status of the Malagasy is reflected in the life expectancy which only approaches 50, and the infant mortality rate of 109 per 1000.

As in many developing countries, fertility in Madagascar has not declined along with death rates over the past two decades. There are several reasons for this. In the first place, Malagasy women marry young. The average age at marriage is 19, with 37% of

TABLE I

Madagascar

selected socio-economic indicators

Population	
1982	8,704,000
Projected year 2000	15,552,000
Crude Birth Rate	46/1000
Crude Death Rate	18/1000
Rate of natural increase (annual)	2.8%
Population doubling time	25 yrs
Total fertility rate	6.4
Infant mortality rate	109/1000
Life expectancy	49.6
% age of population under age 15	46%
GNP per capita	\$330
% age of population in rural areas	81%
Population per physician	10,170

Sources: Population Reference Bureau, 1984 World Population Data Sheet. Washington, D/C/, PRB. AND United Nations. Estimates & Projections as Assessed in 1984. New York: United Nations. World Bank: World Development Report, 1984.

women being married by that age (Population de Madagascar, Ministère de la Recherche Scientifique et Technologique pour le Développement). Childbearing thus begins early and continues into women's 40's; and in the age group 40-44, the fertility rate remains at 10 per 1000. Early (under 19) and late (over 35) childbearing contributes to high infant mortality, which, in a vicious circle effect, maintains high fertility due to so-called insurance births.

Other contributing factors to high fertility in Madagascar are the value attached to large families and the near-absence of modern contraception. Regarding the former, it is interesting to note that at Malagasy weddings the wish made to the newly-married couple is that they have 7 boys and 7 girls. Although in Madagascar, as elsewhere in the developing world, traditional methods of contraception have always been known, modern contraception has been virtually non-existent. Data on the use patterns of modern contraception in Madagascar show that there has been almost no increase between 1976 and 1982, and that only about 1% of women between 15 and 49 currently use a modern method of contraception (Ministère de la Santé, A propos de la Planification Familiale a Madagascar, 1983).

In spite of this situation, there is some indication that an unmet demand for contraception exists and may be increasing. Health workers in clinics and dispensaries report that they are asked by women what can be done to postpone pregnancy. (It is important to note that birthspacing and not termination of childbearing appears to be their intention). Perhaps the best, and certainly the most unfortunate, indicators of unmet demand for contraception are abandonment of children and abortion. Although precise data are not available, the incidence of child abandonment is thought to be increasing and is particularly visible in the capital. Abortions, which pose serious health problems including death, are also believed to be growing in number in spite of the fact that it is illegal under Malagasy law. Some empirical data have been collected. One study conducted in the provinces of Antananarivo and Fianarantsoa showed that 16.5% of women surveyed in 27 health centres admitted ever having had an abortion. For women over age 40, the figure was nearly 50%. Interviews with these women also revealed that over two-thirds had never heard of contraception (FISA, *Donces sur les avortements*, 1983).

In summary, Madagascar is a country which suffers from many of the characteristics of developing countries: low life expectancy and poor health status of its people; economic difficulties related in part to increasing food imports; and insufficient financial resources with which to provide essential social services. All of these problems are exacerbated by the country's rapid population growth. Furthermore, fertility may increase even more due to such factors as reduced breastfeeding and the success of health campaigns in reducing morbidity and mortality

rates. Given a population structure where 46% of Madagascar's population is under age 15 and in the absence of a strong family planning service program, the country's growth rate will continue and probably increase which will most likely negatively affect overall development of the country.

II. AID COUNTRY STRATEGY AND THE ROLE OF POPULATION/FAMILY HEALTH

AID's earliest bi-lateral agreement with the GDRM was signed in 1961. Economic assistance was provided primarily in the form of Food for Peace grants (\$9.1 million), AID grants (\$5.0 million) and AID loans (between \$5.0 and \$6.0 million) between then and 1978. Although the bi-lateral agreement has remained in effect, AID's presence in Madagascar was terminated in the mid-1970's. During 1983 it was decided to reinstate this presence and a team was sent to develop the first Madagascar Country Development Strategy (CDSS) for FY 1986. The strategy was designed to respond to what was identified as the country's most pressing problems, that of the balance of payments deficit and growing foreign debt-service requirements. These financial difficulties have led to severe import restrictions preventing entry of needed inputs for industry and agriculture, resulting in stagnation in both these sectors. Given this situation, it was determined by the CDSS team that "economic recovery for Madagascar depends on increasing production and exporting more of it." (CDSS, P. 8). The new AID program in Madagascar focussed on the agricultural sector.

Among the goals established in this sector is increasing the per capita real income of small farmers and rural workers. Recognizing that per capita income is related to population size, which serves as the denominator in its calculation, the CDSS includes as an objective "increasing GDRM awareness of the need for family planning activities." Upon request, support for start-up family planning activities was recommended in the CDSS.

The CDSS is correct in identifying the need to reduce the population growth rate in order to increase per capita income. However, it is important to note that the relationship goes beyond this mathematical calculation. Reduced fertility leads to improved health status in several ways: decreased infant mortality and morbidity; and improved health of women through longer birth intervals. These health improvements can in turn contribute to a stronger and more productive agricultural labor force with fewer workdays lost to illness. Furthermore, lowered fertility reduces necessary government expenditures for health and education, thus freeing up resources for use in productive sectors.

In general, population/family health objectives are inseparable from those related to agricultural development. Seen from this perspective, the activities proposed in the present report are not only fully consistent with AID's country development strategy for Madagascar, but essential to the attainment of the goals stated therein.

III. GOVERNMENT POLICY ON POPULATION

The Government of Madagascar has no official population policy. Nonetheless, the policy of the GDRM is reflected in documents (such as National Development Plans), institutional structures (such as creation of ministries), government legislation, and official statements, as well as the GDRM's response to the activities of groups and individuals who raise issues concerning population.

Madagascar is currently operating under a Provisional National Development Plan which covers the period 1984-1987, and it is intended that a Five-Year Development Plan for 1986-1990 will soon be adopted. In the current plan, the GDRM's position with regard to population is reflected most fully in the lack of attention given to the subject. No separate sections are devoted to demographic issues, with the plan's focus being on resolving the country's economic and financial crises through strengthening the agricultural, transport, and industrial sectors. In spite of the role of population growth in contributing to these problems, no mention is made of the need to slow growth. Even in discussion of the increasingly severe unemployment problem, the focus is on promoting small to medium scale industries in the informal sector, and on building up labor-intensive programs. Consideration is not given to the size of new cohorts entering the labor force and similarly, agricultural objectives focus on the supply rather than the demand side of the problems in this sector.

More can be seen about the GDRM's population policy in its responses to the Economic Commission for Africa's population inquiry among governments, conducted in 1983. The survey reports that Madagascar is among countries having expressed no policy with regard to current levels of fertility, although it had adopted a policy with regard to population distribution. In this regard, the GDRM policy seeks to affect minor changes within the country, primarily to slow the growth of the largest urban centres.

In spite of the lack of an official population policy, the GDRM has created institutional structures to address the demographic aspects of development. The Office of Population has existed since 1973, when it was created as a preparatory body for the 1974 World Conference on Population. It was then attached to

the Ministry of Social Affairs (which was actually a Ministry of Health) but became the Ministry of Population and Social Conditions in 1976. In 1983, this Ministry was re-organized into the present Ministry of Population, Social Conditions, Youth and Sports. It is felt by some persons within the Ministry that the new institutional arrangement reflects diminished GDRM interest in population, particularly as the emphasis in this Ministry appears to be on sports. The Office of Population is one of seven offices within the Ministry. A National Permanent Committee on Population is also attached to the office. However its mandate is very general and is concerned with addressing the problems of the population of Madagascar (situation of women, youth, particular regions, etc.) rather than issues of demographic interest. The Committee has not been extremely active. Although the Office of Population works with the Directorate General of Planning to ensure incorporation of demographic variables into development planning, this collaboration (in the words of the Director of Population) has "never been very strong."

The most recent and perhaps most direct indicator of the GDRM's population policy is seen in its participation in the World Conferences on Population in 1974 and in 1984. In the first, the GDRM outlined its policy of "responsible parenthood," defined as the right of couples to decide freely on the number and spacing of their children. This policy was explicitly within the context of a "sectoral health policy" aimed at reducing maternal and infant mortality and morbidity. At the 1984 World Conference on Population, the Minister of Population, Social Conditions, Youth and Sports outlined the evolution of this policy to a more global one of "responsible citizenship," which was felt to "correspond better to the model of development specified in the charter of the Malagasy Socialist Revolution."

The apparent difference between the two concepts is that the broader (responsible citizenship) places the emphasis more on the development aspect of the fertility-under-development relationship. As Minister Tiandraza stated at the Mexico Conference:

"In Madagascar we are certainly conscious of the difficulty of breaking the vicious circle of under-development--high fertility-rapid demographic growth--under-development, but it remains that the Malagasy perception of the problems of population and development are based on the conviction that economic and cultural emancipation have priority over the demographic solution."

Elsewhere in his speech, citing the debate over whether the best means of reducing fertility is through promoting family planning or through economic/social development, the Minister stated that "the Malagasy delegation was (in 1974) and still is for the second position."

The population policy of Madagascar as thus stated does not accord high priority to the provision of family planning services. However, in spite of the 1920 French legislation forbidding contraceptives, they are permitted into the country and provision of services are quietly supported. Therefore, the GDRM's policy must also be inferred from its actions, and in this regard for some time there has been acceptance of family planning and increasing support. The private family planning association, FISA (an IPPF affiliate) was officially recognized in 1967, and is permitted to import contraceptives into the country and provide services through its network of clinics. Sale of contraceptives in private pharmacies is also allowed.

In 1984, the GDRM approved a UNFPA-supported observational tour by representatives of the Ministry of Health, the Office of Population, the Directorate General of Planning, and the National Assembly to visit family planning programs in four countries. The report which the group prepared following the trip was submitted to UNFPA and the GDRM late in the summer of 1985. It is not certain what follow-up actions, if any, will be taken. Also of interest is the fact that the Malagasy Parliamentarians have formed a group on Population and Development. Composed of fifteen members, these Parliamentarians conduct sensitization activities within their own areas informing constituencies of problems concerning population growth. They conduct small-scale activities such as a recent survey (financed by UNFPA) to produce a socio-demographic profile of the village of Amboasary and the surrounding area. The group is also actively involved in preparations for the African Parliamentarians Meeting on Population and Development to be held in Harare in 1986.

IV. DEMOGRAPHIC STATISTICS AND RESEARCH

Demographic research has not been accorded high priority in Madagascar and as a result, the country's capabilities in the area are relatively limited. Within the civil service, the job classification of demographer is not yet officially recognized and those trained in demography bear official titles such as statistician or researcher. Nonetheless, there are approximately twenty trained demographers in the country. Most are graduates of the

Institut de Formation et de Recherche Demographique (IFORD) in Cameroon, a centre with a highly quantitative orientation. Lack of financial resources has impeded the execution of extensive demographic research, although demographers interviewed indicated strong interest in carrying out studies in such areas as fertility, infant mortality, and migration.

A. The Office of Population

Presently, demographic research is carried out within several institutional structures:

B. The National Office of Statistics and Economic Research (INSRE)

The Office of Population includes two demographers on its staff. Over the past five years the Office has conducted several small-scale monographic studies. Since 1984, in the context of a UNFPA-financed project on population education, a survey was conducted of 40,000 households to investigate attitudes and practices toward fertility. Data processing had been completed as of September, 1985, and UNFPA was awaiting the arrival of a consultant to assist in analysis of the data.

The National Office of Statistics and Economic Research (INSRE), situated within the Ministry of Finance and Economic Development, was the executing agency for the 1975 general population census in Madagascar (conducted with UNFPA assistance). In February 1985, AID commissioned an Assessment Report on Institutional Capabilities in Statistics, carried out by the U.S. Bureau of the Census. INSRE's staff includes fifteen statisticians and one demographer. (Although the BUCEN report states there are two demographers on staff, the Population Evaluation team was told there was only one). INSRE has not been an extremely dynamic institution, in part due to the fact that (according to the BUCEN report), "though INSRE was originally created as the country's centre for the collection, processing, and analysis of census and survey data, it is quite evident that the government has done little to clear the way or to provide the human and financial resources necessary for staff at INSRE to live up to this mandate."

INSRE's major activities since its establishment in 1968 have been the national population census of 1975 and a major survey of household income and expenditure in 1978. Both have encountered major data processing difficulties, and the results of the latter are not yet available. Other on-going data collection activities of a smaller scale are an annual survey of industry, a monthly price survey, a vehicle registration system, and maintenance of the civil registration system. (Regarding the latter, the BUCEN report notes that it has been allowed to "wither on the vine."). Should the GDRM decide to proceed with another general census of the population, INSRE's director has indicated concern that INSRE's capabilities would be insufficient for its execution.

In summary, INSRE suffers from a number of problems which severely restrict its efficiency. Data processing capability is limited; INSRE'S IBM 370 is "fairly old and is not current technology." Training background of staff is variable. Some of the longer-term staff have little specialized technical training. A major problem is the lack of infusion of younger staff with recent training, partly due to INSRE'S reputation for having little promotion potential. Another constraining factor is that INSRE serves as the data processing unit for the Ministry of Finance, which accounts for approximately 80% of the work processed at INSRE.

C. Ministry of Agricultural Production and Reform (MPARA)

The other major institution with data collection responsibilities is the Ministry of Agricultural Production and Reform (MPARA) which since 1973 has included a Service of Agricultural Statistics. The BUCEN evaluation cited above also included a review of MPARA'S activities and capabilities, from which the following discussion is summarized. With a staff of 40 professionals, MPARA'S major activity has been an annual survey of agricultural area and production. In addition, two major specialized surveys have been conducted, of coffee production in 1969 and of rice production in 1974-75. The major large-scale activity since 1977 has been a comprehensive sample census of agriculture being carried out with FAO assistance. The survey is currently at the stage of coding operations, but problems are being encountered due to the lack of pre-coding during questionnaire design. It is not known when results of the survey will be available.

In summary, MPARA'S data processing capability is limited; it owns one SYMAG Micromachine 4000 and one Osborne microcomputer. Consequently, for the most part the data processing of the agricultural sample survey will be done at INSRE'S computer centre. (The BUCEN report indicated that "the outlook for successfully processing the sample census is not bright"). MPARA'S overall personnel and data processing capabilities would appear inadequate for consideration of any expansion of its data collection activities.

D. Service of Health and Demographic Statistics (SSSD)

Demographic data is also collected on an on-going basis by the Service of Health and Demographic Statistics (SSSD) within the Ministry of Health. Besides its division which collects data on sanitation and health (causes of mortality, morbidity, epidemiology, and so forth), SSSD includes a division of Demography. Since 1983 this division has had responsibility for collecting demographic data. As part of a project financed by UNFPA, three types of monitoring were established: births, deaths, and a general enumeration of the population allowing for the calculation of growth rates and other demographic indicators. The system has been set up in a sample of 1400 Fokontany (administrative unit comprising a group of villages) which constitutes a sample of 10% of Fokontany and 1,200,000 inhabitants.

