

PW AR 1-0312
9/10/94

**USAID's Office of Population:
Program Priorities and Challenges**

by

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**Partnerships, Challenges, and Opportunities:
A Vision for the Future**

**Office of Population
1994 Meeting of Cooperating Agencies
February 22 - 25, 1994
Washington, D.C.**

I. Introduction

The past year has been an exciting and eventful one for all of us in the Office of Population and in the population community at large. We have much to celebrate with a new committed leadership at USAID and State, new policy and program directions, and increased resources. During this transition period, we have reached out to colleagues within and outside USAID to begin a new dialogue and to examine new program approaches and opportunities.

1994 promises to be an equally exciting and challenging year. Although we are still operating with some organizational and administrative uncertainties, we, in partnership with our cooperating agencies, must now begin to translate the new commitment to population and reproductive health into effective programmatic action. This action must lead to real improvements in reproductive rights and choice, in the quality and use of services and in the well-being of the women, children and men in the developing countries we serve.

Let me turn now to some of the program priorities and challenges ahead for the Office of Population.

II. Program Priorities and Opportunities

While the role and current structure of the Office are not changed very much under the new PHN Center, the definition of population has expanded to encompass selected reproductive health interventions, and the way we go about our business will be different.

During the past year there has been open discussion and debate with old and new colleagues about key policy and program issues and priorities in family planning and reproductive health. Over the coming months, we will be undertaking an in-depth review of our portfolio in order to identify how best to pursue new opportunities. We will also be reviewing our current structure to determine the most effective configuration in the future to undertake new initiatives. We will be working closely with our partner Offices in the Center and developing joint responses to issues that cut across the population, health and nutrition sector.

Family planning will remain the centerpiece and predominant component of the Office of Population's program. As Brian Atwood noted earlier, family planning has immediate benefits for the health and well-being of women and children and is the most cost-effective intervention for lowering fertility. Because of USAID's 28 year history in this area, its extensive network of

specialized CAs, its technical expertise and broad field presence, we have a unique role to play and a strong comparative advantage in family planning. Family planning is the foundation that must be further strengthened and upon which we can build new activities. In many settings, family planning programs can be broadened to include selected reproductive health interventions that will not diminish the family planning effort but will improve program impact and address important women's health needs.

There are five programmatic priorities for the Office of Population: Maximizing Access and Quality of Care; Addressing the Needs of Adolescents; Reducing the Tragedy of Unsafe Abortion; Adding Selected Reproductive Health Interventions; and Examining and Strengthening Linkages with Related Areas.

. **First, Maximizing Access and Quality of Care** is fundamental to achieving our objectives. The Office of Population has supported a wide variety of efforts through our network of cooperating agencies to improve access and quality of care. Over the past several years, these efforts have taken various forms, such as the Informed Choice Task Force, the NORPLANT® Task Force, the Working Group on Quality Indicators in Family Planning, and working groups on medical policies and practices. A number of tools and methodologies to assess and improve quality of care have emerged, such as Situation Analysis developed by the

Population Council, the COPE methodology developed by AVSC, Clinic Management Systems developed by IPPF/WHR, client satisfaction studies, and others.

We have held several meetings in the past few months on Quality of Care and Medical Barriers to review our collective experience and to begin to build an even broader effort. We have benefitted from the frank exchange of ideas, and this participatory process has stimulated our efforts to strengthen and improve our program. We see the new title "Maximizing Access and Quality of Care" (MAQ) as encompassing not only the concepts of removing a variety of barriers but also other important activities focused on improving access to and quality of services.

The seeds of our collective efforts are now bearing fruit, but much remains to be done. As we work to provide the broadest possible range of fertility regulation options and offer selected reproductive health services to clients, we must do more to ensure that providers are technically competent, and that appropriate medical guidelines and service practices are used. We must discover ways to improve the information flow between clients and providers. We must provide client-oriented services, and increasingly women-managed and women-centered programs. We must design our programs with sensitivity to gender relationships that affect both women's access to and use of contraception. We must continue to develop qualitative as well as quantitative

methodologies to understand the client perspective and to continually improve program performance. During the course of this week, you will help us further define how we can best work to maximize access and quality of care.

