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POPULATION AND FAMILY PLANNING IN SUB-SAHARAN AFRICA
STATUS, TRENDS, AND USAID ASSISTANCE

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POPULATION AND FAMILY PLANNING IN SUB-SAHARAN AFRICA

STATUS, TRENDS AND USAID ASSISTANCE

October 25, 1989 ¹

I. INTRODUCTION

A review of Africa's² rapid population growth, persistent high fertility, and scattered but impressive progress in family planning produces a mixed picture. On the one hand and threatening to trigger widespread pessimism is the formidable challenge to slow and cope with extraordinary growth that promises to double the region's 500 million population size in only 25 years. On the other hand are recent accomplishments in lowering fertility in at least five countries which sustain hope and suggest that acceptance of modern family planning may accelerate.

Africa is a vast continent of almost infinitely varied cultures, tribal characteristics, customs, beliefs, life styles, and economic arrangements. Most of Africa's relatively newly independent nations are still struggling to achieve nationhood, often in the midst of economic crisis. When considering the prospects for economic development necessary to underpin sustained lowered fertility, one is immediately confronted with a history of state-controlled, ideologically-driven economic mismanagement, a \$130 billion continent-wide external debt, and the reality of fiscal and monetary disorder.

In the environmental arena, relationships with population variables are many and strained. Efforts to preserve the land base essential for future development are being undermined daily by the record growth in human numbers. Ninety percent of Africans depend on wood as their chief source of energy and fuel. Today, forests are being depleted at a disturbing rate due to uncontrolled cutting--some to meet the demand for export of rain

¹ This paper was prepared under contract with the Office of Health, Population and Nutrition, Bureau for Africa, U.S. Agency for International Development with the close collaboration of Dr. C. Gary Merritt, Division Chief.

² Here and throughout this paper, "Africa" refers to "sub-Saharan Africa."

forest hardwoods, often to repay foreign debt, but mostly to be used for household fuel.³

The U.N. Environment Program estimates that overgrazing coupled with deforestation and poor farming techniques is turning 24,000 square miles of African land into desert each year.⁴ As human populations grow, animal populations that provide either income or food increase also. This increase in numbers of livestock often leads to unsustainable use of grazing and water resources resulting in serious land degradation. Periodic droughts and other climatological phenomena often conspire to compound these problems.

In many countries, the standard of living has decreased for the average citizen over the past ten years and per capita income and food production have declined. In some, improvements in life expectancy are at a standstill or are actually receding. In that minority of countries which have undertaken structural reforms and have begun to move toward market economies in recent years, signs of economic revitalization are springing up. This is particularly true in the agriculture sector when farmers are able to obtain free market prices for the food they produce.⁵

In all countries, half of the population is very young --18 years of age or less-- and growing rapidly, promising to double the continent's 500 million population size in only one generation or about 25 years. The likelihood that African economies can support such a doubling, even if economic reforms and restructuring are quickly agreed to and adopted, is uncertain if not doubtful.

Against a background of recent trends in population growth, fertility, and mortality, this report highlights recent accomplishments in family planning acceptance in Kenya, Zimbabwe and elsewhere. It also reviews USAID's support for family planning in the region, emphasizing efforts to increase the accessibility to family planning and contraceptive services. As part of the discussion on the Bureau for Africa's strategy in

³ Goliber, T. 1985. "Sub-Saharan Africa: Population Pressures on Development," Population Reference Bureau, Inc., Vol. 40, No. 1, Washington, D.C.

⁴ Frankel, G. 1984. "Shortage of Firewood Reaching Crisis Level in Third World," p. E2. The Washington Post, November 19, 1984.

⁵ The World Bank-UNDP, 1989. Africa's Adjustment and Growth in the 1980's," a joint World Bank-UNDP publication, March, 1989, The World Bank, Washington, D.C.

this sector, government and private sector approaches are examined, coupled with brief comments on the role of external donor financing.

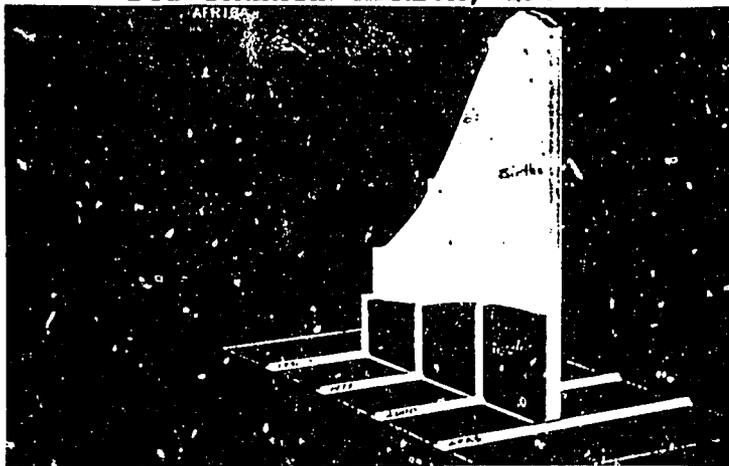
Finally, the report responds to the Congressional concern that "...the Agency should target the equivalent of ten percent of Development Fund for Africa funds for voluntary family planning" by showing that that amount has been exceeded in Fiscal Years 1988 and 1989 and should again be exceeded in FY 1990.

II. DEMOGRAPHIC TRENDS

Figure 1 shows the familiar divergence of births and deaths since 1950. Birth rates remained high, usually over 45 per 1000 and sometimes over 50 per 1000 population while death rates fell to less than 20 per thousand due to public health programs that controlled many infectious diseases, made anti-biotics available and improved sanitation.

By 1995-2000, the projected drop in the death rate to 12 will still outpace the decline in the birth rate to 41 or so, resulting in an increase in the overall rate of population growth to 2.9 percent. This is an exceptionally high rate, five to seven times higher than found in more developed regions and if unchanged, would lead to doubling of population size in 24 years. If longer term projections hold up, in the 75-year period ending in 2025, Africa will have experienced a seven-fold leap in population size, from 224 to 1,580 million.⁶

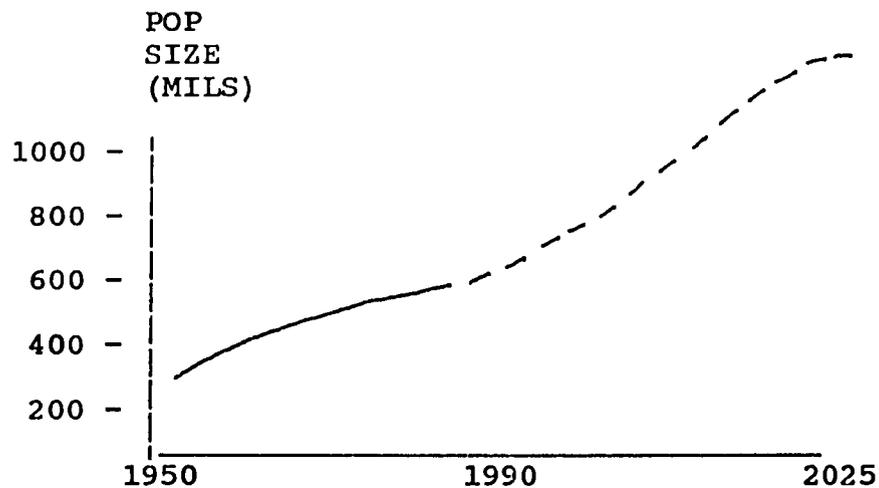
FIGURE 1
BIRTH AND DEATH RATES, ACTUAL AND PROJECTED,
SUB-SAHARAN AFRICA, 1950-2025



⁶ Fox, Robert, 1989. "Africa: Population Growth, Births and Deaths, 1950-2025." A report prepared for the Bureau for Africa, Office of Health, Population and Nutrition, 1989, USAID, Washington, D.C.

The difference between births and deaths is population growth shown in Figure 2. The projections to the year 2025 use the U.N. median projection. (Migration is a negligible factor for the region as a whole, but often is significant between individual countries.)

