



Making the Case for

U.S. International Family Planning Assistance



REPORT

- Five former directors of the Population and Reproductive Health Program of the United States Agency for International Development (USAID) issue a call for renewed U.S. political and financial commitment to international family planning programs.
- USAID has been the largest donor to international population and family planning efforts and a transformative source of leadership and innovation in the field. Its professional staff and technical resources are unparalleled among donor agencies.
- However, its funding peaked in 1995 and has declined in real terms ever since, even as the worldwide demand for family planning and other reproductive health services has grown. As a result, many successful programs in developing countries have stagnated and global fertility decline has slowed.
- At the beginning of a new administration and a new Congress, it is time to reverse the decline in U.S. political and financial commitment to this field of signature U.S. leadership and accomplishment, to satisfy the unmet need for services, and to improve women's reproductive health worldwide. We estimate that USAID's population budget should be increased to \$1.2 billion.



Making the Case for
U.S. International Family Planning Assistance

By

Five Former Directors of the Population and Reproductive Health Program
of the United States Agency for International Development (USAID):

J. Joseph Speidel , Adjunct Professor, University of CA, San Francisco	1978-1983
Steven Sinding , Senior Scholar, Guttmacher Institute	1983-1986
Duff Gillespie , Professor, Johns Hopkins University	1986-1993
Elizabeth Maguire , President and CEO, Ipas	1993-1999
Margaret Neuse , Independent Consultant	2000-2006

SUMMARY OF FINDINGS AND RECOMMENDATIONS

This report documents the urgent need for greater U.S. assistance to family planning programs in the developing world and recommends targeted investment in such programs, primarily through the U.S. Agency for International Development. It describes enormous pent-up and growing unmet need for family planning, which coexists with a basically favorable policy climate among developing country governments. The great majority of these governments are willing if not eager to make family planning and other reproductive health services more available.

The demand is not surprising, given family planning's global success. It has proved to be a powerful health intervention, saving and enhancing millions of women's lives, and has slowed worldwide population growth and spurred economic development.

At the same time, donor interest in family planning has stagnated, in part from the (mistaken) belief that rapid global population growth has been halted; from diversion of resources to other needs, notably the HIV/AIDS pandemic; and from lack of understanding that family planning is a critical part of any successful economic development strategy. The resulting situation endangers the lives of women and children and threatens attainment of global anti-poverty goals. Renewed U.S. leadership in meeting the unmet need in developing countries for family planning is urgently required.

In estimating the resources needed to satisfy this demand, we recognize and applaud the work that developing country governments and non-governmental organizations (NGOs) are doing by themselves. We also base our assessment on a solid understanding of what other donors—bilateral, multilateral, and private foundations—are providing, and our review of USAID's current population and reproductive health programs in 53 countries and at headquarters.

We find that USAID continues to have a technically strong core of professionals in Washington and its missions who oversee family planning. The agency supports a global network of expert non-governmental organizations that provide technical assistance to governments and local NGOs in developing countries.

We identify areas that are underfunded and can be rapidly scaled up with an infusion of resources. While many of our observations can be generalized to the donor community at large, we focus on USAID, our area of expertise.

We recommend that funding for USAID's international family planning assistance be increased to \$1.2 billion in FY 2010, up from \$457 million in 2008, for use in:

- Increased support for core areas such as training and equipping health care providers;
- Expansion of existing successful programs;
- Expansion of programs into additional underserved countries;
- Assurance of USAID's technical leadership; and
- Renewed U.S. leadership and funding for global organizations.

We recommend that the new funding be raised gradually to \$1.5 billion annually by 2014. This would represent an appropriate American contribution to international efforts to achieve the global consensus Millennium Development Goal target of *universal access to reproductive health services*, including family planning, by 2015.

Budget Estimates 2010-2014 (\$ millions)

	2010 52 countries	2011 58 countries	2012 64 countries	2013 69 countries	2014 69 countries
Africa	\$364	\$390	\$417	\$447	\$476
Asia and Near East	\$371	\$398	\$425	\$455	\$485
Europe and Eurasia	\$28	\$30	\$32	\$34	\$36
Latin America & Caribbean	\$116	\$124	\$133	\$142	\$152
Central Program	\$251	\$269	\$288	\$308	\$328
SUBTOTAL	\$1,130	\$1,211	\$1,295	\$1,386	\$1,477
UNFPA	\$62	\$64	\$66	\$68	\$70
IPPF	\$13	\$13	\$14	\$14	\$15
TOTAL	\$1,205	\$1,288	\$1,375	\$1,468	\$1,562

INTRODUCTION

Making the Case for U.S. International Family Planning Assistance is an evidence-based plea to return the United States to global leadership in providing assistance to family planning programs in the developing world. Although we also fully support strengthening other priority reproductive health programs, such as those addressing HIV/AIDS and maternal health, we focus here on family planning because of its central importance to women's health and to overall development, as well as because of its low priority and funding in recent years.

As former directors of the population and reproductive health program of the USAID, we bring to this task close to 200 years of combined family planning program experience. We have had the unique opportunity to observe USAID's programs from both inside and outside, and from both headquarters and the field. Our leadership spanned every presidential administration from Jimmy Carter to George W. Bush. We remain deeply engaged in the issue as executives, scholars, advocates, consultants, and board members of population organizations.

We have watched with concern the stagnation in funding for family planning and reproductive health over the past several years, the decline in donor interest and the growth of administrative restrictions on existing funding. We believe these trends must be reversed if the overall development objectives of the United States, the international community and developing nations are to be realized.

Access to affordable, effective contraceptives is critical in enabling women to make their own reproductive decisions. We believe deeply in the right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so. This right has been affirmed repeatedly during the last four decades by governments around the world, including the United States, and should be supported by increased U.S. funding as soon as possible.

We believe that the U.S. government and USAID in particular have unique capacity to address the urgent need for greater family planning assistance, and this report makes the case for immediate action.

We are also concerned about the negative impact of the Bush administration restrictions on USAID's family planning program, especially the "Global Gag Rule," which rendered foreign NGOs ineligible for U.S. assistance if they were involved in abortion-related activities, even with their own funds. This policy has reduced family planning services in many USAID-supported countries, raising the numbers of unintended pregnancies and unsafe abortions.

In producing *Making the Case*, we consulted many colleagues and other experts in this area and we are grateful for their help and advice. However, the conclusions and recommendations in this report are ours alone.

