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Africa Bureau Sector Strategy
POPULATION AND
FAMILY PLANNING



Office of Technical Resources
Bureau for Africa
Agency for International Development
Washington, D.C. 20523

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PREFACE

Helping to reduce high fertility and mortality has become a top priority for A.I.D. in Sub-Saharan Africa and now plays a major role in the Agency's bilateral efforts to boost economic growth and improve human welfare in the region. In FY88 Congress established the Development Fund for Africa (DFA) to encourage more flexible development assistance tailored for African needs. The DFA was launched with \$500 million for FY88, a level which is expected annually at least through FY90. The DFA carries no specific earmarks for sectors, but Congress emphasized the importance of population and health issues with this language: "the Agency ...should target the equivalent of ten percent (of DFA)...for each...: health activities, and ...voluntary family planning."

In July, 1988 the Bureau for Africa's Annual Budget Submission exercise set planning levels for the period FY88 through FY90. The Agency's budget plans are approaching the targets: total DFA investment in population and family planning will be about \$110 million and in health about \$160 million over this period. Added to these, the Bureau for Science and Technology estimated levels will be about \$85 and \$12 million, respectively. Missions may also obligate about \$6 million for PVO activities through the Bureau for Food for Peace and Voluntary Assistance. Total investments should reach about \$370 million over this period. This level of support should assure Congress and African leaders of the seriousness of A.I.D. commitment to family planning and public health.

Funding alone is not enough to assure good public health and demographic policies and programs. Programmatic success is heavily dependent on the leadership and commitment of Africans themselves. Our investments are conditioned on indigenous policies favoring economic growth and human welfare. To the extent these conditions are present in priority countries, funding and technical assistance will be available. From only about 40 persons in 1982, we estimate there are at present about 115 resident technical officers, advisors and expatriate contractors in Africa employed within the A.I.D. system in this sector. This number is expected to increase to about 130 over the next two years, after which time the number should steadily decline as African professionals fill technical roles and our assistance becomes more policy based and budgetary in nature.

Demographic transformation poses a profound challenge for the long term. The Bureau for Africa offers this brief strategy paper focused on the fertility reduction sub-sector to provide a common framework for debate and planning. The paper identifies priority issues taking different settings into account. It identifies those countries where assistance is welcomed and where we believe the greatest good can be achieved by our long-term commitments. The DFA regional account constitutes a major experiment within A.I.D. It provides special opportunities to develop and implement initiatives that combine activities in innovative ways, free of "population" and "health" account earmarks, and opportunities to compete for even higher levels of commitment. We invite comments and criticisms for revisions, especially those which lead to stronger analyses of the benefits of good health service delivery systems, both private and public, to the dynamics of economic growth.

I. INTRODUCTION

Population dynamics in Sub-Saharan Africa present unique and fascinating challenges for social and economic development. Annual population growth in Africa in recent decades surpassed all previous recorded levels, driven by sustained, extraordinary levels of fertility and steadily diminishing mortality. After twenty years of donor encouragement, led by the United States, most African governments recently have begun to recognize the importance of reducing population growth to help accelerate development: to improve public health, relieve severe dependency ratios and improve potentials for economic growth. Recent surveys show desire for fewer children and increasing use of modern methods of contraception. Both government policies and public demand now favor wider acceptance of family planning.

In concert with the Agency for International Development's Population Policy Paper (1982), Blueprint for Development (1986), Child Spacing for Child Survival Strategy (1987), and Population Strategy (1987), A.I.D. assists governments and private organizations in 40 countries in Africa, focusing population and family planning assistance on the more populous nations with highest growth, greatest need and most favorable policy environment. Assistance in this sector is among the highest priorities in the Bureau for Africa. This paper reviews issues of rapid population growth as a challenge to social and economic growth, and outlines the Bureau's priorities.

II. BACKGROUND

Sub-Saharan Africa (including South Africa) includes a population of almost 500 million, with an annual aggregate growth rate of about 3 percent, a doubling time of about 24 years. If present trends continue, the population will number one billion by the year 2015. In many areas, traditionally high fertility actually increased over recent decades with improving health care and rapid change in traditional cultural practices; meanwhile mortality rates dropped for similar reasons. In Kenya, for example, the growth rate actually increased from about 2.4% to 4.0% between 1950 and 1980, despite donor efforts over the past twenty years to help provide voluntary family planning services and occasional statements favoring lower growth by Government of Kenya leaders.

Figure 1 shows the low levels of use of contraception throughout most of Sub-Saharan Africa and the top panel of Figure 2 (Senegal and Nigeria) illustrates typical patterns of use by type of method. While many surveys report that large families are highly desired and that most males take no interest in nor responsibility for fertility regulation, there is much evidence of unmet demand and market potential for family planning. In areas where high quality family planning services have been made available, as in parts of Kenya, Nigeria, Zaire and Zimbabwe, the prevalence of use of effective methods of contraception has increased dramatically. Figure 2 (lower, Kenya) and Figure 3 (Zimbabwe and Mauritius) show rapid increases and the pattern of methods used.

Despite very promising recent developments, no reductions in fertility have yet been documented on a national scale; childbearing "ideals" remain by far the highest in the world; access to information and services remain limited in

rural areas; women's legal status, and customary laws of inheritance and rights to children still overwhelmingly favor high fertility. Studies suggest more motivation for spacing than for limiting births. Changes in traditional birthspacing practices tend to further increase fertility. Declines in breastfeeding and post-partum abstinence, earlier ages at onset of ovulation and coitus, and improvements in reproductive health offset birthrate declines which are achieved through increased use of contraception.

African fertility levels will fall significantly only after prevalence rates of modern methods of contraception reach levels of twenty-five percent or more. Figures 4 and 5 suggest the probable course of the relationship between contraception and crude birth rates, where the least effective methods are most used and where effectiveness of use of these methods is also low. Success in family planning in Africa requires sustained indigenous and donor effort. Reduced levels of childbearing will not occur quickly.