FIGURE 2
POPULATION GROWTH, ACTUAL AND PROJECTED
SUB-SAHARAN AFRICA, 1950-2025

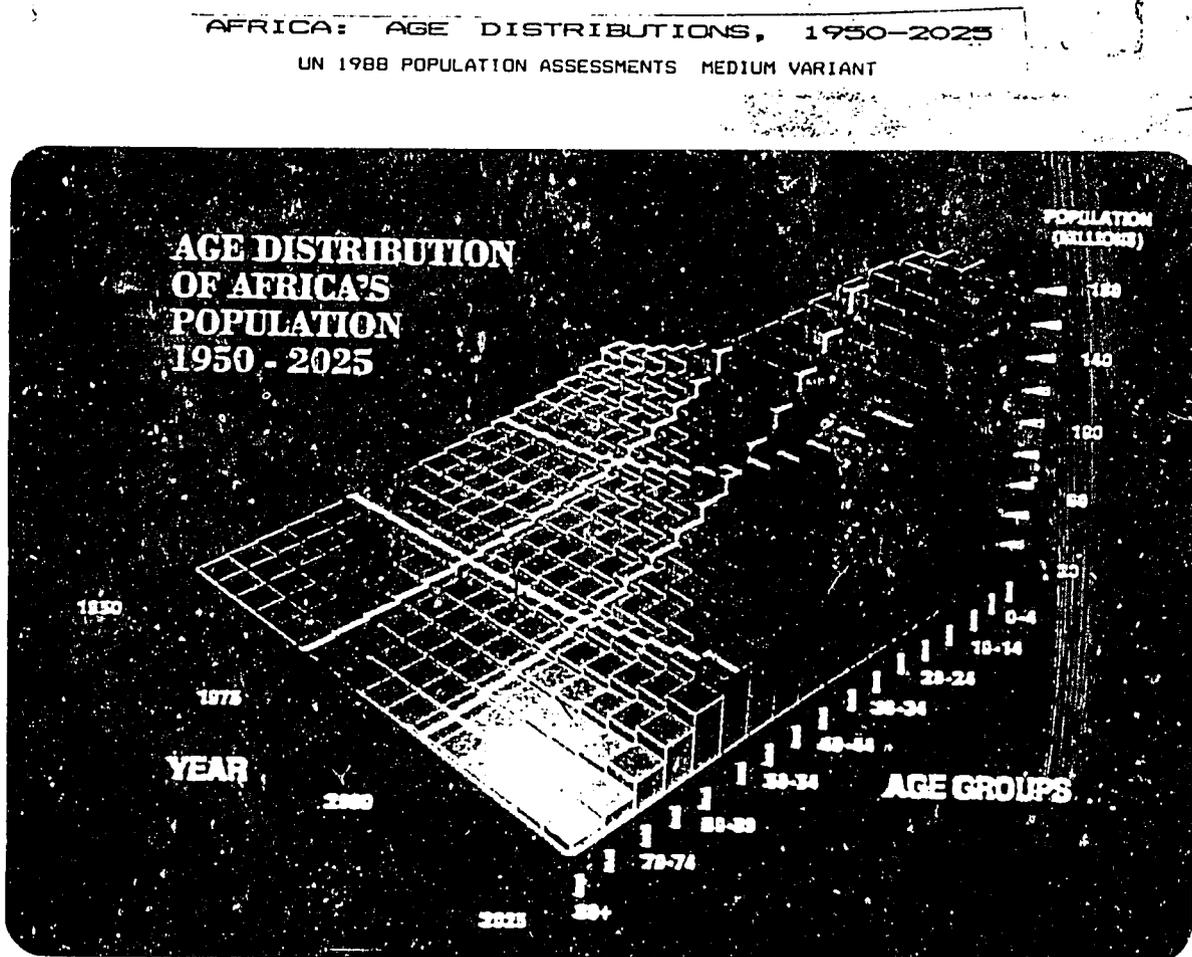


Projections, of course, are not predictions and many would argue that African economies and societies will not be able to sustain a doubling of today's 500 million population size in the short span of one generation or 25 years. In other words, either fertility must come down to give economic growth time to cope with the numbers or death rates will go up.

Additional perspectives on Africa's population dynamics are presented in the figures appearing in the margins.

Figure 3 depicts a three-dimensional view of Africa's population by age groups, 1950-2025. It highlights the projected surge in numbers of young people, most of whom will be consumers for many years before they are producers. Indeed, the economic dependency burden of so many young citizens is a major reason why saving for investment is negligible in most African states and why a vast share of disposable income goes for immediate consumption of essential life-supporting goods.

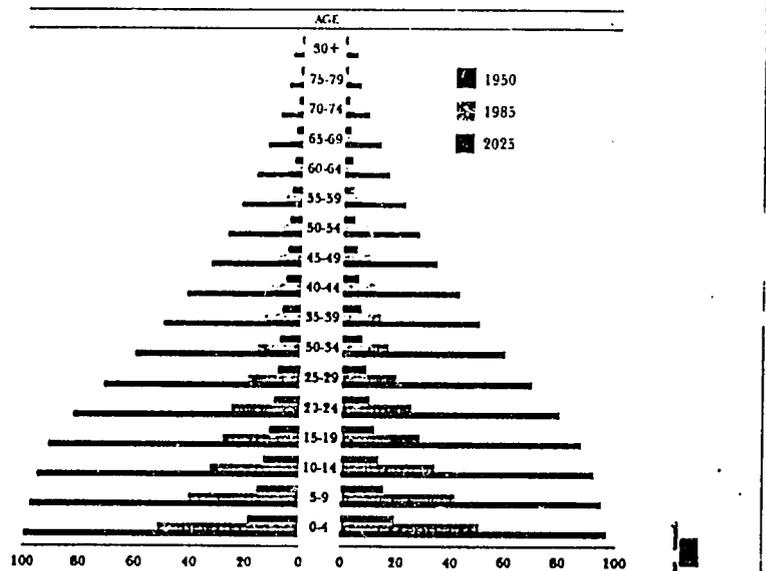
Figure 3
Population by Age Groups, Actual and Projected
1950-2025



And as these large numbers of young people begin their own families, they collectively will produce many more children than did the previous generation --even with a falling birth rate-- simply because of the dramatic increase in their own numbers. For example, in 1950 there were 10 million African females in the prime child-bearing ages of 20-24. By 1975, this number had increased to 18 million and will reach 38 million by the year 2000. Some 79 million African women in this age bracket are now projected for the year 2025.

Figure 4, Africa's "age-pyramid," shows the impact of young people entering the reproductive age.

Figure 4
Africa's Age Structure⁷



Meanwhile, mortality levels which are still high in parts of Africa are falling, particularly infant and child mortality. This offsets declines in birth rates producing a "tandem" relationship that is expected to persist into the early 21st century, thereby keeping the rate of natural increase steady and high.

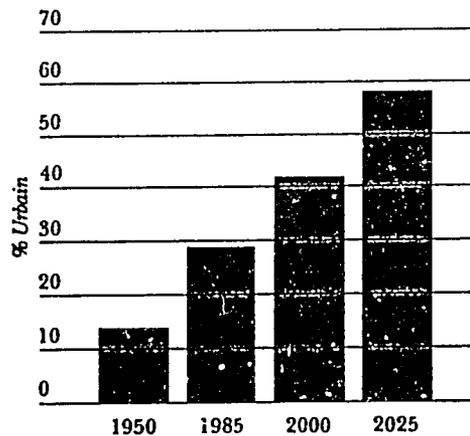
⁷ Pan African Conference of Parliamentarians, 1986. "Tendances Demographiques en Afrique," Harare, Zimbabwe. (Graphics prepared by the Population Reference Bureau, Washington, D.C.)

Rapid urbanization is another demographic characteristic of much of Africa and trends in the shift from rural to urban are shown in Figure 5. Most major cities today are experiencing severe strains in providing basic services, not to mention employment and housing to the unending stream of migrants who are either being forced off the land due to population pressures or who choose to move to cities anticipating a brighter economic future.

In the year 2025, it is projected that over 50 percent of Africans will be urban dwellers contrasted to about 25 percent today.

FIGURE 5⁸

PERCENTAGE URBAN, 1950-2025



The key demographic trends underlying Africa's population projections have limited possibilities for major adjustments in the decade of the 1990's. Because both birth and death rates are locked into very youthful age structures, at the close of the century virtually all nations in Africa will be experiencing high to extremely high rates of population growth. That assumes a continuing drop in the death rate which, however, increasingly will be dependent upon economic improvement. Conversely, if economies falter or collapse, death rates could rise, either gradually or dramatically.

⁸ Goliber, T. p. 27.

III. THE DEMAND FOR AND ACCESS TO FERTILITY REGULATION

Until very recently, it was commonly observed that Africa had some of the highest fertility rates on record, coupled with the lowest levels of contraceptive use in the world. While that generalization remains mostly true today, important changes have begun to take place as revealed by USAID-funded surveys conducted since 1986 in a large number of countries in Africa.

