Trends in National Family Planning Programs, 1999, 2004 and 2009

CONTEXT: *National family planning programs in the developing world vary greatly in strength and coverage, and in the nature of their outreach. Periodic measures of their types and levels of effort have been conducted since 1972.*

METHODS: *In 2009, expert observers in 81 developing countries completed a questionnaire that assessed 31 features of family planning program effort, as well as other program measures. Data were compared with those from similar surveys fielded in 1999 and 2004 to examine trends over the decade.*

RESULTS: *On average, national family planning programs improved their effort levels slightly from 1999 to 2004, and again from 2004 to 2009. The average effort in 2009, however, was only about half of maximum; component scores for service measures and for measures of access to contraception did not reach 50% of maximum in 2009. Differences by region and by effort quartile emerged in subgroup analyses. Overall, improvement of women's health and avoidance of unwanted births were the most important program justifications, ranking higher than fertility reduction, economic development or reduction of childbearing among unmarried adolescents. The subgroups given the most emphasis were poor and rural populations, while unmarried youth and postabortion women received the least. Among external influences, changes in donor and domestic funding were seen as more unfavorable than the merging of family planning programs into broader health services.*

CONCLUSIONS: *Average program effort levels have been sustained, although deficiencies remain. Countries have not yet ensured universal access to a variety of contraceptive choices, through various channels, for both short- and long-term methods.*

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National programs to provide family planning to large populations began in the mid-1960s and have since been established in most developing countries. Assessments of the types and levels of effort of such programs were first conducted in 1972, followed by periodic repetitions in 1982, 1989, 1994, 1999, 2004 and 2009.[1–3] This unique series, termed the Family Planning Effort Index, helps to evaluate the national family planning programs that serve about 90% of the developing world's population.

The original idea of the index was to capture separate features of countries' national family planning programs as independent variables that could be related to such outcomes as changes in contraceptive use and fertility. In each cycle, ratings are produced for individual family planning program features and averaged to provide a single score for each of four dimensions of effort and for overall effort. The index measures inputs, not outcomes, and has been used for causal analysis, to tease out the effects of programs independent from those of the social settings of which they are a part. Individual scores have been used by major donors and agencies to set country priorities and to gauge progress. In addition, they have been used to diagnose program weaknesses, to advocate for program strengthening and to show gains that could result from improvements.

BACKGROUND

An effective national family planning program has certain key characteristics, such as the provision of a variety of contraceptive methods to the general population through a variety of channels. It should use field staff and the mass media to educate the public about methods and where to obtain them. It should employ such outreach approaches as postpartum contraceptive counseling and services, community-based distribution and social marketing. To energize the health bureaucracy to implement program elements, policies at the central level should be clear and supportive, and be accompanied by adequate training, supervision and logistics.

The 1999, 2004 and 2009 assessment cycles occurred during the period of the Millennium Development Goals (MDGs), adopted under United Nations (UN) auspices to heighten attention to eight priority objectives for international advance.* A strong case has been made that family planning can not only advance progress toward most of

*The eight goals are to eradicate extreme poverty and hunger; to achieve universal primary education; to promote gender equality and empower women; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria and other diseases; to ensure environmental sustainability; and to develop a global partnership for development. Each goal is monitored by a set of detailed measures. Detailed information is available at <http://www.un.org/millenniumgoals/bkgd.shtml>.

these goals, but can do so cost-effectively.[4–7] An increase in contraceptive use can lead to declines in child mortality and in maternal mortality (MDGs 4 and 5), not only by preventing unplanned pregnancies and unsafe abortions, but also by modifying the mix of pregnancies to avert those that are at highest risk, thus lowering average death rates.[8–10] MDG 5 also includes full access to reproductive health care, as well as increased contraceptive use and the reduction of unmet need for contraception. Against that background, the index has been an important resource to monitor national activities to improve access to contraceptive methods throughout the developing world; in recent decades, it has been the only source of repeated measures on a uniform set of program characteristics.

This article presents the first analysis of the 2009 assessment and uses those data, as well as data from the 1999 and 2004 cycles, to examine trends over the decade.

DATA AND METHODS

Each cycle of the index surveyed experts in each participating country who were judged to be knowledgeable about the nature and strength of program features. To obtain insight from different perspectives and professional backgrounds, four types of respondents were sought: program staff, usually in the Ministry of Health; local staff of nongovernmental organizations; resident staff of international agencies; and staff of local academic or research organizations. We wanted 10–15 respondents for each country, but preferred having fewer to including persons with only limited national knowledge.

In 2009, respondents from 81 developing countries were surveyed, representing 93% of the developing world and including all of the largest countries and the largest ones within each region. Experts were sought from all countries with populations of more than one million, excluding those that have essentially disbanded their national programs because of plummeting fertility rates, as well as a few middle-income countries with relatively low fertility rates. Other countries were omitted because of nonresponse after repeated contacts. The number of countries represented in 2009 was similar to that in previous cycles (87 in 1999, and 83 in 2004).