Much attention is now focussed on the planned censuses and major surveys scheduled over the next few years. Four countries (Mauritius, Zimbabwe, Botswana and Kenya) should show the beginnings of birth rate declines which are usually first seen in lower rates among older women and some decline in rates among the younger mothers. The HIV pandemic may increase death rates in the reproductive age group in at least the one-fourth of Africa presently affected. However, even with "worst case" HIV projections and radically successful efforts in fertility reduction, population in Africa could well triple over the next fifty years because of the extraordinary proportion of young people in the population. Mothers of children to be born twenty years from now are themselves already born. If birthrates were to decline, health, and some economic benefits would be realized within a decade through lower mortality rates, less school crowding, and possibly higher female economic productivity.

III. POLICY PERSPECTIVE

Prior to 1980, only four African nations (Ghana, Kenya, Rwanda, Mauritius) had national policies calling for reduced rates of population growth. That number increased dramatically over the past seven years: 10 countries (including Gambia, Nigeria, Senegal, Liberia, Burundi, Uganda) now have explicit national policies favoring lower population growth; 12 other countries (Botswana, Benin, Burkina Faso, Cameroon, Madagascar, Niger, Sierra Leone, Somalia, Sudan, Togo, Zambia, and Zaire) are completing population policies this year or next. The United Nations estimates that 31 Sub-Saharan countries now provide at least some direct support for family planning services.

To date most countries officially provide family planning services only as a health measure. Cultural patterns, customary law and, in some areas, the vestiges of colonial policies continue to support high fertility. The latter include high customs, duty and excise taxes on import of contraceptives and equipment, and severe restrictions on marketing. These constraints provide major issues for top level policy dialogue.

Few U.S. supporters of overseas assistance in family planning realize how much has been accomplished. In Asia and Latin America, this process occurred over several decades. In Africa today, parliamentarians, political leaders, top civil servants, and professionals have forged strong international links

across a broad spectrum of disciplines and interests related to public health and family planning. Tens of thousands of Africans have participated in U.S. sponsored population and family planning orientation and training. Population assistance is now a highly significant contribution to our bilateral relations in Africa.

IV. HEALTH AND ECONOMIC PERSPECTIVES AND RATIONALE

By reducing high risk births (those which are less than two years apart, to women less than 18 or older than 35 years of age, and those of parity four or higher) infant, child and maternal mortality rates will fall. Longer birth intervals reduce infant mortality by 10 percent and child mortality by 21 percent. If women at high risk avoid child bearing, about one-half of all maternal mortality can be avoided. When coupled with other child survival interventions, child spacing will have a synergistic benefit on the survival and health of African mothers and children.

With average completed family sizes of between six to eight children, dependency burdens for childrearing and education have reached intense levels. In recent years, many countries have experienced declining per capita levels of arable land and food production and consumption. Family welfare could be improved measurably in the near term through reduced fertility.

In the past thirty years a great deal of research has examined the relationship between economic development and population growth. The 1986 National Academy of Sciences report Population Growth and Economic Development describes inverse relationships between population growth and child health, quality of education, agricultural productivity and equitable income distribution. The overriding conclusion is that, for most developing countries, slower population growth is highly beneficial to economic development. These findings are reflected increasingly in economic development and population policy statements made by African leaders.

V. NEW PROGRAM EMPHASIS

A.I.D.'s twenty years of worldwide experience in the population field have shown that successful family planning programs involve the following: demographic measurement, policy development, training, information, provision of quality family planning services with adequate supplies of a wide variety of contraceptives and a variety of delivery systems, and program operations, research and evaluation. Successes in other regions strongly suggest that each of these areas should be incorporated into a well-rounded program to reduce fertility.

Because of the wide variety of AID/W centrally funded projects developed over the years with universities, PVOs, research institutions, and private firms, A.I.D.'s program has proven highly flexible and responsive to changing host country situations. Rather than supporting each of the above areas in every country, country programs are designed to implement A.I.D.'s comparative areas of strength and complement those of other donors in the field, ensuring that each component of an effective population program is adequately addressed.

Country strategies and action plans must be individually developed, based on specific country resources, needs, political climates and cultures.

Some general principles are especially relevant for family planning programs in Africa. Programs should provide access to a wide selection of methods of contraception through service delivery systems which are client-oriented. An optimal mix of methods gives different age and parity groups access to appropriate contraceptive methods. Couples must be able to make informed choices of methods best suited to their own perceptions of need. Young couples who wish to delay or space births must have access to temporary methods such as oral contraceptives and condoms. Those with two or more children may be more effectively served by longer term methods such as IUD's and implants (when this latter method receives US FDA and/or host country approval). Voluntary surgical contraception should be available for those who have achieved desired family size. No single method should be in the forefront in a national program. Methods appropriate for all age and parity groups should be readily accessible.

The Bureau urges missions and host governments to achieve appropriate method mix and to support innovative methods of service delivery, particularly those developed through the private sector, by:

Eliminating Barriers: making all methods of fertility regulation available and accessible by eliminating legal, logistical and administrative barriers;

Promoting More Effective Methods: including oral contraceptives, IUD's and voluntary surgical contraception;

Promoting the Private Sector: utilizing the private sector to develop and expand the availability of non-clinical contraceptives in commercial, industrial, and private organizations.

Couples need to start planning their families early in their reproductive years if high rates of population growth are to be diminished in the near term. Stronger emphasis should also be placed on information on contraceptive availability, safety and benefits and on consumer education to improve the effective use of temporary methods. In Africa, failure rates of these methods are the highest in the world.

VI. DETERMINING PROGRAM CONTENT

Bureau resources are allocated according to:

a. demographic indicators: infant and maternal mortality, total fertility rate, rate of natural increase and total population;

b. socio-political indicators: legal status of contraceptives and service delivery, government policies and socio-cultural acceptability;

c. service delivery indicators: demand for family planning services, contraceptive prevalence, availability and accessibility of services;

d. infrastructure indicators: management capability, level of trained personnel, number of available service delivery points, institutional absorptive capacity, and existing public sector capabilities;

e. economic indicators: the actual cost of using family planning methods;

f. prevalence of HIV, and host government policies about public awareness, promotion of behavioral change and programs for barrier methods.

