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Family Planning Programs in 2004: Efforts, Justifications, Influences, and Special Populations of Interest

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Family Planning Programs in 2004: Efforts, Justifications, Influences, and Special Populations of Interest

by

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Family Planning Programs in 2004: Efforts, Justifications, Influences, and Special Populations of Interest

John Ross, John Stover, and Demi Adelaja

Context: Six study cycles from 1972 to 2004 were conducted to measure the intensity and types of effort exerted by national family planning programs. In 2004 a simpler questionnaire was used and new questions added to explore current issues.

Methods: Informants in each of 83 developing countries completed a standard questionnaire. The returns were analyzed centrally with immediate feedback provided to the countries.

Results: Family planning effort increased from 1999 to 2004 overall and within each region using unweighted country data; with weighted country data all regions except Asia rose. The 2004 effort profile across 30 indices is nearly identical to 1999. Countries beginning with low scores have improved more than countries beginning at high levels. Policy scores are more favorable than scores for actual services. Contraceptive access is uneven by method and limited in sub-Saharan Africa. Negative *influences* bearing on the programs especially concern changes in domestic and donor funding. The strongest *justifications* for the programs concern improved child and maternal health and avoiding unwanted births. Among *groups of special interest* unmarried youth and postabortion women receive the least emphasis.

Conclusions: Overall program effort rose again despite competition with HIV/AIDS programs and the post-Cairo broadening of attention, as well as decentralization of health programs, and reallocations of donor funding. Increased program effort is consistent with continuing increases in contraceptive practice. National justifications for the programs stress health and prevention of unplanned births more than economic development or fertility reduction. Unexplained questions concern the persistence of the same or better program effort ratings despite fragile contraceptive security, some losses in funding, and worsening institutional environments.

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Family Planning Programs in 2004: Efforts, Justifications, Influences, and Special Populations of Interest

Research to measure the effort levels of national family planning programs, separately from their outcomes, dates to 1972, when Robert Lapham and Parker Mauldin developed the first ratings for developing countries.¹ In 1982, the two developed a questionnaire of approximately 120 items and formulated 30 indices, scoring each one on a five-point scale. This approach was replicated in 1989, 1994, and 1999 for 80 to 90 developing countries in each year.

A large amount of literature has emerged over the years, which has been reviewed elsewhere.² The many technical analyses undertaken have yielded insights into the deeper nature of family planning programs. These cover a broad range of features; significant results include the following.

- When countries were divided into two groups by strength of effort (strong vs. weak), two quite different profiles emerged across the 30 indices studied. That indicates a selectivity in the kinds of effort employed as well as the difference in levels.
- Weaker countries that raised their effort levels improved differentially, changing their profiles to resemble those of the stronger group. Their scores rose for example on adequacy of the administrative structure, use of the mass media, and on the availability of female sterilization.
- Correlations among policies, services, and availability declined over the years, another indication that as countries improved they did not do so uniformly. A greater discrimination of effort emerged. For example, the scores of African countries rose more on policy indices than on method availability, reflecting a time lag from policy formulation to implementation.
- The half of countries with higher average scores had a higher score on every index, showing greater effort across the board, not just on a few items.
- While provision of services followed policy positions closely, actual availability of contraceptive methods did not. In general, availability was especially weak.
- Specialized analyses identified 14 clusters of national programs according to their similarity of effort profiles. Further, four factors were found to be imbedded in the 30 indices, for method access, management features, mobilization of policies with

¹ Lapham, RJ and Mauldin WP, National family planning programs: Review and evaluation. Studies in Family Planning, 1972, 3(3):29-52; and Mauldin, WP and Lapham RJ, Measuring the input of family planning programs. Pp. 215-240 in Hermalin AI and Entwisle B, eds., The Role of Surveys in the Analysis of Family Planning Programs. 1982. Liege, Belgium, Ordina Editions.

