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**HEALTH POLICY
INITIATIVE**

THE FAMILY PLANNING EFFORT INDEX: 1999, 2004, AND 2009

MAY 2010

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TABLE OF CONTENTS

Acknowledgments.....	iv
Executive Summary	v
Abbreviations.....	vi
Background.....	1
Methods and Data	1
Results.....	3
Discussion.....	9
Conclusion	10
Annex A. The Family Planning Effort Indices	12
Annex B. Questionnaire.....	13
Annex C. 2009 FPE National Component Scores, 81 Countries.....	21
Annex D. Regional Component Scores: 1999, 2004, 2009	24
Annex E: Memorandum.....	26
Annex F. Mean* Scores for Program Justifications, Emphases on Special Populations, Influences, and Quality, 81 Countries, by Region.....	38

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EXECUTIVE SUMMARY

Context

National programs to extend family planning to large populations began in the mid-1960s and now exist in most developing countries. They vary greatly in strength and coverage, as well as in the nature of their outreach. Periodic measures of their types and levels of effort have been conducted since 1972, showing increasing strength. These measures have been used as the only consistent assessment of program efforts, for all countries, over time. They have served to inform policy positions and resource allocations, as well as technical analyses of program impact on contraceptive use and fertility declines.

Methods

Questionnaires, completed by 10–15 expert observers in each of 81 countries, score 30 measures of effort, each on a scale from 1 to 10. Additional measures assess four general program characteristics. The 81 countries encompass 93 percent of the developing world population and all of the largest countries in each region.

Results

The latest measures show that the average program effort level has again increased, although by a small amount. Program effort as either a weighted or unweighted average across the developing world increased slightly from 1999 to 2004 and again in 2009. Policy positions are rated highest; service arrangements and actual access to contraceptive methods are rated well below that. The Asian region receives the highest scores and dominates the global averages due to China, India, Bangladesh, Pakistan, and Indonesia. However, all regions contain great diversity among country scores. Within the sub-Saharan Africa region, focus countries of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)¹ are of particular interest, as are historical differences between Anglophone and Francophone countries. On another subject, there are systematic differences between USAID population assistance “graduated countries,” most other Latin America countries, and severely disadvantaged countries.

Conclusions

Average program effort levels remain robust in general, despite concerns about diversion of resources to HIV/AIDS, donor fatigue, and other problems. However, average effort is still only at about half of the maximum, or about two-thirds of the level attained by the strongest countries. The profile of effort across the 30 indicators remains essentially the same as before but with sharp differences across the indicators and considerable selectivity in the contraceptive methods stressed. Regional differences remain much as before, with Asia strongest, sub-Saharan Africa weakest, and Latin America in between. Within sub-Saharan Africa, differences have narrowed considerably between Anglophone and Francophone countries, and PEPFAR countries in the Anglophone group show similar trends to non-PEPFAR countries, whether due to their dissimilar histories or to other factors. “Graduated” countries² outperformed comparison countries during much of the past, but differences since 1999 are small between them and the comparison countries (most of Latin America). Separate questions in 2004 and 2009 show that program justifications rest more heavily on health than on fertility reduction, but adolescent and postabortion emphases rate rather low. Donor and domestic funding changes have been unfavorable—much more so than other influences such as the merging of family planning programs into broader health services.

¹ Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

² Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Trinidad & Tobago, Indonesia, Morocco, Sri Lanka, Tunisia, Thailand, and Turkey.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
FPE	Family Planning Effort (Index)
HIV	human immunodeficiency virus
IEC	information, education, and communication
IUD	intrauterine device
LAC	Latin America and the Caribbean
LTAM	Latin America
MENA	Middle East and North Africa
NP	non-PEPFAR
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SSAF-A	sub-Saharan Africa—Anglophone
SSAF-F	sub-Saharan Africa—Francophone
TFR	total fertility rate

BACKGROUND

National programs to extend family planning to large populations, beginning in the mid-1960s, have been established in most developing countries. They vary greatly in strength and coverage, as well as in the nature of their outreach. Periodic measures of the types and levels of effort were first conducted in 1972, followed by repeats in 1982, 1989, 1994, 1999, 2004, and as reported here, in 2009. This unique series, termed the Family Planning Effort (FPE) Index, has covered about 90 percent of the developing world each time.

The Index is meant to measure inputs, not outputs. The original idea was to capture the efforts of the national public family planning program (or its closest proxy) as independent, separate variables that could be related to such outcomes as changes in contraceptive use or in fertility. The scores constitute a unique resource for understanding family planning activities, with parallel studies only for maternal health programs and HIV/AIDS programs. They have been used for causal analysis to tease out the relative effects of programs and social settings. They have also been used by major donors and agencies to set country priorities and to gauge progress. In addition, the scores have been used to diagnose program weaknesses at national levels and to assess advocacy efforts to clarify where their programs are and are not doing well, as well as to indicate what achievements could be expected if efforts are improved. In at least two countries (Vietnam and Egypt), FPE scores have been applied at the provincial level for program guidance (San et al., 1999; and Khalifa et al., 1999).

The 2004 round introduced new elements that examine the importance of various rationales for family planning programs (child health, maternal health, unmet need, and demographic goals) and the effects of key drivers in recent years, such as changes in donor and national funding, integration with health, and HIV/AIDS. These new elements were meant to provide a picture of the context in which the programs operate and were retained in the 2009 round. They are meant to help clarify the place of these programs in the evolving context of the HIV/AIDS crisis, changes following decentralization of national health systems, and the shift of the family planning community toward broader reproductive health concerns.

The immediate objective of this paper is to provide enhanced understanding of the changes that have taken place over the past five years in family planning efforts and the components of effort, along with a new set of program effort measures as a five-year update of the unique series begun in 1972. The results are meant to inform country-specific discussions about program directions and global planning and to provide updated analyses of program effects on contraceptive use and fertility. They also permit a special analysis of sub-Saharan countries and an exploration of contrasts between the performance of “graduated” and “non-graduated” countries.

Much literature concerning the scores has appeared over the years, summarized in previous reports (Ross et al., 2007; Ross and Stover, 2001; and Ross and Mauldin, 1996). The principal types of writings are (1) those that assess program effects on fertility or contraceptive use separately from the effects of general development and socioeconomic change, (2) those that use the scores to modify program strategies or resource allocation, (3) those that examine the nature of program effort as it changes over time or shows special configurations, and (4) those that focus on the methodology of the research itself.