Table 1 shows the demand for family planning services in ten African countries as reported by women who either do not want another child now or who say they never want another child. Significantly, more than half report they want to postpone pregnancy now. In five countries, 24% to 52% said they wish to stop child-bearing completely.⁹

TABLE 1.

DEMAND FOR FAMILY PLANNING AS INDICATED BY PERCENT
OF WOMEN WHO DO NOT WANT A BABY NOW OR
WHO DO NOT WANT A FUTURE BIRTH

<u>Country</u>	<u>Not Now</u>	<u>Never</u>
Kenya	78%	52%
Burundi	77%	24%
Botswana	74%	38%
Togo	69%	25%
Zimbabwe	68%	33%
Ghana	68%	23%
Senegal	63%	19%
Uganda	56%	23%
Liberia	50%	17%
Mali	49%	17%

⁹ Brackett, James, 1989. "Demand For and Accessibility To Family Planning Services in Sub-Saharan Africa," a report prepared for the Bureau for Africa, Office of Health, Population and Nutrition, USAID, Washington, D.C.

When considering survey data such as these, however, it is important to remember that women alone do not make decisions about future fertility. Frequently, husbands, parents, in-laws, and peers have an equal or greater say in these vital matters.

A more important change, however, is the increase in actual use of modern contraceptives and the increase in knowledge about where one might obtain contraceptive services. Table 2 shows these changes in Botswana, Kenya, and Zimbabwe since 1984.¹⁰

TABLE 2.
CHANGES IN KNOWLEDGE OF CONTRACEPTIVE SOURCES,
CONTRACEPTIVE USE, AND CHILDBEARING PREFERENCES
IN BOTSWANA, KENYA, AND ZIMBABWE

	<u>MODERN CONTRACEPTION</u>		<u>WANT ANOTHER CHILD</u>	
	Know Source	Use Method	Never	Soon
<u>BOTSWANA</u>				
1984	57%	19%	30%	24%
1988	94%	32%	38%	24%
<u>KENYA</u>				
1984	48%	10%	32%	21%
1989	91%	18%	52%	13%
<u>ZIMBABWE</u>				
1984	80%	27%	24%	17%
1988	97%	36%	33%	8%

¹⁰ Brackett, James, 1989.

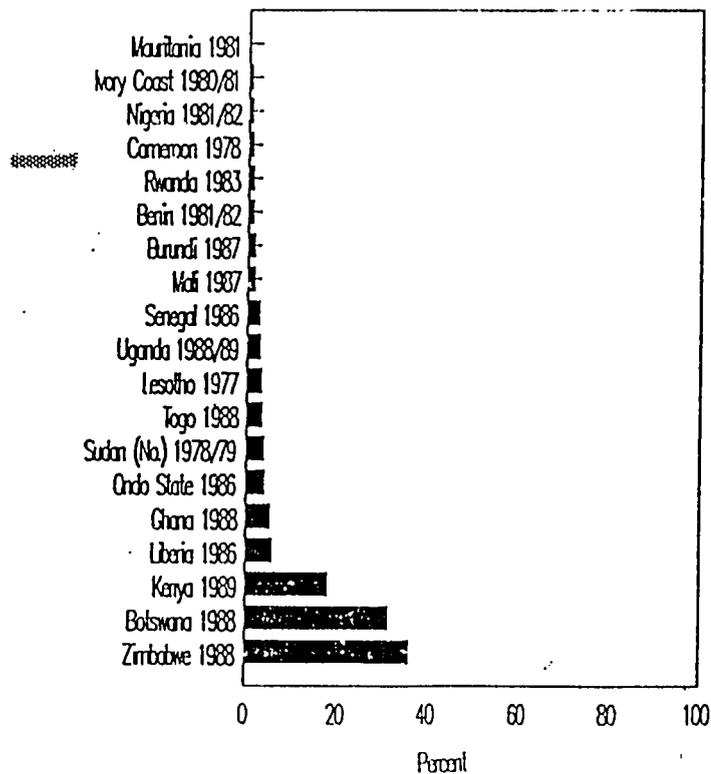
Zimbabwe has the highest level of modern contraceptive use in Africa and Botswana is close behind. At 36% and 32% respectively, they are about where countries like Thailand and Indonesia were in the beginning of the 1980's. Both of these East Asian countries experienced an explosive increase in contraceptive use during this decade. Meanwhile, Kenya seems poised to follow the Zimbabwe and Botswana experiences and local officials and donors alike are encouraged with this recent progress.

In sharp contrast to these recent developments are the levels of contraceptive use by women and men of reproductive age in Southern and West African countries. In Burundi, Lesotho and Rwanda, use rates are below 3%; in all of West Africa, no nation reports use rates above 6%.

Figure 6 shows a profile of contraceptive use in selected countries.¹¹

FIGURE 6

PERCENT OF CURRENTLY MARRIED WOMEN USING



¹¹ Demographic Health Surveys, Institute for Resource Development, Columbia, MD. These surveys were conducted under contract with the Office of Population, USAID, Washington, D.C.

ACCESSIBILITY OF FAMILY PLANNING SERVICES

The essential requirement of every family planning program is to ensure that contraceptive services are close at hand and accessible for the mass of the population. Accessibility to family planning and contraceptive services undoubtedly has improved markedly in the past decade as more African governments have agreed to offer family planning for either health or demographic reasons. Today, 39 of 45 governments support family planning for health reasons; 27 of 45 also support family planning for demographic reasons.

While many factors influence individual couples to adopt contraception, it is axiomatic that before they can do that, they must know about contraceptive methods and have access to reliable information, services, and supplies. "Access" often depends upon distance and the cost of getting there, and whereas people might be willing to travel a great distance and incur considerable expense to obtain a tubectomy or vasectomy or other long-term methods such as implants, they would be less inclined to do the same for pills or condoms which have to be replenished periodically.

Several countries with relatively well-established rural and urban health services have made family planning reasonably accessible to large portions of their reproductive age population. These include Kenya, Zimbabwe, Swaziland, and Botswana. Most other countries, however, have weak or non-existent public health outreach in either rural or urban areas. For example, knowledge of modern methods of family planning varies considerably across countries and generally reflects the level of family planning program development. In Zimbabwe and Botswana, only six percent know of no methods and nearly 80 percent know more than four methods. In Burundi, Liberia and Senegal where programs are at an earlier stage of development, roughly half of the eligible women know of no methods. In Mali, where there is no national family planning effort, nearly 80 percent of women do not know of any methods. This fundamental lack of knowledge is reflected in low levels of contraceptive use and is associated with high birth and population growth rates.¹²

In countries where the health infrastructure is weak, the concept of "community-based distribution" offers an alternative and has been introduced in some places so that contraceptive information and supplies can reach people in the absence of standard health services or in advance of their extension to new or remote areas.

¹² Demographic Health Surveys

Another promising approach to expanding accessibility and which is gaining a foothold in several African countries is "contraceptive social marketing" or "CSM." CSM means using the techniques of private sector marketing to promote use of a product or behavior for the general social good. USAID's contraceptive social marketing project, "SOMARC," currently is active in six African countries including Zimbabwe, Ghana, and Nigeria selling USAID-donated contraceptives at locally affordable prices. Social marketing programs take some of the pressure off the public sector to be all things to all people. If people are motivated, they do not object to paying for quality contraceptives that are conveniently available and reasonably priced.

Lessons learned

Among important lessons learned during USAID's 20-years of experience in assisting African family planning are:

- * moderate levels of contraceptive use i.e. 30% or more among reproductive age couples (as in Botswana and Zimbabwe), can be achieved without commensurate improvements in income, women's status, education, or reduced child mortality. Obviously, if improvements in these areas do take place, they would further enhance contraceptive acceptance, but they are not a precondition for that.

- * the provision of family planning services by both the public and private sectors works better than when undertaken by either one alone. The role of private voluntary organizations usually is a key element in extending services to people beyond the reach of limited government capabilities. Also, the private, commercial retail sector's sale of contraceptives needs to be encouraged (by removal of import restrictions, help in information and promotion campaigns, etc.)

- * it is essential to offer people choices of contraceptive methods that fit their particular needs at a specific time in life. Although providing a wider range of contraceptives compounds logistics management and increases staff training requirements, the extra effort is justified in recruiting and sustaining larger numbers of satisfied users.

- * both birth rates and "total fertility rates" decrease as the rate of prevalence of contraceptive use goes up.

- * no family planning program can succeed unless it puts contraceptive services close to the people in terms of actual distance, and in terms of cost, convenience and quality.

