50 Years of US International Family Planning Assistance:
Where have we been & Where are we going?

DACOR/UAA Development Dialogue
March 6, 2015

Scott Radloff
Bill & Melinda Gates Institute for Population & Reproductive Health
Johns Hopkins’ Bloomberg School of Public Health
Modern contraceptive use has increased 5-fold over 50 years

### 1960-65

- **117 million women using contraception**
  - 86 million in More Developed Countries (MDCs)
  - 31 million in Less Developed Countries (LDCs)

### 2011

- **661 million women using contraception**
  - 100 million in MDCs
  - 561 million in LDCs

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<thead>
<tr>
<th></th>
<th>MCPR</th>
<th>TFR</th>
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<tbody>
<tr>
<td>MDCs</td>
<td>46%</td>
<td>2.7</td>
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<tr>
<td>LDCs</td>
<td>9%</td>
<td>6.0</td>
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<th></th>
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<tr>
<td>LDCs</td>
<td>55%</td>
<td>2.6</td>
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<tr>
<td>Least DCs</td>
<td>25%</td>
<td>4.1</td>
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**Drivers of expanded contraceptive use:**
- Demand for smaller families + healthy timing/spacing of pregnancies
- Improved access to family planning services
- Wider range and safer, more effective method choice
- Population growth (from 3 to 7 billion)

**Source:** Bongaarts, Population and Development Review, 1984; World Contraceptive Use 2011, UN Population Division, 2011.
# Agency Trends over 50 years

<table>
<thead>
<tr>
<th>Decade</th>
<th>Key Trends</th>
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</thead>
</table>
| 1960’s & 70’s | - Agency established in 1961  
- **Population Program started in 1965**  
- Focus on Asia & Latin America, Agriculture  
- Ramp up of DH staff & implementing partners |
| 1980’s    | - Decentralization to field missions  
- Growing commitment to child survival programs  
- Operating budget decline & non-direct hire shift  
- **Increasing focus on private sector** |
| 1990’s    | - **New focus on former Soviet Union countries**  
- Increased attention to results & metrics  
- Continuing growth in health programs  
- Reduction in force & mission closures |
| 2000’s    | - Creation of 3 technical bureaus: GH, EGAT, D&G  
- Shared mandates as PEPFAR & MCC authorized  
- USAID budget function shifted to new State/F  
- **Operating budget increased for staffing under DLI** |
| 2010’s    | - USAID/Forward reforms underway  
- Food Security elevated as Presidential Initiative  
- **Global Health Initiative established**  
- A Promise Renewed, AFG, FP2020 |

U.S. foreign assistance has become “bureaucratically fragmented, awkward and slow, its administration is diffused over a haphazard and irrational structure covering at least four departments and several other agencies.” President Kennedy: *Special Message to the Congress on Foreign Aid,* March 22, 1961

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**International Family Planning: Three Eras**

| Priority Attention | Growing Neglect | Revitalization |

**Era One: 1965-1995**
- Priority Attention
- Dramatic growth in donor attention and funding
- UNFPA established, regular international conferences held
- Early policies, commitment, resources in LAC, EAsia, N Africa
- Country graduation begins late 80s
- Demographic and health rationale primary

**Era Two: 1996-2009**
- Growing Neglect
- Donors attention shifts to other health priorities
- Increased donor use of basket funding approaches
- Greater disparity between middle/low income countries
- USAID funding declines from 1995 peak
- Rights and health rationale become primary

**Era Three: 2010-**
- Revitalization
- Growing attention and partnerships
- USG funding and attention increased under GHI
- DFID & BMGF exert leadership, sponsoring 1st ever Summit
- Attention focused on high need/low income countries
- Growing recognition of demographic/economic in addition to rights and health rationale
We “will not consider requests for contraceptive devices or for equipment for manufacture of contraceptives. Experience has made it clear that the cost of these latter items is not a stumbling block in countries that are developing effective programs.” USAID/Washington message to field missions, March 3, 1965

In “November 1966, I became…aware that we had no basis for creation of an effective AID population assistance program: with just 4 personnel positions, a negative contraceptive policy, and no earmarked funds.” Rei Ravenholt, “Adventures in Epidemiology”, vol. 3.