PART 1: THE GLOBAL UNMET NEED FOR FAMILY PLANNING

In the 1970s, about 680 million women of reproductive age lived in developing countries where USAID had programs. Today, this figure has more than doubled, to 1.4 billion women. Although millions of these women in the developing world are satisfied family planning users, an estimated 201 million have an *unmet* need for family planning. The United Nations estimates that this demand will grow 40 percent by 2050 as record numbers of young people enter their prime reproductive years.

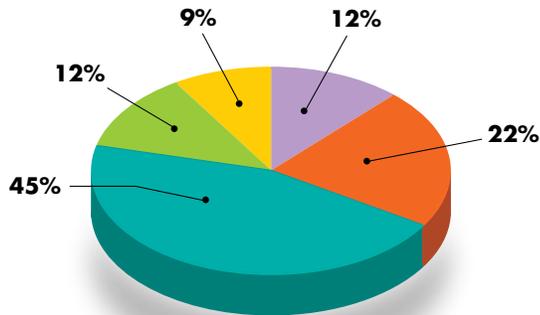
More than half – around 55 percent – of the women with current unmet need live in Asia, particularly on the Indian sub-continent and parts of Southeast Asia. While many of these countries were in the vanguard of the family planning revolution, others still have large under-served populations, particularly Pakistan,

What is Unmet Need?

A woman has an *unmet* need for family planning if she is married, in a union or sexually active, and is able to conceive; wants no more children or does not want to have a child in the next two years; and is not using any modern contraception or is using a traditional method.

Where the 201 Million Women with Unmet Need for Family Planning Live

■ North Africa & West Asia
 ■ South & Central Asia
 ■ Latin America and Caribbean
■ Sub-Saharan Africa
 ■ South-East Asia



Sources: References 1 and 2

Nepal, the Philippines, and northern India. These countries will need assistance in family planning and reproductive health for some years to come and can benefit from continued USAID support.

While the actual numbers with unmet need are the largest in Asia, the *proportion* of women with unmet need is largest in sub-Saharan Africa, and that is where the requirement for funding and technical assistance is most urgent.

Only 18 percent of African women are using modern contraceptives, compared to 56 percent of women in the rest of the developing world. In some African countries, the number of women with an unmet need for family planning exceeds the number already using contraceptives. If this unmet need were satisfied, the use of contraception among women of reproductive age would increase to over 40 percent.²

The number of children African women report they want is quite high, while the number they actually have is still higher. Family planning

services are weak and fragmentary and health systems often do not reach very far beyond urban areas. The status of women is generally quite low, reproductive health is poor, infant and maternal mortality are high, and poverty is widespread. The number of trained health service providers is grossly inadequate, and they are concentrated in urban areas, so that

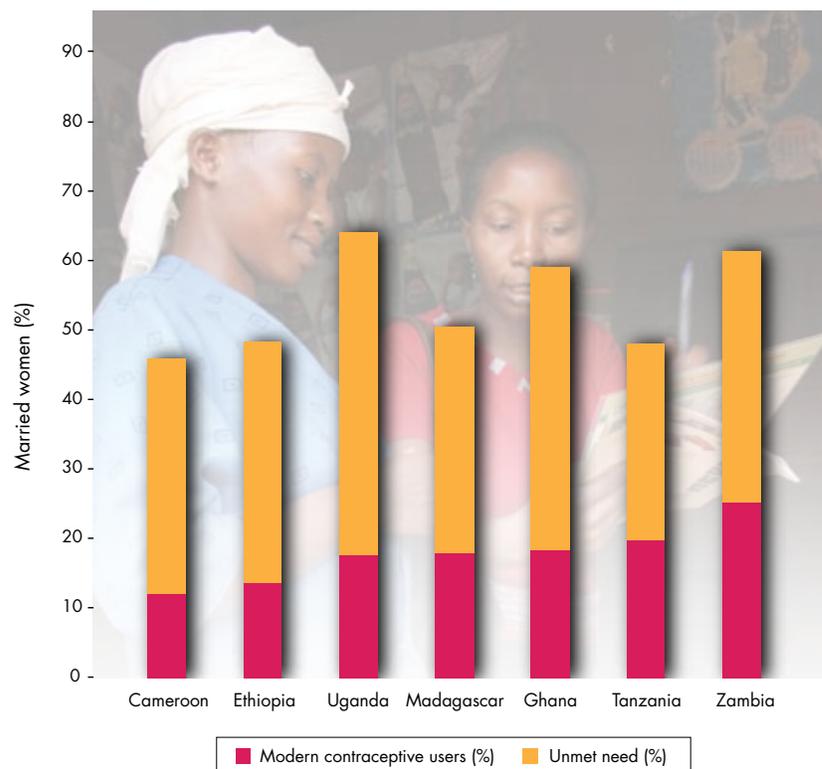
many rural areas have limited or no access to any skilled health care. Health providers are also plagued by poor transportation and working conditions, low pay, outdated and grossly inadequate equipment and supplies, and poor morale.

Despite these challenges, some African countries have had striking success. Botswana, Ethiopia, Kenya, Zambia and Zimbabwe are among those that moved in recent years to provide increased family planning services, achieving rapid increases in contraceptive use and corresponding declines in maternal and infant mortality and morbidity, as well as fertility. In every case, USAID has played a key role.

PART 2: FAMILY PLANNING IS A GLOBAL SUCCESS STORY

For over 40 years, USAID has been a leader in efforts to both improve maternal and child health around the world and reduce high population growth rates, principally

Unmet Need Exceeds Current Use of Contraception in sub-Saharan Africa



Source: Reference 3



Maputo Plan of Action: 2006

At a special African Union (AU) meeting, the continent’s ministers of health adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights, committing their governments to work toward the goal of universal access to comprehensive family planning services in Africa by 2015 and laying out the specific steps needed to get there. A subsequent meeting of AU heads of state recognized that African countries are not likely to achieve their development goals without significant improvements in reproductive health. As a result, these top African political leaders unanimously endorsed the Maputo Plan of Action and committed their governments to its achievement.

through provision of family planning services. This is one of the major success stories in the long history of international development cooperation, comparable with the Green Revolution in agriculture and the Smallpox Eradication programs in public health.

Between 1965 and 2005, use of family planning by women of reproductive age in the developing world (excluding China) rose from less than 10 percent to 53 percent.^{2,5} The actual numbers grew from 30 million users in the early 1960s to 430 million in 2008, a dramatic increase. The result: a significant decline in the average number of children born to each woman during her lifetime, from more than six to just over three.