IV. USAID'S APPROACH IN AFRICA

A. Background

Assistance for reducing high population growth rates and high mortality rates is a priority activity for USAID in sub-Saharan Africa. It is a major focus of the Agency's bilateral efforts to boost economic growth and improve human welfare in the region.

In FY 1988, Congress established the Development Fund for Africa (DFA) to encourage more flexible development assistance tailored for African needs with an annual appropriation of \$500 million through FY 1990. Although the DFA carries no specific earmarks for sectors, the Congress emphasized the importance of population and health issues by stating the Agency should target the equivalent of ten percent each (of DFA) for health activities and voluntary family planning. Total investments during this three-year period are expected to reach \$370 million thereby assuring members of Congress and African leaders of the strength of USAID's commitment to family planning and public health. (Funding details are presented in Table 3, p. 18.)

B. The Policy Perspective

Prior to 1974, only Ghana, Kenya and Mauritius had national policies calling for reduced rates of population growth and expansion of family planning programs. By 1989, an additional four countries, Liberia, Nigeria, Senegal and Zambia had adopted official policies and four others, Rwanda, Sudan, Togo and Zaire had completed drafting them. Twelve other countries (Benin, Botswana, Burkina Faso, Cameroon, Chad, Madagascar, Niger, Sierra Leone, Swaziland, Tanzania, Uganda and Zimbabwe) have put the drafting of a population policy on the national agenda. Today, at least 31 African countries provide some direct support for family planning services.

Most countries, however, officially provide family planning services only as a health measure. Cultural patterns supporting large family sizes, the social security aspects of the extended family, tribal rivalries, customary law, and in some areas, vestiges of colonial policies continue to support high fertility. The latter include high customs duties and excise taxes on importing contraceptives and severe restrictions on contraceptive marketing, including mass media promotional and educational activities. Removal of these constraints should continue to be a topic for senior level policy dialogue until they no longer inhibit program implementation.

Nevertheless, few supporters of U.S. overseas assistance in family planning realize how much has recently been accomplished in the area of policy change in Africa. In Asia and Latin America, the policy change process occurred over several decades. In Africa today, parliamentarians, political leaders, senior civil servants, academics and professionals have forged strong links internally and internationally to promote family planning and public health mostly within the past five years. As a result, assistance for population and family planning programs is a significant part of our bilateral assistance and the assistance efforts of other bilateral and international donors.

C. The Health and Economic Rationale

There is a powerful health rationale for using contraception that, when fully explained, has greatly helped to persuade hesitant local political leaders to support family planning. That rationale focuses on reducing "high risk" births, i.e. births which are less than two years apart, that occur to women less than 18 and over 35 years of age, and births to women who have had four or more pregnancies.

In all societies and not just in developing countries (because it is a biological and not a social phenomenon), if high risk births are reduced, then infant, child and maternal mortality rates also will be reduced. Research in many countries has repeatedly demonstrated that longer birth intervals reduce infant mortality by as much as ten percent and child mortality by up to 21 percent. If women at high risk avoid child-bearing, about one-half of all maternal mortality could be avoided. When added to other child survival interventions such as immunizations, child spacing has a synergistic benefit on the survival and health of African mothers and children.

For many who have traveled in Africa recently, the reply, "It's too expensive" frequently is heard from taxi drivers and others when asked, "Why don't you want more children?" With average completed family sizes ranging from six to eight children in all but South Africa, dependency burdens for child-rearing and education often exceed sustainable levels. Individual family welfare could be improved measurably in the near-term through reduced fertility by increasing the share of disposable income available for each person which in turn could be reflected in improved nutrition, better and longer education, and household savings.

On the macro economic front, 30 years of research examining the relationship between economic development and population growth has produced a professional consensus that in most developing

countries and certainly in the most rapidly growing ones, slower population growth benefits economic development. The 1986 National Academy of Sciences report on this topic, for example, fully described the inverse relationships between rapid population growth and child health and survival, quality and duration of education, agricultural productivity and more equitable income distribution. These findings and views are increasingly reflected in economic development and population policy statements by African leaders.

D. ELEMENTS OF USAID-ASSISTED FAMILY PLANNING PROGRAMS

USAID's more than 20 years of worldwide experience in the population/family planning field have demonstrated that successful programs have the following elements:

- o Policy Development - Working with host governments to develop national policies to slow population growth rates and improve maternal and child health.

- o Information, Education and Communication (IEC) - Assisting host governments and local institutions in research, design, testing, and production of multimedia IEC materials and activities for clinics, schools, community and women's groups. (These same channels are being used to educate people on how to prevent HIV/AIDS transmission.)

- o Service Delivery - Providing a choice of safe, effective and affordable contraception with appropriate counseling, particularly to women in high risk categories. These are women who, if they had another pregnancy soon, might jeopardize their own health or the health of a newborn or a young infant in the family. Assuring a continuous supply of contraceptives is a central part of supporting sound service delivery.

- o Training - Training and re-training is an ongoing activity for both clinic and non-clinic personnel.

- o Research and Evaluation - Operations research and evaluation determine program effectiveness and provide insights on how to improve services, education programs, training and logistics.

Obviously, individual country support packages must be tailored to meet specific needs, fit available resources, consider political realities and mesh with other donor activities. Consequently, USAID would not necessarily support all of the program elements above but typically a selected few where we, as one of several donors, have a comparative advantage.

U.S. government support for family planning is channeled through two accounts within the Agency: (1) the Agency's geographic Bureau for Africa and its "Development Fund for Africa" which supports USAID Mission-based population programs, and (2) the Office of Population in the central Bureau for Science and Technology which funds U.S.-based contractors and cooperating agencies. Much of what has been achieved in African population and family programs to date has been initiated through central Office of Population-funded programs. Typically, small projects implemented through cooperating agencies test new approaches and evolve into USAID Mission-based programs. The latter usually continue to include continuing cooperating agency or contractor technical assistance.

New Program Emphasis

Within the framework of key program elements above, the Bureau for Africa and its Missions abroad have agreed that a central theme in all of our project activities is to increase the accessibility and availability of contraceptive services. By working with both public and private sectors, the objective is to provide access to a wide selection of contraceptive methods through a client-oriented service delivery system that is appropriate for all age and parity groups. In practice, this translates to :

1. Eliminating Barriers: In bilateral and other negotiations, seek to eliminate legal, logistical and administrative barriers to mounting more effective family planning programs. Import restrictions and duties on contraceptives are one example; restrictions on mass media promotion and advertising are another; artificially low government-controlled price-setting on contraceptives is a third.
2. Promoting More Effective Methods: Encourage a shift from less to more effective methods including IUDs, voluntary surgical contraception, and implants. To accomplish this, specialized training programs have to be mounted.
3. Promote Social Marketing: Give priority to accelerating the extension of contraceptive social marketing programs wherein existing commercial retail distributors add contraceptives to their product lines in return for an appropriate markup. Contraceptive commodities at the outset would be provided by USAID at no cost to the country. Additional income from sales typically would support program operations including advertising, promotion, and local staff salaries. Social marketing holds the promise of vastly increasing access to quality contraception in the continued absence of health service outreach or in advance of future health services expansion.

4. Promoting the Private Sector: Devise ways to utilize the private sector's existing retail distribution apparatus to expand the accessibility of non-subsidized but affordable contraceptives. Build upon the experience gained in social marketing wherever possible. Expand the availability of non-clinical contraceptives in commercial, industrial, and other organizations for workers and their spouses. Phase out free distribution of contraceptives in favor of partial cost recovery now and ultimately, full or nearly full cost recovery.

5. IEC: Continue support for public information, education, and communications on contraceptive safety, benefits, and availability. USAID and its contractors have a distinct, worldwide comparative advantage in IEC activities and it is an area where our assistance can be highly effective.

6. New Contraceptive Technology: Prepare the groundwork now with host governments and other local organizations to speed the adoption of Norplant and other injectables which are expected to receive approval from the U.S. Food and Drug Administration soon. Many Africans equate injections with high-quality or "strong" medicine and clinical trials have demonstrated the injectable's acceptability. In addition to their popularity, long-acting injectables overcome many of the organizational and logistical obstacles associated with inadequate health infrastructures.

E. RELATIONSHIPS WITH OTHER DONORS

USAID has been the leading financial and technical supporter of population and family planning programs in Africa since the mid-1970's. Today, our financial support continues to rank first, but other organizations, notably the U.N. Population Fund followed by the International Planned Parenthood Federation and the World Bank are also major contributors. Coordination with these organizations is regularly carried out both at headquarters levels and in the field. In the latter instance, host governments increasingly are assuming the role of principal coordinator of external assistance, a trend we welcome and one which USAID institutional support is designed to strengthen.

