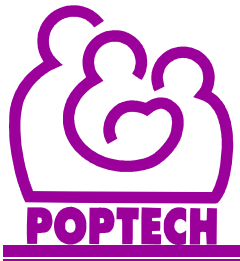

THE FAMILY PLANNING GRADUATION EXPERIENCE:

LESSONS FOR THE FUTURE

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ACRONYMS

APROFE	Asociación Pro-bienestar de la Familia Ecuatoriana (Association for the Well-Being of the Ecuadorian Family)
ASCOFAME	Asociación Colombiana de Facultades de Medicina (Colombian Association of Medical Schools)
BCC	Behavior change communication
BEMFAM	Sociedade Civil Bem-Estar Familiar No Brasil (Brazilian Society for Family Welfare)
CA	Cooperating agency
CBD	Community-based distribution
CCO	Operations Coordination Committee (Mexico)
CDC	Centers for Disease Control and Prevention
CEMOPLAF	Centro Médico de Orientación y Planificación Familiar (Medical Center for Family Planning and Counseling)
CEPAR	Centro de Estudios de Población y Desarrollo Social (Center for Studies in Population and Social Development)
CEPEO	Importação e Comercio de Insumos Farmaceuticos, Ltda. (Importation and Commerce of Pharmaceutical Products, Ltd.)
COESPO	Consejo Estatal de Población (State Population Council, Mexico)
CONAPO	Consejo Nacional de Población (National Population Council, Mexico)
CSM	Contraceptive Social Marketing
DHS	Demographic and Health Survey
FEMAP	Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario (Mexican Federation of Private Health and Community Development Association)
FP	Family planning
FPLM	Family Planning and Logistics Management Project
GDP	Gross domestic product
GH/PRH	Bureau for Global Health, Office of Population and Reproductive Health
GH/PRH/CSL	Bureau for Global Health, Office of Population and Reproductive Health, Commodities Security and Logistics Division
GWG	Graduation Working Group
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMO	Health maintenance organization
ICPD	International Conference on Population and Development (Cairo 1994)
IEC	Information, education, and communication
IMSS	Instituto Mexicano del Seguro Social (Mexican Institute of Social Security)
IMSS/RO	Instituto Mexicano del Seguro Social/Régimen Ordinario
IMSS/S	Instituto Mexicano del Seguro Social/Oportunidades
INFO	Information and Knowledge for Optimal Health Project
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
ISSSTE	Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (Institute of Security and Social Services of State Workers, Mexico)
IUD	Intrauterine device
JHU/CCP	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs
KAPS	Women's Health and Family Planning Service System (Turkey)
KIDOG	NGO Advocacy Network for Women
LAC	Latin America and the Caribbean
M&L	Management and Leadership Program
MCH	Maternal and child health
MEXFAM	Fundación Mexicana para la Planeación Familiar (Mexican Foundation for Family Planning)

MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental organization
ONFP	Office National de la Famille et de la Population (National Office of the Family and Population, Tunisia)
PRB	Population Reference Bureau
PRI	Institutional Revolutionary Party
PROFAMILIA	Asociación Pro-Bienestar de la Familia (The Family Welfare Association)
RH	Reproductive HEALTH
SOMARC	Social Marketing for Change
SSA	Secretaria de Salud (Health Secretariat, Mexico)
STI	Sexually transmitted infection
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USAID/LAC	Bureau for Latin America and the Caribbean
VDMS	Systematic motivational home visits
VFT	Vaginal foaming tablet
VSC	Voluntary surgical contraception
WHO	World Health Organization

CONTENTS

TABLES

APPENDICES

EXECUTIVE SUMMARY

The U.S. Agency for International Development (USAID) has provided family planning (FP) assistance to the developing world for over 30 years. In recent years, funding for family planning has not increased or decreased, and increases are expected to be very modest in the future. With greater demand for USAID's limited resources, The Bureau for Global Health's Office of Population and Reproductive Health (GH/PRH) needs to be more proactive in managing the graduation of countries. Guidance is needed for USAID Missions in countries likely to be candidates for eventual graduation. A Graduation Working Group (GWG) has been formed to assist in this process.

To assist the GWG, the original intent of this report was to synthesize the lessons learned from the phaseout of USAID family planning support. Seven countries were to be examined: Morocco, Turkey, Tunisia, Mexico, Brazil, Colombia, and Ecuador. However, while information and data were available for the process that led up to graduation, little or no data existed to document how successful the graduate countries were in sustaining their FP programs after phaseout. Therefore, the focus of the report was changed to document the common elements among the countries and lessons learned during the graduation process. One recommendation is that in two or three years, when additional data are available, a new report should be prepared to document the factors that appear to be important predictors of a successful graduation.

All but two of the seven countries had graduation strategies, and they were considered important to the success of phaseout. The process of developing and planning the strategy forced the countries to clearly focus their final efforts and allowed buy-in by all those involved in the process. The involvement of all the stakeholders (i.e., public, private, nongovernmental organization [NGO] and commercial sectors, other donors, and advocacy groups) in the graduation strategy process was deemed important as it capitalized upon the efforts of all the organizations and the decisions made were mutually beneficial to all stakeholders.

The best graduation plans were flexible enough to allow for changes that became necessary during the phaseout. One lesson learned from the Mexico experience was that a phaseout plan should be flexible enough to shift resources and approaches as necessary in changing political, economic, and social environments.

All four of the Latin American and Caribbean countries worked directly with NGOs to assist them in becoming sustainable. While reaching sustainability was difficult, the NGOs were able to do so through a variety of methods, including instituting user fees, developing successful social marketing programs, diversifying donor support, and collaborating with the public and commercial sectors by contracting with them to provide family planning and other services. Although the NGOs were committed to providing services to the poorest segments of the population, in efforts to reach financial sustainability, they were sometimes forced to make tradeoffs between becoming sustainable and serving the very poor.

In order to expand the availability of contraceptives and to strengthen the private sector, all of the seven countries had social marketing projects. The types of social marketing

ranged from a government operated program (Tunisia) to NGOs that began with donated products (Ecuador) to a totally commercial sector program (Morocco) to countries that had several types of programs (Turkey, Colombia, and Brazil). In six of the countries, the social marketing programs were able to continue after graduation; in Colombia, Brazil and Ecuador, they provided important revenue for NGOs. The status of the Tunisia program is not known.

The commercial sector had an important role in providing contraceptives and services in several of the countries. However, in some of the countries, government policies such as price controls, distribution of free contraceptives, and advertising restrictions created obstacles to the commercial sector in providing contraceptives. Efforts to expand the role of the commercial sector during phaseout had mixed results. For example, in Brazil, a pilot effort to encourage a large health maintenance organization (HMO) to include family planning in its benefit package failed; however, the creation of a profit-making private contraceptive supply company was successful.

All the countries worked on ensuring the availability of contraceptives after graduation. It is not known which countries have maintained successful systems for the procurement and distribution of contraceptives because of the lack of information. Based on limited information, it appears that contraceptive security may be a difficult goal to sustain. One lesson learned from the Mexico experience was that "replacing donor-funded contraceptives is one of the most challenging aspects of sustainability" (Alkenbrack, Shepherd (2004).

The countries were mixed regarding the split between having public and private sectors be the predominate provider of contraceptives and FP services. In Mexico, Morocco, Turkey, and Tunisia, the public sector provided from 60 to 75 percent of modern contraception, including sterilization. In Ecuador and Colombia, the public sector provided 27 to 38 percent of modern contraceptives. In Brazil, the public sector was the source of 43 percent of contraceptives and the private sector was the source of 54 percent. Efforts were made to increase the role of the commercial and private sectors; however, this was difficult as some of the governments did not always understand the role the private sector could have in providing FP services. This was especially true in Turkey, Morocco, Mexico, and Tunisia.

Advocacy both within the government and the NGO sector was important in most of the countries. For example, in Turkey, the public and NGO sectors worked together to bring about the procurement of contraceptives by the government after USAID's phaseout of donated contraceptives. In Ecuador, an NGO served as a strong advocate for family planning rights and their adoption as part of the Constitution.

The following issues surfaced during the writing of this report that should be addressed by the GWG when it develops guidelines for Missions.

- Rapid and complete phaseout versus phased graduation.

- Is full NGO self-sufficiency a reasonable objective if the NGO is expected to serve the poorest segment of the population?

- What is the responsibility of USAID, the host governments, other donors, NGOs, or others to maintain social safety nets? If indicators reach a certain level, does it make sense to discontinue supporting services to underserved groups?

- Can donor resources be totally replaced?

- Is method mix a problem? What priority should be placed on trying to broaden the range of methods?

Some of the key elements deemed ideal to be in place to graduate successfully are listed below. These are the ideal to work towards; all the elements may not be completely or fully realized at the time of graduation. (For a complete list, see section 5.)

- Sustainable public sector systems that deliver quality family planning services, ensure the continuation of service providers' training, and provide a reliable supply of contraceptives

- A commercial sector and a sustainable NGO sector that can provide affordable, quality services to those that can afford to pay for them

- Population policies or laws in place that support family planning

- Laws and regulations that support the ability of the for-profit and NGO sectors to provide family planning services

- Ease of obtaining low-cost contraceptives for the various FP programs

The relationship between USAID and graduate countries need not end when family planning assistance is no longer provided. The relationship should evolve into a partnership of peers. Some recommendations include providing travel grants and conference support for counterparts in graduate countries, maintaining established data banks, and providing assistance to conduct Demographic and Health Surveys (DHSs) and other special studies.

LESSONS LEARNED

1. Data and information collected from graduate countries through DHSs and other surveys can provide USAID with valuable data that can measure how successful countries are in sustaining their family planning programs. These studies may require continued support beyond graduation, as is currently being done, for example, in Ecuador (see also recommendation 11).

2. Reports on lessons learned from the phaseout of donor support on graduate countries, such as the one on Mexico, provide valuable information for planning the phaseout of USAID assistance and for understanding how family planning programs are affected after donor phaseout.

3. The time needed to develop and implement graduation strategies may be rather lengthy. Time is needed for NGOs to reach self-sufficiency, for governments to develop systems that are sustainable, and for activities to be completed and institutionalized. Graduation might be partial, with continuing support for specific activities; this may mean as long as eight or nine years.

4. All stakeholders (i.e., the public, NGO, private, and commercial sectors; other donors; cooperating agencies [CAs]; and advocacy groups) should be involved in the graduation process (i.e., planning and implementation).

5. New activities initiated during the graduation phase need sufficient time to have an impact and to be institutionalized.

6. It is necessary to clarify to governments and NGOs that USAID is serious about phasing out; the dates of graduation should not be changed unless all parties are in agreement. Everyone connected with USAID, other donors, and CAs should give consistent messages about graduation.

7. Midterm assessments during the phaseout period can be useful in validating the priorities and assumptions of the graduation strategy and recommending new activities or directions.

8. Graduation plans should be flexible enough to shift resources and approaches as necessary in changing political, economic, and social environments.

9. Initially, the NGOs in the four Latin American and Caribbean countries in this report had important roles in introducing the concept of family planning, in advocating for family planning, and in providing services to the poor.

10. A wide variety of mechanisms exists for NGOs to become sustainable; however, it is not an easy process.

11. In implementing programs to become sustainable, the client base of NGOs often shifts from the poor to the more affluent. It is unclear whether in every country some entity (e.g., the government) is prepared to take charge.

12. The attitude, management capabilities, and culture of NGOs were important in how NGOs approached sustainability and how successful they were.

13. Endowment or sustainability funds have been important in assisting NGOs to reach and maintain sustainability, although endowments are no longer permitted by USAID.

14. Social marketing programs can expand the market for contraceptives and, if successful, can become a source of income for NGOs.

15. Government policies, laws, and regulations can be obstacles for the involvement of the commercial sector in the supply of contraceptives and services and for ensuring contraceptive security.

16. The for-profit sector, under the right circumstances, can be an important provider of family planning services and contraceptives.

17. Even when political support is strong, financial commitment by governments may be difficult due to competition from other programs.

18. Planning and managing contraceptive phaseout is difficult, and organizations in both the public and private sectors need assistance in procuring contraceptives.

19. Engaging the for-profit sector in the provision of family planning services is not always easy and the graduate countries were not always successful.

20. The private and public sectors have not always agreed on the issue of contraceptive security. Governments do not always understand the important roles the commercial and NGO sectors can have in providing contraceptives. Also, they do not always understand the impact of policies that ensure the provision of free or subsidized contraceptives on the private sector.

21. Nongraduate countries need to expand the role of the private and commercial sectors in the provision of family planning services and contraceptives.

22. Advocacy within the government and NGO sectors can have an important role in obtaining government support for family planning, changing policies and laws, and ensuring the survival of family planning programs. Advocacy is an important component in any family planning program but especially in a phaseout plan. In addition, it is important to ensure that advocacy for these programs will continue after graduation.

RECOMMENDATIONS

1. Two years from now, when additional DHS and other survey data are available, reexamine the idea of determining the lessons learned from the experiences of the seven graduate countries and perhaps others as well. If GH/PRH decides to reexamine this issue, it would be useful to write two or three graduate country lessons learned reports similar to the one recently completed by the POLICY Project on Mexico.

2. Implement the recommendation in the *USAID Regional LAC Contraceptive Security Feasibility Study* that the five countries in the study develop phaseout or contraceptive security plans. Also, other countries that have not developed graduation strategies or contraceptive security plans should do so as soon as possible.

3. The Graduation Working Group should explore further the issue of the seemingly conflicting objectives of NGOs serving the poor and reaching sustainability (see also section 4.2).

4. GH/PRH should explore whether sustainability or investment funds for NGOs are feasible under current USAID regulations.

5. At least three to five years in advance of contraceptive phaseout, Missions should begin to develop and institutionalize new procurement systems to replace USAID's donated contraceptives.

6. In planning for phaseout, Missions should do the necessary analyses and support discussions among the NGO, commercial, and public sectors to identify the roles of the sectors within a whole market framework.

7. Missions need to build sustainable capacities in advocacy partners (governments, NGOs, and civil society organizations) to act as monitors after the phaseout of USAID family planning assistance.

8. For selected countries, rather than fully phasing out family planning assistance, USAID should fund limited activities in the public sector and/or the private sector that address the unmet needs of the poor, rural, or other groups.

9. Implement a graduate country initiative, as suggested in the Indonesia graduation plan, to assist USAID in maintaining contact with countries that have graduated from USAID assistance.

10. USAID should participate in maintaining the data banks of experts that have been developed by various organizations.

11. Rather than fully phasing out family planning assistance, USAID should provide limited assistance to graduate countries to conduct DHSs, reproductive health (RH) surveys, or to add RH riders to existing surveys.

12. Expand the Global Exchange for Reproductive Health activity under the Management and Leadership Program (M&L) to include all graduated countries. Include the expanded Global Exchange component in the follow-on project to M&L. Open LeaderNet to all graduated countries.

1. INTRODUCTION

1.1 PURPOSE OF REPORT

The U.S. Agency for International Development (USAID) has provided family planning (FP) assistance to the developing world for over 30 years. In recent years, funding for FP has not increased or decreased, and increases are expected to be very modest in the future. With greater demand for USAID's limited resources, the Bureau for Global Health's Office of Population and Reproductive Health (GH/PRH) needs to be more proactive in managing the graduation of countries. Guidance is needed for USAID Missions in countries likely to be candidates for eventual graduation and their backstop teams in USAID/Washington. A Graduation Working Group (GWG) has been formed to assist with this process.

The original intent of this report was to synthesize USAID's experience and lessons learned from the graduation of family planning programs from USAID assistance. Specifically, the report was to examine the factors that appeared to be important predictors for a successful graduation, the essential steps necessary to prepare a successful transition from USAID family planning assistance, and the resources, systems, and capacities that were critical for a successful graduation. Seven countries were to be examined: Morocco, Turkey, Mexico, Brazil, Colombia, Tunisia, and Ecuador.

Because of the lack of information and data about the countries after they graduated, the focus of the report was changed. Based on conversations with several members of the GWG, it was decided that common elements among the seven countries during the graduation process would be examined. Also, the report would suggest key elements that appear to be necessary for a country to graduate successfully. The lack of data and information is discussed in detail in section 2.

1.2 ORGANIZATION

The report begins with a discussion of the reasons it was necessary to change its focus. The main body of the report has four sections. The first discusses the common elements among the seven countries and includes recommendations and lessons learned from the process of implementing and developing their graduation strategies. The second section suggests issues for discussion by the GWG. The third section suggests components that a graduating country should ideally have in place to successfully graduate. The fourth section suggests postgraduate relationships that could be developed between USAID and the graduate countries.

Appendix B contains the list of key people interviewed. Brief summaries for each of the seven countries are in appendix C. Appendix D is a matrix of the countries that compares a cross section of common elements. Appendix E provides additional data for each country and appendix F contains the references.

1.3 METHODOLOGY

The team that wrote this report consisted of a POPTECH consultant and three GH/PRH staff. The team met with the GWG twice, once to go over the scope of work and again to discuss the work plan and outline for the report. The team members interviewed people in person, by telephone, and by e-mail who had knowledge about the seven countries or had additional information about the graduation process. The authors contacted as many people as possible and recognize that the numbers and types of people contacted are not as diverse as would have been ideal for this exercise.

In addition, the team collected, read, and analyzed a broad range of documents. As mentioned elsewhere, the major problem was the lack of current and reliable information and data about the countries after they had graduated.

2. REFOCUSING THE REPORT

The scope of work provided a definition to be used for a successful graduation: "Family planning service delivery continues to support the level of contraceptive prevalence achieved before graduation and inequities in access to services have not increased." Based on this definition, the report was to provide evidence that the countries had successfully (or not) graduated from USAID family planning assistance and the lessons learned from the experience. However, while data and documentation on the **process** that led up to the countries' graduating were available, there were almost no data or information that documented the impact of donor phaseout after the countries actually graduated. Therefore, there was no evidence to prove whether or not the countries were successful graduates. Thus, it followed that because the experiences during and after phaseout of USAID assistance were not known, the lessons learned, evidence, and factors that contributed to a successful graduation could not be determined.

The exception on available information was the draft report on the lessons learned from the phaseout of USAID support in Mexico. However, even the Mexico report acknowledges that the full impact of the USAID phaseout would not be known until the data from the 2003–04 DHS–type survey becomes available (Alkenbrack and Shepherd 2004). In addition, a health assessment on Ecuador included very limited family planning/reproductive health (FP/RH) information regarding Ecuador's experience since graduating in 2001. The report also stated that the full impact of what has happened in Ecuador since graduation would not be known until the latest survey data become available (Coury 2004).

As noted below, the DHSs for Morocco and Turkey were completed only a year after the two countries graduated. Therefore, it is too soon to draw any conclusions about sustainability from the data.

Based on conversations with several team members about the lack of information that could reasonably show factors that contributed to or evidence of a successful graduation, it was decided that the report would focus on the common elements among the countries during the phaseout period.

Table 1 on the following page shows the dates that the countries graduated and the latest accessible data. DHS data—while important—are not enough to understand why a country was successful. A report similar to the Mexico[1] report plus a DHS–type survey are needed to give a total depiction of what happened and why it happened after the phaseout of USAID family planning assistance. While only DHS information is shown below, USAID needs to keep track of other RH studies/surveys as well.

[1] Alkenbrack, Sarah and Carol Shepherd, *Lessons Learned for Phase-out of Donor Support in a National Family Planning Program: The Case of Mexico,* July 2004. (Draft)

Table 1
Status of DHS and Other Surveys

Country	Graduation Dates	Available[2]	Planned
Brazil	1992–2000	1995 DHS	2005 DHS
Colombia	1992–97	2000 DHS	2004 DHS
Ecuador	1992–2001	1999 DMCH Survey	2004 RH Survey
Mexico	Private 1992–98 Public 1992–99	1987 DHS	DHS–type survey in 2003–04. Results expected soon. [3]
Morocco	1996–2003	2003–04 Preliminary DHS Results (Available in French)	
Tunisia	1986–90	1988 DHS	Unknown
Turkey	Cont. 1995–99 Tech. Asst. 1995–2002	2003 DHS (preliminary results available in Turkish)	

Lessons Learned

1. Data and information collected from graduate countries through DHSs and other surveys can provide USAID with valuable data that can measure how successful countries are in sustaining their FP programs. These studies may require continued support beyond graduation, as is currently being done, for example, in Ecuador (see also recommendation 11).

2. Reports on lessons learned from the phaseout of donor support on graduate countries, such as the one on Mexico, provide valuable information for planning the phaseout of USAID assistance and for understanding how family planning programs are affected after donor phaseout.

