

FAMILY PLANNING PROGRAM REVIEW
IN SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

SUMMARY REPORT



U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
AFRICA BUREAU, OFFICE OF SUSTAINABLE DEVELOPMENT

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Introduction

In 2008 and 2009, the U.S. Agency for International Development (USAID) conducted a review of the progress of family planning programs in 11 countries in sub-Saharan Africa since 2003. The purpose of the review was to examine the current status of the family planning programs in these countries and identify and share best practices between countries. The review was based on firsthand observation of the programs through visits to selected countries and analysis of data and information available at USAID. The 11 countries covered by the review were the Democratic Republic of the Congo (DR Congo), Ethiopia, Kenya, Madagascar, Malawi, Mali, Nigeria, Rwanda, Tanzania, Uganda, and Zambia. These are priority countries for USAID health programs. Together they represent 59 percent of sub-Saharan Africa's population and received 71 percent of USAID family planning funding for sub-Saharan Africa in fiscal year (FY) 2009.

Conclusion: During much of the decade, overall funding for family planning remained flat, while the unmet demand for family planning steadily increased. USAID was the lead donor in family planning and increased its funding for these 11 countries, which contributed to a high level of progress in family planning programs in four of the 11 countries. USAID played an important role in supporting the areas essential for program success, including generating commitment by national governments, expanding community outreach and ownership of family planning programs, providing contraceptives, and strengthening program implementation capacity. In addition, the 2009 overturning of the Mexico City Policy has enabled USAID to strengthen its support for individual reproductive choice. However, unmet need for family planning is still high, and a large resource gap remains. The U.S. Government (USG) can help meet this demand and contribute to attaining its development objectives, including national security, democracy, reduction of inequality and poverty, environmental preservation and food security, and improvements in maternal health.

Findings: The findings are based on evidence drawn from the USAID-funded Demographic and Health Surveys (DHS), other empirical studies, and field visits. These are presented in the report in the three following categories:

- a) Background information including demographic impact on development objectives
- b) Performance of family planning programs
- c) Future family planning program scenarios and possible actions

I. Background

The global atmosphere has not been conducive to family planning programs. The current decade witnessed a decided shift in attention and resources away from family planning programs. This occurred in part due to the imperative to aggressively fight deadly diseases such as HIV/AIDS, which increased mortality and stalled population growth. The global "architecture" of health-related aid favored infectious diseases, and Official Development Assistance for reproductive health remained flat from 2004 to 2007. The World Bank's assistance to population projects also declined in the past decade.¹

Along with a couple of other donors, USAID tried to keep family planning "on the radar screen" and doubled its family planning funding for sub-Saharan Africa over the last six years. While these efforts were not adequate to fill funding gaps or substantially reduce binding manpower constraints, they at least forestalled even greater backsliding.

During this period, family planning programs in seven of the 11 countries studied (DR Congo, Malawi, Mali, Nigeria, Tanzania, Uganda, and Zambia) weakened, fertility remained virtually constant, and the unmet need for family planning remained high and continued to grow.

There are grounds for optimism for the future. The Obama administration has rescinded the restrictive Mexico City Policy, and the President and the Secretary of State have expressed determination to prevent unintended pregnancies and to support men and women in their reproductive choices. Conditions in sub-Saharan Africa are also becoming more favorable. The stabilization in HIV/AIDS prevalence rates in almost all countries has reduced countries'

1. World Bank Independent Evaluation Group. 2009. *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population: An Evaluation of World Bank Support since 1997*. Washington, D.C.: World Bank.

fear of negative population growth and increased their acceptance of family planning programs. African women have shown a preference for more convenient methods such as injectables, and demand for long-acting and permanent methods is also increasing. This has the potential of revolutionizing family planning programs during the next decade. The four countries studied where family planning programs have not grown weaker since 2000 – Ethiopia, Kenya, Madagascar, and Rwanda – have shown that it is feasible to rapidly increase modern contraceptive prevalence rates (MCPRs). Opportunities to make up for the decade's lost time have begun to emerge – if the United States and other donors seize the moment.

Dramatic increases in population and unprecedented changes in age structure have occurred during the decade. The total population of the 11 review countries has doubled since 1980, adding 116 million people in the last 10 years alone. Without a reduction in fertility, it will double again over the next 20 to 30 years. Half the adult population is aged 15 to 29, creating a “youth bulge,” or disproportionately large population of younger ages. The changes in age structure in sub-Saharan Africa that are typical of the 11 countries are shown in figure 1 (page 11). Furthermore, 68 million people have turned the “working age” of 15 since 2000, making job creation extremely challenging.

Africa's demographic shifts have profound implications for U.S. development objectives. The review highlights implications for the five following national and international objectives:

- ***Less security, greater fragility:*** The youth bulge, combined with rapid urbanization and scarcities of water and arable land, increases the risk of fragility and conflict.² According to USAID's analysis, all 11 review countries are at high risk of social instability (figures 2–4, pages 11 and 12).
- ***Full democracy:*** The establishment of full democracy is much less likely in countries with a young age structure than in countries with a more mature age structure (figure 5, page 13).³ This subject is being researched exten-

sively, and evidence in support of this conclusion is growing.

