Population Reports

Family Planning Lessons and Challenges

Making Programs Work

Over the past 30 years, family planning programs have helped millions of people to have the smaller families that they want. As programs have learned how to meet people's needs, contraceptive use has spread rapidly.

What makes a family planning program work? Population Reports has identified 10 key lessons about what makes programs succeed, based on a consensus of opinion among respondents to a new survey and a review of family planning research and program findings.

(1) Family planning demand. Most women want to avoid unintended pregnancies, and most couples want to plan their families. Given the opportunity, people chose contraception because it meets their personal needs.

(2) Contraceptive access. Successful programs offer services not only in clinics but also in retail outlets, community centers, places of employment, and people's homes. They maximize access by overcoming geographic, social, economic, informational, psychological, and administrative barriers between people and family planning services.

(3) Choice of contraceptive methods. Successful programs provide a range of contraceptive methods, not just one or two. Offering a variety of methods helps to meet people's diverse needs and helps programs serve the changing needs of women and men over their reproductive lifetimes.

(4) Client-centered quality. For many people, the quality of services is an important factor in the decision to use family planning. Clients are more likely to be satisfied and to
continue using family planning if they are able to make informed choices in a climate of respect for their needs and decisions.

(5) Communication. Communication campaigns have helped millions of people become more aware of family planning and better informed about modern contraceptives. Both mass media and interpersonal communication have helped people make informed choices to adopt healthier reproductive behavior.

(6) Well-trained providers. Programs that train their staffs well are better equipped to meet their clients’ needs. Strengthening the technical and interpersonal skills of family planning providers enhances the quality of care and thus increases clients’ satisfaction with services.

(7) Program leadership. Most successful programs have strong and stable leadership, whose determination, innovation, and managerial skills have brought services to the less educated and the poor as well as the middle class and to hard-to-reach rural areas as well as cities.

(8) Research and evaluation. Programs that analyze their performance improve their performance. Pilot projects, experiments, surveys, evaluations, and other studies guide the development of the most successful programs.

(9) Political commitment. Strong endorsement both from the top of government and from community leaders gives family planning high priority. Political support helps assure adequate resources for programs and also confirms that family planning is the norm.

(10) Financial resources. Well-funded family planning programs accomplish more and accomplish it better. The level of funding helps determine the extent of coverage, the number of service delivery approaches, and the number of methods available.

Challenges and Opportunities

In the 1990s family planning programs face large challenges and new opportunities for service. The consensus of respondents to the Population Reports opinion survey, as well as research and program findings, calls for programs to:

- Satisfy the remaining unmet need for family planning among millions of married women who want to avoid pregnancy now;
- Extend information and services to the young and the unmarried and to men;
- Offer broader reproductive health services that also address issues of safe childbirth, abortion, AIDS, and other sexually transmitted diseases.
- Generate the resources needed to support and sustain high-quality family planning services through the 1990s and into the next century.
Family planning programs have made a difference. Nearly 400 million women in developing countries use family planning to prevent unintended pregnancies. In the last 30 years the percentage of couples in developing countries using contraception has risen fivefold, from less than 10% in the 1960s to over 50% today (202). Fertility has dropped from an average of about six children per woman in the 1960s to about four today (47). (By comparison, in countries that have completed the transition from high to low fertility, about 70% of married women of reproductive age use contraception, and the average couple has about two children.)

The existence of family planning programs helps explain this change—and why fertility in developing countries is falling nearly twice as fast today as in Europe during its fertility transition a century ago, when family planning movements had no modern contraceptive methods to offer, lacked government support, and often faced legal and religious opposition.

During the past 30 years family planning programs have enabled women in developing countries to avoid more than 400 million births (21). Without family planning programs the total fertility rate for 1980–85 would have been 5.2 children per woman instead of 4.2 (16).

Family planning programs and socioeconomic development both have played important roles in recent fertility declines.

Among the developing countries, contraceptive use generally is at the highest levels in countries that are most economically developed and at the same time have the strongest family planning programs. Even in some countries where social and economic conditions have improved little, however, contraceptive use has risen substantially. For example, in Bangladesh more than 40% of married women of reproductive age now use contraception. Independent of the influence of social and economic development, contraceptive use typically is higher in countries with strong family planning programs (94).

Family planning programs provide people with contraceptive information, supplies, and services. Successful family planning programs, as defined here, are those that make possible the rapid spread of voluntary use of modern contraceptive methods throughout a country. Such programs help people achieve their personal reproductive goals. Typically, they also are part of a country's overall plan for socioeconomic development.

In many developing countries family planning programs began as local services offered by voluntary agencies and pioneered by doctors and women's organizations (32, 72). These nongovernmental organizations (NGOs) established the original family planning delivery systems in most countries. Some family planning associations (FPAs) became linked as affiliates of the International Planned Parenthood Federation (IPPF).

As interest in family planning spread in the 1960s and 1970s, some governments used these early networks of services as foundations upon which to construct national family planning programs (32). In most countries family planning programs that became well established in the 1970s grew stronger during the 1980s (109).
Lessons from Family Planning Programs

Lesson 1: Family Planning Demand
Family planning programs succeed because they respond to people's needs.

Lesson 2: Contraceptive Access
The easier contraceptives and services are to obtain, the more likely people are to use them.

Lesson 3: Choice of Contraceptive Methods
Offering a range of contraceptive methods provides more choices and attracts more clients.

Lesson 4: Client-Centered Quality
The higher the quality of family planning services, the more likely people are to use them.

Lesson 5: Communication
Communication improves use of family planning by creating awareness, increasing knowledge, building approval, and encouraging healthy behavior.

Lesson 6: Well-Trained Providers
Motivated, well-trained providers deliver family planning services better.

Lesson 7: Program Leadership and Strategic Management
In successful programs strong leadership and strategic management define goals, attract resources, build support, overcome obstacles, and adapt to change.

Lesson 8: Research and Evaluation
Family planning programs that analyze their performance improve their performance.

Lesson 9: Political Commitment
Political commitment supports and strengthens family planning programs.

Lesson 10: Financial Resources
Well-funded family planning programs accomplish more and accomplish it better.

What makes family planning programs successful? No single formula for the design of family planning programs suits all countries or cultures (16). Family planning programs must do many things well to succeed (109, 155). Still, the experiences of programs during the last 30 years have yielded valuable lessons.

To find a consensus about the characteristics of successful programs, Population Reports asked about 100 professionals knowledgeable about family planning programs to identify the factors that they considered to be most important. Responses came from about 60 people in most regions of the world. Some respondents are family planning officials in developing countries; others are health and population officers and other professionals with the United States Agency for International Development (USAID); still others are experts in research or technical assistance. (For the names and affiliations of all respondents, see bibliography entries 214-270, p. 27). Population Reports also reviewed the literature on family planning programs, particularly studies of the elements of success, and consulted other reviews of lessons learned (see box, p. 6).

Lessons Learned

Perhaps the most important lesson learned from this review of the experience of the past 30 years is that family planning programs succeed when they meet people's needs (see Lesson 1, Family Planning Demand, p. 5). This statement is not as obvious as it may appear. A common view of developing countries has been that "traditional" people—poor, rural, and little educated—are not interested in having smaller families, and thus that programs must "generate demand" for family planning, or that family planning will be widely adopted only after economic development has taken place. While it is true that total demand is less among the poor and rural than among the rich and urban, experience shows that there is substantial existing demand for family planning among most groups, that much potential demand remains unsatisfied, and that widespread, latent demand for family planning has almost always existed before family planning programs began to provide services throughout the country.

How can programs best meet the demand? There is widespread agreement among the Population Reports questionnaire respondents and in research and program findings that the following elements are vital to success:

At the service delivery level:
- Convenient access to contraceptive services;
- Choice of a range of contraceptive methods;
- High-quality, client-centered services;
- Sustained information, education, and communication; and
- Trained personnel.

At the program administrative level:
- Stable program leadership capable of strategic management; and
- Research and evaluation; and

At the government policy level:
- Political commitment; and
- Adequate financial support.

Some of these lessons, such as the importance of making services accessible and of offering a range of methods, have been widely known and followed for a long time. Others, such as the importance of client-centered services and of sustained communication, have become more widely recognized recently. Characteristics that questionnaire respondents in some countries identified as lessons were identified as challenges by respondents in other countries, perhaps a sign that family planning programs are at different stages.

Challenges and opportunities. Even successful family planning programs face new opportunities and challenges. Most respondents to the Population Reports questionnaire, as well as recent studies, agreed that family planning programs must respond to several critical concerns including:
- Satisfying the rising demand for high-quality family planning services;
- Serving young people better;
- Improving reproductive health care, including addressing unsafe abortion; and
- Generating new funding needed to support and sustain programs.
Despite past successes, "tens of millions of people worldwide are frustrated in trying to exercise their right to plan their families by lack of access to good-quality family planning services," a recent IPPF report observes (74). The programs that have learned the lessons of the past three decades of family planning experience will be best equipped to provide better access and services and to meet the challenges of the 1990s.

**1 Family planning programs succeed because they respond to people's needs.**

**Family Planning Demand**

Most couples want to plan their families, when they have the opportunity to do so. Women everywhere want to avoid unintended pregnancies. Young and unmarried people want to avoid the consequences of unprotected sexual relations, both pregnancy and sexually transmitted diseases.

In most countries outside sub-Saharan Africa, a majority of married women of reproductive age do not want to have more children. Among women who want more children, in most countries surveyed in the past 10 years, as many women want to wait at least two years before having a child as want a child right away or are pregnant. Even in sub-Saharan Africa, where most married women want large families, a majority of women want to wait at least two years between births or to have no more children (155, 164). (Throughout this report the term "married" also includes couples "in union," that is, living together as if formally married.)

**Responding to the Demand**

Almost everywhere that contraceptive use has risen, a latent demand for family planning existed before family planning supplies and services were widely available. Many governments underestimated their people's interest in family planning. "The received wisdom was that traditional cultures have deeply embedded in them pronatalist institutions and motivations that are difficult to change," Ronald Freedman has observed (44). But the received wisdom has been proved wrong—first in Japan immediately after World War II, then in Taiwan in the 1960s, later in Colombia and Thailand in the 1970s, Kenya in the 1980s, and Bangladesh and Egypt in the 1990s.