Table 3 shows USAID and other donor funding.

Table 3
Population Funding for Africa Region By Source
And Year Of Obligation (\$Millions)

	<u>USAID</u>				
	FY 86 Actual	FY 87 Actual	FY 88 Actual	FY 89 Actual	FY 90 Planned
DA/DFA	\$26	\$34	\$37*	\$34*	\$37
SAHEL	\$15	\$ 4	0	0	0
S&T/POP	\$49	\$29	\$27	\$31*	\$27
TOTAL USAID	\$90	\$67	\$64	\$65	\$64
	<u>OTHER DONORS</u>				
UNFPA	\$27	\$23	\$28 est	NA	NA
IPPF	\$11	\$12	\$12 est	NA	NA
WORLD BANK	\$13	\$ 2	\$ 3	NA	NA
TOTAL OTHER	\$51	\$37	\$43 est	NA	NA
GRAND TOTAL	\$141	\$104	\$107	NA	NA
USAID as % of Total DONORS	64%	64%	60%		

* Needs confirmation

V. CONCLUSIONS AND OUTSTANDING ISSUES

Africa today is experiencing the world's highest rate of population growth, some seven times greater than found in developed countries. The region's population of 504 million promises to double in size in just one generation or 25 years. This unprecedented and rapid growth in human numbers will severely strain the region's environmental base and debt-ridden economies at a time when difficult structural reforms in the direction of moving toward market economies also will need to be implemented. Whether African societies and economies can sustain such a doubling in such a short span of time is uncertain and, some would say, doubtful.

Because half of the region's population is under 20 years of age, the parents of the next generation are already born--they are today's children. Even if they have considerably fewer children when they begin childbearing than did their parents, populations would still grow simply because the number of reproductive-age people will increase so dramatically.

This demographic reality will severely restrict opportunities to influence population events in the short term. At the same time, it provides an even stronger argument to vigorously pursue family planning activities in the immediate years ahead, building upon recent encouraging developments. Real progress in fertility reduction has occurred and has been fully documented in Zimbabwe, Kenya, Botswana and Swaziland. In these countries, completed family size has decreased by one child or more (from a high of seven or eight children) in only four or five years. In the same four countries, the prevalence of contraceptive use has climbed impressively and may mirror similar developments in East Asia ten years ago when levels of contraceptive use there rose robustly. One could speculate that similar fertility changes have occurred elsewhere, but survey or other evidence to verify that is lacking.

At the same time, survey data (non-existent two-to-four years ago) tell us that the demand for fertility limitation either for the purpose of spacing or preventing future births greatly exceeds current levels of contraceptive use. Significantly, in nine countries with recent surveys, more than half the women said they did not want a pregnancy now. In seven of those countries, 23 to 52 percent of women reported they wanted no more children at all, but with few exceptions, less than six percent used contraception. This raises obvious questions of why this great disparity exists between desire and practice, and leads to the final discussion of issues and constraints and USAID's approach to them which follows.

Issues and Constraints

Key among many obstacles is the lack of accessibility to quality contraceptive services-- due either to distance, price, or plain availability. This is one area where external donor assistance can make a difference and improving accessibility and availability have been given high priority in the Bureau for Africa population/family planning program. To promote this, we have decided to concentrate on working with our host-country counterparts toward:

1. Eliminating barriers to the import and distribution of modern contraceptives.

2. Promoting use of more effective methods including IUDs, voluntary surgical contraception and long-acting implants or injections.

3. Providing vigorous support for contraceptive social marketing in countries where health services are weak or non-existent.

4. In tandem with social marketing, promote private commercial sector involvement in both general retailing of contraceptives and their distribution within larger commercial enterprises to employees and spouses.

5. Continuing support for information, education and communication campaigns to explain the safety, benefits and availability of modern contraceptives.

6. Assisting host governments and local organizations to speed the adoption of "Norplant" and other long-acting injectables which are expected to receive U.S. FDA approval soon.

Other obstacles less amenable to change regardless of donor support include:

o A high demand for children reinforced by culture and tradition

o The relatively low status of women perpetuated by low educational attainment and illiteracy

o A limited understanding of human reproduction

- o Limited knowledge of contraceptives
- o Lack of strong political commitment to providing family planning
- o Weak health service facilities, lack of trained staff and inadequate public health budgets

Organized population and family planning programs, by themselves, cannot be expected to address all of these constraints effectively. Instead, changes in the social status of women and educational and income levels of young people depend on other forces operating in the society. Strengthening public health services and providing staff training are long-term objectives supported by USAID's health program in cooperation with other major donors including the UNFPA, UNICEF, the several Nordic countries, the World Bank and WHO.

The extent to which these additional forces are harnessed toward slowing population growth will be a net gain to sub-Saharan countries. Meanwhile, the challenge of trying to slow and cope with Africa's extraordinary and immediate population growth is both sobering and urgent.

NOTE: The previous sections are intended to "stand alone" as a self-contained report. The preceding portions and the following sections pp. 23-38 comprise the full report.

VI. TRENDS IN CONTRACEPTIVE USE AND PROJECTED COSTS

A. Dimensions of Demand

As a result of USAID-funded surveys, particularly from 1984 to the present, and because of the technical assistance on commodity management provided by the Agency's Office of Population in recent years, more is known about current and potential contraceptive demand in Africa today than ever before. A hypothetical dimension of contraceptive demand is the number of women of reproductive age (WRA) in Africa and the increase in their numbers over the next several decades. In the 20-year period between 1990 and 2010, for example, Africa's reproductive age female population of approximately 120 million will slightly more than double to 250 million or so. (Because most of these women have already been born, one can have a reasonable degree of confidence in this estimate. The future course of mortality, especially for the 0-5 year age group, however, remains an unknown.)*

Another indicator and tending toward a more realistic assessment of potential demand is obtained from survey data as a result of asking women if they intend to postpone another pregnancy or whether they prefer to cease child-bearing altogether. These data were depicted in Table 1 earlier. In ten countries, more than half said they wanted to postpone pregnancy now and in five countries, 24% to 52% said they wanted to stop child-bearing completely.

But we are aware of the very large gap between expressed desire to postpone pregnancy and actual prevalence of contraceptive use among reproductive age women and men. In most of Africa, contraceptive prevalence today is only three to four percent. When projecting future contraceptive demand, therefore, it is by far more prudent as well as more realistic to begin with current use or with data showing changes in total use and method mix between recent surveys. Even in countries with moderately vigorous family planning programs (and in Africa today, only a few programs could be labeled "moderately vigorous"), the prevalence of contraceptive use increases only a percentage point or two annually. Exceptions are worth noting, however, and these include Botswana where contraceptive prevalence recently has increased by 3.25% a year, Zimbabwe by 2.25% and Kenya by 1.6% a year.

*Estimates are based on a mid-year 1989 population size of 504 million, a rate of natural increase of 2.9% annually, and women of reproductive age calculated at 23% of the total population.

For a continent-wide perspective on the anticipated increase in the number of women of reproductive age between 1990 and the year 2010 and an illustrative number of contraceptive users at varying rates of contraceptive prevalence, see Table 4 below:

Table 4
Illustrative Total Numbers of Women of Reproductive Age
and Contraceptive Users in 1990, 2000 and 2010
at Different Prevalence Rates of Contraceptive Use
(In millions of women)

Year	Total WRA	Number	No. of Contraceptive Users with following percentages of WRA using		
			5%	10%	20%
1990	120	6	12	24	
2000	180	9	18	36	
2010	250	12.5	25	50	

B. Contraceptive Method Mix

On a global basis, if socio-economic conditions improve and urbanization proceeds as expected, we can anticipate a rise in the general demand for family planning services. Also, a greater proportion of users will be relying on family planning for limiting rather than spacing births. Overall, these trends will

modify the profile of the contraceptive method mix resulting in shifts to more effective and terminal methods.¹ Without question, the urbanization factor will continue to operate in Africa in the future; whether socio-economic conditions improve quickly or markedly, however, is more problematic.

On the near horizon are two injectable contraceptives, the Norplant five-year injectable and the Net 90, a 90-day injectable. USFDA approval of both is anticipated in 1990 after which USAID and other donors will be prepared to add these to the supply of contraceptive commodities donated to African nations. (Whether they will enter the commercial retail market is unknown at this time, but one can imagine that eventually they will be available from private physicians and possibly pharmacies.) Given the popularity of injections in Africa, it is reasonable to anticipate a robust demand for these two products, but quantifying that now is difficult.

