
U.S. POPULATION

ASSISTANCE:

ISSUES FOR

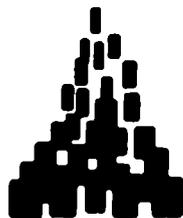
THE 1990s

by

Shanti R. Conly

J. Joseph Speidel, M.D., M.P.H.

Sharon L. Camp, Ph.D.



*Population Crisis
Committee*

Population Crisis Committee

1120 19th Street, N.W.

Suite 550

Washington, D.C. 20036

PC-AAA-207

ISBN 75258

U.S. POPULATION

ASSISTANCE:

ISSUES FOR

THE 1990s

by

Shanti R. Conly

J. Joseph Speidel, M.D., M.P.H.

Sharon L. Camp, Ph.D.

Population Crisis Committee

1120 19th Street, N.W.

Suite 550

Washington, D.C. 20036

1991



Printed on recycled paper

Introduction

The official United States population assistance program was launched in early 1965, when under pressure from the U.S. Congress the U.S. Agency for International Development (AID) announced it would make a little over \$2 million available for technical assistance to family planning activities. AID, which implements the U.S. foreign aid program, had previously supported some demographic research. But a growing sense of urgency regarding the problem of rapid population growth, manifested at the very highest levels of government, including President Lyndon Johnson himself, led to the U.S. decision to stimulate and support action programs to make family planning available in developing countries. In 1967, the fledgling U.S. effort received a major boost when Congress earmarked an increased \$35 million for population activities. Over the next decade and a half, funding for population programs overseas rose steadily, reaching a high of over \$300 million in 1985.

Over the years, AID has provided over \$4 billion in population aid and has developed a large, sophisticated and highly successful population assistance program. From about one-third to one-half of AID's population assistance has been provided directly to about 40 developing countries for projects managed by AID field missions. The rest, administered centrally from Washington, D.C., by AID's Office of Population, has supported a variety of population activities in over 100 countries through worldwide or regional projects implemented through agreements with private U.S. organizations. Through 1986, the Office of Population also provided an annual U.S. contribution to the U.N. Population Fund. The results of combined

efforts by national governments, AID and other donors over the past 25 years are impressive; family planning programs are now institutionalized in many developing countries, about a third of couples in the developing world outside of China use modern contraception, and average family size is falling rapidly in many countries.

Despite significant progress on the demographic front, the number of couples who need family planning is projected to increase by 75 percent over the next decade, reflecting both the growing demand for contraception and the increase in women of childbearing age resulting from demographic momentum. Meeting this demand and avoiding another doubling of the world's population will require that annual expenditures on family planning in developing countries rise from the current \$3 to \$4 billion to over \$10 billion by the year 2000. Developing country governments and consumers will inevitably assume much of this burden, but a major share of these resources will have to come from the wealthy industrialized countries. While other donors have lagged behind the United States and must increase their contributions, U.S. leadership and financial support is critical to achieving this goal.

To help focus attention on the resource needs of family planning programs over the next decade, the Population Crisis Committee (PCC) is taking a hard look at support provided by the major donor countries and governments of the demographically most significant countries. A thoughtful reassessment of the U.S. population assistance effort appears timely given the importance of the overall U.S. contribution, the wavering of the U.S. Administra-

tion's commitment to population assistance in recent years, and the changing demographic profile and needs in developing countries.

A comprehensive review of AID's population program was carried out in 1990 by the U.S. General Accounting Office (GAO) at the request of Congress. The GAO report documented AID's considerable achievements. It also highlighted the current tensions between Congress and the Administration over population assistance policy, and the diffusion of management of the population program within AID. But in PCC's view, the GAO review did not recognize important weaknesses in current management of the program; moreover, its overall recommendations failed to address many critical issues relating to the effectiveness of AID's population program in the future.

Motivated in part by the perceived shortcomings of the GAO effort, PCC has prepared what it hopes is a constructive critique of the U.S. population assistance effort. In preparing this report, the authors solicited comments from many colleagues, both in the United States and overseas, regarding AID's effectiveness as a donor in the population field. While anonymity was promised to all who participated in this effort, the authors would be remiss not to acknowledge their considerable debt to these individuals for their insights in identifying the strengths and weaknesses of AID's population program. As with most such reports, the focus, of necessity, is on those areas where action is needed to strengthen current efforts. These criticisms must, however, be viewed in the context of AID's enormous achievements in population and family planning; we therefore preface our report with an overview of the U.S. contribution to global fertility reduction efforts over the last 25 years.

I. The U.S. Contribution: 1965-1990

From a demographic perspective, much has been accomplished during the period 1965 to 1990. When AID first launched its population assistance program, family planning was a controversial subject with most Third World governments. Today, 95 developing countries provide support to family planning. Contraceptive use in developing countries has risen dramatically, from about 10 percent of women of childbearing age in the early 1960s to about 50 percent today (including China). In Mexico, Brazil, Thailand, and several other countries where AID has provided substantial assistance, levels of contraceptive use now approach those in industrialized countries. Over the past 25 years, average family size has fallen dramatically in many Asian and Latin American countries. A handful of developing countries, primarily in East Asia — Thailand, Korea and Taiwan — have achieved the seemingly unattainable goal of replacement fertility within less than a generation. Even in Africa, where prospects for fertility decline have generally been considered poor, there is now evidence of rapidly increasing contraceptive use and declining family size in Botswana, Zimbabwe and Kenya.

Of course, AID alone cannot take credit for these successes; both national governments and other donors have played a crucial role, and social and economic change has been an important factor in increasing demand for contraception and decreasing desired family size. But U.S. assistance has undoubtedly made an important contribution. Wider availability of modern family planning services has been critical to the demographic revolution which has taken place across much of the developing world. And by helping to make modern contraceptive technology more easily accessible to Third World couples, American foreign aid has helped accelerate the rate of demographic

change and contributed to long-term fertility decline in developing countries.

The detailed achievements of the U.S. population assistance program over the last 25 years are too numerous to elaborate here. But in broad terms, the most important elements of the U.S. contribution to reductions in world birthrates include:

- the magnitude of resources provided by AID, including contraceptive supplies;
- the strong focus on family planning services;
- technical leadership provided by AID and the private U.S. institutions, called Cooperating Agencies, with which it works;
- the remarkable level of innovation in AID's program;
- empirical evaluation of progress through periodic demographic surveys; and
- the technical and managerial assistance provided through AID's field presence.

Together, these factors have contributed to the success of family planning efforts in many countries which have received substantial AID population assistance over the years.

The magnitude of the U.S. resource commitment: The sheer bulk of U.S. assistance has been important, as has been AID's staying power as a donor over time. Since 1965, AID has allocated over \$4 billion for population activities in developing countries. Congress has earmarked substantial funds for population assistance every year since 1967. In most countries where AID has concentrated its assistance, AID has maintained continuity in support for population activities over a period of a decade or longer.

The United States has unquestionably been the dominant presence in the population and family planning field. Historically, AID's financial support has constituted roughly half of all

international aid to worldwide family planning efforts. In a number of countries, AID assistance in the early years accounted for the bulk of national budget allocations for population and family planning. Despite recent political setbacks AID remains the largest single donor in population/family planning today, contributing roughly a third of total assistance from all sources — bilateral, multilateral, and private philanthropic.

Provision of contraceptives: AID has been the largest donor of contraceptive supplies to developing countries. Over the period 1965 to 1990, the Agency spent about \$650 million on the purchase of contraceptives, including over 7.5 billion condoms, 1.6 billion monthly cycles of birth control pills, and about 55 million IUDs. As demand has grown, AID has increased funding for contraceptive procurement; in 1990 alone, AID spent \$66 million, roughly one-fourth of population expenditures, on contraceptive supplies. Although AID currently provides commodity assistance to about 70 countries, the bulk of this assistance has been concentrated in a relatively small number of countries — over 90 percent of contraceptive purchases in 1988 went to 20 countries, and 56 percent to five countries.

AID-supplied contraceptives have had a substantial impact on availability. In many developing countries, AID has been the primary source of contraceptive supplies in the initial phase of family planning activity. The importance of this assistance should not be underestimated, since in many countries local manufacture of contraceptives is non-existent and foreign exchange to purchase imported contraceptives is limited. The donation of contraceptive supplies by AID has enabled developing country governments to provide subsidized contraceptives to consumers who could not afford the full commercial price. AID is also the only donor which has provided systematic assistance to countries in planning their

contraceptive needs and strengthening commodity distribution and management. No other donor has this capacity at present.

Program focus: From its inception, the AID population assistance program has been driven by a consensus that wide availability of modern contraception is crucial to lowering fertility and slowing population growth. Over time, this consensus has been reflected in both AID's program strategy and patterns of resource allocation. AID assistance has consistently focused on expanding family planning services and developing effective delivery systems. Reflecting these priorities, direct operational support for family planning services, together with service-related activities such as training, information dissemination, and contraceptive supplies, have accounted for over three-fourths of overall AID assistance for population.

AID's approach has been criticized for inadequate attention to cultural and behavioral factors influencing demand, and heavy-handedness in pushing contraception. Over time, the Agency has made some refinements in its strategy to address some of these concerns. On balance, however, AID's emphasis on family planning services has brought with it a unity of purpose that has served the program well. Indeed, a large part of AID's success in developing a significant and effective program can be attributed to the concentrated application of resources to the basic problem identified early on — that of inadequate access to contraception. In comparison, population assistance provided by other donors has often been more broadly directed at strengthening overall health systems and has been much less closely linked with increased availability of family planning services.

Technical leadership: AID has strongly emphasized professionalism in its population program and has been the driving force behind the scientific management of population and family planning programs in the developing world. Much of AID's technical strength stems

from the sustained institutional support it has provided to its private Cooperating Agencies; today, the Cooperating Agencies represent a breadth and depth of technical expertise in all key program areas that is unparalleled throughout the world. The strong public-private partnership with the Cooperating Agencies has been key to AID's ability to provide high quality technical advice to governments and private family planning groups in the Third World.

Related to AID's technical leadership has been the success of its long-term institutional investments. For example, AID's support has contributed to the emergence of the Population Council as the premier organization engaged in fertility-related biomedical and social science research worldwide. Similarly, AID funding has helped the Association for Voluntary Surgical Contraception (AVSC) to play a key role in expanding the availability and improving the quality of voluntary sterilization services around the world, and in promoting the use of simpler and safer sterilization techniques for both men and women. Like the Council, AVSC has established a reputation for excellence and has become a leader in its field. These are just two of many institutional successes associated with AID's population program. Moreover, AID's Cooperating Agencies, working with indigenous organizations in developing countries, have helped to cultivate local technical expertise and centers of excellence.

Harnessing of innovation: The bold, pioneering and risk-taking character of AID's population assistance program is remarkable, given the Agency's strong bureaucratic culture and the political controversies that have plagued the program over the last decade. Virtually every major innovation in the population and family planning field can be directly or indirectly linked to AID support; in contrast, few important innovations, if any, are associated with other donor countries.

Alone among the major donors, AID has

consistently and vigorously sought to utilize the private sector in expanding access to family planning services, initially working with private non-profit groups and more recently involving private health care providers and employers. AID also pioneered the development of a variety of successful approaches to extending family planning services outside traditional health networks, including the subsidized promotion and sale of contraceptives through commercial retail networks (social marketing) and community-based outreach programs to provide family planning advice and services to women in their neighborhoods or homes. AID support for the private sector and non-clinical service delivery has had an enormous impact in increasing the availability of contraceptives outside government health bureaucracies, which in many countries are noted for their inefficiency and relatively limited coverage. Largely owing to AID's efforts, couples in dozens of countries, including Bangladesh, Mexico, Brazil, Egypt and Zaire, can obtain high quality and affordable family planning services through a variety of channels.

AID has also encouraged creativity in applying modern technology to the population and family planning field. Through its support to the Johns Hopkins Center for Communication Programs, AID became the first donor to use sophisticated communications know-how to strengthen family planning education activities. With AID support, the Futures Group has applied computer simulation techniques to policy development efforts designed to educate Third World leaders on the long-term effects of rapid population growth. In the bio-medical area, AID has supported the development of revolutionary new contraceptive technologies such as Norplant®.

Emphasis on demographic data and empirical evaluation: From the outset, the AID population program has emphasized research, including the collection of empirical

data on trends in contraceptive use and average family size to evaluate country level performance. In 1972, AID initiated the World Fertility Survey (WFS), followed by two successor activities including the ongoing Demographic and Health Surveys. Under these programs, some 134 national surveys have been completed in 61 different countries, yielding an unparalleled, rich and internationally comparable data base on patterns of fertility, contraceptive use, and infant mortality.

The survey program has served two important purposes. First, in many countries, such as Kenya, the early surveys became a policy lever, helping to direct the attention of national political leaders to high rates of population growth and to establish a national consensus on the need to address this important problem. These surveys further helped to document the substantial unmet demand for family planning, by assessing the proportion of women who desired to limit or space their families but lacked access to the means to do so. Recent first-time surveys in a number of African countries have also served a similar purpose. Meanwhile, second and third-generation surveys in Latin American and Asian countries have helped to chart the progress of family planning efforts and to demonstrate that strong programs directly contribute to fertility decline.

Technical field presence: AID's substantial in-country presence compared to most other donors has been an important strength of its population program. Currently, AID has a network of country missions or offices in about 77 countries, and about 65 field population and health staff in about 39 of these countries. This field presence has helped AID to respond to specific country needs and to design appropriate bilateral population projects. AID's ability to provide technical and managerial oversight for its assistance through a professional corps of field-based population officers has contributed

to effective implementation of bilateral population projects, as well as to the success of country programs.

Country success stories: AID's survey program has helped to document the remarkable success of many country family planning programs in increasing contraceptive use and lowering fertility. In most developing countries, primary credit for these achievements must go to local political and program leaders. But in a number of countries where AID has provided substantial assistance over a sustained period of time, AID's support has clearly been a critical contributing factor to overall program success. For example:

- In *Thailand*, where over 65 percent of women of childbearing age now use modern contraception, average family size has fallen from over 6 children in 1965 to replacement level fertility — 2.1 children. Today, the Thai family planning program is almost entirely supported by the Thai government. But until 1982, AID provided the bulk of contraceptive supplies to the national family planning program, and AID's total assistance of about \$57 million over a 20-year period has been roughly equivalent to half the Thai government investment in family planning over the same time period.
- In *Indonesia*, AID's investment of over \$170 million has helped the Indonesian government to expand availability of services and to increase levels of modern contraceptive use to 48 percent of women of childbearing age. AID continues to provide vital technical support to the Indonesian program, including the recent Blue Circle program to privatize the supply of contraceptives in urban areas.
- In *Bangladesh*, the largest single recipient of AID population funds, AID has committed over \$300 million to population activities since 1979. Until recently, AID was

virtually the sole financier of two important and successful program elements: the involvement of private voluntary agencies in family planning, and the subsidized commercial sale of contraceptives. Throughout the 1970s and 1980s, AID was also the primary supplier of contraceptives to the government family planning program. AID support has been of prime importance in increasing contraceptive use in Bangladesh from 8 percent in 1975 to about 33 percent in 1989, even in the absence of significant social and economic change.

