The population programme in the Islamic Republic of Iran

Report of a case study

The views expressed in this report are those of the authors and not necessarily those of the United Nations Population Fund.

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Preface

UNFPA and UNAIDS collaborate with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and national financial resource flows for population activities.

The case study in the Islamic Republic of Iran forms part of the UNFPA/NIDI/UNAIDS project and was conducted between 29 May and 13 June 2002.

Data for this report were obtained through questionnaires and interviews conducted during this period by Ms. Marja Exterkate and Ms. Marlies de Jager both from the UNFPA/NIDI/UNAIDS Resource Flows Team with assistance of Dr. Fatima Khaleghi, lecturer, Imam Sadegh University, Tehran.

We want to express our sincere thanks to Mr. Mohammed Mosleh-Uddin, UNFPA representative and Ms. Monire-Therese Bassir, programme officer at the UNFPA Tehran office, who provided invaluable assistance before and during the study. Many thanks go to all respondents who shared their time and information with us. In addition, we extend our thanks to our colleague Ernst Spaan for assisting with editing the report.

Due to the complexity of resource flows for population activities in the Islamic Republic of Iran and the short duration of the study, it is possible that this report contains significant omissions or errors. The authors welcome any comments or corrections.

Marja Exterkate and Marlies de Jager
August 2004

1. Objectives and methodological issues

The case study in the Islamic Republic of Iran was conducted between 29 May and 13 June 2002 and forms part of the UNFPA/NIDI/UNAIDS project that measures global financial resource flows for population activities. For this purpose, questionnaires are sent annually to public and private donor organisations in developed countries, and to government departments and national NGOs in developing countries and countries-in-transition. Collecting all this information from a broad range of respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. For better illustrations of the problems, country case studies are carried out. These studies complement our knowledge about financial flows for population activities that were obtained through the mail enquiry and about the policy concerning population in general.

The classification of population activities used in this project closely reflects the principles of the ICPD and the UNGASS Declaration of Commitment on HIV/AIDS. The definitions used in this survey as it relates to population activities covers the 'ICPD costed package' mentioned in paragraph 13.14 of the PoA and the key targets set out in the UNGASS Declaration of Commitment on HIV/AIDS. This means four categories of population activities:

1. Family planning services
2. Basic reproductive health services
3. Sexually transmitted diseases and HIV/AIDS activities (including prevention, care/treatment and support)
4. Basic research, data and population and development policy analysis

The specific objectives of the case study in the Islamic Republic of Iran are:

1. to fine-tune and refine data collection procedures for estimating financial resource flows for population activities:
   - as benchmarks for studying the quality of data gathered through the mail enquiry (e.g. what definitions are used? are data rough estimates or precise?).
   - try to find gaps in key actors: are we missing certain groups of funding agencies? (e.g. private sector).

2. to provide more information on how resource flows are directed towards population activities in relation to the implementation of the ICPD Programme of Action:
   - has the ICPD influenced the population programmes within the country? And how?
   - are there any changes in priority at the government level?
   - are any changes noticeable from project financing to programme financing?
   - how is the co-ordination between and among government departments, national NGOs and donors?
   - try to get an overview of budgets made available by e.g. government, donors, NGOs, and spent on population activities in the country in the last 5 years.

To optimise the quality of the information, the team followed as much as possible a standard strategy:

- 1996 to 1999 financial data were collected through questionnaires during the last years;
- questionnaires requesting data for financial year 2001 and 2000 were distributed to focal points during our visit with the request to fill them in before the end of July;
- interviews were conducted to obtain additional information about various activities of the organisation such as past and current activities, implementation of the ICPD Programme of Action, future plans, et cetera. Annex 1 provides a list of all persons and organisations in Tehran interviewed during the case study. Without any exception, the co-operation of all respondents was very positive.

During the case study it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years. The exact amounts disbursed in the public sector are unclear because (Ardakani, 1998, 1999):

1. The family planning programme is fully integrated in the primary healthcare system.

2. Difficulty of desegregating resources allocated to population and reproductive health by ministry of agriculture, ministry of Jihad, ministry of energy, ministry of roads and communications, ministry of education, and the Iranian Broadcasting Organisation.

3. Since the Islamic revolution, the private sector has also played an increasingly important role in the provision of health services in urban areas. Based on DHS 2000 (preliminary results), some 33% of contraceptive users in urban areas had received contraceptive supplies and services through this sector, in Tehran even 47%.

2. Background information on the Islamic Republic of Iran

The Islamic Republic of Iran, the sixteenth largest country in the world, borders Armenia, Azerbaijan and Turkmenistan in the north, Afghanistan and Pakistan to the east and Turkey and Iraq to the west. The country has access to the Caspian Sea in the north and the Persian Gulf and Oman Sea in the south. The country is divided into 28 provinces, which are further broken into smaller administrative areas: districts (Abolhassani 2002, p.3). It encompasses a total area of 1,648,000 sq. kilometres (UNFPA 2000, p.1). Tehran is Iran's modern capital with almost 12 million people.

Figure 1. The Islamic Republic of Iran

Source: http://www.cia.gov/cia/publications/factbook/geos/ir.html

Iran is a middle income country, with a GDP per capita of US$ 1,650 in 2001 (ILO, 2001). As result of various rehabilitation and reconstruction needs after the Islamic Revolution (1979) and the war with Iraq (1980-1988), economic growth was severely constrained. Economic growth did not exceed two percent per annum during the 1980s, and in the 1990s it has only increased to four per cent (*ibid*). Unemployment has shown a fluctuating but progressive trend in the recent past and has now reached significant proportions: in 2001 unemployment was estimated at 16 percent (*ibid*). Particularly among youth and the higher educated unemployment is widespread. Of those between 15-24 years about 50 per cent is unemployed, with university graduates showing the highest level.

The country is mineral resource rich with 95 billion barrels or almost 10 per cent of the world known recoverable oil reserves. Gas reserves are even more impressive: an estimated 21 trillion cubic meters is one-fifth the world total, ranking Iran second in the world in this category (UNFPA 2000, p.2).

The current political structure laid down by the Constitution of the Islamic Republic of Iran is a democratic system of government with publicly elected executive and legislative branches and an independent judiciary. The head of the executive branch is the President of the Republic elected through direct, nation-wide election held every four years. All citizens are entitled to participate in the elections of the President and members of the Islamic Consultative Assembly, as well as members of the 'Assembly of Experts'. The Assembly of Experts is vested with the power to appoint the supreme religious leader.

The ultimate authority rests with the Supreme leader, who is chosen either by popular consensus or by the Assembly of Experts. He appoints the members of the 'Council of Guardians of the Constitution' a supervisory body that screens every candidate for the legislative and presidential elections and checks all legislation both consistency with Islamic principles as well as the Constitution of the IRI. The Supreme Leader is the Commander-in-Chief of the Armed Forces (including the police), appoints the head of the Judiciary, the director of the National Broadcasting Organisation, head of the Islamic Propaganda Organisation and the editors of two major daily newspapers which were nationalised after the revolution. He also appoints Friday Imams (prayer leaders) who act as his direct representatives at the provincial and local levels. The overall orientation of all economic, social and political policies implemented by the Government as part of the National Development Plan have to be approved by the Leader who can also suggest changes in the allocation of national resources and government budget. He consults, as needed, with the 'Expediency Council'; the body authorised to reconcile differences between the Consultative Assembly and the Council of Guardians. The council can also prepare and approve laws that for one reason or other may be unlikely to be ratified easily by the normal process of legislation (UNFPA 2000, p.4/5).

Demographic and social indicators.

Islam is the state religion and 99.5 per cent of the 64.5 million people are Muslims. The Shia school of thought accounts for 91 per cent and the Sunni Muslims 8 per cent of the population (UNFPA 2000, p.2). About 0.2 per cent of the Iranian people are Christians, 0.07 per cent are Zoroastrians and 0.05 per cent are Jews (Abolhassani 2002, p.3).

Farsi (Persian) is the official language and script, which is spoken by 83 per cent of all Iranians. Twenty-two percent of the population is Turkish-speaking Iranians or Azaris, while the Kurds in the north who account for 5.5 per cent of the population, speak Kurdish. Lori, Baluchi, Arabic, Armenian and Assyrian is also spoken by small minorities. This makes the Iranian social fabric multilingual and multi-cultural, yet homogeneous, which is an ancient characteristic of Persian culture (UNFPA 2000, p.2).

Iran's demographic and social indicators have constantly been improving, as table 1 indicates, especially when looking at the falling infant mortality rate and increasing life expectancy.