The United States played a catalytic role in this revolution by galvanizing global action on family planning. USAID built and sustained programs with large-scale infusions of funds and technical assistance. In every region, countries like Egypt, Bangladesh, Indonesia, Peru, and Zimbabwe, to name just a few, saw rapid increases

in contraceptive use, corresponding declines in average family size, and improved living standards.

However, world population continues to grow at about 78 million people per year, nearly all in developing

countries. This rate of growth could decline, stabilize or accelerate, depending largely upon future rates of contraceptive use. [See Appendix I for alternative population growth projections.] It is in the world’s best interests to ensure that contraceptive usage rates continue to rise – and that will require significant increases in U.S. international family planning assistance.

PART 3: FAMILY PLANNING IS A DECLINING PRIORITY

Donor interest in family planning has waned in recent years. The traditional lead donor, the United States, has not assigned international family planning assistance the same

Rwanda Shows the Way

Rwanda, one of the poorest, most densely populated countries in the world, demonstrates the potential for family planning success in Africa.

Its recent history includes great poverty and one of the most tragic, genocidal civil wars of modern times. But the Rwandan government, under the leadership of President Paul Kagame, understood that high fertility and rapid population growth were stifling the country’s development.

After studies determined existing demand for and how best to allocate its resources, Rwanda encouraged the NGO community to expand family planning services, experimented with new ways to deliver services, and worked closely with donors to coordinate resource infusions. USAID supported all these efforts. By early 2004, Rwanda was poised for a major jump forward.

Only two years later, Rwanda documented one of the most rapid increases in contraceptive use ever recorded, from 10 percent to 27 percent of women of reproductive age.

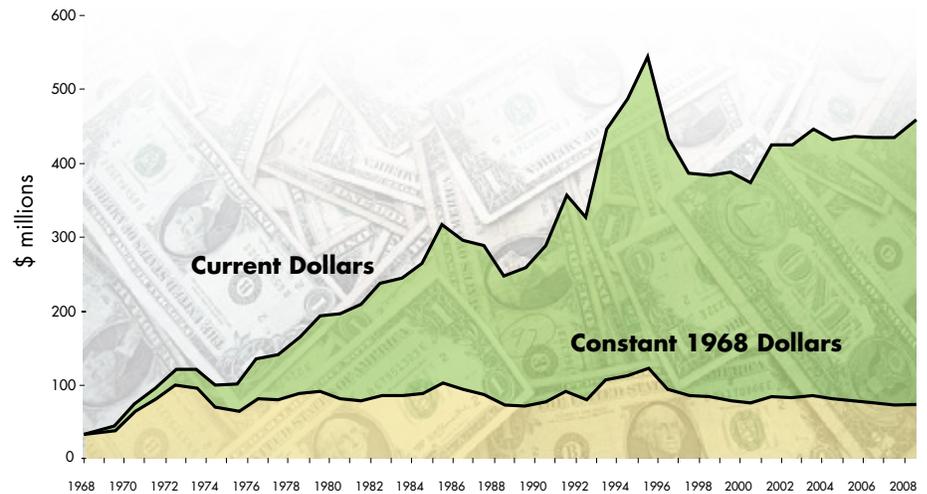
*“Family planning is priority number one—not just talking about it, but implementing it.”
President Paul Kagame, November 2007*

high priority it once had. Thanks to bipartisan support in Congress, however, U.S. funding for family planning programs overseas has not declined as much as it has for other donors, but only flattened out. Although steady population growth has raised demand, and actual dollar appropriations have risen, inflation means that USAID's family planning budget strength today is just about where it was in 1974.

Among the many reasons for the stagnating funding of family planning, three stand out:

- Fear of explosive population growth in the developing world has dwindled. The revolution in reproductive behavior and birth rates documented above means that many policy-makers and commentators assume all necessary action has already been taken. However, the steep decline in birth *rates*

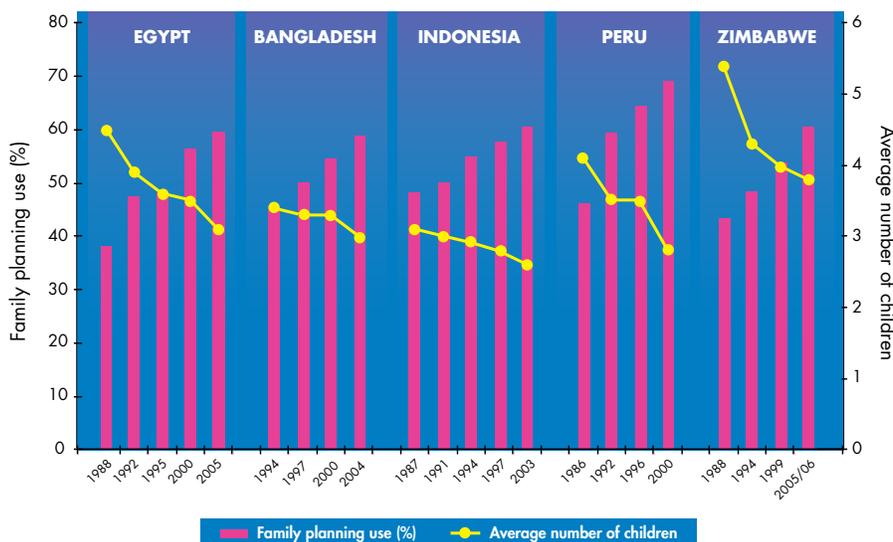
USAID's Budget for Family Planning: Funding Trends (1968-2008)



has obscured the fact that the annual increase in total world population *numbers* has risen from 48 million a year in 1950 to 78 million a year today because of record numbers of young people. The danger that population growth rates could resurge is very real.

- Governments have had to wrestle with competing demands for scarce budgetary resources, notably the HIV/AIDS pandemic. Other major killers such as malaria and tuberculosis also have legitimate claims. Increases in funding to fight these diseases came at the expense of other health and development priorities. One victim was family planning.

Family Planning Use and Average Number of Children in Major USAID-Recipient Countries



[See page number 13 for a case study of the effect of changed priorities in Kenya.]

- The links between family planning programs, lower population growth rates, and the achievement of development objectives – first and foremost, poverty reduction – have not been well understood by policymakers. These links represent a “virtuous circle,” in which success in one area invariably produces positive outcomes in the others.