- ***Greater equity, less poverty:*** Girls' education is a critical element in reducing poverty and building a developed society. Experience in the 11 countries, as elsewhere, shows that high fertility among women at younger ages keeps them away from school. Furthermore, fertility differentials across income groups perpetuate inequity by limiting educational and economic opportunities for poorer households. DHS data from the 11 countries present a stark picture: in Madagascar, Malawi, and Uganda, up to half of poor women aged 15 to 19 were pregnant with their first child, compared with 10 to 20 percent of their richer counterparts (figure 6, page 13).
- ***Environmental preservation and food security:*** Population growth has a dual impact on food security. While increasing the demand for food through sheer numbers, it reduces the capacity to produce food through environmental degradation and reduced availability of arable land per capita (figure 7, page 14). According to studies in six of the 11 countries, population growth has contributed to soil erosion, water shortages, and biodiversity loss, and increased the demand for food.⁴
- ***Maternal health:*** Of the 11 review countries, Rwanda has the highest maternal mortality ratio, followed by DR Congo, Nigeria, and Malawi. Large families with closely spaced children contribute to high maternal mortality in sub-Saharan Africa (figure 8, page 14), though recent studies indicate a substantial decline in maternal mortality, especially in Rwanda. The United Nations Population Fund (UNFPA) estimates that family planning alone could reduce maternal mortality by as much as 40 percent.⁵ A recent USAID study also found that between

2. R. Cincotta et al. 2003. *The Security Demographic Population and Civil Conflict after the Cold War*. Washington, D.C.: Population Action International. Analysis covering 2000 to 2010.

3. E. Leahy et al. 2007. *The Shape of Things to Come: Why Age Structure Matters to a Safer, More Equitable World*. Washington, D.C.: Population Action International.

4. Population Reference Bureau. “Integrating Population, Health, and Environment” briefs for Ethiopia (2007), Kenya (2007), Rwanda (2009), Tanzania (2007), and Uganda (2009); Madagascar: “Linking Population, Health, and Environment in Fianarantsoa Province, Madagascar” (2006).

5. UNFPA. 2009. Statement on the Occasion of World Population Day 2009, Thoraya Ahmed Obaid, Executive Director, United Nations Population Fund.

1985 and 2005, there would have been 42 percent more maternal deaths in developing countries if the use of family planning had not increased.⁶

Family planning influences economic growth and should be used as a development tool. Population growth and age structure are basic parameters that should shape a country's development strategy. A country with a younger age structure has different requirements (for example, a greater focus on education and employment) than one with an older structure (where there would be a greater need for care of an elderly population). Population growth and age structure are both affected by the adoption of family planning, and therefore family planning too should be used as a development tool.

Demographic dividends need to be realized. Youth can be a strong impetus for development if they are given opportunities. A more balanced age structure without a youth bulge allows countries to make the best use of youth by developing a vibrant workforce. Appropriate economic growth and trade policies over the next 30 years are essential for this purpose. In East Asia, this phenomenon, called the "demographic dividend," contributed to almost one-third of the economic growth of the last 30 years.

II. Family Planning Program Performance

The review's 15 findings provide a basis for making comprehensive improvements in USAID-supported family planning programs. Areas of improvement suggested in this review are grounded in the promising practices adopted by the countries through USAID-supported programs.

1. Country program performances varied significantly across the 11 countries in the last decade. Typically, an increase in MCPR results in a decline in fertility, although the relationship is not perfect or immediate for two reasons. First, contraceptive use also reduces abortion rates. Second, total fertility rate is a lagging indicator, as MCPR increases result in fertility declines over a period of about five years. Thus, MCPR is used as the indicator of progress. Based on past family planning program experience, an MCPR increase of one percentage point per year is considered "good" performance.

Applying this criterion to the last decade, the review countries' national programs, within which USAID-supported programs operate, could be classified into three groups:

- *Rapid progress (annual MCPR increase of 1 to 9 percentage points):* Ethiopia, Kenya, Madagascar (prior to the 2009 military coup), Rwanda
- *Encouraging progress (annual MCPR increase of 0.5 to 1 percentage points):* Malawi, Zambia, Tanzania
- *Slow progress (annual MCPR increases of less than 0.5 percentage points):* DR Congo, Mali, Nigeria, Uganda⁷

Irrespective of the pace of decline in fertility, all countries in the above categories except Nigeria had larger increases in MCPR in rural areas than in urban areas. Figure 9 (page 15) presents the above groupings with each country's average annual increase in MCPR.