² Ross JA and Mauldin WP, Family planning programs: Efforts and results, 1972-94, *Studies in Family Planning*, 1996, 27(3):137-147;Ross JA and Mauldin WP, Measuring the strength of family planning programs, IUSSP/EVALUATION Seminar on Methods for the Evaluation of Family Planning Program Impact, Jaco, Costa Rica, May 14-16, 1997; and Ross JA and Stover J, The family planning program effort index: 1999 cycle, *International Family Planning Perspectives*, 2001, 27(3):119-129.

government commitment, and outreach via social marketing, advertising and use of the mass media.

- Program effort was consistently found to have positive effects upon contraceptive use and fertility change, independent of the socioeconomic setting but with a large overlap between the two. Both effort and setting helped, and each had its effects, especially through method availability.
- A diversity of statistical techniques supported these findings: path analysis, multivariate approaches, factor analysis, stem and plot, correspondence analysis, and Bayesian methods.

Four features help to explain the widespread use made of these indices: (1) the simplicity of the 5-point scale, (2) the diversity of 30 features of programs, (3) the indices are applied at one point in time to the whole developing world, and (4) a focus on inputs conceptually separate from effects. The 30 indices provided a data resource that could be related in multivariate work to outputs of interest, as well as to confounding and related variables, including contraceptive use, fertility and fertility preferences, and social and economic characteristics. The ratings also helped those with interests in the substance of program operations and in the levels of effort in different countries and regions. Finally, it permitted an examination of the profiles of effort across the 30 items, and, of particular interest, the underlying dimensions of program effort that are concealed within the various scores.

DATA AND METHODS

In all rounds of the study from 1982 through 1999 the same questionnaire was employed to protect the time trend. However, each study was quite laborious, requiring the identification of likely respondents from different backgrounds and institutions in nearly 100 countries, with extensive follow-up attempts by mail and fax in the pre-email era. Also the questionnaire was lengthy and rather demanding. Therefore, it was thought that a short form should be developed, with fewer items, that could be applied more frequently and at lower cost. As a test of this a "short form" was added at the end of the 1999 questionnaire (termed the "long form"). The short form summarized the meaning of each of the 30 indices in a brief statement and asked the respondent to provide a rating from one to ten. The results of the short and long forms corresponded reasonably closely, with the short form giving somewhat lower ratings overall.³

In the 2004 study reported here, two changes were made in the interest of lower cost and simpler administration. Only the short form was used, recognizing that equivalent "long form" scores might be generated from the relation of scores between the two in 1999. Also, instead of all respondent names being assembled centrally for all the countries, a single study manager was identified for each country, who in turn was instructed regarding the identification of appropriate respondents. It was the manager's task to

³ Ross JA and Cooper-Arnold K, Effort scores for family planning programs: An alternative approach, MEASURE/Evaluation Working Paper WP-01-28, Carolina Population Center, University of North Carolina. <u>www.cpc.unc.edu-measure</u>. July 2000.

select the respondents, explain the short form questionnaire to each one, insure that the form was completed, and return the replies to the authors for central analysis and prompt feedback of results. This system had already been used in a study to measure program effort for national maternal and neonatal programs in over 85 countries, which had worked satisfactorily in 1999 (and was repeated in 2002, with a third round underway in 2005).⁴ The system was also employed to assess national HIV/AIDS programs.⁵

Additionally, four topics were added to the short form questionnaire to inquire into issues surrounding the national programs for family planning that have emerged into prominence since the original questionnaire was developed in 1982. These included assessments of (1) the influences of recent changes in the environment for family planning on overall effort, (2) the major motivations for national governments to support family planning programs, (3) populations receiving special focus, and (4) the quality of family planning services.

RESULTS

The total score: The mean score across all 30 components for the 83 countries included in the survey was 48 out of 100. We can estimate the long term score consistent with the previous rounds by adjusting for the difference between the short and long form results in 1999.⁶ That produces an estimate for 2004 of 56 for all countries. The highest regional score is found in Asia (66), followed by the Central Asian Republics (59), Anglophone Africa (56), Middle East and North Africa (55), Latin America and the Caribbean (53), and Francophone Africa (53). Every region showed improvement from 1999 to 2004. The Latin America average changed little from 1989 through 1999, but it joined the other regions in rising by 2004.

