Trends and Issues Affecting Service Delivery Over the Next Decade

Prepared for the Service Delivery Improvement Division,
Office of Population and Reproductive Health
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This document has been written at the request of the Service Delivery Improvement Division as part of its planning process for the next decade. It focuses primarily upon features that concern the provision of services, not upon all aspects of reproductive health programs. The first five sections present the factual background; the final two sections build on those to suggest future program strategies and options.

1. Demographic and Social Trends

1.1 Demographic Changes

Although the world population growth rate peaked in the last decade, the number of couples in the developing world needing family planning services will continue to increase rapidly in the next decade. This growth is already built into the age structure. In the developing world outside of China, where there were 100 women in union in 2000, there will be 111 by 2005 and 121 by 2010. In Africa the increases are surprisingly large: where there were 100 women in union in 2000, there will be 115 by 2005 and 133 by 2010.

Stated in terms of numbers, the developing world (ex-China) will add 98 million women of childbearing age from 2000 to 2005, and another 92 million by 2010, or 190 million total. A disproportionate share of this growth falls in the subcontinent countries of India, Pakistan, and Bangladesh; they will add 36 million women of childbearing age from 2000 to 2005 and another 34 million by 2010. None of these are contraceptive users at the outset, and nearly all will be requiring services for their reproductive health from the public or private sectors.

A second reality is that fertility declines, as impressive as they have been in some countries, are geographically uneven, and tend to be least in the least developed countries. Moreover, the U.N. fertility projections for much of Sub-Saharan Africa that were issued in 1998 were deemed to be too optimistic and were changed in the 2000 projections to show higher starting levels in 2000-2005 and slower declines.

Other demographic changes of note are the continuing declines in infant and child mortality, as well as reduced mortality at higher ages, in most of the developing world including much of Sub-Saharan Africa. It is not often realized that the common use of the total fertility rate (TFR), which measures births only, suggests greater declines than really occur. The improving survival rates mean that more births now remain in the

population than before, so the real declines are less than the TFRs suggest. This has clear implications for the numbers of people requiring services.

1.2 Social Changes

Urbanization. The prevailing movements into the cities are now so marked that nearly all population growth will occur there over the next 25-30 years. The aggregate rural population size will remain stable.[1] In the developing world the urban populations will grow from 1.9 billion in 2000 to about 3.9 billion in 2030, averaging 2.3% growth per year, vs. a mere 0.1% per year for rural populations. However Africa is an exception: the whole rural population there will grow from 487 million to about 640 million by 2030. An interesting feature of urban growth is that rather little of it is in the largest cities. Only about 6.3% of people in developing regions live in cities of 5 million or more, growing to only 8.5% by 2015. Thus urban service burdens are widely spread, not concentrated in a few places.

Environmental Changes: Environmental changes are complex and controversial, but it is fair to say that for action agencies the presumption must be one of deleterious effects of serious magnitudes. The latest United Nations appraisal[2] for example documents the growth in carbon dioxide (CO2) emissions from fossil fuels and cement production from less than 2000 million tons of carbon in 1950 to over 6000 million tons in 1996. Over half (57%) is in the more developed regions; 43% is in less developed regions reflecting less industrialization but larger populations. Other concerns such as water use, agricultural practices, forest losses, and diminishing biodiversity have aroused much concern. All are aggravated not just by population factors but also by a variety of other forces; however slowing population growth contributes to environmental health. In any case it is the population factors that must be the chief focus of agencies working with family planning and reproductive health.

Poverty Trends: Using the World Bank's definition of poverty (living on less than US one dollar a day), about 1.2 billion people qualify, or one-fourth of the developing world's population. The number of 1.2 billion is about the same in 1998 as it was in 1987. Poverty is most pervasive in Sub-Saharan Africa and in South Asia. Actual poverty levels have fluctuated, as they did during the financial collapses in Asia in 1997. Inequalities among countries have grown over time, since the growth in per capita income has been much faster in developed than in developing countries. The picture is one of overall, uneven gains per capita but with pervasive poverty across much of the developing world.[3] The persistence of severe poverty for large numbers of people makes means that the problem of funding family planning services in the future is not likely to be solved by wealthier populations who can afford to pay for these services. It also means

[1] United Nations Population Division. *World Urbanization Prospects: The 1999 Revision*. New York: United Nations, March 2000.
[2] United Nations Population Division. *World Population Monitoring 2001: Population, Environment, and Development*. New York: United Nations 2001.
[3] Ibid, p. 12.

that fertility transitions may be slow to start in countries with the largest proportions of their populations living in poverty.

1.3 Demographic Impact of AIDS

Almost 40 million people are now infected with HIV. About three million adults and children died from AIDS in 2001. AIDS deaths to adults have resulted in 14 million AIDS orphans. The AIDS epidemic has hit particularly hard in Sub-Saharan Africa. In seven Sub-Saharan African countries over 20 percent of adults 15-49 are infected with HIV. In Botswana, Lesotho, Swaziland and Zimbabwe prevalence is over 30 percent. These high levels of infection are leading to increasing death rates and falling life expectancy. The United Nations Population Division estimates that life expectancy has fallen from 60 years in the late 1980s to 35 in Botswana, 43 in Zimbabwe and 47 in South Africa. In these countries a combination of low fertility and a high AIDS death rate is expected to lead to negative population growth in the next decade. The US Census Bureau estimates that the population growth is slightly below zero in Botswana today. By 2010 it projects negative population growth for five African countries: Botswana, Lesotho, Mozambique, South Africa and Swaziland and zero growth for Zimbabwe.[4] In these same countries, AIDS may account for more than half of all infant deaths. Outside of these hard-hit countries, population projections continue to show positive growth, and the overall additional numbers to come are huge, as documented above. A few countries outside of sub-Saharan Africa have serious and rapidly growing epidemics but none are expected to reach such high prevalence levels as to cause the significant demographic effects seen in Africa. The exact course of HIV/AIDS growth is necessarily speculative; it has often outrun projections; moreover certain very large countries with low prevalence, including India, have more cases than many of the smaller African countries.

In the countries hardest hit by AIDS, the declining population growth rates will be seen by some as a reason to give less emphasis to family planning programs. But population growth has never been a major motivation for African family planning programs. The programs have been supported to improve birth spacing, enhance maternal and child health and reduce the cycle of poverty. The expanding problem of AIDS orphans and the increases in child deaths due to AIDS should in fact lead to more emphasis on family planning and safe delivery programs. In the HIV/AIDS environment it is even more urgent that families have only access to family planning services. This will be particularly true for youth because of the dual vulnerability to HIV infection when starting sexual activity and pregnancy at too young an age.

[4] Karen A. Stanecki. *The AIDS Pandemic in the 21st Century*. Washington, DC: US Census Bureau. July 2002.

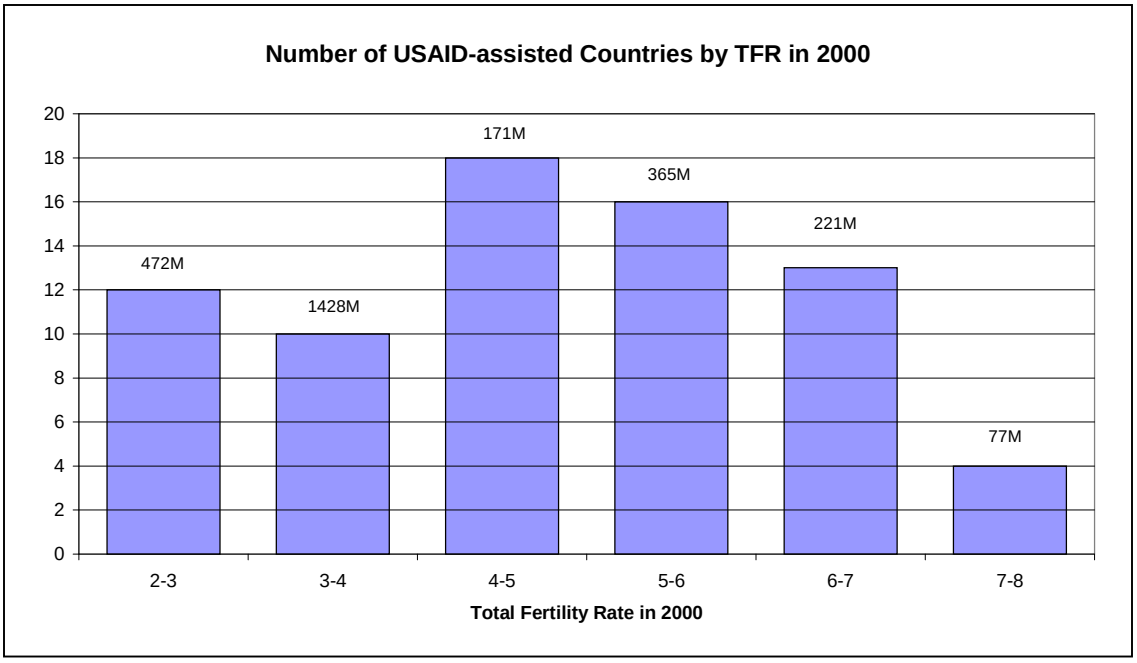
2. Population Programs and Policy Changes

2.1 Total Fertility Rates

The last 20 years have seen the greatest decline in total fertility rates in the history of the world. Among the 133 low- and middle-income countries with populations of more than one million, 84 had a total fertility rate of five or higher in 1980. Today only 44 do. In 1980 only 16 low- and middle-income countries had a total fertility rate of 3 or below. Today, 51 countries have a TFR of 3 or lower. In the 1980s fertility was high everywhere in the developing world. Today high fertility is concentrated in Africa. In Asia the TFR is above 5 only in Afghanistan, Laos, Pakistan and Bhutan and in the Middle East only in Iraq, Oman, Palestine and Yemen.