Past experience normally would provide insights into the shape of future demand, but it is difficult to do analyses of the method mix when only two or three percent of the reproductive age group use contraceptives. For example, the method mix in a population with minimal use may not have any bearing on the mix that will emerge as family planning programs become more widespread and effective. By examining use patterns in countries with five percent or greater prevalence of contraceptive use, some preliminary patterns emerge, but they are not well enough established so that projections could be based on them.

Table 5 below shows use patterns in six countries. It should be noted that the Botswana, Kenya and Swaziland programs have a well-balanced mix of the more effective methods.

¹ Gillespie, D., Cross, H., Crowley, J. and Radloff, S., 1988, "Financing the Delivery of Contraceptives: The Challenge of the Next Twenty Years," Office of Population, USAID, Washington, D.C.

TABLE 5

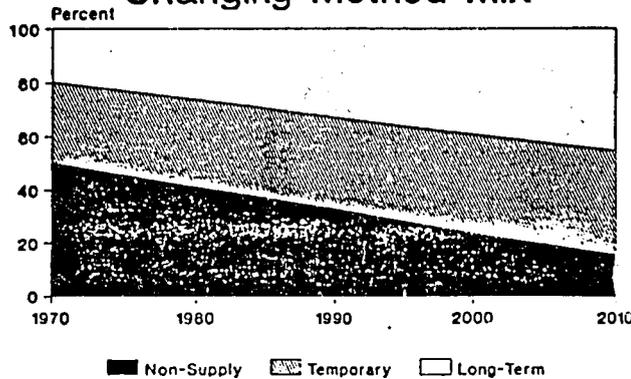
Current Use of Modern Contraceptives
In Six African Countries, By Method²

Country	Year	% Using Modern Methods*	Pill	IUD	Inj	Vaginal	Condom	Steril
Zimbabwe	1988	36%	31%	1%	0%	0%	1%	2%
Botswana	1988	32%	15%	6%	6%	0%	1%	4%
Kenya	1989	18%	5%	4%	3%	0%	1%	5%
Swaziland	1988	15%	5%	2%	5%	0%	1%	2%
Liberia	1986	6%	3%	1%	0%	0%	0%	1%
Ghana	1988	5%	2%	1%	0%	1%	0%	1%

* Total % may not equal sum of methods due to rounding.

Globally, USAID's Office of Population projects changes in the method mix, favoring long-term and permanent methods as shown in Figure 7.³

Figure 7
Changing Method Mix



² Demographic Health Surveys, Institute for Resource Development, Columbia, MD. Swaziland data are from the Swaziland Family Health Survey, 1988.

³ Gillespie, D. et al, p. 10.

C. Contraceptive Commodity Shipments

In Fiscal Years 1987, 1988 and 1989, USAID purchased and shipped the following contraceptive quantities to Africa:

Table 6

USAID Contraceptive Commodity Shipments
To African Countries, FY 1987, 1988 and FY 1989⁴

	Pills	IUDs	Condoms	Foam	Total Value
FY 1987	6.8 mil cycles	166,000	19.5 mil pcs	6.2 mil tabs	\$2.4
FY 1988	15.1 mil cycles	294,000	78 mil pcs	6.3 mil tabs	\$6.5 mil
FY 1989	18.6 mil cycles	263,000	105 mil pcs	8.5 mil tabs	\$7.9 mil

D. Projecting Contraceptive Requirements

Because levels of use are so low in the majority of African countries, no formulas emerge with which to reliably project longer-term needs. Instead, the past and current year's consumption of contraceptives offers the best indicator for the following year's requirement. The Agency's Family Planning Logistics Management Project, now in its third year, provides technical assistance to each USAID-assisted family planning

⁴ USAID Office of Population, Commodity Procurement and Support Division

program and works with host government officials and Mission staff annually to prepare contraceptive procurement tables. This task, which also includes analysis of inventory in the country, provides reasonable assurance that shortages will not occur in the forthcoming year and that adequate supplies will be on hand even in cases of unexpected increases in demand. As a general rule, the logistics management guidelines are designed to maintain at least a 12 month's supply of contraceptives in the country.

Another perspective on future requirements can be obtained by regarding the more rapidly expanding programs as "sentinel programs." This means that patterns established by the leading family planning programs likely will be followed some years later by newer programs as they, too, mature. In a sense, this can serve as an "early warning system" and help managers anticipate future needs.

E. The Future Cost of Contraceptives

In the short-term, i.e. two-to-three years, and given the nascent stage which characterizes most African family programs, it is feasible that USAID can continue to support its share of externally-donated contraceptive commodities by increasing the budget for that purpose by approximately 25 percent each year. Using \$8.0 million as a base which approximates FY 1989 costs, funding increases of 25 percent per year would produce the following budgets:

Table 7

Actual and Projected Future Contraceptive Costs

For USAID-Provided Commodities to Africa

Fiscal Years 1989-1992

FY 1989	\$ 8.0 million
FY 1990	\$10.0 million
FY 1991	\$12.5 million
FY 1992	\$15.6 million

The Bureau for Africa and its USAID Missions, using the DFA account and supplemented by the central Office of Population, fully intend to provide an expanding quantity of contraceptive commodities for national African family planning programs during the years ahead.

VII. PRIVATE SECTOR INITIATIVES: MARKETS, CONSTRAINTS AND INCENTIVES

The explosive growth in the numbers of reproductive-age women and men in Africa in the next two decades is central to considering the potential market for private sector promotion and sale of contraceptives. The total number of women (and also couples) of reproductive age will more than double between 1990 and the year 2010, expanding from 120 million to an estimated 250 million in this period. Table 4 (p. 24) profiled this increase and provided illustrations of the potential numbers of contraceptive users at different levels of prevalence.

Within the context of these numbers, it quickly becomes apparent that the government-managed, external donor-funded family planning programs by themselves will not be able to mount the massive education, promotion and distribution efforts that will be needed if contraceptive acceptance is to increase quickly. Instead, private sector resources must be encouraged to enter the arena if this task is to be accomplished. This also means that creative partnerships between the public and private sectors will have to be established to serve the larger public good.

A. Constraints to Expansion

Regardless how sensible these concepts of greater private sector involvement in family planning may appear, it is essential to examine some of the leading constraints which must be overcome before such involvement can become a reality. During the course of preparing this report, interviews were conducted with manufacturers, pharmaceutical distributors and suppliers working in African countries. Key observations emerging from these discussions included:⁵

- o There is a widespread lack of knowledge about basic human reproduction which makes acceptance of contraception more difficult.

⁵ Roth, Alan D., 1989. "The Private Sector Contraceptive Market in Africa: Reducing Barriers to Expansion," a report prepared for the Bureau for Africa, Office of Health, Population and Nutrition.

- o Biases against contraceptive use are frequently held by African males who, in general, consider it a matter of virility to have many children and who feel that contraceptive use denies them the chance to demonstrate their manhood.

- o The lack of knowledge about family planning among the general public is so extensive that the private sector feels it must wait until governments or non-governmental organizations (NGOs) manage to increase public awareness. This, they said, is a prerequisite before they can attract enough customers to buy their products and make it financially worthwhile.

- o Poverty is so severe and so extensive that not enough Africans can afford to buy contraceptives at regular commercial prices. In fact, staff of USAID's social marketing contractor, SOMARC, report that many African countries are not yet ready for subsidized social marketing of contraceptives, let alone full commercial marketing. Other distributors observed that the lack of a significant middle class in Africa means that the commercial market will be limited to serving the urban elite for some time to come.

- o Government regulations imposing tariffs, requiring product registration, demanding official inspections before shipment and the issuance of import licenses often present formidable obstacles and always are time-consuming to master. For example, some governments view contraceptives as luxury items and tax them accordingly; in others, import licenses can take a year or more to obtain.

- o The lack of foreign exchange was cited by several distributors as the most critical problem preventing them from expanding their markets in Africa. In some countries, the possibilities of obtaining foreign exchange were so slight that distributors chose to ignore those countries entirely.

- o Local government access to donor-supplied and donated contraceptives typically means that finance ministries will not allocate scarce foreign exchange for the commercial contraceptive market.

B. Social Marketing vs. Full Commercial Sales

One of the most complex issues lies in the relationship between social marketing and full commercial sales. The objective of USAID-sponsored social marketing programs has been to sell contraceptives at below market prices while using sales income to support promotion, local salaries, transportation and advertising costs. Typically, USAID donates the contraceptives free of charge. In countries where incomes are low, where health services are weak and contraceptive use is minimal, this strategy makes obvious good sense.