In the early 1960s Taiwan was considered an "underdeveloped" economy and a traditional society where people wanted many children (44). A study found, however, that many couples would have preferred fewer children than they actually had. Couples interviewed expressed interest in obtaining contraceptives, and, when public health nurses offered these same couples contraceptives, many accepted. Such research helped assure Taiwanese policy-makers that people would welcome a family planning program (44).

In Thailand research has shown that, although most Thais were rural, poor, and had little education, latent demand for family planning was strong even before the government family planning program made services widely available in the early 1970s (89, 173).

More recently, studies in Bangladesh have found evidence of popular demand for family planning throughout the country (23). Contraceptive use has risen and fertility has fallen among less educated, poor, rural people as well as among the educated and urban. In recent years improved roads and increased exposure to the mass media have made rural areas less isolated. People have begun to adopt new values, and the family planning program has made contraceptive information and services widely available.

Other examples of popular demand for family planning come from around the world, from places as different as Brazil and Tanzania. In Brazil, despite public opposition to family planning from several important groups and an ambivalent official policy, "Brazilian women overwhelmingly want family planning services" (214). Some 66% of married women of reproductive age use contraception (164). In Tanzania "some donors were shocked" when the 1991-92 Demographic and Health Survey revealed that 30% of married Tanzanian women of reproductive age wanted to prevent pregnancy but were not using family planning—three times the number then using family planning (265).

Egyptian women wait for family planning services. Throughout the developing world people choose family planning, once they are given the opportunity, because it meets their needs. In Egypt about 47% of married women used family planning in 1992, up from 30% in 1984.
Family Planning Lessons and Challenges:
Other Reviews

For other recent overviews of family planning lessons, see:
*Family Planning: Meeting Challenges: Promoting Choices*, the proceedings of the 1992 IPPF Family Planning Congress (179).
*Organizing for Effective Family Planning Programs*, published by the National Research Council, 1987 (95).

Making a choice. Family planning programs work best when they provide people with full information and a choice of services in a climate of respect. Government goals and projections may be an important part of national development planning. But setting targets for contraceptive “acceptors” is not the road to family planning success. Rather, if people are given the opportunity, they choose family planning when it meets their needs (159).

Commenting on the early days of family planning in Colombia, Miguel Trias, executive director of the Asociación Pro-Bienestar de la Familia (Profamilia), notes, “At the beginning we made the mistake of believing that we had to devote most of the effort to ‘educate’ people on the need for and convenience of regulating their reproduction. It took us some time to realize that what the people were expecting from us was the delivery of contraceptive services” (263).

As USAID has stated in its 1994 document, *Strategies for Sustainable Development*, “Targets or quotas for the recruitment of clients should not be imposed on family planning providers; over the long term, meeting the unmet need for information and services is the best way to achieve national demographic goals” (196).

The Challenges of Unmet Need

In the 1990s family planning programs face the challenge of finding better ways to deliver services to the millions of people who would use family planning if they could. One indicator of the size of this challenge is unmet need for family planning. The concept of unmet need describes married women who are able to bear children but are not using contraception despite their own statements that they either do not want to have any more children or want to wait at least two more years before having another child (204).

By this definition, in the developing world as a whole, about 120 million married women—about one in every five—have an unmet need for family planning, either for limiting or spacing births (164). In most countries surveyed by the Demographic and Health Surveys (DHS), between 20% and 30% of all married women of reproductive age have an unmet need for family planning. Outside sub-Saharan Africa, most women with an unmet need do not want to have any more children. In sub-Saharan countries surveyed, most unmet need is for spacing births (204).

Another telling indicator of the challenge facing family planning programs, described as “the ultimate unmet need for family planning” (26), is that more than 50 million women each year terminate their pregnancies with abortions, most of them illegal and dangerous (26, 240).

**Serving the hard-to-reach.** In the 1990s family planning programs must do more to serve the less educated, the poor, and the ethnic minorities, as well as the educated, the employed, and the majority (218, 223, 225, 241, 246, 249, 266, 267). In most surveyed countries, even where contraception is widely practiced, unmet need is greater in rural areas than in the cities, a fact suggesting that access to family planning services is unequal (164, 204).

“The time of just promoting the concept of family planning to the general public is over,” observes Alfonso López Juárez, Director General of Fundación Mexicana para la Planeación Familiar (MEXFAM), Mexico’s International Planned Parenthood affiliate (241). Particularly where contraceptive use has already risen substantially, it is unlikely to continue rising unless family planning programs make progress toward reaching all groups and areas (234).

**The impact of meeting unmet need.** If programs could meet all unmet need for family planning, millions more women would be able to achieve the reproductive control that they want, effectively and safely. The use of modern methods of contraception would rise substantially. Fertility would fall as a result, and population growth rates would slow.

Many family planning specialists believe that the existing demand for family planning and reproductive health services is already so strong that, if every individual’s needs could be met with services, fertility rates would decline as much as, or even more than, most governments call for in their development plans (191). For example, Steven Sinding, John Ross, and Alan Rosenfield have calculated that, in 13 of 17 countries studied, meeting the unmet need for family planning would exceed the government’s demographic objectives for levels of contraceptive use (184). Moreover, demographic objectives do not take account of the specific needs of different groups. A focus on meeting unmet need implies satisfying individuals’ needs (171).

Sinding has calculated that, if all the unmet need for family planning in developing countries were met, contraceptive prevalence would rise from the current level of about 50% to at least 60%. As a result, fertility would fall from an average of about four children per woman to just over three (183). A fertility decline of this magnitude would reduce the annual rate of population growth in the developing world from 2.3% to 1.6% (163). These statistics exclude China, where there is...
The need for contraception is likely to increase further, of women with a need for family planning are not counted of people reaching reproductive age is soaring—a consequence typically estimate unmet need only for women who are development Administration (226).

Meeting the Wider Need

In the 1990s family planning programs that have learned to serve married women now need to reach other groups as well—young people, husbands, and unmarried adults of both sexes (233, 248). A challenge for the 1990s is "not only to meet the rising demand for contraception in general, but also to serve better the needs of all women and men who are struggling to regulate their fertility safely, effectively, and with human dignity" (37).

Demographic surveys and family planning program strategies typically estimate unmet need only for women who are married or in union. Ruth Dixon-Mueller and Adrienne Germain have observed, however, that at least three groups of women with a need for family planning are not counted in conventional estimates of unmet need: (1) single women; (2) contraceptive users who are using an ineffective method, using a method incorrectly, or using a method that is unsafe or unsuitable for them; and (3) pregnant women whose pregnancies are mistimed or unwanted (37).

Men. Also, most family planning programs have paid little attention to men. Although men are half of the reproductive equation, family planning has been considered "women's business." The stereotype that most men do not care about family planning is false, however. Men make or strongly influence many household decisions about reproduction and family planning use (112). Research in Africa suggests that men often know more about contraceptives than women know and may have more favorable attitudes toward contraceptive use (91). In any case, men's needs for family planning cannot be met effectively by many conventional sources of family planning for women, such as maternal and child health clinics. Respondents to the Population Reports questionnaire, among others in the family planning profession, urge that programs do more to reach men (51, 112, 176, 219, 220, 225, 236, 240, 241, 246, 258, 263, 268).

Young people. Young people have been largely left out of the family planning revolution. Few countries provide reproductive health and family planning services freely to youth (176). A variety of traditions, institutional and political barriers, and myths about sexuality have made it difficult to develop effective programs that provide accurate reproductive health information and useful services to young people (49, 248). Many people think that providing family planning services to youth will promote promiscuity, even though there is no evidence of this (49, 112, 219, 240).

Premarital sexual experience is becoming more common among young people in developing countries (114, 132, 164, 176, 209, 240, 248). As countries have become more urban and economically developed, the age at marriage has risen, and young people's sexual attitudes and behavior before marriage have been changing. Ties to extended families and adherence to traditions that governed young people's sexual behavior in the past are eroding.

The old rules may have changed, but they have not been replaced with new behavioral guidelines (88, 209, 273). Thus many young people do not know where to turn for help. "Young people find themselves caught between conflicting messages; media images urge them to promote their sensuality, while parents, educators, and religious authorities tell them to 'just say no'" (273). Young people themselves may not think that family planning is for them. In Mauritius, for example, a survey found that, although sexual activity
Meeting the reproductive health needs of youth requires not only providing services but also changing attitudes, overcoming opposition, building understanding, and educating adults about the problems facing youth in the 1990s (49, 90, 219, 222). Meeting the reproductive health needs of unmarried youth is different from meeting the needs of married couples (176, 249). For example, when MEXFAM began its Gente joven program to serve young people, the staff found that they needed not just to offer services but also to overcome young people’s lack of trust in adult counseling and to break the pattern of poor communication between youth and adults (273).

Programs such as Gente joven are beginning to provide guidance about how to serve young people. For best results, programs should give young people accurate information that provides a basis for making responsible decisions; they should not lecture young people on their behavior (49, 273). Also, programs should provide services in a setting acceptable to youth, who are unlikely to visit conventional maternal and child health, family planning, or other reproductive health facilities (249, 253). “Successful programs reach out to young people on their own turf—at schools, recreational centers, work sites and on the street” (273). Programs should involve youth themselves both in planning and in delivering services (49, 90, 176, 190, 249, 273). To communicate better with youth, for example, the Gente joven program uses volunteers ages 15 to 20 as well as paid professional staff (273).

Often, government policies or unnecessary medical barriers keep family planning and reproductive health services from adolescents. These policies include laws setting minimum ages for clients, rules requiring young people to have parental consent to obtain contraceptives, policies expelling pregnant women from school, and regulations restricting provision of family planning services to young people (49, 180). If family planning programs are to reach youth, the programs must provide confidential services to all who seek them, without regard to marital status or age (176, 249).