Among the 133 countries, the 44 with fertility above 5 are matched by 38 others with fertility between 3 and 5 and 38 countries with fertility between 2 and 3. Another 13 countries are below 2. Twenty years ago USAID needed to concentrate on helping countries begin the fertility transition, but today low- and middle-income countries are almost evenly divided between those that have hardly started, those that are in the middle of the transition and those that are approaching replacement level fertility or are below it.

Among 73 countries receiving USAID assistance 12 have fertility between 2 and 3, 28 are between 3 and 5 and 33 have fertility above 5. Thus a significant number of USAID-assisted countries still have very high fertility, but an equal number are confronting the issues associated with rapid program expansion and sustainability (Figure; TFR data from the United Nations 2000 estimates).



Note: The figure on the top of each bar is the total population of the countries in that category.

2.2 Prevalence of Contraceptive Use

The most arresting feature of contraceptive use is its nearly unbroken increase over a 35-year period across much of the developing world. It has risen to ceiling heights in some countries including China, and it now covers about 60% of all couples in the developing world. In some countries use is still very low, but once an increase has started from the low traditional level of 5% to 10% of couples, the upward movement has rarely been reversed. The ANNEX lists countries according to their prevalence increases.

The downside of this picture is the continuing large proportion of couples in some countries that remain unprotected against unwanted pregnancies, with the substantial proportions that resort to abortions or report the latest birth as unwanted. The failure to use a method, or to use a reliable method, reflects program deficiencies as well as attitudinal problems of fear, religion, and family pressures. Program deficiencies include the sheer unavailability of modern methods, poor service quality, and inadequate educational efforts. Behind these stand policy gaps and weak links between high policy declarations and actual implementation.

Among the regions Sub-Saharan Africa has the lowest levels of modern contraceptive use and in some cases the slowest prevalence increases. Most countries there have lagged in their annual gains for contraceptive use: less than 1% per year in prevalence in ten of 19 countries with repeated surveys, and only 1.0% to 1.5% in seven others. In addition prevalence is almost certainly very low in such large countries without repeated surveys as Ethiopia and D.R. Congo.

2.2.1 Plateaus in Prevalence Increases or in TFR Declines

The question of "plateaus" or "stalling" is complex. We consider fertility and contraceptive prevalence separately, and use both survey findings and the United Nations estimates for past TFR declines. In general we do not find many clear cases of plateaus in the data, but a few do exist. In addition local observations by staff working in particular countries have pointed to plateaus and, program managers have been much concerned about them. It is quite possible that augmented actions were then taken that in fact rejuvenated the former trends. If so that helps explain the rather small number of obvious plateaus in the data.

For fertility the "plateau" question is quite separate from the rough tendency of fertility rates to soften their decline as they approach replacement, as documented in a recent paper by Bongaarts.[5] The concern here is related to action programs in developing

[5] John Bongaarts, "The End of the Fertility Transition in the Developing World." Prepared for the UN Expert Group Meeting on *Completing the Fertility Transition*, New York, Marcy 11-14, 2002. Also Working Paper No. 161, Population Council, Policy Research Division.

countries that show a puzzling hesitation in their fertility decline or in their prevalence increase during the earlier stages of demographic change.

Trends in TFR, through 2000, as estimated by the United Nations Population Division show a few plateaus: Paraguay (1975-80 to 1980-85), Bahamas (1975-80 to 1980-85) and Malaysia (1975-80 to 1980-85). However, TFR declines resumed after all of these pauses. It should be noted that not all countries continued declining all the way to replacement level. The TFR declines have stopped or slowed considerably at 2.5 to 3 children in Chile, Colombia, Guyana and Costa Rica in the last 10 to 15 years. Thus the experience of most countries with relatively low fertility today has been that once fertility started to fall from traditional levels it continued the downward trend.

However, for contraceptive use some developing countries have experienced periods when prevalence remained constant between two surveys. There has been justifiable concern that these periods of stagnation might represent natural plateaus that require a change in program emphasis to restore the trend. The survey evidence is that in some countries progress paused briefly for a period of five years or so but then continued the previous trend. Countries that have experienced short-term plateaus before resuming prevalence increases include Egypt (1981-84 at 30%, 1992-95 at 47%), India (1988-1992 at below 45%), El Salvador (1985-88 at 47%), Guatemala (1983-1987 at 24%) and Jamaica (1993-1997 at 65%). Although these represent a relatively small number of cases in the context of the general tendency for contraceptive increases to continue upward they cannot be ignored and may well have inspired strong program responses that restored the earlier trends.

2.3 Numbers of Contraceptive Users

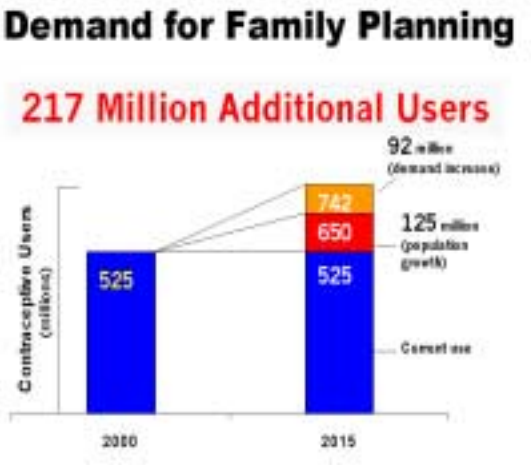
Growth in the absolute number of contraceptive users reflects results from growth in the percentage of couples using a method, compounded with growth in the number of couples. Both have been sharply upward since the mid-1960s, and a brief calculation suggests the implications for services, for contraceptive commodities, and for related personnel (principally in the public sector). From 1965 to 2000, a period of 35 years, the number of women in union in the developing world (including China) more than doubled, from 342 million to 813 million. There was also a rise in the percentage using a contraceptive method, from about 10% to about 60% now. Putting these two changes together yields the historic increase from only 34 million users to about 488 million. That gain reflects a revolution in reproductive behavior, and in the service institutions that have emerged to support it.[6]

Future increases will be exceptionally large. Leaving China aside, an additional 5 percent in prevalence, from 53% (ex-China) to 58%, occurring over the 5 years from 2000 to 2005, combined with population growth, will add 66 million more users, most of

[6] The U.N. Population Division estimates 549 million users as of 2000 and 738 million by 2015, an increase of 189 million (including China). *Levels and Trends of Contraceptive Use as Assessed in 1998*. New York: United Nations, 2000. Page 47.

them for modern methods requiring supplies and services in either the public or private sectors. That is equal to the total of all users in all of Latin America in 2000. During the next five years, to 2010, another 71 million users will be added, with the corresponding supply burdens.

In a 15-year perspective changing family size desires are surprisingly important. Even if contraceptive prevalence stayed constant between 2000 and 2015, developing countries would still face 125 million additional users. But changing family size desires are projected to add another 92 million new users, totaling 217 million additional users expected (Figure).[7] One influence in this is that as couples have fewer children they stop childbearing earlier than before and require contraceptive protection for more ensuing years, which elevates the numbers of users.



Discontinuation rates: note that the 217 million additional users represent a *net* increase. Far more persons will have been in and out of the using group during the 15 year period, many of them using a method for a very short period and being unhappy with the experience. Discontinuation rates are unfortunately high for every resupply method, and the "churning" process, in which persons start and stop use, is very wasteful for service facilities and for the persons involved. The search for a satisfactory method is often frustrated by inadequate counseling and service quality, in addition to poor access to a variety of method choices. In many countries the constraint upon the rise in prevalence is not so much the lack of public interest as it is the difficulties in finding a good method and continuing with it, and it rests with the action programs to address these shortcomings.

2.4 National Policies and Post-ICPD Changes

National government views and policies on population programs have evolved over the last twenty years in response to changing demographic, social and economic conditions. The United Nations survey of national population policies[8] indicates that the percentage of countries stating that their population growth rate was too high increased from 33 in 1976 to 42 by 1996. A similar trend exists for views on the level of fertility. The percentage of countries reporting that fertility was too high increased from 37 in 1976 to 47 in 1996, in spite of the global decline in fertility that took place during this period. Among the 33 USAID-assisted countries with fertility above five all but six (Benin,

[7] Source of figure: United Nations Population Fund (UNFPA). Reproductive Health Essentials--Securing the Supply: Global Strategy for Reproductive Health Commodity Security. New York: United Nations. 2002

[8] United Nations, *National Population Policies*, New York: United Nations Population Division, 1998.

Chad, DR Congo, Laos, Mauritania and Togo) reported to the United Nations in 1996 that their fertility rate was too high.