Recommendation

1. Two years from now, when additional DHS and survey data are available, reexamine the idea of determining the lessons learned from the experiences of the seven graduate countries and perhaps others as well. If GH/PRH decides to reexamine this issue, it would be useful to write two or three graduate country lessons learned reports similar to the one recently completed by the POLICY Project on Mexico.

[2] While more up-to-date data may appear to be available from other sources, the data used to project or estimate such indicators as total fertility rate and contraceptive prevalence are almost always extrapolated from the latest DHS.
[3] Personal communication with Carol Shepherd, September 2004.

3. COMMON THEMES AMONG THE COUNTRIES

3.1 THE COUNTRIES MEASURED AGAINST TWO OF THE CURRENT INDICATORS FOR GRADUATION

The seven graduate countries appeared to fall within the 50–60 percent contraceptive prevalence and 2.6 total fertility rate (TFR) threshold established by GH/PRH as two of the indicators for graduating countries from family planning assistance. All seven of the countries had a contraceptive prevalence of 50 percent or higher. Three of the countries had a TFR of more than 2.6 (Morocco, Ecuador, and Tunisia) at the time of the USAID phaseout. Tunisia, based on the 2004 Population Reference Bureau (PRB) World Population Data Sheet, now has a TFR of 2.0 and a contraceptive prevalence of 60 percent. Table 2 shows the TFR and contraceptive prevalence by country with the data source available nearest to its graduation.

Table 2
TFR and Contraceptive Prevalence by Country

Country Dates of Graduation	TFR	Contraceptive Prevalence Total/Modern	Source of Data
Brazil 1992–2000	2.5	76.7/70.3	1995 DHS
Colombia 1992–97	2.6	76.9/64	2000 DHS
Ecuador 1992–2001	2.9	66.3/52.3	1999 Maternal and Child Health Survey
Mexico Pri. 1992–98 Pub. 1992–99	2.6	68.7/59	1997 Estimated by National Population Council/Mexico
Morocco 1996–2003	2.9	63.3/55	2003–04 DHS
Tunisia 1986–90	4.2	49.8/40.2	1988 DHS
Turkey Cont. 1995–99 Tech. Asst.: 1995–2002	2.23	71/42.5	2003 DHS

3.2 TIME ALLOWED FOR GRADUATION

As noted in table 2 above, the phaseout period for the graduate countries ranged from four to eight years. A Brazil report expressed the timing issue very well.

> The eight year phaseout period was relatively lengthy. For CAs already working in the Northeast …it seemed to give considerable time to work towards program phaseout and program sustainability. However, for CAs just beginning their activities in the Northeast…the eight year period was a relatively short period to start-up, consolidate, and turn-over their program activities. BEMFAM [an NGO] needed all of this lengthy period to achieve nearly full financial sustainability…" (Merrick et al. 2000)

Other reports that were more general in nature and not country specific also discussed the importance of allowing enough time to achieve the desired results when the phaseout

involves a large number of time-consuming tasks, many of which occur sequentially (Bowers and Hemmer 2002; Martin et al. 1999).[4] In addition, the Peru and Dominican Republic Missions (which have not yet graduated) expressed concern that adequate time be given for implementing the phaseout of family planning assistance (in response to the GWG's questionnaire on graduation).

Lesson Learned

3. The time needed to develop and implement graduation strategies may be rather lengthy. Time is needed for NGOs to reach self-sufficiency, for governments to develop systems that are sustainable, and for activities to be completed and institutionalized. Graduation might be partial, with continuing support for specific activities; this may mean as long as eight or nine years.

3.3 PLANNING FOR GRADUATION

Most of the countries had graduation strategies, and they were considered important to the success of phaseout. Tunisia[5] and Ecuador[6] were the only countries of the seven that did not have graduation plans.

The process of developing and planning the strategy forced the countries to clearly focus their final efforts and allowed buy-in by all the participants in the process. Each graduation was different, as the challenges and priorities were unique to each country. However, there were broad issues that were common across the countries, such as the focus on quality of care, social marketing activities, and contraceptive security, and in Latin America and the Caribbean (LAC), on NGO sustainability. For example, in Brazil, the graduation strategy focused on a few issues (sustainability, quality of services, serving the poor, public/private roles) and a few activities to address those issues (training; information, education and communication [IEC]; commodities; investments in for-profit activities; and research/evaluation) in two states of Brazil's poorer Northeastern region and in the NGO and for-profit sectors (Merrick et al. 1995). In Ecuador, the USAID strategy focused primarily on assuring the financial and institutional sustainability of the two largest NGOs that provide family planning services and funding to the Centro Médico de Orientación y Planificación Familiar (CEMOPLAF) to provide services to indigenous populations (Coury and Lafebre 2001). In Mexico, the objectives of the phaseout were to increase access to and use of modern family planning information and services in Mexico's poorest and most densely populated areas and to increase financial self-reliance of public and private sector agencies (Alkenbrack and Shepherd 2004).

Involving all the stakeholders (i.e., public, NGO, and commercial sectors; other donors; and advocacy groups) in the graduation strategy process was deemed important, specifically in Brazil, Turkey, and Ecuador.[7] The experiences in these countries were

[4] Carl Hemmer also reinforced this point in a telephone interview, July 2004.
[5] Rea et al (2004) and telephone interview with Jim Vermillion, July 2004.
[6] Ecuador did not have a formal closeout or graduation plan but USAID assistance was directed during the last years before graduation towards establishing sustainability for the two service NGOs (CEMOPLAF and Asociación Pro-bienestar de la Familia Ecuatoriana [APROFE]) (John Coury, personal communication, October 2004.)
[7] Coury and Lafebre (2001); Merrick et al. (2000); and telephone conversation with Pinar Senlet, July 2004.

that the involvement of all stakeholders capitalized upon the efforts of all the organizations and that the decisions made were mutually beneficial to all stakeholders affected by the phaseout. In Mexico, one lesson learned was, "Multisectoral collaboration and strategic thinking are important for planning and implementing a phaseout." (Alkenbrack and Shepherd 2004) For example, in Mexico, the pharmaceutical companies raised prices astronomically when donor contraceptives were no longer available, forcing organizations to turn to international markets. A partnership formed at the beginning of phaseout between the commercial sector and the NGO/public sectors could have resulted in the creation of mutually beneficial strategies (Alkenbrack and Shepherd 2004).

During phaseout, sufficient time was not always allowed for interventions to have the outcome envisioned. In Mexico, during the graduation phase of the program, emphasis was shifted to rural areas away from urban centers; however, it was felt that the rural activities did not last long enough to have the desired impact or to be institutionalized (Alkenbrack and Shepherd 2004). In Turkey, the Social Marketing for Change (SOMARC) project, with the Women's Health and Family Planning Service System, developed a network of private providers that offered a comprehensive range of family planning services. Impact on service provision was difficult to measure and funding ran out before ways could be found to make the program sustainable. Some former members of the network felt that "…given more time and funding, the project might have had a lasting impact on the provision of FP services." (Armand and Cisek 2002) In Brazil, when one of the for-profit activities did not work out as planned, an assessment suggested that the funds recovered not be used for an alternative for-profit health service investment because of the short timeframe (Merrick et al. 1995).

An important and sometimes difficult part of the planning process was making the NGOs and governments understand that USAID was serious about phaseout. Because of inconsistent messages in the past, some governments and NGOs did not believe that USAID was serious about phasing out family planning assistance. Due to this disbelief, time and funds were not always used as wisely as they could have been during the graduation period. Specifically mentioned in conversations or reports were Turkey, Sociedade Civil Bem-Estar Familiar No Brazil (BEMFAM) in Brazil, Fundación Mexicana para la Planeación Familiar (MEXFAM) in Mexico, and NGOs in general.[8]

Several of the countries conducted midterm assessments during the graduation phase. Because their graduation plans were flexible, they were able to make changes in emphasis, activities, or direction as needed. For example, USAID/Brazil, based on recommendations in a midterm strategy assessment, added a new management component to the two state programs where activities were focused. The assessment also noted that the basic strategy remained valid (Merrick et al. 1995). In Mexico, the phaseout of the NGO sector was extended for one year based on recommendations in an NGO midterm assessment (Bowers et al. 1996) and following a midterm review of the public sector. USAID further intensified its focus on the quality of care in service delivery (Beamish et al. 2000).

[8] Personal communication with Pinar Senlet, July 2004 and Alvaro Monroy, August 2004; Alkenbrack and Shepherd (2004); and Merrick et al. (2000).

The Mexico phaseout plan was flexible to some extent, as noted above. However, a "…valuable lesson learned in Mexico is that a phaseout plan should be a moving template that is flexible enough to shift resources and approaches…" The strategies developed for Mexico did not always allow the system to adapt to major changes. For example, decentralization advanced faster than anticipated. It occurred during the middle of the phaseout period. A greater emphasis on preparing the states for their new roles regarding family planning resource allocation, decisions, and program management would have been appropriate and was needed (Alkenbrack and Shepherd 2004). In contrast, the Morocco phaseout plan had as one of its guiding principles that "the transition plan is dynamic and will require constant fine-tuning…" [9]

One point stressed in several reports was that once a phaseout date was established, contrary messages about phaseout or graduation timing should not be sent to the host country governments and NGOs by other sections of USAID, by other spokespersons of the U.S. government, or by other donors. Brazil and Mexico were two countries where this was specifically mentioned as a problem (Alkenbrack and Shepherd 2004; Merrick et al. 1995; and Bowers and Hemmer 2002).

Because of its importance, a recommendation from the *USAID Regional LAC Contraceptive Security Feasibility Study* bears repeating. The study found that only one country of the five in the study[10] had a phaseout plan for contraceptives (Peru) and none of the five had contraceptive security plans. One recommendation was that phaseout plans or contraceptive security plans be developed as soon as possible. Three of the countries (Bolivia, Peru, and Honduras), in response to the GWG's e-mail questionnaire on graduation, confirmed that they did not have graduation plans. However, graduation plans for Bolivia and Honduras may not be urgent as they may need longer time lines for phasing out based on their TFR, modern contraceptive prevalence, and urban/rural differentials.

Lessons Learned

4. All stakeholders (i.e., the public, NGO, private, and commercial sectors; other donors; cooperating agencies [CAs]; and advocacy groups) should be involved in the graduation process (i.e., planning and implementation).

5. New activities initiated during the graduation phase need sufficient time to have an impact and to be institutionalized.

6. It is necessary to clarify to governments and NGOs that USAID is serious about phasing out; the dates of graduation should not be changed unless all parties are in agreement. Everyone connected with USAID, other donors, and CAs should give consistent messages about graduation.

7. Midterm assessments during the phaseout period can be useful in validating the priorities and assumptions of the graduation strategy and recommending new activities or directions.

[9] "Transition Plan: Achieving Sustainability in Family Planning and Maternal and Child Health (FP/MCH)", USAID/Morocco, April 1996.
[10] The five countries are Bolivia, Honduras, Nicaragua, Paraguay, and Peru.

8. Graduation plans should be flexible enough to shift resources and approaches as necessary in changing political, economic, and social environments.

Recommendation

2. Implement the recommendation in the *USAID Regional LAC Contraceptive Security Feasibility Study* that the five countries in the study develop phaseout or contraceptive security plans. Also, other countries that have not developed graduation strategies or contraceptive security plans should do so as soon as possible.

3.4 NONGOVERNMENTAL ORGANIZATIONS AND THE COMMERCIAL SECTOR

3.4.1 Role of NGOs

In most of the graduate countries, especially in Latin America, NGOs were important in the introduction of family planning. In Colombia, "PROFAMILIA [Asociación Pro-Bienestar de la Familia] not only contributed to the development of family planning in Colombia, but it also helped to create a consciousness of family planning in the minds of Colombians." (Seltzer and Gomez 1998) In Brazil, NGOs were the leaders in introducing family planning, although their direct delivery of family planning services has been limited (Merrick et al. 1995). Also in the past, NGOs traditionally provided services to the poor and marginalized population groups. Over the last 10 years, however, there has been a shift towards serving the middle class as NGOs have been forced to become increasingly sustainable. NGOs were also important advocates for family planning. (These aspects of NGOs are discussed in more detail below.)

Lesson Learned

9. Initially, the NGOs in the four Latin American and Caribbean countries in this report had important roles in introducing the concept of family planning, in advocating for family planning, and in providing services to the poor.

3.4.2 Sustainability of NGOs

All four of the Latin American and Caribbean countries worked directly with NGOs to assist them in becoming sustainable. It appears that the NGOs were or were very near to being sustainable when the countries graduated.[11] However, reaching sustainability was not always easy. An International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) staff member who worked on the Transition Project[12] commented that it was more difficult and complex for NGOs to become sustainable than IPPF/WHR had originally thought.

[11] Sustainable means that the NGOs were financially viable without USAID funding or commodities assistance. It does not mean that the NGOs were not receiving assistance from other donors nor does it mean that the NGOs had 100 percent cost recovery.

[12] The Transition Project was a five-year cooperative agreement between IPPPF/WHR and USAID for $68.8 million that began in June 1992. The objectives of the project were to increase access to family planning services, broaden the range of contraceptive methods available in skewed method mix settings, strengthen the institutional capacity of family planning associations, develop strategies to improve and expand services, evaluate performance and impact of programs, and document and disseminate lessons learned.

In some cases, NGOs reached sustainability at a price. Although the NGOs were committed to providing services to the poorest segments of the population, in efforts to reach financial sustainability, the NGOs were sometimes forced to make tradeoffs between becoming sustainable and serving the very poor. Most of the NGOs were forced to phase out targeted special activities for the poor and experienced a decline in low-income clients after fees were initiated.[13] One exception was the Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario (FEMAP) in Mexico. One lesson learned from the Mexico experience was, "Donors should help organizations identify management strategies that allow them to balance their social objectives of serving low-income populations with sustainability."(Alkenbrack and Shepherd 2004) It is unclear whether in every country an entity (e.g., the government) is prepared to take charge.

The NGOs used a wide variety of methods to become sustainable. Some of the different activities included the following:

- instituting user fees and selling contraceptives (most of the NGOs);
- establishing a revolving fund to purchase contraceptives (FEMAP/Mexico);
- developing successful social marketing programs (FEMAP/Mexico, BEMFAM/Brazil, PROFAMILIA/Colombia, and CEMOPLAF/Ecuador);
- establishing a foundation that solicits donations and grants (FEMAP/Mexico);
- collaborating with the public and commercial sectors by contracting with them to provide family planning and other services (BEMFAM/Brazil, PROFAMILIA/Colombia, MEXFAM/Mexico, and the Asociación Pro-bienestar de la Familia Ecuatoriana [APROFE]/Ecuador);
- diversifying the donor support base (most of the NGOs);
- establishing sustainability funds with USAID assistance (APROFE/Ecuador and CEMOPLAF/Ecuador); and
- establishing an endowment fund with USAID funds (PROFAMILIA/ Colombia).

How the NGOs reacted to phaseout and reaching sustainability depended on the attitude, management capability, and culture of the NGO. BEMFAM in Brazil and MEXFAM in Mexico both had problems at the beginning of the phaseout period because of a lack of commitment to reaching self-sufficiency (Merrick et al. 1995; Alkenbrack and Shepherd 2004). BEMFAM "…successfully institutionalized a new corporate culture, balancing the organization's social service and financial sustainability objectives."[14] In contrast, PROFAMILIA in Colombia had few problems as it had always been noted for its

[13] Wickham et al. (1995); Alkenbrack and Shepherd (2004); e-mail from Honduras, June 3, 2004; Coury (2004); and the *LAC Regional Contraceptive Security Feasibility Study*, DELIVER/POLICY 2004.
[14] *USAID Support for Family Planning and Reproductive Health Programs in Brazil,* No date.

entrepreneurial spirit and good business sense (Seltzer and Gomez 1998). FEMAP in Mexico felt that "…phaseout was a process whose time had come…" and worked accordingly (Alkenbrack and Shepherd 2004).

Several NGOs were successful in creating activities that produced enough funds to cross-subsidize their social programs. In Colombia, PROFAMILIA was very successful in generating revenue from various sources, such as its clinics, social marketing programs, and public sector contracts to fund some of its social programs. In Mexico, originally MEXFAM's clinics were expected to cover their own costs and cross-subsidize the community programs. However, the clinics' profits were only able to cover approximately one third of the social programs. Although the approach used was modeled on the PROFAMILIA/Colombia clinics, the financing structure in Mexico was very different. FEMAP/Mexico had greater success and funded community programs from funds generated by its affiliates (Alkenbrack and Shepherd 2004).

The Dominican Republic's current NGO five-year plan has a component that provides assistance to NGOs to generate sufficient funds to cross-subsidize social programs. The Mission plans to conduct an external evaluation of the NGO program in August 2004. This report may provide valuable information and lessons learned on cross-subsidization and NGO sustainability.[15]

Lessons Learned

10. A wide variety of mechanisms exists for NGOs to become sustainable; however, it is not an easy process.

11. In implementing programs to become sustainable, the client base of NGOs often shifts from the poor to the more affluent. It is unclear whether in every country some entity (e.g., the government) is prepared to take charge.

12. The attitude, management capabilities, and culture of NGOs were important in how NGOs approached sustainability and how successful they were.

Recommendation

3. The Graduation Working Group should explore further the issue of the seemingly conflicting objectives of NGOs serving the poor and reaching sustainability (see also section 4.2).

3.4.3 Sustainability/Endowment Funds for NGOs

In Colombia and Ecuador, endowment and sustainability funds were considered to be important factors for PROFAMILIA, APROFE, and CEMOPLAF to reach and maintain sustainability. In the Coury and Lafebre (2001) report on Ecuador, one lesson learned was, "In preparing local NGO partners for graduation from USAID assistance, the creation of individual sustainability/endowment funds by which annual USAID contributions are linked to partner performance serve as a strong incentive for effecting necessary changes and a useful tool in assuring financial sustainability." The Seltzer and

[15] Dominican Republic e-mail reply to the GWG's e-mail questionnaire on graduation.

Gomez (1998) report on Colombia stated, "An endowment fund was the final, critical component of USAID and IPPF/WHR's assistance to PROFAMILIA."

In discussions with an IPPF/WHR staff member,[16] it was acknowledged that the endowments established under the Transition Project were a contributing factor to some NGOs attaining sustainability. However, there were problems, as the endowments were loans that had to be repaid in dollars. The repayment of the loans became a problem in countries that suffered from very high inflation and devaluation of their currencies. Grants were provided to NGOs to assist them in conducting feasibility studies for the income-generating activities to be funded by the loans.

The Dominican Republic Mission made a strong plea for the reinstatement of the sustainability, investment, or endowment funds for NGOs. (This was contained in the response to the GWG's e-mail questionnaire on graduation.)

It is understood that USAID can no longer provide endowment funds. The legal status of other types of funds, such as the sustainability funds established in Ecuador, is less clear. In the past, USAID Missions were allowed to pay some overhead costs for NGOs and they could put some of their generated income into special funds.

Lesson Learned

13. Endowment or sustainability funds have been important in assisting NGOs to reach and maintain sustainability, although endowments are no longer permitted by USAID.

Recommendation

4. GH/PRH should explore whether sustainability or investment funds for NGOs are feasible under current USAID regulations.

3.4.4 Social Marketing

In order to expand the availability of contraceptives and to strengthen the private sector, all the countries had social marketing projects with the NGO sector and/or the for-profit commercial sector. The types of social marketing programs varied a great deal, from a government-administered program (Tunisia) to NGOs that began with donated products (Ecuador) to a totally commercial sector program (Morocco) and to countries that had several types of programs (Turkey, Colombia, and Brazil).

In Mexico, in addition to the social marketing of contraceptives, assistance in institutional marketing was also provided to two NGOs (MEXFAM and FEMAP) through the USAID–funded SOMARC project. MEXFAM developed a comprehensive marketing strategy that included creating and promoting a new institutional image and developing marketing plans for the MEXFAM clinics. Assistance was provided to FEMAP to redefine its corporate image, and training was conducted in marketing services for affiliates with clinic services (Beamish et al. 2000).

[16] Personal communication with Humberto Arango, August 2004.