2 The easier contraceptives and services are to obtain, the more likely people are to use them.

Contraceptive Access

From the early days of the family planning movement in developing countries, programs have recognized the importance of making contraceptives easy to obtain (160). In the 1970s bringing contraceptives to rural people was still a challenge waiting to be met (68). As millions have migrated to urban areas over the past two decades, this challenge has expanded to include the densely populated “slum belts” located around most large cities.

Many family planning programs have gone far to improve access. They offer services and supplies not only in clinics and other medical facilities but also in retail outlets, community centers, places of employment, and homes. Not only do formally trained physicians and nurses offer services, but so do paramedics, pharmacists, traditional birth attendants, midwives, traditional healers, outreach workers, and shopkeepers (110, 126, 174).
Access has continued to improve in recent years. For example, of 87 countries studied in both 1987 and 1992 by Population Action International and given scores from 0 to 100 based on access to family planning information and services, 33 increased their scores by 20 points or more, and another 24 raised their scores by 10 to 19 points. The most dramatic improvement in access took place in sub-Saharan Africa. Botswana showed the most improvement, gaining 49 points (131).

Family planning programs that have been particularly successful at making services widely available include those in Bangladesh, Colombia, Mexico, South Korea, Taiwan, and Thailand. In Thailand, for example, almost everyone has access to a network of family planning services because service sites are many, good roads assure year-round access, and public transport reaches everywhere (12).

Variety of Sources

Having many different sources of family planning increases access by meeting the needs of different people. Particularly in Asia and sub-Saharan Africa, government programs are the major source of family planning. In 33 of 42 countries surveyed by the DHS as of 1992, governments served more users than private for-profit providers, nongovernmental organizations (NGOs), or other family planning providers. In 25 of these countries governments served a majority of family planning users (164).

In every region nongovernmental organizations (NGOs) also provide many people with services, including in such high-prevalence countries as Colombia and Mauritius. In Colombia Profamilia has been responsible for introducing community-based and commercially based outreach as well as clinic-based services (6).

The for-profit commercial sector is also an important source of family planning in Latin America and the Near East. For example, in 10 of 15 Latin American countries surveyed since 1985, the commercial sector serves a higher percentage of contraceptive users than does the government (164). In Brazil, Paraguay, and Egypt, private providers supply more than two-thirds of family planning users (164).

Ensuring Access

For the individual client, the ability to use family planning depends on many things. Probably most important, as many family planning programs and donor agencies such as USAID have long recognized, a range of services must be within convenient reach, both in distance and travel time (68). Also affecting access are the time needed to obtain services, their cost (including not only the cost of contraception itself but also travel cost and the opportunity cost of time away from work), the ability to arrange for child care and other obligations, and similar constraints.

While a network of clinical services is the backbone of successful family planning programs, other distribution channels such as community-based distribution (CBD) and social marketing help to make supplies more widely available. Such contraceptive methods as oral contraceptives and condoms are well suited to distribution outside of clinics.

Proximity of clinical services. Locating family planning clinics close to where people live is crucial to success. As the geographic density of clinics and other service sites increases, the trip for family planning becomes shorter and quicker for most people (174).

The DHS show that contraceptive prevalence is higher where services are closer, as measured by both travel time and distance (207). In Thailand the median travel time to the nearest family planning facility is short, 15 minutes, and the median distance is only 3 kilometers. Contraceptive prevalence in Thailand is high, at 68%. In the Dominican Republic the distance is also 3 kilometers; the travel time is 20 minutes. Contraceptive prevalence is 56%. In Zimbabwe services are not as convenient. Median travel time is 31 minutes; and the median distance is 5 kilometers. Prevalence is 45%. In Uganda most people have little access. The average person lives 60 minutes and 19 kilometers from the nearest family planning facility. Contraceptive prevalence is only 5%.

In Egypt family planning service sites are accessible to almost everyone (39). Fully 96% of all Egyptian couples live within 4 kilometers and 30 minutes of a family planning facility (207). Convenient access to family planning services, along with widespread access to televised information about family planning, helps to explain rising use of contraception in Egypt, which reached 47% in 1992 (39). (See Lesson 5, Communication, p. 15.) Even in countries with strong family planning programs, however, urban couples have better access to services than rural couples, largely because it is costly and difficult to extend services to sparsely settled rural areas (104).
Community-based distribution. CBD programs help to deliver family planning information and supplies to people who may not have convenient access to service facilities. CBD is especially useful in the early stages of family planning program development. Where people have had little experience with family planning, CBD overcomes unfamiliarity by bringing family planning close to the people in their communities and by providing culturally sensitive information and service delivery (99). Today, CBD appears to be well suited to reaching couples in sub-Saharan Africa (99, 121).

Many studies have shown that adding CBD to clinic-based family planning services has increased the acceptability and impact of programs (52, 121, 172, 173). A recent study by James Phillips and Wendy Greene, reviewing programs in Nigeria, Mali, Sudan, and Zaire, reports that CBD programs have added an average of three percentage points to a country's contraceptive prevalence rate, independent of all other influences (122).

Social marketing. In some countries social marketing, in which contraceptives are distributed at subsidized prices through established commercial retail outlets, helps to provide convenient access to affordable family planning (69, 173, 181, 228, 236). Condoms, oral contraceptives, and spermicides are the contraceptives most often distributed through social marketing. Some programs also offer injectables and intrauterine devices (IUDs), which clients purchase in pharmacies and take to clinics or private physicians for insertion. Advertising and promotion are keys to the success of social marketing, as they are to conventional commercial sales, because they call attention to specific brands, create an image for them, and help clients understand how to use them, how much they cost, and where to buy them (181). As of 1990 major contraceptive social marketing programs were operating in 19 countries (63).

Social marketing programs draw some contraceptive users away from other commercial sources and from free services. Although experience differs widely from one country to another, one estimate is that one-third to one-half of people buying social marketing brands of contraceptives are new users (93).

Maximizing Access

Maximizing access means not only providing convenient services in a variety of ways but also overcoming the political, social, informational, psychological, and administrative barriers that keep people from using contraception or that make it difficult for them to use family planning effectively.

Even if family planning services are otherwise available, many women may lack access because they are not permitted to decide on their own to use family planning. Others may not seek services because the available services have a poor reputation in the community (36, 258). For example, such obstacles as lack of privacy or confidentiality at clinics, or negative attitudes toward certain medical procedures (such as pelvic exams) may deter otherwise motivated women from seeking services (14).

Unnecessary medical requirements discourage some people from seeking family planning, prevent others from choosing their preferred method, and lead still others to discontinue use (180). Removing unnecessary requirements to using family planning safely and effectively can improve access. Such barriers can include overly strict eligibility criteria for certain methods, unnecessary physical examinations, rules requiring frequent follow-up visits, and regulations that prohibit health care personnel other than physicians from delivering family planning services (180). As they review current findings about modern contraceptives, their safety, and their risks, more health care professionals and policy-makers may decide to remove these unnecessary medical barriers to family planning (180, 247, 264, 269).

3 Offering a range of contraceptive methods provides more choices and attracts more clients.

Choice of Contraceptive Methods

Making only one or two contraceptive methods widely available is better than failing to provide family planning at all. But only a range of effective methods can meet people's diverse needs and serve individuals over their reproductive lifetimes.

Successful family planning programs provide as many different contraceptive methods as possible. "As any marketing expert will tell us, the more choices, the more likely the consumer is to select one of the available options" (262). In 12 of the 14 countries considered to have the strongest family planning programs, no single method accounts for as much as half of all modern contraceptive use (109).

Adding Methods Adds Clients

Among the first lessons learned by family planning programs in developing countries was that each new method introduced attracts new contraceptive users and thus raises contraceptive prevalence. Pioneered by USAID in the 1960s and
John Ross and colleagues also found a link between the number of modern methods readily available and contraceptive prevalence. In 8 of 36 countries studied, five or six modern methods were available, and in these countries modern contraceptive prevalence averaged over 60%. In five countries three or four modern methods were readily available, and modern prevalence averaged about 40%. In seven countries, where only one or two methods were available, about 25% of couples used modern contraception. In 16 countries no modern methods were readily available. Not surprisingly, in these countries the use of modern contraception was very slight—less than 10% (174). In Ross’s study a contraceptive method was considered readily available if at least half the population could obtain the method by spending less than two hours a month and less than 1% of their income—a definition developed by Lapham and Mauldin (94).

Contraceptive Prevalence

Contraceptive prevalence typically is higher in countries where more methods are available than in those with only one or two methods (208). Among 72 developing countries studied by Anrudh Jain, for each additional contraceptive method available, contraceptive prevalence is an average of 12 percentage points higher. This effect is largely independent of other program or development influences (78). Jain examined data collected in the early 1980s by Robert Lapham and W. Parker Mauldin (94).

Among 50 countries surveyed since 1985, modern contraceptive prevalence is at least 45% in 13 countries. In 12 of these 13, at least three methods are widely used, according to a review by Population Reports. In Costa Rica, for example, where modern method prevalence is 58%—among the highest levels in the developing world—four methods each attract many users among married women of reproductive age: oral contraceptives, at 21%; voluntary female sterilization, at 14%; condoms, at 13%; and IUDs, at 8%. The exception among these 13 countries is Brazil, where only two methods, female sterilization, at 27%, and oral contraceptives, at 25%, account for almost all of the modern prevalence rate of 57% (164).

The growing availability of Norplant and injectable contraceptives offers more choices and thus more opportunities to improve program performance and clients’ satisfaction. For example, in Kenya use of injectables rose in four years from 3.3% of married women of reproductive age in 1989 to 7.2% in 1993 (85).

Assuring Contraceptive Supplies

No matter how many methods are theoretically available, people will not be able to use them unless supplies of contraceptives are in the right place at the right time. Without good logistics, stock-outs or inadequate supplies often result (208). Meeting the challenge of providing good logistics is important. Supply shortages cause people to become dissatisfied and even force them to discontinue using contraception altogether. Thus, both in national programs and at the international level, “the development of an adequate logistics system should not be postponed” (21). Recognizing the importance of this fact, USAID technical assistance for logistics management has helped programs deliver family planning information and supplies to clients regularly and reliably (117).