METHODS AND DATA

The basic methodology for scoring family planning efforts began with work by Robert Lapham and Parker Mauldin in 1972, who created the original ratings and published scores for a limited set of features and countries (Lapham and Mauldin, 1972). In 1981–82, they developed a full questionnaire to be completed by country experts chosen from various specialties and agencies for each country. The

questionnaire, containing about 120 items, was coded to produce 30 scores under four components: Policies (8 items), Services (13 items), Evaluation (3 items), and Method Access (6 items, enlarged later to 7) (see **Annex A**). That questionnaire, coding system, and set of scores was replicated exactly in 1989, 1994, and 1999.

For the 1999 round, it was decided to retain the existing system but also to compare it with an alternative that would be simpler, cheaper, and less time consuming. Thus was born a shorter form, which asked respondents to rate, on a 1 to 10 scale, each of the 30 measures. This greatly simplified coding and data entry and permitted immediate feedback of results to each country, with a set of interpretative charts. A second change was to identify an expert consultant in each country who was familiar with the national program and could select 10 to 15 local expert respondents to complete the questionnaire. That replaced the labor-intensive system of identifying every respondent centrally, with its concomitant extensive long-distance correspondence. The results from the short form system closely mirrored the results from previous long form questionnaires, so in 2004, the short form system alone was employed and retained in the latest 2009 round (see **Annex B**).

The basic study procedure began in 2009, as in 2004 and 1999, with identification of a qualified consultant in each developing country. The initial target was all countries containing over 1 million inhabitants, with some exclusions for countries that have essentially disbanded their programs due to their plummeting fertility rates, including Singapore, Hong Kong, South Korea, Taiwan, and others, such as Uruguay or Argentina, which can be considered developed. Other exclusions were due to nonresponse after repeated contacts, such as Syria, Saudi Arabia, and Oman. The Health Policy Initiative obtained information for 81 countries—about the same number as in previous cycles of the research.

Each consultant was instructed to identify 10–15 respondents from various specialties and institutional settings—persons who in their individual capacities are knowledgeable about national family planning activities. The respondents completed the standard questionnaire individually, provided in English, Spanish, French, Portuguese, or Russian. After centralized data entry, results were returned to each country with a set of interpretative charts to highlight the principal results to encourage local use of the information. Early results are also provided on request to institutions with a relatively urgent need for the scores as an input in their work and subsequently to concerned national and international agencies.

A wide variety of analytic approaches has emerged over the years. These include cross tabulations of program strength against social setting strength (based on such indicators as education, urbanization, per capita income, and longevity) to relate both as determinants of contraception and fertility. Bernard Berelson was the first to discover the remarkable pattern in which fertility decline followed either stronger programs or better social settings but especially so where both were present (Freedman and Berelson, 1976). The same pattern occurred for contraceptive use, reflecting the close correlation across countries between the total fertility rate (TFR) and contraceptive prevalence. This relationship was again a Berelson discovery—one that has been used repeatedly over the years to generate time trends in contraception from the large United Nations data sets of TFRs. In one important application, the correlation was used to show the implausibility of highly optimistic TFR projections for sub-Saharan Africa, as those projections implied radical increases in contraceptive use.

Other analytic methods have included path analysis to separate the effect of public access to contraceptive methods from the effects of other determinants. The “correspondence method” is another example, as is the “paradigm shift” method. Multiple correlation/regression methods have been used extensively (Mauldin and Berelson, 1978), including one analysis that allocated more than 40 percent of fertility change to program action (Bongaarts et al., 1990).

A special area of research has focused on the nature of program action. For example, a method that uses patterns among different scores has shown differences between the profiles of low-scoring countries and high-scoring countries. Further, those low-scoring countries that raise their scores over time have moved toward the pattern of the high-scoring countries. This convergence indicates that, apart from the overall score, the type of efforts must be considered.