The questionnaire asked respondents to rate their country's national family planning program on 31 aspects of effort, such as involvement of government agencies and use of mass media;* respondents also gave ratings for three related subjects: justifications that drive the program, special populations that receive high priority and external influences that act on the program. Ratings for all items were on a scale of 1 (very weak or no effort) to 10 (very strong effort), except for the item for influences, which was measured on a scale from −5 to +5. Respondents were instructed not to rate any item for which they lacked adequate information. In total, across all countries, 95% of all questionnaire items were filled in. Missing entries were omitted in calculations of country averages. The degree of respondent agreement was measured by the standard deviation of respondent ratings on each item in each country. No particular score showed an unusual degree of variation, and the average standard deviation among the 31 scores was 2.1 within the 10-point scale for each item.

During data entry, all ratings were entered into a master spreadsheet that permitted measures of variation across items and respondents, as well as checks for outliers that required queries to be sent back to the country. Ratings were averaged across respondents and then converted to percentages of the maximum score to allow easier comparisons. Although past experience shows that the best-performing countries have scored at only about 80% of this maximum, it is useful to retain the 100% figure for consistency with past reports. The 31 program items were organized into four components: policies (8), services (13), evaluation (3) and access to methods (7).

Changes in Methodology Across Cycles

This report covers the index cycles for 1999, 2004 and 2009, a decade of experience during which the study methodology has been consistent, except for a few modifications that reduced costs and shortened the data collection and processing time for each cycle. In 1999, a 125-item questionnaire was fielded; items were coded and combined to produce 30 ratings, each representing a feature of national family planning programs. That year, respondents also completed a shorter and simpler form that asked for a single rating for each of the 30 items. Results from the two forms were generally consistent,[11] so only the short form was used in 2004 and 2009.

For the 2004 cycle, the methodology for respondent selection changed from one in which experts in each country were identified and contacted from a central location to one in which they were identified and contacted by a trained local study manager selected for each country. Although the use of country managers was intended to identify capable, unbiased individuals, it is not possible to know the extent of their effect on the reporting process other than to improve compliance by the respondents.

The 2004 round also added an item measuring access to the injectable, increasing the number of items from 30 to 31. In addition, three new elements to gauge the importance of competing justifications for family planning programs, measure emphases on special subgroups in the countries and explore changes in external influences on the national programs. These were retained in the 2009 round and have helped to clarify the place of family planning programs in the evolving context of the HIV/AIDS crisis, changes following decentralization of national health systems and the greater emphasis on broader reproductive health concerns.

Subgroup Analyses

Subgroup analyses were conducted with the 2009 data to compare item scores across regions and between specific groups of countries. We were particularly interested in

*The individual effort items are listed in Table 4.

Sub-Saharan Africa, because it has the highest fertility rates and lowest contraceptive use rates,[12,13] as well as the lowest program effort ratings in our studies, especially on actual access to contraceptive methods. In addition, it suffers from the greatest burdens of HIV and AIDS, and the most severe poverty indicators.[14]

To tease out differences within the region, we divided Sub-Saharan Africa by francophone and anglophone countries, and by those that receive aid under the United States' President's Emergency Plan for AIDS Relief initiative (PEPFAR) and those that do not.* PEPFAR was initiated in 2003 with a commitment of $15 billion over five years to address the global HIV crisis; in 2008, the U.S. Congress approved up to $48 billion over five years for an extension of the program. The funds themselves are divided between treatment and prevention in varying ratios depending on the country. PEPFAR was never designed to advance family planning activities, which were explicitly excluded from its funding and programs of action, and funds from other sources grew very rapidly for HIV/AIDS, while those for family planning did not. Given the size of those commitments and the competition they posed to attention to family planning (and other health ministry programs), it is important to monitor the strength of the associated family planning programs in the countries affected.

We were also interested in examining how—apart from their higher averages—stronger programs differ from weaker ones in their profiles across the 31 ratings. To explore that question, we divided the 81 countries that participated in the 2009 cycle into quartiles by their total score for that year. The top three quartiles consisted of 20 countries each, while the fourth consisted of 21.

Finally, we conducted further subgroup analyses among countries that had once received technical and financial support from the U.S. Agency for International Development (USAID), but had ceased to after their programs were judged to have become stable and relatively successful. These "graduated" countries are of special interest because they present an opportunity to trace how programs fare after the termination of major external support. We examined the family planning programs of the nine graduated countries with available information,† using the survey cycles most closely preceding and following termination of support.