A good logistics system covers planning, procuring, transporting, storing, and distributing not only contraceptives themselves but also any clinical supplies required to provide high-quality services, such as rubber gloves for IUD insertion, and informational materials for service providers and clients (69, 241). As small family planning programs grow, they must coordinate logistics at regional or national levels. For example, the Zimbabwe National Family Planning Council has coordinated logistics management under a central organization that is able to forecast national contraceptive needs, procure supplies, and distribute them throughout the country (246).
The higher the quality of family planning services, the more likely people are to use them.

Client-Centered Quality

Although cultural norms differ, high-quality family planning programs treat women respectfully as individuals, as consumers, and as clients. They offer services at convenient times and places, with adequate privacy for examinations and counseling. They avoid long waits and impose a minimum of bureaucratic burdens or obstacles.

The Client’s Perspective

Clients judge the quality of family planning services every time they come into contact with these services. Most people know good treatment when they experience it, and they certainly know when they are treated badly.

To provide high-quality care, service providers must understand and respect their clients’ values, attitudes, and priorities concerning family planning (101, 252, 211). Because most family planning clients are women, service providers must have an ability to see “experiences, values, issues, and information from the point of view of the women whose lives are affected” (13).

From clients’ point of view, not only the technical quality of services is important but so are other aspects, including privacy and confidentiality, competent counseling, friendly personnel, and the opportunity to make an informed choice about contraception. In a study of a family planning clinic in Santiago, Chile, women defined high-quality care as being treated well. Among the elements of quality that clients identified were hygienic conditions, prompt service, useful and accurate information, adequate time for consultations and counseling, opportunities for learning and personal growth, friendly and interested staff, and being treated as an equal (200).

Women are more likely to use family planning if they respect and have a positive relationship with service providers (10). Research shows that health care providers’ attitudes and treatment of clients often determine which health services women use and even determine whether women seek services at all. For example, in Nepal service providers’ poor treatment was one reason that women made little use of clinical family planning services. A study found that, when lower-status women visited clinics, they received less courtesy and less information than educated, middle-class clients. Women who were treated poorly discussed their bad experiences with friends and neighbors, and thus family planning services developed a bad reputation (177).

Service providers’ treatment of women as clients also may affect how women feel about contraceptive methods. When women believe that the medical quality of services is good, and when they are treated with respect and empathy, minor side effects or problems with particular methods often become more tolerable (258). Satisfied clients are more likely to recommend family planning services to other women (31, 126). “The best and most effective publicity any program can achieve is that which flows by word of mouth,” Miguel Trias of Colombia’s PROFAMILIA has written. “The quality of the programs has to be perceived by our clients to be good enough to recommend to relatives and friends” (188).

Elements of High-Quality Care

Judith Bruce has proposed six indicators of high-quality family planning services (18). These include:

- Access to a choice of methods (see Lesson 2, Access, pp. 8–10, and Lesson 3, Choice of Method, pp. 10–11);
- Provider competence (see Lesson 6, Well-Trained Providers, pp. 17–18);
- Information given clients, including counseling (see Lesson 5, Communication, pp. 15–17);
- Interpersonal relations between provider and client;
- Appropriate constellation of services, meaning the availability of related health care services as well as family planning (see p. 13); and
- Follow-up and continuity of services.

These six indicators are valuable to family planning programs because they all reflect the client’s perspective on services. The success or failure of programs should be judged not only by their impact on fertility but also by the extent to which they help individuals meet their own reproductive goals (77).

Counseling. Personal contact with a family planning provider is at the heart of client-centered quality. Often it is the crucial step in a person’s decision-making process about family planning (126) (see Population Reports, Counseling Makes A Difference, J-35, November 1987).

In counseling, clients and providers meet face-to-face to discuss reproductive health choices and practices. Service providers not only inform their clients but also listen to them and help them to understand their own feelings and needs and thus to make more appropriate choices. In a good counseling situation the provider establishes a relationship of trust and confidence with the client. This relationship is established by expressing empathy (that is, putting oneself in the other person’s position), being respectful, and telling the truth (50). Counseling is a special form of interpersonal communication, and most people require training and practice to become proficient counselors (50).
Informed choice. Family planning programs are responsible for ensuring their clients' right to make their own decisions about family planning (50). Programs that offer client-centered care help people make informed decisions about reproductive health and contraception (18, 31).

To make an informed choice, clients need accurate, clear, unbiased, and useful information and advice about reproduction, family planning, and correct use of contraceptive methods. Many people discontinue using contraception because they lack accurate information, while others never adopt contraception at all for want of information (18).

Service providers should inform clients about both the advantages and the disadvantages of contraceptive methods. Providers should not discourage or promote particular methods at the expense of others that might interest a client (180, 220, 221). Once clients have chosen a specific method, they also need information about proper use, potential side effects and complications, and the follow-up services that are available (98).

Family planning programs provide clients with information in many different ways, including the broadcast media, print materials, and videos, as well as person-to-person discussion (31, 81). Mass-media and interpersonal communication play complementary roles in ensuring that clients can make an informed choice (see Lesson 5, Communication, p. 15). Many people can learn about family planning in the mass media, and some visit family planning providers as a result. Then, at the clinic or other service delivery point, provider and client discuss the client's individual questions, needs, and concerns (129).

When clients make their own informed choices and get the contraceptives they want, they are more likely to be satisfied and to continue use. Studies in a variety of countries have found that women who did not obtain their first choice of contraceptive method were more likely to discontinue use than women who received their first choice (71, 119).

The Challenge of Reproductive Health Care

Many family planning programs could serve women better if they adopted a broader view of reproductive health (4, 19, 40, 193, 240). Adding other reproductive health care to family planning services would enable many women to meet more of their needs with a single visit to a single clinic (19, 41, 240, 252).

What is reproductive health care? Adrienne Germain and Jane Ordway have described a reproductive health approach to providing services as one that enables women to:
- Regulate their fertility safely and effectively;
- Remain free from disease, disability, or risk of death due to reproduction and sexuality;
- Terminate unwanted pregnancies; and
- Bear and raise healthy children (54).

Also, Carmen Barroso, director of the population program at the John D. and Catherine T. MacArthur Foundation, has pointed to three areas that require immediate attention:
- AIDS and other STDS,
- Education about reproductive health and sexuality; and
- The impact of unsafe abortion on women (4).

Providing a reproductive health approach. In deciding which reproductive health services to offer in addition to family planning, programs must focus on activities “that will benefit the most women at an affordable cost and have the highest public health impact," Elizabeth Maguire of the USAID Office of Population has said (107). Family planning programs can become better aware of women's reproductive health care needs if they involve women and women's organizations in the design and delivery of services (19, 40, 112, 240).

In Tunisia the National Family Planning Program (ONFP) was able to provide more comprehensive reproductive health care in one hospital by stressing the cultural significance of the 40th day postpartum, the end of seclusion for mothers and their newborns. ONFP designated the 40th day for follow-up visits and made available neonatal, postpartum, and family planning services to women in a single clinic visit. A 1987 study showed that 83% of new mothers returned for their 40th-day check-up. Of these, 56% began using a family planning method (27). The approach is now being expanded to the entire country.

In Bolivia, where infant mortality is higher than in any other country of the Western Hemisphere except Haiti, the Ministry of Health has launched one of the most comprehensive reproductive health campaigns ever in Latin America. The campaign addresses four components: family planning, prenatal and postnatal care and safe delivery, breastfeeding, and prevention of illegal abortions. A special logo appears outside selected clinics where trained staff members can re-
spond to people's reproductive health needs. A radio and television campaign alerts the public to reproductive health and urges them to visit the clinics (11, 82, 175).

**Safe childbirth.** Better delivery care and better access to delivery care would substantially reduce maternal deaths and illnesses (168, 187, 189). Nearly all maternal deaths and most maternal illnesses occur in the developing world. The number of maternal deaths worldwide each year is estimated to be 500,000 but may be even higher because of underreporting (67). Also, each year many millions of women suffer life-threatening, chronic, or other serious health problems resulting from pregnancy and childbirth (102).

Yet adequate delivery care remains the exception rather than the rule. In 12 of 26 countries that conducted DHS between 1986 and 1989, at least half of all births in the five years before the survey took place without the help of a formally trained attendant (59).

Because delivery care services are so few, pregnancy is often the most hazardous activity women in developing countries undertake. On average, in the developing world a pregnancy is 16 times more likely to end in the woman's death than in the developed world (112). For example, between 1976 and 1985, 30% of all deaths among women ages 15 to 44 in Matlab, Bangladesh, were related to childbearing (42).

**Safe abortion.** The challenge of dealing with the millions of unsafe abortions that women undergo must be met in the 1990s, according to many respondents to the Population Reports questionnaire. Abortion should be "safe, legal, and rare," according to US President William J. Clinton (272). As Miguel Trias of Profamilia in Colombia writes, "The abortion issue will still confront us in the next decade" (263). José Barzelatto of the Ford Foundation urges, "The issue of abortion as a back-up need for contraceptive failure should not be avoided in preparing for the 1994 International Conference on Population and Development" (217).

The statistics are striking: An estimated 10 to 22 million women undergo clandestine abortions each year in countries where abortion is legally or otherwise restricted (66, 120). Of these women, 100,000 to 200,000 die from complications, accounting for 20% to 40% of all maternal deaths (66). Even where contraceptive use is widespread, abortion should be safe because no form of contraception is perfectly effective, and women will seek abortion when contraception fails (217, 229, 255).

Although women who have just undergone abortions may be highly motivated to use contraception, few family planning programs offer postabortion family planning services (28, 240, 244). Where abortion is legal, family planning programs should work with abortion providers to make postabortion family planning services and counseling more available. Family planning programs also can educate women about the importance of obtaining abortions as easily as possible in pregnancy (229).

Where abortion is restricted by law or practice, family planning programs can work with hospital emergency staff and gynecological wards to provide family planning counseling and appropriate health care services to women being treated for abortion complications (75, 96). The US Senate Committee on Appropriations has encouraged USAID to provide support for women who suffer abortion complications and to offer postabortion services (197).