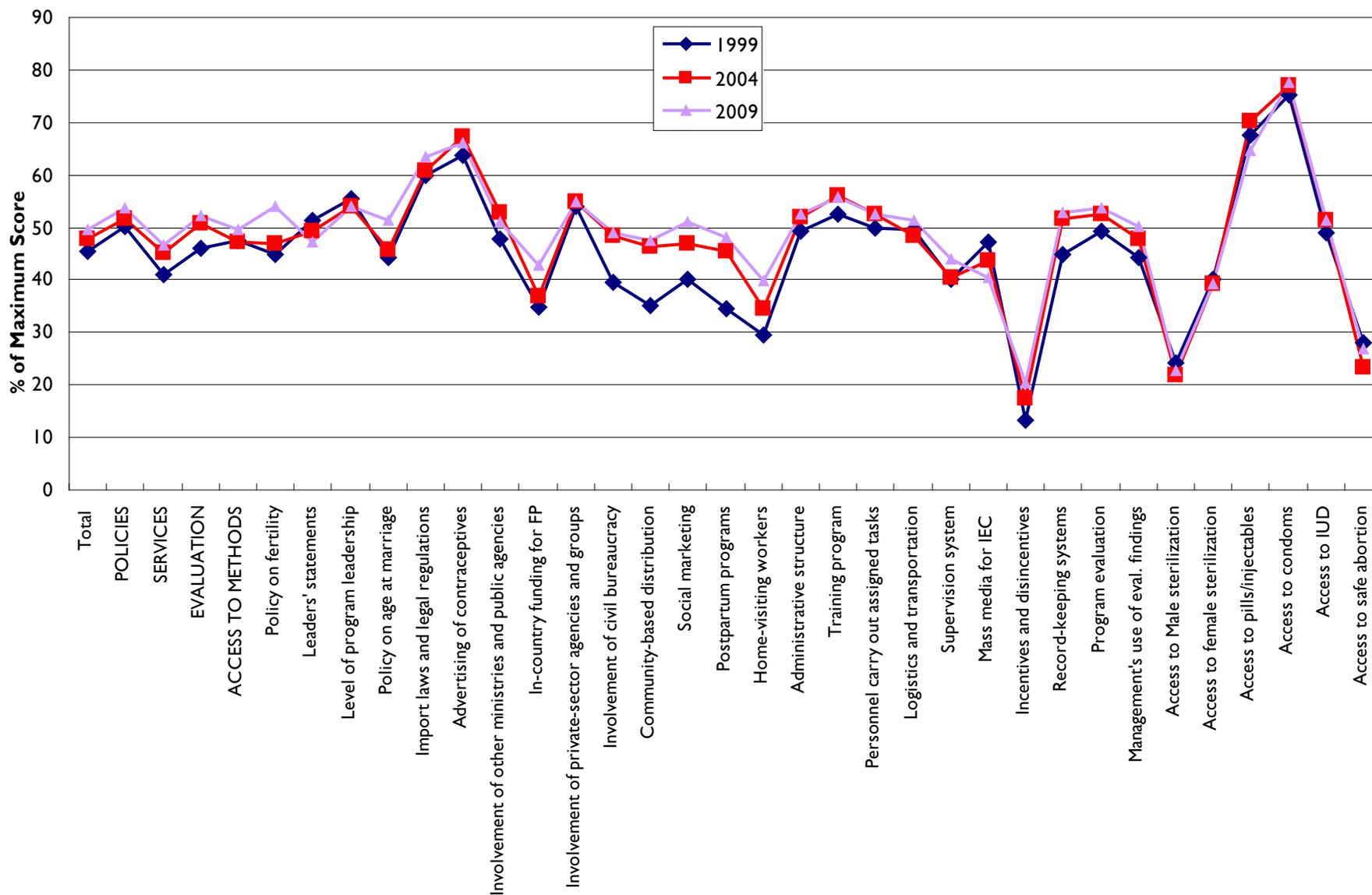
RESULTS

The 2009 study obtained information on the 81 countries shown in **Annex C**, which gives the total and four component scores for each country. Regional averages are shown both unweighted and with population weights: the former relate to the average country and the latter reflect the situation of most people. The weighted averages are higher in Asia due to China's large influence, and secondarily to Indonesia and Bangladesh, which counterbalance the low Pakistan score and the slightly depressed India score. In other regions, the weighted score falls below the unweighted one—due chiefly to Brazil's heavy influence in Latin America and Nigeria's in Anglophone sub-Saharan Africa.

The individual scores for 30 indicators are remarkably consistent across the years. **Figure 1**, for the 61 countries common to the three years, demonstrates the closeness that has emerged. This occurs notwithstanding the studies being conducted independently at five-year intervals, with mostly different respondents. The methodology of expert observers can clearly be implemented to provide assessments not otherwise available. For instance, this methodology has been used for maternal health programs to gauge their efforts, and it shows a similar pattern for the years 1999, 2002, and 2005.

The lines for 2004 and 2009 are very close, but from 1999, there was some improvement in outreach (middle of figure) for community-based distribution, social marketing, postpartum programs, and home visiting workers. However, the Method Access scores to the right did not change.

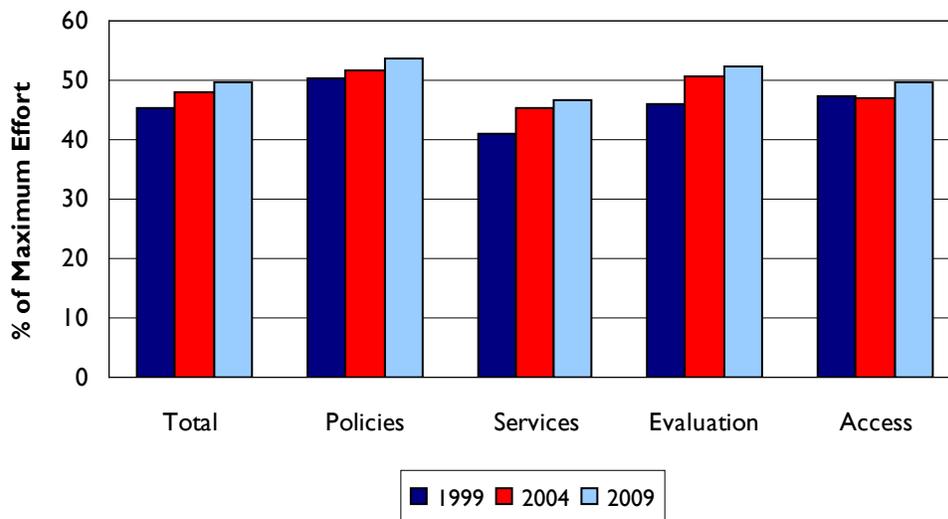
Figure I. Individual Scores for 30 Indicators (1999, 2004, and 2009) for 61 Countries Included in All Three Studies



Trends over the last decade for the total score reveal small, regular increases from 1999–2004 and from 2004–2009 for the 61 countries that are common to all three years (see **Figure 2**). The 2009 results show an average overall FPE Index of just below half of the maximum level. However, the top five countries have an overall Index of about 80 percent. Viewing such an index as a “gold standard,” the global average Index in 2009 is at about two-thirds of this realistic maximum.

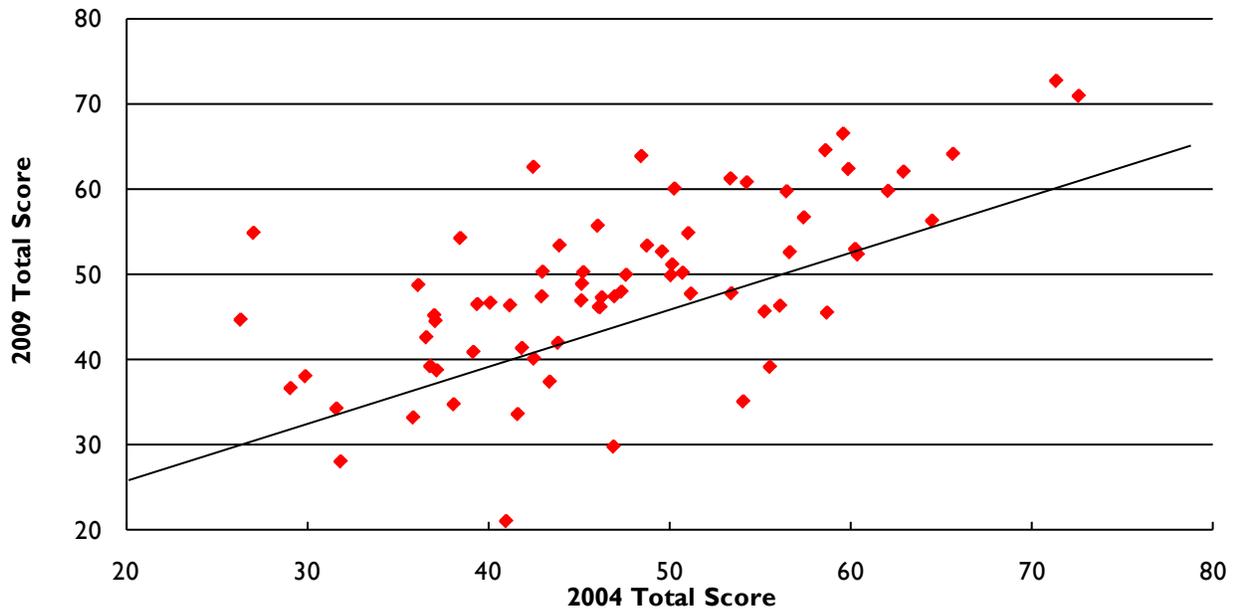
The Four Component Scores also rose when averaged over the 61 countries—again by rather small amounts, with the 2009 scores coming in at about the 50 percent mark. The Policies component rose by 3.5 points, the Services component by 5.6 points, the Evaluation component by 6.1 points, and the Method Access component by 2.1 points, out of 100. The Services component showed the largest gain, but it also began from the lowest starting level. Its 5.6 gain on the initial score of 41.1 represents a relatively appreciable 14 percent rise over the past 10 years. Access to contraceptives did not improve in 2004 but did so in 2009. (**Annex D** contains all **total and component scores** for the three years.)