Government policies on providing family planning services have also undergone significant changes. In 1976 63 percent of countries reported that they provided direct support to family planning services. By 1996 that percentage had climbed to 79 percent.

The major themes of the international population conferences held every ten years illustrate this trend toward greater acceptance of family planning. A major theme of the 1974 conference in Bucharest was a debate about whether family planning or development was the best way to reduce population growth rates. By the time of the 1984 conference in Mexico City most developing nations recognized the need for effective family planning programs. The International Conference on Population and Development (ICPD) in Cairo in 1994 stressed universal access to family planning and emphasized the reduction of unmet need, within a broadened context of reproductive health. Studies of national policy changes since ICPD[9] indicate that countries have made significant progress in adopting a reproductive health focus. In particular policies have been revised to reflect the new focus, and civil society participation in policy discussions has increased. However the actual implementation of new reproductive health programs has lagged the policy reforms, and issues of priorities among multiple programs still require attention, including budgetary solutions.

Thus on the surface, the battles have been largely won to establish favorable policy positions toward family planning and reproductive health. That is, most countries, covering by far most of the developing world's population, have official positions that support provision of family planning services and public information. However just below the surface serious gaps and deficiencies remain, in the more detailed policy positions toward specific barriers to contraceptive use, toward reliable contraceptive commodity supply, and toward important program components such as CBD, CSM, and postpartum and postabortion provision.

These more detailed features are termed "operational policies".[10] They speak to the ubiquitous presence of barriers that impair true access to contraceptive use. They are of several types: personal (e.g. limits on who can receive contraception (e.g. unmarried teenagers); medical (e.g. restrictions on which personnel can distribute certain contraceptives); supply (e.g. stocking rules that cause frequent stockouts); training (e.g. poor training that limits personnel capacity to give good service); and systemic (e.g. weak referral systems). These are only examples; the point is that below the level of high policy there is a network of rules and procedures that requires policy attention and firm implementation of changes.

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[9] Karen Hardee et al., *Post-Cairo Reproductive Health Policies and Programs: A Comparative Study of Eight Countries*. Washington, DC: POLICY Project, The Futures Group Int'l. September 1998; and *Post-Cairo Reproductive Health Policies and Programs: A Study of Five Francophone African Countries.* Washington, DC: POLICY Project, The Futures Group Int'l. August 2000

[10] Harry Cross, Karen Hardee, and Norine Jewell. "Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs**."** POLICY Project Occasional Paper No.7, The Futures Group International: Washington, D.C. 2002.

2.5 Abortion in Relation to Contraceptive Use

Historically, the principal weapon for driving out abortion has been contraceptive availability and use. Since the demise of the USSR the high rates of abortion in its former Republics have been under study, as modern contraceptives have begun to take hold. These natural experiments give telling evidence of women's preference for reliable contraception over repeated abortions. For example in Kazakhstan, DHS surveys have documented a rise of 50% in contraceptive use since 1990, accompanied by a fall in abortion of the same amount. This has even occurred during a period when the desired family size was decreasing. The abortion decline has been especially marked in the capital city of Almaty and among the Russian ethnic minority. Abortion tends more now to be relegated to use for contraceptive failures, which highlights the need to provide reliable contraceptive methods and careful instruction in their use. All these points carry clear implications for programmatic application elsewhere.[11]

Abortion rates and ratios remain very high in much of the developing world, testifying to the frustrations of millions of women in their efforts to avoid pregnancy. The regional picture is estimated as follows:[12]

	Annual Abortion Rate Per 1,000 Females Aged 15-49.	Abortion Ratio Per 100 Births	No. of Abortions (millions), 1999
Asia	26	26	24.2
Latin America	40	45	4.2
Middle East/North Africa	16	13	1.7
Sub-Saharan Africa	20	11	4.4
Central Asia Republics	54	55	0.4
Caucasus	24	46	0.3
Moldova, Russia, Ukraine	49	119	4.2

To make inroads into these figures the key lies with better contraceptive provision. Past investments of resources have been instrumental in that, and future investments will both reduce the numbers of unsafe abortions and the maternal deaths associated with them.

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[11] Charles Westoff, "The Substitution of Contraception for Abortion in Kazakhstan in the 1990s." *Demographic and Health Surveys Analytical Studies,* No. 1. Calverton, Maryland: ORC Macro, Dec. 2000.

[12] John Ross, John Stover, and Amy Willard, *Profiles for Family Planning and Reproductive Health Programs: 116 Countries*. The Futures Group International, 1999. Pp. 64-65.

2.6 Male Involvement in Programs

Gender issues came to the fore prominently in the Cairo meeting in 1994, which gave such stress to women's reproductive heath needs. The associated male responsibilities were detailed in the Programme of Action in five paragraphs under "Gender Equality, Equity, and Empowerment of Women." The document also specifically included the objective "…To increase the participation and sharing of responsibility of men in the actual practice of family planning…" Gender issues were therefore incorporated on both sides: closer attention to the reproductive health needs of women, and insistence upon the contributions of men to help address those needs.

Gender issues are multiple and are often termed "cross-cutting," to indicate that no single program endeavor will suffice. It must be approached as a concern in a broad variety of program activities. However the Cairo call for greater involvement of men is a valid and important one, both for the attitudes they express toward their spouses and for their own behavior. Of all contraceptive use in the developing world, males are involved in one-fifth (19.5% of users), for vasectomy, condoms, rhythm, or withdrawal. [13] This varies little by region, but it varies considerably by country, and that has programmatic implications. The drive for greater condom use may increase the male proportion above one-fifth, although the tendency over time to shift away from traditional methods such as rhythm and withdrawal may act in the other direction. Survey findings for Sub-Saharan Africa on male contraceptive use and fertility preferences show both the generally low use of contraceptives by males (and their wives) there and the considerable variation across countries. Male involvement is greater in other regions but requires improvement there as well. [14]

3. Changes in Family Planning Services

3.1 Contraceptive Method Mix and New Technologies

Programmatically the need is to provide a balance of method offerings, with easy access to each one, and with stimulation of the private sector to add channels for access. That balance is not fully achieved in most countries, and it should be given high priority in donor strategies. Contraceptive use in many countries is dominated by one or two methods. Extremes for one method are illustrated by India and Nepal (sterilization), Vietnam (IUD), and Zimbabwe (pill). Two-method programs include China and Cuba (sterilization and IUD), Indonesia (pill and injectable), and Egypt (IUD and pill), and

[13] United Nations Population Division. *Levels and Trends of Contraceptive Use as Assessed in 1998*. New York: United Nations. 2000. Page 69.

[14] Alex C. Ezeh, Michka Seroussi, and Hendrik Raggers, "Men's Fertility, Contraceptive Use, and Reproductive Preferences," *Demographic and Health Surveys Comparative Studies*, No. 18, Calverton, Maryland: ORC Macro, March 1996.

even there one of the two methods is clearly more important. While it is true that high prevalence levels have been attained in some countries with only two methods dominating, some couples remain dissatisfied or unserviced and experience unwanted pregnancies, abortions, and births.[15] Restricted method availability remains one of the greatest shortfalls of current programs.

In the international picture sterilization and the pill protect more couples than any other methods, but they differ sharply in their annual adoption rates. Sterilization use has built up only gradually over the years, with rather few adopters each year but with nearly all staying in the using pool until they age out. Pill use however depends very heavily upon each year's new starts, since its continuation is so brief (half or more of those adopting stop or interrupt use within a year). Its prevalence is high because of many adopters each year who compensate for the many who quit. Thus supply burdens and costs are high for it, as they are for the other short-term methods, and most commodity costs fall upon the donors. Programs that offer ready access to long-term methods reduce these repetitive costs.

Changes in method mix do not in general occur quickly, though there are exceptions. Recent examples involve the injectable, which has gained popularity in Indonesia, Myanmar, Jamaica, and South Africa.

New Technology: Emergency contraception has emerged in recent years and may well spread widely. That has implications for service providers in both public and private facilities who see women for all reasons associated with pregnancy. Apart from that, two observations for the usual contraceptive technology appear sound regarding the unlikelihood of a significant change: "A new contraceptive method requires many years to gain general acceptance, because the contraceptive market moves slowly and is conservative…." and "No new product currently in development will radically alter the prevailing pattern [of method mix]."[16] Those assessments point to only small changes if any in the foreseeable future, again, apart from emergency contraception. In sum, most changes in actual method mix depend more upon programmatic factors and commercial activities than upon any new technologies in sight.

3.2 Source of Supply by Sector

If one counts by total populations served, the lion's share of all contraceptive users in the developing world has been served by the public sector. This reflects the inclusion of the giants of China, India, Indonesia, etc. as well as the dominance of public supply in many smaller countries. If one counts by countries, most also show more public than private supply. It seems unlikely that this can continue without some modification, given the

[15] John Ross, Karen Hardee, Elizabeth Mumford, and Sherrine Eid, "Contraceptive Method Choice in Developing Countries," *International Family Planning Perspectives* 28(1):32-40.
[16] Bongaarts, John and Elof Johannsson. "Future Trends in Contraceptive Prevalence and Method Mix in the Developing World," *Studies in Family Planning* 2002; 33(1):35.

very large increases to come in total numbers of users and the reluctance of international donors to commit to steady, large increases of funding.