Source: Reference 3



While some countries such as Korea and Thailand recognized early the importance of family planning to their overall development, others have been slow to recognize the catalytic role of family planning in improving women’s health and well-being, stimulating economic development and raising standards of living.

Combined, the factors above have contributed to a dramatic drop in the standing of family planning on the development agendas of many donor agencies and recipient nations. In general, this shift has not resulted from ideological or religious opposition to family planning. While birth control is controversial in a few countries, and among some people in the United States, it is widely accepted in the vast majority of countries.

When we began our careers nearly four decades ago, we had to look hard to find developing countries outside Asia that actively supported family planning. Today, it is unusual to find a country that does not support it, although rhetorical or policy support

is not always reflected in budgets and programs.

As stated in the Introduction, we are not suggesting that family planning is the only aspect of reproductive health that matters, or that family planning is the sole element in a sound population or development policy. We fully support additional funding for USAID’s work against HIV/AIDS and for other aspects of reproductive health care, such as maternal and newborn health.

In the congressional appropriations process, however, family planning has traditionally been a separate line item in USAID’s budget, and we maintain that separate focus here. It is also an *essential and recently neglected ingredient* in sound population policy, and one in which USAID has particularly excelled. We believe that USAID’s very successful efforts in family planning have been fundamental to the bipartisan Congressional support USAID’s population program has enjoyed over the last four decades, and that they are a strong base on which to build.

PART 4: USAID IS AN EFFECTIVE AND CAPABLE AGENCY

USAID has an impressive 40-year track record and unparalleled capabilities and resources in the field of population, family planning and reproductive health. Over this period, the United States has been the largest donor to programs in these areas. While USAID’s budget has stagnated in recent years, it maintains a strong body of professional talent and is the only bilateral donor to have deployed large numbers of staff to developing countries to work side-by-side with local counterparts.

Local cooperation involves areas such as training community health workers, introducing state-of-the-art communications programs, supporting operations research, developing effective supply chains and logistics management systems, improving management, and delivering family planning services in cost-effective ways.

USAID has also invested heavily in creating U.S. institutions – public and private, governmental and non-governmental – that can and do provide top-notch technical and managerial assistance to governments and NGOs in developing countries. The agency has maintained these strengths even through periods when U.S. political leadership has been hostile to international population program efforts.

USAID’s partner NGOs and local organizations, such as John Snow International’s *Deliver Project*, which improves contraceptive

U.S. Foreign Assistance: Mandate in Family Planning/Reproductive Health

“...this support [for family planning/reproductive health] should include expanding access to and the use of quality family planning information and services, to enable individuals and couples to avoid unintended pregnancies and other risks to reproductive health, including those associated with pregnancy, sexually transmitted infections and HIV/AIDS.”

– *Foreign Operations, Export Financing, and Related Programs Appropriation Bill, 2002, 107th Congress, 1st Session, Senate Report 107-58, p. 12.*

USAID's Deliver Project

The *Deliver Project*, implemented by John Snow International, reduces contraceptive spoilage and stock outs in 21 countries by introducing streamlined procurement procedures, improved inventory practices, and modern logistic information systems. These best practices should be introduced in all USAID-recipient countries.

Source: Reference 6

logistics, collectively have expertise in all aspects of international family planning and reproductive health.

While not all government programs can demonstrate rapid response and increased impact, we are confident that USAID's population assistance program is among those that will be able to use additional funds quickly and effectively.

[For examples of USAID's successful innovation in program design, scientific research and data collection, see Appendix II.]

PART 5: MORE MONEY IS NEEDED

In our review of USAID's family planning program, we identified four broad areas where an additional \$749 million over USAID's 2008 budget

of \$457 million can be effectively used. We recommend a FY 2010 appropriation of \$1.205 billion for international family planning assistance, rising gradually to \$1.5 billion by 2014. *[For a full discussion of the methods we used to estimate costs, see Appendix III.]*

1. Increase support for core areas of training and equipping health care providers. For family planning services to expand, greater investment is required in their core components, such as training of additional health providers and purchase of sufficient supplies of contraceptives. The shortage of contraceptives is a chronic problem, yet relatively easy to resolve with increased resources.

Donors and developing countries should increase by fourfold the

USAID's Capacities in Family Planning

- Knows how best to support every aspect of a successful program, including:
 - Commitment from political and other leaders
 - Research, monitoring, and evaluation capacity
 - A broad array of contraceptives, adequate supplies, and effective distribution systems
 - Client education and choice of methods
 - Training, supervising, and equipping service providers
 - Strong management systems
 - Outreach to communities and local leaders
- Identifies and addresses critical challenges: contraceptive supply shortages in the developing world; ways to provide services to young people – the largest generation in history; linking family planning services with HIV/AIDS programs; and the public health crisis of unsafe abortion.
- Partners with host governments, local organizations, other donors, and international NGOs.
- Strengthens local partners' capacities to work on their own.
- Applies practical know-how to the challenges of information and service delivery in resource-poor settings and underserved rural areas.
- Develops and adapts innovative approaches to local circumstances, such as community-based provision of contraceptive supplies and information, and integration of family planning into private sector health systems.

Estimated Costs of Contraceptives and Donor Support



Source: Reference 7

amount spent for contraceptives, from about \$223 million to around \$888 million per year. USAID has provided the largest donor amount of contraceptives, played a leadership role in procurement and logistics management, and provides much-needed logistics expertise to developing country governments and private organizations.

2. Expand existing successful programs. In some countries, USAID supports a comprehensive nationwide family planning program. More commonly, however, USAID supports specialized projects that have national coverage, such as social marketing

of condoms and oral contraceptives. Many of USAID's innovations could be replicated with additional resources in many more countries. For example, USAID could expand globally its successful experience in training community health workers to provide the popular and effective injections of the Depo-Provera contraceptive.

3. Establish USAID family planning programs in additional underserved countries. USAID supports family planning programs in 21 sub-Saharan African countries. The agency should extend its program to many other countries in that region. Generally

speaking, countries in the greatest need of family planning programs are also the least able to launch them due to a lack of infrastructure and human resources.

For example, 17 countries currently not receiving USAID family planning assistance have a combined population of 129 million, representing 17 percent of all of sub-Saharan Africa. The continued lack of economic progress in these countries will act as a brake on the continent's overall development. Most important, millions of women in these countries have no access to the family planning information and services they need to make their own reproductive decisions.