Figure 2. Total and Four Component Scores, 1999, 2004, and 2009, 61 Countries



The change from 2004–2009 is of particular interest for this updated analysis. For the 71 countries common to both years, the mean total Index rose from 47.3 to 48.9 (the median from 46.2 to 47.9). **Figure 3** depicts the pattern of changes: 43 countries improved (shown above the line), while 28 countries fell in their scores (below the line). For example, China and Vietnam appear at the top right, while Chad and Democratic Republic of the Congo are among those at the lower left. The pattern reflects real changes in program effort, as well as measurement error in either or both years, but the modest overall improvement is clear.

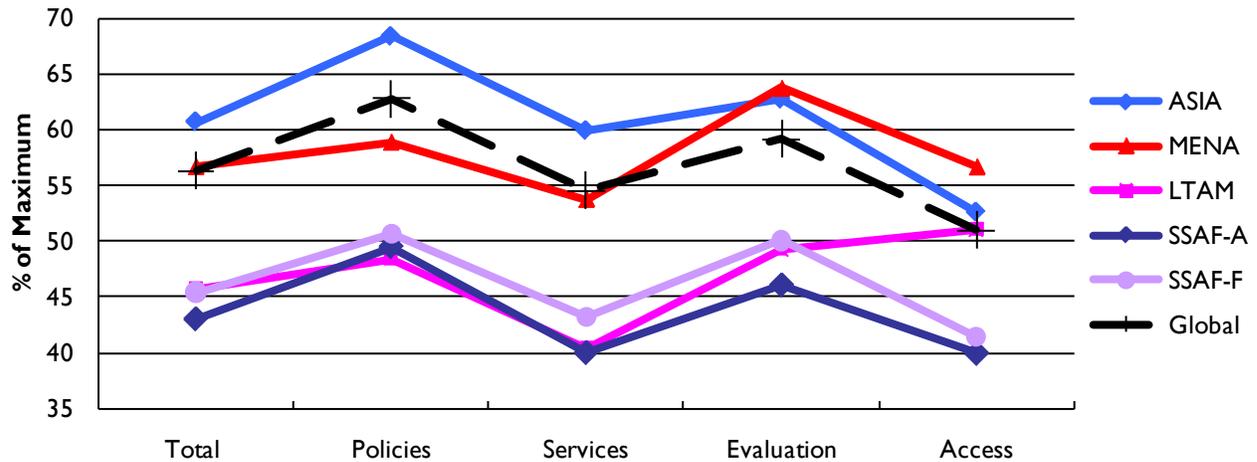
Figure 3. Comparison of the 2004 and 2009 Total Scores, 71 Countries



Regional differences in 2009 are large, as shown in **Figure 4** (based on the weighted averages shown in Annex B). At the left of the figure, Asia’s total score exceeds 60 percent of the maximum, followed by the Middle East/North Africa. Latin America’s average is one of the lower ones, as it was in 2004 and 1999—probably because many services are nongovernmental and respondents think primarily of the government program. The Anglophone and Francophone sub-Saharan African groups score lowest at 45 percent.

The above observations pertain to the total FPE Index. The regional rankings of the Policies component closely mirror the rankings of the total Index. The Policies scores are higher than the Total scores, reflecting the relative ease of establishing Policies, compared with actually providing Services, which register lower scores. The Evaluation scores display greater variability because they are based on only three of the 30 original scores; still, the regional rankings remain essentially the same. Finally, for the Method Access component, Latin America now scores well—most likely because of its active private sector, which national programs usually encourage. Sub-Saharan Africa scores the lowest by far, just above 40 percent, with the other regions above 50 percent.