The annual population growth rate has declined significantly from 3.4 in 1986 to 1.5 (or even 1.2) in 2000/2001. But since more than 50 per cent of the population is under the age of 20, the population growth will continue. Total fertility rates were high in the fifties and sixties and decreased very little during the late seventies after the introduction of a family planning programme in 1976. With the Islamic Revolution in 1979, the family planning programme was suspended. During the Iran-Iraq war period (1980-1988) fertility rates increased due to a pro-natalist policy. After 1989, however, fertility fell sharply till almost replacement level in 2000 (table 1).

Table 1. Basic national demographic indicators, Islamic Republic of Iran

		1956	1966	1976	1986	1991	1996	2000/2001
Population (million)[a]		18.95	25.79	33.71	49.45	55.84	60.06	64.5 [b]
Growth rate [a]		3.1	3.1	2.7	3.4*	2.5	1.5	1.2 (MoH) / 1.5 (SCI)
Per cent urban [a]		31	38	47.0	54.3	57.0	61.3	65 [b]
Crude birth rate [c]			49.0	42.7	47.6	38.2	26.0	18.4[d]
Crude death rate							3.6 *(1997)* [e]	3.8 [d]
Total fertility rate [c]		7.3[f]	7.7 [f]	6.3	7.0	5.5	3.4	2.4 [d]
Contraceptive prevalence rate (all methods) [c]				37.0		64.6	72.9	73.8 [d]
Contraceptive prevalence rate (modern methods) [c]						44.6	55.4	55.9 [d]
Infant mortality rate [b]				114	64	53	34 *(1994)*	28.6 [d]
Life expectancy at birth [b]	Male			57.6	58.5	62.4	67.0	67.8
	Female			57.4	59.3	62.2	69.8	70.6
Literacy rate [b]	Male	22.2	40.1	58.8	71.0	80.6	84.7	86.8
	Female	14.9	17.9	35.6	51.0	67.1	74.2	75.9

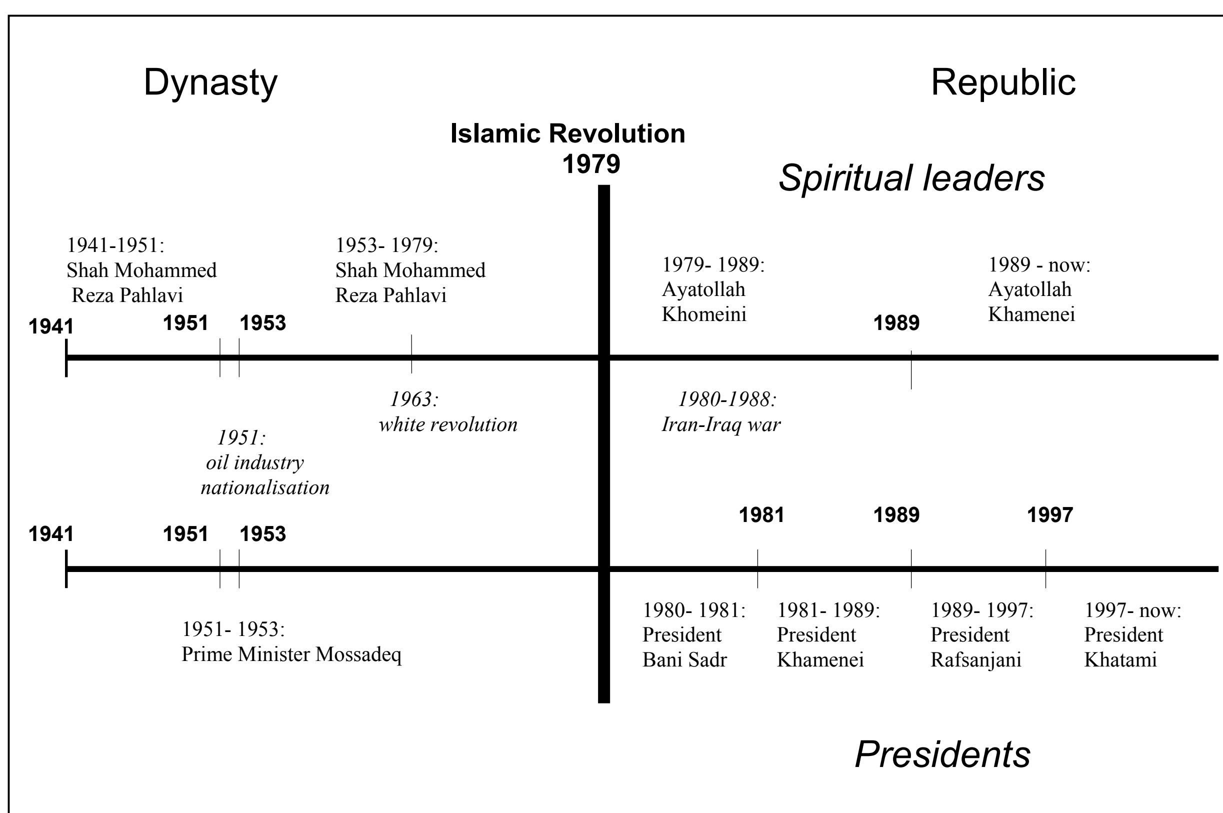
* 3.9% if refugees from Afghanistan and Iraq are included.
Sources:
[a] : census data; Statistical Centre of Iran (SCI) at: www.sci.or.ir
[b]: data from Statistical Centre of Iran (SCI) and MOHME in: UNFPA, 2000.2001
[c] : from: Aghajanian, Akbar, Amir H. Merhyar, 1999, tables 2 , 5, 9 (1992; 1997)
[d]: Demographic Health Survey (DHS) 2000 (preliminary)
[e]: Abolhassani (2002)
[f]: Census data (Moroufi Bozorgi 1967, Amani 1968 and Bulatao and Richardson 1994 in: Abbasi et al. , 2002, p. 26)

The country is strongly urbanised. Since World War Two there has been steady migration from the countryside to urban areas. During the last decades the urban population of the country in comparison to rural communities has almost doubled (Abolhassani 2002, p.3).

3. National population policies and programmes

In order to understand the evolution of the population policies and programmes and the accompanying demographic indicators, figure 2 is included for easy reference.

Figure 2. Time-line of Iran, 1941-now



3.1. Developments of national policy and programmes

In contrast to its regional counterparts such as Turkey and Egypt, Iran came late to a concern for population issues (Hoodfar & Assadpour, 2000, p.19). Until the late 1940s, Iran's population had grown at a very low rate. This was despite the fact that Iran's traditionally pro-natalist culture as well as the prevailing health and social conditions, i.e. high infant mortality and dependence of parents on children as the main source of old-age support, provided a favourable environment for high fertility. However, in this period mortality was high enough to offset the high fertility and keep the rate of population growth at a very low level (Abbasi *et al.*, 2002, p.26).

1956 – 1966: Population policy with explicit health and demographic targets

In the 1950s and 1960s, the rate of population growth was increasing to a level of 3.1 per cent per annum (see table 1, chapter 2). Partly in response to this high growth rate, the government of Iran adopted a population policy with explicit health and demographic targets (Abbasi *et al.*, 2002, p.26).

1967 – 1979: First official family planning policy

In 1967 the first official national family planning programme was inaugurated, in which the Ministry of Health was given responsibility for controlling the birth rate (Abbasi *et al.*, 2002, p.26). This programme had a strong urban focus with women as the main recipients of services, despite the fact that most traditional contraceptive methods (e.g. withdrawal) are male-oriented. The pill, distributed chiefly through a network of Ministry of Health clinics and hospitals emerged as the de facto official contraceptive method (Hoodfar & Assadpour, 2000, p.19).

The family planning programme was launched after the Tehran Declaration (1967) in which family planning was declared a basic human right (Ahmad, 1996, p.23). Devised under the western oriented Shah Reza Pahlavi's aegis, the programme was followed by a number of limited improvements in women's legal status (Hoodfar & Assadpour, 2000, p.19). Polygamy was abolished, child support and custody was made easier, the minimum age for marriage for women raised to 18 years and abortion under certain conditions was made permissible. During this period there was a decline both in the birth and death rate and the population growth rate came down from 3.1 to 2.7 per cent per annum (Ahmad, 1996, p.23).

Rural people did not warmly welcome the policy, as little attention was given to the socio-cultural and religious contexts of society. Therefore, it is hardly surprising that during 1966-76 the Iranian population experienced only a modest fertility transition, despite a reasonable rise in the proportion of eligible couples practising contraception (to 37 per cent in 1977). However, how much of this was attributable to the family planning programme and how much to other factors is open to question (Abbasi *et al.*, 2002, p.26).