According to data from DHS and other surveys government programs now provide about two-thirds of all family planning services in the developing world, excluding China. The surveys do not distinguish source of supply well so some NGO service provision may be included in this figure as well. The private sector (including pharmacies and other providers) supplies most of the remaining services. There are important regional differences as the Figure below shows.

Unlike method mix, there has been no overriding pattern for source mix to change as programs have matured, but clinical methods are typically provided more in the public sector and resupply methods more in the private sector. Once fixed these patterns may persist for some years; many countries in Asia have had a heavy reliance on government services with little change over the past 20 years.[17] However countries in Latin America have tended to rely more on the private sector including NGOs. In numerous Sub-Saharan countries prevalence is still very low and past experience may not apply; source mixes may follow various patterns depending upon both program and commercial initiatives that differ from those observed in Asia or Latin America.

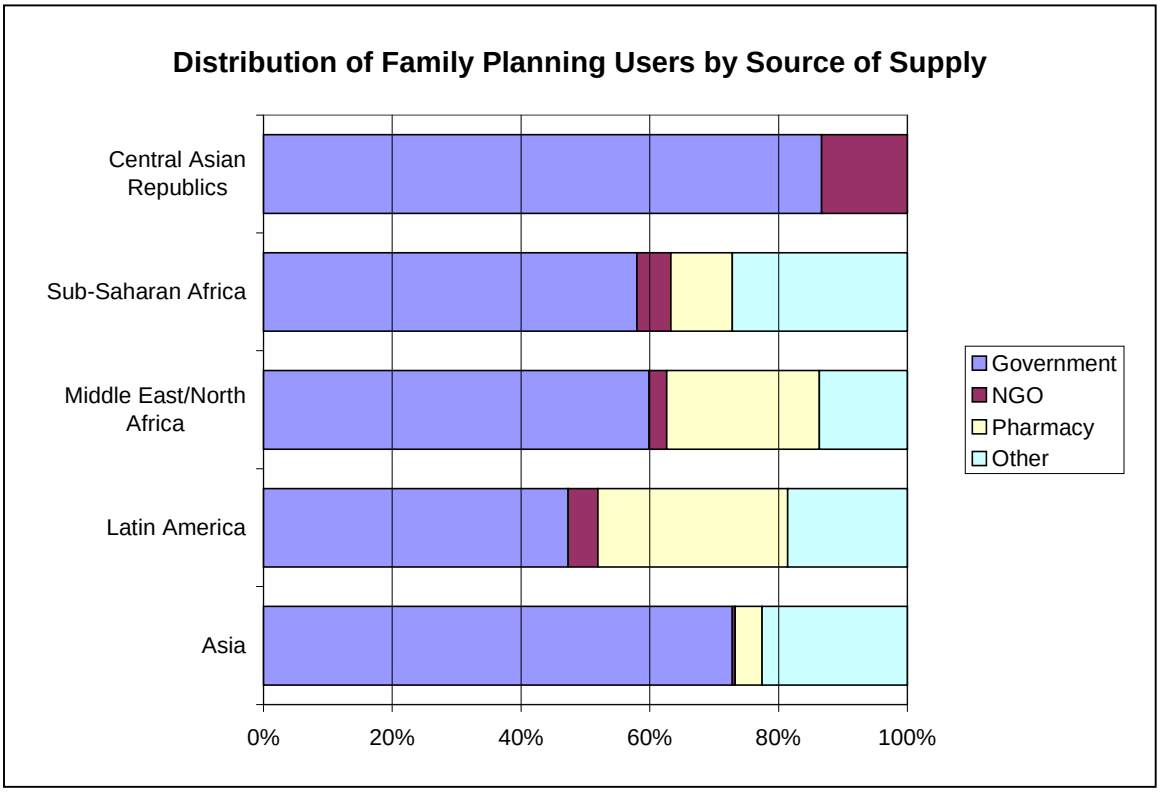
The proportion of services provided by the government is greatest in those countries with the strongest program effort scores, indicating that a strong government program can sometimes reduce opportunities for the private sector. Few countries have relied entirely upon the private sector or have vigorously promoted it as an integral part of the program, and this, together with free or low-cost government services may have slowed growth in the private sector.

However there are interesting exceptions. Indonesia mounted a determined campaign to shift contraception to the private sector and succeeded in moving over half of condom, pill, and injectable use to pharmacies and shops and private medical sources. In Latin America Brazil has been a case of minimal government involvement (although many female sterilizations were done by doctors in government facilities); and in some other countries the government has had a minor share due largely to the exceptional role of a leading NGO agency (Colombia, Dominican Republic, Guatemala; also most supply is non-governmental in Bolivia and Paraguay). In the Middle East, Egypt and Jordan illustrate government shares below half of the total. Otherwise most examples come from Sub-Saharan Africa where total prevalence is low and strong national programs have not yet emerged. These include Benin, Cameroon, Cote d'Ivoire, Ghana, Nigeria, and Uganda, as well as others where the government share of contraceptive provision is about half.

But is there a trend toward greater involvement of the private sector, either for commercial sales or for activities by private medical personnel and facilities? Is the

[17] William Winfrey, Laura Heaton, Tamara Fox, Susan Adamchak, "Factors Influencing the Growth of the Commercial Sector in Family Planning Service Provision". Working Paper Series, No. 6. Washington, DC: The POLICY Project, The Futures Group Int'l., February 2000.

private share increasing significantly? It clearly is in some countries for the condom, and in some for the pill. Time trend charts for each method and each sector show such changes.[18] No overriding trends have yet emerged in national surveys though this may be due in part to definitional problems. Where private agencies are subsidized by donors or governments the sources mentioned by respondents may be difficult to code in such categories as NGO, private medical, and government. In any case it is vital to encourage the private sector in all its forms, whether pharmacies and shops, private medical personnel and facilities, or NGOs.



Source: DHS and other national family planning surveys as compiled in John Ross, John Stover and Amy Willard, *Profiles for Family Planning and Reproductive Health Programs: 116 Countries*. Glastonbury, CT: The Futures Group International, 1999.

3.3 Access to Services

The literal unavailability of modern contraceptives is still a major obstacle to their use in many countries. Estimates by expert observers in some 90 developing countries show the condom and pill to be the most easily available (though still at unsatisfactory levels), the

[18]John Ross, John Stover, and Amy Willard, *Profiles for Family Planning and Reproductive Health Programs: 116 Countries*. The Futures Group International, 1999. Table 2.3.

IUD less available, and sterilization to be least available, especially vasectomy.[19] Leading examples of poor access include such countries as Nigeria, Ethiopia, both Congos, Sudan, Pakistan, Myanmar, Syria, and Saudi Arabia. Average access for five contraceptive methods is poorest in Francophone Africa, with only 29% for the populations concerned having reasonable access. In Anglophone Africa the rating is 47%. It is 61% to 65% in North Africa/Middle East and Latin America, and a higher 86% in East Asia.

Poor access to methods has several dimensions, but from the woman's or couple's standpoint it is simple. They lack access to the following: a variety of methods, close to home, at low cost, in a congenial setting, with few barriers to eligibility. It does not do to offer only one or two methods, far away, with high travel costs, in uncomfortable settings, and with numerous clearance rules that discourage adoption. Access is more than sheer physical access to several methods. True access for many women is constrained by provider attitudes, travel restrictions due simply to being female, blocked access due to youth, and inability to pay. Some constraints apply just to one method, for example sterilization may denied to women below parity 4 or age 35.

The end result is that ready access to a choice of contraceptive methods is not common, and that corrective measures must be taken across many fronts.

3.4 Integration of Services and Quality Improvements

The integration of services for family planning and HIV/AIDS has been a special concern since AIDS emerged in large numbers. Some aspects of integration have worked reasonably well, such as policy positions, and commodities and logistics. Others, such as STI services in family planning clinics, appear more problematic.[20]

Given the scale of the HIV/AIDS problem in many USAID-assisted countries, this issue will be one of continuing concern. Recent work in this area has led to a new USAID report;[21] its guidance suggests that effective integration can be achieved in a number of areas, including mass media, social marketing, community-based distribution, policy, youth-oriented programs and activities targeted to men. A particular opportunity concerns MTCT (mother to child transmission) where the antenatal visit offers a linkage between interventions for HIV and for post-delivery family planning. The HIV/AIDS epidemic also increases the need for good family planning counseling and services during the postpartum period and for breastfeeding counseling and support for HIV-positive mothers.

[19] John Ross and John Stover. "The Family Planning Program Effort Index: 1999 Cycle." *International Family Planning Perspectives*, 27(3):119-129.
[20] See the special issue on integration of family planning and HIV/STI in the June 2002 *International Family Planning Perspectives.*
[21] *FP/HIV Integration. Technical Guidance for USAID-Supported Field Programs*

Other medical services have long been candidates for partial integration with family planning, and some countries have made strides in pursuing these. Interested women receive ante-natal care, tetanus immunizations, and delivery care, along with infant and child care. Surprising proportions of women in most developing countries are seen in one or another of these institutionalized settings; the averages for all developing countries are 65% for antenatal visits, 51% for tetanus immunizations, and 51% for delivery. Regional figures range from only a third of women seen (average for deliveries in Sub-Saharan Africa) to 93% (average for deliveries in the Central Asia Republics.)[22]

3.5 Effects of Health Sector Reforms

Many USAID-assisted countries are implementing a process of health reform intended to improve health system performance and health outcomes. These reforms encompass a range of activities including resource utilization, decentralization, alternate financing sources and a focus on primary care and poverty reduction. Financing changes may include the introduction of user fees in order to ensure sustainable financing or the removal of user fees for preventive services where these fees have been barriers to utilization. Resource allocation changes include greater decentralization of allocation decisions and a greater focus on allocation according to disease burden.