Figure 4. Regional Patterns for Total Score and Four Components



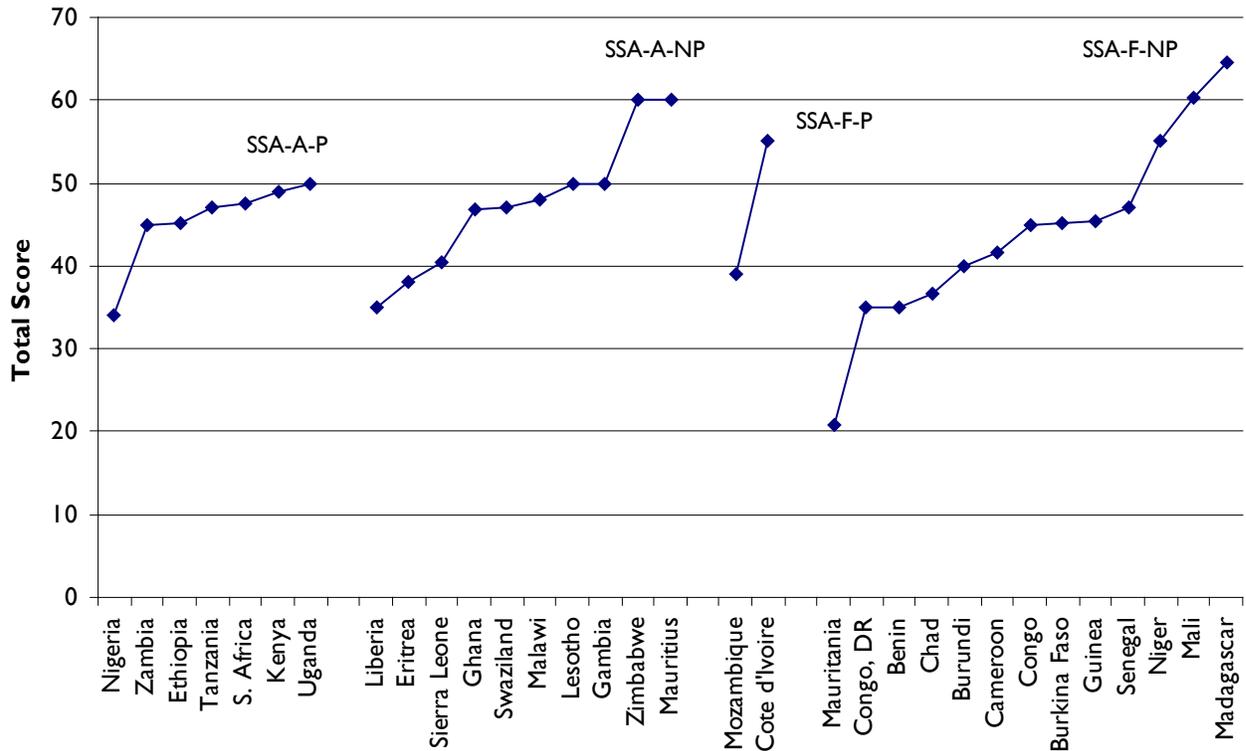
A special focus on sub-Saharan African countries contrasted Anglophone vs. Francophone countries and PEPFAR (U.S. President’s Emergency Plan for AIDS Relief) vs. non-PEPFAR countries. One way to compare the positions of these four groups in 2009, for the Total Score, is shown in **Figure 5**. The midpoints are nearly the same, in the mid-40s to high-40s, but the figure highlights the considerable diversity within every group. The diversity, in turn, suggests more attention to individual cases, with additional information from other sources and from the local context.

Most PEPFAR countries are in the Anglophone group; only three are in the Francophone group (and Rwanda is missing in 2009).³ The pattern for Anglophone-PEPFAR is nearly identical to Anglophone-non-PEPFAR if we discount the two high points for Zimbabwe and Mauritius.

Other analyses show considerable similarity among the four groups in the four components and even in their profiles across the 30 individual scores. Francophone averages still fall a little below Anglophone ones, but Francophone has risen considerably to sharply narrow the gap to Anglophone.

³ Data were not available for Rwanda.

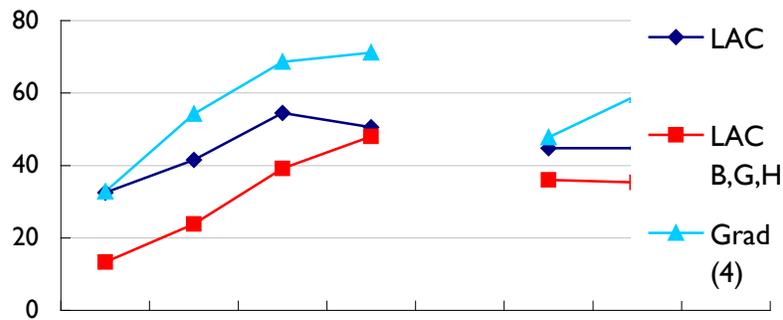
Figure 5. 2009 Total Scores, Four Groups of Countries (Note diversity within each group)



“**Graduated Countries,**” those that formerly received USAID support, are also of particular interest. **Figure 6** shows one way of examining their long-term record in comparison to (1) most of Latin America, which in some ways is the most advanced large region and (2) three Latin American countries that currently receive USAID support (Bolivia, Guatemala, and Haiti). Historically, through 1994, the graduated countries (Brazil, Colombia, Costa Rica, Ecuador, and Mexico in Latin America, plus Indonesia, Morocco, Thailand, and Turkey) performed much better than most of Latin America and much better than the other three countries. However, five of the nine graduated countries are in Latin America, so the group of “most of Latin America” includes some programs with weaker scores. Since 1999 (and the change in methodology), the scores have been much the same for the set of graduated countries and most of Latin America.

To pin down the changes occurring just after the graduation date of each country, one must go to the detailed records, and these are set forth in a separate memorandum provided to USAID in February 2010 (see **Annex E**).

Figure 6. Total FPE Score, 1972–2009, Three Country Groups



Additional features include the basic justifications for the programs, the special populations they emphasize, and exogenous influences that act on them. These, together with an overall quality rating, were included in 2004 and 2009. The results, as unweighted averages by region (see **Annex F**) show, as they did in 2004, the stronger program justifications for women’s health than for population growth or economic development.

Early childbearing by unmarried youth is rated low as a program justification and is neglected even more severely as a special population to be emphasized. Rather low ratings go also to postpartum and postabortion women; it is the poor and the rural groups that are most emphasized.

Influences acting on the programs are measured on a scale from negative 5 to plus 5 to obtain judgments on the direction and magnitude of their effects. The strongest positive influences on family planning programs are considered to be their incorporation into broader reproductive health and their integration with other health services. Moves toward decentralization are seen as less helpful, and changes in both donor and domestic funding are regarded as either negative or barely positive. Interestingly, the net effects of HIV/AIDS programs are positive—although the indicators contain a spread of both negative and positive national ratings within each region, depending on the country involved.

DISCUSSION

After about 45 years of experience, national family planning programs are common in the developing world in varying strengths, from nearly trivial to very strong, established either through the government or a large private organization and either self-standing or merged into a maternal and child health framework. Reasons for their creation have varied; the most common justifications are mainly demographic or mainly health but in reality are usually a mixture. Where one reason has dominated, the other has nearly always been a strong second justification.

In fact, the programs have both lowered fertility rates and reduced maternal deaths by averting large numbers of pregnancies. They have acted as an independent force, as well as by interaction with improved socioeconomic conditions. The impact has been substantial, especially as a weighted population average that reflects the large effects in China, India, Bangladesh, Indonesia, the cluster of smaller Asian countries, Mexico and smaller Latin American countries, and parts of the Middle East. In sub-Saharan Africa, smaller effects have been observed in Kenya and Zimbabwe, although both have weakened in recent years. In general, reductions in maternal deaths and decreases in fertility rates have been slower in the region, reflected in its lower effort scores. For the developing world at large, effects in the 25 most populous countries account for most of the overall fertility decline and deaths saved.