1979 – 1988: Pro-natalist ideology and suspension of the family planning programme

Shortly after the onset of the Islamic Revolution, the family planning programme was suspended. In contrast to the previous regime, high fertility and rapid population growth were favourably looked upon (Abbasi *et al.*, 2002, p.26). The country's new leaders considered the family planning programme as an imperialistic tool for maintaining the dominance of the West over the "Third World", and in particular, its Muslim populations (Hoodfar, 2000, p.20). Thus, a series of pro-natalist policies were pursued by the new regime, but a comprehensive policy on population was not formulated. For example, the economic incentives to large families were provided (UNFPA 2000, p.6) and the minimum age for marriage stipulated by law was suspended (Hoodfar & Assadpour, 2000, p.21). Furthermore, polygynous and temporary marriages were legalised.

During the Iran-Iraq war period (1980-1988) high fertility and population growth was seen as advantageous. Population size immediately began to be considered as a matter of comparative advantage. The creation of a popular "Twenty Million Man Army" was adopted as a national slogan early in the war. On a more personal level, the rising casualties of the war encouraged many middle-aged couples to produce more children to replace those whose loss they were anticipating. The demographic consequences of this pro-natalist policy in the political context of the time soon became evident. The first general census of population and housing conducted in 1986 by the Iranian government indicated that the population had grown at an average annual rate of 3.9 per cent between 1976 and 1986 (Abbasi et al., 2002, p.27). Even after taking into account the huge influx of foreign refugees, the natural growth rate of the population between 1976-1986 is estimated to have been between 3.2 per cent (Zanjani, 1992 in: UNFPA 2000, p.7) and 3.6 per cent (Amani, 1995 in: UNFPA 2000, p.7) per year. This meant a drastic reduction in per capita GDP and a lowering of living standards.

In contrast to the Shah's regime, which concentrated on building an urban middle class while expanding the urban economy by means of oil revenue, the Islamic Republic gave priority to meeting the population's most basic needs: provision of food, basic health care and access to education (Hoodfar & Assadpour, 2000, p.20). This resulted in the fact that budget allocations for education and health more than doubled between 1976 and 1986 (WEDO, 1999, p.99).

1988 - 1989: revival of the family planning programme

The 1986 census revealed that the rate of natural population growth had risen to a level which, it was felt, the economy could not sustain and which would have an adverse effect on the intended socio-economic development of the country, especially the post-war reconstruction efforts (Ahmad, 1996, p.23). The Plan and Budget Organisation (PBO), in charge of organising and co-ordinating government budget and planning priorities, became aware that the government's basic development commitments (for food, health care, education and employment) were rapidly outstripping available resources. Its experts became one of the most important forces in devising strategies to reintroduce a population policy in the mid-1980s. By 1985, a loose coalition was starting to question the pro-natalist policy (Hoodfar & Assadpour, 2000, p.22). The PBO received a mandate to prepare a five-year development plan for the country, in anticipation of the end of the Iran-Iraq war. To stimulate a discussion on the existing pro-natalist policies and the need to introduce family planning the advocates of a population programme followed two strategies (Hoodfar & Assadpour, 2000, p.22/23):

1. Public support for fertility control and the introduction of a family planning programme was generated through a public debate in the newspapers and through other media, like articles about the costs and implications of an expanding and increasingly young population: pros and cons. By 1988 substantial support for the introduction of an official family planning policy was evident.
2. Educating government leaders about the importance of the population issue.

In 1988 the Plan and Budget Organisation organised a national conference on population policy in Mashhad, the most sacred city in Iran, and invited religious leaders, policymakers, scholars, ministers and representatives from all national organisations (Hoodfar & Assadpour, 2000, p.24). It came to the conclusion that to achieve the intended prosperity for the people it was imperative to reduce the population growth rate (Ahmad, 1996, p.23). The conference led to the formulation of a national family planning programme. The programme was ratified by Ayatollah Khomeini shortly before his death in 1989 (Hoodfar & Assadpour, 2000, p.24).

During Five Year Development Plans of the Islamic Republic

1989-1994: First Five-Year Development Plan (FFYDP)

The first post-revolution five-year social, economic and cultural development plan included a policy on population, with government support for a family planning programme (Aghajanian, et al, 1999a). It laid down specific targets for reducing population growth, both by the end of the Plan period and for long-term which was taken up to the year 2011. The targets were first, to reduce the population growth rate to 2.9% in 1993 and 2.3% by 2011 and second, to bring down the total fertility rate from 6.4 in 1988 to 5.7 in 1993 and 4.0 in 2011 (Ahmad, 1996, p.23).

The family planning programme was presented in the context of crisis management, not as an inherent part of the regime's development programme. Religious leaders argue that, within the Islamic context, such a programme can only be justified by social and economic reasons or by another sort of crisis situation (Hoodfar, 2000, p.25). Thus, once the crisis is quelled, the justification for such a programme and the intervention of an Islamic government is to be annulled. This stance of the leading clerics created tension with the programme directors (Hoodfar, 2000, p.25). But despite differing views on the scope of the programme, the religious leaders and programme directors showed the necessary commitment to make it a success. They followed a realistic approach to family planning: the programme should allow couples to decide for themselves how many children they desired, rather than emphasise population reduction and demographic targets. Both those couples who experience difficulty conceiving, as well as to those who wish to limit their family size should be served. Thus the treatment of infertility became a prominent component of Iran's family planning programme (Hoodfar & Assadpour, 2000, p.25).

A major thrust of the Family Planning Law, promulgated in 1993, was to remove or reduce most of the economic incentives for large families (UNFPA 2000, p.8). It also laid down policies for other factors that have a bearing on fertility. These policy measures pertained to literacy, particularly the improvement of attendance of school-age girls, raising the status of women by ensuring their larger participation in development process, improving the health status of the population by paying particular attention to infant and maternal mortality, and repealing laws and regulations which militated against the intended population policies (Ahmad, 1996, p.23).

The Ministry of Health and Medical Education (MOHME) was provided with the necessary resources and authority to provide free family planning information and services to all couples. To put the initiative on a legal footing, in 1989 the government prepared a family planning bill that was approved by the Islamic Consultative Assembly in 1992 (UNFPA 2000, p.8).

Between 1989-1993, the economy grew at a strong rate of 7-8 percent per year and most social indicators improved significantly. However, the full realisation of the objectives of the first Five-Year Development Plan was hampered mainly by the accumulation of debt obligations and the deeply depressed world oil prices in 1993-1994 (UNFPA 2000, p.9).

1995-1999: Second Five-Year Development Plan (SFYDP)

The Islamic government's increased commitment to family planning is reflected in its second social economic and cultural plan. Under this plan, Iran's family planning programme was fully integrated into the primary health care system (Aghajanian, 1999a).

Despite all the daunting economic problems during the past two decades, due to the effects of war, decline in oil prices and the high rate of inflation (24 per cent in 1998/99), the Iranian Government managed to maintain its investment in health, education and social services at a relatively high level. The share of social services and welfare expenditure of the annual government budget continued to grow at a respectably good rate under both the first and second Five-Year Development Plans. The impact of this sustained investment in social services and human capital is clearly reflected in such social indicators as literacy rate, level of school attendance and educational attainment, access to sanitary and other amenities, child and maternal mortality and life expectancy at birth (UNFPA, 1999).

Some of the extraordinary achievements during the first and second Five Year Development Plan periods are the revival of an active family planning programme in 1988, the adoption of the family planning law in 1993, and the reduction of the population growth rate from 3.2 per cent in 1986 to 1.5 per cent in 1996, which is below the target set under the first Five Year Development Plan. Furthermore the Government has succeeded in achieving major ICPD goals (UNFPA 2000, p.9/10).

In 1999, the former Minister of health and medical education, Dr. Marandi, won the United Nations Population Award, for his role in transforming Iran's population policy. The changed policy has succeeded in expanding provision of basic and reproductive health services across the country and substantially reducing the annual rate of population growth.

2000-2004: Third Five-Year Development Plan (TFYDP)

The goal of the third Five-Year Development Plan is to improve the quality of life and welfare of the population through sustained economic growth and the eradication of poverty and illiteracy; empowerment of women and youth, including their involvement in the development process; reduction of maternal and child morbidity and mortality rates; and reduction of fertility and population growth rates, consistent with the country's economic and social development (UNFPA, 1999).

The main targets of the plan are (UNFPA, 2000, p.6):

- Maintaining the population growth rate of 1.65 by 2004.
- Reduce the crude birth rate from 21 per 1000 in 1996 to 16 in 2006.
- Reduce the infant mortality rate from 34 per 1000 live births in 1996 to less than 20 in 2006.
- Expanding the coverage of the PHC network from 90% in 1996 to 98 per cent in 2006.
- Increase the CPR (modern methods) from 55 per cent in 1996 to 75 per cent by 2006.