- In *Mexico* AID has made a significant contribution to fertility decline since 1977, through a different model of assistance than the bilateral programs described above. AID assistance to Mexico, which has averaged about \$10 million annually in recent years, has been channelled largely through U.S. Cooperating Agencies. These organizations have substantially expanded high quality voluntary sterilization services, and have also helped to establish commercial networks for the distribution of subsidized contraceptives. AID has also been an important source of contraceptive supplies in Mexico. AID clearly played a role in increasing the use of contraception among Mexican women of childbearing age from 30 to 53 percent between 1977 and 1987.

These are just four of a number of countries where AID assistance has been instrumental in bringing about substantial, measurable, changes in fertility. Other examples include Kenya, Zimbabwe, Korea, Colombia, Brazil, Morocco, Tunisia, Jamaica and the Dominican Republic. In some countries which have yet to show results in terms of significant, broad-based fertility decline — such as Nepal, Pakistan, the Philippines and Ghana — AID has nevertheless made an important contribution to

expanding and improving family planning services. AID has also recently expanded financial and technical support to nascent family planning efforts in several African countries where high fertility is still the norm.

Only in a few countries, — including for example, Pakistan and the Philippines — have substantial AID investments in population failed to yield significant results. Obviously, the soundness of national family planning programs has a great deal to do with the success of AID government-to-government projects; AID's efforts have been less effective where family planning efforts have suffered from a lack of sustained political commitment and inconsistencies in program strategy. Moreover, in several countries, domestic and bilateral political issues have contributed to periodic disruptions in U.S. foreign aid, with the result that AID support for population activities has lacked continuity.

In conclusion, the U.S. population assistance program is a bold and pioneering effort that has expanded access to family planning services and contributed substantially to reducing fertility in the developing countries. By helping to slow the pace of population growth, the program has made a contribution of great overall importance to the world. Yet the U.S. population assistance program has kept a low profile, and its successes have gone largely unacknowledged by the American public. It is time for Americans and their leaders to recognize that the U.S. population assistance program is a foreign aid success story, and one of which AID and the American public should be proud.

II. Reshaping U.S. Population Assistance for the 1990s

Based on this remarkable track record, there is a general consensus that AID's population program is the largest and very best of any bilateral or multilateral donor agency. Nevertheless, there are some important changes that are needed for the program to respond effectively to the need for expanded family planning efforts in developing countries in the 1990s. This report reflects PCC's assessment of the major issues relating to AID's population/family planning effort; it includes recommendations to the Bush Administration, Congress and AID for policy, budgetary, organizational and programmatic changes that PCC believes to be necessary if AID is to respond effectively to the demographic challenge still ahead.

A. Political Leadership and Commitment

The absence of strong political commitment to population issues within the Bush Administration is a fundamental problem for the U.S. population assistance program today.

American foreign aid has become increasingly politicized, and the priority formerly accorded to population assistance has been undermined by the Reagan-era ideology that population growth is not an important factor in overall development. In the absence of strong support from AID's political leadership, the population program owes its survival to Congressional interest and the commitment of AID professional staff.

For its first 15 years, AID's population program benefited from the strong support of both the executive and legislative branches of government. Presidents Johnson, Nixon, Ford and (belatedly) Carter all strongly and publicly en-

dorsed the need for urgent action to address the problem of rapid population growth. Throughout the 1960s and 1970s, AID's population program enjoyed a remarkable level of bipartisan support in Congress. There was a strong consensus that rapid population growth was one of the most serious global problems facing the world, and one that undermined the prospects for economic and social progress in developing countries.

The Reagan Administration not only failed to share the vision that population was an important problem deserving special attention — it directly challenged these long-held assumptions. The crucial turning point was the declaration by the U.S. delegation to the International Conference on Population in Mexico City in 1984 that population growth was a neutral or even positive factor in economic development — a theory now referred to as supply-side demographics. The announcement effectively ended 20 years of U.S. political leadership on the population issue. The policy shift, initiated by White House conservatives, reflected the increasing influence of political ideology on AID. Lack of interest in population issues and occasional hostility toward programs prevailed throughout the Reagan Administration and, in the absence of any retraction by President Bush or other key Administration officials, Reagan-era ideology continues to have considerable influence today.

The Reagan Administration was also responsible for making abortion the focus of public debates over international population assistance programs and for exporting U.S. political debates on abortion to other countries. Congress had already moved to prohibit AID from funding abortion activities with the passage of the Helms amendment in 1973; a subsequent amendment in 1981 ended AID support for bio-medical research relating to abortion. But in 1984, the Reagan Administration went much further, with its Mexico City Policy prohibiting private family planning groups overseas

from receiving U.S. assistance if they were engaged in any abortion activities, even funded entirely from other sources.

The Administration's abortion policy has been the basis for termination of AID's core institutional support to important family planning groups such as the International Planned Parenthood Federation (IPPF) in 1985 and the United Nations Population Fund (UNFPA) in 1986. (AID has continued support for IPPF programs in some countries on a piecemeal basis, through a grant to IPPF's Western Hemisphere Region and through bilateral grants to some IPPF national affiliates.) The policies put in place during the Reagan years also led to the recent termination of AID financial support to Family Planning International Assistance (FPIA), the international division of Planned Parenthood Federation of America.

UNFPA and IPPF work in many countries where AID has no significant bilateral population programs, and in some countries where AID does not work at all. These multilateral organizations also help to provide political legitimacy for population programs within a North-South context. But despite the importance of UNFPA and IPPF to the global family planning effort, the Bush Administration has not resumed its financial support to these organizations. AID's absence from the table of donor support for these major international population groups sends a message of continuing U.S. ambivalence on the population issue both to other donor countries and to the developing countries. The result has been a loss of U.S. credibility and influence relating to global demographic problems.

The policy reversal on population has undermined the intellectual justification for AID's population program. In the past, the compelling economic rationale for slowing population growth helped to make the case to policymakers that population was an important global problem which deserved special priority and resources. But the ambivalence on the

Major Political Battles Over U.S. Population Assistance: 1981-1990

- 1981** Reagan Administration cuts major increase in population funding for 1982 proposed by outgoing Carter Administration from \$345 million to \$211 million; OMB proposes to eliminate all funding for international population aid from draft 1983 budget, but fails to do so.
- 1981** Administration's ban on AID support for abortion research enacted into law; prohibition against lobbying by AID-assisted organizations added. Congress bans funding for World Health Organization's Human Reproduction Programme over small abortion research component. (Ban lifted in 1985.)
- 1982** AID cancels funding for Alan Guttmacher Institute's journal, *International Family Planning Perspectives*, over two articles on abortion. (Funding restored in 1986 after AGI wins law suit against AID.)
- 1983** \$8 million grant renewal for Pathfinder Fund held up. Released after Pathfinder drops privately-funded abortion projects.
- 1984** Mexico City Policy, which renders foreign organizations involved in abortion ineligible for U.S. assistance, announced by U.S. delegation to Mexico City population conference. International Planned Parenthood Federation defunded over Mexico City Policy. Congress fails to overturn policy on numerous occasions in subsequent years. Treasury Department extends policy to U.S. funding for multilateral banks in 1986.
- 1984** AID makes grant for natural family planning activities to Family of the America's Foundation, a group opposed to all other forms of contraception. Congress acts in 1985 to preserve informed choice by requiring AID grantees to provide information and referral for all contraceptive methods.
- 1985** Administration withholds \$10 million from earmarked \$46 million contribution to United Nations Population Fund (UNFPA) over charges of coerced abortions in China's population program. Congress passes Kemp amendment prohibiting U.S. support to organizations which "support or participate in the management of a program of coerced abortion or involuntary sterilization."
- 1986** AID cancels entire 1986 contribution to UNFPA, blaming Kemp amendment. Funding for UNFPA not restored in subsequent years despite numerous attempts within Congress.
- 1986** AID ends support for adolescent fertility programs in a dozen countries following controversy in Guatemala.
- 1987** Congress creates Development Fund for Africa without mandated levels of funding for population activities; targets of ten percent of total DFA funds established for population, health and environmental programs.
- 1989** President Bush vetoes entire foreign aid bill over \$15 million earmark by Congress for UNFPA.
- 1990** Bush Administration proposes to reduce 1991 U.S. population assistance budget from \$216 million to \$193 million; AID Administrator opposes increase in population aid budget.
- 1990** AID ends support to Family Planning International Assistance over Mexico City Policy, after FPIA exhausts legal challenges to the policy.

population issue demonstrated by the Reagan and Bush Administrations has undermined the priority given to population. As documented by the 1990 GAO report, there has been a subtle shift in AID's focus from promoting reductions in population growth rates to promoting family planning for reasons of health and individual rights and to reduce abortion, without a direct link to economic development. The retreat to a health rationale has marginalized the population issue, so that AID's leadership now considers it simply one among many sectors competing for scarce resources — and one that is clearly not high on AID's current list of priorities. It has also created a disconnect between Administration policy and Congress, which remains very clearly committed to the goal of reducing population growth rates. As the GAO report pointed out, AID's professional staff have sometimes been caught between these differing perspectives.

Disinterest in population is part of a larger problem of weakened commitment to traditional sectoral development priorities; AID's recent leadership has increasingly moved towards a more political and ideological agenda reflected by its theme of "open markets and open societies." Judging by official statements, AID's interests have shifted away from human resource development to macroeconomic policy, trade and private investment. Here, too, there is a growing divergence between Congressional and Administration objectives.

Policy statements and budget allocations reveal the low priority the Reagan and Bush Administrations have assigned to population. Population issues were virtually ignored in AID's 1989 report entitled *Development and the National Interest: U.S. Economic Assistance into the 21st Century*.⁷ Nor was population growth mentioned in the AID strategy paper on the environment. Annual budget requests to Congress for population assistance have consistently lagged behind prior year appropriations; in its 1991 request, the Bush Administration actually

proposed to *reduce* population assistance levels by roughly ten percent compared with 1990 appropriation levels. Since 1985, AID's leadership has diverted over \$60 million in population funds appropriated by Congress to other programs of higher short-term political priority, such as the Afghanistan and Eastern European aid programs, the Private Enterprise Revolving Fund and disaster relief. AID has also dipped into the population account to meet shortfalls in its operating expense budget and administrative reserve. As much as \$28 million in population funds may be diverted to other activities in 1991 alone.

AID's current leadership has reinforced the perception of official disinterest in population issues. Late last year the current AID Administrator, Ronald Roskens, wrote to Congressman Bill Green opposing a proposed increase in the 1991 population aid budget. Admitting that "in the longer term, more funds could be used for population activities," he went on to say that "the same can be said about every traditional development area . . ." In public statements, Roskens has emphasized the need for other donors to increase their support to population activities, arguing that AID is already doing more than its share. Although Roskens is reported to have shown a heightened interest in population issues following a recent trip to Africa, this has yet to be reflected in substantial changes in policy or resource allocations.

Support for population activities has been largely lacking among the powerful Assistant Administrators who head up AID's regional and central bureaus. In recent years, the Africa Bureau alone has taken a strong leadership role in advocating the expansion of family planning activities by AID field missions. Some bureaus are now headed by ideological conservatives considered potentially hostile to population activities. With only a few exceptions, the Agency's political appointees appear more concerned with the extent to which the population program reflects the Agency's current emphasis

Table 1
**Allocation Of AID Population
 Funds For Other Activities, 1985 - 1991**
 (Millions US\$)

Fiscal Year	Appropriation for Population Account	Total Non-Population Activities Funded from Population Account	% of Population Account Used for Other Activities
1985	\$ 290.0	\$ 5.3	1.8%
1986	239.2	6.9	2.9%
1987	234.6	15.5	6.6%
1988	197.9	14.4	7.3%
1989	201.2	16.7	8.3%
1990	216.2	8.1	3.4%
1991* (estimate)	250.0	27.7	11.1%

*1991 estimate includes \$18 million in unallocated reserves; \$1.1 million for operating expenses, \$5.7 million for the Philippines; and \$2.8 million for the Cambodian Resistance and Lebanon.

Source: Agency for International Development

on private sector activities than with its demographic impact. The lack of committed bureau leadership in Washington affects AID's field programs, which are under considerable pressure to respond to bureau priorities.

Despite the lack of interest within AID's top leadership, Congressional interest and professional commitment within the Agency have kept the population program alive. The annual earmarking of population funds by Congress has helped to maintain levels of program funding even in the absence of Administration commitment. After 25 years of activity, the population program has built a strong core of committed individuals within the Agency. Strong leadership is exerted by population professionals both in Washington and the field. A number of the Agency's top development professionals, including some Mission Directors, who represent the career elite, have established a strong record of support for population activities.

At the same time, there is built-in bureaucratic resistance to expanding population activities in the absence of strong leadership from the political level. In allocating resources, the

primary interest of the bureaucracy is to maintain a balance among multiple priorities; any increase for population is perceived to be at the expense of other sectors, given the relatively fixed overall pie. Over the last several years political battles over family planning and abortion have also left many agency professionals reluctant to take the lead in a sector perceived as politically sensitive and out of favor. At the field level, another source of vulnerability for population is the continuing pressure, especially on smaller missions, to focus program strategy on a limited number of sectors. When this policy was previously strictly enforced by the Africa Bureau, the AID Mission in Kenya was the only one in the bureau to include a focus on population.

The picture that emerges is of a program on the defensive. The policy reversal of the past two Administrations has undermined the fundamental rationale and base of support for AID's population program. Changes in AID's overall strategy have left the program vulnerable in terms of its overall importance within the Agency's development mission. Among

AID's top leadership, there are few vigorous advocates for population programs.

The situation is best summed up in the words of a senior career AID population officer: "AID does not really view rapid population growth as one of the most serious transnational development problems...it is abundantly clear that AID's senior leadership is not genuinely interested in population and that it is Congress that is sustaining the program...The politicization of the Agency which is greater today than at any time in my experience is the gravest threat to population — indeed to all development efforts. In five to ten years' time the combination of all these things may result in the U.S. completely abandoning the population field as well as other important areas."

Recommendations for Strengthening Political Leadership and Commitment

- **President Bush must reassert White House leadership on behalf of population issues, and must reestablish a sense of urgency about population problems among Washington policymakers of both political parties.**

Nothing less than the personal involvement of the President can at this point counter the negative legacy of the last ten years. Nothing less will convince the political leadership at AID to treat population issues as a high priority, and nothing less will restore the bipartisan consensus on the importance of U.S. population assistance in the U.S. Congress. For a strong, maximally effective U.S. population assistance program in the future, there must be a resolution of the current political impasse and a renewal of American political leadership in the field.

- **Meanwhile, in the absence of such explicit, high-level political support**

from the Bush Administration, continued Congressional interest and support for AID's population program is vital to its survival. Congress must continue to dedicate funds for population and family planning to maintain adequate budgetary support for these activities, earmarking the overall budget allocation for population, if necessary, to prevent diversion of population funds to other purposes.