By 1967, USAID was authorized to procure/provide condoms, pills, IUDs. (and received $35m in earmarked funds and ability to hire staff).
• **1954 Rome Conference:** Exchange of scientific information on population determinants and consequences.

• **1965 Belgrade Conference:** Focus on fertility as a part of development planning. (Coincided with USAID’s start-up of population programs.)

• **1974 Bucharest Conference:** Debate on the relationship between population issues and development. First inter-governmental with 135 country delegations. (“Development is the best contraceptive”.)

• **1984 Mexico City Conference:** Human rights of individuals and families received emphasis as well as policies that impact on population. (USG announces “Mexico City Policy”.)

• **1994 Cairo Conference:** 20-year Programme of Action adopted with an emphasis on meeting individual reproductive health needs rather than demographic goals.

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• **2000 Millennium Development Goals:** Amended in 2007 to include “universal access to reproductive health” as a sub-goal of maternal health.

• **2015 Sustainable Development Goals:** Expanded from 8-17 goals, “universal access to sexual and reproductive health” a sub-target under “Attain healthy life for all” goal. *Still in development.*
Family Planning rationales

Right to choose number, timing, spacing of children

- In the developing world, 57 percent of women want to avoid a pregnancy.
- 26 percent of these women (222m) are not using an effective means of contraception and are exposed to an unintended pregnancy.
- Unintended pregnancies are highest in the poorest countries of the world and among the poorest women within these countries.

Improved maternal and child health

- If all needs for family planning were met, unintended pregnancies would drop by 70 percent and maternal deaths would drop by 67%.
- If all birth-to-pregnancy intervals were increased to 3 years, 1.6 million under-five deaths could be prevented annually.

Population impacts on development

Age Structure

- Age structure for the poorest quintile is relatively youthful but showing declining cohorts over the past 20 years. The median age is 19 and the TFR is 3.4.

- The richest quintile experienced declining cohorts 40 years ago and experienced an “echo” boom peaking 20 years ago. The median age is 24 and the TFR is 2.7.

Family Planning Use & Need

- Modern contraceptive use is 62% for the richest compared to 52% for the poorest quintile – while traditional method use is 3% and 4%, respectively.

- Unmet need is 6% for the richest quintile compared to 13% for the poorest. Of total demand, 87% is being met with a modern contraceptive in the richest quintile, compared to 76% in the poorest quintile.

Source: EDHS, 2008
Age structure for the poorest quintile is extremely youthful with expanding cohorts each year, especially so in the last 15 years, but is beginning to slow. The median age is 11 and the TFR is 7.9.

The richest quintile has begun to experience a fertility decline over the past ten years. The median age is 15 and the TFR is 4.0.

Modern contraceptive use is 39% for the richest compared to just 13% for the poorest quintile – while traditional method use is 7% and 2%, respectively.

Unmet need, however, is substantially higher in poorest quintile, 42% versus 23%. Of total demand, just 22% is being met with a modern contraceptive in the poorest quintile, compared to 57% in the richest quintile.

Source: UDHS 2011
USAID has been the largest international donor for family planning and the leader in technical innovation over the last 50 years.
It takes 20+ years to move from an emerging to graduate program – and requires sustained commitment and resources: from donors & countries

- USAID funding has been volatile, subject to political and economic forces
- At country level, USAID has stopped funding countries for 10 or more years for political reasons, e.g., Afghanistan, Nigeria, Pakistan, Tanzania
Donor funding has increased each decade, until decline in 2000’s

- Donor funding estimated to rebound in 2010’s based on recent, London Summit commitments
- USAID share has increased from 9% in the 1960s, to 28% in the 1970s, and has ranged between 48% and 62% thereafter
- Based on current dollars – if converted to constant dollars, 1970’s is highest-funded decade, but 2010’s still show a rebound