The first summary statistical bulletin, which covered the first six months of 1984, was published during the summer of 1985 and included comments regarding the operation of the new system. Required reports had been received from all provincial centres except Mahajanga, where the system of data collection had only recently been put into operation. Problems identified with the system were: incomplete understanding of instructions for completing forms and insufficient supervision of data collection in the field. Despite these difficulties, it would appear from this first effort that the system has the potential to provide a large amount of useful data. The major problem likely to limit its achievement of this potential is the fact that the system is not automated, thus requiring extremely complicated and tedious manual recording and calculation.

In summary, SSSD is well-equipped in terms of personnel. Its central office staff includes three physicians (one of whom is currently enrolled in a demographic studies programme in France), one statistician, and nine para-medical staff. In the field, provincial chief physicians and medical inspectors of medical districts have responsibility for data collection and are assisted by para-medical personnel with varying levels of training in statistics. The major limitations of SSSD are thus material, particularly the lack of an automated data collection and processing system.

E. The University of Madagascar

The University of Madagascar has no department of demography; it includes demographic-related issues in courses in various departments such as sociology, economics, and geography. The faculty includes one IFORD-trained demographer, although several others not on the full-time staff teach courses in demography. Due to limited resources, little in the way of demographic research is carried out under the University's auspices. However, a manual on demographic techniques has been produced. In addition, the University's demographer assisted in the preparation of a development plan for the city of Antananarivo. Several demographers are also among the personnel of the National Centre of Scientific and Technical Research and the Office of Population.

In summary, although there is an urgent need for reliable demographic data in Madagascar, only very limited research is being carried out. This appears to be due to lack of financial resources rather than lack of interest or of qualified personnel. Several demographers indicated a desire to conduct studies in various areas, and at least one has submitted a proposal to the Population Council's Determinants of Fertility Research Program.

V. THE MINISTRY OF HEALTH: POLICY, STRUCTURE AND ACTIVITIES

A. Health Policy and Strategy

The overall strategy of the Ministry of Health is based on the objective of developing a national system of primary health care which will insure access of the entire population to both preventive and curative health care services. In order to attain this objective, a two-phase approach was developed.

During implementation of the first phase, from 1976 to 1984, the Ministry focused its efforts on the renovation and improvement of its 700 existing basic health care facilities (health posts, maternity centres, nursing posts) as well as the creation of a network of Primary Health Care Centres. The latter, known as CSSP (Centres de Soins de Sante Primaire) are the most basic type of health facility, consisting of a simple physical structure staffed by a single primary health care worker. During the period up to 1984, the number of CSSP's put into operation was 1250, thus bringing the total number of basic health care facilities to approximately 2000.

It should be noted that, in line with a philosophy of participatory health care, the CSSP network has been constructed jointly by the MOH and local communities. Each community selects the candidate to be trained as a primary health care worker, provides his/her lodging, and assists with the actual construction of the centre. The community also contributes non-medical equipment and assists in the maintenance and general operation of the CSSP. The contribution of the MOH includes provision of fourteen months of training for the primary health care worker, payment of his/her salary, and provision of necessary medical equipment for the CSSP.

Implementation of the first phase of the GDRM's primary health care programme was characterized by a marked increase in the ratio of health care workers to the general population. In 1978 it was believed that there was one para-medical health worker per approximately 6000 inhabitants (This figure is an average of MOH estimates which ranged from 4750 to 7500). Currently, the MOH estimates this ratio at one para-medical worker per 1700 inhabitants. Another major achievement of the first phase was the building of an infrastructure which would facilitate implementation of the activities outlined in the MOH's interim plan for 1984-87, which emphasizes the improvement of maternal and child health. In spite of the intensive efforts of the GDRM in implementing the first phase of its primary health care strategy, it is estimated that over 40% of the rural population still lack access to basic health care services.

Given this situation, the MOH's current approach includes activities designed to continue with the activities started in phase one: specifically, completing the network of CSSP's in those rural areas where these are lacking. Furthermore, the operation of the existing structures is to be reinforced through the training of an additional 100 primary health care workers per year through 1990. At the same time, the MOH intends to move into implementation of phase two of its overall strategy, in which the emphasis will be on the intermediate level of health care delivery.

Major objectives of phase two will be the reinforcement of structures providing intermediate level health care services, which include 98 medical centres, 58 secondary hospitals, and medical surgery hospitals distributed within 110 fivondronam-pokontany (administrative unit below the provincial level) throughout the country. With regard to personnel needs, phase two will emphasize training in general surgery, pediatrics, obstetrics, dentistry, and other specialized areas. Provision of the medical equipment necessary for the practice of these specialities will also be a priority in the coming years, although construction of new intermediary facilities is not foreseen.

There would appear to be some inconsistency in the strategy of the Ministry of Health as outlined above. The approach is justified by MOH officials through the example of a pyramid, with primary health care forming the base with the intermediate level just above. Reinforcement of the latter, it is felt, is necessary to support and maintain the base of the pyramid. In spite of this approach, the MOH continues to state its philosophy of giving priority to preventive over curative health care.

While a detailed financial analysis of the MOH system is beyond the scope of this report, several observations can be made. The training of additional personnel under phase one of the MOH strategy, as well as the payment of their salaries, has had significant financial implications for the MOH, particularly with regard to allocation among budget items. The total MOH budget has remained constant for several years at between 12 and 14 billion Madagascar francs (in September 1985, 675 francs = one US dollar). Thus, in absolute terms, the budget has been decreasing. While in 1976 salaries of personnel accounted for 52% of expenditures, by 1984 this percentage had grown to 72%. The obvious result has been a reduction of funds available for other expenditures, such as purchase of medications and general operating expenses.

B. Maternal/Child Health

Responsibility for these programmes rests with the Maternal/Child Health Service within the Directorate of Community Health. The Vaccination Service of the same directorate shares responsibility for activities directly related to immunization of children and pregnant women. The standard MCH services provided include pre- and post-natal care, delivery, well-baby services, nutritional education and rehabilitation of preschool children, malaria prophylaxis, immunization and health education.

In the field, these MCH services are provided by primary health care workers in CSSP's and by nurses or mid-wives in nursing posts and maternity centres. In general it may be said that the percentage of the population reached by the MCH programme is still relatively low. For example, the MOH estimates that no more than twenty percent of pregnant women attend pre-natal consultation and few of these begin consultation before the last trimester. It is thought that about half of births occur with no assistance from a trained medical or para-medical person. The number of children reached by immunizations and other well-baby services also remains low, as evidenced by the still high rate of death from diarrheal disease (one of every five deaths among children under one year of age). The reader is referred to Annex 6 for additional statistics on coverage of MCH services. The MOH recognizes the insufficiencies in the MCH programme and the need for its strengthening through in-service training of personnel, increased provision of medications, and more intensive health education efforts.

MOH facilities provide no family planning services. However, in many health centres counselling is provided on an individual basis. According to MOH statistics for the first six months of 1984, for example, one-third of the women visiting a health facility received individual counselling in family planning. (Bulletin Semestriel de Statistiques Sanitaires, SSSD). Currently, in approximately 40 MOH facilities, at the request of MOH medical personnel, FISA is providing contraceptive information and services.

VI. PRIVATE VOLUNTARY ORGANIZATIONS PROVIDING FAMILY PLANNING SERVICES

A. Fianakaviana Sambatra (FISA)

Finanakaviana Sambatra (which means in Malgache "happy family") became an associate member of the International Planned Parenthood Federation (IPPF) in 1971 and a full member in 1983. FISA has been a pioneer in promoting child-spacing in Madagascar and it is currently the only organization in the country with the mandate to promote and deliver child-spacing services.

FISA's first family planning and infertility clinic, was opened in 1967. In these early years, activities were conducted under relatively difficult conditions as family planning was extremely sensitive, usually being associated with the notion of birth control. However, between 1972 and 1976 FISA's position and activities were progressively strengthened due in part to the organization's active participation on various regional and national committees created by government to prepare for the 1974 World Population Conference in Bucharest. As government began to view population problems within a larger socio-cultural and development context, FISA was also able to promote the acceptance of child-spacing as an essential component of maternal/child health.

While there has not been official endorsement of family planning by the GDRM, a number of positive developments have taken place within the past five years, including:

- The Ministry of Finance's permission to FISA for the duty-free importation of contraceptives and medical equipment.
- The support by the Ministry of Health to permit FISA to train MOH personnel who in turn have begun providing services.
- The introduction of a Family Life Education Program through the Ministry of Education's school programs.
- The positive support by the Ministry of Population, Social Welfare, Youth and Sports; and
- Interest on the part of a number of private and parastatal organizations (such as JIRANA, OSTIE and FTK) to begin providing contraceptive information and services through their health care systems.

FISA's staff includes 63 salaried personnel located within the central office in Antananarivo and in 12 regional and sub-regional office throughout the country. The Headquarters office is composed of two branches--Administration and Co-ordination--staffed by seven senior level officers including the Executive Director, an IEC officer, Educator, Evaluation Officer, Logistics Officer, Finance Officer and Accountant.

FISA operates twelve clinics in addition to providing family planning services in 40 MOH clinics. Each FISA clinic is staffed by a mid-wife, a female motivator, a regional co-ordinator and a receptionist. A physician conducts periodic consultations. To receive contraceptive services a woman must become a member of FISA by paying a membership fee of 200 malgache francs (about 30 cents) per year. In addition, there is a charge for contraceptives: 450

fmg per cycle of orals (75 cents); 1,000 fmg per injection (\$1.35); 3,000 fmg for IUD insertion (\$4.30); and 350 fmg for twelve condoms (50 cents). In each case, the FISA price is about half the price charged in private pharmacies.

In addition to paying the necessary fees, a woman must meet certain eligibility criteria in order to receive contraceptives. Until 1978, FISA provided no contraceptives to women having less than four living children. Currently, a woman must present proof that she is married or living in a consensual union. She must obtain her husband's signature on a consent form. Two photos must be provided for the FISA membership card, which is obligatory. Finally, contraceptives are furnished to a woman only when she is menstruating. These criteria are not enforced to the same extent at all FISA clinics, or in those MOH centres in which FISA provides services, however the criteria need to be changed and present major problems to many women who would otherwise come for services.

Discontinuation rates are surprisingly low (estimated in 1982 at 0.9%), most likely due to the fact that users must be highly motivated in order to meet the restrictive eligibility criteria. The table below indicates the number of current family planning users, by method, for all FISA clinics in 1984. At the present time, figures on contraceptives provided by FISA in integrated MOH clinics are neither collected by FISA nor by the MOH.

Method	Number	Percentage
Injectables	7,606	51.5
Oral Contraceptives	6,374	43.2
Condoms	638	4.3
IUDs	130	.9
Others	25	.1

The following table indicates the increase in users between 1978 and 1984:

Year	New Users	Continuing Users	Total Users
1977	1,521	3,962	5,483
1984	3,224	11,549	14,773

Source: FISA Statistical Reports,
Mrs F. Ramambasoa

FISA's primary source of funding has been IPPF, which provided an average of \$150,000 annually between 1982 and 1985, and an additional \$32,000 for contraceptives and equipment. Unlike most family planning associations in the Africa region, FISA raises a substantial percentage of its total budget (approximately 30%) through local fund-raising activities and user fees. In recent years, FISA has also received support from organizations including CEDPA, which has trained five FISA officers in management and in August, 1985, CEDPA conducted a management training seminar in-country in collaboration with FISA.

FISA also currently has a \$21,798 project agreement with AVSC for an information and education program for voluntary surgical contraception. (Currently no surgical contraception is offered through FISA). Another source of funding for FISA has been UNFPA. (Assistance in the amount of \$74,850 is being provided through a project for which WHO is the executing agency). Activities under this project are designed to strengthen FISA's capability to carry out information and education campaigns to promote child-spacing as well as increase its capability to provide family planning services. Training, both abroad and in-country, will be provided as well as office and medical equipment, contraceptives, and general operational support.

An overall programme evaluation of FISA was recently conducted by IPPF; however, the report was not available to the team at the time of finalization of this document. In general, it may be said that FISA's primary strength is its established reputation as a pioneer in the area of family planning. It has the further advantage of having an adequate infrastructure for providing services through its network of clinics. A major weakness in FISA's operation is the application of strict and unnecessary eligibility criteria which have the effect of severely limiting access to contraception. In addition, there appears to be somewhat of a lack of dynamism and creativity in FISA's approach and programmes.

B. JIRAMA

JIRAMA is Madagascar's water and electricity parastatal organization. To provide medical services for its 4,200 employees throughout the country, JIRAMA has established one clinic each in Antananarivo, Majunga, and Tamatave. It is estimated that the total population served by these clinics (including JIRAMA workers as well as their families) is approximately 25,000. JIRAMA pays 6% and the worker 1% of his/her salary to cover the costs of medical coverage under the plan.

Since 1981, the head physician of JIRAMA, JHPIEGO-trained, has provided family planning services in the Antananarivo clinic, which serves nearly one-half of all JIRAMA employees. Contraception is

is made available on a daily basis and following appropriate medical screening, no other eligibility criteria is applied. Currently, the initial consultation is with a physician however nurses may see clients for follow-up visits. One cycle of pills is provided, except in exceptional circumstances, to allow for close surveillance of users. JIRAMA purchases its contraceptives from FISA which it then supplies free to clients. Continuing users as of mid-1985 were as follows: Orals, 615; injectables, 25; IUD, 65; condoms, 20. The latter are provided to couples who receive information and choose to practice natural family planning for use during the fertile period of the woman's cycle. JIRAMA's chief physician estimates that there are currently ten to fifteen new acceptors (all methods) per month at the Antananarivo clinic.

JIRAMA plans to extend its family planning services to the clinics in Majunga and Tamatave in the coming year, as well as putting into operation a mobile team within the Antananarivo region. A proposal for assistance in these activities has been submitted to UNFPA. In addition to its potentially wide coverage, particularly if an outreach programme is established, JIRAMA has the advantage of having extremely dynamic and motivated leadership. Its physical infrastructure is adequate, and staff expertise in FP is being strengthened this year through JHPIEGO training for at least one of the staff mid-wives.

C. Fivondronan' ny Tokantrano Kristianina (FTK)

FTK, the Movement for the Promotion of the Family, is a non-governmental organization attached to the Catholic Church of Madagascar. The organization's stated goals are to assist couples to live harmoniously, to aid them in resolving the conflicts of family life and properly educating their children, and to sensitize couples to the need to plan their families through the use of natural methods of family planning.