. **A second priority is addressing the needs of adolescents.** By the year 2000, more than half of the developing world's population will be under the age of 25. Between 20 and 66 percent of girls 15 to 19 years old in developing countries have an unmet need for family planning services. In many countries, this need extends to even younger girls. Yet, family planning and other health programs frequently deny adolescents access to services. As a result, adolescents face high rates of STD/HIV infection, induced abortion and high-risk pregnancy.

By working with the very young, we can help influence lifetime reproductive behaviors and decisions. Many of you already have innovative projects that address the special needs of adolescents. We want to learn from your experience and begin to build more adolescent-specific activities into our portfolio. We will be increasing the level of program resources devoted to adolescents. This year we will focus on interventions that can be introduced within existing projects, particularly in the areas of policy, IEC, training, operations research, and service delivery. Next year, we plan to develop a joint adolescent

reproductive health project with the Office of Health and Nutrition.

. A third priority is reducing the tragedy of unsafe abortion.

It is estimated that over 25 million abortions are performed annually in developing countries and that up to 40 percent of maternal deaths are due to abortion and abortion complications. Under the Helms Amendment, USAID is prohibited from paying for abortion as a method of family planning. However, there is a great deal we can do -- and will do -- to deal with this issue more openly and humanely. We will focus increased attention on studying abortion, its complications, and its consequences; and on supporting training in post-abortion care and post-abortion contraception. The provision of post-abortion family planning has a key role to play in preventing both subsequent abortion and the tragic consequences of abortion for women's health. In order to examine the technical and programmatic issues, we will be convening a joint working group of the Offices of Population and Health on the prevention of unsafe abortion and its sequelae. In addressing this priority issue, we will seek the input and expertise of our cooperating agencies and other partners.

. A fourth priority is adding selected reproductive health interventions. The Office of Population has initiated an in-depth examination of key reproductive health interventions through a series of working groups, meetings, and technical

reviews to identify major program issues and options. This effort has benefitted greatly from the inputs of the Joint Reproductive Health Task Force, whose members include staff of the Offices of Population, Health and Nutrition, and Women in Development.

In collaboration with our PHN Center partners, we recently launched a survey of reproductive health activities supported by USAID Missions and CAS to serve as a baseline for future assistance. Preliminary findings indicate that there are already a wide variety of innovative reproductive health activities underway in the field. These findings will be presented later in the meeting. Another initiative is being launched by the National Academy of Sciences with funding from USAID and various foundations. A panel of experts will be formed to examine reproductive health needs in developing countries and the cost-effectiveness of interventions.

The strategy of the Office of Population when moving into new territory has always been to take a phased approach -- to test and examine new ways of expanding contraceptive choice and improving service delivery on a small scale, introduce modifications as needed, and then replicate pilot efforts on a larger scale. We will follow this successful approach, used in introducing community-based distribution and contraceptive social marketing, to support key reproductive health interventions in

family planning programs. Obviously, what we do and how we do it will vary according to each country's particular needs and setting.

Our guiding principle will be to focus on reproductive health interventions that will benefit the most women at an affordable cost and have the highest public health impact.

The areas of family planning, breastfeeding, post-abortion contraception, safe motherhood and STD/HIV prevention will receive special attention.

Through operations research, pilot and case studies, and survey efforts, we will examine empirically how key reproductive health interventions can complement and reinforce family planning. The new family planning research field station in Ghana will be an excellent vehicle for testing and evaluating reproductive health service delivery strategies. Finally, we will monitor, document and evaluate the cost-effectiveness of integrated programs and ensure that family planning and other key interventions are not compromised.