- **To shore up the rationale for future U.S. population assistance, AID should increase support for competent policy-relevant studies on relationships between population growth and sustainable development with particular emphasis on human resource development and natural resource preservation.**

A strengthened intellectual case for the population program must be built over the next several years. AID might start by recruiting more population economists for its staff, and increasing support for field-based research. The emphasis should be on empirical data collection and analysis, preferably carried out through independent, external, academic centers. As much funding should be allocated to research dissemination as to the research itself.

- **AID should resume support to IPPF and UNFPA recognizing that these organizations work in many countries where AID currently does not work.**

Resumption of support at adequate levels would contribute to overall demographic goals by facilitating the flow of resources to countries which do not receive AID population assistance. It would also enable AID to regain credibility on population issues in an international context, and to exert greater influence over multilateral population assistance programs. Many of

these programs could benefit from a stronger partnership with AID's technical strength and professionalism in the population and family planning fields.

B. Budget

The allocation of AID's assistance among countries does not reflect demography, need or opportunity in any systematic way. Moreover, U.S. funding for population assistance has not kept pace with either inflation or the growing demand for family planning in developing countries. At the present time, there is a critical shortfall in funding for AID's government-to-government population assistance programs in all the developing regions except Africa.

Historically, the primary source of funds for AID-assisted population programs has been the population account; i.e., the share of the development assistance budget that Congress designates each year for population activities. Since 1988, the Development Fund for Africa (DFA) established by Congress has been an important supplementary source of funding, providing a significant level of resources for bilateral family planning programs in Africa. Finally, Economic Support Funds (ESF) have been a major source of U.S. population assistance in a few countries where the United States has had special political and security interests, primarily Egypt and Pakistan.

The United States deserves credit as the largest single source of population assistance. It has historically provided a higher share of official development assistance to population activities (about 2 to 3 percent) than any other donor except Norway. In 1989, it provided roughly four times the amount of assistance provided by Japan, the second largest donor. Levels of U.S. assistance have also been substantially greater than those provided by the

two major multilateral donors, UNFPA and the World Bank.

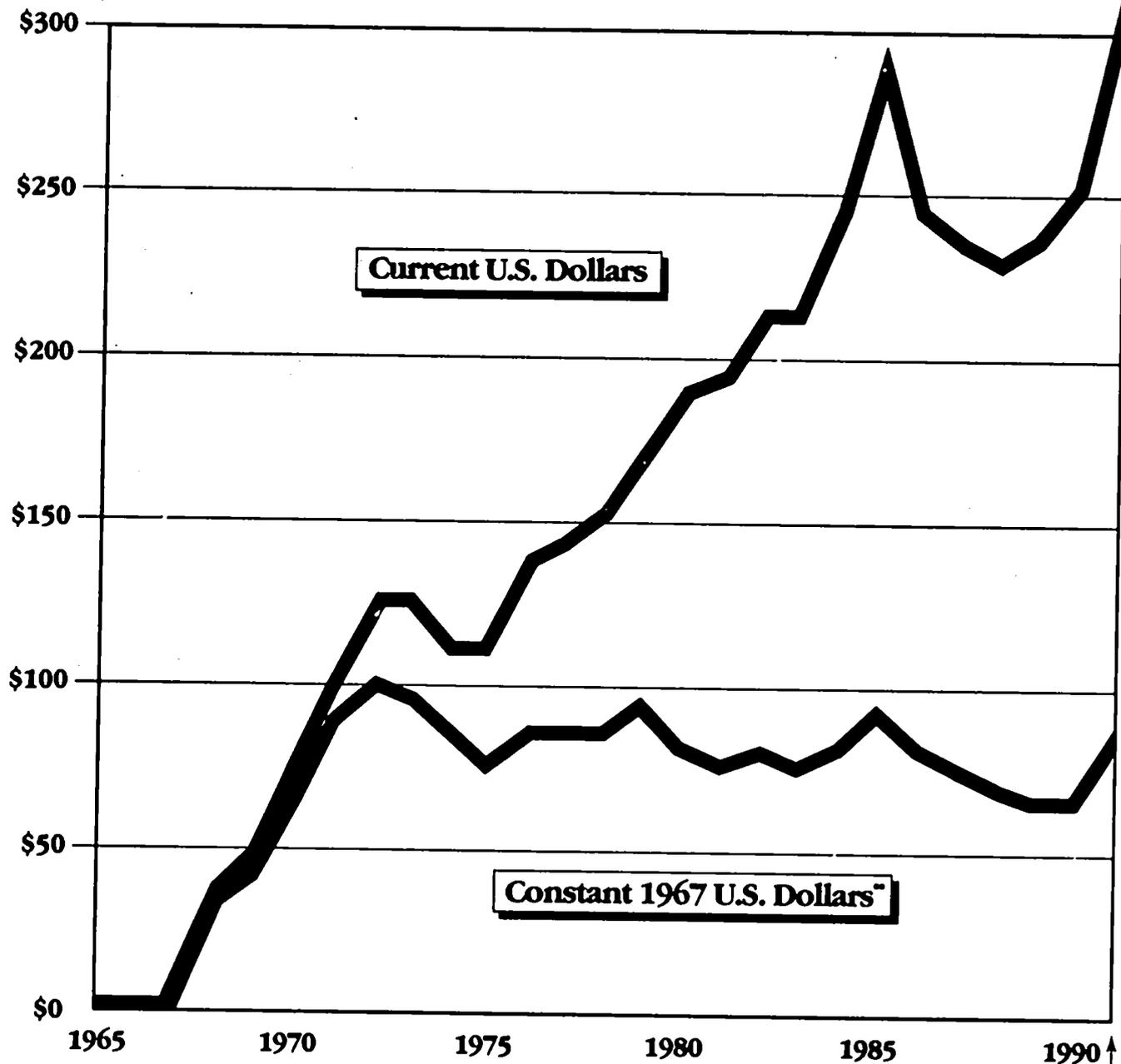
Nevertheless, levels of U.S. funding are inadequate. U.S. funding has not kept pace with inflation, or with the growing number of Third World couples who want and need subsidized family planning. Dollar levels of overall development assistance for population (excluding Economic Support Funds) rose steadily through 1985, stagnated in the second half of the 1980s, and in the last two years increased modestly once again. But adjusted for inflation, the picture is very different; in real terms, funding for the program peaked in 1972 and declined significantly throughout the 1980s; moderate increases in 1990 and 1991 have barely compensated for inflation over the past few years. Over the same time period, the number of women of childbearing age in developing countries increased by an average of roughly 20 million each year. The demand for family planning has also grown rapidly. Many countries are willing and able to make family planning services available, but lack the financial resources to do so.

AID's allocation of population assistance gives inadequate weight to demographic factors, and is too heavily influenced by political and idiosyncratic factors. Political factors play a key role in determining in which countries the United States provides economic assistance, and what levels of aid it provides; this in turn affects availability of population funds. AID does not work at all in several demographically important countries, such as China, Vietnam, Ethiopia and Iran. In Egypt, on the other hand, high levels of bilateral population aid have been made possible by large annual Economic Support Fund payments following the Camp David accords. In several countries, AID has been forced to cut off much needed family planning (and other) assistance to comply with Congressional restrictions requiring the suspension of aid to countries which have fallen behind in debt repayments or are believed to be

Figure 1

Funds Approved for Population Assistance by Congress, 1965-1991*

Millions of US\$



Estimated for 1991

*Excludes Economic Support Funds. Includes Development Fund for Africa allocations after 1988.

**Estimate using U.S. Department of Commerce Consumer Price Index deflator.

Table 2
**Funds Available for AID
 Population Programs by Source, 1982-1991**
 (Millions US\$)

Fiscal Year	Population Account*	Sabel Development Fund/Development Fund for Africa	Economic Support Funds	Grand Total
1982	\$ 211	—	\$ 27	\$ 238
1983	215	3	25	243
1984	242	2	20	264
1985	283	10	19	312
1986	231	15	43	289
1987	216	4	15	235
1988	181	32	18	231
1989	184	38	16	238
1990	212	39	19	270
1991 (estimate)	222	69	31	322

*This figure is based on the AID Operating Year Budget for the Population Account less allocations for non-population activities.
 Source: Agency for International Development

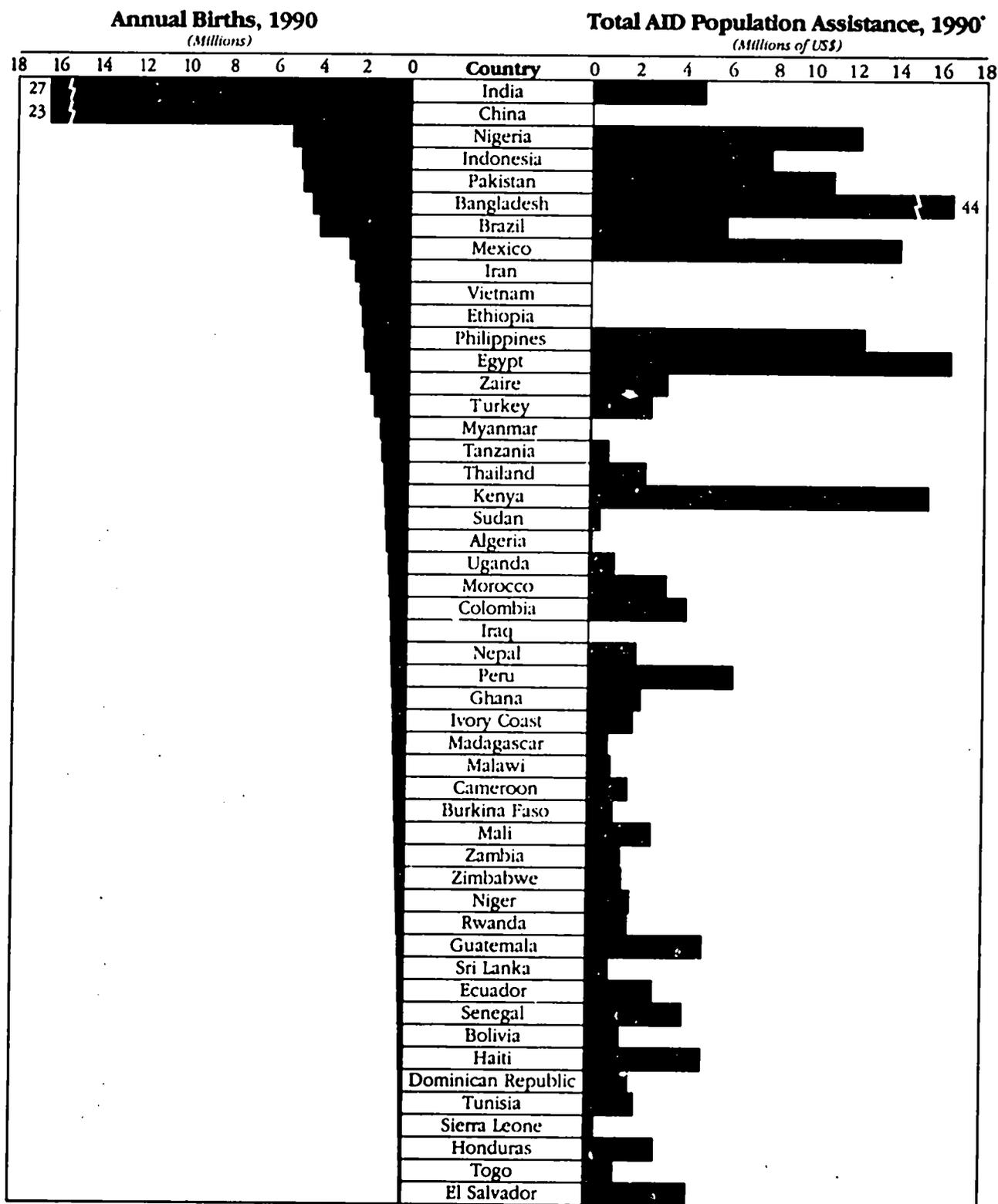
developing nuclear weapons. Political factors were also responsible for AID's disruptive suspension in the mid-1980s of financial support to IPPF and UNFPA.

In recent years both the Office of Population and the Africa Bureau have made some effort to incorporate demographic criteria in their decisions to allocate resources. But the Agency as a whole has no systematic plan to allocate resources to population programs on the basis of global demographic needs and priorities. The result is that AID's levels of population assistance to individual countries are often inconsistent with demographic realities. In India, arguably the most important country demographically in the world, AID's recent population assistance program has been so small as to be almost irrelevant to India's overall effort. In 1990, AID's bilateral (direct government-to-government) population assistance to India, a country of over 850 million people, totalled a negligible \$1.5 million, and in 1991, AID will not provide any bilateral population aid to India at all. At the same time, largely for political

reasons, AID expects to allocate \$6.6 million for family planning to El Salvador — a country of only five million people. Of course, factors other than population size, such as a favorable policy environment and the absorptive capacity to use population assistance effectively, are also important. But there is a powerful case that AID's allocations for population bear very little relationship to the world's demographic problems or family planning needs.

Idiosyncratic and personality factors also appear to have a disproportionate influence over AID's allocation of population resources. In the 1970s and 1980s, for example, the perception that the Africa Bureau leadership was hostile to family planning had a chilling effect on new population activities in both Washington and the field. When the bureau leadership changed and took a more positive attitude, population programs in Africa expanded. Strong and committed Mission Directors played a key role in ensuring adequate funds for many of AID's population successes, for example in Bangladesh and most recently in Kenya. But in

Figure 2
Annual Births and Annual AID Population Assistance,
Selected Developing Countries, 1990



*FY 1990 expenditures for Mission/Regional projects and Office of Population projects combined.
 Sources: Population Reference Bureau, 1990 World Population Data Sheet; Office of Population, AID, Overview of AID Population Assistance FY 1990, forthcoming.

Zambia new population initiatives were stalled for years by a hostile country Director.

A further issue is the limited geographic scope of AID population activity; although AID provides some support to a large number of countries, it assists a relatively small number of countries in a significant way. Overall, about a dozen countries account for roughly half of total AID allocations for population. In the vast majority of developing countries, AID population funding (both bilateral and centrally managed) is too modest to have a significant demographic impact.

The bulk of AID's bilateral population assistance has been concentrated in a limited number of demographically important countries. Over the years, AID's major bilateral recipients of population assistance have included Bangladesh, Egypt, Indonesia, Pakistan, India (for a period of a few years) the Philippines and Kenya. Other countries where AID has provided significant, long-term bilateral support include Tunisia, Morocco, Thailand, Jamaica and Nepal. AID currently operates bilateral population projects in only about 36 of the 77 countries with resident AID missions or field offices. But in 22 of these 36 countries, AID will provide less than \$2 million this year in bilateral population assistance; in only 7 countries will AID provide more than \$5 million.

The paucity of resources available per country is even more marked for the projects implemented by private U.S. institutions with funding from the Office of Population in Washington, D.C. The 40 some AID Cooperating Agencies are active in roughly 100 countries. But in over 50 of these countries, the total annual level of activity amounts to less than \$200,000. Central Office of Population funds are spread too thinly in many cases to have a major impact on levels of family planning use. In only a relatively few countries, such as Mexico, Brazil and Colombia, does AID's Office of Population channel a substantial level of resources through private U.S. institutions.