Health reform can affect family planning in a number of ways.[23] Increased decision making at the local level means that many more decision makers need to understand the importance of family planning. This may create problems for beginning and sustaining family planning efforts in high fertility areas where demand may still be weak but it may be a benefit in lower fertility settings where demand for family planning services is high. Family planning programs can certainly benefit from improvements in health financing. However, basket funding or schemes to have the allocation of funding reflect disease burden may not be favorable to family planning since it tends to be rather better funded than many other health services without such strong donor support.

The effects of health sector reform on family planning will be very country-specific. Generally family planning service delivery is likely to be less autonomous and more integrated in the general resource allocation and mobilization systems of the health sector. This can be good for long-term sustainability but may pose short-term challenges as programs adapt to the new systems.

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[22] John Ross, John Stover, and Amy Willard, *Profiles for Family Planning and Reproductive Health Programs: 116 Countries*. The Futures Group International, 1999. P. 61.

[23] Karen Hardee and Janet Smith, *Implementing Reproductive Health Services in an Era of Health Sector Reform*. POLICY Occasional Paper No. 4. Washington, DC: The Futures Group International. March 2000. See also: Tom Merrick, "Delivering Reproductive Health Services in Health Reform Settings: Challenges and Opportunities. " Work in Progress. 1999.

4. Changes in Population Assistance

4.1 Trends in International Funding

All development assistance by the Industrialized Countries has fallen in real terms, and that has been true as well for family planning and reproductive health programs. The Netherlands Interdisciplinary Demographic Institute (NIDI), using data through 2000, estimated total ODA (Official Development Assistance) of donor countries at about $US 60 billion, of which less than 3% was allocated to population assistance.[24] Total ODA was roughly constant from 1992 through 2000, whereas the percentage for population, which had been rising from about 1.3% in the early 1990s to a high of over 3% in 1997, had been below 3% through 2000.

Of all expenditures (per capita) devoted to population topics, from both national and international sources, about 52% in 1999 went to family planning, 23% to other reproductive health, 16% to STD/HIV/AIDS, and 8% to basic research and policy analysis. The U.S. has been the main player in international population assistance, accounting for 43% of the total in 2000 according to NIDI. This was far above that of the Netherlands (11%), the United Kingdom (11%), Japan (9%), Germany (6%), Sweden (5%), and 8 other countries (including the European Union) at below 5% each. However the picture is quite different on a per capita basis; there the U.S. share falls sharply and that of the other donors increases substantially.

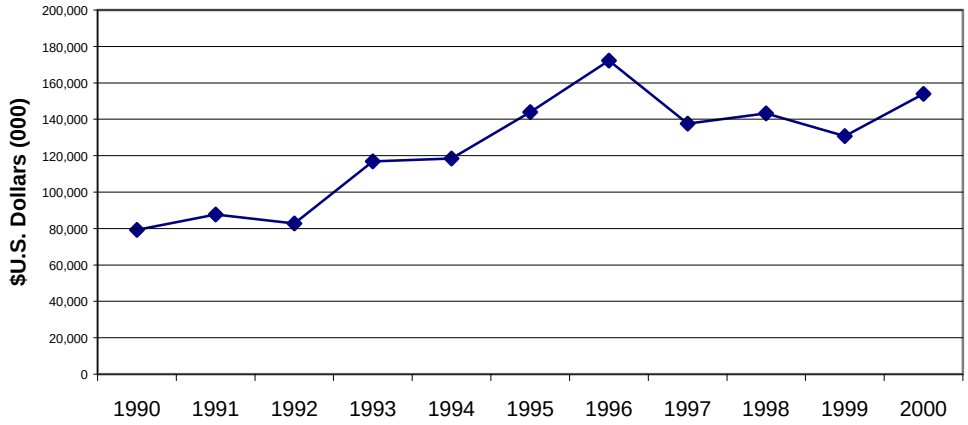
At the Cairo ICPD it was estimated that the cost of providing basic RH care reached $US 17 billion by the year 2000 and would be nearly 22 billion in the year 2015. The nations agreed that donor countries would provide one third of these funds and developing countries the remaining two thirds. However these promises have not materialized. In particular, funding for contraceptive commodities has declined, causing grave concern by USAID and a group of cooperating agencies.

One response to this was the Istanbul conference of April 2001, on "Meeting the Challenge: Securing Contraceptive Supplies," which was meant to call the world's attention to an incipient crisis in contraceptive security.[25] As prevalence of use has risen, compounded with growing populations, the numbers of users needing contraceptives has grown rapidly. Public programs continue to bear the largest supply burdens. They in turn depend very heavily upon donors since local production of contraceptives is generally minor, and foreign exchange for purchases is quite scarce. Yet donors are hardly meeting current requirements, and they do not show convincing commitments to meet the rising supply needs. The UNFPA estimates that the amount required for contraceptives alone is US$572 million in 2000.

[24] NIDI web page, accessed Sept. 3, 2002.
[25] See Carlos Indacochea and Carolyn Gibb Vogel, "Donor Funding for Reproductive Health Supplies: A Crisis in the Making." The Interim Working Group on Reproductive Health Commodity Security (IWG). Published by Population Action International, Washington, DC, 2001.

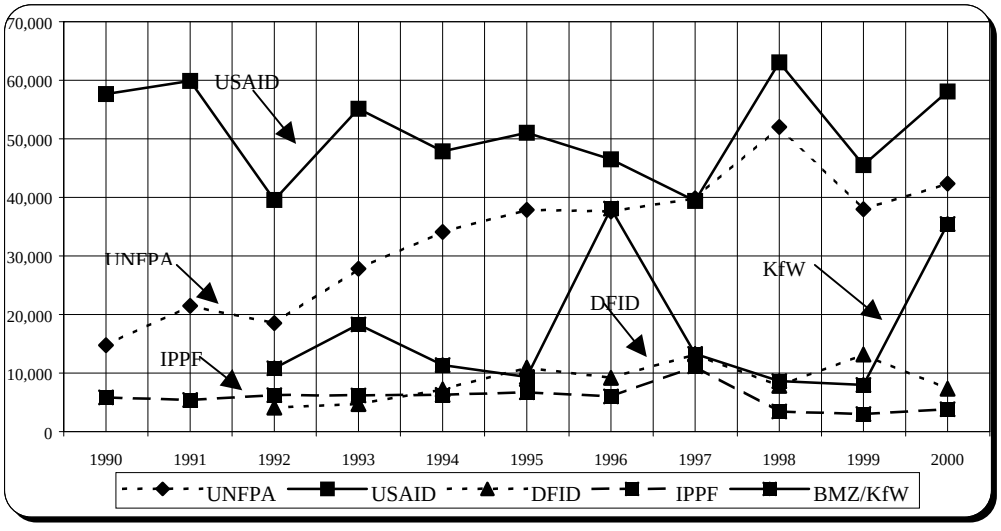
The overall pattern of donor contributions has been uneven and somewhat unpredictable from year to year. The total amount declined from US$172 million in 1996 to only $131 million in 1999. It recovered somewhat in 2000 but not nearly to the 1996 level.

Donor Contributions for Contraceptive Commodities
($U.S. Dollars in Thousands)



Agencies have shifted over the years in their relative contributions to commodity supplies, and will no doubt continue to do so. However USAID has held the lead, followed by the UNFPA, both with some fluctuations in recent years (Figure). In 1999 the UNFPA for example suffered budget cuts and had to reduce its commodity support by two-thirds, until European donors filled part of the gap on an emergency basis. The other agencies have contributed much less (except for KfW in 1996) but have been important in the aggregate, and in particular countries.

Patterns in Contraceptive Supply, 1990-2000, in $US 000



Source: UNFPA Donor Support for Contraceptives and Logistics, 2000.

The prospects for donor improvements are unclear; most agency staffs cannot promise firm budgetary allocations beyond the current fiscal year. That is the realistic context within which planning must go on. Within this unsatisfactory picture the options commonly listed include persistent efforts to increase donor awareness and funding, stimulation of the private sector in all its various forms, and modifications of the method mix toward long-term methods, which would reduce resupply costs.

One hopeful sign is the new efforts to reduce the indebtedness of the poorest countries. The HIPC (Heavily Indebted Poor Countries) Initiative provides a means for countries that qualify to have debt forgiven in return for spending the funds that would have been used to service debts on social development programs. This raises the possibility that some of these funds could be used for family planning. Most will be used for development programs, such as education, health and job creation, that can create a more favorable environment for family planning.