We recommend that USAID initiate family planning programs in 2011 in at least six additional sub-Saharan African countries. The remaining countries in the region should have programs established in 2012 and 2013. This means that by 2013, USAID could be supporting family planning programs in 69 countries worldwide.

4. Assure USAID's technical leadership. USAID is a leader in developing and taking to scale new ways of delivering family planning services; improving old and developing new contraceptives; and monitoring and analyzing project impact. Its core multidisciplinary staff has unique in-depth expertise and experience in all aspects of family planning and reproductive health programs. This technical capacity, unique among donors, is threatened because of steadily declining budgets at the Office of Population and

Community Services in Ghana

A project in Navrongo, Ghana, developed an outreach program with community-based services and special activities to encourage male involvement in family planning. The result: the average number of births per woman dropped from five to four in just four years. Major improvements occurred in maternal and infant and child mortality rates.

The Ghanaian government has officially adopted this outreach approach, but lacks resources to implement it nationwide. An infusion of funds would enable the government to accelerate its plans for national coverage.

Source: Reference 8

Congressional Support

In mid-2008, a bipartisan group of U.S. Senate and House members sent a letter to their respective appropriations committees recommending that USAID's fiscal 2009 budget be increased from \$460 million to \$1 billion. While their exercise and ours used different methods to estimate USAID's funding needs, the results are very similar.

"...It is critical that the United States make a real investment in family planning programs. Such an investment will improve the quality of life for people around the world and will help address preventable problems that threaten resource stability, civil security, and maternal and child survival...."

– July 15th, 2008 letter signed by 13 U.S. Senators and addressed to Chairman Leahy and Ranking Member Gregg of the Subcommittee on State, Foreign Operations, and Related Programs, Committee on Appropriations

"...The direct and rippling positive impact of an investment in family planning is clear. Slowing the population's rapid growth will ease pressure on natural resources and decrease emissions that lead to global warming...."

– March 19th, 2008 letter signed by 91 U.S. Representatives and addressed to Chairman Lowey and Ranking Member Wolf of the Subcommittee on State, Foreign Operations, and Related Programs

Reproductive Health, the home of USAID's technical program.

In 2001, the central office received 36 percent of all family planning funds and had a budget of \$155 million (\$191 million in 2008 dollars). Today, its budget is \$95 million, which is 22 percent of USAID's population assistance budget. Although most of the additional funds we recommend should go to country programs, the agency's technical leadership and support to country programs will be seriously compromised without an increase in central office funding.

5. Reestablish U.S. leadership and funding for global organizations.

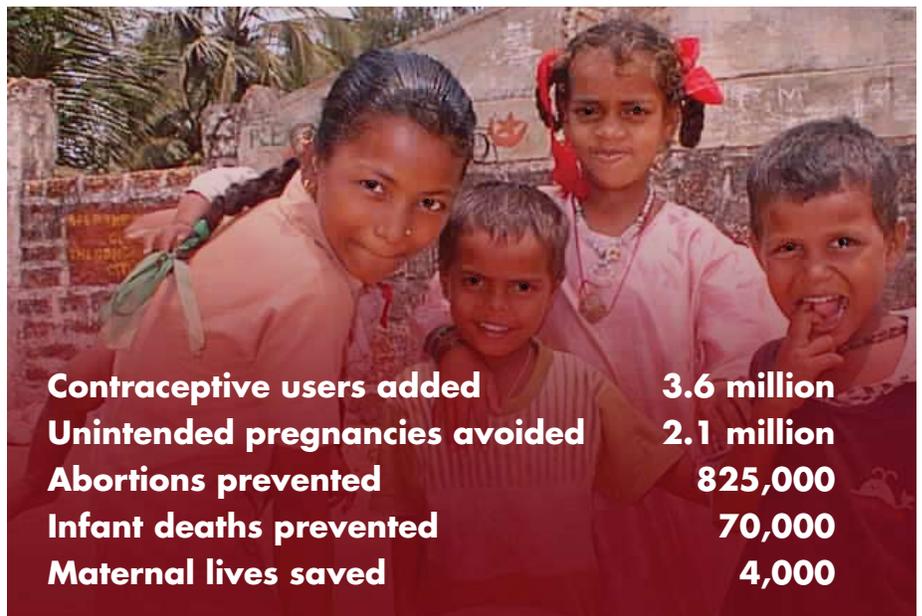
For the past eight years, the United States has forsaken its family planning leadership role among other donors and international institutions. Reduced funding and ideologically based restrictions on that funding have chilled international cooperation and isolated the United States in international debates on

development policy, public health and women's rights. We believe the absence of U.S. leadership has contributed significantly to family planning's overall decline in priority.

To reassert U.S. leadership in family planning, pledges of renewed

commitment from the White House will be a galvanizing force. But the words must be backed by action. It will be essential to reverse the Global Gag Rule restriction as soon as possible, and to again fund the two leading international family planning organizations, UNFPA and IPPF.

Health Impact of Investing \$100 million in Family Planning



Source: Reference 9

Neither has received U.S. government funds since 2000. We recommend that \$62 million be allocated for UNFPA in 2010, and \$13 million for IPPE.

PART 6: THE RETURN ON THIS INVESTMENT WILL BE ENORMOUS

In family well-being: Family planning's most immediate return is in empowering individuals and couples to choose the number, timing and spacing of their children. They are then better equipped to provide each child with adequate food, education and health care. Family well-being and productivity rise as a result.

In health: Increasing the investment in family planning will not only avoid 2.1 million unintended pregnancies, but also reduce the number of abortions, and infant and maternal deaths.

In development: An investment in family planning multiplies the impact of the U.S. foreign assistance budget and a country's own development spending. USAID conducted studies in 29 countries to determine whether investments in family planning saved money for governments by reducing the size of populations needing services. In Zambia, for example, one dollar invested in family planning saved four dollars in other development areas. This return on investment was similar to that found in other countries.