In recent years the central Office of Population has tried to scale down its support for activities in countries which receive large amounts of direct bilateral aid, in order to concentrate its efforts on countries which do not. However, AID missions in most countries continue to require substantial support from Office of Population funds for the purchase of U.S. private sector technical assistance, in large part because developing country governments are usually reluctant to approve the expenditure of funds covered by bilateral aid agreements on U.S. institutions.

There is a critical shortage of AID funding for bilateral population programs outside the Africa Region. Over the history of AID's program, the share of population funds allocated through bilateral channels has increased relative to that of programs funded by the central population office in Washington. Bilateral programs have the potential to make a significant level of resources available in a country, to respond to specific needs identified at the national level, and to provide comprehensive assistance within the framework of a coordinated country strategy. However, the trend towards increased funding for such programs was reversed by Congress in fiscal year 1991, largely in reaction to the perceived lack of support for population programs among the political leadership of AID's major geographic bureaus. Allocations to bilateral programs in Asia, the Near East and Latin America have as a result declined sharply.

Between 1989 and 1991, total allocations from the population account for bilateral programs fell from about \$90 million to \$60 million, a decrease of about 35 percent. (Funding for central programs rose from \$111 million in 1989 to \$162 million in 1990, an increase of almost 50 percent.) The decrease in bilateral funding is most striking for Asian and Near Eastern countries, which together have about 60 percent of the world's population: AID's bilateral population assistance to the region (excluding Economic Support Funds) fell from \$59

Table 3
**Allocation of AID
 Population Assistance Funds, 1965-1991**
 (Millions US\$)

	1965-70	1971-75	1976-80	1981-85	1986-90	1991 Estimate
AID Office of Population/ Other Central Programs	\$ 57.0	\$ 257.1	\$ 432.1	\$ 512.2	\$ 623.7	\$ 162.9
Africa Bureau	3.3	31.6	20.4	70.7	188.6	69.3
Population Account	3.3	31.6	20.4	54.1	63.2	—
Development Fund for Africa/Sahel Development Fund	—	—	—	15.3	125.4	69.3
Economic Support Funds*	—	—	—	1.3	—	—
Asia/Near East Bureau(s)	64.3	129.7	206.3	437.3	380.2	70.0
Population Account	64.3	129.7	179.8	329.1	270.8	38.9
Economic Support Funds*	—	—	26.5	108.2	109.4	31.1
Latin America and Caribbean Bureau	33.6	58.6	34.2	74.4	134.6	20.3
U.S. Contribution to United Nations Population Fund	7.0	90.0	139.4	176.5	—	—
Total	165.2	567.0	832.4	1,271.1	1,327.1	322.5

* Primarily for Egypt and Pakistan.

Source: Agency for International Development

million to less than \$40 million. The overall decrease in bilateral funding is mirrored at the individual country level. Funding for population activities declined in all but a handful of Asian, Near Eastern and Latin American countries. AID has significantly cut back assistance to Indonesia and Bangladesh, countries where family planning has made significant progress but which remain in need of substantial external assistance.

Funding available to bilateral programs has been further squeezed by the diversion of up to \$28 million in FY 1991 population funds to non-population activities and AID's administrative reserve. At the same time that access to bilateral population funds declined in these regions, access to central funds has been lim-

ited by the high priority assigned by the Office of Population to the Africa region and to countries where AID does not have bilateral population programs. Population advocates, including the Population Crisis Committee, supported the FY 1991 earmark for central programs, which have been given short shrift in AID's budget process in recent years, but did not anticipate the magnitude of AID's diversion of \$28 million in population funds and the resulting shortfall of bilateral population funds.

Meanwhile, the Africa Bureau has seen a rise in funding for bilateral population programs. After many years with little progress to show, the Bureau's recent track record has been commendable; between 1987 and 1991 the number of bilateral population programs

tripled from 6 to 18, and total bilateral allocations for population activities may actually double this year from about \$38 million to an estimated \$70 million. This rapid expansion has been fueled by strong Congressional and senior bureau interest, and by the Bureau's access to steadily increasing resources as a result of rising Congressional appropriations for the Development Fund for Africa. Nevertheless, the magnitude of these efforts remains far short of the resources required to address the demographic problems of the continent, which currently has a population doubling time of only 23 years.

A final issue is that AID must find ways to reduce the overhead costs of the U.S. Cooperating Agencies which implement the central program. It is important to recognize that in some countries with limited institutional capacity, overhead costs for U.S. organizations purchase much needed managerial expertise, without which programs would flounder. But there is a growing consensus that, outside of Africa and a handful of very poor countries in other regions, there is a diminishing need for such assistance. Centrally-funded programs have not responded adequately to the increasing sophistication of recipient institutions in many countries. Moreover, while AID's Cooperating Agencies continue to represent an effective mechanism for providing technical assistance in more advanced developing countries, they are often not an efficient mechanism for substantial resource transfer. In important countries like Mexico and Brazil, where AID has no bilateral programs, existing modes of assistance through private U.S. Cooperating Agencies involve a high level of operating costs to manage a large number of relatively small-scale programs, and represent a less than efficient use of available resources.

Recommendations for the Allocation of Resources for Population Programs

- **The Administration and Congress should increase the overall population assistance budget to \$600 million for fiscal year 1992, growing to \$1.2 billion by the year 2000, and depoliticize the resource allocation process.**

Roughly half of this increased budget, representing all sources of funding, should go to regional and bilateral programs, and a half to worldwide programs, including a U.S. contribution to the United Nations Population Fund commensurate with other donor countries. (This level of bilateral support will require increased commitment and staff at the mission level.)

AID should identify priority countries based on demographic significance, need for assistance, and willingness to act on population issues, focusing on those countries that can make a real difference to future world population size. Within this framework, revitalizing AID support to India and identifying AID's comparative advantage vis-a-vis the overall Indian effort deserves high priority.

Where broader political factors necessitate a cut-off in U.S. bilateral economic aid to demographically important countries, Congress and AID need to recognize the importance of continuity to family planning success, and to make it possible for private sector programs to carry on in such circumstances. Moreover, both the regional bureaus and the Office of Population must recognize that even mature family planning programs, such as those in Indonesia and Thailand, have continuing needs for specialized technical cooperation with competent U.S. institutions.

A \$600 million FY 1992 population program would enable AID to increase levels

Table 4

PCC Recommended Allocation of Proposed \$600 Million Population Budget for 1992, by Program Area

	Millions US\$
Contraceptive Supplies	\$ 110
Family Planning Services	265
Training	45
Information and Communications	45
Policy	20
Research	
Social Science/Operations	20
Biomedical Support	30
Sub-Total AID Programs	535
Contribution to UNFPA	65
Grand Total	600

of funding for existing bilateral programs sufficient for rapid demographic change, to initiate new programs in priority countries where AID currently does not have bilateral programs, and to continue assistance to mature programs which still have some need for assistance. It would also enable AID and its Cooperating Agencies to finance some of their innovative service delivery models on a larger scale, again in order to have a demographic impact. Consideration must also be given to reviving and expanding regional projects as a means of providing AID field missions with easy access to flexible, non-bilateral resources.

New and expanded initiatives should include a significant expansion of ongoing training programs for service providers, and of field-based research directed at improving the quality of family planning services, client satisfaction and effectiveness

of contraceptive use. In a number of countries, AID needs to expand ongoing social marketing and clinical family planning programs; these cost-effective approaches should also be extended to countries where they are currently lacking. High priority should also be given to reestablishing a centrally-managed program to provide long-term training in population related fields to developing country professionals.

Of course, AID is not the only player in the population field. Population assistance provided by other donors is growing steadily, albeit too slowly. The World Bank may have an advantage over AID in the level of financial resources it can make available to large countries with well-established family planning programs, such as India and Indonesia. AID clearly needs to work closely with other

bilateral and multilateral donors to ensure an efficient use of available resources.

- **AID should maintain a strong technical support program within the Office of Population, but needs to improve the efficiency of the program.** The maintenance of a critical core of technical competence within AID's population office is essential to good programming throughout the Agency. Within the central program, concentration on AID's traditional areas of strength — service expansion, development of delivery systems, training and information — should continue to receive high priority, but AID should not back off from the research and policy areas where many important needs remain. At the same time, AID needs to take a hard look at those central programs that have proved less successful and rel-

evant, and to encourage the Cooperating Agencies to tighten management controls and keep down their overhead. One of the ways in which centrally-managed resources could be used more efficiently would be to scale up the activities of Cooperating Agencies so that operating costs are spread over bigger programs. But AID should also explore the possibility of new, less management-intensive mechanisms for providing program assistance through AID field offices or special regional programs to non-bilateral middle-income countries.

- **The Office of Population should reassess its geographic priorities in light of recent developments and likely future needs.** There is widespread sentiment that the central program favors the Africa region to the detriment of other

Table 5

Actual and Recommended Country Levels of U.S. Population Assistance: Selected Priority Countries

Country	1990 Population Size	Total AID 1990 Expenditures on Population*	1990 Bilateral AID Population Allocations	Estimated 1991 Bilateral AID Population Allocations	Total 1992 Recommended level of AID Population Assistance*
	(Millions of people)		(Millions US\$)		
India	853	\$ 5.1	\$ 1.5	—	\$ 40
Indonesia	189	8.1	3.3	2.2	10
Brazil**	150	6.7	—	—	10
Nigeria	119	12.3	8.0	8.0	25
Bangladesh	115	44.5	24.8	19.1	30
Pakistan	115	11.1	7.1	13.0	20
Mexico**	89	13.4	—	—	15
Philippines	66	12.5	14.0	6.5	15
Egypt	55	16.3	12.0	21.5	15
Zaire	37	3.4	1.7	4.1	10
Colombia**	32	4.4	—	—	6
Tanzania	26	0.9	3.0	3.8	8
Kenya	25	15.4	4.7	6.0	15

*Combined Total for Regional/Mission projects and Office of Population projects.
**All funding for Brazil, Mexico and Colombia from Office of Population projects.

parts of the developing world. Clearly, Africa is not the only area which deserves attention; India has more people than the entire African continent, and pockets of high fertility remain in virtually every region of the developing world. An expanded budget would go a long way to enabling the central program to accommodate these currently competing needs and priorities.

The central program rightly gives high priority to demographically important countries which do not have bilateral AID programs, but needs to recognize that countries with bilateral programs often have a need for resources outside the control of bilateral grant or loan agreements. The central program should be active in all priority countries, concentrating on complementary and mutually reinforcing programs where significant bilateral activities already exist.

C. Management

Although the Office of Population is the strongest single element of AID's population program, since 1977 it has lacked a formal mandate for overall coordination of the program, or for providing adequate strategic guidance to AID's country level programs.

AID's population staff is inadequate in number to meet the management needs of the program. But despite the dearth of trained and experienced staff at the mission level, particularly in Africa, there is currently no systematic planning for personnel needs in the sector.

The agency-wide trend towards increasing bureaucracy over time has affected the population program in part by increasing reliance on costly and cumbersome competitively bid contracts. Increased restrictions have also undermined the flexibility of the procedures which allow AID field missions to buy in to worldwide technical assistance projects managed by the Office of Population in Washington, D.C., and implemented by private U.S. institutions. These arrangements have been vital to the effectiveness of many AID field programs.

Organizational Structure of AID's Population Program

In January 1991, AID's leadership embarked on a major new reorganization effort to be implemented in May. At this writing it is impossible to gauge how the reorganization will affect the strengths and weaknesses of the current management structure from the perspective of the population program. Population proponents do not expect the current reorganization to solve the problems identified below, however.

As the 1990 GAO report pointed out, management of AID's population program is diffused over a large number of organizational units.

These include the Office of Population, presently housed in AID's Science and Technology Bureau, which has responsibility for centrally-funded programs; the geographic bureaus which allocate funds to regional and bilateral programs; and individual AID field missions which have primary responsibility for developing and implementing country level programs.

In recent years there has been an agency trend towards greater decentralization and delegation of authority to AID's field missions, in recognition that country-based programming is important to the success of U.S. development assistance. From the perspective of the population program, decentralized authority works well where mission leadership has had a strong interest in population activities and where missions have been adequately staffed with technical expertise. Population activities have fared less well where commitment has been low and staff inadequate or weak. The diffusion and decentralization of responsibility for population activities has thus contributed to unevenness among the Agency's field programs.

A striking feature is that there is no single individual or organizational unit within AID with overall responsibility for the Agency's population program. The situation differed significantly between 1971 and 1977 when the Director of the Office of Population was formally charged with oversight of all Agency population activities and the central office had authority over field programs. But in 1978, following an internal Agency power struggle, the Director's responsibilities were largely limited to oversight of programs funded by the Office of Population, although the incumbent still carries the title of Agency Director for Population. The office clearly serves as a focal point for population activities throughout the Agency, but it currently lacks any formal mandate to provide an overall coordinating function or to

contribute technical expertise in field program development.