3.2. District Primary Health Care (PHC) Network

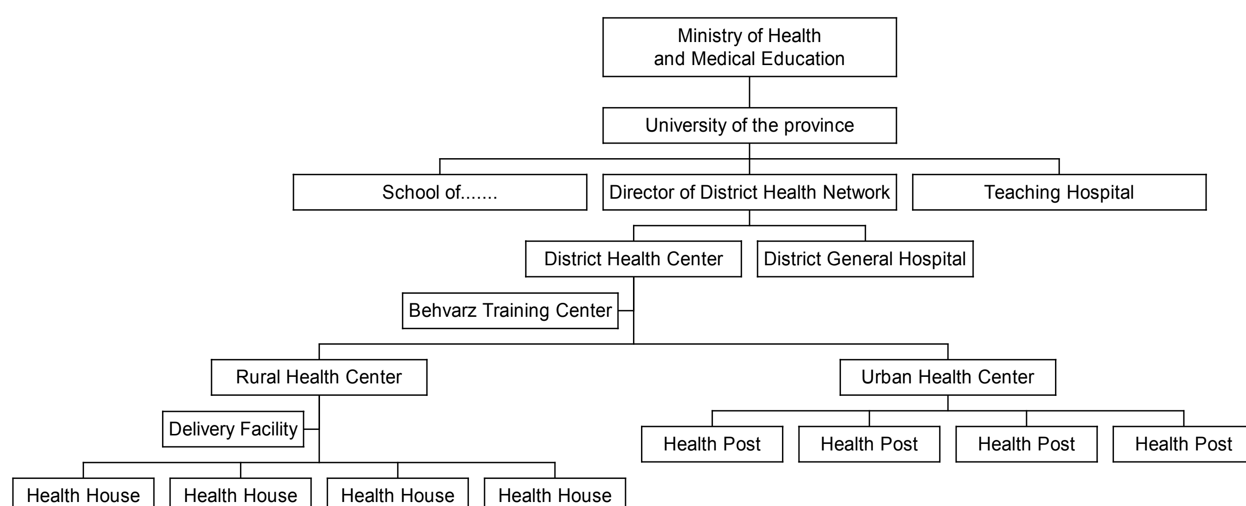
Family planning and reproductive health activities are integrated in the health sector, under the overall responsibility of the Ministry of Health and Medical Education (MOHME). The MOHME presides over the management of the state health system and regulates the provision of private and NGOs' health care services (World Bank, 2000). The Ministry is also responsible for the planning and management of medical education through a unified structure that brings together the health network and the universities, responsible for medical education at the provincial level, in a single management arrangement (World Bank, 2000). Annex II gives the organisational structure of the MOHME.

The public sector is the main provider of health care (see figure 3). At the village and community levels, the Primary Health Care network consists of rural health centres and health houses in rural areas and urban health centres and health posts in urban areas (World Bank, 2000).

The Directorate of the District Health Network (DDHN) is responsible for co-ordinating the activities of the two main autonomous district hospitals and district health centres. The director of the DDHN is the main representative of the Ministry of Health and Medical Education at the district level (Ardakani, RF reports).

The primary aim of reproductive health services is to provide safe pregnancy and childbirth and appropriate methods of family planning. The services include maternal health; pre-natal and post-natal care and safe deliveries; affordable and permissible family planning advice; information, education, counselling and services with a view to increase family planning and to promote breast-feeding to enhance birth spacing. Reproductive health services are also calculated to include prevention and treatment of RTIs, STIs, HIV/AIDS, infertility, IEC and counselling on sexuality and responsible parenthood that involves having males in the programme. Due attention is also paid to adolescent sexual and reproductive health issues (UNFPA, 2000, p.36).

Figure 3. The structure of the Health System in Iran



Source: Farid Abolhassani MD, Director General, PHC Department, MOHME

The basic policies of the Primary Health Care System are stated as follows:

- priority of prevention as a long-term investment;
- priority of rural and underprivileged areas in resource allocation;
- priority of ambulatory care to hospitalisation.

The PHC network is an integrated and stratified health care delivery system with a good referral system. In rural areas, health houses are run by one male and one female community health worker (*behvarz*), who provide basic preventive services. They are supported by rural health centres, which offer guidance, supervision and referral services. In urban areas, health posts provide services similar to those of health houses, while urban health centres provide services similar to those of rural health centres. At the secondary care level, district health centres are responsible for the management of the PHC network, while district hospitals provide frontline referral services for the network. A network of public and private hospitals located in the main cities provide tertiary care (World Bank, 2000; Abolhassani, 2002). A rural health house covers an average of 1,500 people, while an urban health post covers an average of 12,000 people. There are currently more than 16,000 health houses all over the country, which cover more than 90 per cent of the rural population. In addition, health centres have a good coverage all over Iran, since all

graduated doctors are obligated to work in a health centre for a period of two years. By law, all services are deemed free of charge.

Women are advised to determine themselves what is best for them; staff of clinics and health houses encourages this individual approach. The providers' integrity and their recognition of women's and families basic right to informed choice have created considerable good will and trust between citizens and health authorities, particularly in the area of family planning (Hoodfar & Assadpour, 2000, p. 27). Regarding induced abortion, most 'ulama' (learned religious leaders) agree that under some conditions and before ensoulment, abortion is permissible. Abortion remains illegal in Iran, except when the pregnancy is judged to be detrimental to the psychological and physical health of the mother. Abortion was outside the scope of the programme, since it is regarded as a health matter, not a family planning matter.

In 1991, the Ministry of Health and Medical Education (MOHME) established a population and family planning department to oversee family planning service delivery within the primary health care network (UNFPA, 1999, Aghajanian, 1999a). After the ICPD in 1994, the existing family planning programme was broadened to include reproductive health services.

The Government has not (yet) ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), but is firmly committed to improve the status of women. A Bureau of Women Affairs was established under the President's office in 1993, with the mandate to promote the status of women and ensure their active participation in the process of development. After president Khatami was elected (1997), the Bureau changed into the Centre for Women Participation. The Centre's main task is to mainstream gender concerns in the development process on the basis of a directive issued by the President.

How to reach the public?

Most people who have an interest in the family planning programme are people with low income and those living in rural households. Religious leaders played a decisive role in popularising the family planning programme (Hoodfar & Assadpour, 2000, p.29). They were indispensable to the consensus-building process, and the significance of their role was frequently recognised by those working in poor neighbourhoods.

Next to religious leaders, the directors of the family planning programme also tried to involve as many government agencies as possible (Hoodfar & Assadpour, 2000, p.29). This has not been easy, and the situation is complicated by competition between ministries for a relatively larger share of the shrinking government budget.

In order to reach the densely populated, poor and newly urbanised neighbourhoods, the Ministry of Health created an organisation of 'volunteer women health workers', who act as intermediaries between clinics and their neighbourhoods (Hoodfar & Assadpour, 2000, p.30). This volunteer organisation has been successful: the women have welcomed the opportunity to play a public role and they have become a major channel of information and communication between the community and clinic. The organisation started with a pilot project of 200 women from Tehran in 1991; by 1996 the organisation included 20,000 women who worked with 6,000 health centres in major cities. Recent statistics put the number at 41,000 volunteers, covering 12 million poor urban residents (Hoodfar & Assadpour, 2000, p.30). The volunteers serve as major intermediaries between women in the community and the district health centre, with a large focus on family planning (WEDO, 1999, p.101).

The Iran Broadcasting Network is responsible for health messages on all broadcasting channels (8 TV channels and 5 radio channels). They are scheduled for two hours per day for television and two hours per day for radio. In addition they have messages through their own newspaper, magazine and through the Internet. The major priority themes are population; nutrition; mental health; accidents/SOS and HIV/AIDS. The Iran Broadcasting Network falls directly under Religious Leader Ayatollah Khamenei.

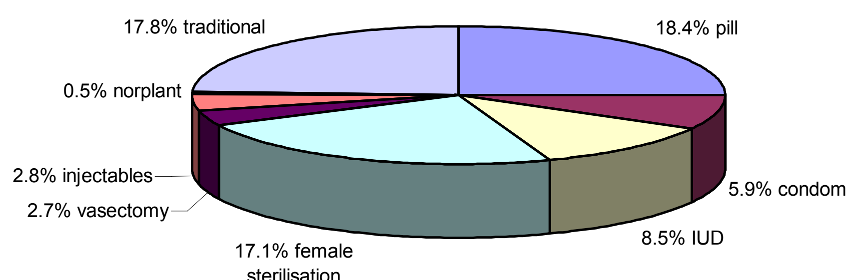
One innovative programme provides mandatory premarital sex education courses for engaged couples. To obtain a marriage license, each couple must attend a short course on sexual and reproductive health issues, ranging from reproductive anatomy to spousal communication. By working systematically with couples who will soon be married, this programme has been both enormously effective and culturally accepted. Iran has also made considerable strides toward developing age-appropriate sex education materials for use in schools, the military and other workplaces.[1]

Since coverage of the PHC network is almost 100 per cent, the main focus now is maintaining that coverage and improving quality of care. One of the challenges is improving the quality of care in the remote rural areas. In rural areas, midwives are only allowed to conduct normal 2nd, 3rd of 4th deliveries. Anything abnormal or the 1st or more than 5th delivery needs to be referred to a doctor. In general the referral system works very smoothly. However, in remote areas, these women are referred to male doctors who are not properly trained for these cases. In Iran, male doctors are not (yet) allowed to work in the gynaecology ward during their training. Therefore, male doctors do not have a practical training in gynaecology/obstetrics. Since quite a number of male doctors are working in remote or rural areas, the referred women do not get the appropriate assistance, which may result in a higher maternal morbidity or even mortality in those areas (correspondence with UNFPA).