4.2 Relations of Donors and Cooperating Agencies

4.2.1 Changing Role of USAID Missions.

The multiplicity of CAs, with their various kinds of expertise, gives USAID a rich set of resources to draw upon. CAs are well established in many countries and are known to the Missions and Regional offices. The rules for competition for government contracts help to keep costs down, and the CTO supervisory arrangements provide for close communications, especially with many CA offices in the Washington area. While adjustments in the relationships are needed from time to time it is unlikely that these major features will change appreciably, given the government context and the large magnitude of operations involved.

A significant change in recent years has been the shift of some central funding to field support. That has enlarged the compass of the Mission priorities and has made for greater variation in what CAs do, since Missions differ considerably in their objectives and in their willingness to fund centrally conceived programs. For CAs, this has caused greater heterogeneity in what they do. That has been reinforced by another change, one that requires cost sharing in some contracts (whereby a CA is required to find a percentage of the contract from non-US government sources, such as foundations). This gives good value for the government since in effect it requires the CAs to find matching funds; a side effect is again a tendency toward program heterogeneity since the matching donors have their own preferences and priorities. A less important requirement in total dollar terms is the requirement that part of each contract's expenditures go to minority owned firms.

Some Missions have been closed in recent years for cost reasons (e.g. several Missions in Francophone West Africa). That moves the relationship with the CAs to the regional offices, where funding may be less. Those closures are in addition to the longer-term

policy of graduating countries that have attained high contraceptive prevalence, such as Thailand, Colombia, and Mexico.

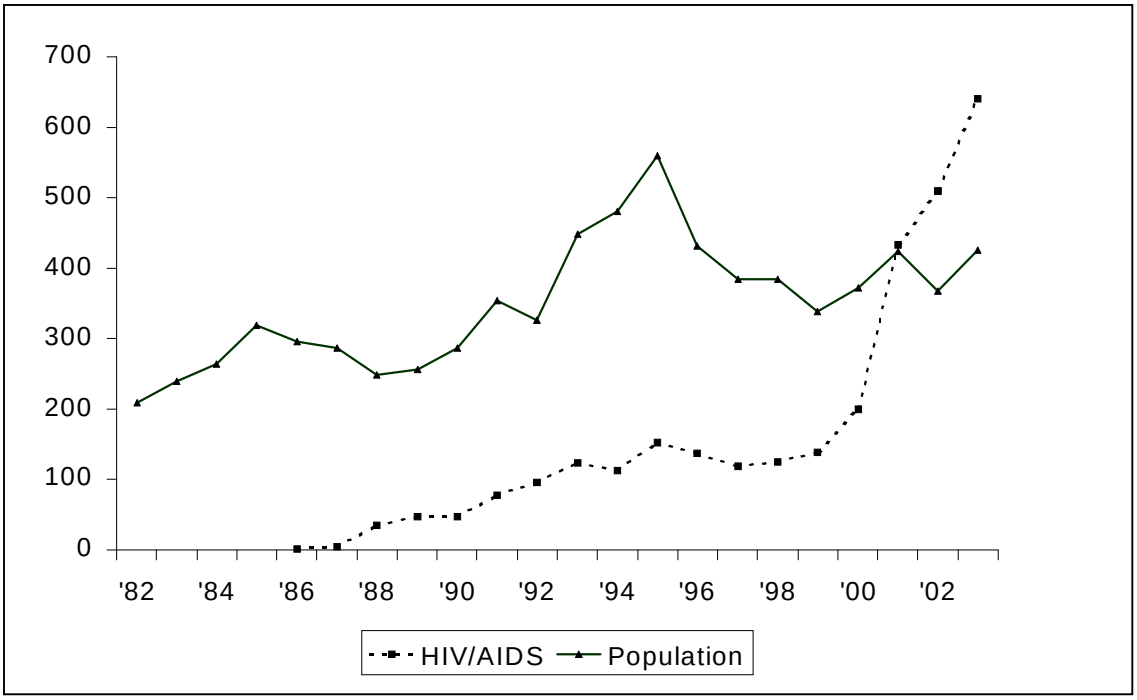
Finally, the advent of the AIDS crisis has modified the priorities of many donors and many CAs. New personnel with different backgrounds have entered the field, a trend that started earlier with the post-Cairo stress on reproductive health and upon gender considerations. The field remains dynamic, and the context for services will undoubtedly evolve further over the next 5 to 10 years. The principal currents of change from the HIV/AIDs crisis have yet to work themselves through, but so far they have shifted managerial attention away from family planning in much of east and southern Africa and elsewhere. That is reinforced by the change of emphasis due to Cairo, and it interacts with a certain sense of fatigue with the old family planning programs. The puzzle for donors is how to reconcile all this with the continuing demographic crisis and how to reduce the very large numbers of unwanted pregnancies, abortions, and births, with what they entail for the women and men involved. Much of the actions that address those needs force attention back to contraceptive use.

4.3 Effects of HIV/AIDS on Population Assistance

While USAID funding for family planning programs has remained roughly constant in current dollars over the past decade funding for HIV/AIDS programs has increased dramatically and will be almost 50 percent higher than family planning funding in 2003. It is hard to know whether the increased funding for HIV/AIDS has had any effect on the total funding levels for family planning. It appears that the increased HIV/AIDS funding has expanded the total pool of development assistance and has not come at the direct expense of family planning. A pessimistic view would be that it limits the potential for future increases in family planning funding since so much money is going to HIV/AIDS. An optimistic view would be that HIV/AIDS advocacy efforts are leading the way to increased funding for development programs in general and population may benefit from this in the future. Further, it is better to look for the synergistic potential in the new funding environment than to focus just on any threat to family planning funding.

The increase in HIV/AIDS programs has changed the way people think and talk about sex and gender issues, and it has provided much new information about sexual behavior that should benefit family planning services. However, in countries with the worst HIV epidemics, the large increase in funding for HIV/AIDS has also attracted many of the best people away from the family planning field into HIV/AIDS. This may create short-term problems for staffing but may also create longer-term opportunities for programs that reinforce each other.

USAID Funding for population and HIV/AIDS



5. Changes in Demand and Related Resources Needed

5.1 Increasing Demand: Trends in Unmet Need

A sea change has occurred in reproductive behavior over the last few decades, with a historic decline in the desired number of children and in the use of contraception and abortion to attain the reduced numbers. The demand for children has fallen, while the demand for contraception has grown and required a constant increase in program resources. Both "demands" fall across a range; for some couples they are intense and for others they are weak, or latent. One function of programs is to assist the subgroup that wants help, thereby changing the environment of behavior for the more ambivalent ones. A key principle is that servicing the current market enlarges that market.

One measure of the market is afforded by unmet need. By the latest estimates about one in six (17%) of married/in union women in the developing world (ex-China) have an unmet need for contraceptive use. They are exposed to pregnancy, do not want it, and lack protection. The percentage is higher among sexually active unmarried women. The

absolute numbers in need come to about 114 million in the developing world including unmarried women, but about 123 million including the former USSR republics.[26]

Because of rising contraceptive use the percentage of women in need has been declining in numerous countries.[27] However increases in population size have outweighed those declines so that the absolute numbers have increased. A related trend is the declines in desired family size that have raised the numbers not wanting another child. The result is that very large subgroups of women, and couples, in the developing world lack the contraceptive use that would protect them from the pregnancies that they do not want. This attests to the continuing gap between need and program response, as well as to the continuing justification for donor support of the programs.

Some have questioned the validity of the unmet need measure, hence attention has gone also to the alternative measure of "intention to use" a method. Many women who say they want a child within two years (and so are classified automatically in surveys as not being in need of contraception), say that they still intend to use a method within the coming year. These spacing intentions apply to very large numbers of women; overall they about equal the numbers of unmet need women who say they do not intend to use.

5.2 Increasing Resource Requirements

A concrete way to grasp the coming increases in resources needed is to consider the growing requirements for commodities. Projections for 116 developing countries for each method are summarized in the following table. It is the resupply methods of the pill, injectable, and condom that are of greatest concern. (The sterilization and IUD figures are for numbers of new adopters, for whom the commodities are less numerous, and the numbers of vaginal applications are relatively few.)

In each cell of the table the number pertains to a single year; for example 596 million pill cycles were needed in calendar year 2000. Thus for the pill there is a 31% rise in the number of cycles needed between 2000 and 2005 (782 million cycles in 2005). That is an impressive increase, but equally impressive is the cumulative number needed during the full five years, i.e. 3,443 million cycles (not shown).

The cumulative numbers for the entire 15 year period appear in the bottom panel of the table. These are large indeed: 14 billion pill cycles, 1.6 billion injectable doses, and 105 billion condoms (including those for HIV). The unit costs will tend to rise each year with inflation, and the pressures on donors will increase. Stimulation of the private sector will become progressively more urgent. It is possible that supply shortages will constrain contraceptive use in some places and will impair the distribution of condoms for HIV.

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[26] John Ross and William L. Winfrey, "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate" *International Family Planning Perspectives*, 2002, 28(3):138-143.

[27] Charles F. Westoff. "Unmet Need at the End of the Century." *Demographic and Health Surveys Comparative Reports*, No. 1, Calverton, MD, USA: Macro Int'l, 2001.