A number of private distributors contacted for this report, however, were critical of the social marketing program for entering the marketplace with subsidized products and taking market share away from them. Social marketing advocates, on the other hand, argue that their objective is to attract new contraceptors rather than take customers away from established distributors. Further, they claim that they target customers who would not be able to afford commercially available products or who physically do not have access to them because retail outlets simply are not stocked with contraceptives or do not exist at all.

In Africa, most experienced observers acknowledge that the current market is so small that for now, conflict between the private and social marketing forces is more hypothetical than real. At the same time, it is recognized that ultimately, the private sector will have to participate in contraceptive sales on a large scale if family planning is to succeed. With that in mind, USAID-supported contraceptive social marketing programs have indicated their willingness to assist the entry and expansion of the commercial sector by consciously supporting the following kinds of activities:

- o Conducting market research
- o Funding generic advertising and promotion
- o Training retailers and distributor staff
- o Exercising care to leave room in the market for unsubsidized, commercial products
- o Educating government officials about the value of an expanded commercial contraceptive distribution activity
- o Working toward removal of barriers such as import taxes and seeking easier registration procedures for contraceptive products

C. USAID Actions to Support Private Sector Expansion

To facilitate a greater role for the private, commercial sector in providing contraceptives in Africa, USAID supports the following actions:

1. Whenever and wherever possible, phase out the free distribution of USAID-provided contraceptives from government clinics and other outlets so that people will become accustomed to paying at least partially for the cost of contraceptive services. Despite the extent of very genuine poverty, the widespread use of disposable income for items such as soft drinks, cigarettes and alcohol suggests that consumers also can afford modest amounts for quality contraception.

2. Increasing family planning education for government officials and the population as whole.

3. Seeking a reduction or elimination of government controls that impede commercial activities and increase their costs. These include price controls, tariffs, licensing and registration delays, inspection requirements and restrictions on advertising.

4. Facilitate access to foreign exchange by including contraceptives in commodity import programs. Another approach would involve reaching agreement with the host government to set up a ratio of donor-supplied contraceptives versus those purchased privately with allocated foreign exchange.

5. Assess the training needs of the for-profit commercial sector and engage contractor assistance to provide this training. Assist with feasibility studies of the potential for commercial retail sales where appropriate.

6. Identify five or so countries in Africa that are the most advanced in terms of levels of contraceptive use and government support of family planning. In these countries, examine the existence of constraints described above to expansion of full commercial marketing of contraceptives. These analyses would be followed by an action plan to reduce or eliminate those constraints.

7. Undertake a study of the dynamics of the contraceptive marketplace to better understand the effects of social marketing on full commercial sales. Also, examine the impact of packaging, pricing and promotion strategies.

A public and private sector partnership has the potential to greatly advance the use of modern contraception in Africa. A careful nurturing of such an arrangement in the immediate years ahead promises to pay major dividends for individual health and national development in the future.

VIII. TRENDS IN COUNTRY AND DONOR FINANCING

A. BACKGROUND

The U.S Government has been the major donor to international family planning programs for the past two decades, and U.S. institutions provide the largest cadre of experienced population specialists in developing countries worldwide. During the past several years, USAID has provided approximately 60 percent of all donor funding for population and family planning programs in Africa.¹

Current demands for family planning services and commodities, however, exceed resources available through USAID, and because the demand for services continues to increase, additional donor support will continue to be needed in the future. Toward this end, the Bureau for Africa intends to strengthen links with other bilateral and multilateral donors at headquarters level, while Mission Directors and field technical personnel continue to pursue dialogues with bilateral and multilateral donors in order to coordinate resources more effectively at the country level.

B. LOCAL LEVEL FUNDING FOR FAMILY PLANNING

A perspective on local funding for family planning can be gained by first examining the status of general health funding within a typical African country. In 1988, WHO documented that 90 percent of 29 reporting African countries were spending less than five percent of GNP on public sector health activities.² This reality places all health expenditures near the bottom of the hierarchy of government budgeting. Because curative services often absorb 65 to 80 percent of these already small health budgets and preventive activities typically receive less than 10 percent, it is evident that the portion going directly to family planning is considerably less. And because most countries do not disaggregate family planning expenditures from broader categories of maternal-child health or primary health care, it is not possible to have a

¹ USAID, Population and Family Planning: Strategy for Assistance in Africa, September, 1988. p.11.

² An Assessment of Donor Coordination and External Financial Mobilization for Health, Population and Nutrition in Sub-Saharan Africa, Lee M. Howard, MD, DrPH, 1989.

precise fix on family planning budgets except to say that they are modest indeed.

While an international consensus on health program goals was largely achieved during the past ten years, major economic crises inflation, debt and famine have worked to constrain progress toward reduction of African population growth and disease incidence. Despite these economic setbacks, the Agency is actively promoting both the concept and practice of self-sufficiency and sustainability of key project inputs. For example, USAID has begun to increasingly emphasize the use of national resources for health care financing. Studies and program support are based on the economic reality that, in the long term, developing countries must finance their own public sector programs. This leads to a focus on testing new financing methods such as cost recovery (either full or partial), self-financing, private enterprise, fee-for-service and various insurance schemes. In current USAID program strategies, the term "Health Care Financing" refers predominantly to this dimension of support for national financing.

C. DONOR FUNDING AND COORDINATION

External concessional funding from all donors to sub-Saharan African countries for all purposes has increased in current dollars from \$10 billion in 1981 to \$16 billion in 1987. Of these total development aid flows to Africa, about four percent of disbursements go to the health sector including population and family planning. USAID's share of all donor funding for health purposes was nearly 16 percent and represented 26 percent of all bilateral health, population and nutrition assistance, the largest among bilateral contributions.³

At a general macro-economic level, donor coordination is receiving major attention both in Africa and through international mechanisms such as DAC/OECD. By contrast, although mechanisms for sectoral health, population and nutrition coordination have been less formal, they nevertheless operate at both the headquarters and country level. Frequently, "donor coordination" encompasses cooperation among regional and country resident donor representatives who are involved with support to a specific project.

Opinions vary about the effectiveness of donor coordination at the country level. Some say it is quite good (often in smaller countries with fewer donors); others say it is good enough and

³ Howard, p.vi.

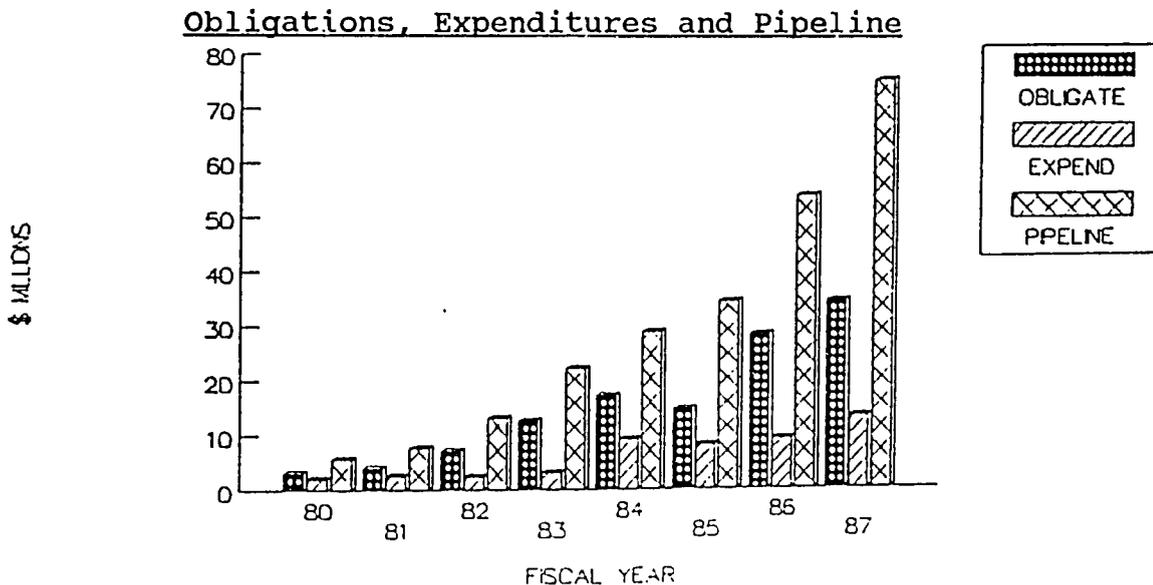
improving it in any major way would not be worth the time and effort; still others claim that it is poor and results in a duplicative, sometimes wasteful and inefficient use of resources. A major missing element, almost all agree, is the frequent inability of health ministry planning staffs to manage the coordination process which means that instead of requesting donor assistance for planned activities, they often are reacting to donors advocating new projects.