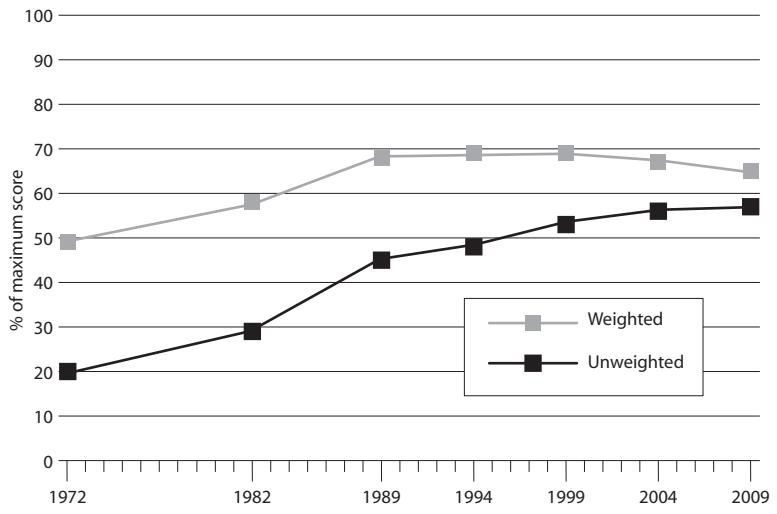
RESULTS

Trends in Total and Component Scores

The average total score across all features among all countries rose from 53% of maximum in 1999 to 56% in 2004 and 57% in 2009 (Figure 1). When the figures are weighted by population size, however, the trend is toward decreasing scores over the decade (from 69% to 65%). That is, the rating pertaining to the average person has fallen, primarily because of declines in a few of the largest countries (as well as the exclusion of a few countries that had high scores in previous years). For example, scores fell between 1999 and 2004, and again between 2004 and 2009, in Bangladesh, Mexico, Nigeria and Pakistan (not shown). The score for Ethiopia—the second most populous African country—declined from 1999 to 2004, but recovered in 2009; scores for Brazil, China and Indonesia fell between 1999 and 2004, but then held steady in 2009.

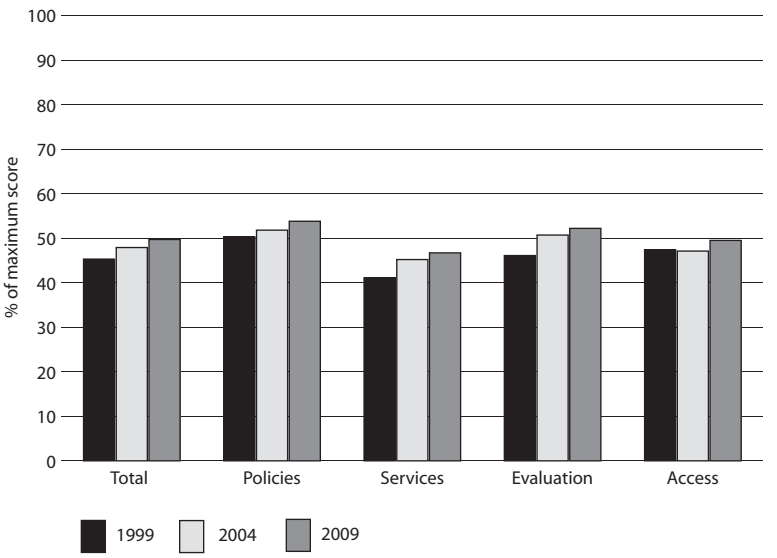
For the 61 countries that were included in all three surveys, the average total score increased about two points from 1999 to 2004, and another two points from 2004 to 2009

FIGURE 1. Unweighted and weighted family planning effort scores as percentage of maximum possible score, 1972–2009



Note: Weighted scores use country population size.

FIGURE 2. Total score and mean scores on four components of national family planning effort as percentage of maximum possible score, by survey year



Note: Based on data from the 61 countries that were included in all three surveys.

*The 2009 family planning effort study included only nine of the 13 Sub-Saharan African countries in the PEPFAR program: seven in anglophone countries and two in francophone countries. The latter group, with only two countries, was too small to permit a separate analysis.

†Brazil, Colombia, Costa Rica, Ecuador, Indonesia, Mexico, Morocco, Thailand and Turkey.

(Figure 2). The 2009 average score was just at half of the maximum level; however, as mentioned previously, even the best programs score only about 80% of the maximum, so the 2009 average is about two-thirds of that more realistic ceiling.

Each of the four component scores increased over the decade: policies by four points, services and evaluation by six points each, and access by two points. Services showed the largest gain (14%; not shown), but it had the lowest initial level of the components, and remained below 50% of maximum. Access to contraceptives did not improve in 2004, but did in 2009; it also remained just below 50% of maximum. (The similarity of the pattern across components is reassuring regarding the study methodology, considering that the studies were five years apart with mostly different respondents.)

Differences by Region

Large differences in program effort existed across regions (Table 1). In 2009, Asia had the highest total score (61% of maximum), followed by the Middle East and North Africa (57%). The anglophone and francophone Sub-Saharan African regions scored quite low at 43% and 45%, respectively. In fact, more than two-thirds of the whole region scored below 50%, and the largest country, Nigeria, scored only 34% (not shown). Latin America's average was also low (46%), partly because many services there are nongovernmental, while the questionnaire is oriented to the government program or another single large-scale program.

Policy scores were especially strong in Asia and in the Middle East and North Africa (68% and 59% of maximum, respectively), but were much weaker elsewhere. Even so, scores for policies rated well above those for services, reflecting the relative ease of establishing policies compared with that of developing and extending services to reach most of the general population, in both villages and urban slums. Scores for evaluation were also consistently above those for services.

Finally, for access to methods, Latin America had a much higher score (51% of maximum) than would be indicated by its other scores, likely because of the important role of the private sector in that region. Sub-Saharan Africa had the lowest score by far on this component, just 40–41% for both subregions, with the other regions at 51–57%.