**AIDS and other STDs.** Worldwide, more than 250 million new cases of sexually transmitted diseases (STDs) are diagnosed each year, of which at least 1 million are infection with human immunodeficiency virus (HIV), which leads to AIDS. In many countries STDs are common among women attending antenatal, family planning, and gynecological clinics. Screening studies at such clinics find that as many as 18% of clients have gonorrhea or syphilis, and 30% have trichomoniasis (92).

In women particularly, symptoms of STDs may not appear until an advanced stage of the disease. If left untreated, STDs can result in pelvic inflammatory disease, chronic pelvic pain, cervical cancer, ectopic pregnancy, and sterility, and may lead to death. Untreated STDs greatly increase the risk of contracting AIDS. STDs in pregnant women can cause stillbirth, congenital malformations and disease, infant blindness, and infant death.

Family planning clinic visits can be opportunities to combat STDs and AIDS by informing, protecting, screening, and treating clients (41, 53, 96, 246, 249). Many family planning providers already are overworked, however, and many programs lack resources to provide additional services (226, 235). "The challenge is making AIDS prevention and family planning work together rather than compete for scarce resources" (222).

Meeting this challenge will require many programmatic changes, including more training for staff and more funding (231, 249, 265). For example, most family planning programs will need to obtain larger supplies of condoms—the contraceptive method that best guards against STDs while at the same time preventing pregnancy.

Family planning programs are trying various approaches to combating STDs and AIDS. IPPF affiliates in Africa and Latin America typically offer counseling and referrals for clients with symptoms (58, 167). Other family planning programs provide further services. For example, in El Salvador the Asociación Demográfica Salvadoreña, a nonprofit family planning organization, screens and treats clients for STDs.

Most people today are continually exposed to new ideas from television and radio. As a result, "ideational factors," as well as economic and social changes, have led a growing number of couples to want smaller families. The mass media have helped make family planning a household word rather than a taboo subject. With the song "Choices," Onyeka Onwenu and King Sunny Ade in Nigeria spread the concept of deciding to avoid pregnancy.
and provides community outreach, distributes condoms, and notifies the sexual partners of infected people (1). (See Population Reports, Controlling Sexually Transmitted Diseases, 1-9, June 1993.)

Providing Better Services

The international family planning movement has always emphasized high-quality services, but many programs still have far to go in making these services a reality. "I am convinced that all program managers are committed to providing high-quality service," Haryono Suyono, leader of Indonesia's National Family Planning Coordinating Board, has written. However, this commitment is often challenged, particularly when program resources are limited" (64).

Although measuring quality and its effect on contraceptive use may be difficult, family planning providers still face the challenge of designing and implementing high-quality services for their clients (14, 20, 182, 216, 233, 239, 249). "The success of family planning programs ultimately hinges on their ability to meet the individual needs of a spectrum of potential clients" (2).

Some aspects of care can be improved at the service delivery level. Judith Bruce and Anrudh Jain suggest using operations research to test different service delivery approaches. Program managers should examine their program's mission statement, the standard of care that the program wants to offer, and whether the program is prepared to offer that standard of care. Research should assess whether clients are receiving the intended level of care and what impact this care has, in both the short run and long run (20). Respectful treatment and adequate privacy during counseling and procedures, for example, may not cost much to provide.

Other aspects of high-quality care require changes at the policy level. For example, involving more women in policy-making at all levels of program planning and management is needed "both for reasons of equity and to ensure the success of policies" (193). Involving women in policy-making also is important to ensuring that programs serve women's interests as well as national interests. "There is little possibility of enhancing women's situations, serving their needs," Bruce contends (19).

5 Communication improves use of family planning by creating awareness, increasing knowledge, building approval, and encouraging healthy behavior.

Communication

Information, education, and communication (IEC) activities bring people and family planning programs together. Communication activities give people the information they need to make informed choices about using and continuing to use contraception and about other aspects of reproductive health. In family planning, as in many other development activities including health and agriculture, communication campaigns create awareness, increase knowledge, and build public approval of new ideas and practices (166).

Learning About Family Planning

Family planning use depends on people's private decisions and actions. These decisions involve individuals, couples, families, and even peer groups. It is not enough for service providers to know about family planning; rather, all of the people involved in making family planning decisions, and especially women, need accurate and full understanding (31, 190).

People receive many contradictory messages about sexual behavior and contraceptives that complicate the messages of family planning campaigns. Also, what many people think they know about family planning is wrong. Thus the need for accurate communication is urgent and continuous.

People obtain information about family planning both from the mass media and through interpersonal communication. Radio and television reach millions of people even in remote areas and are a powerful influence on opinions, attitudes, and behavior (24). People also hear about family planning in schools, social programs, and communities. Even community theater has brought family planning topics to rural people who lack access to radio and television (7).

Interpersonal communication, whether among family members and friends or between service providers and clients, plays an important role in people's decisions about family planning, helping people decide whether, when, which method, and how to use family planning. After exposure to mass media coverage of family planning, people typically discuss family planning with friends or relatives, or they make contact with a provider promoted in the mass media, such as a clinic, a CBP worker, or a telephone counselor.

Communication Campaigns

In family planning programs, communication campaigns play many roles. They make people aware of modern con-
planning. Family planning communication can take advantage of
cultural changes in Peru. The play debunked common rumors about family
planning because it reaches people everywhere, speaks with emotion, depicts role models, and illustrates the consequences of behavior (125).

Engaging, focused. To help people choose healthy behavior, communication must be engaging, relevant, and credible. Communication through entertainment—such as songs, soap operas, dramas, and dances—effectively promotes family planning because it reaches people everywhere, speaks with emotion, depicts role models, and illustrates the consequences of behavior (125).

Successful communication campaigns require focus, both as to audience and as to message. This focus is best achieved through careful planning based on audience research. Communication must suggest to specific audiences both what to do and how to do it. Communication campaigns use audience research to identify audiences, design messages, and choose media that will reach the audiences, and to monitor impact. It is important to test messages with members of the intended audience to ensure that messages are engaging and meaningful (24, 29, 129, 166, 246, 247, 249).

The most effective family planning communication addresses specific groups. For example, in Bangladesh a communication campaign was designed to address rural men because research found that men strongly influence women’s reproductive choices and that many men resist family planning (103). In Tunisia the national family planning program addresses young people who are about to marry or who have just married to inform them about the benefits of birth spacing (215). In Zimbabwe a multi-media campaign that focused on educating men about contraceptive use made a substantial difference (129, 246). Following the campaign, 81% of men exposed to the campaign adopted more positive attitudes about participating in family planning; 55% talked to their wives about family planning; 14% visited a family planning service; and 7% began to use contraception (128, 129).

Communication and Fertility Decline

Once considered a support service, communication is now recognized as a key factor in the rapid increase in contraceptive use during the past two decades (21, 25, 95, 110, 161, 176). Analysis of family planning program effort in 35 countries shows a close relationship between communication effort and the percentage of couples using modern contraception (174). Separate analyses of DHS data from Ghana (116), Nigeria (9), and Kenya (205) show that, among women with otherwise similar socioeconomic characteristics, more exposure to family planning messages in the mass media is linked significantly to more contraceptive use.

Unlike previous generations, which did not have direct and instant access through the mass media to the rest of the world, most couples today are exposed constantly to new ideas. These “ideational factors,” as well as economic and social changes, have led a growing number of couples to...
want smaller families and to use modern contraception to achieve that goal (25).

The potential for fertility declines in developing countries has been underestimated because many studies have neglected the impact of the rapid diffusion of ideas (44). "Interest in smaller families and in family limitation does not necessarily appear suddenly as an unambiguous rational decision of large masses of people," Ronald Freedman and Deborah Freedman have observed (48). Rather, interest in family planning spreads from one socioeconomic group to the next and from the cities to the rural areas throughout a country, depending on available communication channels. These patterns suggest the importance of mass media and communication campaigns in speeding the diffusion of new attitudes about reproduction and thus in speeding the adoption of contraception.

Motivated, well-trained providers deliver family planning services better.

Well-Trained Providers

Family planning programs that train their staff well are better equipped to meet the needs of their clients. Technical training in clinical procedures and knowledge of contraceptive technology are fundamental to safe and accessible delivery of family planning services. Training in interpersonal communication also is essential to the quality of services.

Training Improves Access

Training many providers in technical skills helps family planning programs offer services widely (105). Depending upon the services that they will provide, some family planning providers can be trained in a few days, but retraining and continuing supervision are essential to maintaining skills. Even successful workers can learn new skills to improve services.

Proper technical training enables paramedical personnel and others without formal medical education to deliver clinical family planning services safely (105). Many studies, some conducted as early as the 1960s, have shown that specially trained nurses, midwives, and paramedics can insert IUDs and perform voluntary sterilization as safely as physicians (52, 170).

Continuing education or refresher training keeps providers up to date on contraceptive technology. Introducing new methods such as injectables and Norplant depends on training providers both in technical information and procedures and in how to present the methods to clients.

Training Improves Quality

Programs that offer high-quality services use training to motivate providers and build their counseling and interpersonal communication skills (118). A conference on family planning counseling held in Istanbul in 1992, sponsored by AVSC International and attended by representatives of 25 countries, recommended that, to improve the quality of care through better training:
- Family planning counseling should become part of medical and nursing school curricula;
- Interpersonal communication skills should be incorporated into on-the-job training for all health workers and volunteers;
- Staff members with formal training in counseling should be given responsibility for providing on-the-job orientation of other staff members (3).

On-site training in counseling should be offered because service providers come to their jobs with widely different personal characteristics, attitudes, and expectations that affect their ability to provide care (70). On-site training helps providers to become aware of their own biases and to respect the client's interests and needs (31). Such training also can promulgate a procedure for counseling, such as the GATHER approach (98), that is flexible enough to meet individual needs but also provides a standard for high-quality care.