2. HIV/AIDS influenced national family planning program performance. It is no coincidence that three of the four countries that made rapid progress in family planning (Ethiopia, Madagascar, and Rwanda) also had low HIV/AIDS prevalence rates (less than 5 percent), particularly since the early part of the decade. Only Kenya had an HIV/AIDS prevalence rate of more than 5 percent. On the other hand, the countries that showed signs of progress after a few years of stagnation (Malawi, Tanzania, and Zambia) had higher HIV/AIDS prevalence rates (5 to 10 percent). However, a lower prevalence of HIV/AIDS does not necessarily translate into better performance in family planning; except for Uganda, countries that made slow progress on family planning not only had relatively low HIV/AIDS prevalence rates, but also social, political, and cultural impediments to implementing family planning programs. Notwithstanding these factors, Africa's fear that HIV/AIDS would increase mortality and halt population growth was pervasive in the early part of the decade. Furthermore, seven of the 11 countries, irrespective of HIV/AIDS prevalence, received large amounts of HIV/AIDS funding and had to channel human resources, including management skills, to utilize these funds, thus reducing their capacity for family planning.

6. J. Stover and J. Ross. 2006. "Effects of Family Planning on Maternal Deaths, 1985-2005." USAID. Health Policy Initiative.

7. Although the annual increase in MCPR in Uganda is greater than 0.5 percentage points, a stagnant total fertility rate with no signs of improvement result in its categorization as a "slow progress" country.

3. Inadequate data limit the quantitative assessment of USAID program performance. The highly credible DHS provide MCPR data but are only conducted every five years and do not necessarily disaggregate to the level of USAID project areas. Thus, USAID Missions use estimates of couple-years of protection (CYP), annually derived from service statistics or other reports from project areas, as an indicator for reporting progress. CYP has serious limitations as an indicator because it is sometimes based on contraceptive distribution and not use. In addition, all USAID Missions do not consistently report on it. USAID could establish CYP as a common required indicator for monitoring family planning performance on an annual basis. This could be a management tool for USAID Missions and form part of national health and family planning management information systems as they evolve.

In view of the paucity of data, this review used two criteria to broadly assess USAID program performance: first, whether the allocation of resources by USAID was in accordance with program priorities, and second, the extent to which USAID contributed to program components essential to program success (point 5 below). These measures demonstrate that USAID had a strong and positive impact on national family planning programs. The extent of impact varied according to the national circumstances.

4. Allocation of family planning budgets by USAID Missions has been strategic and in line with country program priorities.

USAID Mission budget allocations should broadly indicate Mission strategies and priorities in relation to program requirements. Family planning allocations for FY 2007 and 2008 showed that all Missions gave highest priority to meeting the existing demand for contraceptive services, allocating 55 to 60 percent of the budget to service delivery and contraceptive supplies. Communication was the next highest priority, allocated about 14 to 16 percent of the budget. USAID Missions in countries with slow progress, however, allocated a larger percentage of their budgets (20 to 30 percent) to communication than to other budget categories. These countries required greater effort to change latent demand for contraceptives to actual use and therefore required relatively larger investments in communications. Policy analysis was the third largest category in budget allocation, representing 16 percent of total allocations in FY 2007 and 11 percent in FY 2008. This shows that as programs build support, Missions do not see the need to allocate large amounts of funding to policy

analysis. A very small percentage (1 percent) was allocated to governance and finance in FY 2007, followed by a larger (though still small) 3 percent allocation in FY 2008. In view of the importance of improving management and attaining sustainability, Missions should regularly review the adequacy and effectiveness of these allocations.

5. USAID contributed significantly to the successes of seven key program components – the “seven C’s.” These components were:

- Country commitment
- Community ownership and access to services
- Contraceptive availability
- Country implementation capacity expansion – human resources and management
- Communication
- Conducive family planning environment
- Cost and funding

USAID contributions to these components varied among the review countries and depended on the program environment.

6. Commitment mattered most to program success. The review underscored the view that explicit, sustained support and leadership on family planning by the most influential members of society – political leaders at the national and community levels and religious leaders at the local level – are essential to success in family planning programs. Such support and leadership indeed accounted for a major part of the successes in Rwanda, Madagascar, Ethiopia, and more recently in Kenya. The international community has credited USAID with generating commitment in these countries through its analytical work and high-level policy dialogue. USAID Missions in countries with encouraging or slow progress are in the process of generating similar commitments, with results beginning to show. This process has to be accelerated in all countries, particularly those with slow progress.

7. The hallmarks of programs that made rapid progress are community partnership and access to family planning services on a large scale.

Three of the four "rapid progress" countries (Ethiopia, Madagascar, and Rwanda) developed partnerships with communities in implementing their family planning programs and generated a sense of program ownership among community members. This process has also been initiated in Kenya. To rapidly scale up their programs, these countries built community-level workforces by recruiting large numbers of community workers and volunteers and increasing access to services at all levels of the health system, especially at the community level. In addition, they recognized the communities for their performance in family planning. In other countries, this process has been slow, but countries with encouraging program performance (especially Malawi) are poised to scale up community-level programs.

8. Integration of family planning and maternal and child health with HIV/AIDS programming has been slow, and family planning is a weak part of maternal and child health programs in most Missions.