Projections of Commodity Requirements, 2000-2015 for 87 Developing Countries That Rely Heavily upon Donors
(All numbers in Thousands)

		Female Steriliza-tion	Male Steriliza-tion	Pill	Inject-ables	IUD	Total Condom	Vaginals
2000	Rest of Asia	1,172	171	315,312	51,847	4,066	1,467,844	64,186
	Latin America	936	44	72,510	6,184	1,313	419,665	39,563
	Middle East/N.Africa	153	13	97,105	2,647	2,163	345,881	20,514
	Sub-Saharan Africa	394	38	103,748	21,170	620	1,037,645	37,682
	Central Asian Rep.	82	18	6,882	616	982	75,456	4,217
	TOTAL	2,738	284	595,556	82,463	9,145	3,346,491	166,163
2005	Rest of Asia	1,371	186	406,855	59,192	5,540	2,309,709	81,878
	Latin America	1,046	78	82,855	6,433	1,521	709,123	36,105
	Middle East/N.Africa	212	17	122,846	5,423	2,800	626,686	28,007
	Sub-Saharan Africa	819	66	156,931	25,331	1,163	1,703,467	45,731
	Central Asian Rep.	143	24	12,338	890	871	139,775	4,839
	TOTAL	3,591	371	781,826	97,268	11,895	5,488,760	196,560
2010	Rest of Asia	1,530	189	493,956	63,315	7,104	3,125,212	98,492
	Latin America	1,141	116	92,314	6,479	1,715	1,001,819	30,907
	Middle East/N.Africa	272	21	145,981	8,451	3,392	905,779	35,728
	Sub-Saharan Africa	1,374	102	228,172	30,266	1,885	2,435,291	55,597
	Central Asian Rep.	210	30	18,412	1,178	677	203,182	5,304
	TOTAL	4,526	457	978,835	109,689	14,773	7,671,283	226,029
2015	Rest of Asia	1,636	187	582,812	65,977	8,735	3,903,198	115,445
	Latin America	1,216	156	100,405	6,325	1,888	1,292,899	24,328
	Middle East/N.Africa	329	24	165,960	11,509	3,900	1,183,572	43,181
	Sub-Saharan Africa	2,094	146	322,206	36,389	2,829	3,251,972	67,267
	Central Asian Rep.	282	36	24,845	1,472	429	266,151	5,686
	TOTAL	5,556	549	1,196,229	121,673	17,781	9,897,791	255,907
	15-YEAR CUMULATIVE TOTAL							
	Rest of Asia	22,932	2,946	7,198,431	966,008	101,626	43,287,730	1,440,741
	Latin America	17,391	1,567	1,394,588	102,088	25,781	13,692,400	526,734
	Middle East/N.Africa	3,862	299	2,133,327	111,836	49,151	12,250,686	509,763
	Sub-Saharan Africa	18,428	1,395	3,203,379	450,661	25,586	33,562,639	821,489
	Central Asian Rep.	2,856	434	248,931	16,603	11,973	2,739,604	80,427
	TOTAL	65,468	6,641	14,178,656	1,647,196	214,116	105,533,060	3,379,154

Finally, this overview of the yearly percentage increases can be derived from the table:

Annual Percent Increases in Resupply Methods

	Pill	Injectable	Condom
2000-2005	5.44	3.30	9.90
2005-2010	4.49	2.40	6.70
2010-2015	4.01	2.07	5.10

These increases, compounded over the years, together with the huge absolute numbers involved, pose serious problems for donor priorities, as commodity supplies must compete with other budget items. A five percent increase in pill supplies is not easily absorbed when it starts from a large base and adds 37 million cycles a year.

5.3 Sustainability of National FP/RH Programs.

Two comments are in order concerning the sustainability of these programs: one for the past and one for the future. Past experience shows that very few national FP programs have been cancelled, once begun. Some have changed form, undergone changing donor and domestic support, and experienced policy modifications, but the essential presence of the national effort has nearly always persisted. Meanwhile, contraceptive prevalence has followed an upward trend that in historic perspective has been quite remarkable. So the past testifies to a basic sustainability in program operations.

For the future, programs are likely to have equal survival instincts, given their bureaucratic roots and the obvious needs that they serve. The real questions concern their strength of effort and funding prospects, not their existence. But much hinges on those, since the numbers of unwanted births, unsafe abortions, maternal deaths, and AIDS cases will be either more, or less, depending upon strength of effort.

For family planning programs, the series of effort measures from 1982 through 1999 show continuing improvements, with the weakest programs improving the most. Even the five-year period after Cairo, from the 1994 study to the 1999 one, also showed an improvement for family planning, notwithstanding the tendency of Cairo to direct attention toward more diffuse goals. For maternal health programs, basic sustainability seems very likely since they are so imbedded in Ministries of Health. And HIV/AIDS programs are clearly sustainable in the foreseeable future.

But sustainability is relative, and donor contributions for population programs have not kept up with inflation and are in jeopardy for contraceptive supplies. Severe pressures are in prospect as the numbers of users expand. The glass, besides being only half full, may well lose some water unless innovative steps are taken and the sense of urgency sharpens.

6. Questions of Strategy

Strategic considerations for future family planning service assistance may focus around two main questions:

1. How can efforts be prioritized geographically to maximize program impact?
2. Given the current set of countries that receive USAID-assistance how can it be segmented to improve program effectiveness?

USAID's population and reproductive health program has three major objectives:

1. Increase the use by women and men of voluntary practices that contribute to reduced fertility
2. Reduce unintended pregnancies and promote maternal and child health
3. Stabilize world population growth

The first objective (reduce fertility) can best be achieved by allocating resources to those countries that have the greatest potential for rapid increases in contraceptive use and declines in fertility. In general, these will be the countries that are about to begin the fertility transition or have already begun the transition. Countries closer to the end of the transition will already have low fertility and will be more occupied with improving the quality of family planning services and sustaining programs than expanding contraceptive prevalence. Countries that have not yet started the transition may be settings where progress in the near term will be difficult. The table below shows how the 73 USAID-assisted countries might be divided into those that have not yet started the fertility transition, those that are in the transition and those where it is well along. There are 18 countries that have not started the transition, 24 that are in the early stages, 19 that have are in the middle, and 12 that are nearing the end. Maximum achievements in increasing contraceptive use and decreasing fertility will be achieved by focusing resources on those countries in the fertility transition now.

USAID-Assisted Countries by Stage of Fertility Transition

STAGE IN THE FERTILITY TRANSITION			
Not yet started	Early stages	Middle	Nearing end
TFR 6.0 Plus	TFR 4.50 - 5.99	TFR 3.00 - 4.49	TFR Below 3.0
Afghanistan	Benin	**Bangladesh**	Dominican Rep.
Angola	**Cambodia**	Belize	Ecuador
Burkina Faso	Cameroon	Bolivia	Guyana
Burundi	Côte d'Ivoire	Botswana	**Indonesia**
Chad	Eritrea	East Timor	Jamaica
Congo	Gambia	**Egypt**	Kyrgyzstan
D.R. Congo	Guatemala	El Salvador	Mexico
Ethiopia	Guinea-Bissau	**Ghana**	Panama
Guinea	Jordan	Haiti	**Peru**
Liberia	Laos	Honduras	South Africa
Malawi	Lesotho	**India**	Uzbekistan
Mali	**Madagascar**	**Kenya**	Viet Nam
Mauritania	Namibia	Morocco	
Mozambique	**Nepal**	Myanmar	
Niger	**Nigeria**	Nicaragua	
Sierra Leone	**Pakistan**	Paraguay	
Uganda	Rwanda	**Philippines**	
Yemen	**Senegal**	Tajikistan	
	Swaziland	Turkmenistan	
	Tanzania		
	Togo		
	West Bank/Gaza		
	Zambia		
	Zimbabwe		

Note: The average TFR is 6.8 in the group that has not yet started the transition, 5.2 in the "Early stages" group; 3.7 in the "Middle" group, and 2.6 among those nearing the end. Countries shown in **bold** are priority countries for the Office of Population.

The second objective (reduce unwanted pregnancies and improve maternal and child health) can best be achieved by focusing on those countries with the largest amount of unmet need (to reduce unwanted pregnancies) and those with the worst maternal and child health conditions. Since the largest health impacts will come in those countries that increase contraceptive use the most, the greatest impact may come by focusing on those countries in transition. Maternal and child health are worst in the highest fertility countries that have not yet started the transition, so special effort is warranted in these countries as well.

The third objective (stabilize world population growth) requires a focus on the demographically largest countries. Just five countries, India, Pakistan, Nigeria, Ethiopia and Bangladesh contain more than half of the new users required to reach replacement level fertility in the developing world. An additional six countries (DR Congo, Indonesia, Philippines, Tanzania, Sudan and Afghanistan) bring the total to about two-thirds. Focusing efforts on improving family planning services in these countries would maximize the achievement of this objective.