Increasingly, family planning programs recognize the importance of training to empower staff members, improve morale and interpersonal skills, and offer exposure to new ideas. For example, in 1988 Ogun State, Nigeria, began short-term training in counseling skills as part of the family planning certification curriculum for nurses (86). In 1991 Ain Shams University in Egypt created a specialty in family planning, apart from the regular ob-gyn program, so that family planning service providers would be better motivated and have a better professional image. About 40 service providers received the degree in the first two years (216). Also, Turkey is now incorporating counseling training into the medical school curriculum (3).
Evidence of the Impact of Training

Although few studies have been conducted that carefully measure how training family planning providers affects client satisfaction, evaluations of training programs demonstrate that training has improved services and helped to attract more clients. In Chad, for example, after providers received training in service delivery, they offered more services than before, helping to increase the number of clients substantially (157). Following a regional training program in West Africa, nurse tutors nearly tripled their scores on a test to measure reproductive health skills. Six months later site visits confirmed that the trained nurses performed better as clinical trainers (83). Counselors in Brazil, Colombia, Honduras, and Mexico improved their understanding of the principles of informed consent and counseled clients more skillfully after participation in AVSC training workshops (5).

A study of the Ogun State, Nigeria, training program found that nurses who participated in the program performed better than other nurses in all the areas of training—interpersonal relations, counseling, information giving, and encouraging continued use. Their clients were more satisfied as a result. Some 84% of clients of the specially trained nurses returned for follow-up visits compared with only 44% of clients of other nurses (86).

Toward Comprehensive Training

In the long run, countries should develop a comprehensive training program in family planning to improve their ability to mobilize and use human resources effectively (105). A comprehensive system should include both preservice and in-service training for all types of clinicians, including physicians, nurses, midwives, and other technicians. It should include training in interpersonal relations for all service providers who advise and counsel clients. It also should include training for managers, supervisors, logistics officers, financial officers, and others involved in the management of family planning programs. Training should be competency-based and include not only workshops but also such approaches as supervisory checklists, refresher training, and problem-solving teams of staff members and managers.

In-service training for these nurses in Mexico keeps them up-to-date and sharpens their skills. A comprehensive training program includes both in-service and preservice training for all providers.

In successful programs strong leadership and strategic management define goals, attract resources, build support, overcome obstacles, and adapt to change.

Program Leadership and Strategic Management

Family planning programs differ greatly in structure and organization, but most successful programs have strong and stable leadership. Without consistent leadership a family planning organization has little chance of success. Because they have limited resources to meet widespread demand for contraception, all program leaders must be strategic managers. They must decide not only what is desirable but also what is possible.

Almost by definition, successful programs are those in which program leaders have made the right decisions and have overcome the obstacles facing them. These leaders have remained in charge of their programs long enough to put into effect the strategies that they have developed. Most important, they have been able to extend services to the less educated and poor members of society, who are a majority in most countries and who would otherwise have little access to family planning. In the past decade many family planning programs have improved their strategic management abilities (21, 109).

Program Leadership

Family planning leaders play many roles. They generate enthusiasm, promote innovation, build support, mobilize bureaucracies, and inspire workers (60). Dynamic leadership can "make inadequate resources do more than anyone can reasonably expect" (231). Also, convinced that "family planning is good for the individual, the family, the country, and the world" (263), leaders are persuasive advocates for family planning.

Leadership helps explain the success of Profaamilia in Colombia. Despite many obstacles, Profaamilia has continually expanded its services and attracted new clients. Observing widespread unsatisfied demand for family planning, in 1965 Fernando Tamayo, a physician, started Profaamilia on a small scale with a clinic in Bogotá. Through continuing and committed leadership and hard work, he and his staff attracted funding, developed political support, confronted opposition, developed new services such as clinics for men, and sought opportunities to provide more services (169). Today Profaamilia operates about 50 clinics, and an estimated 60% of Colombian couples who use modern contraceptive methods obtain them from Profaamilia (148).

Tamayo has been said to have three important leadership qualities: first, "an activist, problem-solving orientation"; second, "the belief that it is possible to implement a family planning program...regardless of political and economic impediments"; and, third, and probably most important, the "ability to set up an organization in which he was able to inspire his staff with his commitment and motivate them,"
educated and urban couples and are extending services to goals, devise activities to accomplish their goals, and take in family planning is rising, and family planning programs of mobilizing all the political, economic, social and other methods, based on a scheme developed by John Stover (35).

Currently, most countries with family planning programs are in Africa. Services are limited, and contraceptives are little used except by the small group who are urban and educated. Many African countries are now reaching the "launch" stage, however, where popular interest in family planning is rising, and family planning programs make more headway. Countries in the "growth" stage, such as Bangladesh, Kenya, and Morocco, have reached most educated and urban couples and are extending services to meet growing demand. In recent years an increasing number of countries, including many in North Africa, Latin America, and the Caribbean, have reached the last two stages in the USAID scheme; they focus on maintaining widespread service delivery while improving the quality of services and becoming less dependent on external donors (35).

Another classification scheme, by Alan Keller and colleagues at the United Nations Population Fund (UNFPA), identifies four stages (84). In the first stage, where prevalence is below 20%, the top priority is to legitimize family planning. In the second stage, where prevalence is 20% to 35%, programs rapidly expand services, often using community-based distribution and social marketing, and make services more acceptable and accessible. In the third stage, where prevalence is 36% to 50%, programs extend services to remote areas, improve quality—by providing more choice of methods, for example—and serve other groups as well as married couples. In the fourth stage, where prevalence exceeds 50%, programs have met much, although not all, of the need for family planning, and their mission is chiefly to improve quality and assure continued funding.

Indonesia offers an example of how experienced leaders can strategically shift emphasis over time to anticipate the changing climate for family planning services. Indonesia’s family planning program has seen three phases in its development: expansion, maintenance, and institutionalization. In the first phase the program emphasized strong promotion and provision of family planning, at times making the strategic decision to extend the reach of services rather than to improve the quality of services, try to become more efficient, and work to assure continued financing.

Recent reviews have defined similarly the stages of growth of family planning programs. The Family Planning Services Division of the Office of Population, USAID, has identified five stages classified by prevalence of modern contraceptive methods, based on a scheme developed by John Stover (35). These five stages are: Emergent, where prevalence of modern contraceptive use is below 8% of married women of reproductive age; Launch, where modern method prevalence is 8% to 15%; Growth, at 16% to 34%; Consolidation, at 35% to 49%; and Mature, where at least 50% of couples use modern contraceptive methods.

Stages of program development. Despite different settings, most family planning programs pass through similar phases. As programs have developed, successful leaders have adjusted their strategies in similar fashion to respond to changing circumstances (35, 84, 201).

At the beginning, when contraceptive prevalence is low, programs seek legitimacy for family planning. As they develop, they first concentrate on rapidly expanding access to meet the latent demand. Then they turn to reaching more of the rural areas and hard-to-reach groups. Then they improve the quality of services, try to become more efficient, and work to assure continued financing.

Leadership has been key elsewhere, too. Haryono Suyono has provided stable leadership to the successful national family planning program in Indonesia for many years. In Thailand Somsak Varakamin, who led the government national family planning program, and Mechai Viravaidya, who guided a private-sector effort to promote family planning and to provide community-based contraceptive distribution (CBD), "each conveyed a sense of enthusiasm and competence that impressed the international community and was contagious within Thailand" (112).

Strategic Management

Successful family planning program leaders practice strategic management. They focus on the long term, set clear goals, devise activities to accomplish their goals, and take a flexible, pragmatic approach (60). They are skilled in "the art of mobilizing all the political, economic, social and other resources of a nation" to build programs (176).

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Currently, most countries with family planning programs in the "emergent" stage are in Africa. Services are limited, and contraceptives are little used except by the small group who are urban and educated. Many African countries are now reaching the "launch" stage, however, where popular interest in family planning is rising, and family planning programs make more headway. Countries in the "growth" stage, such as Bangladesh, Kenya, and Morocco, have reached most educated and urban couples and are extending services to meet growing demand. In recent years an increasing number of countries, including many in North Africa, Latin America, and the Caribbean, have reached the last two stages in the USAID scheme; they focus on maintaining widespread service delivery while improving the quality of services and becoming less dependent on external donors (35).

Another classification scheme, by Alan Keller and colleagues at the United Nations Population Fund (UNFPA), identifies four stages (84). In the first stage, where prevalence is below 20%, the top priority is to legitimize family planning. In the second stage, where prevalence is 20% to 35%, programs rapidly expand services, often using community-based distribution and social marketing, and make services more acceptable and accessible. In the third stage, where prevalence is 36% to 50%, programs extend services to remote areas, improve quality—by providing more choice of methods, for example—and serve other groups as well as married couples. In the fourth stage, where prevalence exceeds 50%, programs have met much, although not all, of the need for family planning, and their mission is chiefly to improve quality and assure continued funding.

Indonesia offers an example of how experienced leaders can strategically shift emphasis over time to anticipate the changing climate for family planning services. Indonesia’s family planning program has seen three phases in its development: expansion, maintenance, and institutionalization. In the first phase the program emphasized strong promotion and provision of family planning, at times making the strategic decision to extend the reach of services rather than to improve the quality of services, try to become more efficient, and work to assure continued financing.

Leadership has been key elsewhere, too. Haryono Suyono has provided stable leadership to the successful national family planning program in Indonesia for many years. In Thailand Somsak Varakamin, who led the government national family planning program, and Mechai Viravaidya, who guided a private-sector effort to promote family planning and to provide community-based contraceptive distribution (CBD), "each conveyed a sense of enthusiasm and competence that impressed the international community and was contagious within Thailand" (112).
quality, so that no one would be denied family planning services for lack of resources. As contraceptive prevalence rose, the program entered the maintenance phase. The focus shifted to expanding the range of available services. Now, in the third phase, contraceptive prevalence has reached 50%, and the program believes that communities and individuals should play a greater role in obtaining and paying for family planning (65).

In no country, developing or developed, is the family planning program self-sufficient in the sense that the commercial marketplace meets all of the demand for family planning (60). Even in countries with “mature” programs, where the commercial sector serves many people, many others cannot afford to pay the full costs of contraception, and the public sector continues to play an important role. In most developing countries, providing family planning is seen as a valuable service that government should provide or subsidize. (See Lesson 10, Financial Resources, pp. 23–25).