Contraceptive Method mix:

According to preliminary figures of the DHS 2000 the total contraceptive prevalence rate was 73.8 per cent. Of this, 55.9 per cent were modern methods, and 17.8% traditional (figure 4).

Figure 4. Contraceptive method mix, 2000



In urban areas, traditional methods account for 22.2 per cent, whereas in rural areas only for 9.9 per cent. In Iran, the higher people are educated, the less likely they are to take modern contraceptive methods. Especially, the knowledge of potential side effects of modern methods make higher educated people more willing to use traditional methods, especially withdrawal.

1 http://www.populationaction.org/resources/publications/InThisGeneration/iran.html

3.3. STI and HIV/AIDS strategy

Except for HIV/AIDS, there is no clearly defined plan or systematic national programme for prevention and treatment of STIs. Most cases of STIs are known to consult private sector specialists for treatment (Ardakani, 1998, 1999). This may be due to the fear of patients of being questioned in the public health outlets. Another reason might be the fact that if STI patients refer to the public health outlets, they are followed up until their treatment is complete, whereas in the private sector there is no such fear of lack of confidentiality. Private physicians usually do not pass data to the public sector. Therefore, the strengthening of private sector resources in this area through further training and support deserves more attention not only for delivery of needed services but also for the collection of basic information and monitoring of the situation (UNFPA, 2000, p.43).

To conduct the National Aids Programme a National Aids Committee was set up in 1995. The Committee is placed under the Centre for Disease Control. The services provided do not fall under the Primary Health Care (PHC) network. PHC falls under the Office of Family Health & Population. Both are sub-departments of the Department of Health within the Ministry of Health and Medical Education (see annex II).

A national HIV/AIDS strategy has been developed which includes clear and internationally comparable procedures for diagnosis and care of HIV positive individuals and the treatment of AIDS cases. Medical and paramedical groups are required to report cases of HIV infection and special procedures have been adopted to safeguard the civil rights, confidentiality and the welfare of the people with HIV/AIDS. There are ninety sentinel surveillance stations for HIV/AIDS as compared with thirty for STIs as a whole. Ten of the latter are part of the sentinel surveillance stations for HIV/AIDS. Despite these efforts, the responsibility of community health facilities in the area of HIV/AIDS diagnosis and treatment is not yet clearly defined. Public education for HIV/AIDS prevention has also been hampered by the same set of cultural taboos and sensitivities that have blocked active inclusion of sex education and sexual health in the reproductive health programme. In the past years some steps have been taken to educate both health personnel working in the public and private sectors and other groups such as students, teachers, the *ulama*, judges, military personnel and law enforcement officers in the area of HIV/AIDS. The resources and experiences gained by the National AIDS Committee can and should be extended to cover other STIs as well. On the whole, STIs are not yet considered as a priority area for intervention by the public health system of Iran (UNFPA, 2000, p.43).

The National AIDS Programme is not large, since previous studies have only shown a low number of AIDS cases. However, the HIV epidemic appears to be accelerating. The UNAIDS/WHO Epidemiological Fact Sheet estimates a total of 369 AIDS cases up till 2001. However, studies about prevalence of HIV/AIDS are very limited and only conducted among certain high-risk groups, like prisoners and drug users. In 2001, 64 per cent of all AIDS cases were injecting drug users (UNAIDS fact sheet, 2002). Prisons are the main source of HIV. However, it is not known to what extent these figures represent the actual situation in Iran and it is feared that the actual situation may be more serious than generally realised. The main concern of the government is the potential spread of infection from injecting drug users to the general population. The strategic geographic situation of Iran and its long common borders with the countries of the Golden Crescent (Afghanistan and Pakistan), which produce a substantial proportion of the world's heroin, have confronted Iran with the problems of drug trafficking and concomitant drug addiction within the country. [2]

The number of drug addicts in Iran has been estimated at more than one million, affecting not only the drug users themselves, but also their families, especially women and children. According to the latest observations, many drug-using men return home from prison with HIV/AIDS. Due to the lack of awareness in society, the wives of such men are at very high risk of contracting HIV.

2 http://www.hivandevelopment.org/regionalupdate/ iran /index.asp

Currently there is a major need for expertise. Some experts do not want to work with HIV-infected people, since there still is a fear of transmission of the disease. Volunteers are very important for all current activities.

The National Aids Programme ran, as a pilot, triangular clinics within five provinces of Iran: Kermanshah, Fars, Sistan and Baluchistan, Oshturan and Mashhad. This pilot turned out to be successful and the number of clinics will now be extended. The clinics provide three kinds of services aimed at STI and HIV/AIDS infections and focussed mainly on injecting drug users:

- education (IEC)
- counselling
- care/treatment

All services in the clinics are free of charge, including Anti Retroviral Therapy (ART). As ART is very costly, a careful selection of people to receive ART is made. People have to comply with specific conditions, for example having a home, not being a drug user and the patient can be monitored etc. Some of the Anti Retroviral drugs are manufactured in Iran.

Since the number of cases is definitely expected to increase in the near future, all therapy being free of charge will probably become impossible. Therefore it is necessary to think about other possibilities like social marketing or insurance possibilities. Furthermore it is very important to educate the general public about the modes of infection of HIV/AIDS and capabilities of HIV-infected persons, for example the fact that an HIV infected person is able to work, if treated with Anti Retroviral drugs. Enlightening of the general public can help reduce discrimination of people living with HIV/AIDS.

4. Key actors and budgeting system

The programme for population activities as defined in this project, is nearly self-sufficient. In Iran, less than one per cent of financial resources originates from international assistance. Therefore the emphasis in this chapter is on domestic resources and actors. We will focus first on the role of the government of Iran, including the budgeting system, after which a section follows on national NGOs, Iranian research institutions and the private sector.

4.1. Role of the Government of the Islamic Republic of Iran

The Ministry of Health and Medical Education (MOHME) is the main source for supplying financial resources for population activities. However, Iran's family planning and reproductive health programme is fully integrated into the primary healthcare system, which makes it difficult to estimate how much of the government's budget is actually spent on family planning and reproductive health services.

Fund Flow and Budgeting System (based on Ardakani, 1998, 1999)

The government's health budget consists of:

1. Recurrent budget: to pay staff and cover day-to-day expenses
2. Development budget: for infrastructure building and other capital expenses

Both are determined and spent as either centrally operated budget used by the central headquarters of the MOHME or as local budget directly paid to the provincial health authority, usually a provincial university of medical sciences and health services, and dispensed by it.

The Management and Planning Organisation (MPO) determine the final amount of both central and local budgets earmarked for different programmes or provinces, after consultation with the relevant departments of the MOHME or the universities of Medical Sciences and Health Services (national and provincial). The main factors taken into account in the allocation of budget for different programmes and provinces are the relative priority of the programme concerned and the population size and relative level of deprivation of the province (UNFPA, 2000, p. 65).

Resources allocated through the central MOHME channel are mainly earmarked for the payment of faculty and staff salaries, purchase of drugs and other medical equipment, daily cost of patient care, maintenance of buildings, equipment and facilities, public education, teaching and research, and in-service or periodic training workshops or programmes.