### USAID FP/RH Assistance by Region over Time

<table>
<thead>
<tr>
<th>Region</th>
<th>FY 1965-77</th>
<th>FY 1996</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>17%</td>
<td>30%</td>
<td>60%</td>
</tr>
<tr>
<td>Asia/Near East</td>
<td>56%</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Latin America/Caribbean</td>
<td>31%</td>
<td>28%</td>
<td>6%</td>
</tr>
<tr>
<td>Europe &amp; Eurasia</td>
<td>0%</td>
<td>6%</td>
<td>1%</td>
</tr>
<tr>
<td>Total Bilateral/Region</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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**Plus Central Funding (excluding UNFPA & Operating Expenses)**

<table>
<thead>
<tr>
<th>Region</th>
<th>FY 1965-77</th>
<th>FY 1996</th>
<th>FY 2012</th>
</tr>
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<tbody>
<tr>
<td>Central</td>
<td>49%</td>
<td>31%</td>
<td>17%</td>
</tr>
<tr>
<td>Total Funding</td>
<td>$119m (avg)</td>
<td>$432m</td>
<td>$610m</td>
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## Top 16 FP/RH Recipient Countries: FY1996 & 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>FY 1996</th>
<th>FY 2012</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>28.9</td>
<td>Pakistan</td>
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<tr>
<td>Peru (grad)</td>
<td>19.1</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Philippines</td>
<td>18.0</td>
<td>Ethiopia</td>
</tr>
<tr>
<td>Egypt (grad)</td>
<td>15.6</td>
<td>Tanzania</td>
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<tr>
<td>India</td>
<td>15.3</td>
<td>Bangladesh</td>
</tr>
<tr>
<td>Bolivia</td>
<td>13.5</td>
<td>Kenya</td>
</tr>
<tr>
<td>Indonesia (grad)</td>
<td>12.5</td>
<td>Uganda</td>
</tr>
<tr>
<td>Mexico (grad)</td>
<td>12.1</td>
<td>India</td>
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<tr>
<td>Nepal</td>
<td>10.6</td>
<td>Afghanistan</td>
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<tr>
<td>Ghana</td>
<td>9.8</td>
<td>Philippines</td>
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<tr>
<td>Kenya</td>
<td>8.4</td>
<td>DR Congo</td>
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<tr>
<td>Ethiopia</td>
<td>6.2</td>
<td>Madagascar</td>
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<tr>
<td>Senegal</td>
<td>5.7</td>
<td>Senegal</td>
</tr>
<tr>
<td>Turkey (grad)</td>
<td>5.6</td>
<td>Ghana</td>
</tr>
<tr>
<td>Brazil (grad)</td>
<td>5.5</td>
<td>Nepal</td>
</tr>
<tr>
<td>Haiti</td>
<td>5.2</td>
<td>Zambia</td>
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</tbody>
</table>

7 Asia; 5 LAC; 4 Africa

$432m \rightarrow \text{Total Funding} \rightarrow \$610m

6 Asia; 0 LAC; 10 Africa
USAID Priority and Graduated countries

24 priority countries, represents 1.4 billion population, 4.3 TFR, 26 MCPR
19 additional assisted countries, represents 465 million, 3.8 TFR, 31 MCPR
24 graduate countries, represents 1.2 billion, 2.1 TFR, 64 MCPR
No significant USAID FP/RH assistance historically

Note: Priority countries include: DR Congo, Ethiopia, Haiti, India, Kenya, Madagascar, Malawi, Nigeria, Pakistan, Rwanda, Tanzania, Uganda, Zambia, Afghanistan, Bangladesh, Ghana, Liberia, Mali, Mozambique, Nepal, Philippines, Senegal, Sudan, Yemen. Other assisted countries include: Albania, Angola, Armenia, Azerbaijan, Benin, Burkina Faso, Cambodia, Georgia, Guatemala, Guinea, Honduras, Jordan, Mauritania, Niger, Peru, Timor-Leste, Togo, Ukraine, Zimbabwe.
Countries are considered for graduation once they reach MCPR of 50 and TFR of 3.0.