Table 3 shows the type of social marketing program in each country. The table is based on the latest information and data available to the team; however, some of the information may no longer be current. "Ongoing" means that the product is still available in the commercial sector or is being sold by the NGO. It does not mean the product is being sold at a subsidized price or at a low-end price (i.e., at a social marketing price). For example, in Brazil, Colombia, and Ecuador, once donated products were no longer available, the NGOs had to procure contraceptives commercially; therefore, they were forced to raise their prices for contraceptives. In Colombia, the contraceptives are priced sufficiently high to cross-subsidize other programs.[17]

Table 3
Social Marketing Programs

Country	Type/Products	Status
Brazil	NGO with donated condoms After phaseout, purchased contraceptives	Ongoing
	CEPEO[18] (private for-profit) (IUDs, diaphragms, female condom)	
	Manufacturers' injectable contraceptives	
Colombia	NGOs, local manufacturers, and donors, including USAID and IPPF After phaseout, purchased contraceptives that had been provided by USAID (oral, condoms, foaming tablets, spermicides, IUDs, and Norplant)	Social marketing activities are self-sustaining and income is used to cross subsidize other services.
Ecuador	NGO (CEMOPLAF) with donated contraceptives After phaseout, purchased products (condom and medicines related to maternal and child health)	Ongoing
Mexico	NGOs and commercial sector (oral contraceptives)[19]	Ongoing
	Institutional marketing for MEXFAM and FEMAP clinics	
Morocco	Partnerships among commercial sector, manufacturers, and pharmacies Used product available in market (oral contraceptives, condoms, IUDs, and injectable contraceptives)	Ongoing
Tunisia	Pharmacies and public sector Administered by and through the public sector using donated products (oral contraceptives, condoms, and IUDs)	Profits went to government and not to Contraceptive Social Marketing (CSM) program. Current status is not known.
Turkey	NGO and commercial sector (condoms)	Ongoing
	Manufacturers (oral contraceptives)	
	Manufacturer (injectable contraceptives)	

Sometimes the social marketing program had broader effects than increasing the availability of contraceptives at a low price. In Morocco and Turkey, the social marketing of condoms assisted in destigmatizing condoms and increased the use of all brands of

[17] Personal communication with Catalina Uribe de Bedout, PROFAMILIA, September 2004.
[18] CEPEO was launched by the PROFIT project as a mechanism for the importation of intrauterine devices (IUDs). PROFIT sold the company to its managers when the project closed.
[19] The MEXFAM program now purchases oral contraceptives for use in its clinics. FEMAP has expanded its program. (Personal communication with Cindi Cisek, September 6, 2004.)

condoms.[20] In Turkey, the social marketing program was instrumental in moving Turkish women from a high-dose pill to a low-dose pill (Armand and Cisek 2002). In Colombia, "…the social marketing initiative helped to develop the commercial market…" in oral contraceptives.[21]

Lesson Learned

14. Social marketing programs can expand the market for contraceptives and, if successful, can become a source of income for NGOs.

3.4.5 Commercial Sector

Government policies were sometimes obstacles to the commercial sector providing contraceptives. SOMARC found that

> Unfavorable policies toward the private sector can undermine the impact of social marketing partnerships. This is especially true for pharmaceutical products. Price controls, advertising restrictions and indiscriminate distribution of free contraceptives through the public sector all contributed to discouraging private sector investment. (Armand and Cisek 2002)

The makers of Norplant cited high production cost and low profit margins as reasons for not registering the product in Turkey (Armand and Cisek 2002). The distribution of free contraceptives by the public sector and the adverse impact on the NGO and commercial sectors was mentioned by almost every report where the government provided free contraceptives.

The commercial sector had an important role in providing contraceptives and services in some of the countries. The for-profit private sector in Brazil had a significant role in the provision of female sterilization in clinics and the provision of oral contraceptives through pharmacies (Adams et al. 1992). In Colombia, the commercial sector was the major provider of oral and injectable contraceptives, vaginal methods, and condoms (Seltzer and Gomez 1998). In Ecuador, the for-profit sector provided the majority of oral contraceptives, injections, and condoms (Coury and Lafebre 2001).

Efforts to expand the role of the commercial sector were mixed. In Brazil, a pilot effort to encourage a large health maintenance organization (HMO) to include family planning in its benefit package failed; however, the creation of CEPEO, a for-profit private contraceptive supply company, was successful. In 2000, it supplied the Ministry of Health (MOH) with IUDs (Merrick et al. 2000). In Turkey, efforts to establish a private sector network to increase the number of users of private providers were not sustainable (Trayfors et al. 1998). In Morocco, the gains in the social marketing program and in increasing the role of the private sector general practitioners were disappointing.[22]

[20] Hajji and Bertrand (no date); Armand and Cisek (2002).
[21] Personal communication with Cindi Cisek (e-mail), September 6, 2004.
[22] *USAID Close-out Report. Key Interventions Support Sustainability of Population Health and Nutrition Programs*. USAID/Morocco, April 15, 2003.

Lessons Learned

15. Government policies, laws, and regulations can be obstacles for the involvement of the commercial sector in the supply of contraceptives and services and for ensuring contraceptive security.

16. The for-profit sector, under the right circumstances, can be an important provider of family planning services and contraceptives.

3.5 PUBLIC SECTOR

3.5.1 Population Policies

All seven countries had favorable population polices and there was strong government support for family planning (see the matrix in appendix D).

3.5.2 Financial Sustainability

All the countries worked on sustainability issues in their strategies. The team only had information on postgraduate experiences of Mexico and Ecuador. Both appeared to have problems maintaining some financial aspects of the family planning programs. One finding from the Mexico report was, "Even when political support is strong, financial commitment by governments does not always translate into financial backing." One factor that affected financial support for family planning was that the program had to compete with other programs for resources both within and outside the health sector (Alkenbrack and Shepherd 2004). In Ecuador, priority was given to medical and curative services over preventive services during government budget constraints (Coury 2004).

The team was told that in Turkey, the political support for family planning is not as strong as it was in the past. Apparently, the reasons for this are that the Minister of Health is giving priority to MCH, not to family planning and USAID is not there as an advocate.[23]

Lesson Learned

17. Even when political support is strong, financial commitment by governments may be difficult due to competition from other programs.

3.5.3 Contraceptive Availability

All the countries worked on ensuring the availability of contraceptives after graduation. The activities included technical assistance in the financial aspects of procurement, procurement, forecasting, and developing and maintaining logistics systems. It appears that most of the countries had systems in place at the time of graduation to forecast, procure, and distribute contraceptives. However, due to the lack of information, it is not known which countries have maintained these systems successfully. Nevertheless, based

[23] Telephone interview with Zerrin Baser, September 2004.

on limited information, it appears that contraceptive security may be a difficult goal to sustain.

The gradual phaseout of contraceptives, as in Morocco and Turkey, helped the countries adjust to financing and procuring contraceptives. However, as noted below, even this is not a guarantee that government financing for contraceptives will continue after phaseout.

Anecdotally,[24] it is understood that Turkey is experiencing contraceptive shortages. According to one source, the contraceptive shortages are being caused by several factors: the government halting the donation mechanism, which was a source of funds for purchasing contraceptives; the Minister of Health giving higher priority to MCH than to family planning; the devaluation of the Turkish lira, thus making importation of contraceptives more expensive; and a shortage of government funds. Apparently, efforts are being made to solve the problem and the MCH–FP Directorate is negotiating with the Ministry of Finance regarding funds to purchase contraceptives.

In Mexico, one lesson learned from the phaseout of USAID support was that "Replacing donor-funded contraceptives is one of the most challenging aspects of sustainability." (Alkenbrack and Shepherd 2004) The procurement of contraceptives in Mexico was particularly difficult at graduation, due to a lack of experience as well as the Mexican financial crisis. Another lesson learned from Mexico was that "Donors should make an effort to prepare organizations for independent procurement." (Alkenbrack and Shepherd 2004)

The *USAID LAC Regional Contraceptive Feasibility Study* confirmed the Mexico experience. For example, Peru has experienced contraceptive stock outs over the past two years due to complications and delays in ordering contraceptives through the United Nations Population Fund (UNFPA) system. The Bureau for Latin America and the Caribbean (USAID/LAC) has been working in Latin America with governments, NGOs, USAID Missions, and international organizations to ensure contraceptive security.[25]

It is estimated that it takes three to five years to have a successful phaseout of contraceptives. This timeframe assumes that preparatory work has been completed before the phaseout process starts, which ensures that the essential host country skills and conditions are in place before the phaseout process begins. The time period allows for testing the system (i.e., completing at least one full procurement cycle).[26]

Lesson Learned

18. Planning and managing contraceptive phaseout is difficult, and organizations in both the public and private sectors need assistance in procuring contraceptives.

[24] GH/PRH/Commodities Security and Logistics (CSL) staff and telephone conversation with Zerrin Baser, September 2004.
[25] Personal communication with Lindsay Stewart, USAID.
[26] Bowers and Hemmer (2002), and Alan Bornbusch, USAID.

Recommendation

5. At least three to five years in advance of contraceptive phaseout, Missions should begin to develop and institutionalize new procurement systems to replace USAID's donated contraceptives.

3.5.4 Decentralization/Health Reform

In several of the countries, decentralization had either already occurred or was being implemented at the same time as the graduation strategy. In Brazil, this allowed USAID to work with two states in the Northeast, as USAID was not allowed to work directly with the national government. Nevertheless, there were concerns about further decentralization in Brazil and its impact on the sustainability of USAID–funded activities (Merrick et al. 2000). In Morocco, the Mission supported the government in its decentralization initiative in two regions. In Mexico, decentralization occurred during the implementation of the graduation strategy and resources were not shifted as needed. Also in Mexico, some believed that the rapid implementation of decentralization should have been anticipated.

During the graduation phase of most of the countries, the issues of health reform, decentralization, and universal health insurance were continually being addressed. The impact of these on family planning programs after graduation is not yet known.

3.5.5 Quality/Access

All the countries tried to address the quality and access issues during the phaseout period. In Brazil, PROQUALI, a client-focused system aimed at attaining quality reproductive health services at the clinic level, was implemented in the two states where USAID believed there was a high unmet need. Efforts also were made to broaden the method mix. In Mexico, quality of care was addressed by training, improving counseling, and expanding method choice and access by focusing activities in rural areas with high unmet needs (Beamish et al. 2000).

3.5.6 Human Capacity Development

Technical assistance for training and human capacity development was almost the first component of the family planning assistance provided to the seven countries. The ability of the governments to maintain and sometimes expand the training systems, however, is not known. For example, in Turkey at the time of graduation, about 10 midwifery schools out of approximately 70 had implemented improved and strengthened family planning and reproductive health preservice training for midwives. It is unknown whether Turkey was able to expand the preservice training to the remaining midwifery schools. Also in Turkey, the inservice training system was strengthened and curricula were developed.[27] Again, it is unknown whether the government was able to maintain the inservice system and provide the needed inservice training.

[27] Trayfors et al. (1998).

In the two Brazilian states in which USAID worked, management inservice training was provided as part of the quality improvement activities. Under an earlier project, FP/RH was included in the curricula in 15 medical faculties (during the 1980s). However, one of the remaining challenges discussed at phaseout was the need for major changes at the university level in the basic medical curriculum and in the specialization required for family physicians.[28]

In Tunisia, in addition to supporting extensive training in clinical methods, management, and service delivery, USAID also supported the establishment of a training center, thereby enhancing institutional capacity. USAID also supported the establishment of an international training center that charged fees for training individuals and groups from other countries (Rea et al. 1993).

According to a Brazil report (Merrick et al. 2000),

> Medical curricula everywhere tend to reflect the national academic tradition regarding: the scope of a subject; distribution of time; curative vs. preventive; hospital-based or community-oriented; basic public health approach or high-tech; evidence-based or based on 'traditional practice'; using standard guidelines or individualistic approach; hands-on or theoretical; and oriented towards specialist or generalist care, etc. Such traditions take considerable time to change. The challenges experienced by the CA working in this area indicate that five years of collaboration is a minimum to achieve any significant impact.

Table 4 shows the number of trainers trained by JHPIEGO under two cooperative agreements from 1993 to 2004. The trainers include qualified faculty trainers from nursing, midwifery, and medical schools, and inservice trainers who use JHPIEGO's competency-based approach.[29] (The table only shows the trainers trained by JHPIEGO and it does not mean to suggest that they are the only trainers in the country.)

Table 4
JHPIEGO Trainer Development Programs

Country	Trainers
Brazil	159
Colombia	1
Ecuador	60
Mexico	0
Morocco	72
Tunisia	6
Turkey	146

3.5.7 Norms, Guidelines and Standards for Service Delivery

It appears that all the countries worked on some aspect of developing or strengthening norms, guidelines, and standards of service delivery, although some were less than perfect. For example, in Brazil, a description included "…a reproductive health guideline, with good and up-to-date norms on family planning care, but with adolescent

[28] *USAID Support for Family Planning and Reproductive Health Programs in Brazil,* no date; Merrick et al. (2000).
[29] *Strengthening Provider Performance in Reproductive Health and Family Planning: Innovations, Lessons Learned, and Results Achieved,* JHPIEGO, March 2004.

reproductive health and birthing care that reflect a very medicalized approach and omits messages on more humanized birth procedures." (Merrick et al. 2000)

In Mexico, the production of official norms was a Mexican initiative with some assistance from USAID and the World Health Organization (WHO). Two key government policy documents prepared subsequently were written in accordance with the official norms and both documents emphasized quality of care (Bemish et al. 2000).

3.6 PUBLIC VERSUS PRIVATE SECTOR DELIVERY OF SERVICES

The countries were mixed regarding the split between the public and private sectors being the predominate provider of contraceptives and family planning services. In Mexico, Morocco, Turkey, and Tunisia, the public sector provided approximately 60–75 percent of modern contraception. In Ecuador and Colombia, the public sector provided approximately 27–38 percent of modern contraceptives. In Brazil, the public sector was the source of 43 percent of contraceptives and the private sector was the source of 54 percent.

In Colombia, the political support for family planning was not sufficient to develop a strong public program, but it was sufficient to enable the private sector to step in and have a prominent role in the delivery of services. Also, the private sector benefited from the absence of legislation that might have prohibited its development (Seltzer and Gomez 1998).

The reason the public sector is the major provider of services in some countries is that the services and/or contraceptives are provided at no cost. Mexico, by law, must provide free contraceptives. However, one of the recommendations in the Mexico report states, "Donors should work with governments to reexamine the impact of policies that encourage free-for-all approaches to publicly provided services…" (Alkenbrack and Shepherd 2004). Turkey has reversed itself on the issue of providing free services/ contraceptives. In an effort to become increasingly self-sufficient, the public sector requested voluntary donations from clients. This has now been discontinued, and currently the poor receive free services and those who are able to pay receive prescriptions that are filled at pharmacies.[30] Morocco provides free contraceptives (Hajji and Bertrand, no date) as do the five Latin American and Caribbean countries that were included in a recent contraceptive security study.[31] It should be noted that in some Latin American and Caribbean countries, fees might be requested for services that are intended to be free.[32]

Some countries have laws or policies that discourage the commercial sector, such as those discussed above. Governments were not always supportive or did not understand the role that the private sector and NGOs could have in providing family planning services; this was especially true in Turkey, Morocco, Mexico, and Tunisia.[33] Also, efforts to increase the role of the private sector were sometimes disappointing (as in

[30] Pinar Senlet, July 2004; and Sine et al. (2004).
[31] *USAID Regional LAC Contraceptive Security Feasibility Study*, DELIVER/POLICY, 2004. The countries included in the study were Paraguay, Peru, Bolivia, Nicaragua, and Honduras.
[32] Personal communication with Maggie Farrell, USAID.
[33] Hajji and Bertrand (no date); Alkenbrack and Shepherd (2004); and Rea et al. (1993).

Morocco).[34] One lesson learned from the Mexico experience was, "Donors should encourage collaboration between public and NGO sectors." (Alkenbrack and Shepherd 2004)

The recent *USAID Regional LAC Contraceptive Security Feasibility Study* raised the issue of the public sector increasingly becoming the major supplier of contraceptives and the need to shift the burden to the commercial and NGO sectors. The study also noted that the commercial sector has become the source of high-end products and that NGO clients have shifted from the poor to the middle class. The report contained some suggestions from various countries on engaging and expanding the role of the commercial sector and decreasing the role of the public sector in the provision of contraceptives. In response to the GWG's questionnaire on graduation, both the El Salvador and Peru Missions expressed the need for expanding the role of the private and commercial sectors.

Lessons Learned

19. Engaging the for-profit sector in the provision of family planning services is not always easy and the graduate countries were not always successful.

20. The private and public sectors have not always agreed on the issue of contraceptive security. Governments do not always understand the important roles the commercial and NGO sectors can have in providing contraceptives. Also, they do not always understand the impact of policies that ensure the provision of free or subsidized contraceptives on the private sector.

21. Nongraduate countries need to expand the role of the private and commercial sectors in the provision of family planning services and contraceptives.

Recommendation

6. In planning for phaseout, Missions should do the necessary analyses and support discussions among the NGO, commercial, and public sectors to identify the roles of the sectors within a whole market framework.

3.7 ADVOCACY

Advocacy both within the government and in the NGO sector was important in most of the countries. For example, after phaseout in Mexico, advocacy efforts by the Mexican Health Secretariat resulted in a regulatory change that allowed it to procure contraceptives internationally. In addition, advocating to the states by the Health Secretariat made them aware of the benefits of consolidating the procurement of contraceptives. One lesson learned from the Mexico experience was, "Advocacy plays an important role in garnering support from governments at all levels and is, therefore, an important component of a phase out plan." (Alkenbrack and Shepherd 2004) In Morocco, taxes and customs were reduced on contraceptives because of advocacy efforts (Hajji 2003).

[34] *Close-Out Report, Key Interventions Support Sustainability of Population, Health and Nutrition Programs 608–007*, USAID/Morocco, April 15, 2003.

In Turkey, the public and NGO sectors worked together to bring about the procurement of contraceptives by the government after USAID phased out donated contraceptives. The MCH–FP Directorate staff led an internal advocacy effort for the procurement of contraceptives. At the same time, the NGO Advocacy Network for Women (KIDOG) supported the MCH–FP Directorate through a high profile external advocacy campaign aimed at the public, public officials, and political leaders.[35]

In most of the graduate countries, NGOs had an important role in advocating for family planning policies and laws. In Brazil, such national groups as the National Women's Reproductive Health and Rights Network and the National Commission for Population and Development "…took the lead in the development of national policy on population, FP/RH rights, including legislative action to establish regulations for surgical sterilization and other aspects of fertility regulation." (Merrick et al. 2000) APROFE in Ecuador "…served as a strong advocate for the promotion of family planning rights and their adoption in the national population policy and eventually as part of the national Constitution." (Coury and Lafebre 2001)

While not yet a graduate country, the experience in Peru shows why public and NGO advocacy is important for the protection of family planning programs.

> From 2000 to 2003, after more than a decade of strong government support, two consecutive Ministers of Health openly opposed family planning… Public advocacy, continuous monitoring, mobilization of the press, and the active participation of NGOs, reproductive health watchdog groups, health forums, and networks of women's development and social organizations have all played a role in protecting family planning from an increasingly well-organized opposition.[36]

Lesson Learned

22. Advocacy within the government and the NGO sectors can have an important role in obtaining government support for family planning, changing policies and laws, and ensuring the survival of family planning programs. Advocacy is an important component in any family planning program but especially in a phaseout plan. In addition, it is important to ensure that advocacy for these programs will continue after graduation.

Recommendation

7. Missions need to build sustainable capacities in advocacy partners (governments, NGOs, and civil society organizations) to act as monitors after the phaseout of USAID family planning assistance.

[35] USAID, *Case Study of Contraceptive Self-reliance Efforts in Turkey: Prospects and Lessons Learned,* The POLICY Project, November 1999.
[36] *USAID Regional LAC Contraceptive Security Feasibility Study*, DELIVER/ POLICY, 2004.

4. ISSUES FOR DISCUSSION BY THE GRADUATION WORKING GROUP

4.1 RAPID AND COMPLETE PHASEOUT VERSUS PHASED GRADUATION

The GWG needs to consider the desirability of a phased or gradual graduation rather than a rapid and complete phaseout. There appears to be a need for certain limited targeted activities to be continued after the majority of family planning activities have been phased out. Two examples are activities that target populations with high unmet need and that provide support for DHSs and other special studies to determine the state of family planning after graduation.

4.2 NGO SUSTAINABILITY VERSUS SERVING THE POOR

Is full NGO self-sufficiency a reasonable objective if the NGO is expected to serve the poorest segments of the population?

In Ecuador during phaseout, the USAID Mission funded through CEMOPLAF a community-based distribution program that specifically targeted the poor and indigenous population as well as the clinics that served these clients.[37]

If the GWG decides that USAID should help address this problem, one suggested solution is for USAID to allow countries to have a phased graduation. GH/PRH could provide limited funding for special activities through NGOs or the public sector that provide services to the poor or those with unmet needs, such as adolescents.