VII. PROGRAM CONTENT

A.I.D. population and family planning activities in the Africa region may contain the following, as determined by country-specific circumstances:

Policy Development - Working with host governments to develop national policies for reduction of population growth and improvement of maternal and child health.

Information, Education and Communication (IEC) - Assisting host governments and local institutions in research, design, testing and production of multimedia IEC activities, including electronic and print media, and developing information networks through schools, women's organizations, etc. Family planning programs may provide exceptional opportunities to encourage modification of sexual behavior to improve reproductive health especially in regards to prevention of HIV transmission.

Service Delivery Systems - Assistance to host governments, local institutions and private sector entities to establish a broad spectrum of service delivery systems capable of meeting current demands and stimulating additional demands for services in both rural and urban areas, with particular emphases on community based delivery systems and cost recovery mechanisms to improve program sustainability. Note that wherever appropriate those family planning programs located in areas of high prevalence of sexually transmitted diseases, especially HIV, should assure that condoms are readily available.

Training - Assistance in both clinic-based and non-traditional service delivery systems ranging from leadership to traditional health delivery personnel such as community midwives. Management of service delivery systems is critical in all settings, for which appropriate training should be provided.

Research - Assistance in the design and conduct of research in behavior, attitudes, service delivery modalities, demography, and management systems.

VIII. PROGRAM STAGES

Countries in Africa are categorized by level of program development and policy climate according to the Agency population sector strategy as follows:

Stage One - countries are those in which an awareness of population issues has begun to emerge, family planning services are not widely available, and

the policy climate is opening to family planning. These programs emphasize demographic data, policy development, training, dissemination of information and education, and pilot service delivery projects. They typically have been initiated by centrally-funded S&T projects and buy-ins, as bridges to regional and bilateral projects (Cameroon, Sudan).

Stage Two - countries are those in which family planning activities now need to be strengthened and expanded. Programs are often characterized by one or two successful efforts, with rising prevalence (Chogoria in Kenya). Program emphasis is placed on service delivery, including implementation issues on developing logistics systems and a variety of service delivery networks, such as CBD, private clinics, public clinics and contraceptive retail sales. Specific activities supported by A.I.D. are those which respond to the most pressing needs of the service delivery system and which complement those of other donors. Funding is usually arranged through bilateral or regional projects (Niger, Senegal, Togo). S&T funding complements on-going activities through expanding, enhancing and evaluating programs.

Stage Three - countries are those with maturing programs which offer a wide variety of services through numerous delivery systems, a supportive policy climate, and some funding from the host government. Prevalence rates are rising and fertility may have begun to decline (Mauritius, Botswana and Zimbabwe). Emphases shift to program sustainability, improvement of use-effectiveness, and utilization of more effective methods. Main program themes include experiments with alternative delivery systems, development of private sector programs, and program evaluation to improve operations efficiency. S&T projects provide support to complementary activities.

IX. CRITERIA FOR ASSIGNING FUNDING PRIORITIES

The Bureau uses the following criteria when developing funding priorities.

Unmet demand for family planning services (survey data, public debates)

Government commitment to reducing the growth rate (documents, public statements, annual budgets)

High population growth rate (censuses, surveys)

Infant and maternal mortality rates (censuses, surveys, program records)

Other donor support (UN, World Bank, other bilaterals)

Prevalence of HIV and other reproductive health issues (case reporting, serologic surveys, studies)

X. CURRENT COUNTRY ACTIVITIES

Table 1 lists current and projected bilateral population projects in Africa, based on the most recent AAPL, the FY 88 ABS and discussions with field officers. This table reflects the momentum of program development in Africa and the large measure of success of A.I.D. assistance in population and fertility regulation to date. Most large countries with A.I.D. bilateral assistance programs have developed or will soon to develop mission-based programs.

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Table 1

BUREAU FOR AFRICA: BILATERAL POPULATION PROJECT STATUS

<u>Before 1988</u>	<u>FY 88 (Planned)</u>	<u>FY 89 (Proposed)</u>	<u>FY 90 (Proposed)</u>	<u>FY91 (Proposed)</u>
Kenya	Botswana	Mali	Madagascar	Tanzania
Ghana	Nigeria	Rwanda	Cameroon	
Zaire	Burundi	Sudan		
Somalia	Niger	Uganda		
Senegal	Swaziland			
Zimbabwe				
CERPCD (Reg)				

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Table 2 provides a tabular display of the Bureau for Africa's country priorities according to the criteria discussed in this paper, tempered by wide consultation with experienced, senior field officers. Table 2 suggests the areas of probable emphasis and priority that should be given in developing country strategy plans.

Table 2

AFR/TR/HPN POPULATION/FAMILY PLANNING PROGRAM PRIORITIES
BY PROGRAM STAGE

Stage	High	Medium	Low	Minimal
Stage I	Cameroon (1)* Sudan (2)	Burundi (2)* Congo (3) Madagascar (1) Zambia (3)	CAR (3)* Chad (3) Guinea (1) Mozambq. (2)	Angola (3)* Comoros (3) Djibouti (3) Ethiopia (3) Cote d' I. (3) Gabon (3) Namibia (3) Eq. Guinea (3) Sao Tome (3) Sierra L. (3)
Stage II	Ghana (1) Kenya (1) Mali (1) Nigeria (3) Tanzania (2) Uganda (1) Zaire (1)	Botswana (2) Burkina (3) Lesotho (2) Liberia (3) Malawi (1) Niger (2) Rwanda (2) Senegal (1) Somalia (3) Swaziland (2) Togo (3)	Benin (3) Gambia (2) Guinea B. (3) Mauritania (3)	Cape Verde (3) Seychelles (3)
Stage III	Zimbabwe (3)		Mauritius (3)	South Africa (3)

* Numbers in parentheses indicate AFR Bureau priority categories for the Development Fund for Africa as of July, 1988.