The mean total score for the 72 countries that participated in both studies rose from 53 to 56. That is a relatively small 6% rise, but it continues the same upward slope as observed in previous periods (**Figure 1**). The initial conclusion is that the programs as a whole did not suffer a reversal in the five-year period from 1999 to 2004. That conclusion stands up for the individual regions (not shown), but it only partially survives when countries are weighted by their populations.

⁴ Bulatao RA and Ross JA, Rating maternal and neonatal health services in developing countries. *Bulletin of the World Health Organization*, 2002, 80:721-727; and Ross JA and Begala J, Measures of strength for maternal health programs in 55 developing countries: The MNPI study. *Maternal and Child Health Journal*, 2005, 9(1):59-70.

⁵ Stover J and Begala J. *Coverage of selected services for HIV/AIDS prevention, care and support in lowland middle income countries in 2003* Washington, DC: Futures Group/POLICY Project, June 2004.

⁶ In 1999 the average total score from the short form fell several points below that for the long form. This difference was added to the 2004 short form score to estimate what the long form would have produced. That extended the time series for the long form as shown in Figure 1. With this procedure the change shown from 1999 to 2004 is identical to the change found in the short form data between 1999 and 2004.

Weighted data change the picture considerably, as shown also in **Figure 1**. Certain large countries have behaved differently from the smaller ones and have introduced declines in the mean ratings in Asia and Latin America, and therefore in the global picture. In Asia, this is largely due to markedly lower scores for China and Indonesia (the national program in Indonesia has evolved in different directions in recent years, and the decentralization of health and family planning functions has introduced many changes). In Latin America, Brazil and Mexico reported lower scores than in 1999. On the other hand, the mean score rose in both sub-Saharan regions and in the Middle East/North Africa, as well as in the Central Asian Republics (in some of which contraception has been replacing abortion).⁷ The sub-Saharan results are unexpected in light of the widespread impression that the HIV/AIDS crises there have weakened all government activities and have diverted attention and resources from family planning.

One dynamic bearing on this is the greater improvement possible in countries that start with low scores. Unlike the top performers, many of which reached ceiling levels some years ago, the low scoring countries have had ample room to move up in the ratings. Dividing all countries into quartiles by their 1972 scores, and following each group as a cohort, **Figure 2** shows the pattern: the top quartile scored high at the start and rose little before plateauing. The second highest quartile rose rapidly from a very low start and now essentially matches the level of the highest quartile. The bottom two quartiles have followed similar paths, rising to about 50% of maximum, and show signs of slowing their advance.

Note that even the highest quartile has leveled off at only 60% of maximum. The individual countries with the highest scores over the years have stabilized at 80% to 85% of maximum. Taking that as a ceiling level, the average score of about 56% can be viewed as about 68% of what appears to be possible. That is roughly two-thirds of the possible, which leaves substantial room for improvement.

In the most recent period, countries starting at lower levels again rose more than others. The fourth of countries with the lowest 1999 scores rose on average by 13 points, while the fourth of countries with the highest 1999 scores fell by about four points.

Score Gail	is by Starti	ing Level (i	neulans
Quartiles in 1999	1999	2004	Gain
1	30.2	43.1	12.9
2	40.1	42.4	2.3
3	49.7	47.1	(2.7)
4	60.2	56.5	(3.7)

Score Gains by Starting Level (medians)

⁷ Westoff CF, Sharmanov AT, Sullivan J, and Croft T, Replacement of abortion by contraception in three Central Asian Republics, 1998. Calverton, MD: POLICY Project and Macro Int'l.; and Westoff C, The substitution of contraception for abortion in Kazakhstan in the 1990s, *Demographic and Health Surveys Analytical Studies*, No. 1. 2000. Calverton, Maryland: ORC Macro; and Westoff CF, Recent trends in abortion and contraception in 12 countries, 2005, DHS Analytical Studies No. 8, ORC Macro, Calverton, MD.