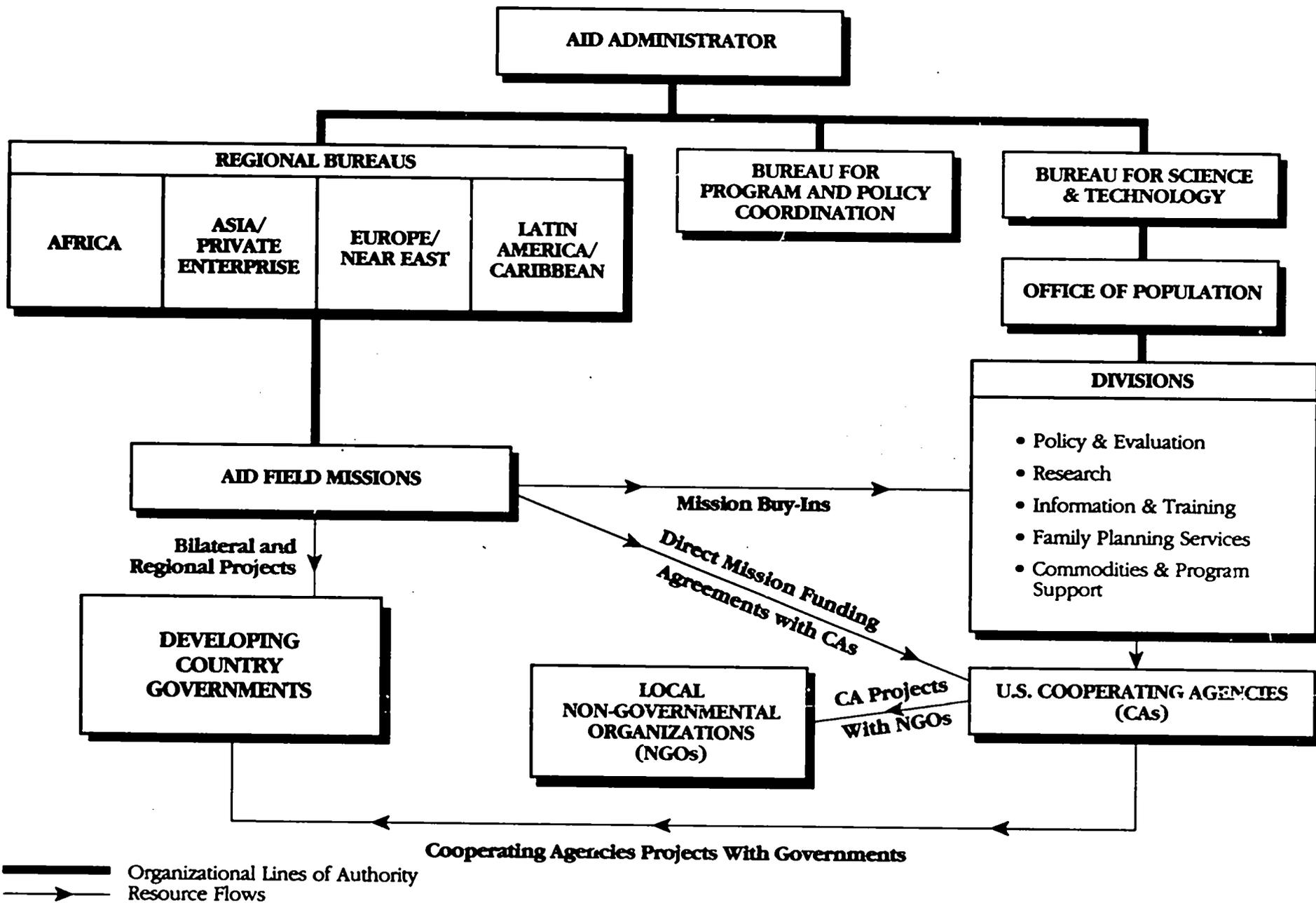
Nevertheless, the critical mass of technical expertise embodied by the Office of Population has been central to the success of the Agency's overall population efforts. The office stands out as the strongest single element of AID's population program; the five technical divisions staffed by approximately 55 professionals provide a broad range and depth of specialized technical skills in the areas of policy development, information and training, biomedical and social science research, family planning services, and commodity management. The office has excelled in its role as the overseer of innovation in the population sector within the Agency. It has successfully developed simplified methods to provide quick and flexible technical support to AID's field programs in a variety of areas. Although the office is frequently at odds with the geographic bureaus, AID population staff in the field clearly look to the Population Office, and more specifically, to the Cooperating Agency programs managed by it, as the most effective channel for obtaining needed technical expertise.

At present, however, neither the Office of Population nor the regional geographic bureaus are providing adequate strategic guidance to AID's field-level population programs. The Health, Population and Nutrition Divisions in the geographic bureaus' Technical Resource Offices are formally charged with responsibility for overall program support. But these bureau offices have been limited to one or two full-time population staff. They lack technical depth and are distracted by the political agenda of the bureau leadership. In recent years, the bureau offices have generally not been perceived to be an effective source of technical assistance or strategic guidance.

The Office of Population has also not taken a sufficiently strong role in providing technical expertise to country level programs in

Figure 3

Organization of AID's Population Assistance Program



strategic planning and analysis. It has no official mandate to do so, and its functionally compartmentalized structure is not conducive to a comprehensive country level approach. Moreover, links between the office and AID field missions are highly informal. In recent years the office has been increasingly absorbed by political battles in Washington and by the management requirements of its own internal project portfolio, particularly as the number of projects has expanded beyond existing staff capacity. While individual staff from the central office and its Cooperating Agencies have participated in program assessment and design activities at the country level, the office itself is not routinely invited nor has it actively sought to guide the direction and focus of AID's country level programs. This represents a missed opportunity to strengthen AID's field population programs, especially where AID technical staff in the field are inadequate or weak.

Finally, coordination is weak among the various AID units responsible for implementing the population program. The lack of direct organizational links between the central Office of Population and AID field missions often leads to problems in communication. Relations between the Office of Population and regional bureaus have varied with the personalities involved at any given time, covering the range from cordial and cooperative to strained and antagonistic. But in recent years, the priorities of the regional bureaus and the central office have increasingly diverged. The central Population Office has differed with the Africa Bureau over its integration of population and health activities, and with the other regional bureaus over their highly ideological approach. As a result, AID field missions and Cooperating Agencies often find themselves caught between the competing control structures of the Office of Population and the regional bureaus, with negative consequences for effective program implementation.

Population Staffing

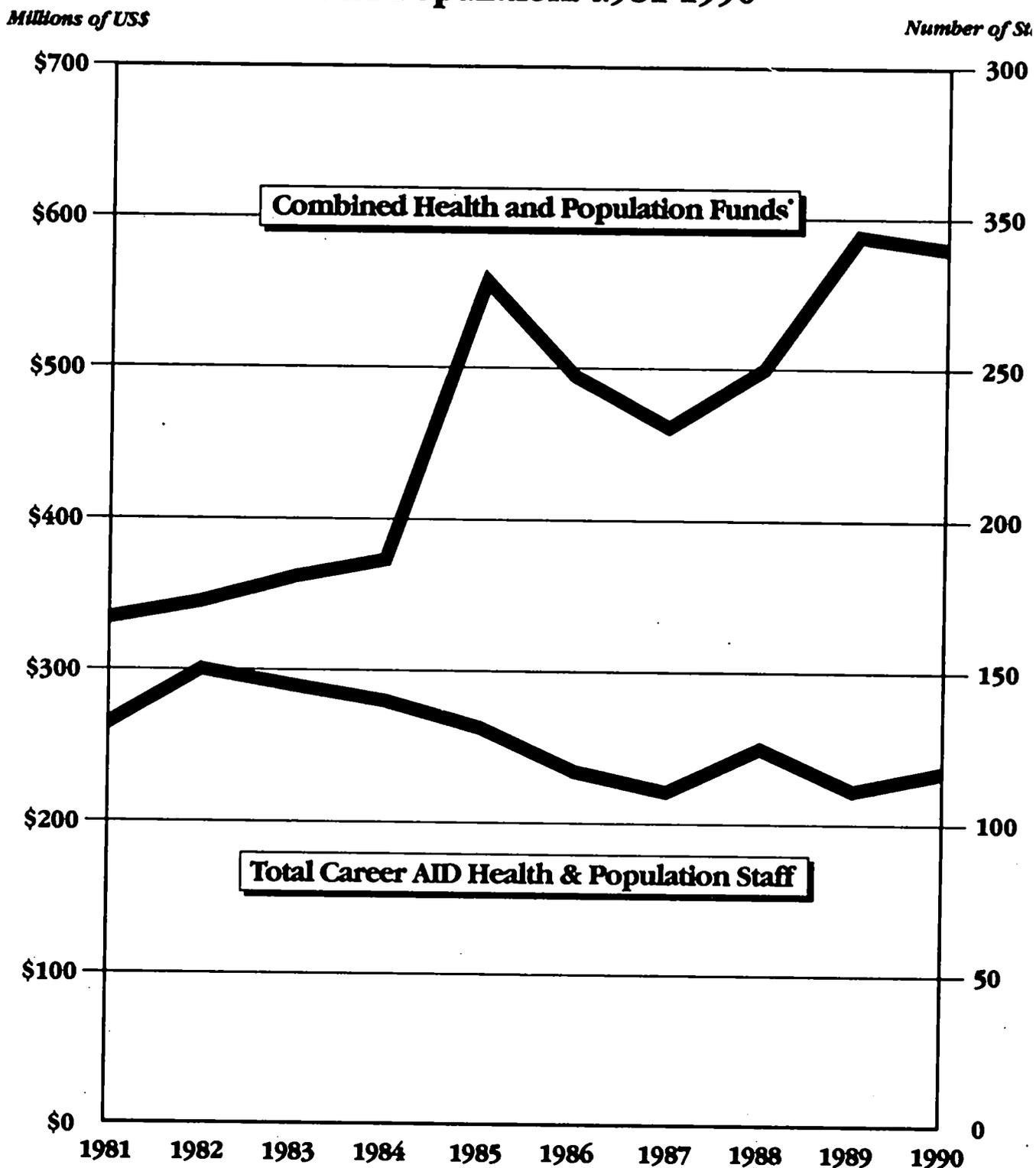
AID's population staff are part of a broader Agency personnel category which includes population, health and nutrition expertise. Health and population staff include both foreign service personnel who rotate among AID field missions and periodically to Washington, and civil service personnel who are permanently based in the Office of Population. Although most such staff come to the Agency with technical credentials in either health or population, in the smaller field missions a single staff member is often responsible for both health and population activities.

The main problem with AID's population staff is that there are simply not enough of them. The multidisciplinary personnel system makes it difficult to analyze trends in the number of staff assigned to work on population activities over time. But there is a consensus that the numbers are inadequate to manage effectively a program of the current size and complexity, and that the staffing problem is most acute for AID field missions.

For the Agency as a whole, the staffing pattern has not changed over time to reflect important structural changes. Increased delegation of authority to the field has not been accompanied by an increase in the proportion of staff assigned overseas. Similarly, the overall mix of technical skills has not reflected the changing balance in functional appropriations. At present, population and health programs totalling about \$600 million are managed by a career corps of 115 professionals, down from about 145 in the early 1980s. Thus, while total funding for health and population in current dollars increased by about 40 percent during the 1980s and the number of bilateral programs in Africa more than doubled, the total number of career population and health officers decreased by about 15 to 20 percent. The ratio of staff to program funds is reportedly lower in population and health than in other sectors like agriculture.

Figure 4

Illustrative Trends in AID Funding and Staffing in Health and Population: 1981-1990



*Development Assistance only; excludes Economic Support Funds.

Source: Unpublished estimates prepared for AID Population Sector Council.

The shortage of population expertise is most evident at the level of AID's field missions, the vast majority of which are understaffed in terms of career population personnel. Currently, AID's field offices in Latin America rely heavily on local contract personnel; in the big Economic Support Fund programs in Egypt and Pakistan, one or two population and health staff are responsible for managing several large, complex projects. Only a small number of missions with a long history of working in population, such as Kenya, Indonesia and Bangladesh, are relatively well-staffed with technical population expertise.

The lack of adequate population staff is particularly critical for AID missions in Africa. Family planning is a relatively new endeavor in many African countries, and African governments look to local AID missions for technical assistance and advice. Yet most AID health and population staff in Africa come from a health background and have limited technical knowledge of population and family planning issues. Although AID has initiated bilateral family planning programs in 18 African countries, there are only a handful of experienced population staff outside of Kenya. In many small missions in Africa, a single, overextended staff person is responsible for family planning, child survival and AIDS activities. The Africa Bureau appears to recognize that lack of adequate population expertise is an important constraint to program expansion, and is attempting to strengthen mission staffing through a variety of contracts. But the real long-term need is for an expanded corps of career population specialists.

A second important staffing issue is that the limited voice of foreign service staff within the Office of Population has detracted from its credibility and perceived relevance to the needs of AID field programs. The Office of Population is dominated by civil service personnel who have never been assigned to an AID field mission and who are constrained from visiting field programs with any frequency owing to a chronic

shortage of travel funds. Currently, only 7 out of about 55 positions in the central office are filled by foreign service staff, most of them assigned to the Family Planning Services Division; at least two Office Divisions have no foreign service positions at all. Only 2 of 8 management positions within the office are filled by foreign service personnel. Opportunities for rotations through the office by foreign service staff are limited by the relative immobility of civil service personnel, and the small number of higher-level positions open to foreign service personnel. The current staffing pattern has contributed to a growing perception that the Office of Population lacks an adequate operational perspective and is out of touch with the field.

While the quality of both AID's foreign service and civil service population staff has improved over time, there is still need for further upgrading. There is still considerable unevenness in the quality of population staff, both in the field and in the central office. The number of staff with medical and doctoral degrees also remains relatively low. But on balance, AID has the highest level of professionalism and the greatest depth of population expertise of any government donor agency, and AID's population staff are generally characterized by a high level of dedication and commitment. The Agency's population staff was significantly strengthened by the recruitment of new entry-level technical expertise through the International Development Intern (IDI) program in the 1970s and early 1980s. However, recruitment under this program in recent years has been significantly curtailed. Meanwhile, in-service training opportunities for AID's population professionals remain relatively limited.

Unfortunately, there is little indication that the Agency is focusing on future staffing needs for the population sector, either in terms of numbers or quality. The Agency as a whole has no systematic work force planning. The personnel management system, and recruitment in particular, is widely recognized to be one of AID's

weakest elements. In recent years a number of older population officers have retired, while others have moved up and out to management jobs within the Agency. But the Agency does not appear to have any systematic plan for either entry-level or mid-career recruitment of population specialists. In recent years, new hiring has been intermittent and somewhat random owing to a series of hiring freezes. Many Agency staff consider the present recruitment system to be an inefficient and lengthy process which discourages excellence.

Bureaucracy

Within the Agency as a whole, there has been a trend over time towards increased micromanagement of projects and bureaucratic red tape. The Agency's procurement guidelines, documentation requirements and clearance process have grown in length and complexity. There is a general consensus that many of AID's problems are largely self-inflicted wounds, but the result is still that Agency program staff spend an increasing amount of time and energy fighting the internal AID bureaucracy. Over the years, increasingly onerous clearance procedures and procurement restrictions have significantly slowed the pace of program implementation and have involved tangible financial costs. The growth of bureaucracy, combined with the politicization of programs and personnel, has led some observers to pronounce the Agency "terminally ill."

The population program mirrors the overall increase in bureaucracy within the Agency. As in other sectors of AID activity, the level of bureaucracy has significantly slowed the approval and implementation of population projects. As AID has become more rigid and focused on process, administrative layers have necessarily increased within its Cooperating Agencies, siphoning away program money for operating expenses. At the country level, AID's reporting requirements and procurement guidelines pose endless bureaucratic hurdles for gov-

ernments and local non-governmental organizations. Staff in the Office of Population and AID field missions are over-burdened by documentation requirements and have difficulty getting away from their desks to monitor programs in the field.

There have been some limited efforts to fight this creeping bureaucracy; for example, some Divisions within the Office of Population have moved towards multi-year planning and approval for Cooperating Agency programs and a reduction in scrutiny of individual project activities. But the tendency towards micromanagement is endemic to the system and its regulations. For example, the AID bureaucracy still requires approval, even on multi-million dollar contracts, for equipment purchases of more than \$500 by a contractor and for salaries of local-hire support staff in contractor field offices. AID should probably not be funding agencies it does not trust to make such decisions.

Increased bureaucracy has undermined the flexible procurement procedures, which are key to a successful partnership of central and bilateral activities in the population sector. The buy-in process, which allows AID field missions to purchase the services of central projects with bilateral funds, was at one time relatively quick and simple. But the mechanism has developed bureaucratic arterial sclerosis. Increasingly, contract amendments to incorporate buy-ins involve long delays in Washington, to the growing frustration of AID field missions. Moreover, in recent years AID's Contracts Office, under pressure from various government procurement watch dogs, has added layer upon layer of additional requirements and restrictions which have substantially limited the responsiveness and flexibility of the buy-in process. Of special concern is the requirement that Cooperating Agencies rely on bilateral buy-ins to supplement operational as well as program costs. The Cooperating Agencies are required to staff their projects at levels that cannot be sup-

ported through central core funding alone, creating pressure on them to generate activity in countries where bilateral funds are available, regardless of whether this represents the best use of their technical resources. Their situation is made more difficult by the fact that, in many countries, local officials are understandably reluctant to use any bilateral funds to pay for overhead costs in the United States.