FTK's activities are carried out by volunteers. The central office is staffed by three couples holding the offices of president, secretary and treasurer. Office space is provided by the Catholic Church. No other direct financial support is received by FTK from the Church. Its operating budget derives entirely from contributions of members and interested persons as well as limited assistance which has been received from IFFLP (\$2,900 in 1984-85 to cover training scholarships).

FTK's major activities are:

--Education sessions for youth, carried out during meetings at schools and youth centres.

- Pre-marital counselling for couples.
- Home visits to couples, designed to improve communication.
- Counselling for couples experiencing marital difficulties.
- Training in natural family planning.

To conduct its training in natural family planning, FTK begins with general meetings for ten to fifteen couples. Advantages of child-spacing are presented, followed by an explanation of the various methods of contraception and their positive and negative aspects. Couples then choosing to learn more about natural family planning sign up for private sessions which are conducted once a month for a period of four months. These sessions are led by couples who are members of FTK and who themselves have received training as trainers of natural family planning. Billings, self-observation, and sympto-thermal methods are all explained during the sessions. Home visits are regularly made to practicing couples during the three months following their initial training.

Since 1978 FTK has taught over 1,000 couples about natural family planning. FTK estimates that approximately 500 couples are currently practicing a natural method as a result of their efforts. Discontinuation is believed to be very low, possibly due to the high level of motivation of couples who choose to practice NFP.

FTK's major strength is the high level of commitment of its members. However, the fact that the organization must rely solely on the efforts of volunteers to sustain its activities presents an obstacle to programme expansion. Although the group has a number of stated goals, there is a lack of direction in the planning of activities. FTK has recently submitted proposals for financing to several different organization: UNFPA, IFFLP, and AID/Antan. The requests are for various items and activities including support for a permanent office staff, office equipment and materials, a vehicle, teaching aids and other IEC materials, training of trainers in NFP, and funds for participation of FTK members in international NFP conferences. While FTK's limited resources should definitely be supplemented by outside assistance, there is a need for FTK to state its needs within the context of a well-developed project with specific objectives. Assistance should be provided to FTK's staff to prepare such a project.

D. SOLIMA

SOLIMA is Madagascar's major petroleum company (parastatal). Its 750 employees, along with their dependents (an estimated total of over 3,000 persons) are served by a medical centre in Antananarivo. The staff of the centre includes four physicians, one mid-wife, two nurses and two health aides. Some outreach activities are carried out, although not on a fixed schedule. Medical care is free of charge to SOLIMA employees and their families; they are reimbursed for 90% of the purchase price of medications which must be obtained in pharmacies.

The chief physician at SOLIMA was trained in laparoscopy at JHPIEGO in 1980. Since that time, he has provided counselling and screening for methods of birth-spacing. However, the centre has no contraceptives. When a woman or a couple expresses interest in family planning, a prescription for either orals or injectables, both available locally in pharmacies, is given. (It should be noted that the cost of oral contraceptives is NOT reimbursed to SOLIMA patients; however, injectables are covered by the 90% reimbursement policy.) Although IUD's are inserted by the physician, they cannot be purchased in the country. Most women obtain IUD's in the nearby Island of Reunion or in Europe. Currently around 50 women are using IUDs, 80 oral contraceptives, and 150 are on injectables.

In 1982, AVSC provided laparoscopic equipment to SOLIMA for a planned a centre for surgical contraception. However, it was later determined by SOLIMA that this was not a priority of the health care programme. The equipment was transferred to a hospital in Tamatave, where it is used by a JHPIEGO-trained physician to carry out diagnostic and some surgical procedures.

SOLIMA's medical centre appears to be well-placed to continue and expand coverage of child-spacing services as a part of its health care programme for employees. The chief physician believes this is a necessary service and is motivated and trained to provide information and supplies. Steps should be taken to insure that contraceptives are made available free of charge at the centre.

E. OSTIE

The Organisation Sanitaire Tananarivienne Inter-Entreprise (OSTIE) is a participatory medical care programme for employees of private enterprises in Antananarivo. Companies which belong to OSTIE pay 5% toward the cost of participation of their employees, who themselves pay 1% of their salaries toward the medical coverage. OSTIE operates five clinics in the capital, providing a

full range of medical services for approximately 35,000 workers and their families, or an estimated 100,000 persons. Total staff at the five locations include thirty physicians (three of whom are JHPIEGO-trained), five mid-wives (one JHPIEGO-trained), and forty nurses.

For the last two years the chief physician at the main OSTIE medical facility has been providing family planning, with contraceptives donated by the Pathfinder Fund. Approximately 800 women are users with the majority on orals. AVSC has agreed to provide OSTIE with financial support of \$36,000 for the establishment of a laparoscopic service. This will be located in the new and largest OSTIE clinic in Antananarivo, which was opened in June, 1985. This centre will serve as OSTIE's family planning education and service centre. In addition to the laparoscopic service, family planning education sessions and consultations are planned for two mornings weekly, beginning in late 1985. Eventually, it is planned that all physicians as well as mid-wives working at the centre will provide services.

OSTIE is potentially a major provider of family planning services given the large number of persons served, its progressive policy regarding FP, and the number of JHPIEGO-trained personnel on staff. Another advantage is the spacious and relatively modern new clinic which has just opened. However, use of this centre as the only site for FP services (women visiting OSTIE's four other clinics are referred here) as well as only offering FP two-mornings a week will be restrictive and should be reconsidered.

VII. AID -SUPPORTED POPULATION AND FAMILY PLANNING ACTIVITIES IN MADAGASCAR

For several years AID has provided population assistance to Madagascar through centrally-funded projects such as JHPIEGO, CEDPA, IFFLP, Pathfinder Fund and AVSC. Activities include:

A. Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). Since 1977, at least thirty-five medical and paramedical personnel have received theoretical and clinical training in the United States, Morocco and Tunisia. Training has been in reproductive health including contraceptive techniques, family planning program administration, sexually transmitted diseases, laparoscopy, treatment of infertility, and surgical contraception. As part of the program, laparoscopic equipment has been provided to ten medical centres where trainees are based. (See Annex 8 for a list of JHPIEGO

trainees and hospitals with laparoscopic equipment.) Laparoscopic equipment is used in Madagascar primarily to conduct diagnostic surgery and to occasionally carry out voluntary surgical contraception on older grand multiparous women. The team interviewed two physicians who use this equipment. One stated he had performed 1325 tubal ligations since 1975. Another indicated he performs approximately 60 tubal ligations each year. There has been no systematic follow-up of the participants who have attended training courses to determine what utilization is made of the laparoscopic equipment donated by JHPIEGO.

B. Centre for Development and Population Activities (CEDPA). In 1984 two members of FISA attended a CEDPA sponsored training course designed to strengthen the management skills of women family planning programme administrators. In August, 1985 CEDPA conducted an in-country workshop on women in management at an approximate cost of \$10,000.

C. International Federation for Family Life Promotion (IFFLP). The private organization, Fivondronan my Tokantrano Kristiana (FTK) received \$2,900 in 1985 to support staff for out of country training and a small amount of monies for the purchase of natural family planning literature.

D. Pathfinder Fund. For over two years contraceptives and medical kits have been supplied by Pathfinder Fund to the Organization Sanitaire Tananarivieene Inter-Entreprise (OSTIE). To date, these supplies have been sent to the U.S. Embassy and once cleared through customs, delivered to OSTIE.

E. Association For Voluntary Surgical Contraception (AVSC). AVSC has financed several small-scale projects in Madagascar. These include:

--FISA: Financing in the amount of \$91,798 provided over three years for the development and printing of a family planning brochure, operational expenses for conducting seminars and provision of audio visual and medical equipment to promote voluntary surgical contraception activities.

The project began in 1985. The first phase, which is the production of the brochure, has been completed and six thousand brochures have been printed. Regional seminars are scheduled to take place in each of the six provinces beginning in July, 1985. FISA is now awaiting receipt of the audio visual equipment for use in the seminars. The project is proceeding well and according to plan.

--SOLIMA: AVSC contacted this major petroleum company in 1982 to determine their interest in integrating surgical contraceptive services within their family planning activities. Laparoscopic equipment was furnished for use by the JHPIEGO-trained physician.

Original plans were to expand the medical centre to allow performance of contraceptive and gynecological surgery. However budgetary constraints prevented this construction to be carried out. It has since been decided that surgical contraception is not a high priority of SOLIMA's medical service plan. The laparoscopic equipment was thus transferred to a hospital in Tamatave where another JHPIEGO-trained physician uses it to conduct diagnostic procedures and some surgical contraception.

--OSTIE: AVSC has an agreement with OSTIE to provide \$36,000 in equipment and IEC assistance to establish a laparoscopic service in one of OSTIE's clinics. The equipment has been received and OSTIE is awaiting a visit from an AVSC consultant for installation. In July, 1985, OSTIE opened a new clinic which will serve as their family planning education and service centre.

--Anglican Church: AVSC has provided funds to the Anglican Church for the publication of informational brochures on family life. Films and audio visual equipment are being provided and are expected to arrive in country shortly. Design of the brochure is underway.

VIII. OTHER DONOR ACTIVITIES

A. UNFPA

The major donor in the area of population/family planning is UNFPA. Since 1978, Madagascar has been the site of the UNFPA regional office which also covers the Comoros Islands and Mauritius. Although Madagascar meets UNFPA's criteria for priority countries, assistance to Madagascar has consistently fallen below its potential. The first major activity was assistance to the 1975 general housing and population census. A UNFPA needs assessment conducted in 1979 was followed by a flurry of activity which soon diminished due to UNFPA budgetary constraints and in-country difficulties in project approval and implementation.

In total, UNFPA assistance through 1985 has totalled \$2.4 million. In addition to the 1975 census assistance, major activities have been the establishment of the system of health and demographic statistics (SSSD, Ministry of Health) and a population education project with the Ministries of Education and Population, for which UNESCO is the executing agency. Budgets for these two projects for 1985 are \$62,000 and \$249,800 respectively. A third operational project will provide \$74,850 in assistance to FISA, with WHO as co-executing agency. WHO was also the executing agency for a UNFPA-financed observational tour of family planning programs in Mauritius, Indonesia, Tunisia and Cuba made in 1984 by a member of the national assembly and representative from the Ministry of Health, the Ministry of Population, Social Conditions, Youth and Sports, and the Directorate General of Planning.

UNFPA's 1985 budget of \$614,380 also includes one project not yet approved, to provide assistance to the Ministry of Population, Social Conditions, Youth and Sports for the printing of a document presenting a socio-demographic profile of Malagasy youth. Two other projects have been approved but not yet executed. The first is for development and application of a demo-economic planning model within the Directorate General of Planning (ILO to be the executing agency). The second project will provide assistance to the National Institute of Statistics and Economic Research in the revision of the national system of civil registration.

A final activity likely to be undertaken by UNFPA is a project to strengthen the maternal/child health program of the Ministry of Health. This project has been in preparation for over three years but a final project document has not been approved. In late 1985, UNFPA plans to bring in a consultant to review the situation and finalize a plan of activities.

B. UNICEF

UNICEF's assistance programme for 1986-1990 will continue to focus on the three areas which have been emphasized in the past. These include health (50% of budget allocation), public education (20%), and preschool education (20%). The remaining 10% of the budget is reserved for miscellaneous activities.

In the health area, priority will be given to strengthening the expanded program of immunization (EPI) programme through supply of vaccines, particularly for immunization against polio and measles. Some material assistance will also be provided, including cold chain equipment and logistical support. Other UNICEF activities include:

--oral rehydration: In-service training of 2,000 primary health care workers and the eventual construction of a plant for the in-country production of up to two million ORS packets per year.

--nutrition: Establishment of 100 centres for nutritional education and rehabilitation within existing health care facilities. Production and utilization of a growth monitoring chart and continuation of research on the nutritional status of the population of Madagascar.

--health personnel: Training of 500 new primary health care workers, who will also be provided necessary medical supplies and some logistical support (vehicles and/or mopeds).

--medications: Supply of anti-malarial medications and insecticides.

--water supply: Mobile teams to control water quality.

--training: Supply of teaching aids to six para-medical schools and assistance in the re-training of para-medical personnel in oral rehydration therapy and immunization.

C. French Development Assistance

Assistance from the French government does not involve any direct financing of projects in the areas of population or family health. As is customary for French assistance, a significant number of ex-patriate medical personnel do work in country. Seventy-five percent of the budget of approximately \$3 million allocated for health assistance covers the salaries of these medical advisors. These include 75 who work in hospitals throughout the country. In addition, substantial support has been provided to the military hospital in Antananarivo. The Institut Pasteur of Madagascar also receives the equivalent of \$350,000 annually in medical supplies and medications. Up to five French advisors teach at the Medical School each year; two are posted to the dental school at Majunga; and varying numbers of visiting professors teach specialized courses each year. Finally, scholarships for medical studies are furnished to approximately thirty Malgache students annually.

IX. RECOMMENDATIONS

Given the situation described in the preceding pages, and the newly re-established relations between the United States and Madagascar, the need to proceed with prudence, and with great sensitivity to the country's political and social context, cannot be overemphasized. In making the following recommendations, the team has taken into account this need as well as the need to avoid straining Mission's limited management capability. The list of recommendations appears in rank order according to the priority the team and GDRM feels should be accorded each.

The five areas include strengthening family health service provision in the MOH; population policy activities; demographic statistics and research; support to existing private organizations; and information, education, and communication. In the following paragraphs, discussion of objectives within each area, proposed activities, and potential sources of assistance (AID and other) are presented.

(1). Strengthening Family Health Service Delivery within the MOH . Recommended activities in this area are designed to achieve two objectives. First, orientation of health personnel and second upgrading of clinical skills. The former involves providing information to increase understanding of reproductive health and awareness of the benefits of child-spacing. Although a growing number of health personnel recognize the need to provide couples

with family health information and services, these services are not currently available within the MOH system. In fact, many health staff are ill-informed about the interrelations between numerous, closely-spaced pregnancies and the health of mothers and children.

To address this problem, a series of national and regional level seminars covering aspects of reproductive health including infertility, sexually transmitted diseases, and contraception should be conducted. Each seminar will last three to four days. Participants should be health leaders, planners, and administrators both within the MOH and in other organizations which deliver health services. The seminars should include presentations of recent research findings by medical experts, round tables in which participants take an active role, and question and answer sessions. Organizations which could assist in organizing and supporting these seminars are JHPIEGO or INTRAH.

A second aspect of assistance in strengthening service delivery is upgrading the clinical skills of health personnel to enable them to provide reproductive health information and services including child-spacing as well as treatment of such problems as infertility and sexually-transmitted diseases. The first step should be to train a core group of 8 to 10 trainers. These trainers would, in turn, have the responsibility for conducting a series of short in-country training courses in reproductive health for service delivery personnel. Each of these training courses should be tailored to the type of participant, whether physician, nurse, midwife, or other. INTRAH is recommended as a source of this type of assistance; UNFPA may also wish to support some of these training activities.