Sub-Saharan Africa is over-represented in the lowest two groups, as is Latin America, while Asia is over-represented in the two highest groups. However, all regions have members in every group, testifying to a persistent diversity among countries within each large region.

Scores for 30 Program Functions and for Score Components

The overall effort index is composed of 30 items, or program functions, and these are organized into four components, for policies, services, evaluation, and method availability. **Figure 3** shows the 30 items, as measured in both 1999 and 2004 on the short form. The correspondence is remarkably close for two independent studies conducted five years apart with largely different respondents. The same closeness appears within each region as well (not shown). That is reassuring as to the methodology, and it gives greater confidence in the substantive results.

Most ratings cluster in a middle range, and the exceptions differ in ways that are plausible. For example, the use of incentives and disincentives, which fell out of favor many years ago, are rated lowest of all. Access to male sterilization is rated very low while access is rated high for both the pill and condom.

The similarity of patterns in the two cycles of the study also point to a general stability in the character of these programs. Average scores changed very little, reflecting a continuity in the fundamental character of programs overall. The few scores that did change noticeably concern program outreach: for community-based distribution, social marketing, and postpartum programs, which is a good sign.

The four components of the scores show systematic differences in effort that hold true in every region. Policies are always stronger than services (**Figure 4**), which reflects the relative ease in issuing favorable policies compared to the difficulties of implementing them. However, policy strength differs considerably from one region to another: it is greatest in Asia, and least in sub-Saharan Africa and Latin America, where the health rationale has always eclipsed a narrower family planning rationale.

Availability of Contraceptive Methods: Especially important is access to a variety of contraceptive methods, and this too varies considerably by region. The overall rating shown above for the availability component is detailed for individual methods in **Table 1**. While the regions are quite similar in their high levels of pill and condom access, and their moderate levels of injectable access, they vary sharply in access to the IUD and to female sterilization. The IUD values fall within a moderate range, those for female sterilization within a lower range. Access to male sterilization is uniformly low, except in Asia. Regional preferences differ sharply: in survey data the IUD is favored in North Africa and the Middle East and in the Central Asian Republics, while its use is negligible in every one of the sub-Saharan countries. Asian and Latin American countries are inconsistent: some have high IUD use and others have rather little.

Asia ranks first in average access across the six methods, at 60% of maximum; next is a cluster at 53% for Latin America, Middle East/North Africa, and Central Asia Republics. Below those are Anglophone sub-Saharan Africa at 49% and Francophone countries at 46%. The grand mean is 51%.

The study also asked for ratings on the reliability of supply lines for each method, for example for the pill: "How well does the pill supply system operate (it avoids stockouts or interrupted supplies and guarantees a reliable flow at local levels)." In every region, these supply ratings fell below the access ratings for condoms (average 77% rating for access vs. 71% for supplies). The same was true in nearly every region for the pill (67% vs. 58%) and the injectable (61% vs. 55%). In contrast, little supply-access difference existed on average for the IUD and male and female sterilization; for them a continuous monthly supply component is less critical in comparison to the pill, injectable, and condom.

Assessments of the Programs

Respondents were asked to provide information on the following topics, which were included for the first time in this 2004 round of the study. These were relatively simple exploratory efforts, but the results are provocative and for the most part follow plausible patterns.

- Major justifications of the programs
- Special populations given attention by the programs
- Major influences affecting the national family program
- General quality of the programs.

The results are summarized by region in **Table 2** and discussed in detail below. (Regional averages give countries equal weights.)