Also, if the outcome of the evaluation of the Dominican Republic's NGO cross-subsidy program is positive, countries could be encouraged to use it as a model.

4.3 SOCIAL SAFETY NETS AND UNMET NEEDS

What is the responsibility of USAID, the host governments, other donors, NGOs, or others in maintaining social safety nets? If indicators reach a certain level, does it make sense to discontinue supporting services to underserved groups?

While most of the countries agreed that there should be a safety net for the poor, there was little discussion of how to proceed. There were concerns, once the government began charging for contraceptives or services, about how the government would determine the people that qualified for free or subsidized services. Nicaragua has two programs that target poor geographic areas and/or poor families for packages of assistance that include family planning.[38] Also, as discussed above, Turkey implemented a voluntary donation mechanism for contraceptives to augment the budget for contraceptives; since the donation was voluntary, it provided a safety net for the poor (Sine et al. 2004).

Almost all the countries in their graduation strategies addressed the issue of reaching the poor, rural, or indigenous populations with special targeted activities. The seven graduate

[37] Maggie Farrell, USAID, October 2004.
[38] *USAID Regional LAC Contraceptive Security Feasibility Study*, DELIVER/POLICY, 2004.

countries had contraceptive prevalences ranging from 50 to 77 when they graduated; nevertheless, concerns were still expressed about people with unmet need and how they would be reached after phaseout. For example, in Brazil, the concern was about reaching adolescents and other underserved groups in the northern states and the poor in cities and rural areas (Merrick et al. 2000); in Morocco, the rural and the hard-to-reach geographically (Hajji and Bertrand, no date); and in Ecuador, men and youth (Coury and Lafebre 2001). In Colombia, the issue of unmet need was discussed in terms of high abortion rates that could be lowered through the use of family planning (Seltzer and Gomez 1998).

In some countries, contraceptive prevalence figures can mask great disparities among groups. For example, in Mexico, while contraceptive prevalence was reported to be 80 percent in the major cities, it was only 40–50 percent in mountainous areas and as low as 9 percent in communities of extreme poverty (Alkenbrack and Shepherd 2004). In Brazil, in the Northeast, women without education reported that they had 2.3 more children than desired. This was significantly higher than the level of undesired children reported for Brazil as a whole (0.7) (Merrick et al. 2000).

Except for limited information based on two reports, the impact of USAID graduation on access is unknown at this time. In Ecuador, "…government agencies, international donors, private and voluntary organizations (PVOs) and NGOS, and the private sector report worsening conditions for family planning and reproductive health care, especially among the poor." (Coury 2004) The 2005 RH survey may provide additional information on the access issue in Ecuador. In Mexico, the shift by NGOs in clients from the poor towards the middle class and the cut of some special programs that funded activities for the adolescent, rural, and indigent population may have resulted in a change in access since Mexico graduated. The 2003–04 DHS–type survey may provide the data needed to confirm the change in access due to USAID graduation (Alkenbrack and Shepherd 2004).

As discussed above, one way for USAID to address the issue of meeting the needs of the underserved populations is for USAID to permit certain countries to partially graduate. To those countries, USAID would provide limited support for activities that address the needs of the underserved population that are not being reached by the NGOs or the public sector.

Recommendation

8. For selected countries, rather than fully phasing out family planning assistance, USAID should fund limited activities in the public sector and/or the private sector that address the unmet needs of the poor, rural, or other groups.

4.4 TOTAL REPLACEMENT OF USAID RESOURCES

Can host governments realistically be expected to totally replace donor resources when they are withdrawn? Should graduation plans address this issue and assist governments in addressing this issue?

None of the reports that were completed before or just after graduation of the seven countries appeared to address the issue of the cost of totally replacing donor funding. This includes more than contraceptives, that is, everything that USAID usually supports,

such as training, IEC materials, research, monitoring, evaluation, and replacement of equipment and vehicles. Obvious issues, such as the procurement and financing of contraceptives, were addressed in monetary terms.

4.5 METHOD MIX

Is it a problem and what priority should be placed on trying to broaden the range of methods? What advice should be given to Missions that have a method mix problem and have limited time and/or funds before graduation? It should be noted that in some countries, availability is not the issue as a wide range of contraceptives are available. The question is whether or not people have access and whether they can choose freely.

One of the tenets of USAID has been that good quality of care means having an adequate range of methods available to meet the needs of users. In principle, a family planning program should offer a sufficient number of methods to meet the needs of clients who desire to either space or limit their pregnancies. Despite the wide availability of modern contraceptives and a range of contraceptive methods, there are examples of the predominance of one or two contraceptive methods. The reason for this seeming limited choice or concentration appears rooted in women's inclination to stay with a method; in the biases of service providers and programs (based on supply, cultural norms, or incentives); and of clients to accept such recommendations (Seltzer 2002).

Brazil and Morocco both tried to address the method mix issue with limited success. According to the Morocco 2004 DHS, 40 percent of all women used oral contraceptives and 5.4 percent used an IUD, which was the next most popular method. The Mission recognized the method mix issue and made various efforts to introduce other methods; however, the activities were not as successful as hoped. In addition, there was the added problem that for religious and political reasons, female sterilization could not be promoted.[39]

In Brazil, almost 80 percent of contraceptive users relied on only two methods: female sterilization and oral contraceptives. The graduation strategy focused on expanding the choice of methods available to women, improving counseling, and making better information available to clients for contraceptive choice and proper use (Merrick et al. 2000). The success of these efforts is not known.

[39] *Morocco 30 Years of Collaboration Between USAID and the Ministry of Health, A Restrospective Analysis of Family Planning*, MEASURE, no date.

5. KEY ELEMENTS FOR SUCCESSFUL GRADUATION

Based on information obtained from graduation plans and other sources,[40] the following are key elements that are ideal to have in place for a successful graduation. These are the ideal to work towards and all the elements may not be completely or fully realized at the time of graduation.

- Population policies or laws in place that protect the right of women and men to have access to family planning services
- A sustainable public sector system in place that delivers quality family planning services, which includes a cadre of people that have the depth of knowledge and skills to solve problems that arise
- A sustainable public sector system that ensures the continuation of the training of service providers, including physicians, nurses, midwives, and others. This includes trainers, materials, curricula that have been developed and are in place for preservice and inservice training, and a system for updating curricula
- Sustainable contraceptive financing, procurement, logistics, and distribution systems in place in the public sector
- Up-to-date national family planning or reproductive health norms, national standards, and service delivery guidelines that are disseminated, implemented, and monitored
- Available IEC materials and the capacity within the public sector to produce additional and updated materials as needed
- No laws, regulations, or policies that unnecessarily limit the ability of the for-profit and NGO sectors in providing family planning services and contraceptives or limit the procurement or importation of contraceptives
- Strong advocacy groups within the government and the private sector
- A commercial sector and a sustainable NGO sector that can provide affordable quality services to those who can pay; the private NGOs and the commercial sector need to be strong enough to become larger providers if conservative forces or budget constraints cause the public sector to reduce services
- Postgraduation plans for countries once graduation has occurred

[40] Interviews with John Coury, July and August 2004, and Marie McLeod, July 2004; e-mail from the Dominican Republic, Peru, Honduras, El Salvador, and Guatemala in response to the GWG's e-mail questionnaire on graduation; and Seltzer and Gomez (1998).

6. POSTGRADUATION RELATIONSHIPS

The relationship between USAID and the graduating country need not end when family planning assistance ends. The relationship should evolve into a partnership of peers. Specific activities in phaseout plans could address how the graduate country will stay connected to the international development community; the need for this ongoing connection was mentioned in numerous reports and interviews. The discussion and recommendations below are based on conclusions and recommendations from various reports.[41]

The *Graduation Strategy for USAID Assistance to the Indonesia National Family Planning Program* (March 2004) recommends that USAID/Washington develop a new program, the Graduate Country Initiative. The initiative would assist USAID in maintaining contact with countries that have graduated, but which still have important regional or even international roles. The report proposes "…that USAID/Washington take the lead in exploring the interest of regional and pillar bureaus in the creation and funding of a mechanism that would provide travel grants, conference support, and technical assistance/mentoring arrangements between graduate country experts and their counterparts in neighboring non-graduate countries."

USAID has helped train cadres of development experts in graduate countries. These experts are a resource that should not be lost. Various efforts have been made to create data banks and they should be maintained. Some of the data banks that have been created are the data bank for all of Latin America and the Dominican Republic, the list developed by the Centre for African Family Studies, and "Population Experts in Developing Countries," published by the Institute of International Education.

USAID has assisted many countries in gaining the expertise to conduct DHS and health surveys. Some countries after graduation have been able to conduct DHSs with government funds and assistance from other donors; however, not all countries have been able to do so. USAID needs a mechanism and a commitment to continue to assist countries in doing some type of data collection, whether it is a DHS, health/family planning surveys, or country assessments. The countries need this information to assist them in making informed judgments and decisions about their programs. In addition, USAID needs the information and data provided by these instruments to assess the impact of graduation on family planning programs. A line item within the current MEASURE project could provide limited funding for DHSs in graduate countries or add-ons to other surveys. Some of the countries, such as Brazil, have expertise in conducting DHSs, and only limited funds for minor local costs would be needed. However, in other countries, such as Morocco and Ecuador, considerable financial support and external technical assistance may be needed.[42]

Under M&L, Management Sciences for Health has established the Global Exchange for Reproductive Health, which fosters communication related to reproductive health and

[41] Seltzer and Gomez (1998); interview with John Coury, August 2004; *Graduation Strategy for USAID Assistance to the Indonesia National Family Planning Program,* March 2004; Hajji and Bertrand (no date); Coury and Lafebre (2001); and Martin et al. (1999).
[42] Susan Wright and Lindsay Stewart, USAID.

population issues between the global community and Colombia, Ecuador, Mexico, Morocco, and Turkey. This activity could be expanded to include all graduate countries, and it could be a component to any follow on activity to M&L. In addition, selected people in each graduate country could become members of the LeaderNet and exchange ideas and experience through the LeaderNet web site.

Recommendations

9. Implement a graduate country initiative, as suggested in the Indonesia graduation plan, to assist USAID in maintaining contact with countries that have graduated from USAID assistance.

10. USAID should participate in maintaining the data banks of experts that have been developed by various organizations.

11. Rather than fully phasing out family planning assistance, USAID should provide limited assistance to graduate countries to conduct DHSs, RH surveys, or to add RH riders to existing surveys.

12. Expand the Global Exchange for Reproductive Health activity under M&L to include all graduated countries. Include the expanded Global Exchange component in the follow-on project to M&L. Open LeaderNet to all graduated countries.

APPENDICES

APPENDIX A

SCOPE OF WORK
(from USAID)

SCOPE OF WORK

LESSONS LEARNED FROM COUNTRIES THAT NO LONGER RECEIVE USAID FAMILY PLANNING ASSISTANCE: DOCUMENT REVIEW AND ANALYSIS

I. Background

USAID has provided family planning assistance to the developing world for over 30 years. In recent years funding for family planning has been straight-lined; increases are expected to be very modest at best in the future. With greater demands for USAID's limited resources, especially in Africa, the Office of Population and Reproductive Health (PRH), in collaboration with the Regional Bureaus and PPC, needs to be pro-active in managing the process of graduation from USAID family planning assistance. Guidance is needed for USAID Missions in countries likely to be candidates for eventual graduation, and their backstop teams in USAID/W, to actively plan and manage a transition process to prepare the country program for continued success after graduation. However, PRH and USAID/W have not fully synthesized the lessons learned from graduation experience to date. USAID needs to verify and ensure that the country programs selected for graduation and the processes used to phase over the programs are the most appropriate and will lead to long-term sustainability of family planning service delivery and impacts.

During the last 10-15 years, a number of countries have "graduated" from USAID family planning assistance. The graduation process and documentation of it have been different in every case, and the results or impact on family planning service delivery are particularly difficult to document and assess once direct assistance has ended. While the documentation may vary from case to case, analysis of the documentation and interviews of program managers who have experienced various phases of these transitions are important first steps to develop lessons learned from our experience with graduation and identify areas where better assessments and documentation of experience is needed.

II. Scope of Work

A. Objective/Product

The consultant will prepare a document that synthesizes USAID's experience and lessons learned from our experience with graduation of country programs from USAID family planning assistance. (If possible the consultant will be assisted by a New Entry Professional if one can be identified and a staff person if available from USAID). More specifically, the document should examine:

- What factors appear to be important predictors for a successful graduation
- What are essential steps for USAID, host country and local institutions to prepare a successful transition from USAID family planning assistance
- What resources, systems and capacities are critical (e.g., funding, institutions, contraceptive supplies) for successful graduation

In addition, the document should include evidence-based findings and lessons learned on the following:

- Length of time generally needed or optimal for a successful graduation process
- Options for approaches to graduation (e.g., transition to other donor funding; full self-financing; development of the private sector, primarily self-financing with only limited, targeted support from USAID)
- Key programmatic aspects that must be considered in a transition process: contraceptive security, institutional sustainability and capacity for change management, financing**,** private public mix, access of key segments of the population to products and services, etc.
- Post-graduation needs and how these can be addressed without compromising the transfer of responsibility to host country institutions.

B. Working Definitions

Graduation: phase out of USAID family planning assistance to zero or almost zero (sometimes combined with phaseout of other health programs, but not in every case). Successful graduation: family planning service delivery continues to support the level of contraceptive prevalence achieved before graduation and inequities in access to services have not increased.

C. Relationships and reporting

The working group on family planning program graduation includes members from GH/PRH and Regional Bureaus. The working group developed this task and will serve as an advisory body for the Consultant, under the leadership of Margaret Neuse GH/PRH. Day to day management and coordination of this consultancy will be done by Marguerite Farrell, GH/ PRH/SDI. At key points, the Consultant will report back to the working group to share information, get feedback and ensure that the report is on the right track.

D. Resources for the Analysis

A range of documents and other resources are available for this analysis.

1. Country graduation documentation concerning FP assistance:
    - Morocco
    - Turkey
    - Mexico
    - Brazil
    - Colombia
    - Tunisia
    - Ecuador

2. Documentation on graduation from the health sector including transition planning, close-out reports, endowments and sustainability funds, SOTA presentations (LAC) and other relevant topics and possibly graduation from other sectors: check CDIE

3. Project-related documentation. A number of USAID-funded projects have focused on graduation-related activities and prepared reports associated with sustainability, etc.
    - CMS
    - IPPF/WHR
    - M&L
    - Deliver
    - Policy
    - Evaluation project
    - Frontiers

4. Other relevant documentation.
    - Contraceptive security assessments
    - Policy studies relevant for program sustainability

D. Principal tasks and requirements

One Consultant is likely to need approximately 6 weeks to accomplish this review and to share drafts at different stages with the graduation working group. The tasks will include:

1. Prepare workplan (review with working group)
2. Collect and review relevant documents
3. Interview key informants by phone and/or in-person
4. Collect information from graduated countries via electronic network
5. Analyze surveys that have already been collected from the LAC Missions on graduation
6. Prepare outline of the report (review outline with working group)
7. Draft summary report (review with working group and revise as needed)
8. Issue summary report presenting evidence-based findings and lessons learned
9. Participate in discussions and disseminate findings in ways likely to reach a broader audience including Mission staff (i.e., brown bag, powerpoint presentation, electronic postings, etc.)

Skills and knowledge required:

- Some experience with USAID health and FP programs
- Ability to track down and find documents and key informants
- Good writing skills: ability to synthesize a wide range of documents and findings in a succinct, coherent document
- Highly collaborative
- Self-starter

Suggested elements of the summary report (should be no more than 20-25 pages)

- Executive summary
- Narrative describing the principal common threads and evidence-based findings, including but not limited to:
    - important predictors or major factors for a successful graduation;
    - useful steps for missions to prepare for a transition from USAID assistance;
    - resources, systems and capacities critical for successful graduation;
    - optimal timeframe for a successful graduation process;
    - post-graduation needs and how these have been or could be addressed
- Short (2-page) descriptions of each graduated country experience before, during and after graduation, including key statistics if available

Annexes

- Reference list
- Interviewee list

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Bureau for Global Health (GH)

Office of Population and Reproductive Health (PRH)

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Mary Vandenbroucke, Latin America and the Caribbean

Bureau for Europe and Eurasia

Nathan Blanchet, Office of Environment, Energy and Social Transition, Division of Health Reform and Humanitarian Assistance (EEST/HRHA)

Harriett Destler, Office of Democracy, Governance, and Social Transition (DGST)

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Joseph Dwyer

OTHER CONTACTS
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Zerrin Baser, Consultant (former POLICY Project staff)
Alice Payne Merritt, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP)
Ward Rinehart, JHU/CCP
Jerry Sullivan, ORC MACRO
John Townsend, Population Council
Martin Vaessen, MEASURE II
Jim Vermillion, Nicaragua
Tim Williams, John Snow, Inc.
Marcia Townsend (formerly with IPPF)

APPENDIX C

COUNTRY CASE STUDIES

COUNTRY CASE STUDIES

BRAZIL

OVERVIEW AND DEMOGRAPHICS

Brazil is an upper middle–income country with a per capita gross domestic product (GDP) of US$ 7,625, which is higher than average for the Latin American and Caribbean region. Although income levels are relatively high, Brazil has one of the largest socioeconomic disparities in the world. The median income of the wealthiest 10 percent of the population is 30 times greater than the poorest 40 percent. "Social marginalization, inequality and regional disparities, especially among the black and mixed-race population, constitute the core of Brazil's social and economic challenges." (World Bank)

Brazil Demographic and Health Indicators

Population	174,485,000
Infant Mortality Rate	33/1,000
Maternal Mortality Rate	160/100,000
Contraceptive Prevalence (total)	76.7%
Contraceptive Prevalence (modern) ▪ Sterilization ▪ Oral Contraceptives ▪ Condoms ▪ Injectable Contraceptives ▪ IUD ▪ Vaginal Methods	70.3% 40.1% 20.7% 4.4% 1.2% 1.1% 0.1%
Total Fertility Rate	2.5
Unmet Need ▪ Total ▪ Limiting ▪ Spacing	 7.3% 4.7% 2.6%

Sources: UNICEF 2002, World Bank 2002, Brazil DHS 1996

PREPHASEOUT

In the early 1960s, Brazil's population growth rate was 3 percent, the average number of births per woman was six, and contraceptive prevalence was a mere 10 percent—a stark difference compared with current demographic indicators. In 1967, USAID assistance began through the IPPF affiliate, BEMFAM. Through USAID support, BEMFAM and later other nongovernmental organizations (NGOs) provided FP services, trained health care providers, and conducted basic demographic and operations research. During this time, USAID, the United Nations Population Fund (UNFPA), and the Ford Foundation were the only consistent sources of family planning programs.

During the late 1960s and through the 1970s, Brazil's economy experienced rapid growth. High per capita income made it difficult to continue assistance; thus, in 1975, USAID ceased development assistance to Brazil. By the early 1980s, debt crisis and high oil prices led to economic deterioration. With Brazil's transition to democratic rule,

USAID was able to reopen its doors in 1985. The FP strategy focused on NGOs, the private commercial sector, and state-led governments. The program focused on the following strategic areas:

- creating a supportive policy environment for family planning;
- supporting demographic and operations research;
- strengthening service delivery through commodity assistance;
- training health care providers, primarily NGOs; and
- developing IEC materials for providers and clients.

During the 1980s, the provision of health care was mainly through the private sector, financed through the country's national social insurance scheme. Middle and upper economic quintiles were the main beneficiaries of this system, and few resources were used for primary care. In the late 1980s, under health sector reform, the social insurance health system was eliminated and greater control and financial support was given to municipalities through a revenue-sharing scheme. However, this plan faced many challenges, as Brazil was also facing economic decline. The middle and upper income segments of the population moved toward the private sector, and the poorer segments were left underserved.

PHASEOUT (1992–2000)

In 1986, the first demographic health survey (DHS) was conducted in Brazil. The survey revealed large disparities in health status among regions. Thus, in 1992, USAID shifted its strategy to concentrate efforts in two of the poorest states, Bahia and Ceara, and clearly stated that family planning assistance would end by 2000. The new strategy for phaseout focused on the need to work directly with state health systems; to access the commercial sector for service delivery, commodity production, and distribution; and to develop sustainability plans for USAID–supported NGOs.