Government policies in all 11 countries call for integrated services. USAID Missions have been cautious in integrating family planning and maternal and child health into HIV/AIDS programs due to the President's Emergency Plan for AIDS Relief (PEPFAR) restrictions on using HIV/AIDS funds for family planning. Thus, the extent of support for HIV/AIDS and family planning efforts varied among Missions depending on their sense of the rules. A USAID study covering four of the 11 countries indicated that Rwanda and Kenya were further advanced on integration than Ethiopia and Uganda.

Integration of family planning with other development programs is still in its infancy, as only three Missions (Rwanda, Madagascar, and DR Congo) have integrated health and family planning with environmental programs, while others are in the process of doing so. Integration or linkages with relevant activities of other programs, such as youth, gender, education, and democracy and governance, should also be explored.

As integration proceeds, two factors must be taken into account. First, programs need to adapt differentiated strategies and customized approaches for integration based on the specific country or epidemiological situation. Even within a country, the situation may vary in different areas. Spatial mapping should provide a sound basis for different

approaches. Second, accountability for results in family planning in an integrated system is essential, as otherwise family planning services could be ignored or diluted. In some cases, a vertical program under an overall integrated system may help keep the focus on family planning.

9. The private sector, most notably through USAID-funded social marketing programs, has demonstrated its effectiveness even under the most challenging conditions and has the potential for expanding its reach.

Social marketing programs funded by USAID and implemented in the private sector have shown results both in mobilizing communities and delivering services, even under difficult conditions. The social marketing program provided about 70 to 80 percent of the contraceptives in countries with low commitment and slow program progress. Thus, USAID could encourage governments to develop partnerships with the private sector and expand social marketing and for-profit private sector activities to strengthen programs and attain sustainability in the longer term.

10. Contraceptive availability has improved, but contraceptive security has not yet been achieved.

In addition to inadequate funding, weak logistics has been a major constraint to increases in MCPRs. USAID has been at the forefront of supplying contraceptives and helping countries improve their logistics systems. As a result, countries that have made rapid progress in increasing the MCPR have experienced no contraceptive stock-outs. In other countries, there are rarely stock-outs in warehouses, but problems remain in getting contraceptives to service delivery points. These problems are being addressed by all 11 Missions; in some, expansion of the role of the private sector, particularly in contraceptive distribution to service delivery points, is being considered.

Another issue related to contraceptive supply is that choice of methods is skewed toward pills and condoms, which have a potential for high dropout. The demand for injectables is increasing, and USAID Missions are helping countries change policies to allow community-level workers to administer injectables. Malawi, Madagascar, and Uganda have already done so. Furthermore, the demand for long-acting and permanent methods such as sterilization and implants is also increasing. Missions are giving high priority to helping countries provide these services. These efforts could be expanded as more resources are made available.

11. Health systems need to be stronger, particularly in organizational and management capacity, to further improve the use of existing resources and program performance. All four countries with rapid family planning program progress have been strengthening program management in order to reach communities effectively. This includes improving supervision and ensuring that commodity logistical systems are adequate and that accountability for and focus on family planning exists in a decentralized organizational structure. For example, Rwanda has been strengthening program management through the adoption of performance-based financing. Kenya relies on HIV/AIDS program strengthening as family planning is integrated. These efforts could be replicated in other countries, and USAID could allocate larger resources to governance and management of health and family planning programs.

The U.S. Government's Global Health Initiative (GHI) emphasizes health system strengthening, and it will certainly help in improving family planning program performance. However, to guarantee that this occurs, USAID should ensure that program organizational structures have a focal point for family planning and that program management requires accountability for results. A "hands on" approach to management improvements – one district at a time, using local management institutions – will be valuable. New technologies such as mobile phones and geographical information systems can also be used to advance family planning programs to the cutting edge of modern program management, implementation, and monitoring.

12. A comprehensive and systematic approach to communication and social mobilization is needed. Almost all Missions support family planning communication and social mobilization programs. In countries with slow increases in M CPR, Missions have placed greater emphasis on communication than others. All Missions should adopt a more comprehensive and systematic approach to communication and social mobilization to help improve the contraceptive prevalence rates for several reasons. First, as new contraceptive methods are introduced, communication with clients is critical to explain the advantages and side effects. Second, turning demand into effective use requires personal communication to help a person make a choice according to circumstances and personal preferences. Third, quality of care will be extremely important for continuing the contraceptive use. Regular feedback from

clients provides a sound basis for improvements in quality of care. Fourth, the information revolution under way has tremendous potential to improve communication and introduce new ways of social mobilization. These are waiting to be explored and used in all 11 countries.

13. Broader efforts are needed to create conducive conditions for program expansion. Research and evaluation capacity in all countries would be improved with the involvement of local institutions. Learning from past experiences in a systematic and regular manner can give a sound basis for program improvements.