Justifications for the National Program: Given the profound changes in the international context for family planning we wished to assess current justifications for it as viewed within individual countries. Respondents rated each of seven possible justifications for the program (**Table 2, panel A**) on a scale from 1 to 10 (negligible importance to great importance). Reduction of population growth fell considerably below the others, but enhancement of economic development rated as well as the reduction of unmet need or the lessening of unmarried childbearing by adolescents. Highest however, above 80% of maximum, was the trio of improving child health and women's health, and avoiding unwanted births. That is consistent with the post-Cairo perspective, as is the neglect of population growth, especially in Latin American and in the Central Asian Republics. Reduction of adolescent childbearing is not rated very high, and it is scored especially low in the Middle East/North Africa.

Special Populations: to what extent does the national program give particular emphasis to special populations? Respondents rated each of the populations in **Table 2, panel B** from 1 to 10 (negligible emphasis to great emphasis). The differences were not great among the five populations, and all fell at about half of the maximum score. Unmarried

youth received the lowest average score at 48%, with especially low scores in Asia and also in the Middle East/North Africa, where in addition counseling for postpartum and postabortion women were rated very low.

Major Influences on the National Program: The respondents were asked to rate each influence in **Table 2 panel C** on a scale from -5 to +5 to indicate whether its effect on the program was negative or positive. The ratings were averaged for the *net effect*, but many responses were quite negative for the effect of changes in funding, both domestic and donor, and they were not very favorable for the effects of decentralization. Responses were favorable, if a little mixed, for the effects of HIV/AIDS programs, whereas we expected stronger negative indications that would have squared with numerous observer reports, especially in sub-Saharan Africa. The most favorable ratings were for the integration of family planning with other health services and for the incorporation of family planning into a broader context of reproductive health; however neither of these exceeded 60% of the maximum of a 5 rating.

Anglophone sub-Saharan Africa is a negative outlier regarding influences on the programs. Its ratings are remarkably low on all six influences in panel C. Three other regions are equally negative regarding the effects of decentralization, but it is uniquely negative on the other influences. Anglophone sub-Saharan Africa also gave some of the lowest ratings in panel B.

The net ratings are useful to show the general placement of donor and domestic funds in relation to the other influences. However, they conceal the distributions along the -5 to +5 scale. For changes in donor funding, 53% of countries recorded negative ratings, and 26% recorded negative ratings for changes in domestic funding. (Negative ratings reflected lost funds, not damaging effects of the funds received.) In contrast, hardly any countries received negative ratings for the other influences. The distributions for those rested largely on the positive side, though with a wide range. Decentralization was the least positive. The net influence of HIV/AIDS programs upon the family planning programs was also positive, but with strong regional differences: least positive in Anglophone sub-Saharan Africa and considerably more positive in Francophone sub-Saharan Africa.

Putting the results together from the three topics above, domestic and donor funding are clearly judged to have deteriorated in some countries. Decentralization of programs is seen as a mixed blessing, and only moderately positive ratings go to the integration of family planning into other health services or its incorporation into a broader RH context. The reduction of population growth received a low priority, in contrast to the improvement of maternal and child health and reducing unwanted births. The various special populations of interest received about the same stress, with somewhat less for unmarried youth. All this probably accords with the impressions of program observers, but until now no cross-country set of data was available for confirmation.

Overall Quality of Programs: Respondents were asked to rate the overall quality of family planning program services on a scale from one to ten, as follows:

"Please rate the general quality of family planning services. (Good quality includes a focus on client needs, with counseling, full information, wide method choice, and safe clinical procedures.)"

The concept of "quality" is somewhat general but it is commonly used and it can be assumed that close observers of a national program can at least gauge whether it is very poor, very good, or somewhere in the middle. Regional ratings varied around the global average of 52%, at only about half of the maximum of a 10 rating.