As a complement to the above training and orientation activities, delivery of health services should be strengthened through the provision of needed medical supplies and equipment. The system of collection of health statistics under the Health and Demographic Statistics Service (SSSD) should also be reinforced, particularly through the provision of hardware, technical assistance, and staff training necessary to automate the system. UNFPA is a potential source of support for the latter activities.

(2) Population Policy. Assistance provided in this area should be directed at two general objectives: providing guidance to the GDRM in deciding which stance it ultimately wishes to officially adopt with regard to population; and encouraging the systematic incorporation of demographic factors into sectoral development planning. It is important to note that proclamation of an official population policy should by no means be seen as a pre-requisite for expansion of activities in population and family planning. Exerting pressure on the GDRM to issue such a policy before it feels ready to do so would have negative repercussions. Nonetheless, the

uncertainty demonstrated by the GRDM appears to be causing reluctance to proceed with family planning service expansion, particularly within the Ministry of Health. For this reason, the GRDM should be encouraged to make clear its position and policy on family planning and eventually to develop a population policy.

The first step toward this end must be education of policymakers to the implications of rapid population growth and its relationship to the attainment of Madagascar's stated development objectives. While it is true that awareness appears to be greater than several years ago, there exists only a partial understanding of these relationships.

Moreover, there is the tendency to view the demographic "problem", to the extent that one is acknowledged, as a population distribution and allocation of resources problem.

A national seminar on Population and Development is strongly recommended. The GDRM, through the Office of Population as well as the Directorate General of Planning, has expressed interest in the organization of such a seminar. The Director General of Planning suggested to the team that timing of the seminar should coincide with the beginning of preparation of the five-year national development plan in late 1986. The seminar should be built around computerized simulations of various development scenarios, using a data-base constructed in-country in collaboration with Malgaches and specific to the country's situation. Rather than attempting to recommend actions to be taken regarding population growth, the seminar should clearly demonstrate, using data from Madagascar, the implications of demographic factors for various sectors such as agriculture, education, and health. The initial seminar should be followed by specific sectoral analyses using the same computer technology in collaboration with appropriate Ministries. The Futures Group, through RAPID II, is the recommended source for conducting these activities.

Regarding integration of population factors into development planning, closer collaboration between the Office of Population and the Directorate General of Planning should be encouraged. Within planning it will be important to create an institutional structure to ensure the incorporation of demographic factors into sectoral development planning. UNFPA is an appropriate source of funding to establish such a structure. In addition, short-term training for GDRM personnel in applied population and development planning, in the U.S., in Madagascar, or at third-country training sites should be supported, most likely through such projects as BUCEN, INPLAN, or DDD.

Material support should be provided for the Parliamentarians' group on Population and Development. Given its position and the influential role of several of its members, this group could play a major role in sensitizing government officials. The group expressed a desire to establish a documentation centre on population and development and should be supported in this effort. This could be done in the context of the RAPID project.

(3). Demographic Statistics and Research

Lack of reliable data presently hinders program development and evaluation. A national fertility survey has never been conducted in Madagascar, nor has a contraceptive prevalence survey (CPS). A full scale CPS would not be advisable as, due to the limited number of outlets providing family planning. However, a national family health survey is recommended which would combine elements of fertility, contraceptive prevalence, and KAP-type information. This could be conducted through the Family Health and Demographic Survey project (FHDS) and should include involvement of both the Office of Population and the Ministry of Health.

As a complement to this activity, small-scale studies and/or surveys in areas related to population and family-health should be financed. Examples of relevant research is a project proposed by the Office of Population to investigate social and economic determinants of rural-urban migration in one region of Madagascar. Research interests of faculty at the University of Madagascar should also be examined for possible funding of small-scale research projects. The Futures Group, under RAPID II as well as the Demographic Data for Development (DDD) project could support these activities.

A decision regarding the next general census of the population has not yet been made. Should the GDRM decide to go forward with the census, appropriate support should be provided. Through BUCEN short-term technical assistance is recommended in specialized areas (cartography, sampling, and so forth) as necessary. Short-term training can also be provided through the same source, as well as some software. UNFPA is a possible source of funding for needed hardware and for general assistance in census execution.

Additionally, Malgache candidates should be named to participate in short-term training, such as INPLAN seminars.

(4). Support to Existing Private and Parastatal Organizations

Several private organizations are currently active in providing information and family planning services. It is recommended that their efforts be supported through the financing of three to four small-scale support activities per year, to include

assistance for contraceptive supplies, equipment, training, and IEC. An appropriate source of funding would be FPIA which could also assist these organizations in clearly defining their needs in the context of well-defined projects. AVSC should continue to support VSC activities which are on-going but should not undertake expansion of its activities due to the need to support a full range of contraceptive services.

For the time being, FISA is undoubtedly the principal organization active in family planning in the country. Although FISA will need to make some changes in its policies, for example with regard to eligibility criteria, the organization should receive additional support, particularly for contraceptives, training and IEC activities.

The three organizations reviewed in this assessment which currently provide contraceptive services--JIRAMA, OSTIE, and SOLIMA--should also be assisted by FPIA. JIRAMA, with its dynamic leadership should receive contraceptives and medical supplies as well as training support. SOLIMA should receive similar assistance. OSTIE should be assisted to ensure that its newly-opened family planning centre in Antananarivo is successful and serve as a possible model for other such clinics.

FTK, the natural family planning association of Madagascar, has extremely limited resources and have a dedicated staff of highly-motivated volunteers. FTK should be supported in its efforts to reinforce and extend its natural family planning activities. It is recommended that a representative from IFFLP visit FTK to review its program, determine its needs, and develop a project proposal for general support for a period of two to three years.

(5). Information, Education and Communication

If the MOH is interested in expanding its family health service programme to include the introduction of child-spacing, it is essential that a strong national family health IEC programme be developed. As described elsewhere in this report, the current IEC programme is not well developed. This is due primarily due to lack of financial resources and shortage of personnel trained in information, education and communication.

In order to clearly identify the Ministry of Health's MCH IEC needs, it is recommended that a comprehensive IEC needs assessment be carried out with assistance from Johns Hopkins University Population Communication Services (PCS) project. The results of this assessment, along with the results of the baseline family health survey described above, should be used to prepare a national IEC programme. Particular attention should be given to development of a media plan appropriate to the societal conditions (literacy rates,

access to mass media, etc.) as well as to careful design and testing of messages consistent with the cultural context of Madagascar. PCS is recommended as the source of support for this activity. Once the national IEC programme is planned, PCS could provide short-term technical assistance in specialized areas as well as training to upgrade the IEC skills of selected MOH personnel. UNFPA would be a possible source of general support for the implementation of the national programme.

X. IMPLEMENTATION PLAN

As has been explained previously, the recommended activities will be implemented by AID-financed cooperating agencies. The first step in implementation will be visits made by representatives of the various cooperating agencies to initiate activities with the appropriate ministries or other organizations. A proposed timetable for these initial visits appears on the following page. It was developed based on discussions with the Malgache contact persons who agreed upon dates for these visits. Once these activities are underway, each cooperating agency will operate independently, requiring only minimal support from AID/Antananarivo.

Regarding the cooperating agencies which are already working in Madagascar: AVSC should continue its on-going support to those organizations with which it currently has agreements. Visits of AVSC representatives will be made only for the purpose of monitoring existing activities. Due to the need to provide more broad-based and general support for family planning, no further expansion of AVSC activities in Madagascar should occur in the foreseeable future. The nomination and funding of Malgache candidates for JHPIEGO training in the U.S. and at third-country training sites should continue. However, JHPIEGO's activities in Madagascar should be limited to this for the present time.

Monitoring of the overall Madagascar program will be carried out through quarterly visits by the REDSO/ESA Population Officer. The local training officer will handle logistics involved in out-of-country training for Malgache participants. Each co-operating agency conducting activities in Madagascar will brief and de-brief the AID Representative during his/her visit. When possible, he/she will also stopover in Nairobi to brief the Regional Population Officer. All sub-projects or activities proposed will be submitted to both AID/Antan and REDSO/ESA for review and approval.

ANNEX 1

PERSONS CONTACTED

Ministere de la Population, des Conditions Sociales, de la Jeunesse
et des Sports

Ministre, Ndremananjary Jean Andre
M. Senn Harrison, Directeur de la Population
Mme. Monique Andreas, Directrice de la Condition Feminine

Ministere de la Sante

Dr. Jean-Jacques Seraphin, Ministre de la Sante
Dr Paul Randimbiuahiny, Directeur des Services Sanitaires et
Medicaux
Dr. Paul Randrianaino, Directeur, Service de Lutte Contre les
Maladies Transmissibles
Dr. V. Rakotoarivelo, Chef de la Division Centrale SMI
d'Antananarivo
Dr. Andriamiharisoa, Medecin Resident Centre Medical
Dr. Lock Yong, Medecin Chef Hopital Secondaire
Dr. Laurent Ramialison, Hopital Itaosy
Dr. Rakotomanga, Adjoint Chef Service Provincial Tamatave
Dr. Randriamanjaka, Medecin Inspecteur C.M. Tamatave
Dr. Givance, Medecin Inspecteur C.M.
Dr. Raharimanana, P.M. Tamatave
Dr. Osee Ralijaona, Chef de Service, Direction des Services
Sanitaires
Dr. Ralantonisainana Daniele, Chef de Service
Dr. Ratsifasoamanana Lala, Chef de division ONG
Dr. Jean Louis Razafimahatratra, Medecin Inspecteur
Dr. Razakamaniratsoa, Medecin Chef Maternite Tamatave

USAID

Mr. Samuel Rea, AID representative
Mr. David P. Rawson, DCM
Mlle. Agnes Rakotomalala

Other Organizations

Mr. Jean Claude Corbel, FAC (French Cooperation)
Dr. Celaletine Algan, WHO
Mr. Paul Blay, World Bank
Mr. Ottorino Jannone, UNDP Resident Representative
Dr. Hakizimana, WHO
M. Claude Paulet, UNFPA Representative
Mme. Malou Marfing, UNESCO consultant
M. Ajavon Ayi. IPPF representative, Nairobi

Ministry of the Interior

Mr Adrien Dahy, President of Executive Committee of the Province of
Tamatave

FISA (private family planning association)

Mme. Bodo Ramabason, Executive Director
Mme Raharimanana, Sage femme FISA Tamatave
Mme Razafindravao, "Animatrice" FISA
Dr. Daniel Ralantonisainana, Chef de Service de Medicine de Soins
Dr. Daniel Radaonarivony, Chef de Service Provincial de Sante d'
Antananarivo
Dr. Emmanuel Razafindrakoto, Medecin Inspecteur de l'Imamina Est
Mr. Manitra Andriamasinaro, IEC
Mme. Alice Rajaonah, Presidente Nationale
Mme. Yvette Randena, Vice-President Nationale
Dr. Bert

Direction Generale du Plan

M. Jean Robiarivony, Directeur

Assemblee Nationale

M. Michel Kapoma, President du Groupe National des Parlementaires pour la
Population and le Developpement
M. Jean Louis Ramandraiarisoa, Deputy

Catholic Relief Service

Patrick Johns

JIRAMA

Dr. Monique Rakotomalala, Chef de Service Medical

FTK (Natural Family Planning Association)

M. and Mme. Randriambelo, National Presidents
M. and Mme. Rabarijaona, Secretaries General
M. Randriamihoatra, National Treasurer
Mme. Rafaralalao, National Treasurer

Universite de Madagascar

M. Tovoanahary Rabetsitonta, Demographer
M. Rafrezy Andrianarivelo

SOLIMA

M. Odon Randriamananten

OSTIE

Dr. Samuel Ratsirahonana, medecin chef

Anglican Church

Msr. Remi Joseph Rabenirina

ANNEX 2

SITE VISITS

Province of Antananarivo

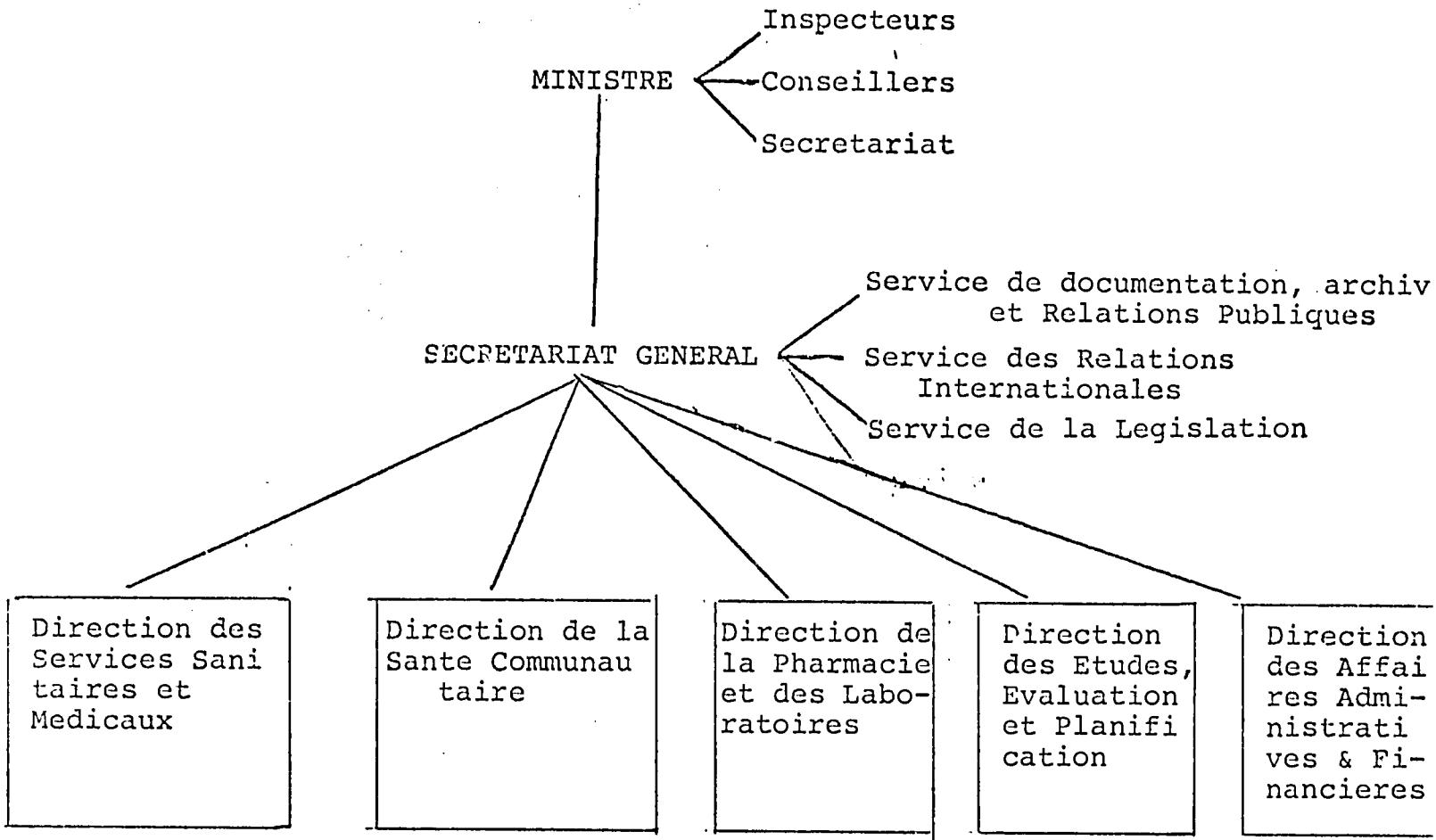
Poste d'infirmierie de Faliarivo
Poste Sanitaire d'Antsahadita
Centre Medical Imerintsiantosika
Centre de soins de sante primaire d'Ankasilanga
Siege de la Circonscription
Hopital secondaire d'Itaosy
C.S.S.P. Antsahamaro
Poste sanitaire d'Ambohibao sud
Centre Medical d'Ambohitrolomahitsy
Hopital Secondaire de Manjakadriana
Centre de P.M.I. d'Antananarivo