PART 7: CONCLUSION

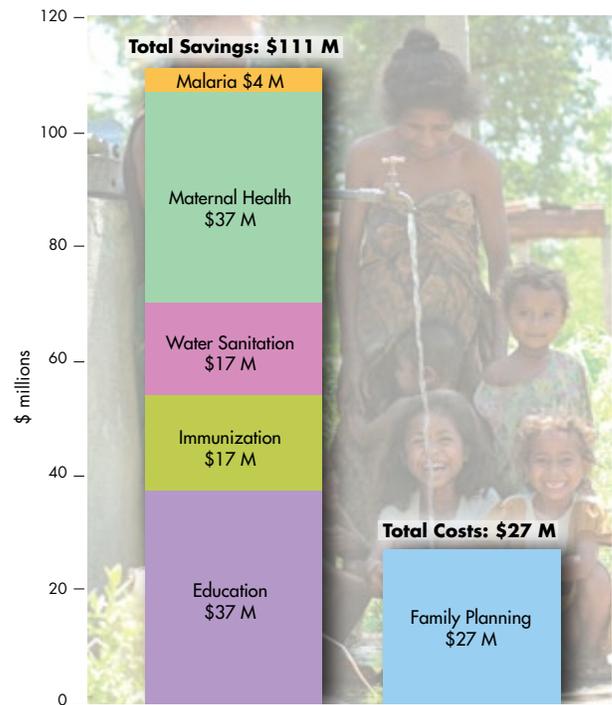
The United States once led the world in supporting access to affordable, high-quality family planning education and services for people in developing countries. In one of the great success stories of the modern era, women around the world now bear half as many children as their grandmothers did, contributing greatly to maternal and child health and global economic growth. USAID was instrumental in this achievement and in reducing the burden of poverty and disease worldwide.

In recent years, however, donor interest in family planning has waned and U.S. funding for it has stagnated, even as the unmet need has risen in many parts of the developing world and global population continues to grow. The demand is urgent for expanded access to contraceptive information and services as a central component of any economic development strategy, and even more so as developing countries struggle to deal with the effects of the global economic crisis.

As former directors of USAID's family planning program, we are certain that the agency remains fully capable of restoring the United States to its position of global leadership in assisting family planning programs in developing countries.

The commitment of \$1.2 billion in international family planning assistance in FY 2010, rising to \$1.5 billion annually by 2014, would represent an appropriate American contribution to international efforts toward the Millennium Development Goals of ending poverty by 2015. We cannot think of a better investment toward global well-being.

Family Planning and MDGs: Cost Savings in Zambia



Source: Reference 10

APPENDIX I:

Global Population Growth Projections – and Their Assumptions

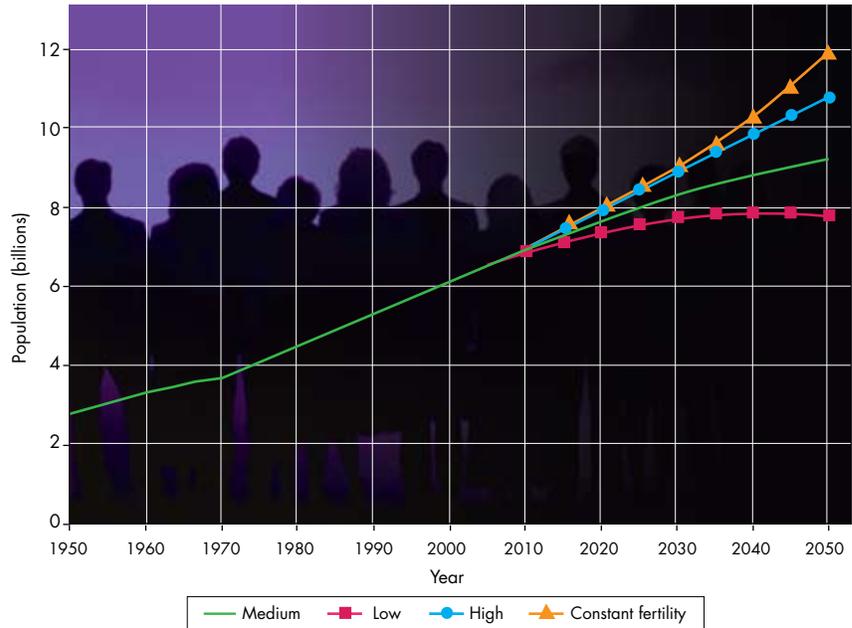
United Nations projections of the future size of world population make it clear that almost all population growth will occur in developing countries. They also make it clear that the use of family planning is a key factor in the size of the world's future population.

According to the graph to the right, the most recent *low-growth* scenario (probably overly optimistic) is that the world will have **7.8 billion** people by 2050, compared to 6.7 billion now. **It assumes that the rate of contraceptive use will grow faster worldwide than it is rising now.**

The more likely *median* projection is for **9.2 billion** people in 2050. That is almost a 50 percent increase over today's number. **Both of these projections assume a substantial increase in access to and use of family planning in the poorest countries of the world.**

However, if current levels of fertility remain unchanged – that is, **if contraceptive use remains stable** – world population could reach the *constant fertility projection* of **11.9 billion** by 2050. No official projection considers the alarming implications if global contraceptive use declines – as it could without greater investment in family planning programs.

World Population (1950-2050), by Projection Variants



Source: Reference 11

APPENDIX II:

Three USAID Success Stories

1. Program Innovation: Community-Based Distribution

Access to family planning services is a problem in many countries where under-funded national health systems of clinic-based physicians cannot reach poor and rural populations. USAID, appreciating that it can take decades to expand such formal health systems, has promoted community-based distribution (CBD) of family planning information and services instead, using well-trained community lay persons.

Beginning in the 1970s with research and pilot studies in Asia and North Africa, CBD programs have now shown impressive results in dozens of countries throughout the developing world. Probably no other single innovation has accounted for as much of the global rise in contraceptive use,

and CBD is the mainstay of many programs.

In some areas, comprehensive community-based health systems have expanded both in geographic coverage and in the range of services offered. In Indonesia, CBD services grew to include a full range of essential community health services including immunization and oral rehydration therapy, HIV/AIDS prevention and treatment, vitamin supplements, referral for emergency obstetrical care, and malaria prophylaxis and bed nets. Today, virtually no developing country lacks a CBD component in its health system.

2. Scientific Innovation: Delivery of Depo-Provera

Depo-Provera is a popular and safe injectable contraceptive. One injection protects against pregnancy for three months. Where it has been made widely available, it is typically

a very popular choice of method, and often leads to a dramatic increase in overall use of contraceptives.

Despite its popularity, local health authorities in developing countries often hesitate to allow non-professional health workers to administer Depo-Provera because it requires a syringe, which poses a risk of disease transmission if not properly sterilized. There are also problems relating to reliable supply and distribution. USAID staff knew that the full potential of Depo-Provera was not being realized and that a great many women lacked easy access to it.