With 1999 as a baseline, over the entire decade, effort declined slightly in Asia, not only for the total score, but also for policies, evaluation and access, while it rose somewhat for services (Table 2).* Each of the other regions improved over the period, although after 2004, anglophone Sub-Saharan Africa improved only slightly overall and, in fact, declined in services and evaluation. On the other hand, the total score for francophone Sub-Saharan Africa improved impressively, rising seven points over the decade. The flat trend in family planning services in the anglophone countries may reflect the competition with HIV and AIDS services, because HIV prevalence there is among the continent's highest.[13]

When we look at the 61 individual countries included in the three most recent index cycles, some countries with poor scores in 1999 have since moved upward, toward the

TABLE 1. Total score and mean scores on four components of national family planning effort as percentage of maximum possible score, by region, Family Planning Index Survey, 2009

Program effort	Asia	Middle East/ N. Africa	Latin America	Sub-Saharan Africa	
				Anglophone	Francophone
Total	**60.7**	**56.7**	**45.8**	**43.0**	**45.4**
Policies	68.4	58.9	48.4	49.5	50.7
Services	59.9	53.7	40.4	40.0	43.2
Evaluation	62.7	63.8	49.3	46.1	50.1
Access	52.6	56.7	51.1	39.9	41.4

Note: Based on data from 81 countries.

TABLE 2. Total score and mean scores on four components of national family planning effort as percentage of maximum possible score, by region, according to survey year

Program effort	1999	2004	2009
Total	**45.3**	**47.9**	**49.7**
Asia	55.0	55.8	53.8
Central Asia	44.3	49.1	53.3
Middle East/North Africa	47.9	50.2	54.0
Latin America/Caribbean	43.8	46.3	49.0
Sub-Saharan Africa			
Anglophone	44.1	47.1	47.3
Francophone	38.8	42.0	45.6
Policies	**50.3**	**51.8**	**53.8**
Asia	62.4	61.3	58.8
Central Asia	45.3	50.0	54.7
Middle East/North Africa	50.6	60.2	58.3
Latin America/Caribbean	47.5	47.3	50.7
Sub-Saharan Africa			
Anglophone	52.6	51.7	53.0
Francophone	42.9	46.0	51.6
Services	**41.1**	**45.2**	**46.7**
Asia	49.9	53.5	52.1
Central Asia	40.1	44.8	49.1
Middle East/North Africa	43.6	44.5	49.7
Latin America/Caribbean	37.7	43.1	45.6
Sub-Saharan Africa			
Anglophone	40.9	45.6	44.2
Francophone	37.2	40.7	43.2
Evaluation	**46.1**	**50.7**	**52.2**
Asia	58.0	54.6	54.4
Central Asia	39.6	50.8	59.7
Middle East/North Africa	50.6	53.8	62.2
Latin America/Caribbean	42.2	50.8	50.6
Sub-Saharan Africa			
Anglophone	41.1	49.4	47.4
Francophone	45.8	46.5	48.7
Access	**47.4**	**47.1**	**49.5**
Asia	54.5	53.9	51.1
Central Asia	54.6	56.4	56.9
Middle East/North Africa	52.2	47.2	53.4
Latin America/Caribbean	52.7	49.4	52.7
Sub-Saharan Africa			
Anglophone	41.1	42.9	46.5
Francophone	33.5	37.5	41.8

Note: Based on data from the 61 countries that were included in all three surveys.

*Data presented in Table 2 differ from those presented in Table 1 because Table 2 includes only the 61 countries that participated in all three cycles.

TABLE 3. Total family planning effort scores as percentage of maximum score, by Sub-Saharan group and receipt of PEPFAR aid, 2009

PEPFAR	Score	Non-PEPFAR	Score	Total mean
TOTAL	45.7	TOTAL	45.6	45.6
Anglophone	**45.4**	**Anglophone**	**47.6**	**46.7**
Nigeria	33.6	Liberia	34.8	
Zambia	44.6	Eritrea	37.9	
Ethiopia	45.3	Sierra Leone	41.1	
Tanzania	47.0	Ghana	46.4	
South Africa	48.0	Swaziland	46.7	
Kenya	48.7	Malawi	47.8	
Uganda	50.4	Lesotho	50.0	
		Gambia	50.3	
		Zimbabwe	59.9	
		Mauritius	60.6	
Francophone	**46.8**	**Francophone**	**44.1**	**44.5**
Mozambique	39.2	Mauritania	21.0	
Côte d'Ivoire	54.4	Congo, D.R.	34.3	
		Benin	35.1	
		Chad	36.7	
		Burundi	40.2	
		Cameroon	41.4	
		Congo	44.8	
		Burkina Faso	45.6	
		Guinea	46.2	
		Senegal	47.5	
		Niger	55.0	
		Mali	61.4	
		Madagascar	64.0	

Notes: PEPFAR is U.S. President's Emergency Plan for AIDS Relief initiative. Countries listed by ascending size of total effort score.

middle, while others with top scores have declined over the decade, also toward the middle. The result is a convergence of scores: The standard deviation for scores has diminished, the 25th percentile score has risen and the interquartile range—the difference between the values found at the 25th and 75th percentiles—has lessened (not shown).