Province of Tamatave

Polyclinique de Tamatave
Bureau de la FISA
Maternite de Tamatave
Dispensaire de Tamatave
Poste Sanitaire de Foulpointe
Sante Maternelle et Infantile de fenerive
Hopital Secondaire de Fenerive Est

ANNEX 3

MINISTRY OF HEALTH STRUCTURE



REPARTITION DES INFRASTRUCTURES SANITAIRES PAR
PROVINCES ET PAR CATEGORIE DE FORMATION SANITAIRE

PROVINCE	CSSP PS/PI/PA	CM HSS	HMC/HP HG	Gdes Mat HMC/HG	Labo	DU/BMH SMI/SS	E.S.M.	TOTAL
ANTANANARIVO . . .	367	39	04	04	04	27	05	424
ANTSIRANANA . . .	195	13	03	03	03	11	03	189
FIANARANTSOA . . .	450	34	04	04	04	15	06	492
MAHAJANGA . . .	373	27	04	04	04	03	06	385
TOAMASINA . . .	372	23	03	03	09	17	07	408
TOLIARY . . .	298	25	04	04	04	13	08	318
T O T A L . . .	2.065	161	22	22	28	80	35	2.419

1/ Non compris les Etablissements spécialisés et les 35 Circonscriptions médicales avec les 6 Bureaux Statistiques des Provinces.

- HG : Hôpital Général, seulement à Tananarivo
- HP : Hôpital principal, dans chaque chef lieu de Province
- HMC : Hôpital Médico-Chirurgical
- HSS : Hôpital secondaire simple sans chirurgie
- Cm : Centre Médical, formation sanitaire ayant 1 médecin
- DU : Dispensaire Urbain, dans les grands centres urbains
- PS : Poste sanitaire : formation ayant un infirmier et une sage-femme
- PI : Poste d'Infirmier : formation ayant un infirmier
- PA : Poste d'Accouchement : formation ayant une sage femme
- CSSP : Centre de Soins de Santé Primaire : formation ayant 1 aide sanitaire
- SMI : Santé Maternelle et Infantile
- SS : Santé Scolaire
- BMH : Bureau Municipal d'Hygiène
- Labo : Laboratoire

ADDITIONAL INFORMATION ON MORTALITY

Infant mortality, estimated on the basis of census data at 72 per thousand in 1975, was in 1981 estimated to be 92 per 1000. A study of a sample of 3,000 women attending maternal/child health centres resulted in what is probably a more realistic figure of 140 per 1000. Infections and parasitic diseases, diarrhoea, measles and malaria are the primary causes of this high mortality rate.

About half of the deaths annually registered are of children less than one year old. Among them, 20% are caused by diarrhoeal diseases. The typical pattern of closely spaced and numerous pregnancies is also a factor contributing to high infant/child mortality and morbidity. On the average, a Malgache woman reaching the age of 50 has borne 6.4 children. A recent study showed that at the age of 35, a woman already has had an average of 7 pregnancies, of which 5 live births, indicating a pregnancy loss rate of around 30%. According to Ministry of Health statistics for the first semester of September 1984, maternal mortality is 4.6 % and the rate of abortion ratio of the number of abortions with regard to the number of live births is 52%. An inquiry made by FISA in 1983 among a sample of 1,375 women indicated that 64% of abortions had been the result of undesired pregnancies. Another 30% were therapeutic abortions or were due to abnormalities of pregnancy.

Malnutrition is considered to be directly responsible for about 5% of child deaths. An inquiry made in a rural area in the province of Antananarivo in 1979 indicated prevalence of serious malnutrition (weight in relation to age under 60% of the standard) of 2.3%, and moderate malnutrition (weight in relation to age between 60 and 79% of the standard) of 31.5%. The rate of malnutrition increases with birth order, from 29% among children up to the sixth birth to 36% for sixth-born and higher. Malnutrition is particularly prevalent at the time of weaning: nearly half of children between age two and three are affected.

ANNEX 6

MATERNAL/CHILD HEALTH PROGRAM

It is estimated by the Ministry of Health that only 20% of women receive health care during pregnancy. The large majority of those who do present for pre-natal consultation do so during the last trimester of pregnancy. Furthermore, among those women attending pre-natal consultations, no more than half deliver at a health facility (thus estimated at 1% of all deliveries). Few return for post-natal consultation.

Factors believed to account for the low rate of consultation include lack of easy access to health facilities; lack of resources including food in maternity centres; women's involvement in agricultural and domestic activities, particularly during harvest periods; and a possible reluctance to be treated by male health care personnel.

As a consequence, most births occur at home, with the assistance of traditional matrons. The MOH does not recognize these matrons and has no plans to train them or otherwise integrate them into the public health care system.

Dtcoq vaccination coverage was 30% in 1982; . The BCG coverage rate for under fives is 40%, and the number of children under one year old who have been vaccinated increased from 10,000 in 1977 to 54,000 in 1981. Coverage for anti-polio vaccine, for which a major effort was undertaken beginning in 1982, is unknown.

All figures cited should be interpreted with caution, as the coverage rates show very important regional variations. Thus, in the province of Majunga where an important vaccination campaign was conducted, a pre-inquiry indicates a Dtcoq-polio-BCG covering rate of 6%. Anti-measles vaccination, not included in the EPI program up to now because of its cost and technical difficulties for its transportation and conservation, will start in 1985 with the assistance of UNICEF.

The importance of diarrhoeal disease and the resultant high mortality rate (20% deaths among children under one year of age) make combatting diarrhoeal disease a MOH priority. The aim is to reduce the incidence of these diseases to 8% for children under five and to decrease by 43% the mortality caused by diarrhoeal disease. This is to be attained primarily through extensive use of oral rehydration salts, of which 2 million packets annually will be produced in-country beginning in 1988.

Activities to address the problem of malnutrition, as well as malaria prophylaxis, are carried out in the primary health care centres of the MOH as well as in approximately 11,000

nivaquinization centres and around 35 health education and nutrition centres (FESN). Both the FESN and the nivaquinization centres are staffed by volunteers of women's organizations such as the Red Cross. In the latter, sessions are held once weekly for pregnant women and pre-school children. Regarding the problem of malnutrition, Catholic Relief Service supplies 100 centres, mostly private, with rice, oil, and powdered milk. These centres are attended by around 68,000 children under five. Mothers are allowed monthly rations of 2 kilos each of rice and powdered milk and one litre of oil.

Family health activities in each Medical Circumscription are the responsibility of the chief medical inspector, who supervises up to sixty medical facilities. The many tasks for which he is responsible, including collection of health statistics, difficulties of transportation and shortage of vehicles, insufficient personnel and the large number of facilities to be visited have resulted in a relatively inadequate level of supervision. Certain facilities may be visited once a month, while others may pass an entire year with no inspection.

The severe shortage of medications and of surgical equipment is felt at all levels of the health care system. One center visited by the team had been without aspirin for five months. To address this problem the MOH has re-organized the system for ordering medications, which had formerly been the responsibility of the chief medical inspector for each region.

Beginning in 1985, the MOH established a list of essential medications and will allocate 40% of the operating budgets of medical centers (excluding salaries) to the purchase of these medications and minor surgical equipment.

GDRM Statement at Mexico City
Population Conference, August, 1984

CONFERENCE INTERNATIONALE SUR LA POPULATION
Mexico 6 au 14 août 1984
Fonds des Nations Unies pour les Activités
en matière de Population

Discours de
Monsieur le Docteur Rémi TIANDRAZA
MINISTRE de la POPULATION, de la CONDITION SOCIALE,
de la JEUNESSE et des SPOPTS
de la
REPUBLIQUE DEMOCRATIQUE MALGACHE

Monsieur Le Président,
Honorables Délégués,
Mesdames et Messieurs,

Au nom de la délégation malagasy, permettez-moi de m'associer aux honorables délégués qui m'ont précédé à cette tribune pour adresser mes chaleureuses félicitations à vous, Monsieur le Président, ainsi qu'à tous les Membres du Bureau pour votre brillante élection à la tête de notre Conférence.

Je saisis l'occasion qui m'est offerte, pour adresser ma gratitude et mes remerciements au Gouvernement et au peuple du Mexique pour avoir accepté d'abriter cette Conférence-bilan du Plan d'Action Mondial de la Population, dix ans après la Conférence de Bucarest.

Il y a dix ans en effet, en tant que Directeur de la Population au Ministère des Affaires Sociales, nous avons eu l'honneur de conduire la délégation malagasy en Roumanie et de participer activement aux débats. Nous voici à nouveau réunis pour essayer, chacun en ce qui nous concerne, de faire un bilan de la première décennie du Plan d'Action Mondial que nous avons adopté.

Depuis, nombreux sont les événements qui se sont succédés à Madagascar, tant sur le plan politique, que sur le plan de la population, objet de notre débat aujourd'hui au sein de cette auguste Assemblée.

Si sur le plan de la Population, un recensement général a été effectué dès 1975 grâce à l'assistance du FNUAP, sur le plan Politique, avec l'avènement de la Charte de la Révolution Socialiste Malagasy et de la III^e République, un Ministère à part entière, celui de la Population et de la Condition Sociale, unique en son genre, a été créé.

La création de ce département prouve, s'il en était besoin, la prise de conscience du Gouvernement Malagasy de l'importance du problème de la population dans le cadre du développement économique et social du pays, et de la réaction positive à la Conférence de Bucarest.

Comme le disait si bien avant hier, le Directeur Général de la Banque Mondiale, un débat passionné avait eu lieu à Bucarest entre ceux qui pensaient que le moyen le plus rapide d'abaisser les taux de natalité consistait à promouvoir le planning familial, et ceux pour qui la baisse de la fécondité passait par le développement... J'avoue que la délégation malagasy était et est toujours pour la seconde position en prônant avant tout l'éducation et la sensibilisation en matière de population.

Depuis ce débat passionné de Bucarest, l'accroissement de la population constitue une préoccupation de premier plan pour la plupart des nations du Tiers-Monde. Il faut préciser ici que c'est la population des pays en voie de développement qui était au centre de la discussion à Bucarest. Il n'était nullement question du vieillissement de la population des pays industrialisés. Beaucoup d'encre a coulé et d'innombrables moyens et incitations ont été entrepris pour convaincre les pays du Tiers-Monde que la croissance démographique trop élevée constitue le principal frein à leur développement et pour préconiser comme solution à l'explosion démographique, la limitation des naissances, la stabilisation à plus ou moins long terme de la population.

Monsieur Le Président,
Honorables Délégués,

Parfaitement d'accord avec le Plan d'Action Mondial, Madagascar estime " qu'il est vain d'isoler les problèmes démographiques et impossible de les résoudre indépendamment des problèmes relatifs au développement

social et économique ". La Charte de la Révolution Socialiste Malagasy place à ce sujet, l'homme et ses besoins au centre du processus de ce développement, et envisage la population dans une société où l'homme est le " primo vere " et le but de l'activité sociale et économique.

Procédant de cette vision, la tâche cruciale à laquelle s'attelle sans répit la nation malagasy consiste à réaliser un degré de développement économique et social capable de garantir à chacun de ses citoyens un niveau de vie qui ne connaîtrait pas la crainte de la famine, de la maladie, du chômage et des autres privations matérielles, et qui donnerait accès à l'instruction et aux autres facilités visant à épanouir la personnalité de l'homme et de la femme malagasy sous tous les aspects.

Plusieurs mesures qu'il serait trop long à développer dans le cadre d'une déclaration comme celle-ci, ont été prises à cet effet, qui ont trait à la nationalisation des secteurs-clés de l'économie nationale, à l'intégration effective de la femme dans la vie politique, économique, sociale et culturelle du pays, à la démocratisation de l'enseignement, à l'alphabétisation des adultes et à l'éducation populaire, à la démocratisation des soins de santé par la mise en place des centres de soins de santé primaire et la multiplication des centres de protection maternelle et infantile, à la création d'emploi pour les jeunes par la coopérativisation et la mise en place des villages communautaires, etc...

Monsieur Le Président,
Honorables Délégués,

Nous sommes heureux de constater que la plupart des orateurs qui nous ont précédé ont insisté sur le rôle de la femme dans la politique de la Population. D'après nous, il ne peut pas y avoir de réussite dans cette politique de la population si l'on ne donne pas à la femme le rôle et la place qui lui reviennent. Il y a un proverbe qui dit : " Eduquer

un homme c'est éduquer un individu, mais éduquer une femme ou une fille c'est éduquer une nation. Consciente de cette vérité, la Charte de la Révolution Socialiste Malagasy considère la femme comme un pilier et le gage de la révolution et en tant que tel, elle a son rôle à jouer sur tous les plans de la vie nationale. Une Direction de la Condition de la Femme et de l'Enfance existe au sein du Ministère de la Population. Ce n'est pas un secret pour personne que dans la plupart de nos pays du Tiers-Monde la femme est reléguée au second plan surtout en matière de scolarisation. Ainsi donc, c'est avec une volonté politique d'inverser cette situation, en donnant la priorité à la scolarisation, à l'éducation, bref en améliorant la condition de la femme que nous serons en mesure de transformer notre société et d'avoir des résultats significatifs sur le plan de la politique en matière de population.

A Madagascar, nous sommes certes conscients de la difficulté qu'il y a à briser le cercle vicieux sous-développement forte fécondité-rapide accroissement démographique-sous-développement, mais il demeure que la perception malagasy des problèmes de population et du développement se fonde sur cette conviction que l'émancipation économique et culturelle prime sur la solution démographique.