Coordination

During the initial phaseout period, donors, NGOs, and cooperating agencies (CAs) questioned the commitment of USAID to phaseout. To ensure maximum collaboration for sustainability, capacity building, and high-quality service delivery after phaseout, USAID held annual meetings with UNFPA, CAs, and BEMFAM. At this time, USAID determined funding levels based on past years' activities and results. These meetings, combined with an end to commodity donations and efforts to make BEMFAM self-sufficient, indicated that USAID was fully committed to phasing out FP assistance. As a result, this led to improved collaboration between USAID partners and greater partnerships between the public and private sectors.

BEMFAM

BEMFAM implemented several new activities to ensure self-sufficiency by the end of the phaseout period. The organization strengthened its social marketing department and introduced a new product, PROSEX condoms. In addition, BEMFAM heavily promoted its clinics and laboratories in urban areas and developed contractual agreements with

municipalities. Through agreements with local governments, BEMFAM provided a range of services, which included

- training municipal health teams,
- monthly supervision to each health post,
- monthly supply of commodities,
- training in stock management and recordkeeping, and
- free IEC materials on FP/RH.

By the time USAID phased out of family planning in Brazil, BEMFAM had reached 91 percent self-sufficiency.

PROQUALI

In 1995, USAID collaborating agencies and the state governments of Bahia and Ceara developed a joint strategy which led to PROQUALI, a client-focused model of service delivery designed to improve RH services in public sector health facilities. The PROQUALI program, implemented by JHPIEGO and the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP) and Management Sciences for Health (MSH), included a process for facility accreditation and incorporated management training, inservice training of health care staff, physical improvements in the facility, and a reliable supply of contraceptives and information, education, and communication (IEC) materials. In addition, a fairly expansive IEC/behavior change communication (BCC) campaign was developed to increase the visibility of the PROQUALI program.

Policy

Before the 1994 International Conference on Population and Development (ICPD) in Cairo, women health activists were already promoting a comprehensive approach to reproductive health and had gained momentum for a supportive family planning environment. USAID collaboration with these groups in the early 1990s as well as the support of participants to the ICPD had a pivotal role in creating supportive national FP policies. After the Cairo conference, advocacy efforts by national groups, including BEMFAM, led to public support for FP/RH and changes in legislation. By 1997, Brazil developed national policies on population and reproductive health and rights, including regulations for sterilization, a service that was previously prohibited.

Method Mix

As indicated in the health indicators in the table on the preceding page, there is a heavy reliance on only two contraceptive methods: female sterilization and oral contraceptives. According to BEMFAM, 60 percent of sterilizations occurred during a Caesarean section (traditionally, this is the way to avoid the illegality of sterilization). USAID efforts to expand contraceptive choice during the phaseout period included several initiatives, such as

- acceptability and clinic performance studies for reintroducing the IUD and the introduction of injectable contraceptives, emergency contraceptives, and female condoms;

- social marketing of two 3–month injectable contraceptive brands and condoms;

- establishment of a contraceptive supply company, CEPEO, which reintroduced a lower priced IUD as well as spermicides and diaphragms; and

- collaboration with the MOH to conduct workshops on emergency contraceptives; such efforts led to the registration of emergency contraceptives by the top five pharmaceutical manufacturers and importers.

Given that the above activities were initiated during the phaseout period and that the uptake of new contraceptive methods takes time, it is difficult to determine whether a shift in method mix occurred without a recent population-based survey.

Commodities

There is local manufacturing capacity in Brazil, which easily allows the national procurement of oral contraceptives, IUDs, injectable contraceptives, and diaphragms. In addition, many states and some municipalities purchase contraceptives locally for their public programs. A basic medicines package is available to municipalities, but does not include contraceptives—it is a state decision.

Before the implementation of the phaseout strategy, USAID provided commodities to Pathfinder, which in turn supplied local NGOs. USAID ceased donations at the start of the new strategy, causing an NGO shift to the private sector to purchase contraceptives. In order to ensure that NGOs and the public sector could access lower priced commodities, USAID, through the PROFIT Project, created a local contraceptive supply company, CEPEO. CEPEO bid on public sector procurements at the municipal level that were too small to interest larger companies. CEPEO supplied reasonably priced IUDs and later expanded product selection to include spermicides, diaphragms, and female condoms.

Capacity

USAID supported a leadership development program that had the objective of creating a cadre of public health leaders for the Ceara State Secretariat of Health. Training focuses on leadership skills development and helps participants develop individual professional action plans. The program was successful and is now entirely sustainable.

As previously discussed, USAID focused on quality improvement at the facility level through the PROQUALI program. The system, widely supported by local governments, gave increased responsibility to nurses and nurse auxiliaries. Adoption of the PROQUALI model allowed nurses to provide all contraceptive methods (except IUD insertions), prenatal care, and Pap smears. Furthermore, PROQUALI led to increased access to RH information as well as improved service quality. Ceara adopted the

PROQUALI model into its primary health care system and family health program, where quality criteria were developed for adolescent health, prenatal care, sexually transmitted infections (STIs), hypertension, diabetes, dental health, and immunizations.

While the PROQUALI program focused on the quality of care and service delivery, Pathfinder developed a multipurpose management information system for reproductive health, called SISMAC. This software program was designed to assist the state government with commodity logistics, service provision, routine monitoring, management planning, and decision-making. The MOH indicated that SISMAC would function as an independent system at the national level. It is unclear whether SISMAC was expanded to the central level after USAID phaseout.

POSTPHASEOUT

In order to address the large disparities in health services in Brazil, USAID placed its efforts in two poor states in the northeastern region of the country. There is little information on family planning and reproductive health after the USAID phaseout; however, World Bank data indicate that the poorest quintile account for only 2.2 percent of the national income. Furthermore, Brazil ranks second in the world for income inequality, with 49 percent of the population in the northeast region classified as poor.

Since USAID phaseout, BEMFAM has remained active in Brazil, but it appears family planning has been overtaken by a broader focus on reproductive health. BEMFAM's initiatives have expanded since phaseout to include sex education in schools (with a focus on STI/HIV prevention), health sector reform, and south-to-south technical assistance. BEMFAM continues to work with men on HIV/STI prevention and the condom social marketing campaign remains a success.

COLOMBIA

BACKGROUND AND DEMOGRAPHICS

Colombia is a lower middle–income country with a gross national income per capita of US$ 1,820. It is a culturally diverse country with more than 81 indigenous groups. Over the past 35 years, Colombia has struggled with growing poverty, inequality, and armed conflict, resulting in involuntary migration. In 2001, 67 percent of the population was living in poverty and unemployment was as high as 18 percent, further exacerbating the disparities in health and wealth. The top 20 percent of the population earns 60 percent of the national income (World Bank), and rural poverty is as high as 80 percent, according to UNFPA.

Colombia Demographic and Health Indicators

Population	44,200,000
Infant Mortality Rate	28/1,000
Maternal Mortality Rate	120/100,000
Contraceptive Prevalence (total)	76.2%
Contraceptive Prevalence (modern) ▪ Sterilization ▪ Oral Contraceptives ▪ Condoms ▪ Injectable Contraceptives ▪ IUD	64.0% 28.1% 11.8% 6.1% 4.0% 12.4%
Total Fertility Rate	2.7
Unmet Need ▪ Total ▪ Limiting ▪ Spacing	 6.0% 4.0% 3.0%

Sources: MEASURE *Communication*, *Unmet Need for Family Planning: Recent Trends and Their Implications for Programs* (March 2003); PRB World Population Data Sheet (2003)

PREPHASEOUT

From the 1950s until the mid–1960s, Colombia's total fertility rate (TFR) was close to 7, resulting in a population growth rate of 3 percent—one of the highest in the world. It was during this time that Colombia shifted from a military dictatorship to a democracy. This change undoubtedly contributed to a supportive environment for family planning, allowing for private sector growth in FP provision and a turnaround in the growing fertility rate. By the mid–1960s, the TFR had fallen to 3 and the government of Colombia was explicitly supporting family planning. The government translated support into practice by subsidizing FP services in local health centers through the maternal and child health program and later into postpartum services in 90 hospitals nationwide. It is important to note, however, that these services were more accessible in urban areas and through the private sector, which accounted for approximately 50 percent of family planning users (U.S. Library of Congress). It was during the mid–1960s that USAID first began assistance to the Asociación Colombiana de Facultades de Medicina (ASCOFAME) for public health training. Assistance was later extended to the MOH for family planning, but ended in the mid–1970s when the Colombian government claimed

that it no longer needed the support. From this point, USAID focused its assistance on the private sector (primarily PROFAMILIA), and its technical assistance through its cooperating agencies.

ASCOFAME

ASCOFAME was integral to the strides made in the area of family planning. In the mid–1960s, ASCOFAME set up the Division of Population Studies, which was first to carry out demographic research and program evaluations. The results from these studies prompted policy and program developments by the government, NGOs, and external donors. ASCOFAME placed high value on leadership, research, and training, making the organization pivotal in establishing a cadre of professionals trained in population and demography. In addition, ASCOFAME created a network of health centers and hospitals to provide family planning services, which was later adopted by the Maternal and Child Health (MCH) Division of the MOH.

PROFAMILIA

Evolution and Strong Management Foundation

As previously mentioned, the private sector had a significant role in FP provision. PROFAMILIA, an IPPF affiliate, was founded in 1965 and has since been the leader in family planning in Colombia. In the 1970s, PROFAMILIA provided family planning to one third of all users, and by 1986 its share increased to 40 percent. It was the primary source for IUDs as well as male and female sterilization. PROFAMILIA became a model for managing private family planning programs. Seltzer et al. (1996) attributed its wide success to

- strong leadership, which entailed a programmatic approach to program development, a good business sense, and an entrepreneurial spirit;
- effective strategies for marketing, innovation, and fundraising;
- high-quality performance management by capturing the number of users, method mix, and price the client paid per method; and
- placing a high value on the people and relationships associated with the institution, thus creating an environment for delivering quality services. From its inception, PROFAMILIA has ensured transparency of information and performance, from senior management to clinic and field staff.

Service Delivery Strategies

In addition to PROFAMILIA's management approach, its service delivery strategies were integral to self-sustainability and program success. As described in detail below, since the beginning, the organization's policy to ensure sustainability included a fee-for-service approach, whereby each client was required to contribute, however little the donation, for the service received. A sliding scale system was used based on the client's ability to pay, which was determined by the provider and/or counselor. PROFAMILIA's

activities to improve quality, reach rural and urban poor, ensure sustainability, and expand method mix are broadly summarized below.

PROFAMILIA **rapidly expanded**, so that within the first eight years of its existence, 42 clinics were fully operational throughout the country. This expansion was made possible in part by increasing the role of paramedical personnel to provide family planning. Because Colombian law did not prohibit medical functions to be carried out by paramedical personnel, PROFAMILIA was able to train nurses in family planning (e.g., IUD insertion). This strategy was later adopted by the MOH for its public health facilities. Through a branding approach, it was not only able to gain visibility as a quality FP service provider, but such an expansion also demonstrated the increasing demand for family planning.

As mentioned above, PROFAMILIA used innovative strategies that were effective in reaching the rural and urban poor. The organization created a novel approach for its time—**community-based distribution** (CBD)—whereby family planning was brought to rural areas through the National Federation of Coffee Growers. Field workers were trained and employed by PROFAMILIA and were responsible for IEC activities in their respective communities. Under the CBD program, nonmedical community workers were allowed to provide oral contraceptives to women without a prescription, a novel approach for the Colombia context. CBD agents were identified to distribute and sell contraceptives at highly subsidized prices in villages. The distributors would purchase quantities that they thought they could sell and were allowed to retain 50 percent of the price. This minimized loss in supplies. The program was later expanded to urban areas.

In the early 1970s, PROFAMILIA implemented a **self-sustaining social marketing program**. It worked with local manufacturers to purchase contraceptives wholesale and then sold products to commercial outlets at a reduced price, adding a margin of profit to help subsidize the CBD program. In addition, PROFAMILIA had independent contracts with manufacturers in Germany and the United States to purchase large quantities of oral contraceptives at subsidized prices. These agreements allowed PROFAMILIA to distribute approximately 5 million cycles per year through its own distribution networks. Similar systems were later set up for IUDs and Norplant. The social marketing program, combined with the CBD program, allowed broad programmatic reach (i.e., low-income as well as higher income clients).

To increase the acceptance of **voluntary surgical contraception** (VSC), PROFAMILIA employed two approaches. The first approach entailed establishing mobile units that could take VSC to rural areas, remote urban areas, and internally displaced persons. The second approach consisted of creating clinics only for men. Such strategies led to the increased acceptance of VSC, especially among men.

Overcoming Challenges

During the mid–1980s, the CBD and social marketing programs faced major challenges as revenue significantly declined. The factors that contributed to the low profit margins included

- higher costs of acquiring contraceptives,

- MOH–established selling costs of certain drugs,
- Colombian government prohibitions on nonprofit organizations selling donated products, and
- greater competition in the condom market due to increasing demand for HIV/AIDS prevention.

In order to address these concerns, PROFAMILIA carried out several operations research activities to determine cost-effective strategies. By the late 1980s, the CBD and social marketing programs had been combined under a new community marketing program to reduce operational costs. Another approach to ensuring sustainability of family planning services was the diversification of services and partners. PROFAMILIA began to offer a range of reproductive health services and would charge more than actual costs but less than other private facilities. The revenue generated from these services was then used to subsidize FP services, especially for those who could not afford to pay for them. By the late 1990s, PROFAMILIA also had contracts with public and other private health entities, such as Blue Cross/Blue Shield, social security institutions, and other health insurance organizations. A major contribution by USAID to create a US$ 6 million endowment fund was unique to Colombia at the time and continues to help subsidize FP services in the country.

Public Sector

Background

When ASCOFAME's population program was adopted by the MOH, it was immediately integrated into the MCH Division. From the late 1970s until the mid–1990s, the public sector market share remained relatively the same at 27 percent, with fluctuations in between. Although the public sector was not the predominant entity in family planning, the MCH program was nationwide, so that the MOH's health promoters were able to expand services into rural areas by providing oral contraceptives and condoms and making referrals for clinical FP services. As PROFAMILIA's program evolved, the public sector also adopted similar strategies, such as allowing IUD insertions by nurses.

Contraceptive Logistics

The MOH program has continued to rely on external support, especially for FP commodities. Under decentralization, contraceptives continued to be managed at the central level; it was not until the mid–1990s that the lower levels controlled procurement and distribution. As reported in Seltzer et al., family planning provision in the public sector probably did not reach its full potential, largely due to poor logistics capacity, resulting in recurrent stock outs and maldistribution.

ECUADOR

OVERVIEW AND DEMOGRAPHICS

Ecuador is a diverse country, both culturally and ethnically, with very marked contrasts in its social and economic environments. Within a relatively small territory, it possesses four distinct geographic regions divided into 22 provinces: the mountains, the coast, the Amazon, and the Galapagos Archipelago. In 2004, Ecuador had an estimated total population of 13.4 million and a diverse racial mix that includes a significant indigenous population. Sixty percent of the population is now concentrated in urban areas compared with less than 30 percent in the 1950s.

Information indicates that poverty is substantial, may be increasing, and disproportionately affects the rural population. Between 1995 and 1998, the level of poverty increased from 56 to 63 percent, and extreme poverty increased from 20 to 27 percent. The inequality in the distribution of income increased markedly between 1990 and 2000. The share of total income of the wealthiest 10 percent of the population increased from 35 to 45 percent of the national income, while the share of the poorest 10 percent decreased from 1.8 to 1.1 percent.

Migration exacerbates Ecuador's most serious social and economic problems. In the past decade, increasing numbers have left rural areas for the cities and other countries in search of work or to join relatives. One estimate shows that 2 million Ecuadorians live in other countries. In 1999, 386,400 people emigrated; 2,800 of these were physicians.

Ecuador Demographic and Health Indicators

Population	13,400,000
Infant Mortality Rate	30/1,000
Maternal Mortality Rate*	55.4 to 207/100,000
Contraceptive Prevalence (total)	66.3%
Contraceptive Prevalence (modern)	50.9%
▪ Sterilization	23.1%
▪ Oral Contraceptives	11.2%
▪ Condoms	2.7%
▪ Injectable Contraceptives	3.4%
▪ IUD	10.4%
▪ Vaginal Methods	0.1%
Total Fertility Rate	3.0
Unmet Need (women in union)	
▪ Total	10%
▪ Limiting	5%
▪ Spacing	5%

Sources: CEPAR; Ecuador ENDEMAIN 1999; 2004 World Population Data Sheet, PRB

*The national maternal mortality ratio, according to different sources, ranges from 55.4 to 207 per 100,000 live births, depending on the survey and analytical methodology. Estimates of maternal mortality in provinces with predominantly indigenous and Afro-Ecuadorian populations are more than 3 times the national average. The most recent estimates for those areas range from 135.6 per 100,000 in Loja to 39.3 in Los Rios (Coury 2004).

PREPHASEOUT

Ecuador has had a population policy since October 26, 1987, and since 1988, the legal and statutory basis for family planning rights has been contained in the Ecuadorian Constitution. USAID assistance was instrumental in the development of the population policy through support to such local groups as the Center for Studies in Population and Social Development. Technical assistance came from USAID–funded projects, such as the RAPID computer model presentation developed by the Futures Group.

From the beginning, family planning support from USAID and other international donors focused on an expanded approach through improved maternal and child health. Also over the years, efforts were made to reach special target groups, such as the poor living in rural and marginal areas. Efforts to reach underserved couples helped reduce the large gap in contraceptive use between rural and urban populations.

During the years of USAID support, the TFR decreased from 6.2 (1970) to 3.3 (1999). Over the same period, contraceptive prevalence in Ecuador increased, from a 1979 level of 33.6 percent of women in union to 66.3 percent in 1999. More dramatic were the changes among women in rural areas, where use increased from a low of 22.3 percent in 1979 to 58.4 percent in 1999, a significant 162 percent increase. This compares with the rise in use in urban areas from 47.7 percent in 1979 to 71.2 percent in 1999, or a 49 percent increase.

PHASEOUT (1992–2001)

In the early 1990s, because of a major reorganization throughout the Agency, USAID and the Department of State agreed to reduce the Agency's geographic presence by closing operations in those countries with minimal strategic priority. As a result, plans were put in place to close out population programs over the short term (three to four years) in Chile, Costa Rica, the English-speaking Caribbean, and Colombia, and over a slightly longer term in Mexico, Brazil, and Ecuador.

In turn, USAID/Ecuador was instructed to reduce its portfolio and staff. The Mission's Strategic Plan and its Results Review and Resource Request reflected the closure of the population program by September 30, 2000. This was subsequently extended by one year to September 30, 2001. In the health portfolio, the Mission focused on the development of maternal and child health service delivery models, particularly for rural areas, which was accomplished through a grant to CARE International and its Support to Local Organizations Project. In the population sector, emphasis was placed on assuring the financial and institutional viability of the local NGO partners working in family planning and population.

Because of the environment at the time, it was extremely difficult—if not at times virtually impossible—for USAID and other donors to work with public sector institutions. For more than 20 years, Ecuador suffered major political, environmental, and economic disruptions: five presidents in five years; coastal flooding with cholera outbreaks, landslides, and volcanic eruptions; closures of the entire banking system and conversion of the monetary system to the U.S. dollar; and major labor strikes, including

workers in the public health sector. Such a situation created havoc in the health system and had a serious, adverse impact on earlier gains made regarding the health indicators.

During the phaseout period, USAID worked with three organizations, the Association for the Well-being of the Ecuadorian Family (APROFE), the Medical Center for Family Planning and Counseling (CEMOPLAF), and the Center for Studies in Population and Social Development (CEPAR).

APROFE

APROFE is a private, nonprofit organization that provides family planning and other reproductive health services through its 21 standing clinics, community outreach distributors, a marine unit, and a mobile clinic. Activities are carried out in 15 cities located in 10 of the 22 Ecuadorian provinces, including the remote Galapagos Islands.

JHPIEGO provided assistance to develop APROFE's pilot clinic as a national family planning and reproductive health training center. USAID purchased training equipment and remodeled APROFE facilities. The center conducted training-of-trainers activities that focused on quality of care and incorporated gender issues and the provision of all reproductive health services. APROFE remains one of the strongest advocates in the LAC region for the promotion of gender awareness.

APROFE also served as a strong advocate for the promotion of family planning rights and their adoption in the national population policy and eventually as part of the national Constitution. APROFE was also one of the first family planning groups in the LAC region to open discussions for sex education and the importance of meeting the reproductive health needs of adolescents.