24 countries have been graduated to date, including 10 recently, depicted here.

2 countries are on a graduation track: Peru and Honduras.

Most of the countries in the lower-left quadrant are in the E&E region, where low fertility is a consequence of high levels of abortion.
FP/RH funding for the 13 priority countries more than tripled between 2002 and 2013.

Significant increases in modern contraceptive prevalence have been recorded in all but 3 of the countries in this period, averaging 1.7 points per year.

Greater than 2 point annual increases achieved in Ethiopia (14-28% in 5 years), Malawi (28-42% in 6 years), Rwanda (6-45% in 12 years).

To accelerate progress, funding to these countries has been increased.

Progress is expected over the next five years.

*Excludes Sudan and Afghanistan, which do not yet have trend lines.
For 9 Ouagadougou Partnership Countries

- The Ouagadougou Partnership was established in 2011. Key partners include the Gates Foundation, Hewlett Foundation, The French Government, USAID and 9 francophone West African Countries.
- West Africa is the region that has made the least progress, although we are seeing increased political commitment and a slight improvement in MCPR.
- All 9 Ouagadougou countries have pledged to FP2020.
- All countries have Costed Implementation Plans.

Key Issue: Addressing low demand for FP through SBCC and improving access to services in hard-to-reach areas.

* Excludes Mauritania, which does not yet have a trend line.
Performance: Average annual change in MCPR

Successful programs can achieve a 1 point increase in MCPR per year. Of the 34 countries tracked, half have achieved/exceeded this increase over the last inter-survey period. Nine of the original 13 priority countries have achieved this success.  

Note: 13 original priority countries are noted with purple bars.

Source: two most recent DHS surveys.
A renewal of commitment to international FP

The London Family Planning Summit, July 2012

“I want to bring every good thing to one child before I have another.”

- Over 150 leaders from governments, donors, civil society, private sector
- 23 governments made commitments to address policy, financing, delivery barriers
- 26 donors/foundations made new financial commitments of $2.6 billion over 8 years
- New financial commitments from country governments totaled $2.0 billion
- 1,292 NGOs from 177 countries signed the Civil Society Declaration
- Led by DFID and Gates Foundation with support from USAID and UNFPA

SDG’s impact on continued momentum
## Countries Making Commitments to FP2020

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<thead>
<tr>
<th>Country</th>
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<tbody>
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<td>Ethiopia</td>
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<td>Ghana</td>
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<tr>
<td>India</td>
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<td>Kenya</td>
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<td>Malawi</td>
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<td>Mozambique</td>
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<td>Niger</td>
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<td>Philippines</td>
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<tr>
<td>Pakistan</td>
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<td>Rwanda</td>
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<td>Senegal</td>
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<td>South Africa</td>
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<td>Senegal</td>
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<td>Uganda</td>
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<td>Somalia</td>
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<td>Zambia</td>
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<td>Zimbabwe</td>
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<td>Sierra Leone</td>
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<td>Sierra Leone</td>
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<td>Liberia</td>
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<td>Cote d'Ivoire</td>
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<td>Tanzania</td>
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<td>Indonesia</td>
<td></td>
<td>Nigeria</td>
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<tr>
<td>Solomon Islands</td>
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<td>Pakistan</td>
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+ 10 recent pledges since the 2012 event:

- Myanmar
- DRC
- Benin
- Guinea
- Mauritania
- Mauritania
- Mali
- Togo
- Cameroon
To reach the 120 million goal means bending the curve upward in reaching more women with life-saving family planning information, services, and supplies.