Family planning programs that analyze their performance improve their performance.

Research and Evaluation

Research and evaluation have guided the development and expansion of family planning programs for the past 30 years. Research is not just measurement but also a state of mind in which programs continually examine the assumptions that underlie their objectives, design, and implementation. Only through research can programs find and adopt successful approaches to delivering services.

Three major types of research have benefited family planning programs: pilot projects and experiments, of which the best known is probably the Matlab project in Bangladesh; survey research; and operations research including project evaluation.

Pilot Projects and Experiments

Most successful national family planning programs started on a small scale. Pilot projects and experiments have provided a low-risk means of testing new approaches (218). They have yielded important lessons about service delivery (32, 46).

When countries have tried to launch ambitious large programs immediately at full scale, these programs typically have existed more on paper than in the field. Large programs that cannot deliver promised services lose credibility among intended clients and family planning personnel (126, 210). In contrast, in a small program satisfied users spread the word about family planning and encourage wider use, helping the program to grow (44). Also, a program that delivers on its promises wins advocates for family planning, who can help obtain the resources needed to expand services. Successful small programs typically attract the interest, funding, and donor assistance that they need in order to expand (93). As they grow, they apply the lessons learned from experience to become successful large programs (52).

In the 1960s and 1970s small studies and field experiments paved the way for the successful larger national programs in Indonesia, South Korea, and Thailand (44). Probably the best reported example of starting small and building on lessons learned, however, is the Family Planning Services Project in Matlab, Bangladesh, which began in 1977.

The Matlab project. The Matlab experiment and its extension to the national level have demonstrated that, by making a choice of contraceptives accessible to most people and by emphasizing direct personal communication between service providers and people in their communities, programs can raise contraceptive prevalence and reduce fertility rates among poor, rural people with little formal education. In this pilot project the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR.B) introduced special family planning services, along with maternal and child health services, to residents of some villages in the Matlab subdistrict, a rural area typical of much of Bangladesh. The project was designed so that researchers could compare the experimental villages with an otherwise similar set of villages that received only the usual government family planning services. After the initial design proved to have little impact, the project in 1977 began offering intensive services that corrected for deficiencies in the initial approach.

In the experimental villages, young, married, literate, high-status women, trained as field workers, offered a range of contraceptive choices to women and provided information, counseling, and regular follow-up visits (124). Within 18 months of offering services in the experimental villages, contraceptive use rose from less than 7% to more than 30%, while in the comparison villages contraceptive use rose hardly at all (134).

There were doubts that the resource-intensive Matlab approach could be incorporated successfully into the national family planning program because of the large costs involved (110, 123). When the ICDDR.B Extension Project tested the Matlab approach in other subdistricts as part of the regular government family planning program, however, contraceptive prevalence also rose dramatically in those areas (134).
Since then, Bangladesh has incorporated lessons learned from the Matlab Extension Project into its national family planning program (23).

More recently, in Bangladesh, the Jiggasha approach to providing family planning has been developed using extensive baseline research, communication studies, and other qualitative and quantitative measurement. Jiggasha began in 1989 in Trishal, a typical rural subdistrict. In this approach, government family planning field workers and rural community members use traditional communication networks and techniques of community participation to provide modern contraceptive information and supplies. Survey research has demonstrated that the program has increased awareness and use of family planning in Trishal while enabling the field worker to use her time much more efficiently (112, 206).

The Bangladesh family planning experience suggests that, "without any form of governmental duress, the poorest societies in the world, and ones with life expectancies no higher than 50 years, can achieve contraceptive prevalence rates above 50% and total fertility rates below four" (22).

### Comparative National Surveys

Much of what we know about fertility levels and trends, contraceptive use, and reproductive attitudes and intentions in the developing world comes from four comparative national survey programs, initiated and supported chiefly by USAID, that have been conducted in the 1970s, 1980s, and 1990s. These are the World Fertility Survey (WFS), the Contraceptive Prevalence Surveys (CPS), the Demographic and Health Surveys (DHS), and the Family Planning Surveys (FPS). In the past 10 years the DHS and FPS have interviewed more than 300,000 women of reproductive age, constituting nationally representative samples, in over 50 countries. Recent surveys also have interviewed men.

These surveys have provided data on contraceptive use, reproductive attitudes, demand for family planning, child health, AIDS, and related topics (115). The findings have helped many programs to understand people's reproductive desires, and to estimate demand for family planning, and to identify groups especially in need of services.

Surveys have shown that in most countries contraceptive use has been rising but that large potential demand for contraception remains (see pp. 6-7). (See Population Reports, The Reproductive Revolution: New Survey Findings, M-11, December 1992.)

### Operations Research and Evaluation

Applying analytic techniques to program activities—operations research—has provided a rational basis for introducing many key innovations and improvements in family planning programs. Family planning programs benefit most from such research when:

- The questions raised are important, substantive, and relevant;
- Information is collected and analyzed regularly and guides all stages of program development;
- Many types of information, including survey data and service statistics, are used; and
- Qualitative data—for example, measures of client attitudes—as well as quantitative data are used.

Surveys serve a wide variety of important purposes for family planning programs, from measuring national levels of contraceptive prevalence to pre-testing messages, as shown here in Bolivia.

Some of the lessons learned that are described in this report are the findings of research and evaluation. These include:

1. Adding new contraceptive methods to a program increases contraceptive use (see Lesson 3, Choice of Contraceptive Methods, p. 10);
2. Trained family planning personnel other than physicians, midwives, and nurses can deliver services safely and effectively (see Lesson 6, Well-Trained Providers, p. 17);

Research has played an important role in the introduction and adoption of community-based distribution (CBD) (see Lesson 2, Access, p. 10) (57, 106). Many experimental studies have demonstrated that family planning services can be provided outside of clinics (52). As program managers have recognized that CBD is effective and politically acceptable, they have become willing to increase the scope of CBD programs (218).

Research should be built into family planning programs from the beginning, when the opportunity to organize for data collection is greatest, but programs that have not included research strategies in their planning still can benefit from operations research (218, 226, 237, 240, 246, 250, 256, 257, 262). If decision-makers can participate in research design from the start, and if they are trained to understand research findings, they are most likely to use the results (218, 260). Research design should include plans for dissemination of findings as well as for collection and analysis.

**Project evaluation.** Virtually all family planning programs benefit from evaluating their operations. Programs evaluate their activities both during the course of operations, to help managers improve operations (process evaluation), and also at the end of projects, to derive lessons for future use (impact evaluation) (15). Measuring how program activities affect client behavior such as clinic attendance, contraceptive use, and continuation rates is particularly valuable. Increasingly,
programs are developing qualitative indicators of performance in addition to such familiar quantitative indicators as the contraceptive prevalence rate (CPR) and couple-years of protection (CYP) (15).

At the same time that objectives for a project are being set, indicators to measure the attainment of these objectives should be established. Even if evaluation is not included in the design, however, some programs can be evaluated using the information that they routinely collect about their service activities for administrative purposes.

The Need for Contraceptive Methods Research

Research on contraceptive methods also is important, because having more and better methods responds to people's needs. (See Lesson 3, Choice of Contraceptive Methods, pp. 10-11.) While a range of effective methods is currently available, more people could meet their changing needs throughout their reproductive lives if even more methods were developed.

For example, interest is growing in developing a new generation of spermicides that protect against HIV and other STDs. Also needed are new methods such as more postcoital contraceptives, other methods that protect against both pregnancy and STDs, and more methods for men in addition to condoms and vasectomy, according to respondents to the Population Reports questionnaire. Respondents also recommended that research should improve existing contraceptive methods, making them more convenient to use, reducing side effects, and lowering costs.

New Poster Available!

For advocates of family planning, a new poster proclaims, "Family Planning Helps Everyone." Produced by Population Reports for the International Conference on Population and Development in Cairo, September 1994, the poster illustrates how family planning helps women, children, men, families, nations, and the world.

Copies of the poster are available, free of charge to readers in developing countries, from:

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Political commitment supports and strengthens family planning programs.

Political Commitment

Most family planning programs need political support to operate successfully (226, 231, 241, 246, 247, 251, 256, 268). In Thailand political leadership transformed a pronatalist government policy into a remarkable family planning success story (12). In Indonesia the strong personal commitment of President Soeharto has been a key to making the family planning program a national movement from the highest levels of government to virtually every village (65, 113, 224). In Zimbabwe an Act of Parliament in 1985 created the Zimbabwe National Family Planning Council, with an annual grant of government funds to support the program. The importance of this support was recognized internationally when President Robert Mugabe received the 1989 Soeharto Global Statesman in Population Award (246).

The existence of an official policy or statement of government support, however, does not guarantee effective action (210, 250, 254). For example, Pakistan has had a national population policy since 1960, but frequent changes in government personnel and a lack of high-level support for family planning have held back the program (110). Despite substantial international donor support, family planning has received low priority from the government, and thus it has been difficult to operate an effective national program (226).

In some countries where political leaders have not actively supported family planning, they have given tacit approval and created a climate of tolerance, enabling nongovernmental organizations, international donor agencies, and the private sector to meet the rising popular demand for family planning (240, 263). For example, in some Latin American countries contraceptive use has become widespread without strong population policies or government family planning programs (214, 270). While the governments of Costa Rica and Mexico have provided strong support for family planning, governments in Argentina, Brazil, Chile, and Colombia have been reluctant to provide contraception, partly because of opposition from the Catholic Church. In these countries the impetus for providing family planning came first from the medical profession and then from family planning associations (110).

Assuring Supply, Endorsing Demand

Political commitment is needed both to assure the availability of contraceptives and to endorse the rising demand for them (123, 210). On the supply side, political commitment must be translated into adequate resources and budgets (21, 233, 234, 265). Also, favorable policies, laws and regulations must exist so that couples have the legal right to obtain contraception and so that contraceptives can be imported, manufactured, and distributed (76, 215, 250).