Differences Within Sub-Saharan Africa

Within the anglophone group, the PEPFAR countries' average score was 45% of the maximum, somewhat below the rating of 48% for the non-PEPFAR countries (Table 3). Scores for the two groups largely overlap. At the low end, Nigeria (34%) is matched by Liberia and Eritrea (35% and 38%, respectively); the non-PEPFAR group has the two outliers at the high end: Zimbabwe and Mauritius (60% and 61%).

The average family planning effort scores for the entire PEPFAR and non-PEPFAR groups were equal (46% each); however, those averages should be approached with caution, because most PEPFAR countries are anglophone. Mozambique and Cote d'Ivoire are the only representatives of the francophone PEPFAR group, and their scores fall well within those of the non-PEPFAR francophone group, which range from 21% for Mauritania to 64% for Madagascar.

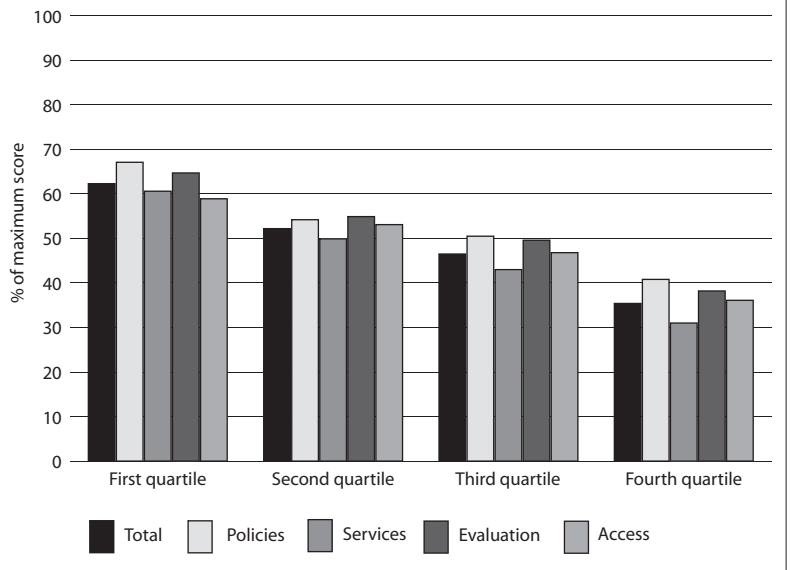
A more telling comparison within the anglophone group concerns the types of effort (not shown). The PEPFAR group was decidedly weaker than the non-PEPFAR group in two field outreach ratings (community-based distribution and postpartum programs), in five separate ratings of program implementation (involvement of the civil bureaucracy in support of the program, strength of the administrative structure, training, logistics and staff performance of assigned tasks), as well as in five of the ratings for access to methods (male and female sterilization, the pill, the IUD and safe abortion). Condom access is a prominent exception: For this indicator, the PEPFAR countries scored much higher, reflecting their stronger anti-HIV programs.

The full anglophone and francophone groups differed in ways that mirror the above features. The francophone group was weaker than the anglophone group on every item listed above, except for access to contraception. The mean score for the full anglophone and francophone groups were 47% and 45%, respectively; the lower average for the francophone countries was because of the low mean score for its non-PEPFAR members (44%). Differences among the individual means in the four cells were not large, but were consistent with the above, given the quite substantial country differences.

Program Comparisons by Quartiles

The program score quartiles differed greatly by total score: from a low of 35% to a high of 62% of maximum effort (Figure 3). By overall component scores, the groups seem to agree in what they stress most, as each quartile is strongest in policies and evaluation, and weakest in services and access. The top quartile, however, was stronger for particular components, with its largest advantages among administrative placement of program leadership, favorable statements by government officials, civil bureaucracy support, community-based distribution, social marketing, postpartum contraceptive services, workers making home visits, logistics and supervision of staff (not shown). The bottom

FIGURE 3. Total score and mean scores on four components of national family planning effort as percentage of maximum possible score, by quartile, 2009



Note: Based on data from 81 countries.

TABLE 4. Changes in median percentage of effort score between surveys before phase-out and after phase-out of USAID support

Program effort	Change
Total	**6.2**
Policies	**5.8**
Government's official policy or position concerning fertility/family planning and rates of population growth	0.0
Favorable statements by leaders	20.0
Level of family planning program leadership	5.4
Age-at-marriage policy	10.5
Import laws and legal regulations regarding contraceptives	12.7
Advertising of contraceptives in the mass media allowed	6.9
Other ministries/government agencies involved	6.0
In-country budget for program	45.2
Services	**1.1**
Involvement of private-sector agencies and groups	5.1
Civil bureaucracy used	12.7
Community-based distribution	0.0
Social marketing	2.2
Postpartum programs	10.7
Home-visiting workers	–2.0
Administrative structure	13.6
Training programs	0.0
Personnel carry out assigned tasks	0.0
Logistics and transport	–2.0
Supervision systems	3.0
Mass media for information, education and communication	6.7
Incentives and disincentives	9.5
Evaluation	**9.9**
Record-keeping systems	4.3
Program evaluation	9.3
Management use of evaluation findings	6.0
Access	**4.8**
Male sterilization	–0.1
Female sterilization	–3.8
Pills	4.8
IUD	5.6
Condoms, diaphragms and spermicides	0.0
Safe abortion	1.3

Notes: Based on data from nine countries. One effort item, access to the injectable, is not included, because it was not included separately in all the cycles. USAID=United States Agency for International Development.

quartile was particularly weak on certain scores and was well below the two middle groups in terms of most of the features listed above. In addition, it was very weak in program funding, with most of budget coming from outside donors, and suffered from low ratings on training, task completion by staff and administrative structure. The scores on the 31 items for the two intermediate quartiles showed similar patterns, with the second quartile consistently higher. In general, however, these two quartiles fell about halfway between the top and bottom ones.