Decisions about which countries should receive population assistance cannot always be made on demographic criteria alone. Therefore, it is useful to consider how services can be targeted to best serve the needs of each country. A previous strategy paper suggested a typology that divided countries into five categories based on prevalence.[28] Different services needs were described for each category. While those categories still have some relevance, it may be better today to think of the four categories of countries described above: those that have not yet started the fertility transition, those that are in the midst of it, and those that are nearer to the end of it. The categories may be characterized as follows:

- **Pre-transition**. In these countries the use of family planning is very low and is concentrated among urban elites. Although demand for family planning may be low in some countries, it may be high in others, reflected in large amounts of unmet need. The family planning services challenges in these countries include expanding the availability of services to most of the population and stimulating adoption of the easiest to deliver methods (pills, condoms, injections). The greatest challenge may be how to train personnel and provide quality services in an expanding network that may have very low utilization rates.
- **Transition countries**. In the two middle groups of countries unmet need is high and prevalence is increasing rapidly. Many countries in this category may be reliant on one or two methods. Major challenges involve providing more method choice and funding the rapid expansion of services required.
- **Low fertility countries.** In these countries a majority of women are already using some form of family planning. The major service issues are quality, sustainability and adolescents. Continuation rates may be low because of poor quality service. There may be considerable method switching and abortion may be used when contraception fails. With large numbers of couples using family planning, issues of financing and sustainability become very important. In some countries adolescent fertility may be the biggest problem.

Some family planning services are the same no matter which category a country is in, while others may be quite different. In pre-transition countries where utilization is low, health workers need to provide a variety of services. In countries with higher prevalence the higher volume of clients may provide opportunities for specialization. The training approaches to these two situations may be different.

[28] USAID, Family Planning Services Division, *Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties.* Office of Population. May 24, 1990.

To the extent that countries in these four categories do require different types of assistance, USAID may want to consider organizing its technical assistance along these lines as opposed to geographic regions. For example, perhaps there should be one global project for services to pre-transition countries, one for transition countries and a third for low fertility countries.

The actual choice of priority countries is of course more complex than just the TFR level. Choices must reflect the absorptive capacity of the country, which in turn may be affected by the level of civil conflict. Consideration must be given to the severity of need, and to the absolute size of the country. A variety of perspectives can be added to those, which we consider next.

7. Implications and New Departures

The trends and strategy considerations described above suggest that many elements of the service environment will be essentially unchanged in the next decade while others will be very different and will require different responses.

Among those elements that will probably not change appreciably are the following:

- Technology. With the possible exception of emergency contraception the family planning methods available will be essentially those that are available today.
- Countries. Countries are chosen for USAID population assistance for a variety of demographic, economic, geographic and political factors. Some countries may graduate from USAID assistance and a few new ones may be added but the list is not likely to change as rapidly as it did in the past decade, when many Latin American and some Asian countries were graduated and country programs were switched to regional programs in West Africa.
- Pillars of good programs. These will remain for the next decade: enlarged access to quality service delivery, with a focus on informed choice, well trained providers, and continuous supplies.

Among the trends that may affect the delivery of family planning services in the future, three stand out as being most important: urbanization, integration, the growth in numbers of users coupled with limited funding increases.

7.1 Urbanization

Most of the population growth in the developing world will take place in urban areas. An even larger share of the growth in new users is likely to be urban as well. This suggests that USAID will want to strengthen approaches that work well in urban areas. These include clinic-based services, social marketing and other private sector initiatives. Increased urbanization offers the prospect that service delivery can become more cost-

effective. With more users participating in the cash economy it may be easier to implement different forms of user fees. The greater concentration of users may allow more high-volume service delivery points, which could make training more efficient and concentrate services among the most experienced personnel who will devote more time to family planning services than their rural counterparts do.

Still, most of the developing world currently is rural: 60% is rural overall (ex-China), 63% is rural in Asia (ex-China), and 70% is rural in Sub-Saharan Africa. The large, low-prevalence populations in the Indian subcontinent and most of Sub-Saharan Africa will continue to require major resources and close attention, along with the emerging shifts to the cities.

7.2 Integration

The change to a reproductive health focus, the increased emphasis on the HIV/AIDS epidemic and the on-going efforts in health sector reform, mean that the integration of family planning services with other reproductive health services is likely to become a major issue for the next decade. The first experiences with integrating family planning and STI services did not prove very successful. Other areas of population assistance have integrated activities more rapidly, including policy, evaluation, and commodities and logistics.

Family planning services are likely to be faced with several integration challenges. There has always been some integration of family planning and safe motherhood at the clinic level. But the services provided by USAID have generally been separate. In the future more emphasis may be needed on the linkages between family planning and pre- and postnatal care, postpartum services, postabortion services and programs to prevent mother-to-child transmission of HIV. This trend may be intensified by the greater emphasis on serving urban populations where clinic-based services are more easily offered. Health reform may also require more integration by decentralizing resource allocation decisions and attempting to rationalize health financing. In that environment vertical programs may be more difficult to implement.

Apart from health reform, which is already started in scores of countries, it is likely that some of these changes will be very gradual over the next decade. However, it is time now to begin exploring ways to operate effective family planning services under changing circumstances.

7.3 Growth in Numbers of Users and Limited Funding Increases

The tremendous growth in the number of family planning users in the future will require changes in the way family planning services are offered. If USAID funding does not increase sharply and other donors do not start to contribute much more then family planning programs will be faced with doing more with less.

The total number of modern method users in USAID-assisted countries in 2000 was about 116 million.[29] Population funding at about $400 million dollars, represents about $3.40 per modern method user. The number of modern method users in these countries is expected to increase to 190 million by 2010, a 60 percent increase. That would result in expenditure of only about $2.11 per modern method user if USAID population funding remained constant in real terms. This deficit is so large that it can only be addressed through drastic measures.

1. Business as usual. That would mean less services and less availability for the increasing number of users. The result would probably be much slower increases in prevalence in the future and a decline in quality and choice.
2. More efficient use of funds. The trend towards urbanization and higher levels of prevalence will reduce the cost per user in some countries. Greater efficiencies can contribute to the solution. However, the greatest efficiency gains come when prevalence increases from below 10 percent to 20 percent or so. As prevalence rises beyond 20 percent, the efficiency gains are much less. Since most USAID-assisted countries are in the middle prevalence range now, it is not likely that greater efficiencies alone can solve this problem.
3. More contribution from national governments. National governments should certainly contribute more to their family planning program and many will do so in the coming years. However, since in most countries national funding is much less than half of the total, even a doubling of national funding would not make up a deficit of 60 percent overall.
4. More contribution from users. More user fees and greater participation by the private sector can contribute to the solution. However, it is very unlikely that all new users could be accommodated by the private sector in the next 10 years.
5. Reduce the number of USAID-assisted countries. In order to maintain the current level of spending per modern method user, USAID could focus its assistance on fewer countries. To solve this problem entirely by concentrating on fewer countries USAID would have to withdraw from enough countries to keep the number of modern method users in USAID-assisted countries roughly constant. One way to implement this strategy would be to withdraw from all the 18 pre-transition countries and the 12 low fertility countries listed in the above table. That would still leave a deficit of 18 million modern method users that could be made up by withdrawing from a single large country or from many smaller countries. (As a further comment, closer coordination by USAID with the other major donors might lead to efficiencies that would keep vital resources flowing to most countries, and USAID might take the lead role in pursuing this.)

Of course, the solution to this problem should be some combination of the above. But unless USAID funding can be increased significantly it is likely that all of the above solutions would need to be partially implemented to prevent the effectiveness of USAID assistance from dropping to unacceptable levels.

[29] This estimate includes only modern method users in the state that was Uttar Pradesh in 2000 rather than all of India.

The rapid increase of modern method users in Latin America forced USAID to face many of these same problems in that region in the past 10 years. There, it was possible to graduate many countries from USAID assistance. In the future there may be fewer opportunities for graduation, making the choices that much harder.

ANNEX

ANNUAL INCREASE IN CONTRACEPTIVE PREVALENCE, BY LEVEL OF USE
AT THE EARLIER PERIOD, DEVELOPING COUNTRIES

	Annual percentage-point increase in contraceptive prevalence		
Prevalence at earlier period	<1.0	1.0 - 1.9	2.0 or more
Less than 15 per cent	Benin	Cameroon	
	Cote d'Ivoire	Haiti	
	Ghana	Lesotho	
	Iraq	Malawi	
	Mali	Nepal	
	Mauritania	Oman	
	Nigeria	Pakistan	
	Senegal	Rwanda	
	Sudan	Uganda	
	Yemen	United Rep. Of Tanzania	
15-34 per cent	Guatemala	Bolivia	Bangladesh
	Jordan	Botswana	Grenada
	India	Egypt	Morocco
		Honduras	Zambia
		Kenya	
		Malaysia	
		Nicaragua	
		Philippines	
		Syrian Arab Rep.	
35-49 per cent	Dominica	Algeria	Antigua and Barbuda
	El Salvador	Barbados	Iran (Islamic Rep.of)
	Saint Lucia	Dominican Republic	Saint Vincent and the Grenadines
		Ecuador	
		Indonesia	
		Paraguay	
		Peru	
		South Africa	
		Tunisia	
		Zimbabwe	
50-64 per cent	Colombia	Bahrain	Republic of Korea
	Trinidad and Tobago	Jamaica	
	Panama	Mexico	
	Puerto Rico	Singapore	
		Thailand	
		Turkey	
		Sri Lanka	
		Viet Nam	
65 per cent or more	Costa Rica	Brazil	
	Mauritius	China	
		Hong Kong SAR	

Source: *Levels and Trends of Contraceptive Use as Assessed in 1998*. UN Population Division 2000, p. 26.
Note: Annual percentage-point increase is calculated for the period between the 1980s and 1990s, on average.