Monsieur Le Président,
Honorables Délégués,

En matière de population, la politique de Madagascar qui fait intégrante de sa stratégie globale de développement socialiste demeure fondée sur la parenté responsable telle qu'officiellement proclamée à Bucarest en 1974. Mais alors qu'à cette époque, cette notion définie comme le droit reconnu aux couples de décider librement, en toute connaissance de cause et en toute responsabilité du nombre de leurs enfants et de l'espacement des naissances, s'inscrivant dans le cadre d'une politique (sectorielle) de santé, visant essentiellement à la

réduction de la morbidité et de la mortalité maternelles et infantiles, on parle aujourd'hui de citoyenneté responsable. Cette conception apporte une évolution qui correspond mieux au modèle de développement préconisé par la Charte de la Révolution Socialiste Malagasy.

En effet, la réalisation de ce modèle exige la participation responsable aux efforts de développement national de chaque citoyen, jeunes et adultes, mariés comme célibataires, citoyen dont les décisions, même les plus personnelles, interfèrent souvent avec les phénomènes démographiques et d'environnement, ainsi qu'avec leurs déterminants et leurs conséquences sur la vie de la famille, de la collectivité et de la nation entière.

Il n'en demeure pas moins vrai qu'à la base de cette nouvelle notion, se retrouve le fameux tryptique savoir, vouloir et pouvoir, notre cheval de bataille depuis Bucarest. Mais ici au lieu de ne s'appliquer qu'aux couples et aux parents, le tryptique vaut et s'adresse à l'individu, au citoyen quelque soit son statut.

Conséquemment à ces considérations, est reconnue officiellement l'impérieuse nécessité de l'éducation en matière de population comme indispensable instrument d'exercer cette responsabilité de citoyen.

Avant de pousser plus loin notre analyse, il serait bon de rappeler ici le tryptique, base de notre action éducative orientée vers le couple.

a) Savoir : Les couples doivent être informés sur l'objectif essentiel de la politique en matière de population qui est celle d'améliorer les conditions d'existence de leur famille et de leur faire prendre conscience de leur responsabilité lorsqu'ils décident de fonder une famille, d'accepter la charge morale et matérielle des enfants qu'ils mettent au monde, avant que la société s'en occupe.

b) Vouloir : Aussi longtemps que les couples n'auront pas des garanties suffisantes quant à la santé et à la survie de leurs enfants ils se montreront méfiants à l'égard de toute politique de limitation des naissances. Tout comportement humain correspondant à la satisfaction d'un besoin ou d'une aspiration, les hommes n'acceptent de modifier leurs attitudes que s'ils sont convaincus que le changement proposé leur sera bénéfique. Il y a un proverbe populaire qui dit : " On peut assez facilement conduire un cheval à l'abreuvoir mais on ne peut pas l'obliger à boire".

c) Pouvoir : L'accès à une authentique parenté responsable suppose une information et une éducation qui n'entraînent pas nécessairement un besoin de contraception; éducation à la connaissance et à la maîtrise des processus biologiques de procréation dans la reconnaissance et le respect de la personne du conjoint, de la femme.

Dans le cadre de la citoyenneté responsable, cette éducation en matière de population se définit dans notre pays comme une action éducative qui contribue à donner à l'individu une éducation civique, familiale et sexuelle et à lui faire prendre conscience des problèmes de population et d'environnement afin qu'il puisse, en pleine connaissance de cause et en toute responsabilité, définir de lui-même, le devoir et le rôle qui lui incombent d'améliorer la qualité de la vie au sein de la famille et de la communauté et de la société dans laquelle il vit. Par référence aux efforts de développement économique et social nouveau, cette éducation prend de sens en tant qu'élément de l'éducation pour le développement, objet de la restructuration de notre système d'éducation, c'est-à-dire d'une éducation au service des diverses politiques sectorielles qui font partie intégrante de la stratégie globale de développement. Ces politiques sectorielles concernent notamment, l'autosuffisance alimentaire, la santé publique, l'éducation et l'enseignement, l'offre de main-d'oeuvre et l'emploi, l'habitat, la production et la distribution des biens et services, la modernisation des zones rurales, etc...

Monsieur Le Président,
Honorables Délégués,

Il est un domaine, en matière de population, auquel le Gouvernement de Madagascar accorde la plus haute priorité. Il s'agit de la jeunesse, qu'il cherche à responsabiliser et à faire participer d'une manière effective à tous les efforts de développement du pays. Les groupes d'âges de jeunes représentant un important pourcentage de l'effectif total de la population, en fait, qui dit " population " dit surtout " jeunesse " dans les pays comme le nôtre. C'est cette vérité qui est à l'origine de l'intégration de l'ancien département de la jeunesse au Ministère de la Population et de la Condition Sociale à Madagascar. Mais nous aurons toute l'année prochaine pour parler de la jeunesse !

« L'année 1984 marque non seulement le Xè anniversaire du Plan d'Action Mondial sur la Population, mais également le Xè anniversaire de la reconnaissance par la communauté internationale de l'impérieuse nécessité de l'instauration d'un nouvel ordre économique international. Cette année apparaît à cet égard comme une étape où l'on doit s'arrêter pour regarder le chemin parcouru, avec les raccourcis, les méandres et les grands détours pour atteindre les objectifs finals. Bien que la définition de ces objectifs ne procédât pas d'un élan exclusivement philosophique, force est aujourd'hui de reconnaître la nécessité de nous débarrasser de cet affublement d'espérances qui nous permet de nous tromper mutuellement, pour enfin, envisager et entreprendre des mesures concrètes pour l'édification et le renforcement de cet ordre économique et social international nouveau, seule solution valable et viable aux problèmes de développement en général et à ceux de population en particulier.

Je ne saurais terminer mon intervention sans rendre hommage au FNUAP dans son ensemble et à Monsieur SALAS, son Directeur Exécutif, pour l'action qu'ils mènent et qui contribue sûrement à l'épanouissement social, culturel et économique de tous les peuples.

Je vous remercie de votre attention.

12/15/84

47

MADAGASCARANTANANARIVO/ANTANANARIVOCENTRAL MEDICAL DE SOLIMA (SOCIETE PETROLIERE DE MADAGASCAR

***NOT EQUIPPED FOR PERFORMING LAPAROSCOPIC PROCEDURES (01/82)

RAJOELISON (8499)	MANAGEMENT-ADM	06/83 USA, J HOPKINS			
RANDRIAMANANTENA, ODON HONORE (4809)	ENDOSCOPY(PHY)	09/80 REG, TUNISIA(CA-6)	CP: 09/80 TUNISIA		
RANDRIAMANDRATO, AUDE EMMA (4876)	ENDOSCOPY(NUR)	01/82 REG, TUNISIA(NCA-6)	CP: 01/82 TUNISIA		
***NOW ADMINISTRATOR IN PRIVATE COMMERCIAL INDUSTRY (07/84)					

CENTRE DE SANTE MATERNELLE ET INFANTILE

RAVELONANOSY, MONIQUE RASENDRARIVE (4795)	GEN PHYS CLIN	07/83 REG, TUNISIA(NCA-6)	CP: 07/83 TUNISIA		
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CENTRE NATIONAL DE PASTORAL CATHOLIQUE

RABARIJAONA, LOUIS-ODON (8541)	MANAGEMENT-ADM	06/84 USA, J HOPKINS			
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CLINIQUE SAINT FRANCOIS D'ASSISE

***OPERATED BY NUNS (01/82)

LAPROCATOR (LPMF-115) INSTALLED 02/15/82 FINAL TOT SIGNED	RAZAFINARIVO, LOUIS HAROVCLA (1540)	ENDOSCOPY(PHY)	09/81 USA, J HOPKINS	CP: 09/81 TUNISIA	FV: 02/82
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FAMILY PLANNING ASSN. OF MADAGASCAR (FIANAKAVIANA SAMBATRA)

ANDRIAMAHENINA, BERT (8129)	MANAGEMENT-ADM	07/78 USA, J HOPKINS			
ANRIANANTENAINA, KAMIADANARISOA (6472)	GEN NURSE CLIN	05/84 REG, TUNISIA(NCA-6)	CP: 05/84 TUNISIA		
RABEHARISOA, JEANETTE (8194)	MANAGEMENT-ADM	07/79 USA, J HOPKINS			
RAMALANJAONA, MARIE C (8079)	MANAGEMENT-ADM	11/77 USA, J HOPKINS			

MATERNITE DE L'HOPITAL GENERAL BEFELATANANA

***AFFILIATED WITH ECOLE NATIONALE DE MEDECINE UNIV DE MADAGASCAR

***MANY DELIVERIES PER ANNUM (06/83)

SYSTEM A (H-1288) INSTALLED 02/16/84 FINAL TOT SIGNED	ANDRIANIVO, JEAN (4651)	ENDOSCOPY(PHY)	04/81 REG, TUNISIA(CA-6)	CP: 04/81 TUNISIA	FV: 02/82
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AFRICA

12/15/84

48

ANTANANARIVO/ANTANANARIVO . . . (CONTINUED)
MATERNITE DE L'HOPITAL GENERAL BEFELATANANA . . . (CONTINUED)

LAPROCATOR (LPM-1278)
INSTALLED 12/12/80
FINAL TOT SIGNED

LAPROCATOR (LPMF-220)
INSTALLED 02/05/82
FINAL TOT SIGNED

RABETSITONTA, AIMEE HONDRINE (4880) ANESTHESIA-TECH 04/82 REG, TUNISIA(NCA-6)	CP: 04/82 TUNISIA		
RADIOSOLONIANINA, CHRISTIANE (1852) GEN PHYS CLIN 03/84 USA, J HOPKINS			
RAKOTOMALALA, JEAN PAUL (4971) ENDOSCOPY(PHY) 03/84 REG, TUNISIA(NCA-6)	CP: 03/84 TUNISIA		
RAKTOMANGA, LUCIEN (6476) ANESTHESIA-TECH 07/84 REG, TUNISIA(NCA-6)	CP: 07/84 TUNISIA		
RAMIALISON, LAURENT (4356) ENDOSCOPY(PHY) 06/79 REG, TUNISIA(CA-6) SEX TR DISEASES 10/82 USA, J HOPKINS MICROSURGERY 11/84 USA, J HOPKINS	CP: 06/79 TUNISIA	FV: 12/80	
RAZANAJATOVO, HARIVONINTOSA (4890) ENDOSCOPY(NUR) 05/82 REG, TUNISIA(NCA-6)	CP: 05/82 TUNISIA		

MINISTRY OF HEALTH

RAMAKAVELO, MAURICE (8336) MANAGEMENT-ADM 11/77 USA, J HOPKINS			
RANDIMBIVAHINY, PAUL (8544) MANAGEMENT-ADM 05/84 USA, J HOPKINS			

MINISTRY OF POPULATION

RAMANANTSOAVINA, DONA (8542) MANAGEMENT-ADM 06/84 USA, J HOPKINS			
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O.S.T.I.E. (ORGANISATION SANITAIRE INTER-ENTERPRISES)

RABARISON, EDMOND RICHARD (1833) SEX TR DISEASES 10/83 USA, J HOPKINS			
RAFITOSON, FLAVIEN (1619) INFERTILITY 02/82 USA, J HOPKINS	CP: 03/82 TUNISIA		
RATSIRAHONANA, SAMJEL (8454) MANAGEMENT-ADM 07/82 USA, J HOPKINS			
RAZAFINDRAVANOMBOATR, RUFINE (7389) GEN NURSE CLIN 03/83 REG, TUNISIA(NCA-6)	CP: 04/83 TUNISIA		

ISD - COMPUTER CENTER

AFRICA

ANTSIRABE
-----HOPITAL LUTHERIEN ANDRANOMADIOLAPROCATOR (LPMF-733)
SHIPPED 01/22/84 UNDER NCA-6
FINAL TOT SIGNEDRAKOTOMALALA, HUBERT NJARA (4907)
| ENDOSCOPY(PHY) 01/83 REG, TUNISIA(NCA-6) | CP: 01/83 TUNISIA | FV: 07/84 |-----
ANTSIRANANA/ANTSIRANANA
-----HOPITAUN PRINCIPAUN ANTSEANANA

***AFFILIATED WITH ECOLE NATIONALE DE MEDECINE UNIV DE MADAGASCAR

ANDRIAMANANTSARA, LAMBOSOA (1850)
| GEN PHYS CLIN 03/84 USA, J HOPKINS | | | |
ZARA, MAURYS ADAF (5143)
| GEN NURSE CLIN 10/84 I/C, MOROCCO(NCA-20) | CP: 10/84 MOROCCO | | |-----
FIANAR/FIANARANTSOA
-----HOPITAL PRINCIPAL FIANARANTSOA

***AFFILIATED WITH ECOLE NATIONALE DE MEDECINE UNIV DE MADAGASCAR

LAPROCATOR (LPMF-148)
INSTALLED 01/27/82
FINAL TOT SIGNEDRAHAGA, ODETTE F (4686)
| ANESTHESIA-TECH 01/83 REG, TUNISIA(NCA-6) | CP: 01/83 TUNISIA | | |
RAMONJA, JEAN MARIE (1434)
| INFERTILITY 02/81 USA, J HOPKINS | CP: 02/81 TUNISIA | FV: 01/82 |
••SUFFICIENTLY SKILLED AND TRAINED TO DO TL BY LAPAROSCOPY (01/82)
RAZAFISAMBATRA, NORBERT JULES (4696)
| ENDOSCOPY(NUR) 02/83 REG, TUNISIA(NCA-6) | CP: 02/83 TUNISIA | | |-----
MAJUNGA/MAHAJANGA
-----HOPITAL PRINCIPAL DE MAJUNGA

***AFFILIATED WITH ECOLE NATIONALE DE MEDECINE UNIV DE MADAGASCAR

LAPROCATOR (LPMF-144)
INSTALLED 01/30/82
FINAL TOT SIGNEDRAZAFINTSALAMA, DESIRE LAZAO (4810)
| ENDOSCOPY(PHY) 09/80 REG, TUNISIA(CA-6) | CP: 09/80 TUNISIA | FV: 01/82 |

 MANAKARA/FIANARANTSOA

HOPITAL MEDICO-CHIRURGICAL

*Laprocator to be
 installed, April 1985*

RADESA, FRANCOIS DE SALES (3320)			
ENDOSCOPY(PHY) 05/84 REG, MOROCCO(NCA-20)	CP: 07/84 MOROCCO		

 TAMATAVE/TOAMASINA

HOSPITAL PRINCIPAL TAMATAVE (TOAMASINA)