In summary, the top quartile scored highest on nearly all of the ratings (29 of 31) and the bottom quartile scored lowest on all 31. The gaps between the two groups varied, however, revealing the kinds of effort that especially differentiate strong from weak programs.

"Graduated" Countries

Among countries that had their USAID assistance phased out after their programs were judged to have become stable and relatively successful, their effort scores improved after "graduation," on average (Table 4). The median total score for the nine countries rose by six percentage points; scores for three of the four components rose (policies, by six points; evaluation, by 10 points; and access to methods, by five points), while the services score remained basically stable. All the averages, however, mask important variations.

The dominant pattern across countries was that, following graduation, scores for individual items improved at the central level, but less so in field operations. All eight policy scores improved, especially the share of funding provided by local sources, which reflects the withdrawal of USAID support. For services scores, there were central-level improvements (i.e., assistance from the civil bureaucracy, administrative structure, use of mass media, import laws and legal regulations, and rules governing the advertising of contraceptives), but there was very little change in field outreach (i.e., community-based distribution, social marketing, home visiting and task implementation) or in supervision, training and logistics. An exception is the change for postpartum programs, which may have been helped by their urban locations. All three evaluation items—each of which is centrally administered—showed improvement. The six access scores showed negligible improvement, except for the pill and the IUD. The change in scores varied across countries (not shown), as did the actual levels before and after phase-out.

Central changes were made more readily than changes in the field. Overall, however, these programs survived and improved after the termination of many years of foreign assistance.

Future Prospects

Whether national programs will continue the upward trend of effort that the average country experienced between 1999 and 2009 depends in some measure upon four additional considerations, which were included in the surveys: the balance among competing justifications that drive the programs, the choice of which special populations should receive the most effort, the impact of external influences that act on the programs and the quality of the programs (Table 5).

Among program justifications, improving women's health and avoiding unwanted births rated the highest overall in 2009 (83% each), along with reducing unmet need for contraception and improving child health (78% each). These rank considerably above the reduction of population growth (70%), the advancement of economic development (69%) and, unexpectedly, the reduction of childbearing among unmarried adolescents (63%). However, there was substantial variation by region: For example, Asia placed greater stress on reducing population growth and fostering economic development (80% and 74%, respectively) than did Latin America (30% and 43%) or Sub-Saharan Africa (anglophone, 59% and 64%, respectively; and francophone, 51% and 63%); however, those regions emphasized maternal and child health

(75–85%) and avoidance of unwanted births (79–85%).

Overall, the poor and those living in rural areas are special populations that received emphasis within programs (67% and 70%, respectively), perhaps because both exist in very large numbers and both tend to be important concerns of public programs. Postpartum outreach ranks below those (59%), followed by postabortion outreach (52%), with unmarried youth receiving the least emphasis (38%). Again, there are regional differences. Although the Asian ratings closely follow the overall averages, Latin America—which is heavily urban—ranks lower than the overall average for rural populations (54%) and higher for unmarried youth (51%). Central Asia, with high abortion rates, focuses more upon postpartum and postabortion activities (75% and 69%, respectively). The Middle East and North Africa region gives lower than average emphasis to unmarried youth (29%), while that population receives special emphasis in anglophone and francophone Sub-Saharan Africa (45–53%), where premarital sexual activity and fertility are high.

In terms of influences acting on the programs, by far the lowest ratings go to changes in both donor funding and domestic funding (–4% and 14%, respectively). The low averages conceal the distributions of ratings, which fell heavily upon the negative side, that is, most individual ratings were below zero. Those results echo the widespread perception that funding specifically for family planning has not kept up with inflation or has fallen in absolute terms. The strongest positive influences were programs' incorporation into broader reproductive health and their integration with other health services (54% and 49%); moving toward decentralization was considered a weaker influence (32%). Interestingly, the influence of HIV and AIDS programs was positive (39%); however, a sharp contrast exists within Sub-Saharan Africa between anglophone countries—with their greater HIV/AIDS burdens—and francophone countries (16% vs. 51%). Other regional differences included the weaker influences in Latin America of decentralization and of integration with and incorporation into broader health and reproductive health services; the latter two are considered important in Central Asia.

The quality of the programs was explored in a single questionnaire item, which asked the respondent to rate the general quality of family planning services, where good quality included a focus on client needs, with counseling, full information, wide method choice and safe clinical procedures. The overall rating was moderate (54%), and there was little variation by region (45% in Latin America to 61% in the Middle East and North Africa).