This 2009 cycle of the research finds, as before, that of the four main components of effort, Policies score highest, as it is easiest to establish favorable policies. Services and Method Access score well below Policies. By region, East Asia has been strongest and sub-Saharan Africa weakest (with little difference between Francophone and Anglophone averages). Southeast and South Asia, including the sub-continent, are quite variable, with China, India, and Indonesia dominating the averages. Latin America scores below expectations probably because much of the effort is in private hands. The Middle East/North Africa scores are relatively high.

The contraceptive methods stressed are highly selective. Usually only two or three of the available choices receive real attention: sterilization and the intrauterine device (IUD) in China; just the IUD in Vietnam; mainly the IUD in the Middle East; and mainly the pill and injectable in sub-Saharan Africa. Vasectomy is neglected nearly everywhere except in China; female sterilization is trivial in Africa and the Middle East, although important in Latin America. Condoms are often offered but are sometimes marketed more for the prevention of sexually transmitted infections than for contraception. This selectivity reflects cultural preferences, the nature of the clinical services available, and the historical accidents of which methods were established early.

It is surprising that the average scores have continued to rise since 1999, even in small increments, given the unsupportive environment since Cairo for close attention to contraceptive provision. It is also unexpected to see the modestly positive ratings for the influence of HIV/AIDS on the programs. However, those are averages, and even the average is quite low for Anglophone sub-Saharan Africa. Moreover, the ratings are negative for numerous countries, especially in the high-prevalence countries in East and South Africa.

In sub-Saharan Africa, the gaps have been closing between the Anglophone and Francophone groups, and they are relatively small between PEPFAR and non-PEPFAR groups. But those again are for averages; within each group there is a marked diversity of effort, so the more relevant focus for action decisions is on the individual country.

CONCLUSION

Average program effort levels remain robust in general, despite concerns about the diversion of resources to HIV/AIDS, donor fatigue, and other problems. However, average effort is still only at about half of the maximum, or about two-thirds of the level attained by the strongest countries. The profile of effort across the 30 indicators remains essentially the same as before but with sharp differences across the indicators and considerable selectivity in the contraceptive methods stressed. Regional differences remain much as before, with Asia strongest, sub-Saharan Africa weakest, and Latin America in between. Within sub-Saharan Africa, differences have narrowed considerably between Anglophone and Francophone countries, and PEPFAR countries in the Anglophone group show similar trends to non-PEPFAR countries, whether due to their dissimilar histories or to other factors. “Graduated” countries outperformed comparison countries during much of the past, but differences since 1999 are small between them and the comparison countries (most of Latin America). Separate questions in 2004 and 2009 show that program justifications rest more heavily on health than on fertility reduction, but adolescent and postabortion emphases rate rather low. Donor and domestic funding changes have been unfavorable—much more so than such other influences as the merging of family planning programs into broader health services.

These ratings can support numerous improvements. Clearly, the highest levels of many governments need to allocate larger resources to the provision of education, supplies, and services devoted to contraception, including encouragement to the private medical system and commercial outlets. That means increased

local funding, as well as a quest for increased foreign assistance. Second, policy positions need strengthening in many countries. However, better policies require better implementation, and health officials, parliamentary committees, and finance/planning ministries must be actively involved, since better policies move through new budget lines, import rules, personnel assignments, and facility management. Third, the actual access by the population at large to contraceptives urgently needs strengthening—and that means a greater diversity of methods to avoid excessive reliance on costly resupply methods and an extension of offerings out to the rural population. Closely related are outreach activities—to improve the ratings for postpartum, CBD, and CSM programs. Moreover, overtures to youth and stronger postabortion offerings are clearly needed. Any individual country can examine its national program according to each of the 30 ratings to identify weak spots and opportunities for improved effectiveness.

In addition, the research results can be employed for planning and advocacy work at all levels—the international donor community, regional planning groups, and country management. An example is the interface between family planning and HIV/AIDS programs in east and southern Africa, where the results show difficulties in their joint work. Finally, the research community can now access this global update of effort ratings for the 81 countries that cover more than 90 percent of the world’s population. The data are fully available to concerned agencies and individuals in the reproductive health field.

ANNEX A. THE FAMILY PLANNING EFFORT INDICES

This annex provides summary descriptions of the 31 items included in the Family Planning Effort Index. These are organized under the four components of Policy and Stage-Setting Activities, Service and Service-Related Activities, Recordkeeping and Evaluation, and Availability and Accessibility of Fertility Control Methods.

The Family Planning Effort Scale

Policy and Stage-Setting Activities	<ol style="list-style-type: none"> 1. Government's official policy or position concerning fertility/family planning and rates of population growth 2. Favorable statements by leaders 3. Level of family planning program leadership 4. Age-at-marriage policy 5. Import laws and legal regulations regarding contraceptives 6. Advertising of contraceptives in the mass media allowed 7. Other ministries/government agencies involved 8. In-country budget for program
Service and Service-related Activities	<ol style="list-style-type: none"> 1. Involvement of private sector agencies and groups 2. Civil bureaucracy used 3. Community-based distribution 4. Social marketing 5. Postpartum programs 6. Home-visiting workers 7. Administrative structure 8. Training programs 9. Personnel carry out assigned tasks 10. Logistics and transport 11. Supervision 12. Mass media for information, education, and communication (13. Incentives/disincentives
Recordkeeping and Evaluation	<ol style="list-style-type: none"> 1. Recordkeeping 2. Evaluation 3. Management use of evaluation findings
Availability and Accessibility of Fertility Control Methods	<ol style="list-style-type: none"> 1. Male sterilization 2. Female sterilization 3. Pills 4. Injectables 5. Condoms, diaphragm, spermicide 6. Intrauterine devices 7. Safe abortion

ANNEX B. QUESTIONNAIRE

**International Family Planning
Program Study**

—2009 CYCLE—

Country

Conducted by

Futures Group

Characteristics and Strength of Effort

- This questionnaire is intended to provide internationally comparable information for about 90 countries. It concerns large-scale family planning programs, and it will update previous investigations of the characteristics and strength of effort of these programs.
- Throughout this questionnaire, we refer to “the family planning program.” In most countries, there is only one large-scale program, and usually it operates under government auspices. The focus is on the national picture of family planning activities. If these are merged with maternal and child health activities, please focus on the family planning aspects.
- Do not respond for pilot projects or small service networks. The focus is at the national level.
- Please do not complete questions for which you lack information—other respondents in your country may handle those. Please confer with other individuals as you wish, and answer the items simply in your personal capacity, giving your own best judgment. All responses are entirely confidential.
- Thank you for your assistance with this study. In return, please note that you can obtain without cost a variety of software programs. These are on the web at FuturesGroup.com (go to “Resources” then to “Software”).