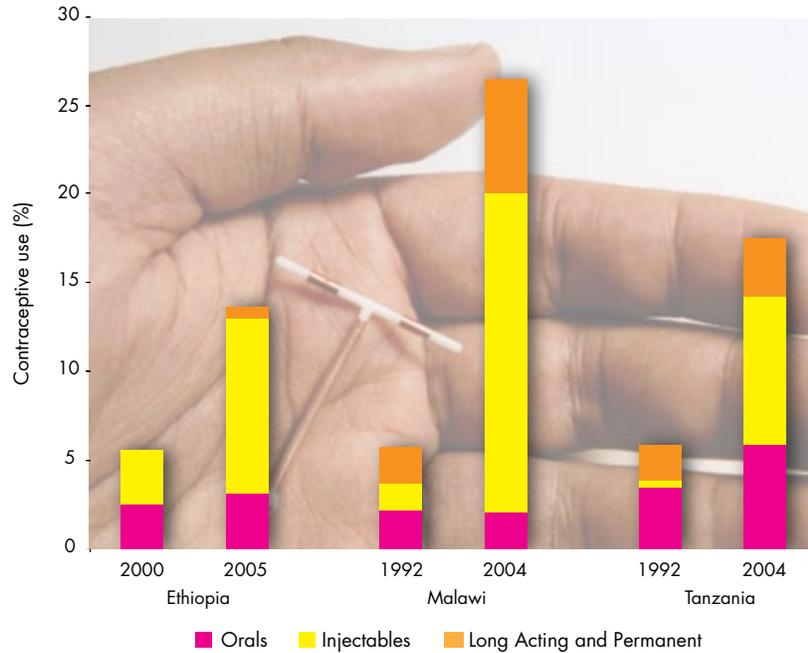
In the early 2000s, USAID successfully tested the feasibility of providing Depo-Provera through CBD workers, and some countries, like Madagascar and Uganda, have greatly expanded this approach.



But the requirement for intramuscular injection still limits its use in most places to clinics and professional health staff. USAID helped establish a public-private sector partnership with PATH, Pfizer, and Becton Dickinson that led to the development of Uniject, a self-contained, syringeless one-shot system for vaccinations that is highly portable, can be administered at home, and is easily



Rising Proportion of Injectables in Contraceptive Method Mix Concomitant with Increase in Family Planning Users



Source: Reference 3

disposable. New research by Pfizer makes possible the delivery of Depo-Provera with Uniject. Initial test results look promising. A 2010 launch is anticipated which will make this popular and effective contraceptive available to millions more women.

3. Data Collection Innovation: The Demographic and Health Surveys (DHS)

USAID's Demographic and Health Surveys (DHS) are often hailed as among the most important contributions of USAID to the world of reproductive health – indeed, to health programs in general. Begun three decades ago, these surveys periodically collect data on health status, contraceptive use, disease incidence, health budget allocations, facility use and population distribution in countries throughout the world. To date, more than 200 DHS surveys have been carried out in 75 countries. Often, they are the

principal source of reliable data on which governments and donors can act. Kenya's experience offers a typical example.

APPENDIX III

Methodology: Estimating New Funding Requirements

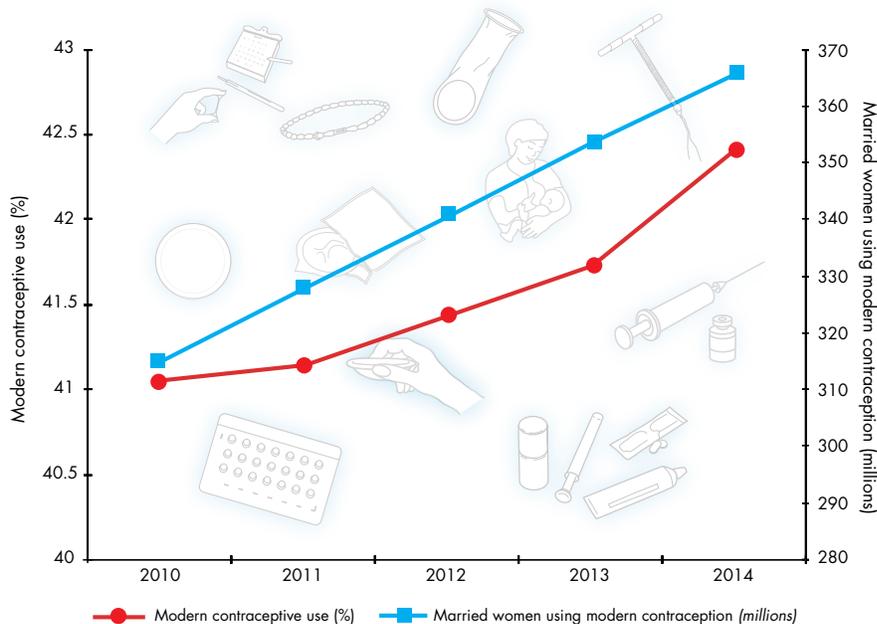
It was not possible for us to develop a budget for each country, so we employed the following method to estimate the budgetary requirements for countries receiving USAID assistance.

- We first determined the annual rate of increase in modern contraceptive use for each of the 52 countries that received USAID support in 2007, and conservatively assumed that this annual rate would stay the same through 2014.

- Based on research, we next estimated the cost of providing modern family planning services to a contraceptive user to be \$17.23.¹³ We then calculated the cost for each country to supply services to its existing and new clients.
- This exercise resulted in an estimated total cost for the countries themselves and for donors.
- To determine USAID's portion of this cost, we used a formula developed by UNFPA and others: We assume that one-third of the total cost will be borne by donors* and that USAID would contribute about 45 percent of the donor contribution,^{14,15} an estimate based on current and past experience – or about 15 percent of the total cost.
- USAID's level of support for a particular country is based on many considerations. In order to capture USAID's regional priorities, we used the agency's 2007 allocations, including those for the central program.

*The amount that donors contribute to countries varies widely and depends on such things as the countries' own resources. For example, in India, donors contribute a very small percentage of the overall amount spent on family planning. In contrast, donors may contribute up to 80 percent of the funds a poor African country devotes to family planning.

Increase of Contraceptive Use and Users in USAID-Recipient Countries (2010-2014)



Sources: References 2 and 3

DHS Spotlights Priority Change in Kenya

In 1998, Kenya was acclaimed for rapid progress in introducing family planning services. In 20 years, its average family size had dropped from eight children to fewer than five. But USAID's 2003 DHS for Kenya showed that progress had stalled or even reversed in some areas of the country.