Category 1 includes ten countries with demonstrated commitment to sound and/or improved economic policies, good potential for economic growth, relatively large populations (over 7 million), and capacity to manage serious debt or foreign exchange problems. Increased levels of DFA resources and detailed AID/W oversight are envisioned.

Category 2 consists of ten countries which continue to implement or are committed to sound economic policies and/or have good records of economic growth. Three have strong growth potential but are experiencing difficulties in implementing economic reform programs (Tanzania, Sudan and Mozambique).

Category 3 includes the remaining countries which receive bilateral assistance.

XI. BUREAU FOR AFRICA AND BUREAU FOR SCIENCE AND TECHNOLOGY

U.S. government support for family planning is channeled through two accounts within the Agency: (1) the Bureau for Africa's Development Fund for Africa which supports mission-based population programs, and (2) the Office of Population within the Bureau of Science and Technology, which funds U.S.-based cooperating agencies. Much of what has been achieved in Africa in population to date has been initiated through S&T funded programs. Typically, small projects initiated by S&T and implemented through cooperating agencies have evolved into larger, mission-based programs. The latter usually continue to include a significant element of U.S.-based technical assistance and/or intermediary services funded through mission "buy-ins" to S&T projects.

The Bureau for Africa's population strategy is highly interdependent with the resources of the S&T Office of Population. The priorities shown on Table 2 reflect the rankings of both the Africa Bureau and S&T's Office of Population. S&T shares a strong commitment to the development of Mission-based projects and sectoral programs and supports the use of appropriate locally hired technical staffing for mission agreements.

XII. A.I.D. AND OTHER DONORS

The U.S. has been the major donor to international family planning programs for decades and U.S. institutions provide a most experienced cadre of population specialists. Yet current demands for family planning services and commodities well exceed resources available through A.I.D. Because demand for services continues to increase, additional donor support is needed. Careful coordination with programs funded by other agencies will help to promote more efficient services. The Bureau for Africa will strengthen links with other bilateral and multilateral donors at headquarters level, and urges Mission Directors and field technical personnel to include other donors in coordinating resources for population programs.

The World Bank has exerted strong and effective efforts in recent years to engage some African governments in policy dialogue on population issues and to encourage them to support family planning programs. The United Nations can play a stronger role in countries where U.S. activities may be less effective. Japan has become a major bilateral donor; ways must be found to facilitate much greater commitment of Japanese resources in support of major family planning programs.

XIII. FUNDING NOTE

There will always be some indispensable role for public sector subsidy in promoting public health, and much of the impetus for this at this stage in Africa seems necessarily to come from external assistance. Ultimately, however, much of the cost of assuring access to a range of good quality methods for fertility regulation should and can be borne by the private sector. Family planning program cost projections suggest that sixty percent or more of program costs will initially have to be borne by external donors, with the US supporting perhaps one-half or more of these costs. Of the remaining forty percent which is non-U.S. financed, perhaps one-half the costs might be borne by the host country government, with the private sector paying the remainder. However, as programs expand and total costs grow, we

must focus on establishing full and partial cost recovery mechanisms to increase program sustainability. These will ensure that family planning falls increasingly into the control of local processes, and that it becomes a "beneficiary" of the economic growth being stimulated by other, larger patterns of development.

XIV. CLOSING

The population and family planning sector is among the highest priorities for the Bureau for Africa. Table 3 shows the recent pattern of A.I.D. investment. While the overall trend of A.I.D. obligations for Africa has generally been constant, except for the unusual infusion of funds in 1986, there has been a steady increase in the proportion funded by the Bureau for Africa. This table also shows the large percentage of resources provided by the S&T Bureau. The new Development Fund for Africa, established in 1987, has no sectoral "earmarks" with established minimum or maximum levels of funding for population and it therefore places no restrictions on the level of funding that may be considered for family planning programming.

The Bureau welcomes comments for updating this strategy. Although the basic tenets should hold, the Bureau for Africa will revise priorities periodically to reflect economic progress, host country leadership, program achievements, Congressional priorities and A.I.D. interests.

The Bureau is pleased that A.I.D.'s Population Sector Council has endorsed this strategy.

Health, Population and Nutrition
Officers for Africa Region

REGION CODE	COUNTRY	POSITION TITLE	INCUMBENT
AFR/TR/HPN		SUP HLTH/POP DVL OFF	MERRITT CHARLES GARY
AFR/TR/HPN		HLTH DEV OFF PHSN	SHEPPERD JAMES D
AFR/TR/HPN		HEALTH SCIENCE SPEC	ALLISON ADRIENNE
AFR/TR/HPN		HLTH/POP DVL OFF	THOMAS JOHN H
AFR/TR/HPN		HLTH/POP DEV OFF	MICKA MARY ANN
AFR/TR/HPN		HEALTH SCIENCE SPEC	LYERLY WILLIAM H JR
AFR/TR/HPN		HLTH/POP DVL OFF	COURY JOHN
AFR	MALAWI/PH	HLTH/POP DVL OFF	GURNEY CHARLES R
AFR	USAID/MALAWI	IDI(HLTH/POP/NUTR)	NEWTON GARY W
AFR	KENYA/PH	SUP HLTH/POP DVL OFF	OOT DAVID A
AFR	KENYA/PH	POPULATION DVL OFF	SLOBEY LAURA L
AFR	KENYA/PH	HLTH/POP DVL OFF	LANKENAU LINDA L
AFR	KENYA/PH	HLTH/POP DEV OFF	GINGERICH MOLLY M
AFR	UGANDA/D	HLTH/POP DVL OFF	COHN PAUL D
AFR	NIGERIA	AID AFFAIRS DIRECTOR	MERRILL HANK
AFR	NIGERIA	HEALTH DEV OFFICER	CASHIN GERRY
AFR	REDSO/ESA/NAIROBI	POPULATION DEV OFF	DANART ARTHUR H
AFR	REDSO/ESA/NAIROBI	HLTH/POP DVL OFF	BARBIERO VICTOR K
AFR	REDSO/WCA/ABIJAN	POPULATION DEV OFF	HOLFELD JOYCE M
AFR	REDSO/WCA/ABIJAN	HEALTH DEV OFFICER	DEBOSE CHARLES S
AFR	CAMEROON/EHR	HLTH/POP DVL OFF	LEINEN GARY E
AFR	GHANA/D	POPULATION DEV OFF	KIRKLAND JAMES R
AFR	SWAZILAND	POPULATION DVL OFF	FOOSE ALAN C
AFR	SWAZILAND	POPULATION DVL OFF	SELVAGGIO MARY P
AFR	SUDAN/HP	HLTH/POP DVL OFF	MACKIE ANITA
AFR	SUDAN/HP	POPULATION DVL OFF	STEWART KATHERINE
AFR	ZAIRE/PHPOP	SUP H/POP DV OFF PHS	POST GLENN LANE
AFR	ZAIRE/PHPOP	POPULATION DVL OFF	BRADSHAW LOIS E
AFR	ZAIRE/PHPOP	HEALTH DEV OFF	PAYNE CAROL A
AFR	LIBERIA/HRD	HEALTH DEV OFFICER	ZAMORA FRANCISCO J
AFR	MAURITANIA/D	HEALTH DEV OFFICER	MANDEL PAMELA A
AFR	NIGER/GD	HLTH/POP DVL OFF	STOVER CARINA
AFR	BURKINA FAS/HR	HLTH/POP DVL OFF	GREENE RICHARD S
AFR	MALI/GD	HEALTH DEV OFF	WOODRUFF NEIL J