To give a summary picture of program effort, please rate the following items. Score each item from 1 to 10, where 1 represents non-existent or very weak effort and 10 represents extremely strong effort. Try to answer each item; omit it only if you lack information.

Component	Description	1= Non existent to 10= Extremely strong									
		1	2	3	4	5	6	7	8	9	10
POLICY AND STAGE-SETTING ACTIVITIES											
Policy on fertility reduction and family planning	Extent to which government policy stresses family planning for demographic reasons over health reasons or is simply neutral or opposed	1	2	3	4	5	6	7	8	9	10
Statement by leaders	Extent to which the head of government, as well as other officials, speak publicly and favorably about family planning at least once or twice a year	1	2	3	4	5	6	7	8	9	10
Level of program leadership	High level of seniority of the director of the national family planning program and whether director reports to a high level of government	1	2	3	4	5	6	7	8	9	10
Policy on age at marriage	Extent to which legal age at marriage for females is set at 18 years or higher and is enforced	1	2	3	4	5	6	7	8	9	10
Import laws and legal regulations	Extent to which import laws and legal regulations facilitate the importation of contraceptive supplies or extent to which contraceptives are manufactured locally	1	2	3	4	5	6	7	8	9	10
Advertising of contraceptives allowed	Extent of freedom from restrictions on advertising of contraceptives in the mass media	1	2	3	4	5	6	7	8	9	10
Involvement of other ministries and public agencies	Extent to which other ministries and government agencies assist with family planning activities (e.g., delivery of supplies, services, information, education) or other population activities	1	2	3	4	5	6	7	8	9	10
Percent of in-country funding of family planning budget	Extent to which total family planning/population budget is derived from in-country sources (e.g., 1 for 10 percent, 5 for 50 percent, 10 for 100 percent)	1	2	3	4	5	6	7	8	9	10

SERVICE AND SERVICE-RELATED ACTIVITIES											
Involvement of private-sector agencies and groups	Extent to which private-sector agencies and groups assist with family planning or other population activities	1	2	3	4	5	6	7	8	9	10
Civil bureaucracy involved	Extent to which the civil bureaucracy of the government is used to ensure that program directives are carried out, and whether its senior officials take responsibility for program directives being carried out	1	2	3	4	5	6	7	8	9	10
Community-based distribution	Extent to which areas of country not easily serviced by clinics or other service points are covered by community-based distribution programs for distribution of contraceptives (especially rural areas)	1	2	3	4	5	6	7	8	9	10
Social marketing	Extent of coverage of the country by a social marketing program (subsidized contraceptive sales at low cost in commercial sector, especially in urban areas)	1	2	3	4	5	6	7	8	9	10
Postpartum program	Extent to which all new mothers in the country receive postpartum family planning assistance.	1	2	3	4	5	6	7	8	9	10
Home-visiting workers	Extent of coverage of population by workers whose primary task is to visit (rural) women in their homes to talk about family planning and maternal and child health	1	2	3	4	5	6	7	8	9	10
Administrative structure	Extent to which administrative structure and staff at national, provincial and county levels are adequate to implement the family planning program	1	2	3	4	5	6	7	8	9	10
Training program	Extent to which training programs, for each category of staff in the family planning program, are adequate to provide personnel with information and skills necessary to carry out their jobs effectively	1	2	3	4	5	6	7	8	9	10

Personnel carry out assigned tasks	Extent to which all categories of family planning program staff (administrative, medical, paramedical, field) carry out assigned tasks effectively	1 2 3 4 5 6 7 8 9 10
Logistics and transport	Extent to which the logistics and transport systems are sufficient to keep stocks of contraceptive supplies and related equipment available at all service points, at all times and at all levels (central, provincial, local)	1 2 3 4 5 6 7 8 9 10
Supervision system	Extent to which the system of supervision at all levels is adequate (regular monitoring visits with corrective or supportive action)	1 2 3 4 5 6 7 8 9 10
Mass media for IEC	Frequency and extent of coverage of mass media messages that provide population with information on family planning and service sites	1 2 3 4 5 6 7 8 9 10
Incentives and disincentives	Extent to which monetary or other incentives are used to encourage the adoption of family planning	1 2 3 4 5 6 7 8 9 10
RECORD KEEPING AND EVALUATION		
Record keeping	Extent to which systems for client recordkeeping, clinic reporting and feedback of results are adequate	1 2 3 4 5 6 7 8 9 10
Evaluation	Extent to which program statistics, national surveys, and small studies are used by specialized staff to report on program operations and measure progress	1 2 3 4 5 6 7 8 9 10
Management's use of evaluation findings	Extent to which program managers use research and evaluation findings to improve the program in ways suggested by findings	1 2 3 4 5 6 7 8 9 10
AVAILABILITY AND ACCESSIBILITY OF METHODS AND SUPPLIES		
IUDs	Extent to which entire population has ready and easy access to IUDs	1 2 3 4 5 6 7 8 9 10

	How well does the IUD supply system operate (it avoids stockouts or interrupted supplies and guarantees a reliable flow at local levels)	1 2 3 4 5 6 7 8 9 10
Pills	Extent to which entire population has ready and easy access to pills	1 2 3 4 5 6 7 8 9 10
	How well does the pill supply system operate (it avoids stockouts or interrupted supplies and guarantees a reliable flow at local levels)	1 2 3 4 5 6 7 8 9 10
Injectables	Extent to which entire population has ready and easy access to injectables	1 2 3 4 5 6 7 8 9 10
	How well does the injectable supply system operate (it avoids stockouts or interrupted supplies and guarantees a reliable flow at local levels)	1 2 3 4 5 6 7 8 9 10
Female sterilization	Extent to which entire population has ready access to voluntary sterilization services for women	1 2 3 4 5 6 7 8 9 10
	How well does the supply system provide necessary equipment and medical supplies for female sterilization services at clinical facilities?	1 2 3 4 5 6 7 8 9 10
Male sterilization	Extent to which entire population has ready access to voluntary sterilization services for men	1 2 3 4 5 6 7 8 9 10
	How well does the supply system provide necessary equipment and medical supplies for men's sterilization services at clinical facilities?	1 2 3 4 5 6 7 8 9 10
Condoms	Extent to which entire population has ready and easy access to condoms	1 2 3 4 5 6 7 8 9 10
	How well does the condom supply system operate (it avoids stockouts or interrupted supplies and guarantees a reliable flow at local levels)	1 2 3 4 5 6 7 8 9 10

Abortion	Extent to which entire population has ready and easy access to safe abortion or menstrual regulation (whether legal or not)	1	2	3	4	5	6	7	8	9	10
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Please rate the general quality of family planning services. (Good quality includes a focus on client needs, with counseling, full information, wide method choice, and safe clinical procedures.)	1	2	3	4	5	6	7	8	9	10
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INFLUENCES ON THE FAMILY PLANNING PROGRAM

Note that for the following questions the scale is different.