***AFFILIATED WITH ECOLE NATIONALE DE MEDECINE UNIV DE MADAGASCAR

LAPROCATOR (LPMF-120)
 INSTALLED 06/29/83
 FINAL TOT SIGNED

ANDRIAMIALLY, LALAORIVELD (4969)			
ENDOSCOPY(PHY) 03/84 REG, TUNISIA(NCA-6)	CP: 03/84 TUNISIA		
RAKOTOARISON, ARMAND (3306)			
GEN NURSE CLIN 03/84 REG, MOROCCO(NCA-20)	CP: 03/84 MOROCCO		
RALAMBONDAINY, HENRIETTE LILIAN (4768)			
ANESTHESIA-PHYS 03/83 REG, TUNISIA(NCA-6)	CP: 03/83 TUNISIA		
RAZAKAMANIRAKA, JOSEPH (8193)			
MANAGEMENT-ADM 07/79 USA, J HOPKINS			
INFERTILITY 02/82 USA, J HOPKINS	CP: 03/82 TUNISIA	FV: 06/83	

PROVINCIAL HEALTH SERVICE (MOH)

RAMAROSON, SOLOFO RAHARY (8543)			
MANAGEMENT-ADM 06/84 USA, J HOPKINS			

 TULEAR

HOPITAL PRINCIPAL DE TULEAR

*Laprocator installation
 proposed; await reply from
 institution*

HOSPITAL LUTHERAN EJEDA

RAVELOJAONA, HUBERT (1851)			
GEN PHYS CLIN 03/84 USA, J HOPKINS	CP: 06/84 TUNISIA		
RAVELONJANAHARY, JUSTIN (4917)			
ENDOSCOPY(PHY) 05/83 REG, TUNISIA(NCA-6)	CP: 05/83 TUNISIA		

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ANNEX 9

Importance des nombres de femmes protégées par les firmes pharmaceutiques, la FISA et le F.T.K. en volume et en pourcentage de 1979 à 1982

Tableau n°2

		1 9 7 9	1 9 8 0	1 9 8 1	1 9 8 2
Firmes pharmaceutiques	Nb	13.173	15.530	10.372	11.748
	%	58,8 %	61,8 %	55,9 %	57,6 %
FISA*	Nb	9.224	9.454	8 011	8.584
	%	41,2 %	37,7 %	43,2 %	42 %
F.T.K.**	Nb	-	126	171	65
	%	-	0,5 %	0,9 %	0,4 %
T O T A L	Nb	22.397	25.110	18.554	20.397
	%	100 %	100 %	100 %	100 %

*FISA = Fianakaviana Sambatra ou "Famille heureuse" (PF)

**FTK = Union des ménages chrétiens (PF naturelle)

REMARQUE :

- 57 % de la contraception sont faites par les Médecins prescrivant des ordonnances ;
- 42 % par la FISA et 0,4 % seulement par les méthodes naturelles de la F.T.K.

ANNEX 9

E VOLUTION DU NOMBRE DE FEMMES DE 15 à 49 ans
 pratiquant la contraception à Madagascar
 de 1976 à 1982

Tableau n°1

	1 9 7 6	1 9 7 7	1 9 7 8	1 9 7 9	1 9 8 0	1 9 8 1	1 9 8 2
Nb de femmes pratiquant la contraception	16.212	17.850	18.208	22.397	25.110	18.554	20.397
Nb de femmes de 15 à 49 ans	1.785.375	1.823.141	1.862.126	1.902.330	1.943.753	1.956.407	2.006.780
% des femmes protégées	0,90%	0,97%	0,98%	1,17%	1,3%	0,95%	1,01%

Représentent les 23% de l'estimation de la population de 1976 à 1982
 (cf. Rapport SSSD 1980 p.9)

REMARQUES : La proportion des femmes protégées contre les grossesses indésirées est très faible.-

ANNEX 9
 STATISTIQUES DE L'ASSOCIATION UNION DES
 MENAGES CHRETIENS OU F.T.K
 en 1980 - 1982

Tableau n°9

DIOCESES/ANNEES	ANTANANARIVO			FIANARANTSOA			ANTSIRABE			MANANJARY**			T C T A L		
	1980	1981	1982	1980	1981	1982	1980	1981	1982	1980	1981	1982	1980	1981	1982
ACTIVITES															
Sensibilisés.....	180	160	300	156	220	1150	258	299	112	-	-	-	594	679	1562
Couples adhérents...	40	50	96	-	76	92	-	62	288	-	-	-	-	188	4
P.F.N. : Méthode d'auto-observations (sympto-thermique et glairer cervicale)...	40	67	10	29	32	32	45	72	23	-	-	-	126	171	

*P.F.N. : Planification familiale naturelle
 **Centre ouvert en octobre 1982.

L'Association continue à intensifier ses activités en :

-multipliant ses efforts en matière de recrutement et de formation des utilisatrices et éducatrices; plus tard, des animatrices.

Le nombre de gens sensibilisés en Education familiale a presque triplé de 1980 à 1982. Il est passé de 594 à 1562. Mais le nombre de couple pratiquant la P.F. naturelle a diminué nettement.

Le mouvement ne dispose pas des personnels salariés travaillant en permanence, seuls les week-end, jours fériés, congés annuels leur sont réservés pour faire face aux activités du mouvement telle que la P.F.N.; Par ailleurs, les problèmes matériels et financiers demeurent un handicap pour la bonne marche de ses activités (ex : thermomètre, etc...).

ANNEX 9

REPARTITION DES FEMMES (en %) selon les
méthodes (nouvelles et anciennes clientes séparées)

Tableau n°6

Année	Pilules		Injections		Stérilet		CONDOM		Autres méthodes		TOTAL	
	N	A	N	A	N	A	N	A	N	A	N	A
1 9 7 8	34%	35,5%	62,7%	62,6%	1,8%	1%	1,5%	0,08%	-	-	100%	100%
1 9 7 9	40%	35,5%	56,9%	63,1%	1,5%	1,09%	1,6%	0,3%	-	-	100%	100%
1 9 8 0	58,7%	47%	37,5%	51,2%	2,5%	10,5%	1,3%	1%	-	10,3%	100%	100%
1 9 8 1	53,4%	44,4%	41,7%	53,3%	2%	10,6%	2,9%	1,6%	-	10,1%	100%	100%
1 9 8 2	53%	40,4%	40,6%	57,5%	1,6%	10,5%	4,3%	1,3%	0,5%	10,3%	100%	100%

SOURCE DES DONNEES : FISA

REMARQUE :

Si en 1978 la méthode la plus employée par les nouvelles était l'injection (62,7%), en 1982 ce pourcentage n'est plus que de 40,6% alors que la proportion des nouvelles qui emploie la pilule est passée de 34% à 53%.

Chez les anciennes 57,5% préfèrent toujours les injections contre 40,4% pour les pilules.

Par ailleurs si l'emploi du préservatif masculin semble avancer progressivement, le stérilet par contre perd du terrain.

PLAN TRIENNAL : 1986 - 1988.

RESUME DES REVENUS ET DEPENSES

FORMULAIRE "F"

ASSOCIATION : "FIANAKAVIANA SAMBATRA"(FISA).

ANNEX 10 IPPF SUPPORT TO FISA

ELEMENTS DE REVENUS & DEPENSES	R�el 1984	BUDGET APPROUVE 1985	PREVISIONS		
			1986	1987	1988
<u>LISTE PAR TITRE DE STRATEGIE :</u>					
STRATEGIE A : "Intensifier la sensibilisation et l'information sur la PF aupr�s des personnalit�s influentes".	244. 680	771. 320	1. 182. 600	2. 601. 720	838. 700
STRATEGIE B : "Intensifier la collaboration avec les Minist�res, les Institutions et les organisations non gouvernementales".	6. 202. 845	6. 539. 000	8. 041. 540	9. 804. 040	12.064. 265
STRATEGIE C : "Susciter l'int�r�t de l'opinion publique sur les avantages de la PF	27. 608. 409	34. 997. 663	35. 653. 715	46. 550. 996	42.218. 321
STRATEGIE D : "Am�liorer et d�velopper la capacit� de gestion et les ressources"	42. 268. 951	50. 228. 278	57. 090. 719	61. 514. 055	68.462. 251
FRAIS DE SOUTIEN DES PROJETS (Formulaire "B")	27. 220. 508	18. 546. 090	21. 659. 053	24. 461. 193	27.295. 077
TOTAL PARTIEL DES FRAIS DES PROJETS	103. 545. 393	111. 082. 351	123. 669. 627	143. 432. 009	149.099. 644
FRAIS ADMIN. ET DE SERV. GENE (AGS) (Form."C")	36. 704. 522	23. 198. 418	33. 860. 123	31. 682. 588	40.842. 166
TOTAL DEPENSES	140. 249. 915	134. 280. 769	157. 529. 750	175. 114. 597	169.941. 830
<u>MOINS REVENUS NON PROVENANT DE L'IPPF ("D")</u>	50. 763. 029	50. 897. 806	55. 624. 000	69. 561. 200	69.280. 020
FOIDS REQUIS	89. 486. 886	33. 382. 963	101. 905. 750	105. 553. 397	120.661. 810
<u>MOINS SUBVENTION/ESPECES IPPF RECUE/ APPROUVEE/ DEMANDEE</u>	92. 895. 005	83. 380. 000	101. 905. 750	105. 503. 397	120.651. 810
<u>REEL/BUDGET EXCEDENT/DEFICIT</u>	3. 408. 119	(2. 963)	-	-	-

ANNEX 11 _ UNFPA SUPPORTED TRAINING

BOURSES, VOYAGES D'ETUDES, STAGES ET CONFERENCE EN SANTE FAMILIALE ET PLANIFICATION FAMILIALE

DOMAINE	LIEU DE REALISATION	PERIODE	SOURCE DE FINANCEMENT	PARTICIPANTS
Fédiatrie	Barcelone Paris	Sept-Oct.1980 (2 semaines)	FNUAP	Pr. Razanamparany Marcel, Chef du Service Fédiatrie, Ministère de la Santé
Gynéco-obstétrique	Université Libre de Bruxelles, Belgique	Juillet 1981 (1 semaine)	FNUAP	Pr. Laurent Ramialison, Chef du Service Gynécologie, Befelatanana, Ministère de la Santé
Documentation en santé familiale	Centre International de l'Enfance, Paris	Oct-Déc.1982 (2 mois)	FNUAP	Melle Andriamampihantona Sahondra, Sociologue, Ministère de la Santé
Santé familiale	Port-Louis Maurice	Nov-Déc.1982 (1 mois et demi)	FNUAP	Dr. Sahondra Randrianarimanana, Chef de Division SMI, Ministère de la Santé Mme Ravaoarisoa Joséphine Odette, Sage-femme, Division SMI, Ministère de la Santé
Planification et gestion des programmes de service en matière de planification familiale, de santé et de développement	Washington USA	Sept-Oct.1983 (1 mois)	FNUAP	Dr. Raholisoa, Médecin de Tuléar Dr. Razanadraibe, Médecin-Chef SMI de Fianarantsoa
Supervision et évaluation des programmes de SMI	Washington USA	Août-Sept.1984 (1 mois)	FNUAP	Mr. Rabotoveloson Georges, FISA (ONG)

DOMAINE	LIEU DE REALISATION	PERIODE	SOURCE DE FINANCEMENT	PARTICIPANTS
Santé Familiale	Port-Louis Maurice	Sept-Oct. 1984 (1 mois et demi)	FNUAP	Dr. Sylvie Rakotoarivelo, Chef de Service de la Santé de la Mère et de l'Enfant, Ministère de la Santé. Mme Bardy Jacqueline, Sage-femme, Service Prosanté Tamatave, Ministère de la Santé
Information sur les programmes de santé familiale	Maurice, Indonésie Tunisie, Cuba New York	Nov-Déc.1984 (1 mois)	FNUAP	Mme Chantal Raveloharisoa, Direction Générale du Plan M. Senn Harison, Ministère de la Population M. Miniminy Joël, Assemblée Nationale Populaire Dr. Edmond Ribaira, Directeur de la Santé Commu- nautaire, Ministère de la Santé
Programme intégré de planification familiale	Indonésie	Janvier 1985 (3 semaines)	PNUD/ Gouvernement Indonésie	M. Roger Rakotoson, Direction Générale du Plan Melle Noro Rakoto, Ministère de la Population Dr. Hantaniaina Raveloson, Chef de Division, Service de la Médecine des Soins, Ministère de la Santé Dr. Liliane Rajacah, Médecin, Zone de Démonstration Itaosy, Ministère de la Santé
Santé familiale	Port-Louis, Maurice	Mars-Avril 1985 (1 mois et demi)	FNUAP	Mme Andriamihajamanana, Ministère de la Population M. Samuel Richard, Ministère de la Population

PROJET

TITRE : "DEVELOPPEMENT DE LA CAPACITE ET DES RESSOURCES
DE L'ASSOCIATION".

ORGANISME D'APPLICATION ET D'EXECUTION "FIANAKAVIANA SAMBATA"
(FISA)

ORGANISME DE FINANCEMENT : U . S . A . I . D .

DATE DE SOUMISSION : MAI 1985.

ASSISTANCE :

Bien que la représentation de l'USAID à Antananarivo n'ait été effective en 1984, l'assistance que cet organisme a accordée à la FISA remonte en fait au financement d'un stage aux Etats Unis à l'endroit du Directeur Général. Cette assistance en termes de formation n'est encore matérialisée qu'à partir de 1983. 4 membres du personnel ont en effet bénéficié d'un stage/formation :

- . 1983 : 1 cadre au CEDPA, Washington;
- . 1984 : 1 cadre à Santa Cruz, Université de Californie;
- . 1984 : 1 sage-femme à Tunis, Tunisie;
- . 1984 : 1 cadre à Freetown, Sierra Léone;
- . 1984 : 1 sage-femme à Dakar, Sénégal;
- . 1985 : 1 cadre à la Conférence des ONG (Forum), Nairobi, Kenya

Cette assistance, par la suite, est sortie du cadre de formation pour aller vers des projets spécifiques. La FISA est en effet exécutante de deux projets conjointement avec le CEDPA (Centre for Development and Population Studies) et l'IPAVS (International Project Association for Voluntary Action) lesquels projets sont financés par l'USAID. Le premier projet constitue une formation à l'intention de femmes gestionnaires et le second est une formation sur les méthodes contraceptives incluant la contraception chirurgicale.

JUSTIFICATION DU PROJET :

Le projet, soumis à l'USAID pour assistance et participation financière, a sa justification dans les activités auxquelles s'adonne la FISA, aux contraintes budgétaires auxquelles elle est confrontée et aux recommandations de l'IPPF lesquelles elle est tenue d'exécuter.

Depuis 1983, l'Association a œuvré avec des organisations gouvernementales et non gouvernementales dans des projets à activités multisectorielles. La participation active dont elle a fait montre dans ces activités se justifie par le fait que la planification familiale, première préoccupation, doit être intégrée dans les activités visant au bien-être des communautés, et qu'il appartient de ce fait d'initier des projets auxquels des entités seront

sollicités à apporter leur concours. Ainsi, un projet a été élaboré (voir annexe) et auquel l'engagement de l'USAID est vivement sollicité.