56.2
57.2
53.0
49.1
52.7
48.5
51.6

Average ratings were highest for countries in Asia and the Central Asia Republics. Francophone SSA services were rated below those in the Anglophone SSA countries, a pattern that departs from the very low Anglophone ratings above. However, both are at rather low levels; also, quality services in Latin America was rated low. Country variation was large: for example within Asia, Thailand, Malaysia, and Vietnam received high ratings (73% - 76%) while Myanmar and India received very low ratings (25% and 39%, respectively). Within Latin America, high ratings went to Chile (79%) and to Costa Rica, Jamaica, and Mexico (65% - 68%), and low ratings resulted for Haiti, Puerto Rico, Uruguay, and Venezuela (29%-33%).

DISCUSSION

The results of this study are welcome but somewhat unexpected. The continued upward movement of the total effort score for national family planning programs is surprising in view of the intense reports from the field that stress diminished attention to family planning in much of Africa and elsewhere, as well as the declining emphasis given to it within some donor organizations. The HIV epidemic, particularly in Africa, is believed to have diverted attention from contraceptive services, even though that is counterproductive. A more general but persistent theme is the changed ideological climate in the post-Cairo period, which is thought to have broadened attention toward other reproductive health topics. While that has almost certainly modified funding allocations by donors, it is difficult to know the extent of actual changes within individual countries in either intentions or practices. In any case, the data emerging from this study show, on net, an increase in family planning effort. The overall increase might have been even larger except for the HIV competition and the broadening of focus, although the slope in **Figure 1** for the 1999-2004 period is about the same as before. The increase might be explained away by methodological arguments, although those are seldom cited when results agree with expectations. Given the conflict between field impressions and study data it is best not to discard the data, but to keep both in hand pending further information.

Several patterns within the data are in fact supportive: **Figure 3** shows the nearly identical correspondence in the score profiles in 1999 and 2004. It also highlights the plausible differences in access to the various methods, as well as the very low score for incentive measures. From cycle to cycle, the upward trend in the average total score is consistent and smooth, not erratic. Groups of countries that scored high in 1972 and 1982 have remained high, and those at very low levels have moved sharply upward, with an even pattern of separation between them through time. All such results have occurred across studies that were conducted independently, with long intervals between. An unreliable methodology could not have yielded these patterns, and it is preferable to trust the 2004 results rather than to discount them in favor of advanced expectations.

A notable finding is the sharp difference between Anglophone and Francophone countries. The Anglophone ratings are below the Francophone ratings on six of the seven justifications for national programs in **Table 2** and on ratings for most special populations, but the differences are greatest on the influences that act on the programs. In Anglophone countries, the heavier burden of the HIV pandemic has probably been important, given the high HIV prevalence in South Africa, Namibia, Botswana, Zimbabwe, Zambia, and other east and south African countries.

The rising effort score is consistent with the continuing upward trend in contraceptive use in the developing world, and that too needs explaining given the difficulties outlined above. Possible explanations, besides program effort and commercial activities, include the currents of modernization that drive down the demand for children, such as rising education levels and female employment, and ever higher proportions of populations living in cities. Despite the growing population base the *percentage* of couples using a method has still risen.⁸ That has required growth in the capacities of the service sectors, whether private or public, to handle the rising numbers of users, especially since most growth has been in resupply methods. While increased program effort and increased contraceptive practice have both persisted, unexplained questions remain as to how this has happened despite fragile contraceptive security, some losses in funding, and worsened HIV institutional environments.

⁸ United Nations, "World Contraceptive Use 2003: Trends in Contraceptive Prevalence, 1990-2000," Wall Chart. New York: United Nations Population Division. December 2003. Also J.A. Ross, J. Stover, and D. Adelaja, *Profiles for Family Planning and Reproductive Health Programs: 116 Countries*. 2nd edition. Futures Group, 2005.

These measures of effort for national family planning programs are the only thing of the kind, with their various strengths and shortcomings. They offer a long time series, with each round covering most developing countries. A common questionnaire is employed; the data pertain to a single time frame, and the cost is reasonable. The scores can be supplemented by additional, topical questions, as was done in the 2004 round. The reliability of the data appears to be good at the global and regional levels and with some caution at the country level. Against these strengths are expressed reservations that the scores are grounded in the judgments of observers who themselves are chosen by judgmental means, in contrast to empirical information from survey-type variables based on representative samples of households. Concerns that the scores were set some 25 years ago and may no longer capture the key features of national programs can be addressed by the addition of supplementary questions in each round.