We certainly do not have all the answers now. We will be able to incorporate selected reproductive health interventions more quickly into some areas of the Office's ongoing program than others. For example, it will be relatively easy and inexpensive to include reproductive health messages in family planning IEC

campaigns, to raise reproductive health issues in the course of policy dialogue with host-country leaders, and to address reproductive health questions in ongoing research. Many of our training programs already include selected reproductive health interventions in addition to family planning.

A high priority this year will be to begin to launch operations research activities and case studies of integrated family planning/reproductive health services. With time and adequate resources, the Office's entire portfolio will increasingly reflect a definition of population that includes both family planning and selected reproductive health interventions.

. **A fifth priority is examining and strengthening linkages with related areas and programmatic synergies.** Family planning and reproductive health decisions are not made in a vacuum and it is important that we improve our understanding of the less proximate determinants of behavior and address them as appropriate. At the policy level, for example, there is much more that can be done to promote girls' education and improve the status of women that will have positive consequences for contraceptive use, child spacing, and maternal mortality. We must encourage the development of population policies and policies in other areas that are consistent and complementary. Stronger cross-sectoral linkages may also be beneficial at the service delivery level. For example, CARE is experimenting with complementary family

planning/natural resource programs -- co-locating these programs and training staff in each to do referrals to the other. There are also opportunities to incorporate family planning concepts into child survival and maternal health programs. We will be discussing some of these programmatic linkages in separate break-out sessions tomorrow on female literacy and education, gender, child survival and environment.

III. Challenges Ahead

The 1990s have been labeled "The Critical Decade" for population programs. The need for family planning and reproductive health services is enormous and growing. Resources are not growing as fast. In order to meet the needs, we must:

. **Maintain a focused and balanced program**, while improving quality, coverage and impact. The Agency's new population and health strategy describes global goals for the development community -- stabilizing population growth, improving maternal and child health, and slowing the spread of HIV/AIDS -- to which USAID's program will contribute. Our population efforts must have an impact at the individual, country and global levels. We must reach as many people as possible without compromising quality and individual choice. Operating within resource constraints, we must find the right balance between increasing

our attention to reproductive health, without diminishing the family planning effort, and maintaining our ability to have a measurable impact. This CAS meeting is an important opportunity to examine policy and program issues in the family planning and reproductive health arena that are critical to meeting these goals.

. Build new partnerships within and outside USAID. Reaching the goals I mentioned requires combined and coordinated efforts; we cannot do it alone. We need to expand and strengthen the constituency for family planning and reproductive health both here and abroad. Building on common ground, we must work more closely with women's health advocates, environment groups, other community organizations and minority-serving institutions. We have much to learn from each other's experiences and perspectives that will strengthen family planning and reproductive health programs worldwide.

We must build stronger partnerships with host-country public and private sector institutions at all levels. Programs will reach their full potential and be sustainable over the long term only if local institutions, local communities and particularly local women, are full partners in program design, implementation and evaluation.

. **Strengthen donor coordination.** In recent years, there have been notable improvements in donor coordination at all levels. But we must do more. Key areas for more coordinated effort include the provision of contraceptive commodities and condoms for HIV/AIDS prevention, reproductive health services, policy dialogue, program evaluation and resource mobilization. To meet the escalating needs, donor and host country resources allocated to family planning and reproductive health must increase substantially. However, even at current resource levels, our reach can be expanded and our impact increased by building more systematically on the comparative strengths of each donor and the complementarities that exist among programs.

We need your help to improve family planning and reproductive health programs. This CAS meeting is an opportunity to build a new vision of what USAID's population program should and can do and to begin to move from dialogue to action. We are excited about the opportunities to work more closely with our colleagues in the Health and Nutrition Office; to strengthen collaboration with the Women in Development Office and other Centers in the Global Bureau; to expand in new directions with our old partners; and, finally, to welcome new partners and build new coalitions.