Given the interrelationships of family planning with a wide range of other sectors (from economic growth to agriculture to democracy and governance and education), there may be scope for developing cross-sectoral programs that mutually reinforce one another and contribute to and benefit from family planning programs. In addition, youth and girls' education are critical to economic development and family planning and require cross-sectoral efforts. These efforts need to be linked to those being carried out for orphans and vulnerable children under HIV/AIDS programs.

14. Inadequate funding, cost, and sustainability are serious constraints to program expansion. Even though USAID funding for family planning doubled in the last six years, global funding levels remain inadequate in relation to requirements. Encouragingly, the governments of five of the 11 review countries have started to contribute to family planning funding, though the amounts are far from adequate and reliance on donors is likely to continue. This raises the question of whether the programs will be sustainable, which USAID could help countries address by:

- Conducting national health accounts, along with reproductive health subaccounts, on a regular basis
- Introducing and expanding community health insurance programs that include reproductive health
- Reviewing policies that provide contraceptives for free and undertaking studies of price elasticity
- Improving the use of existing resources through cost-effectiveness analysis

15. USAID's internal capacity must be strengthened if family planning programs are to be expanded. Seven of the 11 countries are PEPFAR focus countries, and they all are focus countries of the President's Malaria Initiative. While health officers in these countries are highly committed to family planning, they have to struggle to manage multiple portfolios. Many Missions have not been able to devote adequate senior staff time to family planning programs. The commitment at higher levels (such as Mission Director and Ambassador) varies from country to country. Missions should consider creating new positions and appointing senior full-time staff dedicated to population and family planning. Further, they could establish intersectoral groups to involve other sectors in family planning programs. The USG could engage its ambassadors and high-level officials in family planning program advocacy to help generate commitment at the highest levels of the host governments.

III. Future

The moment for family planning has come and must be seized. The international atmosphere for family planning has become conducive for setting ambitious goals and taking bolder actions. This section presents options for setting goals for the next five to 15 years.

Scenarios for future program improvements: Because unmet need continues to be high in all 11 countries (figure 10, page 15), USAID commissioned a study from the Futures Institute to estimate the cost and effort required to meet the current unmet need. The Institute gave two scenarios.⁸ The first lays down the ambitious goal of satisfying the unmet need for contraception by 2015, which would require an annual MCPR increase of three percentage points – a rate considerably higher than the average during the decade. The second scenario is based on a more realistic assumption of satisfying unmet need by 2025 through an annual increase in contraceptive use of about 1.4 percentage points, a marginal increase over the last decade.

The cumulative cost through 2015 of the first scenario is an estimated \$4 billion, or an average of \$567 million annually for the seven-year period 2009 to 2015. The estimated cumulative cost of the second scenario (meeting unmet need by 2025) is \$3 billion.

8. J. Stover 2009. *The Future Cost of Family Planning in Eleven Priority Countries in Sub-Saharan Africa*. Glastonbury, Conn.: Futures Institute.

The additional \$1 billion in costs incurred in the first scenario would be more than offset by expected savings in health care costs and, more importantly, in preserving the lives of mothers and children. Meeting the unmet need by 2015 would:

- Avert 31 million deaths of children under age 5, reducing child mortality by 45 percent
- Prevent 87 million unintended pregnancies
- Avert 18 million abortions
- Reduce maternal mortality by 20 percent
- Reduce the number of HIV-positive children by 56,000
- Save \$2.4 billion in child immunization costs
- Reduce the school-age population by about 33 million by 2025, when the benefits will peak, which will decrease the number of teachers required by 748,000 and result in a total cost savings of \$1.5 billion by that time⁹

Possible actions: Pursuing the ambitious scenario of meeting unmet demand by 2015 would require an unprecedented level of international and national efforts and resources. Potential key actions include:

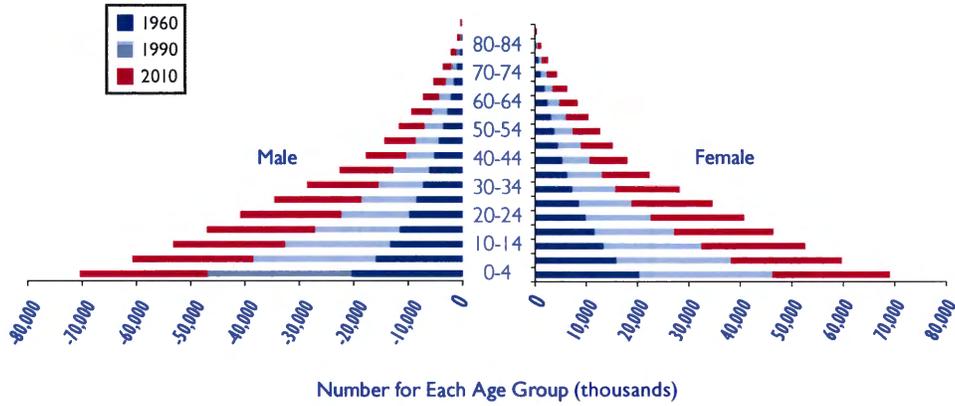
- **Strengthening international and national commitment:** The U.S. Government could exercise its influence as a member of the G20 and as a stakeholder in the World Bank and International Monetary Fund to take the lead in drawing global and national attention to the importance of population and family planning programs in Africa and in building understanding of and commitment to them.
- **Making family planning a fundamental part of development and foreign assistance strategies:** The U.S. Government could leverage large development programs, such as the Millennium Challenge Account and other presidential initiatives, to strengthen family planning programs.