TABLE 5. Mean scores for additional program considerations as percentage of maximum possible score, by region, 2009

Program consideration	All	Asia	Central Asia	Latin America/ Caribbean	Middle East/ North Africa	Sub-Saharan Africa	
						Anglo-phone	Franco-phone
Justification							
Reduce population growth	69.8	80.0	30.2	29.9	66.5	59.1	51.2
Enhance economic development	69.2	74.4	67.8	43.0	66.6	63.9	63.1
Reduce unmet need	78.2	80.6	80.1	79.3	69.0	71.5	67.2
Reduce nonmarital adolescent childbearing	62.7	63.3	80.5	62.8	39.6	63.1	76.3
Improve women's health	83.3	83.2	91.1	83.3	82.6	82.2	84.6
Improve child health	78.0	77.0	87.5	75.4	80.8	80.1	83.4
Avoid unwanted births	83.3	84.3	86.5	84.9	78.8	78.8	79.8
Emphasis on special populations							
Poor	66.8	71.4	50.9	66.4	63.7	49.7	49.1
Rural	70.0	76.6	59.9	53.5	72.5	51.4	48.1
Unmarried youth	38.3	34.8	59.1	50.5	28.5	45.2	52.9
Postpartum women	59.0	59.8	74.6	56.9	63.1	48.5	58.9
Postabortion women	52.2	52.6	69.1	53.0	45.9	47.3	55.3
Influence							
Changes in donor funding	–3.7	–5.0	32.2	–2.7	–5.9	–6.9	4.4
Changes in domestic funding	14.2	15.4	33.7	–1.7	22.3	11.3	12.5
Decentralization	31.7	32.7	25.9	9.8	34.3	44.9	34.0
Integration with other health services	49.1	48.9	73.1	38.3	52.5	50.6	54.2
Incorporation into reproductive health	54.1	54.9	73.2	49.8	49.1	51.7	53.4
HIV/AIDS programs	38.7	41.7	54.2	33.2	34.4	15.6	51.2
Quality	53.8	56.0	51.5	44.8	60.8	45.6	48.6

Notes: Based on data from 81 countries. All scores weighted for regional populations. Negative scores indicate detrimental effects.

DISCUSSION

National family planning programs, established by country governments or large nongovernmental organizations over the last half-century, are common across the developing world. Reasons for their creation have varied, but the most common justifications are mainly demographic or health-related, usually a mixture of the two.

The record captured in family planning effort scores from 1972 through 2009 is mixed. While the average national score has been increasing over time, the 2009 level was only a modest 57% of maximum, so there is substantial room for improvement. Nevertheless, the average did not decline, despite reduced funding, greater diversification of health systems and the competing demands of the HIV and AIDS epidemic.

The average is somewhat higher when weighted by population size, reflecting the relatively high scores of China, Indonesia, Bangladesh and other large countries. Although higher, that average has moved slightly downward over the longer term, partly reflecting the withdrawal from the study of some countries with high scores that attained replacement fertility and ended their traditional programs, as well as declining scores for a few of the largest countries. In 2009, the weighted average was at about two-thirds of maximum, which is somewhat more favorable when measured against the standard of about 80% achieved by the strongest programs.

The averages, however, conceal major disparities. A few large countries and some smaller ones scored well, while other large ones—such as Pakistan, Nigeria and Ethiopia—scored far lower. In Sub-Saharan Africa, the scores of more than two-thirds of countries were below half of the maximum, and that of the largest country, Nigeria, was only 34%. Of particular concern for this region is the poor

record of actual access to contraceptive methods for most of the population, because poor access precludes contraception adoption. Further, the examination of scores by particular items for blocks of countries highlights the need for a better diversification of effort, as shown in the comparisons of countries by quartile and by anglophone, francophone and PEPFAR differences. All these contrasts show the importance of looking beneath the total score to understand the detailed character of effort.

The efforts of national programs are clearly lagging behind the demand for services. Desired family sizes have fallen over the years across the developing world,[15] and neither the public nor the private sector has kept up with the rising need for contraceptive provision. Surveys consistently show that substantial proportions of births are unwanted or mistimed.[16] Infants are born closer together than desired, and short birth intervals have been associated with an increased risk of child mortality. Measures of unmet need have fallen in some countries but remain high overall, and wanted fertility rates are well below actual rates in most countries. Finally, the resort of women to unsafe abortion testifies to the failure of national programs and the private sector to make contraceptive access and information broadly available to the general public.

To address the large gaps between desired and actual family sizes, and the unmet need for contraceptive use, national and state governments have numerous options. The energies of the private sector can be assisted by removing restrictions on the importation and local manufacture of contraceptives, reducing or removing customs duties and other taxes that discourage private provision of medical services and contraceptive supplies, and permitting unrestricted advertising in the media.

Every developing country can do more to create an environment in which its entire population—not just married couples, but also unmarried persons (including adolescents)—has ready access to a variety of contraceptive methods. Most programs are quite selective in the methods they choose to make accessible and the channels through which they can be obtained. Some country differences are inevitable, but greater use of neglected methods and channels can pay dividends. There continue to be opportunities for expansion of outreach with the continuing shift of populations to cities and the increasing proportions of births that are professionally attended; they increase, for example, the potential to provide postpartum contraceptive services through private as well as public facilities. There are important submarket needs for family planning for new arrivals in city slums and intermittent users among mobile populations.