**AFRICA BUREAU
COUNTRY CATEGORIES UNDER THE DPA**

Category I:

Countries with good economic performance, good potential for economic growth

**Cameroon
Ghana
Guinea
Kenya
Madagascar
Malawi
Mali
Senegal
Uganda
Zaire**

Category II:

**Countries with good policy performance but limited potential;
poor policy performance but high development potential**

Botswana	Burundi
Gambia	Lesotho
Mozambique	Niger
Rwanda	Sudan
Swaziland	Tanzania

Category III:

All other countries

Burkina Faso	Cape Verde
CAR	Chad
Comoros	Congo
Cote d'Ivoire	Djibouti
Equatorial Guinea	Ethiopia
Guinea Bissau	Liberia
Mauritania	Mauritius
Nigeria	Sao Tome/Principe
Seychelles	Sierra Leone
Somalia	South Africa
Togo	Zambia
Zimbabwe	

5677G:7/01/88

AGENCY FOR INTERNATIONAL DEVELOPMENT
 Development Fund for Africa
 FY88 thru FY90: Approved Budget Plans *
 (\$000's)

Sector Country	HEALTH (+CS+HIV)	POP/FP	Reg.to (Health)	Country (Pop)	Totals (Req'st)	
AFR REGIONAL**	25610	11723	11128	2050	50511	
Botswana	0	3700	1125	30	4855	
Burkina	985	125	450	30	1590	40
Burundi	1826	6650	744	60	9280	350
Cameroon	4692	475	0	30	5197	
CAR	900	0	1023	0	1923	
Ghana	4007	0	750	395	5152	
Guinea	615	0	1915	0	2530	
Ivory Coast	0	730	3018	150	3898	
Kenya	5671	24593	0	30	30294	
Liberia	3300	0	1240	60	4600	
Malawi	11214	1089	1860	30	14193	
Mali	4250	2035	525	0	6810	350
Niger	9130	7948	450	60	17588	125
Nigeria	4830	30000	10064	180	45074	925
Rwanda	170	2480	1023	60	3733	
Senegal	3756	43	600	30	4429	
Sudan	17920	3415	0	90	21425	
Swaziland	1722	1860	744	0	4326	
Tanzania	1164	2067	0	135	3366	
Togo	4032	0	1124	0	5156	
Uganda	1683	1528	0	350	3561	
Zaire	17265	5002	3100	90	25457	
Zambia	1245	340	0	60	1645	
Zimbabwe	1372	2000	0	120	3492	
small activ's	5272	2614	0	0	7886	25
DFA TOTALS	\$132,631	\$110,417	\$37,423	\$4,040	\$280,471	\$1,815