9. Analysis conducted by Ania Chaluda for the 11 review countries. August 2009. Education and Data Policy Center, Academy for Educational Development.

- *Ensuring adequate emphasis on family planning under the Global Health Initiative:* In a departure from the previous administration, GHI has allocated additional resources to maternal and child health and family planning. Its implementation could ensure that the family planning program emphasis is retained.
- *Allowing flexibility in the use of resources for family planning programs:* As additional financial resources for health are provided to USAID Missions, they should also be allowed greater flexibility in using them according to country priorities, if they are to be made accountable for results.
- *Improving program design and implementation:* USAID Missions could further improve family planning programs by helping countries:
 - *Consider family planning as a development tool:* Enhance the capacity of finance and planning ministries to base development strategies on population growth and age structure changes and to influence those factors through family planning programs.
 - *Develop an employment-oriented youth policy:* To make youth a positive force for development, help countries adopt policies and programs that will prepare them to meet the demands of a 21st century workforce. Family planning advocacy and services should be part of these efforts because high adolescent fertility could continue to create demographic pressures.
 - *Make family planning a part of environment and food security programs:* Recognize that population growth is an important part of the equation in reducing environmental degradation and achieving food security.
 - *Establish or strengthen systems that monitor program performance and results:* With larger investments in family planning, focus on program reporting and monitoring and results.
 - *Generate strong country-level commitment:* Continue to generate commitment at all levels of government and civil society.
- *Build community ownership and partnerships:* Intensify, refine, and adapt the processes of building community partnerships and ownership.
- *Improve contraceptive availability at service delivery points:* Improve forecasting, logistics, and reporting systems to make quality services and a broad range of methods, including long-acting and permanent methods, easily accessible to clients.
- *Address manpower shortages:* In the short term, improve allocation and productivity while health system strengthening efforts address long-term solutions.
- *Give a high priority to management improvements at all levels:* Assess management requirements and help communities, health centers, and district offices bring about improvements through a "hands on" approach.
- *Make partners accountable for building capacity of local institutions:* Review the capacity building efforts of existing partners to determine their adequacy and actions that need to be taken to strengthen them.
- *Create a more conducive environment for family planning:* Strengthen the research and evaluation capacity of country institutions for continuous learning and support multisectoral programs focusing on girls' education and youth mobilization.
- *Move toward financial sustainability:* Commission studies of the price elasticity of contraceptive demand and the cost-effectiveness of different interventions to develop policies and programs that will lead to sustainable programs.
- *Strengthen the internal capacity of Missions:* Ensure senior-level staff dedicated to family planning are available and mobilize entire Missions to support cross-sectoral family planning programs.
- *Providing additional resources:* Meeting unmet need in the 11 review countries by 2015 will require \$567 million a year over the next seven years. This represents a more than threefold increase in USAID funding over the 2010 level of \$175 million.

Figure 1

Phenomenal Population Growth, Age Pyramids for Sub-Saharan Africa in 1960, 1990, and 2010



Source: United Nations 2009. World Population Prospects. The 2008 Revision Population Database.

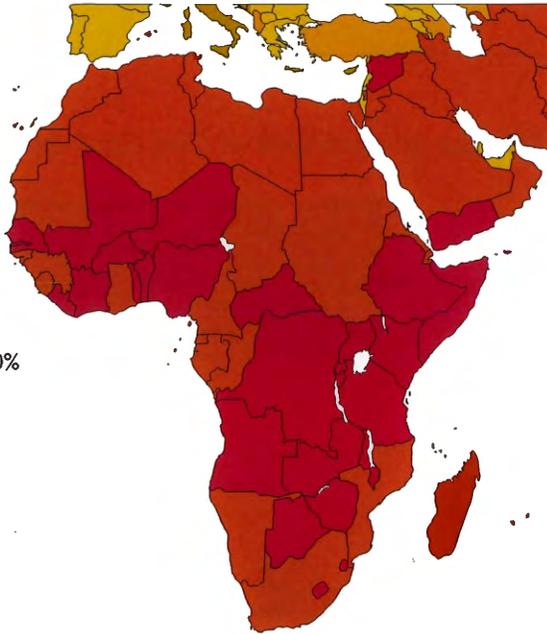
Figure 2

Map of the Youth Bulge as a Risk Factor for Demographic Stress

YOUNG ADULTS, 2005
Young Adults (aged 15-29 years) as a Proportion of All Adults (aged 15 and older)

DEMOGRAPHIC STRESS CATEGORY

- Extreme: 50% or more
- High: 40% to less than 50%
- Medium: 30% to less than 40%
- Low: Less than 30%
- No data



Source: R. Cincotta et al. 2003. *The Security Demographic: Population and Civil Conflict after the Cold War*. Washington, DC: Population Action International.