This can be achieved through:

- increased country commitments
- increased donor engagement
- high impact/best practices
- new technologies
FP2020 Implications for USAID

- Expanding the circle of commitments and voices to FP
- Focus on countries with highest need/commitment for FP will dovetail in many cases with USAID
- USAID’s expertise in innovation/high impact practices can be tapped & built upon
- USAID can assist countries in developing effective plans for expanding access
- Working in partnership is key to success
- An unprecedented opportunity for progress in Africa & South Asia

“everything we do contributes to FP2020”
<table>
<thead>
<tr>
<th>Partnership</th>
<th>Focus</th>
<th>Major Partners</th>
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<tbody>
<tr>
<td>Reproductive Health Supplies Coalition</td>
<td>Contraceptive Security</td>
<td>DFID, Bill and Melinda Gates Foundation, UNFPA, implementing partners, Pharma</td>
</tr>
<tr>
<td>Alliance for Reproductive, Maternal &amp; Newborn Health</td>
<td>RMNH in 10 focus countries</td>
<td>DFID, AusAID, Bill and Melinda Gates Foundation, other donors at country level</td>
</tr>
<tr>
<td><strong>Ouagadougou Partnership</strong></td>
<td><strong>FP in Francophone West Africa – 8 countries</strong></td>
<td>French MOFA, Bill and Melinda Gates Foundation, Hewlett, GIZ, EU, UNFPA, WHO</td>
</tr>
<tr>
<td>*FP2020</td>
<td>Expanding access to FP in 63 poorest countries</td>
<td>DFID, Bill and Melinda Gates Foundation, UNFPA, other donors, foundations, countries, civil society</td>
</tr>
<tr>
<td>Implementing Best Practices Consortium</td>
<td>Utilization of high-impact FP best practices</td>
<td>WHO, multilateral and implementing partners</td>
</tr>
<tr>
<td>Initiative for Combination Prevention Technologies</td>
<td>RH products that prevent pregnancy and HIV/STIs</td>
<td>NIAID, NIH/OAR, domestic and international RH organizations</td>
</tr>
<tr>
<td>Contraceptive R&amp;D Collaboration</td>
<td>Coordinate mid/late-stage new contraceptive products</td>
<td>Bill and Melinda Gates Foundation, NICHD</td>
</tr>
<tr>
<td>*USAID-UNFPA Collaboration</td>
<td>Commodity Security, Population and Development Data, Gender, Youth, High-Impact Practices, Total Market Approach</td>
<td>UNFPA</td>
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</tbody>
</table>
FP2020 technical progress

TWO EXAMPLES

1. Coalition of donors strikes a “Volume Guarantee for Implants”
   - Donors: USAID, DFID, UNFPA, Gates Foundation, Children’s Investment Foundation Fund
   - Brokered by the Clinton Health Access Initiative
   - Guarantee first with Bayer (Jadelle) and later with Merck (Implanon)
   - Lowers price from of implant from $18-27 to $8-9 per unit.
   - Fastest growing long-acting reversible contraceptive

2. Gates Foundation grant to JHU for “PMA2020”
   - Use of smart phone technologies for conducting household surveys
   - Employs resident female enumerators to conduct interviews
   - Rapid turn-around data in close to real time
   - Launched in 8 countries to date in Africa/Asia + 3 more this coming year
   - Focused on FP and WASH, but expandable to other sectors
“The goal of family planning programs is not the promotion of a single method of birth control, nor merely reduction in number of births; the real goal of all of these efforts, public and private, is to advance each individual’s health and economic and social development by enabling all persons to choose voluntarily those reproductive patterns which enhance their wellbeing, individually and collectively.”  --Rei Ravenholt, 1970

“Family Planning could bring more benefits to more people at less cost than any other single ‘technology’ now available to the human race. But it is not appreciated widely enough that this would still be true if there were no such thing as a population problem.”  --Jim Grant, UNICEF, 1992

“We are united in our determination to prevent unintended pregnancies, reduce the need for abortion, and support women and families in the choices they make. To accomplish these goals, we must work to find common ground to expand access to affordable contraception, accurate health information, and preventive services…we must also commit ourselves more broadly to ensuring that our daughters have the same rights and opportunities as our sons: the chance to attain a world-class education; to have fulfilling careers in any industry; to be treated fairly and paid equally for their work; and to have no limits on their dreams. That is what I want for women everywhere.”  
-- President Barack Obama, January 22, 2009