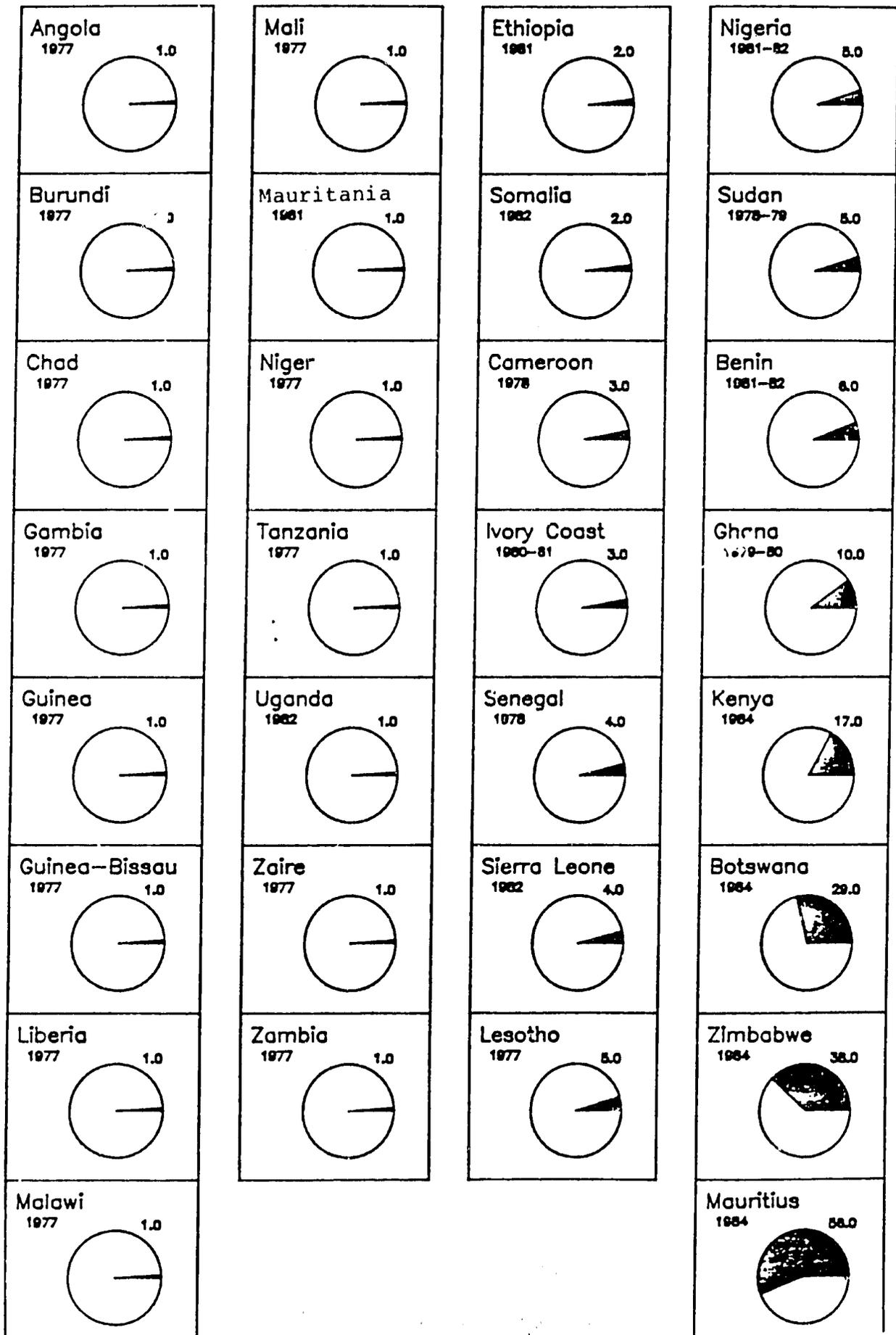
* These figures do not include an estimated \$40 million per year from A.I.D.'s Bureaus of S&T and FVA/PVO. These include an estimated \$24 of POP account (or 30% of ST/POP OYB) and about \$16 million of HEALTH account per year: about \$120 million TOTAL over the three years.

** About 50% of African Regional funds are obligated to specific country programs (also true of much of the S&T funding). These are not reflected by country in the above projections.

Grand total of A.I.D.(FY88-90): \$400,000
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CONTRACEPTIVE PREVALENCE IN SUB-SAHARAN AFRICA

Percent of Currently Married Women 15-44 Using Contraception



Contraceptive Prevalence and Changes in Selected African Countries

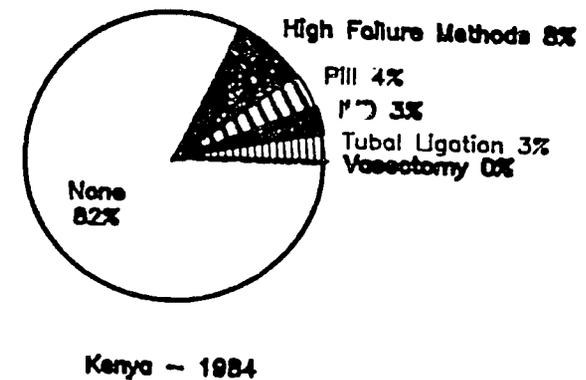
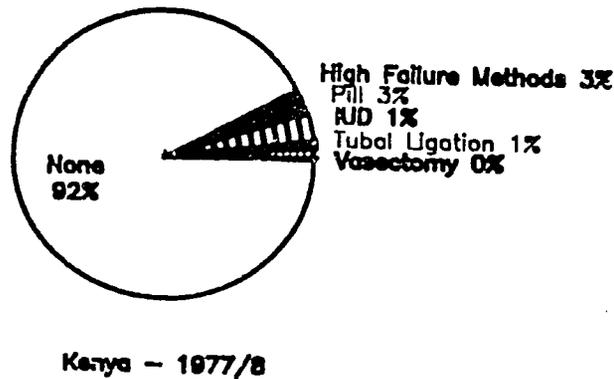
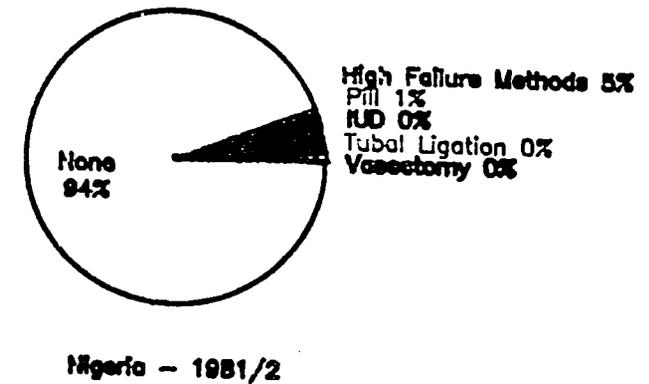
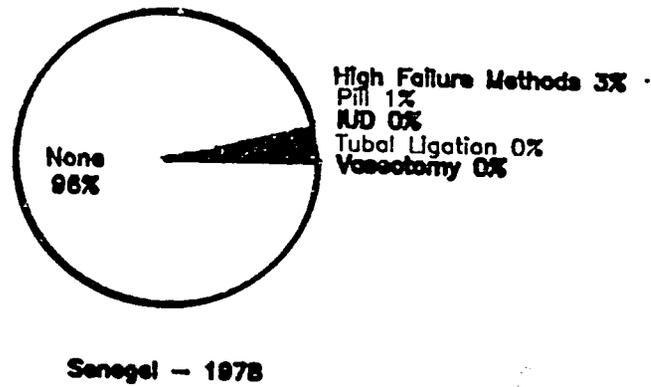
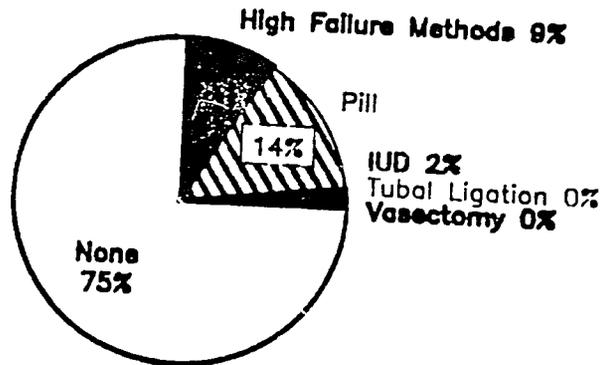
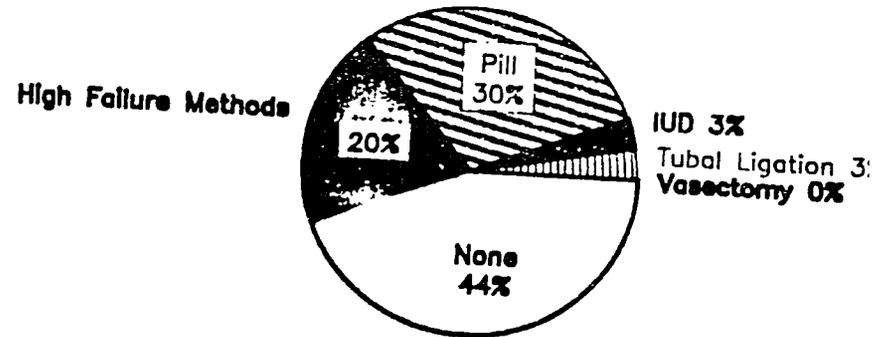