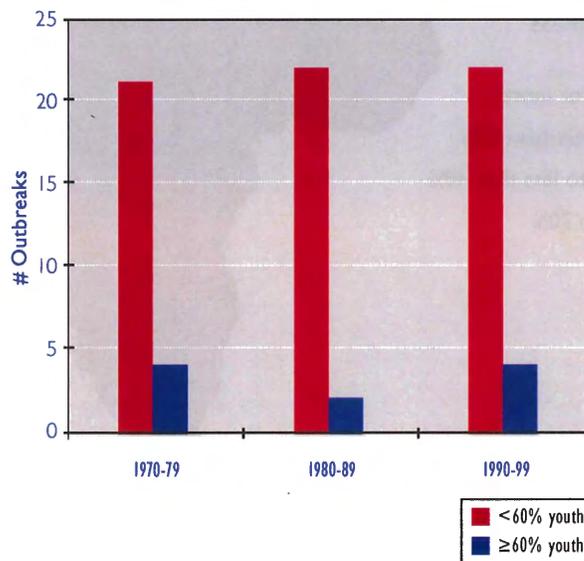
Figure 3

Demographic Risk Assessment					
Countries with Very High Levels of Demographic Risk of Civil Conflict					
Country	% Young Adults (aged 15-29) in Adult Population (pop. 15 and older)	% Urban Population Growth/Year	Hectares of Cropland Availability/ Person	Cubic Fresh Water Availability/ Person	Working-Age Adult Deaths (% over 5-year period)
DR Congo	52.3	4.9	0.14	22,878	7.4
Ethiopia	50.3	4.6	0.14	1,483	7.1
Kenya	55.5	4.6	0.14	913	9.3
Madagascar	48.0	4.9	0.19	18,307	4.0
Malawi	51.2	4.6	0.18	1,352	11.2
Mali	54.5	5.1	0.34	7,321	5.2
Nigeria	50.2	4.4	0.24	2,196	5.6
Rwanda	53.5	4.2	0.13	581	9.6
Tanzania	53.1	5.3	0.13	2,372	8.6
Uganda	55.2	5.7	0.25	2,389	6.9
Zambia	56.5	2.7	0.48	9,508	15.2

Source: R. Cincotta et al. 2003. *The Security Demographic: Population and Civil Conflict after the Cold War*. Washington, DC: Population Action International.

Figure 4

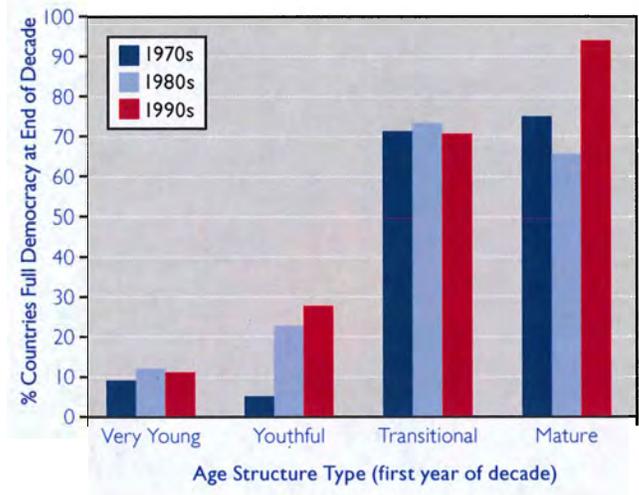
Number of Outbreaks of Civil Conflicts by Age Structure, 1970-99



Source: Richard Cincotta and Elizabeth Leahy. 2006-2007. Woodrow Wilson Center "Population Age Structure and Its Relation to Civil Conflict: A Graphic Metric." *ESCP Report*, Issue 12.

Figure 5

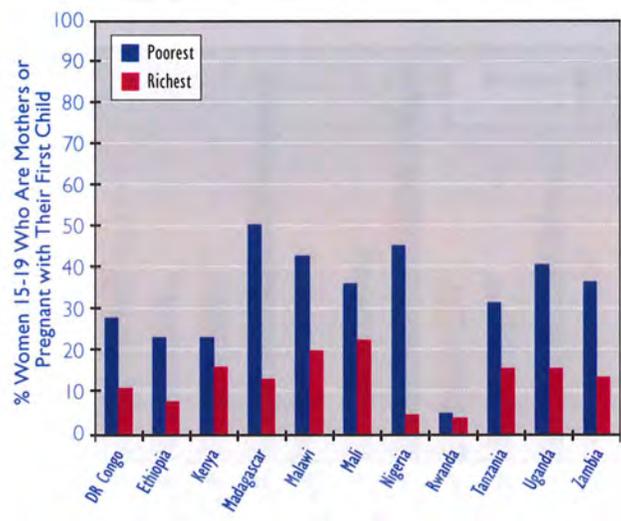
Governance and Age Structure



Source: Population Action International. 2007. *The Shape of Things to Come*.