A further issue is the Office of Population's increasing reliance on competitively bid contracts for the implementation of centrally-funded population projects. In the past, the Cooperating Agencies consisted almost exclusively of family planning non-profit organizations and universities with a long tradition of commitment to international population programs, which received support working through five year grants and cooperative agreements. In recent years, however, government procurement regulations have forced the program to move to short-term competitively bid contracts. The competitive bidding process is costly and time-consuming for both AID and its Cooperating Agencies. The process emphasizes quick results over long-term institution building and puts too many program decisions in the hands of project monitors in AID's Washington headquarters. Although most of AID's long-time Cooperating Agencies still have cooperative agreements, which in principle permit greater flexibility and autonomy than a contract, AID has a tendency to micromanage them just the same. The sense of public-private sector partnership, which has characterized AID's population program, is jeopardized by current procurement trends.

Recommendations for Changes in the Management of AID's Population Program

- The Office of Population should have a greater role in overall program coordination and a stronger voice in AID's field programs.**

Recentralization on the pattern of the 1970s is not necessarily the answer; most program authority should continue to be vested in AID's field missions. But the central office should have sign-off authority over the substance of AID's country level programs, following other measures to build a closer and stronger partnership with AID missions.

AID's past experience in the population field, as well as that of other organizations like the World Bank, has demonstrated the importance of a critical mass of expertise for maintaining a focus on the population sector. In any reorganization, AID must recognize the importance of a strong centrally-organized group to provide specialized technical support and to assist in strategic planning. "The key," as one AID population staffer put it, "is people, money and commitment at the mission level, with a strong central technical group to bolster and backstop the country programs," and to fill in where the people or commitment are missing.

The technical support function should be recentralized from the regional bureaus to the Office of Population — formalizing a shift that has already occurred at an informal level. This would create a direct line of communication between the central office and AID field missions. The Office of Population should reduce its current project management responsibilities by streamlining the central project portfolio, and reallocate staff positions to strategic and technical support for AID missions on a geographic basis; new positions will also need to be created. Expansion of the Office of Population's responsibilities to include backstopping for country programs will over time make it more responsive to the needs of AID's field programs. Greater contact with cen-

tral specialists will help upgrade the expertise of field staff.

Population expertise may need to be maintained within the regional bureaus if they continue to be the heart of the Agency's power structure, so that population is not neglected by the bureaus as a consequence of recentralization of the technical support function. Several population staff positions should remain within any regional bureau structure, to play an advocacy role for population, to coordinate bureau and central resource allocations, and to initiate and to manage regional programs.

Under AID's current reorganization effort, serious consideration is being given to consolidating all technical staff within a single organizational structure. According to this proposal, the Office of Population would be relocated, along with other technical offices, within a newly-created Bureau of Operations which would also oversee AID's regional and country level programs. This plan would establish a unified technical staff in the population sector to which all field missions would look to for program support, giving de facto sign-off authority to the Office of Population in its new incarnation. This proposal would accomplish much the same result as the recommendation above and should be encouraged if the reorganization effort continues to move forward along these lines.

- **The Agency needs to increase population staff substantially, with priority to AID field missions, particularly those in Africa.**

It is high time for the Agency to take a rational approach to staffing, recognizing that budget and staffing go hand in hand, and that both the number and quality of staff are important. Overall staffing

strength needs to be increased by a factor of at least 25 to 30 population officers, not including attrition through retirement or promotion. The highest priority should go to the Africa Bureau, where at least one career population officer (and one health officer) should be assigned to every AID mission. To meet these needs, AID must resume recruitment of both mid-career and entry-level professional staff. Reestablishment of a continuing, competitive entry level professional recruitment program is particularly important to keep the Agency infused with fresh young talent.

Unfortunately, staffing issues relating to population programs are unlikely to be resolved until such time as the Agency undertakes a serious overhaul of its broader personnel management system. Sweeping changes in AID's present approach to recruitment and hiring are needed if AID is consistently to attract the best and the brightest.

- **To facilitate more creative tension between the central Office of Population and the Agency's field programs, AID management needs to promote more staff exchanges between the field and the central office.**

The travel budget for population staff must be increased. (Congress did in fact provide additional funds for travel this year, but the Administration chose not to allow their use.) Additional travel money should be used not only for monitoring visits to the field by central Population Office staff, but also for travel to Washington by mission population staff for consultations with central office staff, short-term training, and for attending important professional meetings such as the annual meeting of AID Cooperating Agencies.

AID management and the Office of Population also need to reduce rigidity in

the current staffing pattern. The establishment of several new field backstopping positions in the Office of Population would create additional opportunities for foreign service field staff to rotate through the central office. But civil service staff would also benefit from periodic two-year excursion assignments overseas; in their absence, their positions could be filled by foreign service staff on rotation to Washington. Although administrative authority for such exchanges currently exists, they are unlikely to occur unless AID management shows more flexibility in use of personnel and actively supports and rewards staff who undertake such assignments.

□ **Population-related training opportunities for senior and mid-level AID staff should be expanded.**

Many population professionals would benefit from a six-week training course which would require them to set aside their day-to-day responsibilities in order to refocus on underlying demographic and family planning program management issues. The Agency's senior management cadre should also be sensitized and exposed to demographic problems and population program approaches through AID's existing seminars for high-level managers.

□ **AID's leadership and the Office of Population should streamline procurement processes that are vital to effective implementation of the population program.**

The Office of Population should seek authority to return to non-competitively awarded cooperative agreements for implementation of the central program. Lesser reliance on competitively bid contracts by AID would greatly streamline the foreign aid procurement process. Extending the length of funding agreements and

simplifying the approval of projects would also help to ensure that both AID and Cooperating Agency staff spend less time pushing paper.

It should be recognized that non-competitive funding agreements to long-established population organizations are in the best interests of the program. Cooperative agreements provide a more appropriate mechanism for working collaboratively with non-profit groups on programs of an innovative nature and for building long-term cooperation between U.S. and developing country organizations. Such people-to-people ties are among the most important — if difficult to quantify — products of U.S. development assistance. Within the United States they help expand the community of people who understand and support the goals of U.S. development aid.

AID's leadership needs to simplify the procedures for integrating the expertise of U.S. private institutions into AID field mission programs. Restrictions on the flexibility of the buy-in procedures, such as funding ceilings, should be minimized. The Office of Population should support all core institutional costs of Cooperating Agency programs as well as adequate program funds for non-bilateral and small bilateral countries. Budget allocations to the big bilateral programs should include funds for mission buy-ins. The missions and their local counterparts should have the flexibility to use these funds to support the in-country programs of those Cooperating Agencies they find most useful.

D. Program Strategy

AID's efforts in family planning a not adequately reinforced by activities

in other development fields, for instance by a stronger emphasis on opportunities for women. AID's support for family planning services is valid, but assistance is constrained by too many restrictions on program approaches and birth control methods. Program strategy has also been vulnerable to swings in political ideology; the current emphasis on the private sector and cost recovery is distracting AID from the critical goal of expanding access to family planning.

AID does not have a broad, strategic approach to population stabilization. Many facets of social and economic development serve to lower fertility, and there is a wide range of non-population initiatives AID as a whole could embrace which would support and complement its family planning efforts. But AID has generally neglected to exploit links between family planning and women's status and education, or to look for connections between family planning, AIDS and child survival programs. Recently, the Africa Bureau has sought to stimulate more coordinated and mutually reinforcing programs at the country level. Broadly speaking, however, AID has not used either its other development or security assistance funds to support programs in other sectors which provide incentives for smaller family size, or to support activities like female education, despite a specific Congressional mandate to do so. Changing this would require, first, a commitment from AID's leadership, and second, better working relationships among AID's technical people.

There is a consensus that AID's overall program approach of improving the availability and quality of voluntary family planning is appropriate and effective. The program focus on family planning information and services makes sense and in fact appears to be AID's comparative advantage. AID's approach has emphasized

the importance of voluntarism and informed choice in provision of family planning services and AID's philosophical commitment to these fundamental principles has been a positive influence in a number of countries. In Bangladesh, for example, AID has consistently encouraged the government not to give undue emphasis to voluntary sterilization, but to make other methods widely available, and to take steps to prevent coercion.

Nevertheless, AID's approach to family planning methods is too narrow. AID's strategy is limited to certain birth control technologies and excludes others. For example, although injectable contraceptives are approved by regulatory authorities in over 90 developed and developing countries, AID will not finance their purchase because current policy prohibits the purchase of contraceptives that are not approved for use in the United States. As a result of political pressure from U.S. conservative groups, AID has also backed away from involvement in safe abortion services, adolescent fertility and sexuality education, all of which are important elements of a comprehensive approach to reproductive health and fertility reduction. (There is no formal policy prohibiting support for adolescent programs or sexuality education. But free-standing programs for minors have been informally discouraged, as is evident from their virtual absence from AID's current program efforts despite the growing problem of adolescent pregnancy in many developing countries.) At the same time, AID has paid a level of attention to natural family planning, the only contraceptive method endorsed by many conservative political groups, disproportionate to its level of use or effectiveness in developing countries.

Current AID restrictions on abortion-related activities, for which Congress and the Administration share responsibility, are particularly problematic in the strings they attach to U.S. population assistance. U.S. policy on abortion is flawed from a demographic perspective, be-

cause it fails to recognize that abortion is a necessary back-up to even the most effective methods of contraception, and that no country has reached replacement fertility without some reliance on abortion. It is flawed from a public health perspective because unsafe abortion remains a major cause of maternal morbidity and mortality in many developing countries.

The preoccupation of U.S. policymakers with abortion has deterred some donor countries and many developing country governments from supporting abortion-related activities for fear of jeopardizing AID funding, even where health policymakers consider unsafe abortion to represent a major public health problem. By cutting off support to important family planning organizations, such as UNFPA, IPPF and FPIA, the current policy on abortion may have served to decrease access to family planning and to increase both unintended pregnancies and abortions. Moreover, there is evidence from countries like Bangladesh and Turkey that U.S. policy has reduced the availability of good quality and affordable abortion services, probably increasing the number of deaths from unsafe abortions. U.S. policy has also helped to stifle public debate on reforming old abortion laws, since family planning groups who receive AID funds may not speak out on the issue. In sum, current U.S. population assistance policy relating to abortion has had a profound and negative impact on the health of developing country women and on progress toward world population stabilization.

AID's heavily ideological emphasis on the private sector and cost-recovery is distracting population programs from the much more important issue of access to family planning. AID's overall program has always been vulnerable to swings in political ideology between one Administration and the next. Under the current Administration, AID's leadership has developed what can only be characterized as an obsession with privatization and financial sustainability. In the population field, the application of this

policy is contributing to a growing neglect of public sector programs. There is inadequate recognition among AID's leadership that achievement of demographic objectives will require continued subsidies of family planning services in many countries, and for certain types of services, such as contraceptive sterilization, in most countries.

The private sector — both voluntary and for profit — is clearly an important channel for delivering family planning services. But in almost all countries there is a need for a mix of both public and private sector services. In a number of successful programs, including those in Thailand and Indonesia, the public sector has been the primary vehicle for providing nation-wide coverage by family planning services. In some advanced developing countries, as in the United States, the public sector represents a critical (and affordable) channel for continuing to reach low income groups with family planning. Public sector health facilities are, moreover, likely to gain in importance with expanded use of more effective, clinical methods such as the IUD, implants, and sterilization.

The problem is that AID's emphasis on the private sector has become an article of faith, and is being applied in a relatively unselective manner. Even where the public sector is relatively competent, as in Mexico and Turkey, AID has been unwilling to acknowledge that the highest returns may lie in investing in the expansion of family planning within existing, relatively well-developed public sector institutions. Although many ongoing projects provide assistance to public sector programs, there is considerable political pressure on field missions to orient new and follow-on projects to the private sector. This pressure has been particularly intense in the Asia and Near East regions. Over the past few years, substantial resources have been allocated to a succession of central projects focusing on the private sector (such as the TIPPS project, the Enterprise Program and its proposed successor PROFIT), although the

demographic impact of these activities is questionable.

The same problem exists with AID's current approach to financial sustainability. No one disagrees that family planning programs must be cost-effective and focus resources on those in greatest need of them. But AID needs to define its financial goals for family planning programs carefully and realistically. Experience has shown that, although improved cost-effectiveness and *partial* cost-recovery are often feasible, *self-sufficiency* is not a realistic goal for family planning programs in most developing countries during the 1990s. Moreover, there may be a potential trade-off between cost-recovery and achievement of demographic objectives; in Bangladesh, a substantial increase in prices of subsidized contraceptives sold through the Social Marketing Program, motivated by AID's concern for greater cost-recovery, resulted in the loss of a half million low-income customers. Finally, AID should recognize that cost-recovery and financial sustainability are different objectives. A program can be sustainable without cost-recovery if its costs can be picked up by government revenues, as with the national family planning program in Thailand.

Recommendations for AID's Population Program Strategy

- **AID should retain its current focus on family planning, but broaden its approach to a more comprehensive strategy for fertility reduction.**

The expansion and improvement of family planning service delivery systems should remain the primary focus of AID's population assistance program, and AID should not diffuse or weaken this approach by shifting to a broad reproductive health or maternal and child health orientation. However, AID should adopt a broader family planning strategy which includes assistance to adolescent programs

and sexuality education where there is a demand for these programs, and support for injectable and other contraceptive methods approved by international health agencies and by AID-recipient countries, even if they are not approved for use in the United States.

Finally, if AID is to adopt a more rational policy relating to abortion, Congress must act to repeal the Helms amendment and overturn the Mexico City Policy. AID should be prepared to support safe abortion services and abortion-related research and training when requested to do so by foreign governments. At a minimum AID should abandon its crusade against abortion activities by other donors, host country governments and private organizations, and resume support to FPIA, IPPF and UNFPA.

- **AID's field missions should be encouraged to develop programs in other sectors which reinforce family planning efforts as part of country strategies.**

AID country level programs should seek to exploit the synergies between family planning and, for example, female education, through projects which expand access to primary and secondary education for girls. Within the Science and Technology Bureau as well as in AID field missions, there should be closer collaboration between AID's family planning and health programs, particularly in the area of AIDS education and prevention, child survival, and breastfeeding. However, this collaboration should never be at the expense of family planning programs.

- **At the country level, AID's population program strategy needs to be flexible and pragmatic rather than rigid and ideological.**

AID's institutional strategy must recognize the differences in the evolution and current needs of national family planning programs, and avoid application of ideological principles across the board in a mechanical way.