On the demand side, statements of support from national leaders and favorable publicity in the national mass media can help to develop a public consensus for family planning (249, 265, 269). In a family planning program's early stages, strong endorsement from prominent national government leaders
can stimulate community leaders, professional groups, and other opinion-leaders to discuss issues in public that previously were considered too sensitive or personal (219, 226, 248).

When political leaders publicly and explicitly recognize and endorse family planning, they confirm to the public that using contraception is acceptable and desirable (222, 259). Unless there is latent popular demand for family planning, however, programs are unlikely to succeed even if leaders strongly support and promote them. When political leaders promote family planning in the absence of latent demand among the people, programs can become overzealous, frequently with counterproductive results as people resist being pressured. In most countries latent demand for family planning is great, however. In these countries leadership support confirms that it is acceptable for people to use family planning.

Leaders and Their People

National leaders tend to reflect the opinions and attitudes of their people. At the same time they provide an example for people to follow. In a society that is unreceptive to change, so are most leaders. In societies that are changing, however, opinion-leaders tend to be innovative (165). In these countries strong political commitment to providing family planning both reflects the rise of new popular attitudes toward reproduction and helps to diffuse new reproductive behavior (45, 165, 198).

Thailand provides an example. For the past 30 years the country has been changing rapidly. For example, in 1965 only 6% of villages had access to electricity; in 1980, 36%. The provincial road system expanded from less than 3,000 kilometers in 1965 to nearly 20,000 in 1984. Thailand’s government was once pronatalist, as late as 1956 offering couples bonuses for having large families. Then, in 1970, the government changed course and began to promote family planning widely. Most Thais welcomed the change. For example, in focus-group discussions many Thais spontaneously expressed approval of the government’s new family planning policy (89).

The most effective family planning programs operate where governments have a commitment not only to providing family planning but also to improving people’s lives in other ways (45). Better child survival, women’s education, and improved living standards may create more demand for family planning and facilitate delivery of high-quality family planning services. As programs in East Asia have demonstrated, political commitment to family planning most often leads to a rapid rise in contraceptive use when combined with strong support for other economic and social development activities (94).

Financial Resources

Financial support is crucial to the success of family planning programs. Experience shows that the funding level helps determine the extent of progress toward the ideal of universally available contraception, with a variety of service delivery approaches, and a wide range of methods (84, 176). In reality, however, many programs today have too little money to meet the current demand for services.

Virtually all family planning programs seek to make contraceptives available to clients either free of charge or at easily affordable prices. In developing countries as a whole, contraceptive users pay only about 10% of the total cost of family planning. International donor agencies, such as the United States Agency for International Development (USAID), pay about 15%. Since the early days of family planning in developing countries, financial and technical assistance from USAID has played a major role in providing access to contraceptive information, supplies, training, and services (17). Still, developing-country governments pay about 75% of family planning costs (93, 192). (See Population Reports, Paying for Family Planning, Series J, No. 39, November 1991.)

Government and Donor Commitment

The financial support that a government commits to family planning is a measure of its political commitment. Allocating money in the national budget makes an even stronger—and
Challenges and Opportunities

Challenge 1: Meeting Unmet Need
As a greater proportion of people want to control their fertility, and as the population of reproductive age grows larger, family planning programs face accelerating demand for services (see p. 6).

Challenge 2: Serving Youth
Not just new services but also new attitudes, new policies, and new approaches are needed to meet the reproductive health needs of young people (see p. 7).

Challenge 3: Adopting a Reproductive Health Care Approach
Family planning programs seek to address a wider range of reproductive health care needs, such as safe childbirth and control of sexually transmitted diseases (see p. 13).

Challenge 4: Finding Adequate Funding
Meeting existing and future demand for services requires more support for family planning and reproductive health programs from national governments and international donor agencies (see pp. 23-25).

Paying for Family Planning

Without free or subsidized family planning services, most people in developing countries would be unable to afford the full costs of using modern contraception. The average person in a developing country would spend 4% to 6% of annual income to purchase one year's supply of oral contraceptives or condoms at full market prices, whereas in the developed world, despite much higher prices, the average person would spend only 1% of annual income (21). The full cost of an IUD insertion or a voluntary sterilization also is much more than most people in developing countries can afford at one time (130).

Research shows, however, that most people, even those who cannot afford the full costs of contraception, are willing to pay something for family planning services that meet their needs (100). Even when free services are available, some prefer to purchase services because they appreciate quality, because they mistrust the motivation behind the offer of free services, or because of convenience (100, 173). Although sometimes small, commercial markets for contraceptives exist in virtually all countries. In some countries contraceptives also are sold by retail outlets at subsidized prices through social marketing programs (see Lesson 2, Access, p. 10).

The Indonesian national family planning program has demonstrated that, as more people use contraception, the private sector can play a greater role in supplying it. In 1987 the KB Mandiri (self-reliant family planning) program was begun in order to increase the number of contraceptive users who buy their services from private-sector providers. The government's "Blue Circle" campaign has promoted the services of private-sector family planning providers, identified with a blue circle logo, and has supplied them with contraceptives so that users have to pay only for services (65). Within four years after the start of the KB Mandiri program, more than 8,000 "Blue Circle" midwives and physicians were providing family planning services in urban centers throughout the country (142). The percentage of users who receive their services from private sources rose from 12% in 1987 to 22% in 1991. Also, the percentage of contraceptive users who pay some fee for their services rose from 36% in 1987 to 62%, although often the fee paid is a fraction of the full cost of contraceptive supplies and services (34).

Concerned about the rising cost of paying for family planning, some donor agencies are calling for developing countries to make their programs more self-sustaining. If donor aid declines, however, government subsidies must rise, or more of the responsibility for providing health and family planning services must shift to private health care practitioners and commercial outlets, and consumers must bear more of the cost (130). Such shifts could decrease access to contraceptive information and services and mean poorer services for millions of people. In the quest for sustainability, advises

more consequential—statement of support for family planning than adopting a population policy or making speeches exhorting people to use family planning. Although most governments officially support family planning, funding for family planning programs averages less than 1% of developing-country budgets, according to the United Nations Population Fund (176). While in some cases family planning is a substantial share of a country's health budget, other expenditures consume far more resources. Military spending, for example, averages 19% of total developing-country budgets (93).

Government budgetary and financial support from international donors work together to multiply total family planning program resources. Bangladesh is an example (23). Both the Government of Bangladesh and international donors have dramatically increased financial support to the national family planning program over the past 20 years. The government commitment rose from US$7 million in 1972-73 to $41 million in 1982-83 and to $100 million in 1992-93 (8). Support from international donors rose from about $55 million in 1987-88 to about $100 million in 1990-91, most of it from USAID and the World Bank (158).

Often, donor support acts as a catalyst to government action. For example, in Kenya donor financing since 1983, including some US$60 million from USAID, has enabled Kenya's national family planning program to back up its policy commitment to family planning with expanded and improved services, which have made possible the rapid rise in contraceptive prevalence (38).

While donor support has played an important role in providing family planning to millions of people, donors could be playing a greater role. "Family planning successes have been bought with a small slice of the development dollar," a World Bank report observes (21). In 1990 population assistance by the 18 major donors constituted just 1.2% of development assistance, a smaller share than in the 1970s (110).
Some countries where contraceptive use is already widespread may be able to shift more of family planning costs to users without reducing use, but countries where the demand for contraception still is rising rapidly must depend on public support. Even where contraceptive use is widespread, family planning programs, not the commercial marketplace, make it possible for most couples to practice family planning. Even in countries with strong economies, many people lack access to the cash economy and thus cannot purchase family planning services. Women, who are the vast majority of family planning clients, often lack their own financial resources, have restricted access to household money, or have little say in household spending decisions.

For family planning to become more widely available, governments must continue their commitment to provide free or subsidized family planning services for those who need them. Many agree that governments and donors must continue to provide most of the funding for family planning programs in the 1990s (21, 80, 186, 226, 229, 231, 257, 331).

Meeting the Funding Challenge

How can family planning programs generate the funding needed to support and sustain family planning services throughout the 1990s? Can programs assure high-quality services for all who want and need them now and in the future?

Most developing-country governments have found it difficult to increase family planning budgets because their economies are under pressure and they have many other development needs (43, 267). Meanwhile, donor contributions to family planning programs declined in real purchasing power during the 1980s (56). While donor contributions are rising again, most donor countries face many other demands for development assistance as well as for population assistance (21).

Government funding and donor support for family planning programs in developing countries currently amount to about US$4 billion per year (21, 93). If contraceptive prevalence is to rise from the current level of about 50% to 65%, government and donor financial support would need to equal about $6.2 billion annually (33). The draft Program of Action of the International Conference on Population and Development (ICPD) estimates that satisfying all need for family planning would raise contraceptive prevalence to nearly 70% by 2015. The cost of family planning programs in the developing countries would be about $14 billion (in 1993 US$) (191, 194). Even a small shift in donor spending priorities could go a long way to assuring funding that would meet the rising demand for family planning and reproductive health services (130, 176). The draft Program of Action for the ICPD estimates that external assistance for family planning programs will need to rise to US$6 billion in 2015 (194). At the International Forum on Population in the 21st Century, sponsored by the United Nations in Amsterdam in 1989, the international community agreed that donor support for population programs should rise from just over 1% to become 4% of overall development assistance (30).

Donor population assistance budgets are being pressed to support not only family planning but also other social needs. For the past 30 years, however, the evidence has mounted that effective service delivery is key to client satisfaction and to widespread contraceptive use (196). Thus donors should maintain their focus on supporting delivery of high-quality family planning services. At the same time, family planning programs and other programs that focus on women, the environment, health, and other social development issues should cooperate as much as possible; progress in each area reinforces the others (36, 61, 112, 196, 231).

Governments, both in developing countries and in donor countries, provide family planning for various reasons—as a health measure, as a human right, to improve the situation of women, in response to popular demand, and to lower fertility and slow population growth for economic and environmental reasons. People everywhere want family planning to improve their lives. Substantial public commitment to family planning programs has improved the lives of millions and has aided national development in many countries over the past 30 years. If family planning programs help even more people to meet their own reproductive health needs in coming years, the benefits to society will grow.

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