TOTAL: $32.3 billion appropriated

- Peace & Security: $10.7b (33%)
- Global Health: $9.1b (28%)
- Economic Development: $3.6b (11%)
- Humanitarian Assistance: $4.1b (13%)
- Education & Soc Services: $1.5b (5%)
- Environment: $0.8b (5%)
- Democracy & Gov: $2.6b (8%)

Note: includes budgets managed by Department of State and USAID; excludes program management: $1.670 billion

Source: www.foreignassistance.gov

International assistance programs make up 0.6% of the federal budget -- and has been declining since 1965 when it made up 2.5% of the budget.
You may be wondering about the U.S. …

United States

- Female Sterilization: 25%
- Vasectomy: 13%
- Pill: 17%
- Condom+: 14%
- Not Using: 17%
- Trad: 6%
- IUD: 6%
- Inject: 1%
- Implant: 1%

Note: Use of long-acting, reversible contraception in the U.S. has grown from 2.4% to 8.5% between 2002 and 2009, mostly due to increases in IUD use. Guttmacher Institute, 2012.
Intn’l & USG Goals & Indicators for FP

<table>
<thead>
<tr>
<th>Contribution to the Millennium Development Goals and Targets</th>
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<tbody>
<tr>
<td>• MDG 4: Reduce Child Mortality</td>
</tr>
<tr>
<td>• MDG 5A: Improve Maternal Health</td>
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<tr>
<td>• MDG 5B: Universal Access to Reproductive Health</td>
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<tr>
<td>• Also, MDGs for poverty, education, gender, HIV/AIDS, and environment</td>
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<table>
<thead>
<tr>
<th>Global Health Initiative</th>
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<tr>
<td>• Prevent 54 million unintended pregnancies</td>
</tr>
<tr>
<td>• Increase contraceptive prevalence by up to 2 percentage points each year</td>
</tr>
<tr>
<td>• Reduce first births to women under 18 by 15 percent</td>
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<table>
<thead>
<tr>
<th>Additional Performance Measures</th>
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<tr>
<td>• Increase the percent of births spaced 3 or more years apart</td>
</tr>
<tr>
<td>• Reduce the percent of births order 5 or higher</td>
</tr>
<tr>
<td>• Increase the percent of demand satisfied through modern contraception</td>
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</table>
Features of USAID Assistance

- Technical staff on the ground
- Significant technical capacity at HQ
- Network of implementing partners
- Results-focus and reporting
- Support through non-state actors, in addition to governments
  - Bilateral assistance outweighing multilateral support
  - Financial accountability; aversion to basket funding
- Intensity of Congressional direction, oversight, requirements
<table>
<thead>
<tr>
<th>Ten Essential Elements of Successful FP Programs</th>
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<tbody>
<tr>
<td>1. Supportive Policies</td>
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<tr>
<td>2. Evidence Based Programming</td>
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<td>3. Strong Leadership and Good Management</td>
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<td>4. Effective Communication Strategies</td>
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<tr>
<td>5. Contraceptive Security</td>
</tr>
<tr>
<td>6. High Performing Staff</td>
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<tr>
<td>7. Client-Centered Care</td>
</tr>
<tr>
<td>8. Easy Access To Services</td>
</tr>
<tr>
<td>9. Affordable Services</td>
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<tr>
<td>10. Appropriate Integration of Services</td>
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**Source:** Population Reports 2008, JHU.

<table>
<thead>
<tr>
<th>Selected, High-Impact Practices (HIPs)</th>
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<tbody>
<tr>
<td>✓ Community-based services &amp; task-shifting / task-sharing</td>
</tr>
<tr>
<td>✓ Postpartum FP</td>
</tr>
<tr>
<td>✓ Post-abortion FP</td>
</tr>
<tr>
<td>✓ Mobile outreach services (“mobile, dedicated, free”)</td>
</tr>
</tbody>
</table>
Reimert Ravenholt’s
90th Birthday
9 March 2015
to: Betty Ravenholt & Family
3156 E. Laurelhurst Drive NE
Seattle, WA 98105
a/o, <ravenrt@oz.net>