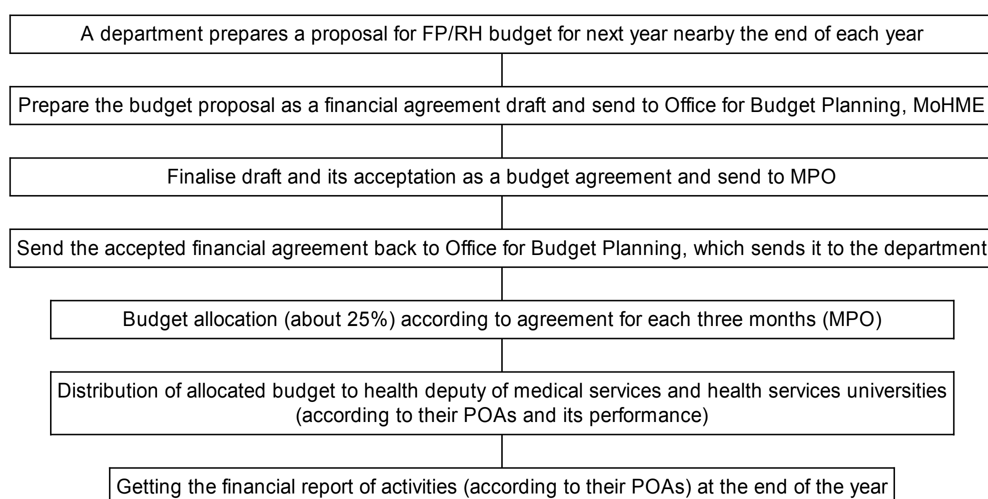
The budget earmarked for local health expenditures by the provincial health authorities (medical universities) are paid directly by the Management and Planning Organisation (MPO) to the concerned local authority. Such directly dispensed budgets are usually of the developmental type and are meant to build new facilities or expand/maintain the existing facilities, initiate new service delivery units or facilities, recruit new staff needed for teaching, research or delivery of services or to initiate research projects. These expenses are expected to be eventually incorporated in the normal, recurrent budget.

In addition to these resources, most government departments, especially those engaged in the delivery of services, are expected to develop and maintain a special account for revenues from special services. Although all such special revenues are by law turned over to the national treasury, a major part of them is actually turned back to the local service delivery unit and spent on activities or projects designed to strengthen it.

Procedure for Central Health Budgets

All departments in the MOHME should send a budget proposal to the Office for Budget Planning in the MOHME. This Office collects all proposals and sends it to the Department for Management and Resource Expansion and Parliament Affairs for review. From there it goes to the deputy minister of the MOHME for approval. He will send it to the Management and Planning Organisation (MPO), which is responsible for planning and preparing budgets of all government ministries and organisations. The MPO falls directly under the president.

Figure 5. Procedure for budget allocation



Once approved, the budget proposal is referred back to the MOHME Office for Budget Planning, which then takes care of the quarterly budget allocations to public health service providers. The latter report back on their activities, service and financial performance at the end of each fiscal year. For the family planning and reproductive health budget, it takes less than two months between proposal writing and acceptance. Figure 5 presents the basic procedure in schematic form.

Procedure for Provincial Health Budgets

At provincial level, universities sent their proposals directly to the MPO. In addition, proposals for some other ad-hoc activities would go directly to the MOHME. All budgets allocated for PHC flow directly from the MPO to provincial universities, differentiated by programme. To illustrate, a university in a large city may operate three programmes: PHC in rural areas; treatment and medical education. Each of these three programmes has a separate budget, part of which will be requested from the MOHME (Office for Budget Planning) and part directly from the MPO.

From the provincial universities funds flow further down to the district levels health centres and hospitals and local level health facilities.

Financial Flows

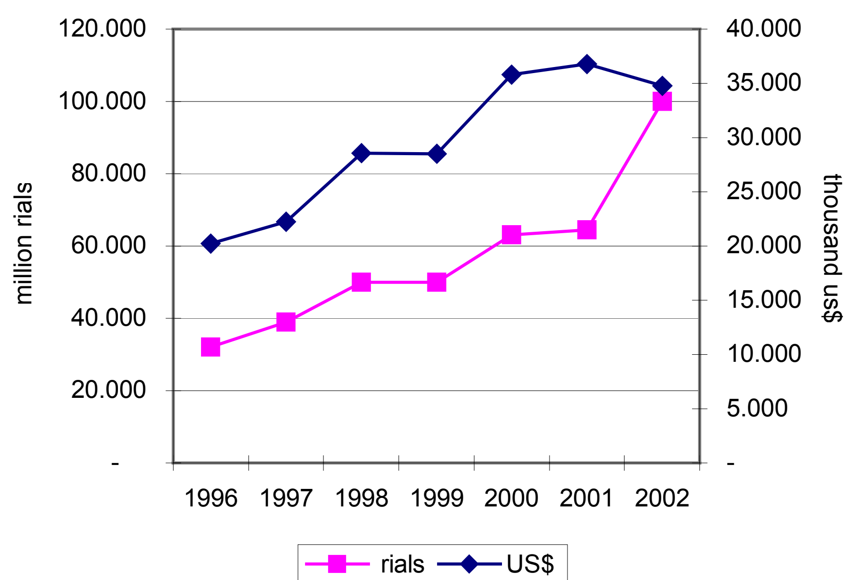
Between 5 to 8 per cent of the annual government budget goes to health. The share of health and nutrition in Social Services (education, housing, health and social security) has been more than 15 per cent during 1981 – 1995 (Ardakani, 1998, 1999).

Prior to 1989, there was no specific budget line for family planning activities. Between 1991 and 1992, approximately 13 billion rials had been allocated for family planning. By 1993, the family planning budget was 16.8 billion rials (Aghajanian, 1999a).

Since 1994, spending on reproductive health has more than doubled to 6.1 per cent of the total health budget (WEDO, 1999, p.100). This was due to greater reallocation to reproductive health and family planning.

Between 1996 and 1998, the actual budget that the Department of Family Health and Population received from the Ministry of Finance was equal to the accepted budget. Since 1999, the actual budget was roughly 10 per cent less. This difference was due to declining oil revenues.

Figure 6. Allocated budget at central level for population activities, Department of Family Health and Population, 1996-2002



The amount of national resources earmarked for family planning and reproductive health by the MOHME (the accepted budget) has risen from 6.6 billion rials in 1991 to 32 billion rials in 1996 (US$ 20 million) to 50 billion rials (US$ 28.5 million) in 1998. It was kept at the same level in 1999, after which it increased to 64 billion rials in 2000 and to 100 billion rials (US$ 35 million) in 2002. In 2002, more than 40 per cent of the budget was spent on buying contraceptives; 40 to 45 per cent for surgical methods and 10 per cent for training and research.

In spite of this increase in current dollars, the inflation of 25 to 50 per cent makes this increase less spectacular. Despite all intentions and efforts, the government of Iran has had much less to spend, due to economic problems. In addition, due to high growth rate of the population, there has been a decrease in the per capita share of spending (Ardakani, 1998, 1999).

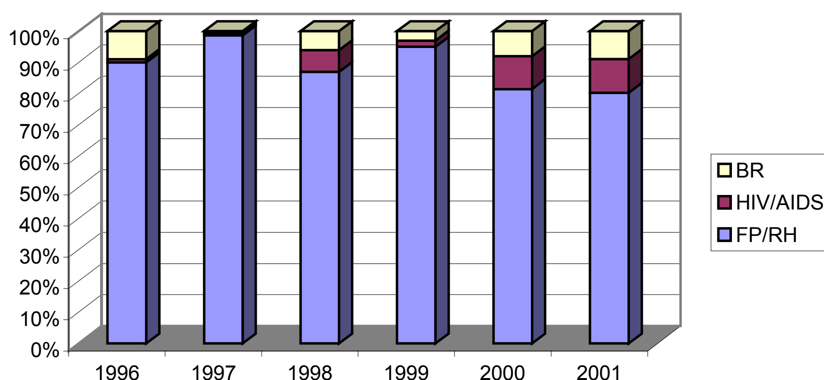
Table 2. Share of population activities in total government budget (all departments)

	1997	1998
Total government budget	45,137 billion rials	86,355 billion rials
Total government budget allocated for health	2,859 billion rials (= 6%)	4,662 billion rials (= 5.4%)
Total health budget allocated for primary health care	Roughly 28%	Roughly 29%
Of which:		
Provincial budget (directly from PBO to provincial level)[a]	836 billion rials	1,017 billion rials
central budget (directly to MOHME)	102.6 billion*	109.4 billion*
* of which for population activities:	93.5 billion	99.7 billion
Family planning	84.6 billion	86.8 billion
Reproductive Health	7.6 billion	10.7 billion
STD, HIV/AIDS	0.8 billion	1.83 billion
Basic research, data and population policy and development analysis	0.5 billion	0.4 billion

Source: Assai Ardakani, RF reports.
[a] Financial flows for population activities at provincial level are integrated in primary health care and it was not possible within the time period to estimate the amount of this.

When one takes a closer look at the expenditures by category, one sees that roughly 90 per cent goes to family planning and reproductive health activities. In response to the emerging HIV/AIDS epidemic, since 2000, significantly more expenditures have been made for HIV/AIDS activities.