More specifically, AID must acknowledge the need for investments in *both* private and public sector family planning programs, and recognize that the specific mix of activities will inevitably vary from country to country. AID also needs to recognize that, in most developing countries, family planning programs will continue to require some level of public subsidy for the foreseeable future. Cost-recovery efforts should be selectively focused on certain countries and activities, with the emphasis on market segmentation, which takes into account varying ability to pay. AID should assist national governments in identifying consumers who are unable to afford the full cost of services, and in targeting public resources to the needy. Above all, AID's current leadership needs to keep in mind the demographic objectives of the program; it must ensure that programs do not lose clients or forsake the poor in their zeal to promote the private sector and recover costs.

E. Program Issues for the 1990s

In general, individual AID population projects have been well designed and implemented. But as family planning programs shift towards providing services on a far more comprehensive scale, AID has not moved far or fast enough towards meeting their changing needs for assistance. AID needs to take a more active role in finding new mechanisms to meet the global demand for contraceptive supplies, and in improving the quality of services in

large public sector programs. Future centrally-funded projects need to be designed on a scale which enables them to have a significant demographic impact, and to be more closely integrated with bilateral population programs.

AID also needs to take a more broad-based approach to technical assistance, giving greater emphasis to the creation of institutional capacity in the developing countries themselves. Finally, AID programs need to be conceived in a much longer term context, in order to facilitate program planning and the achievement of long-term demographic objectives.

AID's bilateral population projects have supported a broad range of service delivery and related activities, with special emphasis on support for contraceptive supplies, training and contraceptive social marketing. Some bilateral programs — for example, those in Bangladesh and Indonesia — have been better performers than others, such as those in India and Nigeria. Over the years, AID has developed a good sense of what works and what doesn't in family planning. But one problem has been a lack of adequate mechanisms to share successes and experiences across field missions and geographic bureaus; as a result, there has been a tendency for AID missions to reinvent the wheel continually from one bilateral program to another. Moreover, AID's assistance has been highly project-oriented, even in countries which have developed substantial capability to plan and to implement family planning programs. Some countries are ready to graduate to a looser form of general program support.

AID's centrally-funded population projects also generally receive high marks for providing specialized expertise in key program areas. As with AID's bilateral programs, there is some unevenness within the central portfolio; some Co-

operating Agency programs are clearly more effective than others. The buy in mechanism, which allows AID field missions to use bilateral resources to obtain assistance from centrally-funded projects has been a flexible and important bridge between the central and bilateral programs. By allowing Missions to vote with bilateral funds, the mechanism has also provided important feedback on the vitality and relevance of centrally-funded programs. The Demographic and Health Surveys and the Association for Voluntary Surgical Contraception projects, for example, have been in great demand by AID field staff and developing country officials.

The real issue, however, is not the effectiveness of individual AID activities, but to what extent AID's overall program is successfully assisting developing countries to establish large-scale, national family planning service delivery systems with potential demographic impact. The challenge for family planning programs in most developing countries today is that of replication and "massification" (the new buzzword for scaling up projects) without loss of quality. There is a need to expand successful approaches across countries and scale up proven service delivery models to a national level. Given the magnitude of the needs, other donors and national governments must share in this responsibility, but AID, as the largest and most innovative donor, clearly has a critical role to play. Ultimately, whether or not the world's demographic problems are solved may depend to a large extent on how effectively AID supports the large-scale expansion of family planning efforts. Yet AID's current efforts in this area are inadequate in a number of respects.

First, AID is not moving aggressively enough to address the growing demand for contraceptive supplies associated with the expansion of worldwide family planning efforts. Demand for contraceptives has escalated in the past two decades; the number of family planning users in developing countries more than doubled

from 1970 to 1980, and increased again substantially to 360 million by 1990. If current trends continue, there will be more than 660 million family planning users in developing countries by the year 2000. The need for large numbers of condoms for AIDS prevention programs will further boost the costs of meeting Third World contraceptive requirements.

This enormous increase in demand over a relatively short period has created substantial pressure on AID, as the largest single source of commodity assistance. In response to sky-rocketing requests from developing country governments for contraceptive supplies, AID allocations for contraceptive procurement have risen from about 10 to 25 percent of the overall population budget; in 1990, funding for contraceptive supplies reached a record of \$66 million. AID alone, however, can no longer meet the demand for contraceptive supplies, and increasingly, developing countries are looking to the other multilateral and bilateral donors for commodity assistance.

At the same time that developing countries are experiencing a commodities crunch, however, AID is perceived to be edging away from its long-standing commitment to contraceptive supply. Given the financial implications of escalating demand, AID is clearly uncomfortable with its role as the world's primary source of contraceptive commodity assistance. Within AID, there is substantial support for the view that the Agency should focus limited resources on technical assistance, leaving commodity support to donors who lack AID's institutional capability. There is also valid concern that AID's comparative advantage does not lie in commodity assistance; AID often pays more than the world price for certain contraceptives because of the Congressional requirement that it buy only U.S. goods, and it will not provide injectable contraceptives because they are not approved for use in the United States.

AID is phasing out of contraceptive supply in a number of countries, raising concern that it

is not safeguarding its considerable investments in social marketing programs and other successful service delivery efforts by ensuring adequate supplies. In Bangladesh, just as family planning efforts are beginning to show tangible results, AID has moved to transfer responsibility for contraceptive supplies to the World Bank which has little experience in the field. In Nigeria, AID has failed to make adequate contraceptive commodities available to the new service delivery programs it has initiated. In Mexico, Turkey and Indonesia too, AID is moving to terminate its long-standing role in contraceptive supply.

AID's program leadership subscribes to the broader perception within the international population community that a multilateral institution, such as UNFPA, should take the lead in establishing a global fund to meet the needs for contraceptive commodity assistance. AID has participated in a UNFPA-led consultative group established to estimate the contraceptive requirements of developing countries over the next decade, and is actively working with other donors to establish a new multilateral mechanism for commodity assistance. However, AID's ability to play a leadership role in this respect is constrained by the Bush Administration's continued withholding of support from UNFPA and subsequent loss of influence over international cooperative efforts.

A further issue relating to demographic impact is that AID's bilateral programs give inadequate attention to the quality of family planning services. Quality of care is increasingly recognized to be a critical factor in family planning success; high quality counseling, services and follow-up appear closely related to effective long-term use of contraception and, as a consequence, to demographic impact. Recent experience and research in a number of countries has demonstrated that the quality and frequency of contacts between family planning workers and clients, the adequacy of training and supervision, and above all, availability of a

wide choice of contraceptive methods, are important factors in increasing and sustaining contraceptive use. The quality of clinical services is particularly important given the increasing popularity of long-acting, effective clinical methods of contraception. But there are major deficiencies in these areas in many family planning efforts, particularly in large public sector programs.

The problem is that AID's efforts to improve the quality of family planning services have been too Washington-centered. The Office of Population has convened a Task Force of Cooperating Agencies to explore systematic approaches to improving the quality of family planning services. But technical meetings to discuss issues relating to quality of care have been largely confined to Office of Population and Cooperating Agency headquarters staff, and programmatic efforts to improve quality of care have generally been limited to small-scale Cooperating Agency activities. With a few exceptions, such as the Matlab Extension Project in Bangladesh and a recent Population Council study in Kenya, AID is not giving sufficient attention to the challenge of improving the quality of services in large national public sector programs. AID field missions and aid-recipient governments need to be more involved in ongoing efforts in this area.

In several other respects, AID's central program is not adequately oriented to the large-scale expansion of family planning services. Many AID Cooperating Agencies, particularly those involved in the direct provision of family planning services, have had difficulty moving away from their traditional role of establishing beachheads of family planning activity. At the country level, many centrally-funded programs continue to support small-scale targets of opportunity. Although there has been a gradual trend in recent years towards fewer and bigger activities, the average size of a Cooperating Agency subproject is only about \$70,000; individual subprojects often provide services to

very limited areas and populations. Particularly in countries where family planning is well-established, this approach is often perceived to be anachronistic, or as one AID staffer put it, "self-indulgent dilettantism."

Part of the problem is that the allocation of resources within the central program has emphasized the continuing search for new solutions, sometimes at the cost of adequate support for the expansion of proven approaches. For example, although contraceptive social marketing has proved an excellent vehicle for bringing family planning to large numbers of people at very low cost, the scope of individual country level projects funded under the single central Social Marketing of Contraceptives project has been severely constrained by available resources. The lack of adequate resources has limited the demographic impact of social marketing efforts in important countries like Mexico and Brazil, as well as others like Bolivia and Morocco. In contrast, social marketing efforts supported through bilateral channels have been funded at substantially higher levels and have achieved significantly greater coverage.

The central population program also needs to be better integrated with bilateral activities. AID field missions currently have too little input, too late, in the development and design of new centrally-funded initiatives. Resource allocations to individual central programs also often do not reflect country level needs and priorities. The Office of Population needs to consult more closely with AID's field population staff in the development of new centrally funded projects, and in the allocation of resources to those projects.

By the same token, AID field missions need to do more to ensure that Cooperating Agency capabilities are better integrated within country strategies; currently, only a few Missions consistently include the Office of Population or individual Cooperating Agencies in

strategic planning for population sector activities. Sign-off authority on mission population projects would help promote this integration between central and bilateral programs.

AID's current approach to technical assistance is also a constraint to scaling up programs on a worldwide basis. The central program has become diffuse and over-specialized; there is a separate contract for every conceivable program specialty. The Office of Population perceives each Cooperating Agency to have its own special niche, and has generally encouraged each institution to develop expertise in a limited technical area. Many of the Cooperating Agencies believe the current approach does not respect their need for organizational autonomy and evolution, or recognize the real benefits to field programs of more overlapping and mutually reinforcing mandates. While the emphasis on specialization has helped to build a depth of expertise in specific program areas, from the field perspective existing technical resources are highly fragmented. There is a need, particularly in Africa, for more broad-based institutional capacity.

AID's highly compartmentalized approach to building technical capacity, for example, cannot effectively address existing needs for expanded access to high quality clinical family planning services. Although many Cooperating Agencies are involved in clinical service delivery, AID essentially looks to just two organizations to provide technical leadership and assistance in this area. While these organizations provide assistance of excellent quality, they are limited in their capacity to respond to the magnitude of worldwide needs in this area. In order to significantly increase access to clinical contraception, it is clear that other Cooperating Agencies must expand their involvement in the provision of high quality clinical services. The same is true for other specialized fields, such as logistics, information and training. These needs argue for a move away from

short-term contracts to long-term cooperative agreements.

The current approach to technical assistance is also not efficient from a management perspective. The number of projects managed by the Office of Population appears to have reached the point of diminishing returns, given bureaucratic requirements for managing each project. For AID population officers in the field, working with a large number of central Cooperating Agencies is time-consuming and tends to turn field staff into traffic cops controlling a constant stream of expatriate visitors. For developing country institutions which receive AID assistance, working with many U.S. organizations creates problems of coordination and is costly in terms of overhead. Moreover, the small size of many central subprojects is inefficient; developing and managing many small activities creates excessive paperwork for both AID and Cooperating Agency staff.

AID is also not giving sufficient attention to the long-term institutional development needs of Third World family planning programs. There is no doubt that AID and its Cooperating Agencies have contributed substantially to the development of technical capacity in family planning in developing countries. But there is a need for far greater emphasis on the development of the professional and management capacity of developing country institutions. A serious deficiency in this context is the lack of a centrally-organized and coherent long-term training effort for developing country population professionals. In the past, support for long-term training from the Ford and Rockefeller Foundations, and to a lesser extent from AID, helped to build the first generation of population program leadership in many countries. But these program managers and policymakers are now aging, and there is a need to develop a new generation of leadership. Building sector leadership is particularly important in the African context, where family planning programs

are just beginning to get off the ground.

Finally, AID's assistance has too short a time horizon. AID has a tendency to start pulling out of country programs at the first real sign of progress, and to terminate support prior to the accomplishment of long-term demographic objectives. For example, AID is phasing out support in Indonesia, where contraceptive prevalence is about 50 percent and average family size is a little more than three children. But services beyond Sumatra, Java and Bali are still weak and only a limited number of contraceptive methods are widely available.

Another problem relating to AID's time horizon is that although bilateral and central population projects are approved for a three to five year period, funding levels for individual activities are usually determined on an annual basis. This reflects the annual political process through which Congress approves funds for the program each year, which in turn is mirrored in annual budget allocations to central and bilateral programs, and the cyclical renewal of country level projects. The annual funding cycle creates considerable uncertainty regarding the continuation of AID support; on the one hand, the resources provided by AID encourage local institutions to expand the scope of their activities; on the other, long-term planning is difficult in light of the precarious nature of AID assistance. Unfortunately multi-year Congressional authorizations (much less appropriations) for foreign aid are traditionally a non-starter on Capitol Hill.

Recommendations for Enhancing the Impact of AID's Population Programs in the 1990s

- In the short-term, AID should not abandon its long-standing commitment to contraceptive commodity assistance; over the longer-term, AID should continue to work closely with**

other donors to develop new mechanisms for providing contraceptive supplies.

Contraceptives are the life-blood of family planning programs; while AID is correct to look to other donors to share the burden of providing contraceptive supplies to Third World family planning programs, it needs to be cautious in divesting itself of responsibility in this area. AID has been a long-standing and reliable donor of contraceptive supplies; it is impossible to predict if other donors have the capacity to respond to existing needs in a comprehensive and timely fashion, or if they are likely to have similar staying power over time.

Congress and the Administration should support the creation of a global contraceptive fund, and AID must continue its ongoing efforts with other donors to establish a new multilateral institutional framework for contraceptive commodity assistance. The Office of Population will need to assist in the development of an appropriate organizational structure, and in the orderly transfer of its current responsibilities for helping countries project, plan and manage their contraceptive requirements. U.S. financial support to such a mechanism should be free of any restrictions.

- **AID's bilateral programs must move quickly to address the quality of family planning services in large national programs in a more systematic and comprehensive way; ongoing centrally-funded activities to strengthen quality of care must be reoriented to support these efforts.**

The Office of Population needs to involve AID's field population staff more fully in the current debate on how best to improve the quality of services. Both the

central and bilateral programs should expand support for field-based research on possible cost-effective program improvements, along the lines of the Matlab Extension Project in Bangladesh. Support for ongoing training of both clinical and non-clinical field level service providers should be expanded, and current evaluation efforts, including the Demographic and Health Surveys, should include feedback on the quality of services and client satisfaction.

Quality of care concerns could also provide a framework for revitalizing AID-supported field research on family planning program operations. Ongoing program-related research, which has in the past lacked a coherent strategy, has already been moving tentatively in this direction. AID should consider refocusing these efforts to address the quality of family planning information and services in an explicit and systematic manner.

- **AID's central program as well as AID's bilateral allocations need to give greater consideration to issues of demographic impact.**

While the Office of Population should not lose sight of its role as the overseer of innovation for AID's population program, it should be free to be more selective in its support for new, experimental approaches, focusing on those that show the greatest promise for large-scale replication. The office should also expand support for proven, effective approaches, such as contraceptive social marketing and voluntary sterilization. Major changes are also needed in the design of Cooperating Agency service delivery subprojects; most of these activities should be designed on a substantially larger and demographically more significant scale. In addition, the Cooperating Agencies should

provide expanded support for long-term institution-building activities designed to develop the infrastructure needed for universal family planning coverage.