Figure 6

Fertility and Income Status, Women Ages 15-19



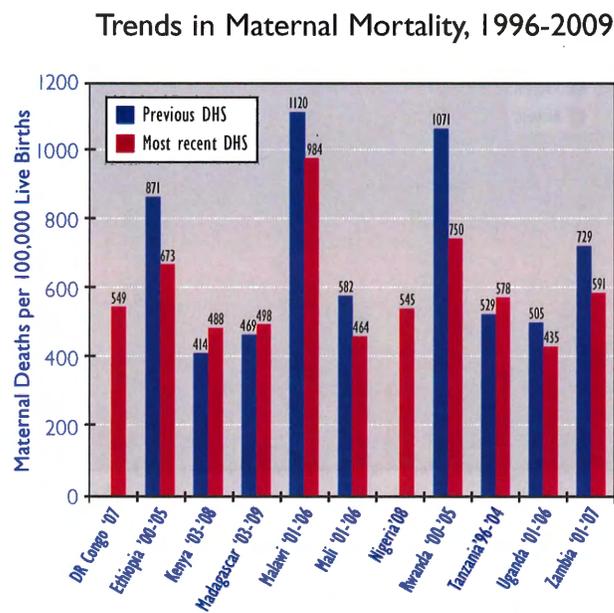
Source: Most recent DHS. 2004-2009.

Figure 7



Source: International Food Policy Research Institute, June 2009.

Figure 8



Source: DHS, 1996–2009. Comparable data for DR Congo and Nigeria are not available.

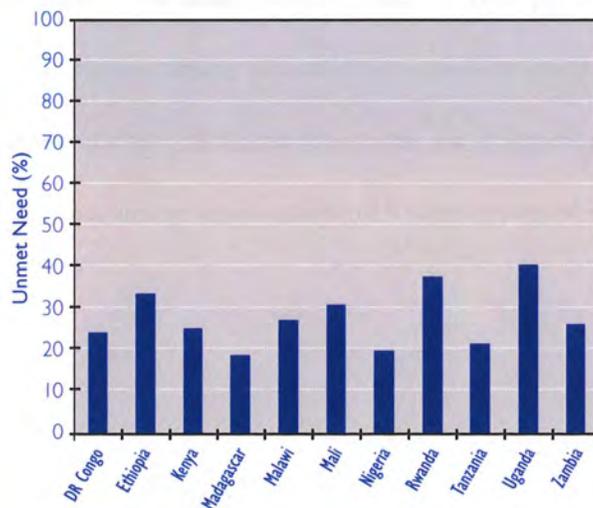
Figure 9

Average Yearly Increase in MCPR between Last Two Surveys (percentage points), 1999-2009	
Rapid progress	Average Increase
Ethiopia 2000-05	6.0
Kenya 2003-08	1.5
Madagascar 2003-09	2.3
Rwanda 2005-07	8.5
Encouraging progress	
Malawi 2000-04	0.6
Tanzania 1999-2004	0.5
Zambia 2001-07	0.8
Slow progress	
DR Congo 2001-07	0.3
Mali 2001-06	0.1
Nigeria 2003-08	0.3
Uganda 2001-06	0.8

Source: Two most recent DHS, 1999-2009. 2001 data for DR Congo are from the MICS. Yearly increase for Ethiopia calculated with data from the L10K Baseline Survey, 2008 and the 2005 DHS. MCPR does not include LAM.

Figure 10

Unmet Need by Country



Source: Most recent DHS, 2004-2009.

Family Planning Program Review Findings:

- 1) Country program performances varied significantly across the 11 countries in the last decade.
- 2) HIV/AIDS influenced national family planning program performance.
- 3) Inadequate data limit the quantitative assessment of USAID program performance.
- 4) Allocation of family planning budgets by USAID Missions has been strategic and in line with country program priorities.
- 5) USAID contributed significantly to the successes of seven key program components.
- 6) Commitment mattered most to program success.
- 7) The hallmarks of programs that made rapid progress are community partnership and access to family planning services on a large scale.
- 8) Integration of family planning and maternal and child health with HIV/AIDS programming has been slow, and family planning is a weak part of maternal and child health programs in most Missions.
- 9) The private sector, most notably through USAID-funded social marketing programs, has demonstrated its effectiveness even under the most challenging conditions and has the potential for expanding its reach.
- 10) Contraceptive availability has improved, but contraceptive security has not yet been achieved.
- 11) Health systems need to be stronger, particularly in organizational and management capacity, to further improve the use of existing resources and program performance.
- 12) A comprehensive and systematic approach to communication and social mobilization is needed.
- 13) Broader efforts are needed to create conducive conditions for program expansion.
- 14) Inadequate funding, cost, and sustainability are serious constraints to program expansion.
- 15) USAID's internal capacity must be strengthened if family planning programs are to be expanded.