Figure 7. Expenditures by the Iranian Government by population category (%)



4.2. Role of national NGOs, research institutions and private sector

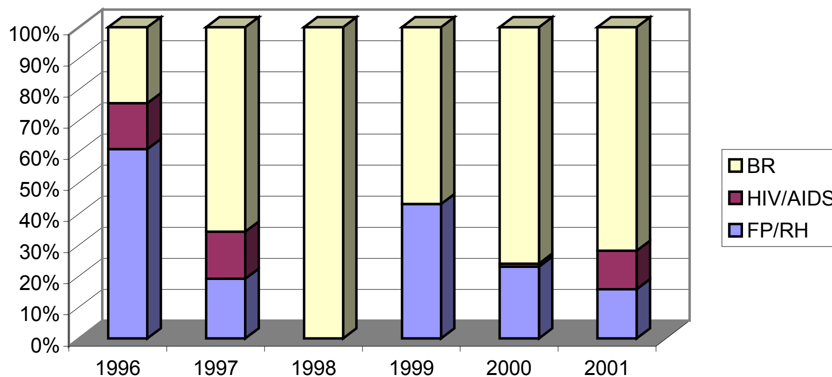
Although there are many Non Governmental Organisations (NGOs) in Iran, the relation with the government is complex. According to the MOHME (1998, p.17), the following are the problems and constraints regarding the promotion of the role of NGOs and the private sector in FP/RH activities:

1. Registration difficulties. There is no law for registration of NGOs: some are registered as a social or research institute at different ministries. Problem: how and where to register?
2. Defective mechanism in supporting NGOs.
3. Lack of supervision by government on the private sector.
4. The private sector is not involved in planning, monitoring and evaluation of health care activities, unless a full range of FP/RH services are provided by them
5. Lack of mechanism for allocation of governmental and international agency resources to NGOs for implementing FP/RH activities.

In general, the existence of national NGOs depends on foreign assistance. Until 1999, more than 96 per cent of the income originated from international donors. In 2001, five per cent of the income came from the Government, almost 80 per cent from international sources, and the remainder was generated by own sources.

None of the NGOs that were visited during the case study were involved in service delivery. Activities rather focussed on awareness creation, advocacy, IEC and (applied) research (figure 7). There seems to be no need for NGOs to set up a separate system of service delivery, as this would duplicate the governments' efforts. Major NGOs are the Family Planning Association of the Islamic Republic of Iran (FPAI), The Association for Family Health Education and Promotion (AFHEP), Iranian Institute of Health Sciences Research (IHSR) and the Institute for Women Studies and Research (IWSR).

Figure 8. Expenditures made by national NGOs by population category (%)



Family Planning Association of the Islamic Republic of Iran (FPAI)

The FPAI was established in 1994. Funding from IPPF has decreased over the years, but in addition funding was received from UNFPA and the Netherlands Trust Fund.

The FPAI has focussed its work in advocacy and information delivery on family planning and reproductive health issues in deprived areas in Tehran and in the rest of Iran. They publish a quarterly journal, organise seminars and publish a newspaper. These are distributed to their members and volunteers in Iran (roughly 2,000, e.g. government organisations, libraries). The organisation is not involved in service delivery, since the government and the private sector take up these activities, and, in general, those services run very well.

The total expenditures of FPAI for these activities has fluctuated between 615 million rials (US$ 350,000) in 1999 and 246 million rials (US$ 140,000) in 2001 (RF database).

The Association for Family Health Education and Promotion (AFHEP)

The Association for Family Health Education and Promotion (AFHEP) was formally established as an NGO at the end of 2000. It currently has 190 members, 90 per cent of them are health specialists (health educators, physicians, obstetrics/gynaecology), who can act as consultants. Many of them work at ministries, universities, all over Iran.

The main focus of health education (health is a “right”, not a “privilege”) is the family or households. Achieving health for all families is not possible without increasing and reforming the knowledge and attitudes to change unhealthy and risky behaviours. The ICPD PoA and ICPD+5 documents are being used as a basis for AFHEPs activities.

The objectives of AFHEPs programmes are:

- To promote public health education with the aim to improve the level of awareness; reforming attitudes and improving the behaviour of all family members.
- To promote healthy life styles, especially among the family’s youngsters.
- To prevent risky behaviours, especially among teenagers.
- To promote women’s and girls rights in the family.
- To promote children’s rights.
- To challenge for prevention of domestic violence.
- Educational activities for HIV/AIDS prevention.
- To promote male participation in reproductive health.
- To promote family mental health.

These objectives are realised through for instance applied research and educational interventions; educational workshops for government personnel; producing educational films and videos and preparing multimedia educational packages.

Most of AFHEPs funding originates from UNFPA and from the Municipality of Tehran. In 2001, AFHEP executed two projects (RF database) with a total expenditure of 100 million rials (US$ 57,000):

- Review of RH IEC material produced in five provinces of Iran
- NGOs collaboration for prevention of HIV infection and supporting its victims.

Iranian Institute of Health Sciences Research (IHSR)

The IHRS was founded in 2001 by a group of academics that felt the need for a separate institute for those interested in public health research. The Institute has currently 14 academic staff members. In addition to courses offered at universities, they offer possibilities for visible and applied research in one of the following areas:

1. Health service management
2. Medical sociology or social medicine (more epidemiological)
3. Reproductive Health Group

About 10 per cent of the funding originates from the government, while the other 90 per cent is funded by activities, research etc.

Institute for Women Studies and Research (IWSR)

The Institute for Women Studies and Research (IWSR) was founded in 1986 with help of Imam Khomeini, with the aim to promote the status of women. The objectives of the IWSR are:

- To recognise and identify women's issues and problems for the purpose of setting plans for the improvement of women's conditions.
- To raise the scientific and technical knowledge of women researchers.
- To develop women's studies in national scientific and cultural centres.
- To protect and support women's rights.
- To eliminate discrimination and injustice based on gender.

The realise these goals the following activities are executed:

- Training courses for experts and professionals of women's issues.
- Establishment and running of a communication network between scientific and cultural centres.
- Organisation of seminars, exhibitions, festivals, scientific and cultural competitions.

Private sector

Parallel to the public sector is the private sector. The official family planning programme was suspended immediately after the revolution and a large amount of contraceptives were distributed by the MCH clinics affiliated with the MOHME throughout that period. The private sector continued it's normal functions in this area more or less uninterrupted (Assai Ardakani, 1998,1999).

Since the Islamic revolution, the private sector has also played an increasingly important role in the provision of health services. Based on DHS 2000 (preliminary results), some 33 per cent of contraceptive users living in urban areas obtain their contraceptive supplies and services through this sector. In Tehran this proportion is even 47 per cent. Privately operated pharmacies would seem the major outlet for the distribution of condoms; private sector clinics and hospitals in a number of cities have developed facilities for the treatment of infertility (Ardakani, 1998, 1999). In rural areas, the public sector is the most important source: 91 per cent of users obtain contraceptives through the public sector.

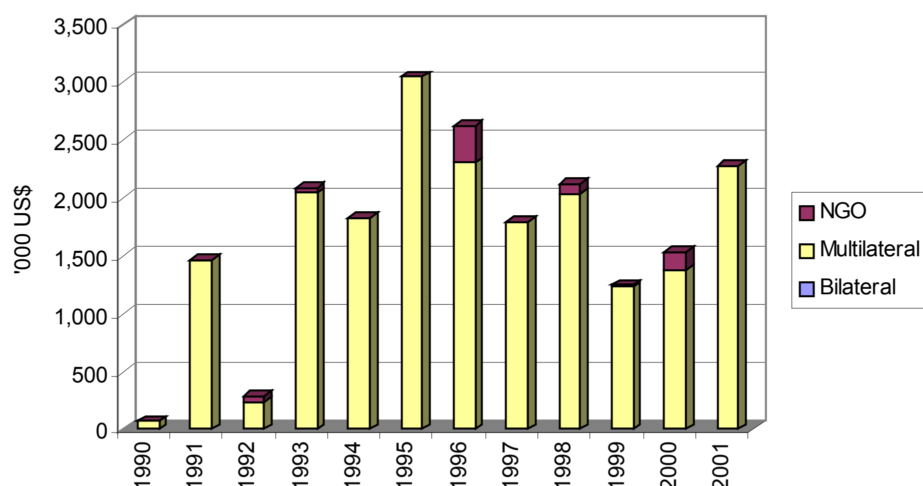
4.3. Role of the international donor community

Since it's initiation of the family planning programme in 1989, the programme received some support from the international donor community, mainly multilateral organisations. This involved both financial support as well as technical assistance (Ardakani, 1998, 1999). Overall, international assistance received for population activities is insignificant at far less than 1 per cent of total funds.