Probably no complete substitute for this kind of study will emerge since the alternatives face severe logistics difficulties. Each sample survey and each situation analysis of service points must be mounted individually through a lengthy process within each country, without the option of producing uniform data on 80 to 90 countries at once. Depending upon the research interest, however, the large body of secondary data from sample surveys and situation analyses can be mined for conclusions that have wide generality. Data from the six rounds of this research, conducted from 1972 through 2004, are also available to the research community.

Table 1. Ratings for Access to Modern Contraceptive Methods

	Mean access for all methods	IUD	Pills	Injectables	Condoms	Female sterilization	Male sterilization
Asia	59.6	56.4	73.4	58.3	78.7	51.3	39.3
Central Asia Rep.	53.8	72.0	56.0	47.8	76.4	49.6	21.1
Middle East/North Africa	52.3	64.7	77.5	52.7	74.8	31.5	12.4
Latin America	53.4	51.6	71.1	56.7	74.3	44.3	22.2
Anglophone SS Africa	49.1	36.3	67.7	60.5	76.4	33.2	20.6
Francophone SS Africa	46.1	41.3	66.6	60.7	77.2	19.9	11.0
All Regions	51.3	50.5	68.2	56.1	75.9	36.5	20.6

Table 2: Ratings for Issues Bearing on National Family Planning Programs.

A. Ratings for Justifications of the National Program

	Reduce population growth	Enhance economic development	Avoid unwanted births	Improve women's health	Improve child health	Reduce unmarried adolescent childbearing	Reduce unmet need for contraceptive services
Asia	63.2	70.2	79.4	80.2	78.3	59.0	74.9
Central Asia Rep.	38.3	71.4	85.5	90.6	86.7	73.4	66.8
Latin America	44.2	59.4	85.8	86.2	81.7	76.8	74.3
Middle East/North Africa	68.5	72.7	73.2	77.4	74.5	30.9	65.5
Anglophone SSA	58.3	68.6	79.4	82.8	78.5	66.4	68.8
Francophone SSA	48.8	71.7	85.1	88.4	86.8	76.9	73.1
All Regions	46.4	67.2	82.4	85.9	81.8	67.7	70.0

B. Emphasis on Special Populations by the National Program

D. Emphasis on Specia	b. Emphasis on Special Populations by the National Program									
	Unmarried youth	The poor	Rural populations	Counseling and contraceptive services for postpartum women	Counseling and contraceptive services for postabortion women					
Asia	36.4	63.5	67.1	58.3	53.2					
Central Asia Rep.	59.0	57.2	67.6	71.3	69.3					
Latin America	51.6	61.4	53.0	58.2	48.3					
Middle East/North Africa	24.6	61.2	62.2	43.4	26.7					
Anglophone SSA	44.8	43.6	46.9	51.3	47.2					
Francophone SSA	51.5	44.2	48.9	49.8	48.7					
All Regions	47.8	54.0	56.5	57.4	52.3					

C. Ratings for Influences on the National Program

C. Ratings for influences on the National Frogram										
	Decentralization	HIV/AIDS programs	Incorporation of family planning	Integration of family planning with other health services	Changes in donor funding	Changes in domestic government funding				
Asia	27.7	40.2	56.1	54.0	5.8	12.8				
Central Asia Rep.	24.6	65.6	68.4	68.3	28.6	31.9				
Latin America	28.2	41.1	53.4	49.0	-2.4	13.2				
Middle East/North Africa	43.1	34.2	61.3	53.1	-15.6	9.4				
Anglophone SSA	27.4	12.7	39.8	40.6	-21.0	-3.8				
Francophone SSA	40.9	52.3	58.6	58.0	-2.1	24.9				
All Regions	32.6	44.0	59.2	54.5	-0.6	12.7				