In preparation for the termination of USAID/Ecuador assistance, APROFE initiated a strategic plan to strengthen its financial and administrative management to reach sustainability. It was proactive in seeking out contracts with industries and commercial sector institutions to provide their personnel with FP and other services. In addition, it created a sustainability fund with the assistance of USAID in the amount of $5.15 million (at the time of graduation) and additional reserved accounts for contraceptive procurement, construction of new facilities, and an employee retirement fund.

CEMOPLAF

CEMOPLAF is a private, nonprofit organization offering RH and FP services. CEMOPLAF, officially established in September 1974, began operation as part of an agreement between USAID and the MOH, managing four clinics.

In the early years, USAID assistance, provided through Family Planning International Assistance, allowed CEMOPLAF to train other physicians and midwives in FP. The major expansion of CEMOPLAF occurred during the period 1982–91, when USAID/Ecuador financed activities through a grant to IPPF/WHR. During that period, 10 additional clinics were opened throughout the country.

In 1995, USAID funded a social marketing program with CEMOPLAF through the Futures Group's Social Marketing for Change Project (SOMARC). Despite some administrative difficulties at the beginning, the program became very successful in marketing contraceptive methods and medicines related to maternal and child health. Social marketing now represents a considerable income for the institution and helped CEMOPLAF achieve financial sustainability.

In 1996, CARE's Support to Local Organizations project, which was financed by USAID/Ecuador bilateral child survival funds, entered into a partnership with CEMOPLAF to implement and test two community health models in rural areas. Both model programs were considered successful in increasing the use of services that reduce the causes of maternal mortality.

CEMOPLAF also partnered with World Neighbors to implement two service delivery strategies in 12 communities located in the rural Bolivar province, which has a very high indigenous population.

During the phaseout period, USAID placed special emphasis on assisting CEMOPLAF to strengthen its administrative structure and financial management. As a result of locally hired and technical assistance from USAID CAs, CEMOPLAF was able to develop a viable, long-term strategic plan. At the time of graduation, CEMOPLAF had a strong foundation for financial sustainability in its USAID–funded sustainability fund.

CEPAR

CEPAR was created as a private, nonprofit institution dedicated to investigating Ecuadorian demographic variables (including FP) and their relationship to national development. With USAID financial and technical assistance, CEPAR periodically conducted national demographic and reproductive health surveys and related special studies. It also served as an effective advocate for national population and health reform, including the development of the national population policy, and conducted an intensive training program in this area. CEPAR became an acknowledged leader in the area of health policy.

Since 1987, the U.S. Centers for Disease Control and Prevention (CDC), through a partnership with USAID/Washington, has collaborated with CEPAR and provided technical assistance in carrying out four demographic and maternal and child health surveys. CEPAR had the primary role in the design and implementation of these national surveys as well as in data analysis and dissemination of the survey findings. USAID contributed the major share of the costs for the various national RH surveys. In addition, USAID contributed to the costs of conducting the 2004 RH survey.

During the phaseout period, CEPAR became increasingly aware of the reduction and eventual termination of USAID financial support and began to modify its structure and modus operandi. While maintaining its principal focus on demographics and the implications of population growth, it expanded its scope beyond responsible parenthood to explore other factors influencing social development in Ecuador.

The USAID centrally managed institutions that worked with CEPAR over the years were successful in transferring the technology and in developing local technical capacity, particularly in areas of demographic research, analysis, communication, and policy reform advocacy. However, the degree of their success in developing CEPAR as an institution capable of assuring its sustainability beyond the termination of USAID assistance was questionable at graduation.

POSTPHASEOUT

There is limited information available about what has happened in Ecuador since the phaseout of FP assistance. Based on one current health assessment (Coury 2004), which contains limited FP information, it appears that the situation has deteriorated. The report acknowledges, however, that a serious constraint in conducting the health assessment was the lack of current, representative, and reliable information. When data from the 2004 RH survey become available, they may provide a better description of the current situation.

Coury (2004) states that APROFE, CEMOPLAF, and CEPAR have survived, but in the current economic environment they are largely unable to fill their original mandates. These include providing FP services to the poorest populations (CEMOPLAF and APROFE) and regular analysis of national demographic and health information (CEPAR).

The report also notes that government agencies, international donors, private and voluntary organizations, and the private sector all report worsening conditions for FP and RH care, especially among the poor.

MEXICO*

OVERVIEW AND DEMOGRAPHICS

Mexico is the second most populous country in Latin America after Brazil; however, Mexico's population per square mile is over twice as high. From 1994 to 1995, Mexico experienced a severe financial crisis and has recovered to be the country with the highest per capita income in Latin America. Although the gross national income per capita is US$ 5,910, huge regional and ethnic disparities remain. More than half the country's population is poor, living on less than $2 per day; nearly 24 percent are extremely poor, living on less that $1 per day. The median income for the wealthiest 10 percent makes up 40 percent of total income. Nonetheless, Mexico has made huge strides in health and education, with a literacy rate of over 90 percent (World Bank).

Mexico Demographic and Health Indicators

Population	106,200,000
Infant Mortality Rate	25/1,000
Maternal Mortality Rate	83/100,000
Contraceptive Prevalence (total)	68.0%
Contraceptive Prevalence (modern)	59.0%
Total Fertility Rate	2.8

Source: 2004 PRB World Population Data Sheet

PREPHASEOUT

Policy

Since its inception, the family planning program has received strong political support, mainly from the Institutional Revolutionary Party (PRI), which dominated Mexican politics for more than 70 years. The General Population Law went into effect in 1974; the national population policy was set in place in 1975. According to the law, all state organizations must provide free information, education, and health services and supplies related to family planning.

Donors

Although there was wide donor presence at the time, USAID was the largest foreign donor to the Mexican FP program between 1985 and 1995; USAID's average annual budget for FP in Mexico was approximately US$ 10 million. USAID assistance was provided through approximately 20 U.S.–based CAs, which have provided technical and financial assistance to Mexico's public and NGO institutions. Others also provided FP program funding; UNFPA has had a substantial role, while other donors and foundations, to a lesser extent, funded individual projects.

*Summary of *Lessons Learned from Phase-out of Donor Support in a National Family Planning Program: The Case of Mexico.*

Public Sector

Established in 1974, The National Population Council (CONAPO), is an interinstitutional organization that coordinates the country's population and demographic planning and policies. According to Mexico's law on international support, CONAPO coordinates program planning for all organizations receiving support. CONAPO served as a liaison between USAID and the public sector (including social security institutions) and had an important role conducting research on family planning.

The Health Secretariat (SSA) and two parastatal organizations—the Mexican Institute of Social Security (IMSS) and the Institute of Security and Social Services of State Workers (ISSSTE)—are the major providers of family planning services.

The SSA serves as Mexico's health safety net by providing services to all individuals that do not have formal health coverage. Within the SSA sits the General Directorate of Reproductive Health (GDRH). Until 1991, 100 percent of SSA's commodities were donated by USAID.

The IMSS is the larger of the two social security organizations and serves a greater number of people than any other organization in the country. It operates through two operational systems: the IMSS Régimen Ordinario (IMSS/RO), which offers health services to the privately employed and federal employees in urban areas, and the IMSS/Solidaridad (IMSS/S, now IMSS/Oportunidades), which offers health services to uninsured people in urban and rural areas. The objective of the IMSS/S program is to serve marginalized populations in the least developed states. The program provides primary care to 11 million people in 17 states—approximately 30 percent of the population. Ninety percent of the program's clients are indigenous agricultural workers, composed of 46 different ethnic groups.

The ISSSTE is another social security institution for state and federal employees and teachers. Workers are entitled to purchase any health service covered by insurance, including contraceptives and family planning services. Employees contribute 2 percent of their monthly earnings to ISSSTE and additional funding comes from the government.[1]

Private Sector (NGO)

MEXFAM**,** the Mexican affiliate of IPPF, was established in 1965. Since 1984, it has offered FP in the poor areas of 32 cities and indigenous regions. Before phaseout, it depended on a wide range of donors to meet its program needs. MEXFAM worked through six programs in Mexico, including the community doctors' program, the rural CBD program, the industrial program, and the youth program, all of which are referred to as social programs because they serve social welfare ends.

FEMAP, founded in 1973, is a decentralized network of largely autonomous and self-reporting NGO FP organizations that operates in poor areas within 87 cities and thousands of rural communities. Before phaseout, there were 30 affiliates. Although it targeted low-income groups, FEMAP still managed to be one of the organizations least

[1] Personal communication with ISSSTE interviewee.

dependent on donors, with USAID being the only source of international support. FEMAP and its affiliates provide a wide range of programs and services: FP services to factory workers, hospital and outpatient care, CBD of contraceptives, HIV/AIDS prevention, youth programs, and research and training on issues relevant to poor communities. FEMAP relies on a community-based approach that allows its affiliates to establish themselves in the localities they serve. Affiliates are self-financing, which FEMAP achieves through careful cost control, cost recovery, and income generation.[2]

PHASEOUT (1992–1999)

At the time the decision was made to phase out, family planning was strong and national indicators showed that much progress had been made since program inception. Several factors contributed to the decision to graduate or phase out FP in Mexico. With contraceptive prevalence at 63 percent in 1992 and the TFR at 3.44 in 1990,[3] the program appeared ready. In addition, HIV/AIDS prevalence was increasing in the rest of the world and a shift in priorities began to affect the level of funding available for FP worldwide. A final factor was the perception that Mexico was a wealthy country and no longer required assistance from donors; the per capita income was US$ 5,379 in 1990.[4] However, these optimistic national indicators (contraceptive prevalence, TFR, and per capita income) masked great disparities among states. For example, while contraceptive prevalence was said to be 80 percent in Mexico's major cities, it was only 40–50 percent in mountainous areas and as low as 9 percent in communities of extreme poverty.[5]

Coordination and Commitment To Phase Out Implementation

Only a limited number of countries had experienced a phaseout of population support before Mexico's phaseout of donor support. Few evaluations, if any, existed that documented and provided insight to the process. After the decision was made in 1992 to phase out support for family planning, a Memorandum of Understanding was signed.

The objectives outlined in the memorandum were to increase access to and use of modern family planning information and services in Mexico's poorest and most densely populated areas, and to increase the financial self-reliance of public and private sector agencies with which USAID has been collaborating for several years.[6] This agreement included USAID and the major public sector institutions: CONAPO, SSA, IMSS, and ISSSTE. There was a separate grant agreement signed between USAID and IPPF/WHR, which was responsible for coordinating phaseout in the NGO sector. This was done under the IPPF Transition Project, which was a globally funded USAID project that worked on building IPPF affiliate sustainability in the LAC region. Two committees were convened by USAID and one coordinating body was selected to take the lead on each project.

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[2] Quesada, Nora, *Mexico Contraceptive Logistics System: Review of Accomplishments and Lessons Learned—Nongovernmental Organizations (1992–1999),* USAID Family Planning Logistics Management (FPLM) Project and John Snow, Inc., 2000.
[3] World Health Report 1993.
[4] World Development Report.
[5] Personal communication with current MEXFAM/former SSA interviewee.
[6] G. Bowers et al., *USAID/MEXICO Population Assistance Program: Midterm Assessment of Private Sector Component,* May 1996.

Public Sector

The public sector phaseout committee, named the Operations Coordination Committee (CCO), was comprised of USAID, CONAPO, SSA, IMSS, and ISSSTE. CONAPO had the lead role in coordinating phaseout, as it is the organization legally responsible for coordinating donor assistance. However, because CONAPO does not have a service delivery system, the SSA was delegated as the lead institution responsible for distributing contraceptives during phaseout. The committee performed a situation analysis of the family planning program and defined the goals, objectives, and activities for the public sector phaseout plan.[7] This committee was also responsible for monitoring the plans and activities outlined in the phaseout strategy, with technical assistance from the CAs working in Mexico.

The USAID plan for the public sector was comprised of two components: contraceptive commodities and technical assistance. The commodities component required a 25 percent reduction in the level of contraceptive support in each of four years beginning in 1992. During this time, the government of Mexico planned to phase in support by procuring increasing levels of commodities. The technical assistance component, referred to as the targeted states approach, was focused primarily on 9 out of 32 states and was designed to maximize USAID's impact on low-income and underserved populations within the country. These nine priority states (Chiapas, Guanajuato, Guerrero, Hidalgo, Estado de México, Michoacán, Oaxaca, Puebla, and Veracruz[8] [9]) were chosen on the basis of a range of indicators that included percentage of rural population, infant mortality rate, and TFR. These states made up 54 percent of the total Mexican population, 67 percent of the rural population, and 53 percent of women of reproductive age.

Private Sector (NGO)

IPPF led a second committee that was responsible for phaseout of assistance to the two major NGOs involved in family planning, FEMAP and MEXFAM. With assistance from USAID, MEXFAM and FEMAP worked with IPPF to develop a five-year strategy for phaseout. IPPF was responsible for disbursing funding for technical assistance and commodities as well as monitoring implementation of phaseout activities.

The NGO component of the phaseout plan targeted the two major family planning organizations, MEXFAM and FEMAP, which serve urban, periurban, and rural populations. Phaseout resources to FEMAP and MEXFAM, distributed through IPPF, focused on increasing domestic support for MEXFAM and FEMAP, improving the organizations' income-generating capacities, and ensuring the organizations' long-term financial sustainability. It was intended that support for commodities and technical assistance would end by 1997, but both contraceptive donations and technical assistance were extended for a year. During phaseout, MEXFAM received US$ 9.1 million for technical assistance and US$ 1.8 million worth of contraceptives; FEMAP received US$ 5.4 million for technical assistance and an additional US$ 4.5 million in contraceptives during phaseout.

[7] Personal communication with Engender Health interviewee.
[8] Seltzer et al., *Midterm Program Review of the U.S.–Mexico Program of Collaboration on Population and Reproductive Health*, POPTECH, March 1996.
[9] By the end of the phaseout period in 1999, this number had grown to 14 (IMSS, page 2).

MEXFAM

MEXFAM assumed that USAID support would continue for several more years and planned to use USAID resources while making only minor adjustments. It continued most elements of its service and information delivery program, with emphasis on its social program that served the poor rural and periurban populations. The plan was to use USAID funding, as well as the funding generated through user fees and sales of contraceptives, to expand the clinical programs, and to cross-subsidize the social programs.[10] MEXFAM established new medical centers to provide a range of health services to both lower and middle-class clients. The idea was that the income from these clinics would subsidize MEXFAM's five social programs, including assistance to community doctors in poor urban areas, a rural CBD program, a factory-based program, and a youth program. With assistance from the SOMARC project, MEXFAM began a social marketing program not dependent on donated commodities; the commodities were purchased from Schering.

FEMAP

FEMAP used its phaseout resources to strengthen its technical and management capacity and to help transfer these skills to its affiliates.[11] From 1992 to 1997, FEMAP expanded its scope by increasing the number of its affiliates from 30 to 42. FEMAP implemented a successful low-cost/high-volume strategy, which allowed for self-sufficiency while serving the poor (88 percent of clients were living in poverty in 1997). FEMAP used the phaseout assistance to establish a social marketing program (with assistance from SOMARC), improve management, promote high standards of quality, set norms for staff training, develop pricing strategies for contraceptives, and support the different IEC activities of the several affiliates. The affiliates also received USAID donations from FEMAP. Commodities and technical assistance were both discontinued in 1998.

Although there was consensus and collaboration between USAID and the public and private sectors for phaseout planning, there was little collaboration between the public and NGO sectors. It is possible that the government may not have seen how collaborating with NGOs would be beneficial, especially since the public sector was responsible for serving the majority of Mexico's FP clients. In addition, it appears that intrasectoral and central–state level coordination and communication within the public sector was weak.

Challenges to Phase Out Implementation

Over the course of the five-year phaseout plan, Mexico's FP program faced many challenges, some of which were due to decisions made by stakeholders and others that were due to unforeseen events. These challenges to phaseout implementation are outlined below and discussed in full detail in the report, *Lessons Learned from Phase-out of Donor Support in a National Family Planning Program: The Case of Mexico* (Alkenbrack and Shepherd 2004).

[10] The social programs are the community family planning programs serving poor rural and periurban populations. They are also referred to as program extensions.
[11] Bowers et al. (1996).

Internal Factors

- Insufficient time to build sustainability among NGOs
- Outdated USAID policies and operational guidelines
- Unpredictable resource allocations
- High turnover of USAID staff
- Inconsistent messages from USAID officials about the end of phaseout
- Impression of strained relations between U.S. and Mexican government organizations
- Lack of participation by multisectoral stakeholders
- Conflicting organizational politics (within the NGO sector)

External Factors

- Impact of reproductive health integration
- Mexico's financial crisis
- Impact of decentralization

POSTPHASEOUT

Commitment to Family Planning

Although support for family planning remained strong through phaseout, external factors in the mid–1990s, such as the financial crisis and the HIV/AIDS epidemic, resulted in competition for scarce resources. This complicated the Mexican government's ability to phase in resources to replace donor funding. Although support for family planning is still relatively strong, there is a perception that since the election of President Vicente Fox and the National Action Party in 2001, support for and attention to the FP program has weakened. Despite this, the government is still in favor of FP. In fact, the family planning norms now allow emergency contraception to be sold over the counter. This is a very contentious issue throughout the world, and Mexico is one of a few countries to have passed this regulation.

Commitment to FP at the state level has not been as strong as at the national level. Until the onset of decentralization, the government, including the FP program, had been highly centralized and vertical. In the late 1990s, state governments were not prepared for the new responsibilities resulting from decentralization. Family planning stakeholders had little training to prepare them for decentralization and did very little to garner financial support from the central government or other donors. Furthermore, state decision-makers did not view FP as a priority. Lack of future planning became so problematic during

phaseout that the central government amended a regulation to ensure that states allocated money to family planning.

Legal and Regulatory Changes

The legal and regulatory structure governing the performance of family planning services has continued to evolve. Changes have taken place during and after phaseout. Some of the changes after phaseout were based on USAID–funded research studies, which defined weaknesses and areas of improvement in the regulatory structure governing family planning. Illustrative legal and regulatory policies, which have an impact on the current state of family planning, are briefly described below.

- In 2000, the General Population Law was amended, creating a direct link between CONAPO and the COESPOs—the state level population councils. This amendment provides a legal context and regulations for the COESPOs and supports a new role in implementing the national population program at the state level. This was an important change accompanying the shift to decentralization.

- Another key regulatory change that permits the Health Secretariat to procure commodities on the international market was made after phaseout as a result of lobbying by the SSA. This regulation has also encouraged collaboration between the Health Secretariat state officers, who are now participating in pooled procurements coordinated by the central level. These pooled procurements help to achieve economies of scale and to negotiate price reductions.

- Laws granting free contraceptives to public health institutions are still in place.[12] This law also establishes the right of all individuals to decide upon the number and spacing of their children as well as the right to information and services needed to make informed choices. This means that public sector institutions cannot charge for contraceptives, which eliminates an important mechanism for meeting funding shortfalls.

Institutional Changes

The phaseout of USAID support necessitated major changes, not only in the family planning program but also in the institutions themselves. Some of these changes were directly related to the impact of phaseout; others were attributed to changes needed for adapting to an evolving program. The financial crisis and decentralization were also major factors affecting these changes.

- **CONAPO**: In 2003, CONAPO created the City Council for Population Policies, a council of civic and academic organizations to support discussion and guide the policy debate on population, with the overall objective of enhancing the performance of the National Program on Population. This change was made in response to the decrease in attention and funding for family planning.

[12] 1974 General Law on Population and the General Law on Health.

- **SSA** underwent restructuring during phaseout. Following the Cairo conference in 1994, the General Directorate for Reproductive Health (GDRH) was created to merge the family planning and maternal and child health management units. This post–Cairo era change occurred in the midst of phaseout, complicating implementation of both restructuring and phaseout. A more recent reorganization is underway with the SSA now. The GDRH will be eliminated, although the process has been on hold for some time while the government finalizes decisions about the new structure.

- **IMSS** has suffered significant staff reductions since phaseout. IMSS personnel are now responsible for establishing norms but are no longer involved in supervisory activities or technical support. Supervisory roles that were funded by USAID were eliminated after phaseout.

- **ISSSTE** was forced to downsize substantially in response to funding reductions during phaseout. Since 1993, the number of people working in family planning at the central level has decreased from 25 to 3. These three employees are responsible for the entire health program, leaving insufficient time to dedicate to family planning.

- **MEXFAM** shifted its focus toward clinical services. To improve supervision of activities and personnel, MEXFAM reorganized its operational structure into five regions, with a manager of clinical services in each region. MEXFAM also began to work with adolescents and youth in addition to the general population, which has helped to cross-subsidize family planning services for the poor.