Figure 2

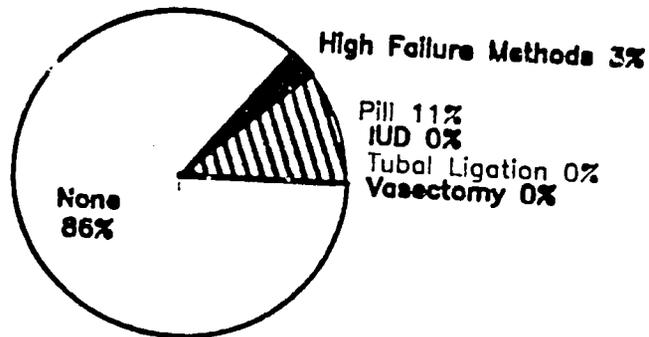
Contraceptive Prevalence and Changes in Selected African Countries



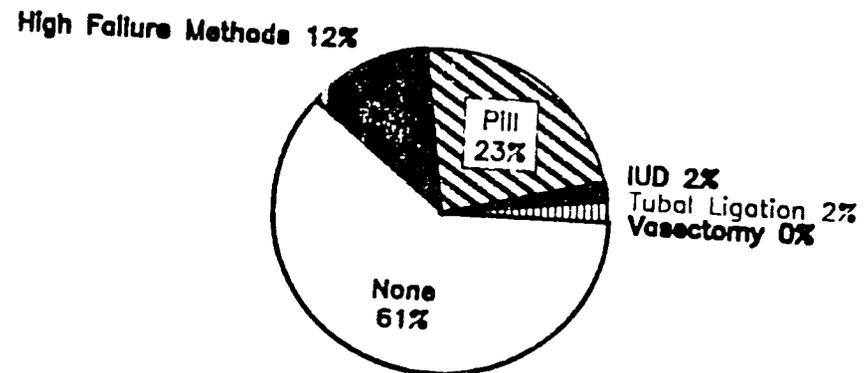
Mauritius - 1971



Mauritius - 1984



Zimbabwe - 1979



Zimbabwe - 1984

Figure 3

FIGURE 4 CRUDE BIRTH RATES, 1980, AND PREVALENCE OF CONTRACEPTIVE USE, 1977-1983