Figure 1. Trends in the Total Effort Score, 1972-2004



Figure 2. Increases in Total Effort Score by Quartiles in 1972

Figure 3. Close Match of the 30 Effort Scores Between 1999 and 2004, Listed by Component (72 countries common to both years)



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Figure 4. Effort Scores by Component and Region

Table 2: Ratings for Issues Bearing on National Family Planning Programs

A. Ratings for Justifications of the National Program

	Reduce population growth	Enhance economic development	Avoid unwanted births	Improve women's health	Improve child health	Reduce unmarried adolescent childbearing	Reduce unmet need for contraceptive services
Asia	63.2	70.2	79.4	80.2	78.3	59.0	74.9
Central Asia Rep.	38.3	71.4	85.5	90.6	86.7	73.4	66.8
Latin America	44.2	59.4	85.8	86.2	81.7	76.8	74.3
Middle East/N. Africa	68.5	72.7	73.2	77.4	74.5	30.9	65.5
Anglophone SSA	58.3	68.6	79.4	82.8	78.5	66.4	68.8
Francophone SSA	48.8	71.7	85.1	88.4	86.8	76.9	73.1
All Regions	46.4	67.2	82.4	85.9	81.8	67.7	70.0

B. Emphasis on Special Populations by the National Program

	Unmarried youth	The poor	Rural populations	Counseling and contraceptive services for postpartum women	Counseling and contraceptive services for postabortion women
Asia	36.4	63.5	67.1	58.3	53.2
Central Asia Rep.	59.0	57.2	67.6	71.3	69.3
Latin America	51.6	61.4	53.0	58.2	48.3
Middle East/N. Africa	24.6	61.2	62.2	43.4	26.7
Anglophone SSA	44.8	43.6	46.9	51.3	47.2
Francophone SSA	51.5	44.2	48.9	49.8	48.7
All Regions	47.8	54.0	56.5	57.4	52.3

C. Ratings for Influences on the National Program

	Decentralization	HIV/AIDS programs	Incorporation of family planning into broader context	Integration of family planning with other health service	Changes in donor funding	Changes in domestic government funding
Asia	27.7	40.2	56.1	54.0	5.8	12.8
Central Asia Rep.	24.6	65.6	68.4	68.3	28.6	31.9
Latin America	28.2	41.1	53.4	49.0	(2.4)	13.2
Middle East/N. Africa	43.1	34.2	61.3	53.1	(15.6)	9.4
Anglophone SSA	27.4	12.7	39.8	40.6	(21.0)	(3.8)
Francophone SSA	40.9	52.3	58.6	58.0	(2.1)	24.9
All Regions	32.6	44.0	59.2	54.5	(0.6)	12.7

Countries Included in the 2004 Study

Asia

Bangladesh Cambodia China India Indonesia Malaysia Mongolia Myanmar Nepal Pakistan Philippines Thailand Vietnam

Central Asia Rep.

Kazakhstan Kyrgyzstan Tajikistan Turkmenistan Uzbekistan

Caucasus

Armenia Azerbaijan Georgia

Latin America

Argentina Bolivia Brazil Chile Colombia Costa Rica **Dominican Republic** Ecuador El Salvador Guatemala Guyana Haiti Honduras Jamaica Mexico Nicaragua Panama Paraguay Peru Puerto Rico Uruguay Venezuela

Anglophone SS Africa Ethiopia Gambia Ghana Lesotho Liberia Malawi Mozambique Namibia Nigeria South Africa Swaziland Tanzania Uganda Zambia Zimbabwe **Francophone SS Africa** Benin Burkina Faso Burundi Cameroon Central African Rep. Chad Congo Congo, DR Côte d'Ivoire Guinea Madagascar Mali Mauritania Niger Rwanda Senegal Togo Guinea-Bissau

Middle East/N. Africa

Egypt Jordan Lebanon Morocco Turkey Yemen