Program planning can benefit by addressing large disparities by province or state. In some large countries, such as India and Indonesia, the national total fertility rate (TFR) has fallen impressively, but fertility remains high in large subregions.[17,18] For example, Uttar Pradesh and Bihar have TFRs of 3.8 and 4.0, respectively—the highest of all Indian states—and only 29% of couples in each state use a modern method.[18]

As an overview, the record of increasing family planning efforts over the last several decades documents the historic emergence of large organized programs to put contraceptives into the hands of whole populations. A remarkable feature of that record is the strengthening of programs in the lowest-scoring countries, to create convergence of effort at an intermediate level of roughly half of maximum. This trend toward convergence is likely to continue, because as the highest scoring countries move to and below replacement fertility, they tend to dilute or terminate their programs. Closer convergence will also occur if weaker programs continue to improve, and if there are improvements in the programs already at moderately high levels, the average level will continue to rise.

To bring such improvements about, action rests primarily with the countries themselves, with a sharper appreciation of the extent to which the prevention of unwanted births relieves pressure on other health and economic sectors. International and regional agencies also have critical roles to play, and monitoring mechanisms such as these effort indicators can help to allocate resources, diagnose program shortfalls and identify cost-effective means to strengthen programs.

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RESUMEN

Contexto: *Los programas nacionales de planificación familiar en el mundo en desarrollo varían enormemente en esfuerzo y cobertura, así como en su alcance. Desde 1972 se han conducido análisis periódicos de los niveles de esfuerzo de dichos programas.*

Métodos: *En 2009, observadores expertos en 81 países en desarrollo completaron un cuestionario que evaluó 31 características del esfuerzo de los programas de planificación familiar, así como otras medidas programáticas. Los datos se compararon con los obtenidos en encuestas similares aplicadas en 1999 y 2004 para examinar las tendencias a lo largo de la década.*

Resultados: *En promedio, los programas nacionales de planificación familiar mejoraron ligeramente sus niveles de esfuerzo de 1999 a 2004 y, de nuevo, de 2004 a 2009. El puntaje (que mide el nivel de esfuerzo) promedio en 2009, sin embargo, fue solamente cercano a la mitad del máximo; en 2009, los puntajes de los componentes que miden los servicios y el acceso a la anticoncepción no llegaron al 50% del valor máximo. En los análisis por subgrupo, surgieron diferencias por región y por cuartil de puntaje de esfuerzo. En general, el mejorar la salud de las mujeres y evitar los embarazos no deseados fueron las justificaciones más importantes de los programas, aún más importantes que el reducir la fecundidad, fomentar el desarrollo económico o bajar las tasas de fecundidad en adolescentes solteras. Los subgrupos que recibieron mayor énfasis fueron las poblaciones pobres y rurales, mientras que las jóvenes solteras y las mujeres en etapa de postaborto recibieron el menor énfasis. Entre las influencias externas, los cambios en el financiamiento de donantes y del gobierno nacional se percibieron como más desfavorables que la fusión de los programas de planificación familiar con los servicios más amplios de salud.*

Conclusiones: *Los niveles de esfuerzo de los programas han sido sostenidos, aunque algunas deficiencias continúan. Los países todavía no han logrado el acceso universal, a través de varios canales, a una variedad de opciones anticonceptivas, tanto para métodos de corto como de largo plazo.*

RÉSUMÉ

Contexte: *Les programmes de planification familiale nationaux du monde en développement varient largement en termes de force, de couverture et d'approche. Des mesures périodiques des types et niveaux d'effort déployé sont effectuées depuis 1972.*

Méthodes: *En 2009, des observateurs experts de 81 pays en développement ont été invités à répondre à un questionnaire d'évaluation de 31 caractéristiques d'effort programmatique de planification familiale, entre autres mesures. Les données obtenues ont été comparées à celles d'enquêtes similaires effectuées en 1999 et en 2004, dans le but d'examiner les tendances sur 10 ans.*

Résultats: *En moyenne, les programmes de planification familiale nationaux ont amélioré légèrement leurs niveaux d'effort entre 1999 et 2004, puis, de nouveau, entre 2004 et 2009. En 2009, l'effort moyen ne représente cependant qu'environ la moitié du maximum atteint. Les cotes composantes des mesures de service et de celles d'accès à la contraception n'atteignent pas 50% du maximum en 2009. Des différences régionales et par quartile d'effort se révèlent dans les analyses de sous-groupes. Dans l'ensemble, l'amélioration de la santé des femmes et la prévention des naissances non désirées sont les justifications programmatiques les plus importantes, classées avant la réduction de la fécondité, le développement économique ou la réduction de la maternité parmi les adolescentes non mariées. Les sous-groupes recevant le plus d'attention sont les populations pauvres et rurales, alors que les jeunes célibataires et les femmes après-avortement sont les moins considérées. Parmi les facteurs d'influence extérieurs, les changements survenus dans le financement national et des donateurs paraissent plus défavorables que l'amalgame des programmes de planification familiale au sein de prestations de santé plus larges.*

Conclusions: *Les niveaux d'effort programmatique moyens sont soutenus, bien qu'ils présentent encore certaines lacunes. Les pays n'assurent toujours pas l'accès universel à une variété de choix contraceptifs, à travers différents circuits, qu'il s'agisse des méthodes à court ou à long terme.*

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