- **The Office of Population should streamline the central project portfolio, while encouraging individual Cooperating Agencies to expand the scope of their activities.**

Ultimately, developing country needs may be better served by a smaller number of technical assistance institutions with several specialties and overlapping mandates; from the perspective of both AID and recipient institutions in developing countries, it is likely to prove simpler and less costly if multiple technical assistance needs can be met from a single source. In the long-term, encouraging individual Cooperating Agencies to broaden their current base of expertise will bring greater richness and organizational strength to the overall program.

- **There is a need for better and closer coordination of central and bilateral activities.**

The Office of Population needs to work more collaboratively with AID field missions to define unmet country needs, and to involve field population staff more closely in the development of central programs. AID's field missions in turn need to work with the Office of Population and its Cooperating Agencies to integrate the expertise and potential activities of centrally-funded agencies into strategic planning efforts at the country level, and to coordinate the mix of central and bilateral activities.

- **AID should give high priority to resurrecting a centrally-managed program for long-term professional training in population-related fields**

for developing country program personnel.

Special attention should be given to the Africa Region in building sector leadership.

- **AID needs to take a longer-term view of population program assistance, recognizing the need to allow five to ten years at a minimum for these programs to demonstrate results.**

In countries which have made significant progress but which still need substantial external assistance, AID should consider moving from a project to a program mode of assistance in order to reduce the level of bureaucratic involvement. AID should coordinate these efforts with the World Bank and other donors, which may have a greater availability of financial resources. The achievement of replacement level fertility should be AID's ultimate objective at the country level, and AID should not back away from its investments until this goal appears both attainable and sustainable.

Summary of Recommendations

I. Major Recommendations for the President and Congress

- ❑ President Bush must reassert White House leadership on world population issues.
- ❑ Congress must continue to designate funds for population assistance within the annual foreign aid appropriations.
- ❑ Total U.S. population assistance should be increased to \$600 million for fiscal year 1992, growing to \$1.2 billion by the year 2000.
- ❑ The allocation of population funds must better reflect global demographic priorities.
- ❑ The United States should resume support to the United Nations Population Fund and the International Planned Parenthood Federation.
- ❑ Congress should eliminate statutory restrictions on the program relating to abortion.
- ❑ Congress should specifically authorize a series of policy studies on relationships between population growth and sustainable development.

II. Recommendations for the Agency for International Development (AID)

- ❑ AID should broaden its current approach to birth control to include injectable contraceptives, safe abortion services, and adolescent and sexuality education programs.
- ❑ AID's field missions should be encouraged to expand programs in other areas which reinforce fertility reduction, such as female education.

- ❑ AID must take a less ideological approach in determining the mix of support for public and private sector activities in population and in setting financial sustainability goals for family planning services.
- ❑ AID must continue to provide substantial amounts of contraceptives and work with other donors to develop new ways of providing contraceptive commodity assistance.
- ❑ Greater attention must be given to improving the quality of services in large national family planning programs. AID should refocus ongoing field research on family planning program operations to address quality of care issues.
- ❑ To achieve greater demographic impact, AID's existing service delivery programs, particularly those undertaken by private collaborating institutions, need to be designed on a significantly larger scale. Successful social marketing and clinical family planning programs should be expanded and more widely replicated.
- ❑ AID should undertake recruitment of about 25 to 30 additional population staff, giving priority to AID field missions, particularly in Africa.
- ❑ Short-term training opportunities for AID's mid-level population professionals should be expanded. AID seminars for senior managers should sensitize them to demographic problems and family planning program issues.
- ❑ AID must take a longer-term view of population assistance. AID should move towards broader program (rather than project) support in countries which have

made significant progress but which still need external assistance, coordinating these efforts with other donors.

III. Recommendations for the Office of Population

- Responsibility for technical support to AID's country level population programs should be centralized in the Office of Population, which should also be given sign-off authority over the substance of these programs.
- Activities supported from the Office of Population through private U.S. institutions need to be better coordinated and integrated at the country level with AID's bilateral population programs.
- AID management must promote staff exchanges between AID's field missions and the Office of Population.
- The Office of Population should streamline its worldwide technical support program, and encourage individual collaborating U.S. institutions to expand the range of technical services they provide.
- AID needs to shift back towards a greater use of non-competitive cooperative agreements in working with established population organizations. AID should streamline the vital buy-in process through which AID field missions obtain technical services from worldwide projects managed centrally by the Office of Population.
- AID's Office of Population should improve the efficiency of its worldwide technical support program, including measures to lower the overhead costs of its private U.S. collaborating institutions.
- The Office of Population should give higher priority to important needs outside of Africa and to complementing country level programs funded through AID field missions.
- Greater attention should be given to the long-term institution building needs of family planning programs. AID should reestablish a worldwide program for professional training in population-related fields.

Annex 1

Country Allocations for Population from the Economic Support Fund Account

(Millions US\$)

Fiscal Year	Egypt	Pakistan	Jordan	Tunisia	Zimbabwe	Total
1977	\$ 4.0	—	—	—	—	\$ 4.0
1978	6.0	—	—	—	—	6.0
1979	6.5	—	—	—	—	6.5
1980	10.0	—	—	—	—	10.0
1981	18.5	—	—	—	—	18.5
1982	22.4	4.3	—	—	—	26.7
1983	20.0	4.8	—	—	—	24.8
1984	—	20.3	—	—	—	20.3
1985	6.0	6.9	—	5.0	1.3	19.2
1986	18.0	20.6	—	4.0	—	42.6
1987	15.0	—	—	—	—	15.0
1988	15.0	—	2.5	—	—	17.5
1989	10.0	2.5	2.5	0.5	—	15.5
1990	12.0	6.5	—	—	—	18.5
1991 (estimate)	21.5	9.0	0.7	—	—	31.2

Source: Agency for International Development

Annex 2

AID Regional Bureau Population Project Allocations by Country, Estimates for 1991

(Millions US\$)

Asia Bureau		Africa Bureau		Europe/Near East Bureau		Latin America/Caribbean Bureau	
Bangladesh	\$19.01	Botswana	\$0.80	Egypt	\$21.50*	Bolivia	\$0.05
Indonesia	2.18	Burkina Faso	1.06	Jordan	0.69*	Dominican Rep.	0.04
Nepal	1.33	Cameroon	1.40	Morocco	1.75	Ecuador	0.83
Sri Lanka	0.20	Cape Verde	0.10	Pakistan	13.00*	El Salvador	6.64
South Pacific	0.80	Ghana	3.30	Philippines	6.50	Guatemala	3.72
		Guinea	1.00	Romania	1.50	Haiti	2.52
		Ivory Coast	0.57			Honduras	2.94
		Kenya	6.02			Jamaica	0.66
		Madagascar	10.95			Peru	1.87
		Malawi	0.32				
		Mali	6.01				
		Niger	4.64				
		Nigeria	8.00				
		Rwanda	3.86				
		Senegal	2.84				
		Tanzania	3.77				
		Uganda	1.50				
		Zaire	4.07				
		Zambia	0.01				
		Zimbabwe	1.65				

*Economic Support Fund allocations: \$21.5 million for Egypt, \$0.69 million for Jordan, and \$9.0 million for Pakistan.

Source: Agency for International Development

Allocation of Funds for Office of Population Programs, Estimates for 1991

<i>POLICY DIVISION</i>	Proposed Budget (Millions US\$)
Demographic and Health Surveys	\$ 5.2
Population Policy Initiatives	3.3
Expert studies on Population Issues	
Population Reference Bureau Materials	
Resources for Awareness of Population Impacts on Development (RAPID)	
Options for Population Policy	
Demographic Data Initiatives	5.1
U.S. Census Bureau	
East-West Population Institute	
Evaluation (New Project)	2.0
Sub-Total	15.6 (9.6%)
<hr/>	
<i>RESEARCH DIVISION</i>	
Population Council: Contraceptive Development	5.6
Strategies for Improving Service Delivery:	
Operations Research and Technical Assistance	7.9
Population Council	
TVT Associates	
Natural Family Planning	2.3
Family Health International	8.4
Contraceptive Research and Development	4.2
Sub-Total	28.4 (17.5%)
<hr/>	
<i>INFORMATION AND TRAINING DIVISION</i>	
Johns Hopkins Program for International Education in Reproductive Health	6.0
Family Planning Training for Paramedical, Auxiliary and Community Personnel	5.2
Program for International Training in Health	
Development Associates	
Population Communication Services	5.6
Population Information Program	2.5
International Population Fellows Program	—
Family Planning Management Development	4.0
Sub-Total	23.3 (14.3%)
<hr/>	
<i>FAMILY PLANNING SERVICES DIVISION</i>	
Association for Voluntary Surgical Contraception	13.0
Population Technical Assistance	2.4
Contraceptive Social Marketing II	5.5
Family Planning Services: Pathfinder International	8.6
Service Expansion and Technical Support	10.0
ACCESS (new CEDPA Project)	2.0
PROFIT (new private sector project)	8.2
Expansion of Family Planning in Latin America/Caribbean (IPPF Western Hemisphere)	6.0
CARE (new funding agreement)	2.0
Sub-Total	57.7 (35.5%)
<hr/>	
<i>COMMODITIES & PROGRAM SUPPORT DIVISION</i>	
Family Planning Logistics Management	6.4
Centers for Disease Control	
John Snow, Inc.	
Contraceptive Procurement	19.9
Sub-Total	26.3 (16.2%)
<hr/>	
<i>OTHER</i>	
UNFPA*	10.0
Operating Expenses/Other	1.2
Sub-Total	11.2 (6.9%)
TOTAL	162.5 (100%)

* Tentative planning figure for UNFPA. Unlikely to be committed in the absence of changes in Administration policy.

Annex 4

Table A

**AID 1990 Population
Expenditures by Country**

(Thousands US\$)

Region: Asia

Country	By AID Asia Bureau & Missions	By AID Office of Population	Country Total
Bangladesh	\$ 42,987	\$ 1,478	\$ 44,465
Burma	0	4	4
Fiji	0	20	20
Hong Kong	0	20	20
India	4,225	878	5,103
Indonesia	5,639	2,446	8,085
Malaysia	0	39	39
Nepal	870	1,304	2,174
Papua New Guinea	0	210	210
Singapore	0	100	100
Solomon Islands	0	1	1
South Korea	0	10	10
South Pacific Region	272	1	273
Sri Lanka	100	918	1,018
Taiwan	0	7	7
Thailand	164	2,318	2,482
Tonga	0	1	1
Western Samoa	0	1	1
Multiple Countries	4	1,253	1,257
Asia — Total	54,261	11,009	65,270

Source: *Overview of AID Population Assistance for FY 1990*, Office of Population, Agency for International Development, forthcoming.

Annex 4

Table B

AID 1990 Population Expenditures by Country

(Thousands US\$)

Region: Europe/Near East

Country	By AID Europe/Near East Bureau & Missions	By AID Office of Population	Country Total
Afghanistan	\$ 908	\$ 0	\$ 908
Algeria	0	153	153
Bahrain	0	2	2
Cyprus	0	2	2
Egypt	15,593	757	16,350
Israel	0	134	134
Jordan	789	1,012	1,801
Kuwait	0	1	1
Lebanon	24	21	45
Malta	0	1	1
Morocco	3,048	499	3,547
Pakistan	9,709	1,424	11,133
Philippines	10,637	1,839	12,476
Tunisia	1,133	1,027	2,160
Turkey	0	2,823	2,823
Yemen	0	726	726
Multiple Countries	1,825	749	2,574
Europe/Near East--Total	43,666	11,170	54,836

Source: *Overview of AID Population Assistance for FY 1990*, Office of Population, Agency for International Development, forthcoming.

Annex 4

Table C

AID 1990 Population Expenditures by Country

(Thousands US\$)

Region: Latin America/Caribbean

Country	By AID Latin America/Caribbean Bureau & Missions	By AID Office of Population	Country Total
Anguilla	\$ 0	\$ 2	\$ 2
Antigua	0	21	21
Argentina	0	29	29
Aruba	0	3	3
Bahamas	0	9	9
Barbados	0	179	179
Belize	52	22	74
Bolivia	117	1,436	1,553
Brazil	430	6,263	6,693
Caribbean Region	922	108	1,030
Chile	0	1,499	1,499
Colombia	483	3,948	4,431
Costa Rica	868	113	981
Dominica	0	7	7
Dominican Republic	1,087	786	1,873
Ecuador	1,935	1,029	2,964
El Salvador	4,105	588	4,693
Grenada	0	20	20
Guatemala	4,678	531	5,209
Guyana	0	5	5
Haiti	4,757	462	5,219
Honduras	2,404	676	3,080
Jamaica	840	298	1,138
Mexico	538	12,854	13,392
Montserrat	0	6	6
Netherlands Antilles	0	12	12
Nicaragua	0	6	6
Panama	0	30	30
Paraguay	80	563	643
Peru	2,437	4,213	6,650
St. Kitts	0	6	6
St. Lucia	0	17	17
St. Vincent	0	10	10
Suriname	0	10	10
Trinidad & Tobago	0	439	439
Uruguay	0	187	187
Venezuela	0	125	125
Virgin Islands	0	4	4
Multiple Countries	516	1,581	2,097
Latin America/Caribbean--Total	26,249	38,097	64,346

Source: *Overview of AID Population Assistance for FY 1990*, Office of Population, Agency for International Development, forthcoming.

Annex 4

Table D

AID 1990 Population Expenditures by Country

(Thousands US\$)

Region: Africa

Country	By AID Africa Bureau & Missions	By AID Office of Population	Country Total
Benin	\$ 0	\$ 1	\$ 1
Botswana	366	268	634
Burkina Faso	161	901	1,062
Burundi	602	12	614
Cameroon	585	1,158	1,743
Cape Verde	10	91	101
Central African Republic	0	136	136
Chad	118	160	278
Congo	0	21	21
Cote D'Ivoire	151	1,832	1,983
Gambia	0	407	407
Ghana	1,033	1,129	2,162
Guinea	0	354	354
Guinea-Bissau	0	20	20
Kenya	11,359	4,058	15,417
Lesotho	185	110	295
Liberia	106	557	663
Madagascar	135	661	796
Malawi	0	993	993
Mali	1,396	1,010	2,406
Mauritania	110	13	123
Mauritius	0	383	383
Mozambique	0	13	13
Niger	1,567	367	1,934
Nigeria	10,325	1,957	12,282
Rwanda	820	994	1,814
Senegal	3,451	848	4,299
Seychelles	0	1	1
Sierra Leone	0	373	373
Somalia	450	66	516
Sudan	178	275	453
Swaziland	500	257	757
Tanzania	122	847	969
Togo	104	1,239	1,343
Uganda	2	1,096	1,098
Zaire	2,268	1,120	3,388
Zambia	150	1,250	1,400
Zimbabwe	0	1,518	1,518
Multiple Countries	7,412	3,193	10,605
Africa—Total	43,666	29,681	73,355

Source: *Overview of AID Population Assistance for FY 1990*, Office of Population, Agency for International Development, forthcoming.