International funding is directly disbursed to the ministries (not to a national budget). In this case, the donors allocate their funds directly to the MOHME. A contact person at the MOHME then authorises the donor to directly transfer the money to the university (in the province). There is no direct relation between the donor and the Management and Planning Organisation (MPO, see paragraph 4.1), but the contact person of the MOHME informs the MPO. Only the procedures for loans go through the MPO.

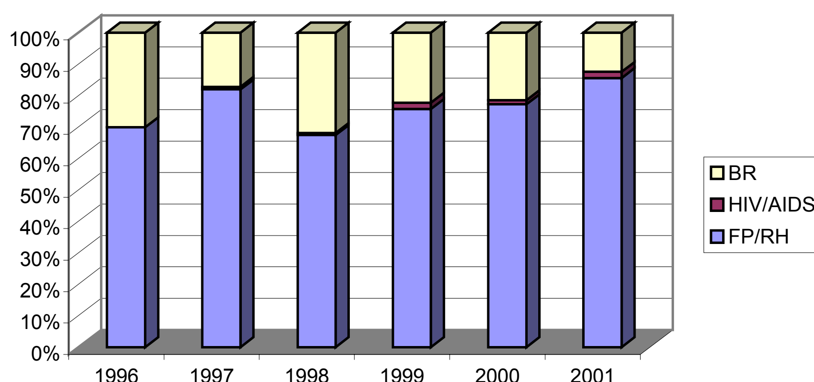
As is shown in figures 9 and 10, most of the funding is channelled through the multilateral channel and is spent on family planning and reproductive health activities.

Figure 9. Donor funding by channel of distribution, 1990 –2001



Source: UNFPA/NIDI Resource Flows database

Figure 10. Expenditures made by international donors by population category (%)



Source: UNFPA/NIDI Resource Flows database

United Nations Population Fund (UNFPA) is the major donor organisation providing financial and technical support in the field of population in Iran. Its programme has focused mainly on capacity building, training, school curriculum development and the improvement of services in the field of reproductive health and family planning, next to assisting in population research and data collection efforts. UNFPA has supported Iran since the early 1970s, but the UNFPA programme came to a halt during 1979-1984. Between 1984-1993, UNFPA' s assistance was mainly aimed at building up the Iran capacity to devise and (further) develop the managerial, administrative and technical know-how for the execution of population and family planning programmes. UNFPA's second country programme for Iran (1994-1998) was devised in line with Iran's second Five-Year Development Plan (see section 3.1.). The total UNFPA budget for this programme was US$ 10 million, with an additional allocation of US$ 1.8 million for 1999. The programme contributed to improved family planning/reproductive health services, the reduction of maternal mortality, an

increase in contraceptive prevalence and a broadening of the method-mix (UNFPA, 1999). In addition, UNFPA contributed to the strengthening of demographic data collection and analysis (including design and execution of the 1996 Population and Housing Census) and advised the Iranian Plan and Budget Organisation in its drafting of a population policy paper as input for the Third Five-Year Development Plan. UNFPA was also instrumental in including population issues, including family planning and reproductive health in school curricula, gender sensitisation training and fostering the involvement of national NGOs in population activities (ibid, p. 7).

UNFPA's third country programme (2000-2004), with a total proposed funding of US$11 million, has as its general goal of with the help of Imam Khomeini, and development strategies and advocacy) with the aim to improve reproductive health status and reproductive health rights; contribute to a reduction in gender disparities; promoting improved reproductive health/family planning services and achieving a sustainable balance between population, economic development and resources. UNFPA activities also include IEC on HIV/AIDS prevention among youth and schools.

UNFPA's expenditures for its programme in Iran between 1996-2001 has fluctuated through the years, but averaged US$ 2 million per year.

5. Concluding remarks

The implementation of the ICPD Programme of Action in the Islamic Republic of Iran takes place within the context of religious and cultural values. Several factors have contributed to the success of Iran's current family planning programme. First, religious leaders played a decisive role in popularising the population programme. Second, the lessons learned of the first family planning programme (1967-1979) were brought to bear and sufficient staff was available. Third, the existence of an excellent primary health care network, with a wide coverage was an important precondition. Lastly, the high degree of educational level among females and the governments' commitment to primary health care and population activities are important factors.

The characteristics of Iran's population policy are its self-reliance: international donors play a minor role in population activities in Iran, in particular in terms of funding. Less than 1 per cent of the budget for population activities originates from the international community.
Iran has a comprehensive primary health care system with a wide coverage (over 95 per cent of population): in urban areas coverage is nearly 100 per cent of the population through a network of public and private sectors; in rural areas coverage is around 75 per cent of the population through the primary health care system. Thus, there is no need for potential donors or national NGOs to establish new clinics. The role of national NGOs is focussed on awareness creation and research, and not service delivery. Furthermore, family planning and reproductive health are integrated in primary health care, while health and medical education are also integrated. Iran has set up a pre-marriage counselling and blood-testing programme. This innovative programme is obligatory for marriage couples and provides them with information and counselling on reproductive health issues.

As to HIV/AIDS, although the spread of the disease is still relatively limited (mainly drug users and prison in-mates) there are concerns that it is spreading; the government is setting up a National AIDS Programme, including free ART drugs, partly self manufactured. The government has increased its budget for HIV/AIDS prevention and treatment in recent years.

Despite Iran's success in family planning, reproductive health and HIV/AIDS prevention/treatment, challenges remain. One major challenge is how to sustain its per capita health spending and free provision of health care services, in the face of a growing population and declining oil revenues and high inflation. In the long term, it could mean a decline in per capita health spending and/or introducing service fees for certain health interventions. Cost recovery measures, social marketing and a greater involvement of the private sector and insurance are options to be explored.

The improvement of quality of care and the extension of services remain issues to be addressed in the future: this would also include services for adolescents and men. Mass communication remains highly important in order to reach a large public. Although more than 90 per cent of the country receives national and provincial TV and radio broadcasts, health messages are often indirect and not always sufficiently clear. Furthermore, the position of national NGOs needs to made more stable, in particular in terms of the registration law. Finally, the position and further empowerment of women would benefit from the ratification of CEDAW convention.

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Annex I. Persons contacted

Multilateral Organisations

UNFPA		
	Mr. Mohammed Mosleh-Uddin	Representative
	Ms. Monire-Therese Bassir	Programme officer

Government of the Islamic Republic of Iran

Ministry of Health and Medical Education, Department of Health, Centre for Health Development		
	Dr. Rahbar	Senior expert of the department
Ministry of Health and Medical Education, Department of Health, Office of Family Health and Population		
	Mr. Mohammed Eslami	Executive Deputy
	Dr. Delavar	Director General
Ministry of Health and Medical Education, Department of Health, Centre for Disease Control, AIDS department		
	Dr. Moatamedi	Director
Ministry of Health and Medical Education, Department of Health		
	Dr. Gheraghchi	Adviser for Deputy Minister for Health; director of UNFPA project in 5 provinces.
Ministry of Health and Medical Education, Department for Research and Technology, National Centre for Research and Technology in Medical Sciences		
	Ms. Ramezani Tehrani	Director
Centre for Women's Participation		
	Dr. Ahrari	Deputy director research and training, Vice president
	Dr. Shakeri	Project manager
Islamic Republic of Iran Broadcasting Network, Medical and Policy Making Centre (MPMC)		
	Mr. Ghasemi	Consultant
	Ms. Faraji	Committee for population
Management and Planning Organisation (MPO)		
	Ms. Hakim	

National NGOs

Institute for Women Studies and Research (IWSR)		
	Ms. Amadi Qomi	Managing Director
	Mr. Neshat	Deputy Director
The Association for Family Health Education and Promotion (AFHEP)		
	Ms. Fariba Kavehzadeh	
	Mr. Saeid Parsinia	Managing Director
	Dr. Sh. Rafieifar	Chief of Board of Directors
The Family Planning Association of Iran (FPAI)		
	Dr. Abolghasem Pour Reza	Member of Executive Committee
	Mr. Keivan Shokraie	Member of Executive Committee
	Mr. Khosro Refaie Shirpak	
	Ms. Padidah Faeghi	Programme Assistant
Iranian Institute of Health Sciences Research (IHSR)		
	Mr. Montazeri	Public Health Specialist
	Ms. Goshtasbi	MCH specialist

Fieldtrip

Health Centre		
	Mr. Mosavi	Director
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	Ms. Bagheri	Behrvaz
	Mr. Ghavami	Behrvaz
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	Dr. Shahriari	
	Dr. Rahbar	
Shahide Behesti Medical University Co-ordinator		
	Dr. Gharaei	
	Ms. Zamani	

Annex II. Organisational chart of the Ministry of Health and Medical Education of the Islamic Republic of Iran