There was no mystery about the reason. Overwhelmed by the spread of HIV/AIDS, the Kenyan government had shifted human and financial resources away from family planning and into the AIDS battle, particularly for antiretroviral drug therapy. Most donors, including USAID, followed suit.

Surprised and disturbed by the DHS results, the Kenyan government asked USAID to help put its family planning program back on course. USAID responded with emergency shipments of contraceptives, help in putting contraceptives into the Kenyan health budget as a regular line item, and retraining and redeploying health workers.

The results of this turnabout have yet to be documented, but it is clear that without the DHS, the neglect of Kenya's family planning programs and the result would most likely have taken much longer to discover. And without a strong local mission presence, USAID would not have been able to respond as quickly as it did.

Sources: References 3 and 12

BIOGRAPHIES

J. Joseph Speidel is a Professor at the University of California, San Francisco, Bixby Center for Global Reproductive Health. Between 1995 and 2003 he directed the population program at the William and Flora Hewlett Foundation. He previously served as Vice President and President of Population Action International and directed the USAID Office of Population from 1978 to 1983. Dr. Speidel is a graduate of Harvard College, Harvard Medical School and the Harvard School of Public Health. He is the author of more than 100 publications on population-related topics.

Steven W. Sinding served as Director of the USAID Office of Population from 1983 to 1986, following field assignments as a population officer in Pakistan and the Philippines. From 1986 to 1990 he was the Director of USAID's Mission to Kenya. Following a 20-year career at USAID, Dr. Sinding served for a year as Senior Population Advisor to the World Bank and then moved to the Rockefeller Foundation as Director of the Population Sciences program. From 1999 to 2002 he was a Clinical Professor of public health at Columbia University, and in 2002 became Director General of the International Planned Parenthood Federation in London. He retired from IPPF in 2006, and is now a Senior Fellow at the Guttmacher Institute and an international consultant. He currently resides in Vermont.

Duff G. Gillespie is a Professor at The Bill and Melinda Gates Institute for Population and Reproductive Health, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health. Before joining Johns Hopkins in February 2004, Duff Gillespie was a Visiting Scholar at the David and Lucile Packard Foundation. Prior to the Packard Foundation, he was Senior Deputy Assistant Administrator for the Global Health Bureau at USAID, the most senior career position in the Agency. He has worked in the population and health field for 33 years and was the Director of USAID's Office of Population for seven years. Dr. Gillespie received the Arthur Flemming Award in 1977 for pioneering operations research on community-based primary health care delivery systems. He was a recipient of Presidential Rank Awards in 1988, 1990, and 2001. He received the Administrator's Distinguished Career award from USAID in 2004.

Elizabeth Maguire is President and CEO of Ipas, a global non-profit organization dedicated to reducing unsafe abortion and enhancing women's reproductive health and rights. Her 37-year career includes 9 years at Ipas and over 22 years with USAID's population assistance program where she served as Director of the Office of Population from 1993 to 1999. Prior to USAID, Ms. Maguire directed Latin America media and publications programs at the Population Reference Bureau (1971-75). She is multi-lingual with broad technical and executive management expertise, extensive field experience in all regions, and an MA in Demography from Georgetown University.

Margaret Neuse has over 30 years experience in designing, implementing, and evaluating maternal, child, reproductive, and primary health care programs in developing countries in Africa, Asia, and Latin America. Before she retired as a Senior Foreign Service PHN Officer with USAID in 2007, she served for over six years as the Director of USAID's Office of Population and Reproductive Health. She is now a consultant providing strategic and operational assistance to a number of implementing organizations. She has an MPH from Tulane University and an MA in Latin American Studies from Stanford University.

REFERENCES

1. Guttmacher Institute and UNFPA. *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care*, New York, 2003.
2. Population Reference Bureau. *Family Planning Worldwide 2008 Data Sheet*.
3. Demographic and Health Surveys. MEASURE DHS. Macro International Inc.
4. Solo J. *Family Planning in Rwanda: How A Taboo Became Priority Number One*. IntraHealth International, North Carolina, 2008.
5. United Nations Population Division. UN Department of Economic and Social Affairs. *World Contraceptive Use*, 2007, New York: United Nations, 2008.
6. USAID. John Snow International, *Deliver Project*, <http://deliver.jsi.com>.
7. UNFPA. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2007*.
8. Debuur C, Phillips JF, Jackson EF, Nazzar A, Ngom P, Binka FN. The impact of the Navrongo Project on contraceptive knowledge and use, reproductive preferences, and fertility. *Studies in Family Planning* 2002 Jun;33(2):141-64.
9. Testimony by Dr. Nils Dauaire before the Senate Subcommittee on State and Foreign Operations, April 18, 2007.
10. USAID. Health Policy Initiative, *Achieving the MDGs: The Contribution of Family Planning, Zambia*.
11. United Nations Population Division. UN Department of Economic and Social Affairs, *World Population Prospects: The 2006 Revision*, New York: United Nations, 2007.
12. Central Bureau of Statistics (CBS), Kenya, Ministry of Health (MOH), Kenya.
13. Personal communication with John Stover, The Futures Institute.
14. USAID. http://www.usaid.gov/our_work/global_health/pop/history.html.
15. UNFPA. *Global Population Assistance Report 1995*, New York, 1997.

Acknowledgements

The authors wish to recognize Virginia B. Bowen, Sabrina Karklins, Sadaf Khan, and Özge Tunçalp with the Bloomberg School of Public Health, Johns Hopkins University for their research assistance and support; Joanne Omang and Kathy Bonk with the Communications Consortium Media Center (CCMC) for editing; and Mark Beisser at the Johns Hopkins Center for Communication Programs (CCP) for the overall design of the report. This publication was supported by a grant from the David and Lucile Packard Foundation and the Bill and Melinda Gates Institute for Population and Reproductive Health, Bloomberg School of Public Health, Johns Hopkins University.





Photo credits:
Virginia Lamprecht, Lamia Jaroudi/CCP,
Bonnie Gillespie, Frederick Noronha, Steven Nowakowski, David Alexander,
Rick Maiman/David and Lucile Packard Foundation, courtesy of Photoshare

For additional copies of *Making the Case* for International Family Planning please go to:
<http://www.jhsph.edu/gatesinstitute>

Publication Date: 01/09