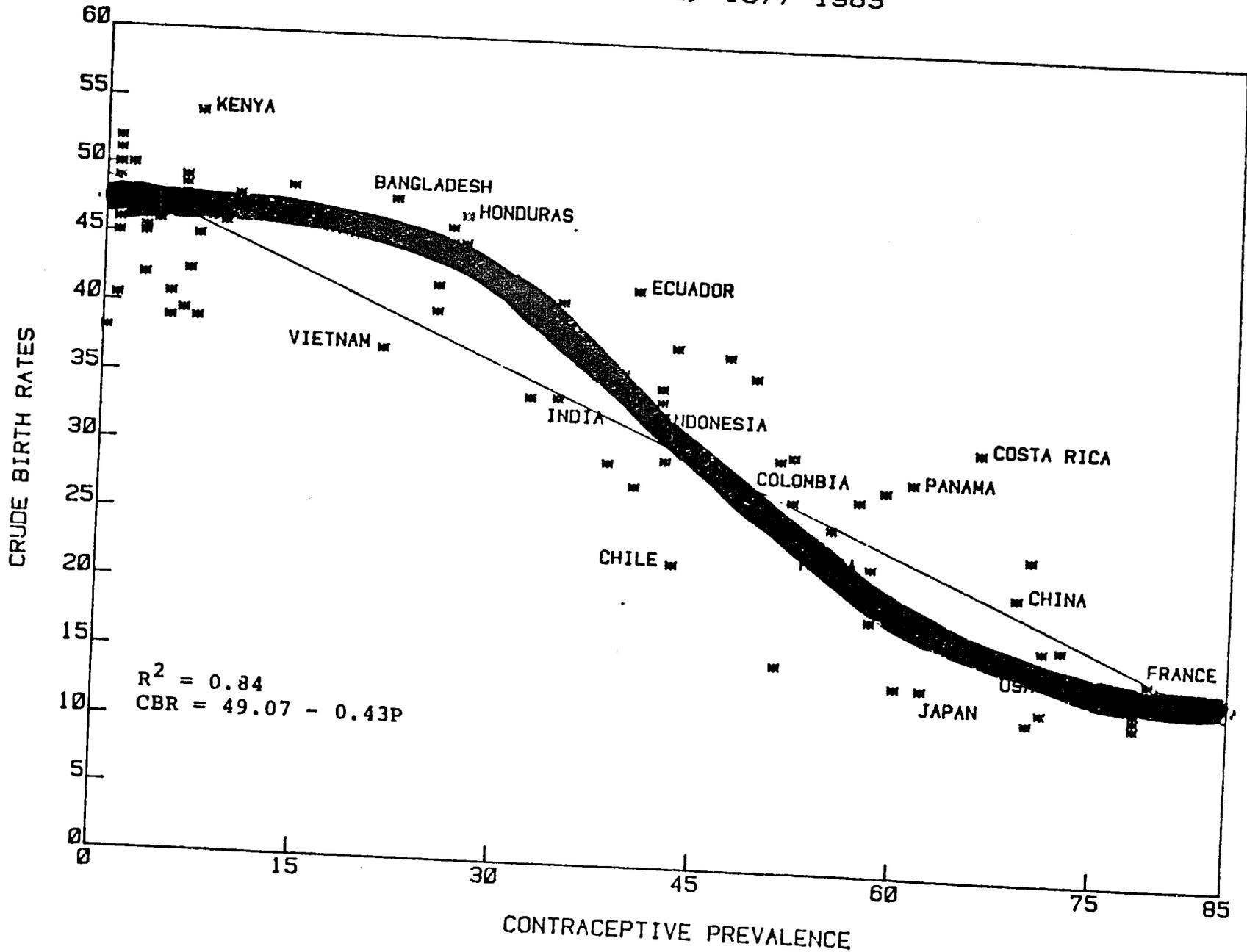
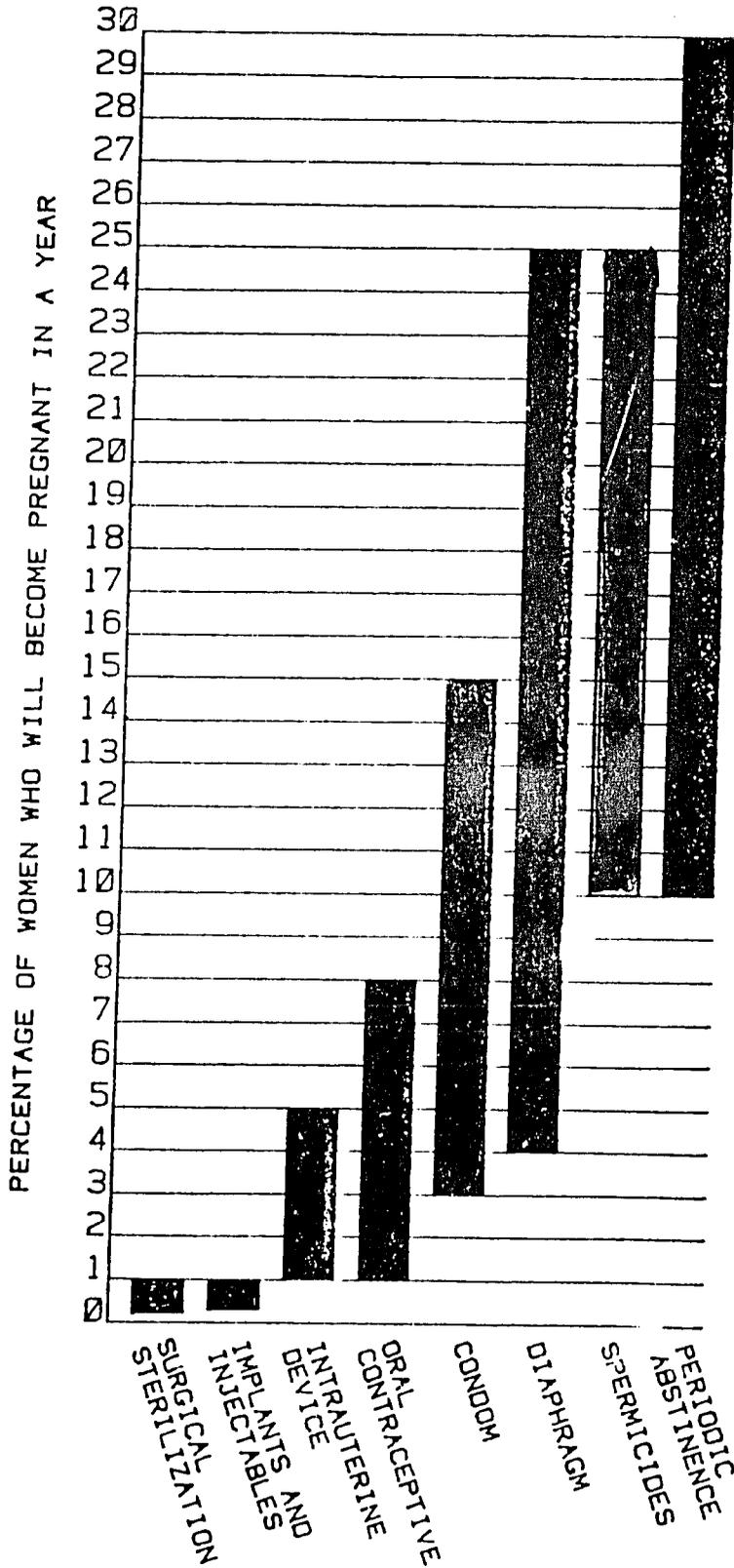


FIGURE 5:
ESTIMATED RANGE OF FAILURE RATES
FOR MAJOR CONTRACEPTIVE METHODS
UNDER USE CONDITIONS WORLDWIDE



FUNDING BY COUNTRY

FY88-90 DFA ABS PLANS

FUNDING LEVELS (MILLIONS)