Current Coordination Mechanisms

Most stakeholders in the public and NGO sectors agree that other coordination and collaboration mechanisms have dwindled since phaseout. Weakened coordination may be due partly to the financial crisis and a loss of attention on family planning because of competing priorities. For example, FEMAP used to conduct three or four coordination meetings annually, but now has only one a year, and relies mostly on Internet, telephone, and fax communications.[13] Following USAID's phaseout, discussions about procurement for contraceptive supplies have not taken place regularly among organizations or sectors. Organizations have developed their own strategies to ensure a supply of contraceptives, impeding the opportunity for improving price negotiations, economies of scale, and overall efficiency of the program.

Financing

Public Sector

- **Lack of expertise in forecasting and projecting financial requirements**: Initial plans called for SSA to continue to forecast centrally and then to procure contraceptives through local vendors for all states. There was never an

[13] Personal communication with FEMAP interviewee.

intent that these functions should occur at the state level or that the SSA would procure internationally as this was illegal at the time. Training occurred at all levels; however, the state levels focused more heavily on logistics management and distribution than on forecasting. There was some training for procurement at the central level. This hurt the ability of the states to project financial requirements for contraceptives.

- **Insufficient information about costs of family planning**: Mexico's phaseout plan did not include training in budgeting or studies on the costs of FP services and supplies.

- **The 1994–95 financial crisis**: The fiscal crisis complicated efforts to obtain increased budget support for family planning. The central government awarded only a fraction of the amount requested by organizations.

- **Donor dependence**: Successful efforts in securing additional support from non–USAID donors, such as UNFPA, weakened the arguments for increasing government budget support. Moreover, since donors provided the majority of contraceptives before phaseout, organizations had no historical expenditures for contraceptives, so that past public budget allocations did not reflect need.[14]

- **Competing priorities for other health and nonhealth needs (at both the central and state or delegation levels)**: Even in cases where substantial funding was transferred to the state level, the funds were not always used to purchase contraceptives. This was due to a lack of awareness of the benefits of FP and competition with other health services that, according to stakeholders, were equally or more urgent than FP.

- **Exorbitant prices charged by domestic suppliers**: The domestic suppliers in Mexico took advantage of the fact that organizations were not permitted by law to procure internationally after phaseout by charging very high prices for contraceptives.

- **Inadequate advocacy support**: In many cases, states had no experience in mobilizing funds for contraceptives. ISSSTE expressed difficulty in approaching members of Congress to raise awareness of the need for greater financial support. In addition, ISSSTE believed that the members were not adequately informed about the meaning of graduation and, as a result, family planning was not a priority for them.[15]

NGO Sector

MEXFAM and FEMAP have faced many challenges to sustainability since the USAID phaseout, including

- high costs of community programs,

[14] Personal communication with ISSSTE.
[15] Personal communication with ISSSTE.

- exorbitant prices being charged by domestic suppliers, and

- provision and promotion of free contraceptives in the public sector limits NGO sector revenue generation.

Some short-term solutions have been implemented to address some of these issues, but challenges remain. Other donors and foundations have significantly increased their contributions to MEXFAM, and to a much lesser extent, FEMAP. MEXFAM depends on this funding to provide support for the program extensions—the rural and urban underserved communities where MEXFAM is not able to recover its costs. Although MEXFAM has been successful in diversifying its donor support base, it recognizes that this is a temporary solution to phaseout. Indeed, several foundations have recently announced intentions to reduce commitments to MEXFAM. It is, therefore, MEXFAM's medium-term objective to "increase revenues [through operations, thereby becoming] less dependent on external resources." [16]

FEMAP's operation is different from that of MEXFAM in that it believes that even the poorest clients are able and willing to pay for services. The majority of clients that FEMAP and its affiliates serve live in poverty and are charged for all services and supplies; exemptions are provided for individuals who do not have the ability to pay. Currently, FEMAP's annual contraceptive budget is approximately US$ 400,000. Members pay a mark up of 20 percent for centrally procured supplies, which provides a financial surplus for FEMAP. This revolving fund has produced a return that has continued to grow.

[16] Personal communication with current MEXFAM/former SSA interviewee.

MOROCCO

OVERVIEW AND DEMOGRAPHICS

Over the past 30 years, Morocco has made huge strides in health and human development. From the 1970s to early 2000, gross national income doubled from US$ 550 to US$ 1,190, the average life expectancy increased from 55 to 68, the total fertility rate decreased from 6.3 to 2.8, and, most striking, the infant mortality rate declined from 115 to 39 per 1,000 live births. Despite these successes, poverty, particularly in the rural areas, remains a challenge. In rural areas, 25 percent of the population lives in poverty and has limited access and poor quality health services.

Morocco Demographic and Health Indicators

Population	31,000,000
Infant Mortality Rate	40/1,000
Maternal Mortality Rate	227/100,000
Contraceptive Prevalence (total)*	63%
Contraceptive Prevalence (modern)*	55%
▪ Sterilization	2.7%
▪ Oral Contraceptives	40.1%
▪ Condoms	1.5%
▪ Injectable Contraceptives	2.1%
▪ IUD	5.4%
▪ Vaginal Methods	.2%
Total Fertility Rate	2.5
Unmet Need	11%

*Among married women of reproductive age
Source: Preliminary results from 2003–04 DHS

PREPHASEOUT

USAID assistance to Morocco began in 1971, with five project phases lasting to 1999. Although the last phase (from 1996–2003) can be characterized as the phaseout or transition period, it is important to note that the activities preceding this timeframe helped establish increased capacity and sustainability. From 1971 to 2000, the family planning program in Morocco focused on interventions fundamental to a well-functioning FP program: management, supervision and training, logistics, IEC, research and evaluation, and policy and advocacy.

During the first bilateral agreement or phase (1971–77), there seemed to be limited MOH commitment to FP, and the relationship between USAID and the MOH was somewhat distant. Activities during this period focused on contraceptive provision and the launch of systematic motivational home visits (VDMS). VDMS was designed to increase the availability of family planning services at the household level. VDMS was later expanded to include some MCH interventions and covered 85 percent of the country, including hard-to-reach populations.

From 1978 to 1984, USAID concentrated its efforts on strengthening the management capacity of the MOH and developing a logistics system for pharmaceuticals. Phase II was marked by several achievements:

- the government of Morocco included a line item for FP in its 1983–85 budget,
- the National Center for Training and RH was created in order to train health professionals in VSC procedures,
- the first contraceptive prevalence survey was implemented, and
- small-scale IEC activities were introduced.

By 1984, the relationship between the MOH and USAID had significantly strengthened. The MOH focused heavily on family planning and began to focus on the private sector. During phase III (1984–91), USAID activities included provision of contraceptives, expansion of the VDMS program, support for VSC, and IEC. This was the first time the strategy included child survival activities and involvement of the private sector.

From 1989 to 1996, marking phase IV, USAID was fully engaged with the MOH in a number of activities, including

- policy reform to begin to address growing concerns of sustainability. The early policy issues were health policy reform, hospital cost recovery, and extension of health insurance;
- increased private sector involvement, with the launch of an oral contraceptive, which, like the condom, also relied on products available in the market and without a subsidy from USAID;
- improving quality of care to increase use of services; at the same time, national standards were developed that established a link between training and service delivery, which supported the training strategy of decentralization and included the creation of nine regional family planning training centers;
- development of an IEC program within the MOH to serve as a vehicle to formulate a national strategy on information as well as to reach a consensus on family planning at the national level; this activity in turn led to the development of a training curriculum for MOH personnel and material for media coverage; and
- a redesign of the health information system to improve the use of service statistics to monitor and measure the impact of all health programs in all provinces.

Of the US$ 31 million in assistance provided for FP and child survival during this phase, $12 million was set aside for contraceptives. In 1996, a transition plan was developed for USAID to gradually withdraw financing and for the MOH to take on greater financial responsibility.

PHASEOUT

From 1993–2000, the main objectives for USAID were to increase the use of services and the sustainability of the program. There were three facets to achieving sustainability: an improved policy environment, reinforced capacity to manage FP/MCH programs, and increased diversification of the resource base. Interestingly, this move to sustainability required an increase in USAID resources. An important part of the success of the strategy was a written agreement that was developed and signed by the MOH and USAID, which specified the MOH's assumption of expenses year by year. This became a key indicator to measure the government's commitment to the sustainability of the program. The gradual transfer of contraceptive purchases by the MOH began in 1995. In 1996, the MOH purchased 23 percent of the contraceptives and 100 percent of the vaccinations. By 2000, the MOH was purchasing 100 percent of the contraceptives, and needs were forecast through 2004.

VDMS

As previously mentioned, VDMS was a strategy based on regular home visits and was the first collaborative effort between the MOH and USAID. Under this model, government nurses visit families, collect data on reproductive health, give contraceptive advice, provide condoms and/or oral contraceptives, and refer women to the nearest health center for IUD services. Nurses would follow up with clients on a quarterly basis. This innovative strategy was later expanded to provide services to isolated geographic areas. In addition to FP, health workers would also offer MCH services. By the 1990s, the VDMS system had been limited to rural areas, with a new strategy whereby mobile teams visit a predetermined area on specific days to provide select health services.

Policy

In the 1960s, Morocco recognized the need to address the rising population growth rate. In this decade, the king explicitly linked the population growth problem with socioeconomic development and created a High Commission on Population. He also repealed laws that prohibited the promotion and sale of contraceptives. By 1966, the National Family Planning Program was created under the MOH and FP was integrated into existing health service delivery.

Although commitment to FP dates back to the 1960s, service delivery, research, commodities, and other items were heavily subsidized by donors and NGOs. In order to increase government resources for family planning, USAID focused on the sustainability of FP programs through private sector growth and public sector capacity building. Advocacy materials were developed that were aimed at increasing awareness among policymakers for the need to dedicate funds for FP. Awareness-raising activities included

- conducting national health accounts and providing assistance to ensure that the MOH could calculate the annual budgetary needs;

- a market segmentation study to determine the size of the market and how the market could be segmented, to evaluate demand, and to estimate service needs;

- market research on contraceptive availability, which exhibited to the MOH the cost of commodities;

- a study on purchasing options and assistance with developing tenders for contraceptives, and;

- a multicountry study of tax waivers for importing contraceptives.

Based on the multicountry study and other advocacy work, in 2000, the Population Directorate succeeded in convincing the Ministry of Economy and Finance to reduce taxes on contraceptives, thus reducing the budget needed for the public sector as well as reducing price pressures on social marketing products.

It is important to note that a key policy decision to integrate family planning into maternal and child health activities has contributed to the sustainability of FP, especially when funding began to decline. The MOH has been extremely successful in ensuring the integration of services at the local levels.

Systems and Human Capacity

During phase V, the MOH, with technical assistance from the FPLM Project, strengthened its logistics system. It was reoriented from the centralized supply system to a system based upon demand. Thousands of health professionals were trained in the new system and standardized procedures were institutionalized. Forecasting, purchasing, and warehousing were also improved. Because of problems with general drug distribution by the MOH, contraceptive logistics remained a vertical program and was not integrated with the essential drug program.

From the inception of USAID FP programs in Morocco, training health professionals was a key priority. Human capacity was improved in the areas of FP, contraceptive logistics, IEC, management, information technology, monitoring, and research. "According to the 1983 project evaluation summary, the training component was one of the most successful elements of USAID's assistance to the MOH." The government of Morocco exhibited its commitment to increasing the management capacity of health programs throughout the country by

- creating a National School of Health Administration to provide two-year training to provincial health officers;

- improving quality assurance in clinics at the national level through team building and training activities;

- strengthening preservice and inservice training for institutional strengthening and developing sustainability plans, financial management systems, and communication networks;

- increasing capacity in research, evaluation, and use of results to plan and implement programs; and

- improving management capacity to use data for decision-making (i.e., revision of forms, integration of data into single report forms, development of a computerized data entry system, and training of managers in the use of data).

Information, Education, and Communication

USAID placed a high priority on increasing IEC capacity within the MOH during the last phase of assistance. The MOH received state-of-the-art technical equipment that allowed the production of high-quantity and high-quality materials at low cost. This, in part, fostered good working relationships between the MOH and radio and television media. In addition, the IEC program worked with MOH teams, community development agents, and NGOs, providing training in health education, group facilitation, and communication techniques.

Finance and Public/Private Partnerships

Under the National Family Planning Program, contraceptives and services are provided at no cost in government health centers. In order to increase coverage as well as the funding base for family planning services and commodities, a social marketing program was launched in 1989. The program was a collaborative partnership among manufacturers, pharmacists, and distributors. The first product launched by the program was the PROTEX condom, which became self-sustaining by 1993, largely due to a 30 percent tax on sales revenue. The condom launch was successfully followed by oral contraceptives. Both campaigns were accompanied by successful communication strategies and training of pharmacists and other sales personnel. Training initiatives began in 1996, reaching 4 percent of general practitioners; by 1999, the number increased to 40 percent. This was supported, in part, with promotional materials, training in office management, and quality assurance material. The social marketing program was expanded to include an injectable contraceptive in 1997 and IUDs in 1998. Brands were selected in negotiation with distributors so that products were offered at reduced prices without a USAID subsidy. Initial sales were promising, but then declined sharply because of several factors: they were not well accepted by users, service providers did not become active promoters, and there were problems with the positioning of the general practitioner.

The strategy for diversifying the funding base was to increase the role of the private sector in service delivery. Although the provision of contraceptives in the private sector increased from 28 percent in 1994 to 37 percent in 1999, this was less than expected. Access to affordable, quality FP services remains a problem and impedes private sector provision of injectable contraceptives and IUDs. Problems include limited consumer purchasing power, competition, and most importantly, that private general practitioners are poorly positioned to offer these services. Further stimulation of demand and repositioning of private general practitioners is necessary to increase use of private sector services.

In 1999, Special Objective 7 was initiated to consolidate gains in population, health, and nutrition and to ensure that the programs built by USAID, the MOH, and other partners would continue to achieve their objectives without USAID support in the future. The Memorandum of Understanding for this unilateral program was planned to continue through September 2004, but with a change in the overall Mission strategy, Strategic Objective 7 ended a year earlier than planned. On September 30, 2003, USAID/Morocco and the MOH formally marked the end of USAID assistance to the health sector in a well-publicized, highly positive ceremony.

POSTPHASEOUT

Preliminary results from the 2003–04 DHS indicate positive improvements in contraceptive prevalence and the TFR. From 1997 (prephaseout) to 2003 (graduation), the total fertility rate declined from 3.1 to 2.5; modern contraceptive prevalence increased from 49 percent to 55 percent in the same time period. The public sector is the main source for female sterilizations, IUD insertion, and injectable contraceptives, while the private sector is the predominate source for oral contraceptives and condoms. Given that the DHS was conducted in the same year as graduation, it is unclear whether the achievements in TFR and contraceptive prevalence can be attributed to sustainable FP efforts and initiatives by the Moroccan government and other in-country stakeholders or whether they are the result of previous USAID support.

TUNISIA

OVERVIEW AND DEMOGRAPHICS

Tunisia is one of the most progressive countries in the Arab world, and its commitment to family planning has reflected that fact. From 1964 to 1990, USAID was the primary donor supporting family planning activities in Tunisia. During that time, the TFR dropped from 7.1 to 3.7. The current (2004) TFR is estimated to be 2.0. The infant mortality rate dropped from 145 to 39 (per 1,000), and is currently estimated to be 22 (2004). Total contraceptive prevalence increased from negligible levels in the mid–1960s to 50 percent in 1990, and is estimated to be 60 percent in 2004.

Tunisia Demographic and Health Indicators

Population	10,000,000
Infant Mortality Rate	22/1,000
Maternal Mortality Rate	70/100,000
Contraceptive Prevalence (total)	60%
Contraceptive Prevalence (modern)	49%
▪ Sterilization	12.6%
▪ Oral Contraceptives	7.3%
▪ Condoms	n/a
▪ Injectable Contraceptives	n/a
▪ IUD	25.3%
▪ Other	4.2%
Total Fertility Rate	2.0
Unmet Need (1988 DHS: Current information not available)	
▪ Total	38.6%
▪ Limiting	17.3%
▪ Spacing	21.3%

Sources: 2004 World Population Data Sheet, PRB; Global Population Profile 2002, Issued March 2004; UNFPA 1988 DHS

PREPHASEOUT

The first project agreement for family planning between USAID and the government of Tunisia was signed in 1968. By January 1968, the government of Tunisia had established centers for IUD insertion in only 10 maternal and child health centers and 14 hospitals nationwide. Ten mobile teams were providing periodic family planning services in approximately 150 villages. There were no professionally trained health educators, and the FP program was being operated by a minimal staff attached to the MOH in Tunis. In 1967, there had been approximately 9,500 acceptors of IUDs and 742 female sterilizations; the number of women who had begun to use oral contraceptives was 590.

From 1968 to 1980, USAID assistance concentrated on public education, infrastructure development and training, contraceptives, and development of institutional capability in the national government FP program. Some of the achievements during this period follow.

- Contraceptive prevalence, estimated at 10 percent in 1975, reached 21.3 percent in January 1979.

- The government of Tunisia expanded the FP program's educational and administrative structure into all major provinces.

- Pilot programs tested various household and CBD systems.

- The National Training Center began operation in 1979.

- The clinical program expanded to include voluntary female sterilization.

However, despite success in some areas, a USAID evaluation found that there had been a "leveling off of family planning acceptors due primarily to the lack of services in rural Tunisia."

Addressing these and other problems, USAID concluded in 1981 that the key objectives of USAID's strategy in the 1980s should be to enhance service delivery and coverage, to increase contraceptive prevalence, and to reduce the Office National de la Famille et de la Population's (ONFP) financial dependence on USAID. To address these objectives, USAID undertook two projects in the 1980s.

PHASEOUT (1986–1990)

Tunisia did not have a formal graduation plan. The two projects mentioned above were a centrally funded project of US$ 9 million (1982–86), and a bilateral project of US$ 8.3 million, entitled Family Planning and Population Development (1986–1990). (Because these projects had the same objectives and are described in reports as almost one project, the discussion of both projects is combined.)

The objectives of the two projects were to

- improve problem solving to help ensure effective use of government of Tunisia and donor resources;

- increase access to family planning, especially in rural areas, by funding mobile units, fixed clinics, and outreach to homes through the animatrices (prime movers) in the public sector and the contraceptive social marketing program in the private sector;

- improve service delivery in highly effective clinical methods, especially female sterilization and IUDs, to increase contraceptive prevalence;

- increase the capacity of Tunisian training institutions; and

- produce survey findings about contraceptive knowledge and practices.

A description of the program components follow.

Management, Planning, and Administration

ONFP emphasized decentralization management initiatives throughout the 1980s. It invested heavily in setting up regional service delivery infrastructure; staffed key positions with highly professional, well-trained, and committed personnel; and attempted to give the delegates genuine authority to manage regional budgets.

USAID provided assistance through the 1980s to support ONFP's decision to decentralize management decision-making and to strengthen local managers' capability for solving problems.

Services and Service Delivery

Between 1978 and 1988, USAID assistance was directly targeted to improving service delivery of effective, modern methods (e.g., female sterilization and IUDs) and to diversify service delivery modes.

Major achievements during this period include female sterilization, training in and provision of IUDs, and strengthening of mobile units.

Female Sterilization

USAID funded the training of physicians and anesthesiologists. By 1988, female sterilization was the second most used method and accounted for 25 percent of the increase in prevalence between 1978 and 1988.

Training in and Provision of IUDs

In the late 1970s and 1980s, USAID funded the training of midwives, physicians, and trainers in IUD insertion, which had an important role in the increase in prevalence; in 1988, IUDs were the most used method. Increased use of IUDs accounted for over 45 percent of the increase in prevalence between 1978 and 1988.

Mobile Units

To expand rural outreach and access, USAID provided funding to strengthen the mobile units. By 1985, the number of new acceptors reached through mobile units had increased by 54 percent over the 1982 figure, and mobile units were producing one third of the output of the entire family planning program. In some governorates, mobile units contributed as much as 74 percent of program output.

Evaluation and Operations Research

In the late 1970s and 1980s, USAID supported three major surveys and seven major operations research studies at ONFP. The surveys provided information on fertility, family planning, infant and child mortality, and maternal and child health care.

In-Country Training Capacity

With USAID assistance, ONFP built up the capacity for training its staff in family planning. At graduation, it could provide management, clinical, and inservice training. Also, preservice training was institutionalized in the country's schools of medicine, social work, and nursing.