A dilemma results from the inability of planning bodies and health ministries to better articulate their needs: interviews conducted this year by a Bureau for Africa consultant with 21 development financing sources and with officials in Africa confirmed that the existing donor funding potential is not being fully exploited and that the articulated demand in the form of proposals to donors is far short of the potential supply of available financing.⁴

When situations such as the above are coupled with limited absorptive capacity (in terms of trained managers, technical staff and ability to exercise financial control), the issue of demand for and supply of aid becomes even more opaque. Although most will agree that over the long run, concessional assistance for population and family planning should increase, we must also be prepared to adjust resource transfer levels to keep "pipelines" (i.e. funds that are obligated but unspent) manageable.

Figure 8 below shows the pipeline as of May 1989 for family planning assistance to African countries from USAID.

Figure 8



⁴ Howard, p. 27.

While it is not unusual for annual obligations to exceed expenditures in the early years of program support, when the pipeline begins to reach double the annual obligation amount and almost five times the expenditure rate, careful monitoring is necessary.

At the same time, it must be recognized that a \$75 million pipeline to support family planning on a continent of more than 500 million people, including 120 million couples of reproductive age, is not excessive. Also, as pro-family planning policies are translated into action, sums such as these will draw down quickly even if the implementing ministries and organizations are beset with inefficiencies.

Figure 9 depicts funding by country, FY 88-90.

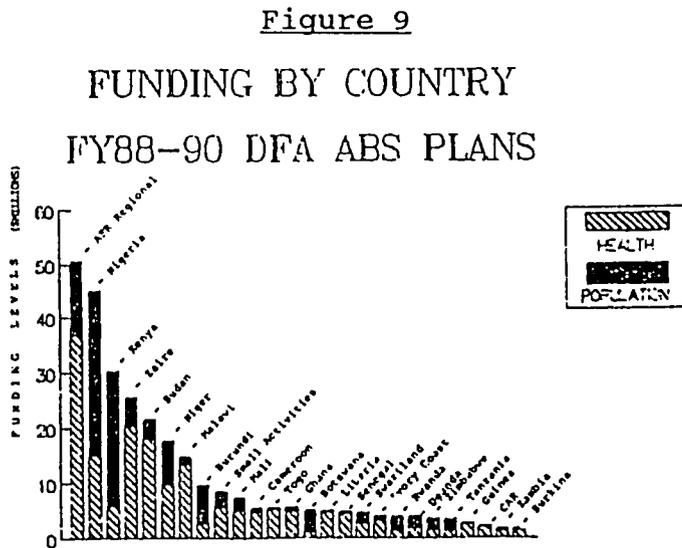


Table 8 recaps donor funding for population/family planning from FY 85 through FY 90.

	USAID				
	FY 86 Actual	FY 87 Actual	FY 88 Actual	FY 89 Actual	FY 90 Planned
DA/DFA	\$26	\$34	\$37*	\$34*	\$37
SAHEL	\$15	\$ 4	0	0	0
S&T/POP	\$49	\$29	\$27	\$31*	\$27
TOTAL USAID	\$90	\$67	\$64	\$65	\$64
	OTHER DONORS				
UNFPA	\$27	\$23	\$28 est	NA	NA
IPPF	\$11	\$12	\$12 est	NA	NA
WORLD BANK	\$13	\$ 2	\$ 3	NA	NA
TOTAL OTHER	\$51	\$37	\$43 est	NA	NA
GRAND TOTAL	\$141	\$104	\$107	NA	NA
USAID as % of Total DONORS	64%	64%	60%		

* Needs confirmation

D. FUTURE PROGRAM SUPPORT

There will always be a clear need for public sector support for promoting public health, including family planning. Much of the impetus for improving family planning and public health systems in Africa now comes from external assistance and will continue to come from that source as long as local economies are performing poorly or are in disarray.

Ultimately, most of the costs for providing family planning services will have to be borne by the host country's own public and private sectors. During the immediate years ahead, however, it seems reasonable to accept projections of family planning program costs which suggest that 60 percent or so of program costs initially will have to be supported by external donors, with the U.S. share covering roughly one-half of that or more. Of the remaining 40 percent which is non-donor financed, perhaps one-half of the costs could be borne by the host country government with the private sector paying an equal share.

As programs expand and total costs grow, we collectively must focus on establishing partial or even full cost-recovery mechanisms to increase program sustainability. Accomplishing this will ensure that family planning is increasingly controlled by local processes, and that it becomes a "beneficiary" of the economic growth being stimulated by other, larger patterns of development.

Given the anemic state of many African economies, however, it would be prudent to maintain modest expectations in the cost-recovery area except, perhaps, for the value of contraceptives themselves which form only a minor part of the costs of providing family planning services. (With an estimated total cost of nearly \$20.00 for providing "one couple year of protection," contraceptives typically represent about one-fourth of that amount.)⁵

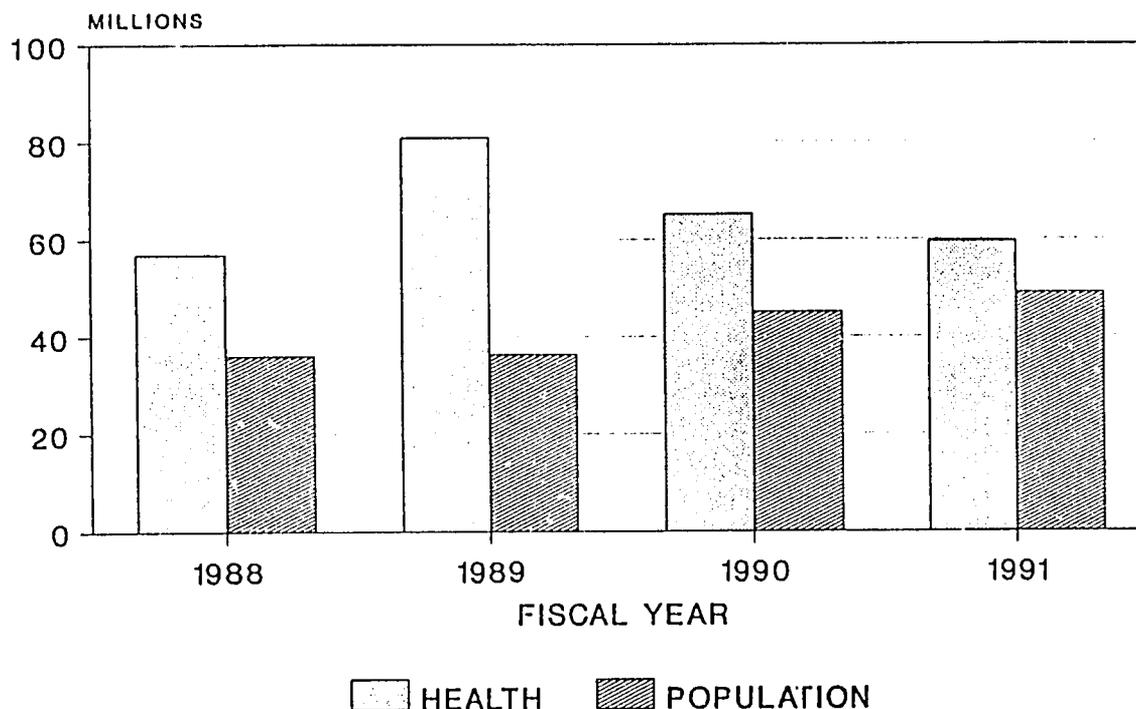
Figure 10 shows Bureau for Africa actual and projected funding in both the health and population sectors, FY 1988 through FY 1991.

⁵ "Financing the Delivery of Contraceptives: The Challenge of the Next Twenty Years," D. Gillespie, H. Cross, J. Crowley and S. Radloff, USAID, Washington, D.C. October 7, 1988.

Figure 10

Bureau for Africa Actual and Projected Funding

Fiscal Years 1988-1991



The population and family planning sector ranks high among the priorities for support within the Bureau for Africa. While the overall trend of USAID obligations for Africa has generally been constant in recent years, there has been a steady increase in the proportion of funding directed toward population activities. Combined with support from USAID's central Office of Population, the Africa Bureau is confident about its ability to meet its share of support requested by countries in Africa as they begin to address the urgent need to slow their high rates of population growth.

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