B. L'International Planned Parenthood, l'IPPF, fédération à laquelle la FISA est membre, se trouve face à une situation financière précaire et son apport en faveur de ses affiliés se trouve de ce fait réduit. Dans l'attente des résultats des tractations entreprises par le Bureau Central en vue d'améliorer la situation, le Secrétaire Général a exhorté toutes les associations à trouver d'autres sources de financement afin que les programmes ne soient pas lésés. Une mention particulière a été faite aux démarches/contacts à faire auprès des représentants de l'USAID en vue de pallier aux lacunes. La FISA a émis à profit la visite rendue auprès du représentant de l'USAID à Antananarivo et la visite du représentant de l'USAID de Nairobi pour parler des domaines dans lesquels l'association nécessite une assistance.

C. L'équipe d'évaluation générale des programmes dépêchée par l'IPPF en Avril 1985 a relevé les faiblesses de l'association dans l'exécution de son programme, faiblesses dues en grande partie au manque de formation et au manque de moyens. Les recommandations ont d'ailleurs insisté sur la nécessité de combler ce vide le plus vite possible.

3. RESUME DU PROJET :

Ce projet qui s'étale sur trois années (1985 - 1988) comprend l'assistance en matière de participation financière dans un projet, formation des membres du personnel, équipement et impression. Toutefois, un budget supplémentaire est sollicité pour 1985, certaines formations et certains matériels étant nécessaires pour cette année. Son budget se resume comme suit :

1985.....	US \$	55,545
1986.....	US \$	29,680
1987.....	US \$	36,150
1988.....	US \$	23,650

4. OBJECTIFS :

- Améliorer la capacité de l'association pour une meilleure coordination et gestion de son programme
- Développer les ressources de l'association en vue de répondre aux besoins de la communauté et à l'extension des activités.
- Intensifier la collaboration avec les organisations gouvernementales et non gouvernementales dans les projets intégrés.

5. ACTIVITES DU PROJET :

A. Participation dans un projet

5. PROJET PILOTE DE DEVELOPPEMENT INTERNE :

A. Présentation d'un projet :

Le projet s'intitule "Projet pilote de développement interne" (voir annexe) et l'apport de l'USAID dans ce projet portera sur le financement de formation et l'élément voyages d'études.

B. Formation :

1/ Recherche du personnel à l'extérieur

La brochure de l'USAID où figurent toutes les Universités/Institutions disposant des stages/formation relatifs aux activités PF/POP ont permis d'identifier les centres et thèmes qui satisfont les besoins en la matière de formation. Des Animateurs, C.R., et des cadres du Siège seront les bénéficiaires de ces stages et l'avancement de cet élément formation pour 1985 est vivement souhaité (voir page suivante)

2/ Formation Animateurs

Cette formation de 10 jours réunira tous les animateurs en Juillet 1986 et vise à améliorer leurs aptitudes à assumer pleinement leurs tâches.

3/ Formation en Evaluation

Elle réunira en 3 jours en Août 1986 tous les CR et se propose pour but de maîtriser les techniques d'évaluation.

4/ Personnel Médical

Ce projet d'une durée de 10 jours sera exécuté dans toutes les antennes.

C. Equipement :

Cette rubrique comprend notamment des équipements de bureau pour le Siège (1 véhicule, 1 appareil photocopie et des rames pour duplication). Des instruments médicaux et contraceptifs sont aussi sollicités.

D. Éléments divers :

On procédera à la publication de dépliants

- 11 sur la FISA

- 1 sur la préparation des jeunes au mariage.

- 1 poster

6. APPORTS DE L'USAID :

Code	Description	TOTAL	1986	1987	1988
10	BUDGET SPECIAL 1985	55,545			
20	Projet intégré	23,400	5,850	5,850	11,700
30	Formation staff		21,000	21,000	
	Formation Animateurs		3,365		
	Formation Evaluation		3,035		
40	Equipement				
	Equipement de bureau	3,500	3,500		
	Instrument médicaux	5,000	4,000	500	500
	Contraceptifs	25,300	5,550	8,300	1,450
50	Éléments divers				
	Impression	17,280	9,720	7,500	
	GRAND TOTAL	178,475	56,130	43,150	23,650

1985 :

- International Center for Population and Family Health

1 Fieldworker (Antsirabe) 23 September - 20 October 1985
 1 Fieldworker (Tananarive)

Titre : "Adolescent Fertility Management"

- Center for Development & Population Activities :

1 Liaison Officer : 23 September - 25 October 1985

Titre : "Supervision and Evaluation as management Tools"

- Tulane University, N. Orleans

1 Educator : (6 weeks)

Titre : "Population, communication and Research."

1986 :

- University of Connecticut :

1 IEC Officer - 17 February - 4 April 1986

Titre : "Master Training Program".

Management Science for Health :

1 Executive Director } 6 weeks
 1 Drug Supplier

1987 :

- Cornell University :

1 Evaluation Officer - 15 August - 10 September 1987

Titre : "Communication, Planning and Strategy".

Management Science for Health :

1 Administrative Officer; } 6 weeks
 1 Finance Officer

REQUISITION DE BUDGET :

	US \$
1° - <u>Impact budgétaire pour 1985 :</u>	
a) Formation médicale 550.000 x 6 provinces	4,750
b) Formation personnel FISA :	16,000
Zion Illinois	6,000
CEDPA	7,000
Tulane University	7,000
c) Instrument/Equipement :	
1 véhicule Toyota X	7,500
1 Appareil PAPANICOLAU	8,000
Kit N° 2 Cyn Emergency K 7 ✓	
20 x 154,69	3,095
Kit N° 3 the IUD Backup ✓	
20 x 160	3,200
	55,545
2° - <u>Participation dans un projet :</u>	
a) Formation 4 cadres moniteurs :	
1986 : 5850 x 1	5,850
1987 : 4 cadres moniteurs	
5850 x 1	5,850
1988 : 4 cadres moniteurs	
5850 x 2	11,700
	23,400
b) Formation 2 responsables et 2 dirigeants :	
1986 : 715 x 4	2,860
1987 : 715 x 4	2,860
1988 : 715 x 4	2,860
3° - <u>Formation Personnel FISA à l'extérieur :</u>	
1986 : Université Connecticut, Boston(3)	21,000
1987 : Boston (2), Cornell University(1)	21,000
4° - <u>Formation Animatours</u>	3,085
5° - <u>Formation Evaluation</u>	3,365
6° <u>Equipement</u>	
1986 : Photocopieuse : 1 x 3,000 X	3,000
Ramos Gastetner 50 x 1 x	500
<u>Instruments médicaux</u>	
1986 : Seringues en verre 5cc : 100 x 1	100
10cc : 100 x 2	200
Aiguilles 400 x 0,50	200
1987 : Seringues en verre & aiguilles	500
1988 : Aiguilles & Seringues en verre	500
	5,000

Contraceptifs :

a) Contraceptifs

- Ovostat 28 Organon

1986 : 5.000 x 0,50	2,500
1987 : 5.500 x 0,70	3,850
1988 : 6.000 x 0,90	5,400

- Stediril Wicht Dyla

1986 : 5.000 x 0,50	2,500
1987 : 5.500 x 0,70	3,850
1988 : 6.000 x 0,90	5,400

- Lippes Loops CUT'S

1986 : 100 x 5,50	550
1987 : 100 x 6	600
1988 : 100 x 6,50	650

7° - Éléments divers :

a) Impression :

- Dépliant sur FISA (1986) 4.000 x 0,84	3,780
- Dépliant sur jeunes (1987) 5.000 x 1,50	7,500
- 1 poster (1986) 3.000 x 2	6,000

12,280

RESUME DES ACTIVITES
Cout en US \$

1985	1986	1987	1988
- Formation medicale Cout : 4,750	- Projet Integre 5,850 Participation : 2,700	- Projet integre Particip. : 5,850	- Projet Integre Particip : 11,700
- Formation aux USA Cout : 29,000	- Formation aux USA Cout : 21,000	- Formation USA Cout : 21,000	- Equipements Cout : 500
- Equipement (vehicule, appareil, kits) Cout : 21,795	- Formation animateurs Cout : 3,085	- Equipements Cout : 500	- Contraceptifs Cout : 11,450
	- Equipement : 3,500 - Formation Evaluation Cout : 3,365	- Contraceptifs Cout : 8,200	
	- Equip. Instrum Medic. Cout : 4,000	- Impression depl. Cout : 7,500	
	- Contraceptifs Cout : 5,550		
	- Impression poster depl. Cout : 9,780		
TOTAL : 55,545	TOTAL : 56,130	TOTAL : 43,150	TOTAL : 23,650

13

SYNTHESE DES ACTIVITES

ANNEX 13 JIRAMA: PLAN OF ACTIVITIES

ACTIVITES	OBJECTIFS IMMEDIATS 1an		OBJECTIFS A COURT TERME 2ans		ENSEMBLE des BESOINS
	ANTANANARIVO	CENTRES PERIPHE- RIQUES	MAHAJANGA	TOAMASINA	
<u>A. SANTE MATERNELLE ET INFANTILE</u>					
PEDIATRIE -- PUERICULTURE					
1°-VACCINATIONS (enfants)	825	150	178	178	1.331
2°-RECUPERATION NUTRITION- NE.....	10/jour	5/jour	5/jour	5/jour	25
3°-S.R.O.....	750/an	130/an	120/an	120/an	1.120
4°-BIBERON.....: 1er AGE	25	5	5	5	40
2è AGE	25	5	5	5	40
(grandes multipares) Adu- ltes et femmes encientes	25	5	15	15	60
<u>B. PLANNING FAMILIAL</u>					
1°-CONTRACEPTIFS ORAUX (Nombre de femmes	1 200	120	200	200	1.720
2°-STERILITES	60	6	20	20	106
3°-LIGATURES	20		5	5	30
4°-CONDOMS	1 200	120	200	200	1.720

QUANTIFICATION DES MOYENS A METTRE EN ŒUVRE

MOYEN	BESOIN IMMEDIAT	BESOIN A COURT TERME	OBSERVATIONS
1°) - <u>EQUIPEMENT HUMAIN</u>			
1- SAGE FEMME	Formation à l'étranger : Savoir être : communication ; Savoir faire : maîtrise technique en matière de P.F. Durée : 1 mois	2 SF (Formation à l'étranger)	Traitement et éventuelle embauche à la charge de la JI.RA.MA. Superviseur de la mise en application du programme
1- SAGE FEMME	Formation loco-régionale par le biais de séminaire d'information et de communication	2 SAGE FEMMES	Formation loco-régionale assurée par le superviseur formé : • séminaire de formation 15 jours tous les trois mois • Séminaire d'information et de communication une fois par mois
2- ASSISTANTE SOCIALE		4 ASSISTANTES SOCIALES	
2 - AIDE SANITAIRE	— " —	4 AIDES SANITAIRES	
2 - CHAUFFEURS		2 CHAUFFEURS .	
2°) - <u>EQUIPEMENT MATERIEL</u>			
2.1 - PLANNING FAMILIAL			
• Boite de Cuqeco.....	2	4	
• BALANCE PESS PERSONNE..	2	2	
• TENSIOMETRE COMPLET....	2	2	
• NECESSAIRES POUR ANALYSES D'URINES.....	(en fonction du nombre des femmes suivies)		(en fonction du nombre des femmes suivies)
• NECESSAIRE POUR DEPISTAGE du K du Col.....	1	2	

2

NOTES	BESOIN IMMEDIAT	BESOIN A COURT TERME	OBSERVATIONS
2.2. - PEDIATRIE PUFICULTURE			
• PESE BEEB à CURSEUR	2	2	
• TOISE	2	2	
• TROUSSE DE SOINS COMPLET	2	2	
• STERILISATEUR	2	2	
• BOUILLIÈRES	3	2	
• BIBERON	200	200	
• BATTERIE ELECTRIQUE	1	2	
• BALANCE PESE ALIMENTS	1	2	
• BOL MIXER	1	2	
• CUISINE COMPLETE	1	2	
• GLACIERE (Chaîne froide)	1	2	
2.3. - MATERIELS ROLLANTS			
• VOITURES TOUT TERRAIN (4x4)	2	2	Nécessaire pour les campagnes d'action et de sensibilisation (suivi, contrôle, maintenance)
2.4. - MATERIELS PEDAGOGIQUES			
• MATERIELS AUDI-VISUELS	1	2	(Film et projection)
• MEGAPHONES	2	2	Pour l'éducation de base
• APPAREIL à POLYCOPIER + des RAMES DE PAPIERS + ACCESSOIRES	1		
• PLANCHES ANATOMIQUES			
• FLANELLOGRAPHES			
• BIBLIOGRAPHIE			

QUANTIFICATION DES BESOINS

N A T U R E	BESOIN IMMEDIAT	BESOIN A COURT TERME	Q U A N T I T E
A. MATIERES MATERNELLES INFANTILES			
VACCIN B.C.G.	200	80	280
1 ^{er} - VACCIN EDUTAX	200	80	280
2 ^{es} - VACCIN TETRACOQ	700 X 5	250 X 5	4 750
3 ^{es} - REGENERATION NUTRITIONNELLE	500.000 FMS	250.000 FMS	750.000.-FMS
4 ^{es} - PRODUITS LAITERS	6.000.000 FMS	3.000.000 FMS	19.000.000.-FMS
B. PLANCHING FAMILIAL			
1 ^{er} - CONTRACEPTIFS ORAUX			
• Continues.....	330 X 13 = 4 290 cycles		
• Nouvelles.....	(1 500-330) x 5 = 76.050	400 X 6,5 = 2.660	14 405 soit 12 caisses de 1200 cycles
2 ^{es} - STERILIS EN CUIVRE	100	100	200 soit 10 boites de 20
3 ^{es} - LIGATURES	20	10	30
4 ^{es} - GONDOIS :			
Continu	330 X 144 = 47 520		
Nouvelle	1170 X 72 = 84 240	520 X 72 = 37 440	169 200 soit 13 caisses 6000 ou 780 boites de 100
5 ^{es} - TROUSSES MEDICALES			
(1) MINILAP	4		4
(5) TROUSSE VASDOT	4		4
(6) TROUSSE DIU	4	4	8

17

CHRONOGRAMME DES ACTIVITES
PLANIFICATION ANNUELLE : OBJECTIFS IMMEDIATS ET A COURT TERME

DECOUPAGE MENSUEL DES ACTIVITES

sous forme de diagramme en insistant sur les points suivants :

- 1°) - Démarrage escepté du projet
- 2°) - Formation : - extérieure
 - loco régionale
- 3°) - Mise en application du programme :
 - planification des actions à entreprendre
 - planification des suivis et des contrôles
 - planification des séances d'information et de communication
- 4°) - Evaluation du taux d'évolution du programme