Information, Education, and Communication

From the 1970s, the work of the animatrices had been central to ONFP's education efforts in rural areas. USAID supported training of the animatrices and educators, the production of information brochures and forms, and the purchase of motorcycles.

Until the mid–1980s, the program relied more on interpersonal communication than on mass media. Beginning in 1986, however, USAID became the sole donor for mass media campaigns conducted in 1988 and 1989.

Contraceptive Social Marketing (CSM)

A social marketing program began in 1986 within the ONFP Communication Directorate with USAID assistance. The effort was administered by and through a public sector program as the government did not want a separate CSM program outside the government. ONFP staff stocked and shipped three brands of oral contraceptives, one brand of condoms, and IUDs to about 30 pharmacy wholesalers around the country. The wholesalers in turn sold the contraceptives to over 1,000 pharmacies. An evaluation report (Rea et al. 1993) had concerns about sustainability because of the prices charged for the contraceptives and the fact that the revenues went into a general ONFP account rather than into a specific social marketing account.

POSTPHASEOUT

There was no information available to the team about what happened after USAID family planning assistance was phased out, except for one report completed in 1993. However, the fieldwork was conducted in May 1992, only about one and a half years after USAID terminated its last bilateral population project. The report (Rea et al. 1993) stated that whereas the prospects for the continuation of the program were good because of strong political commitment, the level and scope of benefits (especially contraceptive commodities, training, IEC, and research) appeared to have declined in the one and a half years and would continue to decline over the years as the government of Tunisia struggled to find funds for program components and contraceptive procurement. While it is unclear how accurate the current data are, it appears that the TFR has continued to decline and contraceptive prevalence has increased in the last 14 years. The current total contraceptive prevalence is 60 percent, of which 49 percent is modern methods (2004 World Population Data Sheet). The 1988 Tunisia DHS showed a total contraceptive prevalence of 50 percent, with 40 percent being modern methods. The TFR in 1988 was 3.7 (1988 DHS) and is currently 2.0, based on the 2004 World Population Sheet.

TURKEY

OVERVIEW AND DEMOGRAPHICS

Turkey is a lower middle income country with a per capita GDI of US$ 2,790. Between 1999 and 2001, the country suffered natural disasters and a financial crisis but has since recovered as a result of focusing on economic reform. Regional and socioeconomic disparities exist, especially in the area of health. There continues to be a heavy reliance on traditional contraceptive methods (such as withdrawal), and abortion rates remain high.

Turkey Demographic and Health Indicators

Population	71,300,000
Infant Mortality Rate	39/1,000
Maternal Mortality Rate	70/100,000
Contraceptive Prevalence (total)	64%
Contraceptive Prevalence (modern) ▪ Sterilization ▪ Oral Contraceptives ▪ Condoms ▪ Injectable Contraceptives ▪ IUD	38% 5.7% 4.7% 10.8% 1.1% 20.2%
Total Fertility Rate	2.5
Unmet Need	unavailable

Sources: Preliminary results from the 2003 DHS

PREPHASEOUT

USAID assistance in population and family planning began in 1975, after the Mission closed. During the 1970s, Turkey's TFR was almost 6 and contraceptive prevalence was 38 percent. By the early 1990s, Turkey was considered a success story, as the TFR had declined dramatically to 2.7, and contraceptive prevalence had risen to almost 63 percent; knowledge of modern methods was almost 99 percent.

Although there were achievements in contraceptive prevalence and the TFR, the use of modern methods remained low (35 percent), with a heavy reliance on traditional methods, such as withdrawal. Huge disparities exist, with high unmet need among the urban poor and rural populations. The wide practice of abortion further reinforced issues related to unwanted pregnancies.

PHASEOUT (1995–2002)

The USAID phase down strategy began in 1995; funding for family planning was reduced from US$ 7.2 million in 1995 to US$ 5.6 million in 1996. It was intended that FP assistance would end by 1999. The USAID phaseout strategy encompassed the following Strategic Objectives for phaseout:

- Increase the availability and effective use of quality family planning and reproductive health services, and;

- Improve Turkey's self-reliance in FP and RH by enhancing public and private sector abilities to meet consumer demand for these services without USAID support.

In order to meet the above Strategic Objectives, the USAID strategy was divided into three main components: policy, quality, and access. Several other organizations, such as UNFPA, IPPF, EU, JICA, and GTZ, also contributed to efforts in family planning during the period of phaseout. In addition, the government of Turkey began to expand the number of health facilities that offered FP services, while the role of the private sector in family planning also expanded.

Policy

The policy objective was to strengthen both policy and the Turkish government's budgetary support for the FP program from the governmental, private, and NGO sectors. Until the beginning of phaseout, USAID had been supplying the public sector with nearly all of its contraceptive requirements. In 1994, the MOH and USAID mutually agreed to a gradual phasedown of contraceptives. In the first year of phaseout, USAID would satisfy 80 percent of program needs for condoms and oral contraceptives and 100 percent of IUD requirements. Donations for condoms and oral contraceptives would decrease thereafter by 20 percent each year. IUDs would be donated to meet full program needs until 1999, when donations would drop by 50 percent, with complete phaseout by 2000.

A budget analysis conducted by the POLICY Project revealed that the Turkish government would need to secure an estimated US$ 4 million by 2000 in order to meet contraceptive requirements for the public sector. In 1996, the Turkish government began purchasing contraceptives, with yearly budgetary increases; by 2000, the government was spending US$ 2.4 million, meeting half the budgetary needs. By 2002, the MOH spent US$ 3.5 million on contraceptives, a noteworthy achievement, given the economic crisis in the previous few years.

NGOs also had a significant role in FP/RH advocacy and promoting sustainability. Turkey's NGO Advocacy Network for Women (KIDOG) advocated at high administrative and political levels to increase awareness and promote support for family planning and reproductive health issues. KIDOG used the mass media to call for immediate government budgetary support for contraceptives, which resulted in a thrust by the president to mobilize funds.

In 2001, the Turkish government adopted a targeting strategy based on a market segmentation study and a feasibility study, which revealed that many public sector users were able and willing to pay for contraceptives. The government piloted a donation policy in seven provinces; clients were asked to donate an amount with which they were comfortable. The intent of implementing such a strategy was to generate revenue for the gap between public sector contraceptive requirements and public budget allocations. Clients that stated their inability to pay were provided with free contraceptives. The strategy was expanded to 18 provinces, reaching two thirds of the population; more than 60 percent of the clients made a donation.

Access

The objective of this component was to increase access

- to FP/RH services and contraceptives in the private and public sectors,
- to postpartum and postabortion services, and
- for underserved populations.

In 1996, the MOH changed its regulations to expand FP/RH services in MOH facilities. All methods, including permanent methods, were to be provided at all MCH/FP centers, and nurse-midwives were now allowed to provide depot-medroxyprogesterone acetate (DMPA) injections. Private sector provision of FP/RH services was successful in that it was the source for 75 percent of oral contraceptives and condoms.

Quality

The intent of this program component was to improve services and information, family planning training, and IEC materials for providers and clients. USAID provided technical assistance to the public sector to improve quality. In addition, USAID worked with the private provider network, the Women's Health and Family Planning Service System (KAPS), and implemented provider training programs in contraceptive technology, counseling, total quality management, quality customer service, clinical skills development, and infection prevention. During the phaseout period, USAID significantly improved clinical training by developing and disseminating national FP service guidelines, developing a standardized competency-based curriculum, and establishing a system of training.

POSTPHASEOUT

Since phaseout, a new government has come into power and reversed the donation policy, stating that contraceptives should be free of charge in the public sector. Although the MOH provides free contraceptives, it targets individuals with an inability to pay. Clients who are willing and able to pay are given a prescription, and they purchase supplies in the private sector.

APPENDIX D

COUNTRY FAMILY PLANNING SUMMARY MATRICES

COMMERCIAL SECTOR

Brazil 1992–2000	Colombia 1992–1997	Ecuador 1992–2001	Mexico 1992–1999	Morocco 1996–2003*	Turkey 1995–2002
▪ Local manufacturing capacity: oral contraceptives ▪ PROFIT and SOMARC worked together to set up contraceptive supply company (CEPEO).	▪ Local manufacturing capacity: oral contraceptives, vaginal foaming tablets (VFTs), injectable contraceptives	▪ CARE assisted CEMOPLAF with studies on **sustainability** of its clinics after USAID assistance.	▪ Local manufacturing capacity: injectable contraceptives (Aplicaciones Farmaceuticas's market includes the Dominican Republic, El Salvador, Honduras, and Nicaragua.) ▪ Schering and SOMARC lobbied unsuccessfully to make oral contraceptives available over the counter.	▪ Services included private doctors, mainly general practitioners, who • have no training in family practice, • tend to be in individual practices in cities and small towns and are professionally isolated, and • are hampered by restrictive regulations concerning advertising, networking, and branding. ▪ During phaseout, CMS concentrated on • promoting policy changes to improve FP/RH services in the private sector, • helping private general practitioners incorporate FP services, and • improving the quality of those services. ▪ No dramatic improvements were obtained but the policy discussions and work with general practitioner organizations did open doors for future changes.	▪ Individuals with the ability to pay purchase contraceptives in the commercial sector.

* Morocco: Planning for phaseout began in the mid–1990s under the final bilateral project that ended in 2000. Transition to full graduation occurred under a Special Objective from 2000–03.

NGOS, INCLUDING SOCIAL MARKETING

Brazil 1992–2000	Colombia 1992–1997	Ecuador 1992–2001	Mexico 1992–1999	Morocco 1996–2003*	Turkey 1995–2002
▪ Focus on BEMFAM: **sustainability**/cost recovery and quality ▪ IPPF Transition Project worked with BEMFAM and SOMARC to launch the PROSEX commercial condom—an important income stream for the financial sustainability of BEMFAM.	▪ Focus on PROFAMILIA: high quality, **self-sustaining**, strong business model ▪ IPPF Transition Project assisted PROFAMILIA in diversifying to a broad set of health services, which was competitive with the commercial sector and helped cross-subsidize FP services for the poorest group. ▪ Endowment set up; used by PROFAMILIA for renovations/ diversification of services	▪ SOMARC set up a social marketing program that later folded. ▪ APROFE and CEMOPLAF: endowment/ **sustainability** funds set up for postphaseout activities	▪ MEXFAM • Focus on **sustainability** and HMIS • Move towards social marketing ▪ FEMAP • Self -sustaining through cost recovery, cost control, and income generation • Offers wide range of services beyond FP ▪ IPPF Transition Project assisted MEXFAM and FEMAP in achieving sustainability by introducing new medical services, which helped cross-subsidize FP services for the poor. ▪ Mission focus • Increase access • Broaden method mix • Strengthen capacity • Develop strategies to improve and expand	▪ Manufacturer's model, with only technical assistance in marketing to manufacturers, pharmacists, and distributors ▪ Distributors assumed all costs of the CSM program, including contraceptives and packaging, and contributed funds for social marketing campaigns sanctioned by the MOH. ▪ NGOs are not important in service delivery: less than 1 percent of DHS respondents reported obtaining their products or services from the IPPF affiliate.	▪ Manufacturer's model used by SOMARC: demand created and clients would use the commercial sector for product

PUBLIC SECTOR

Brazil 1992–2000	Colombia 1992–1997	Ecuador 1992–2001	Mexico 1992–1999	Morocco 1996–2003	Turkey 1994–2000
▪ Phaseout strategy focused on two states (poor) ▪ USAID restrictions did not allow direct assistance to Brazilian central government; focus on private sector and local governments	▪ AVSC trained MOH hospital teams at the state level to train others in surgical contraception	▪ Phaseout strategy limited to the MOH through CARE–APOLO Project community health models and Internet communication facilities for PHN resource center ▪ Commitment of USAID central funds for postphaseout DHS in 2004	▪ Mission focus • Increase access and improve quality • Increase capacity in rural areas • IEC • Research ▪ Major provider of clinic-based FP; MOH (SSA) provides care to individuals with no formal health coverage ▪ Phaseout targeted nine states (rural/periurban)	▪ Mission focus on public sector capacity building and systems development (e.g., monitoring and evaluation, information systems, DHS, NHA), especially for regional teams in the context of decentralization ▪ Gradual increase of government responsibility ▪ Procured all contraceptives by 2000 ▪ **Sustainability** given priority ▪ Gradual transfer of responsibility for all aspects of the program to the MOH (i.e., financial responsibility but also technical assistance by central staff for regional programs) ▪ The MOH procured all contraceptives for the public sector by 2000 and maintained **free distribution in public clinics.**	▪ The MOH procures and distributes contraceptives. ▪ **Targeting of free contraceptives to the poor** via a voluntary contribution structure; piloted in 7 provinces and expanded to 16 provinces where more than 60 percent of the clients make full or partial donations; eventually collected approximately enough to close the financing gap.

PUBLIC–PRIVATE PARTNERSHIPS

Brazil 1992–2000	Colombia 1992–1997	Ecuador 1992–2001	Mexico 1992–1999	Morocco 1996–2003	Turkey 1994–2000
▪ BEMFAM contracts with municipalities to provide supplies and improve quality.	▪ PROFAMILIA contracts with the public sector to provide supplies and improve quality.	▪ Local NGO (CEPAR) was provided with an endowment-like fund and works closely with the MOH and national statistics office (INEC).	Two parastatals ▪ Mexican Institute of Social Security (IMSS) provides coverage to the uninsured in rural areas. ▪ Institute of Security and Social Services of State Workers (ISSSTE) provides coverage to state and federal employees.	▪ Ongoing policy discussions with participation of the director of population to promote private-sector FP services and products ▪ The MOH negotiated reduced costs of airtime for generic advertising of CSM products and assumed responsibility for managing the social marketing program while transferring financial management to the IPPF affiliate.	

POLITICAL COMMITMENT

Brazil 1992–2000	Colombia 1992–1997	Ecuador 1992–2001	Mexico 1992–1999	Morocco 1996–2003	Turkey 1994–2000
▪ National policy on population, FP/RH, and rights ▪ Comprehensive approach to RH prior to Cairo	▪ Official policy on population	▪ Strong support for FP ▪ Policy since late 1980s based on USAID technical assistance to the MOH and CEPAR, on health reform, including support for FP services	▪ Completely decentralized and integrated FP into RH; many thought that this resulted in a decrease in commitment ▪ NGOs participated in public sector–led National Population Council ▪ No line item for commodities, therefore inadequate funding	▪ Strong government commitment to FP from 1960s ▪ FP policy in mid–1970s ▪ FP integrated into the general public health program from the beginning, rather than offered as a vertical program ▪ Weaker commitment to permanent methods of FP. VSC is technically a component of the national program and has received extensive USAID support, but is not considered appropriate for religious reasons	▪ Government policy: the MOH services are free of charge ▪ Members of the Turkish NGO Advocacy Network for Women (KIDOG) had an important role by influencing stakeholders (i.e., parliamentarians and government executive leaders) to support the MCH–FP Directorate's proposed solutions to the phaseout of donor support for FP.

INFORMATION, EDUCATION, AND COMMUNICATION

Brazil 1992–2000	Colombia 1992–1997	Ecuador 1992–2001	Mexico 1992–1999	Morocco 1996–2003	Turkey 1994–2000
▪ Large IEC/BCC campaign developed for PROQUALI (similar to Gold Star in Egypt) ▪ Training of journalists	▪ 1970s–1980s: media had a significant role in FP IEC	▪ Johns Hopkins University, with local NGOs, supported and designed the IEC campaign.	▪ During the first three years of phaseout, 36% of MOU funding was used for IEC. ▪ Knowledge of FP improved during the phaseout. ▪ MEXFAM provides sex education materials in the public schools.	▪ Public IEC campaigns began in the early 1990s.	

APPENDIX E

COUNTRY DATA

COUNTRY DATA

Demographic and Health Data	Brazil		Colombia		Ecuador		Mexico	
	1990	2001	1990	2001	1990	2001	1990	2001
Gross National Product (GNP)	$2,800	$3,090	$1,190	$1,910	$900	$1,370	$2,830	$5,550
Percentage of GNP Spent on Health, Public Sector		3.2%		3.6%		2.3%	2.5% (1995)	2.7%
Population Growth Rate	1.7	1.3	2	1.7	2.3	1.6	1.9	1.4
Total Fertility Rate	2.7	2.2	3.1	2.6	3.7	2.9	3.3	2.5
Maternal Mortality Rate (per 100,000)		260		130		130		83
Infant Mortality Rate (per 1,000)	50	35	29	25	43	25	37	25
Contraceptive Prevalence (Total)	76.7 (1995)		66.1	76.9	52.9	65.8	52.7	68.5 (1997)
Contraceptive Prevalence (Modern)	51 (1996)		33	64	42.4	50.1	45.3	60.1
Unmet Need	18.3 (1991)	7 (1996)	11.1	6.2 (2000)	24 (1987)		14.1% (1996)	
Percentage Urban		81%		75.5%		63.4%		74.6%

Quintile Breakdown	Brazil (1996)			Colombia (1995)			Ecuador*			Mexico*		
	L	M	H	L	M	H	L	M	H	L	M	H
Total Fertility Rate	4.8	2.1	1.7	5.2	2.8	1.7						
Contraceptive Prevalence (Modern)	56	74	77	42.2	62.7	65.7						
Percentage Using Public	69	44.8	30.9	44.3	26	18.2						
Percentage Using Private	28.9	53.6	67.5	54.7	73.8	81.3						
				2000								
Total Fertility Rate				4.4	2.4	1.8						
Contraceptive Prevalence				54	67	66						
Percentage Using Public				46.1	27.9	20.9						
Percentage Using Private				48	68.8	76						

*Data by quintile not available

L = Low	M = Medium	H = High

Methods Used	Brazil	Colombia	Ecuador	Mexico	
	1996	2000	2000	1992	1997
Surgical (Female)	53.6	27.1	22.5	27.3	30.6
Surgical (Male)	3.12	1		.8	1.2
IUD	1.63	12.4	10.1	11.1	14.2
Oral Contraceptives	30.86	11.8	11.1	9.6	6.9
Injectable Contraceptives	2.09	4	3.5	3.2	3.2
Condoms	8.49	6.1	2.7	3.1	4
Barrier/Spermicide		.8	.2		
Periodic Abstinence		6	7.9		
Traditional		6.3	6.5	7.7	8.4
Other		.9	1.4		
Percentage Public	43%	27.4%	38.5%	66.8%	72.3%
Percentage Private	56.7%	69.4%	61%	33.2%	27.7%

Demographic and Health Data	Morocco		Tunisia		Turkey	
	1990	2001	1980	1990	1990	2001
Gross National Product (GNP)	$1,030	$1,190	$1,360	$1,430	$2,270	$2,420
Percentage of GNP spent on Health, Public Sector		2%		5% (1995)		4.4%
Population Growth Rate	2	1.6	2.7	2.4	2.3	1.6
Total Fertility Rate	4	2.9	5.2	3.5	3	2.4
Maternal Mortality Rate (per 100,000)		220				70
Infant Mortality Rate (per 1,000)	66	41	72	41	64	38
Contraceptive Prevalence (Total)	41.5	63	34	49.8	63	63.9
Contraceptive Prevalence (Modern)	22.1	54.8		45 (1992)		
Unmet Need	16% (1995)		20% (1988)		11.2 (1993)	10.1 (1998)
Percentage Urban		56.1%	65.5% (2000)			66.2%

Quintile Breakdown	Morocco (1992)			Tunisia*			Turkey (1993)		
	L	M	H	L	M	H	L	M	H
Total Fertility Rate	6.7	4.2	2.3				3.7	2.5	1.5
Contraceptive Prevalence (Modern)	18	38	48				21	33.1	45.5
Percentage Using Public	80.6	73.2	40.9				65.8	62.7	37.8
Percentage Using Private	19.4	26.7	58.9				32.6	36.6	60.3
							1998		
Total Fertility Rate							3.9	2.7	1.7
Contraceptive Prevalence							24	38	48
Percentage Using Public							65.2	66	37.8
Percentage Using Private							30.9	33.1	63.6

*Data by quintile not available

L = Low	M = Medium	H = High

Methods Used	Morocco (2003)	Tunisia	Turkey (2003)
Surgical (Female)	2.7	11.0	5.7
Surgical (Male)			
IUD	5.4	16.3	20.2
Oral Contraceptives	40.1	8.7	4.7
Injectable Contraceptives	2.1	.8	1.1
Condoms	1.5	1.2	10.8
Barrier/Spermicide	.1	1.0	
Periodic Abstinence	3.8		
Traditional	4.4	9.0	28.5
Other	.1		
Percentage Public			57%
Percentage Private			39%

APPENDIX F

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