Forces affecting the family planning program can either strengthen or detract from its effectiveness. Check zero (0) if there is no difference either way; check a negative number from -1 to -5 if the influence is negative; or check a positive number from 1 to 5 if the influence is positive. (1 in either direction means little influence and 5 in either direction means strong influence.)

Decentralization (the shift of decision making and resources from the central government to lower administrative levels)	-5	-4	-3	-2	-1	0	1	2	3	4	5
HIV/AIDS programs	-5	-4	-3	-2	-1	0	1	2	3	4	5
Incorporation of family planning into a broader context of reproductive health	-5	-4	-3	-2	-1	0	1	2	3	4	5
Integration of family planning with other health services	-5	-4	-3	-2	-1	0	1	2	3	4	5
Changes in donor funding	-5	-4	-3	-2	-1	0	1	2	3	4	5
Changes in domestic government funding	-5	-4	-3	-2	-1	0	1	2	3	4	5

How important is each of the following as a current justification for the national family planning program? (1 means negligible importance; 10 means great importance.)

Reduce rate of population growth	1	2	3	4	5	6	7	8	9	10
Enhance economic development	1	2	3	4	5	6	7	8	9	10
Help women and men avoid unwanted births	1	2	3	4	5	6	7	8	9	10
Improve women's health	1	2	3	4	5	6	7	8	9	10
Improve child health	1	2	3	4	5	6	7	8	9	10
Reduce unmarried adolescent childbearing	1	2	3	4	5	6	7	8	9	10
Reduce unmet need for contraceptive services	1	2	3	4	5	6	7	8	9	10

SPECIAL POPULATIONS

To what extent does the family planning program give particular emphasis to special populations? (1 means negligible emphasis; 10 means great emphasis)

Unmarried youth	1	2	3	4	5	6	7	8	9	10
The poor	1	2	3	4	5	6	7	8	9	10
Rural populations	1	2	3	4	5	6	7	8	9	10
Postpartum women for counseling and contraceptive services	1	2	3	4	5	6	7	8	9	10
Postabortion women for counseling and contraceptive services	1	2	3	4	5	6	7	8	9	10

FINAL QUESTIONS

- A. You were invited to work with other individuals if you wished. Did you do so? Yes ___ No___
- B. How long have you been closely acquainted with the national family planning program? _____ years
- C. During most of this time, what has your relationship been to the program?

D. If you are an employee of the program:

Title: _____

Duties: _____

E. If you live outside of the country:

Number of visits to the country in the last two years_____.

Approximate total time spent in the country during the last two years _____

F. Any final comments or suggestions?

ANNEX C. 2009 FPE NATIONAL COMPONENT SCORES, 81 COUNTRIES

	Total	Policies	Services	Evaluation	Access
Asia					
Afghanistan	50.7	56.0	51.6	53.4	41.8
Bangladesh	56.4	61.1	53.1	49.5	60.2
Cambodia	55.8	59.9	58.5	51.1	48.2
China	72.9	83.0	74.8	75.4	56.7
India	53.5	59.0	51.0	55.8	50.7
Indonesia	59.9	68.6	56.9	67.3	52.3
Malaysia	62.2	61.9	58.8	74.1	63.8
Myanmar	28.1	22.3	26.1	33.7	35.9
Nepal	56.8	58.4	55.0	48.3	62.0
Pakistan	45.7	59.6	42.5	45.3	35.9
Philippines	29.8	35.7	28.8	34.5	23.1
Sri Lanka	55.4	55.0	55.2	62.7	53.0
Viet Nam	71.1	77.8	67.4	63.3	73.8
AVERAGE	53.7	58.3	52.3	54.9	50.6
WEIGHTED AVERAGE	60.7	68.4	59.9	62.7	52.6
Central Asia					
Armenia	38.1	49.7	31.6	46.1	33.3
Azerbaijan	49.0	44.4	50.5	63.2	45.3
Georgia	46.6	48.1	43.1	50.3	49.8
Kazakhstan	37.5	42.7	31.2	33.6	44.7
Kyrgyzstan	42.0	40.1	37.2	51.9	48.9
Tajikistan	62.8	67.0	56.5	74.9	64.2
Turkmenistan	64.3	57.6	64.3	78.7	65.8
Ukraine	47.9	49.2	38.6	62.1	57.3
Uzbekistan	60.2	65.9	56.3	59.5	61.1
AVERAGE	49.8	51.6	45.5	57.8	52.3
WEIGHTED AVERAGE	50.4	52.7	44.5	58.1	55.2
Middle East/North Africa					
Algeria	63.6	71.0	62.4	74.3	52.9
Egypt	60.9	71.9	57.6	69.4	51.0
Iran	57.9	48.7	58.4	54.1	69.3
Jordan	51.3	61.2	41.7	54.1	56.4
Lebanon	53.5	49.1	50.4	63.2	60.1
Libya	20.4	21.5	7.9	13.3	45.2
Morocco	66.7	71.7	65.7	80.5	56.8
Turkey	52.7	51.7	46.3	68.4	59.1
Yemen	38.8	44.3	36.5	37.6	37.2
AVERAGE	51.8	54.6	47.4	57.2	54.2
WEIGHTED AVERAGE	56.7	58.9	53.7	63.8	56.7

Latin America					
Bolivia	48.8	46.3	46.4	50.7	55.4
Brazil	39.3	45.9	32.9	40.7	43.0
Chile	64.7	68.4	64.1	76.4	56.6
Colombia	50.0	52.4	42.4	42.1	64.7
Costa Rica	53.1	55.0	49.2	44.6	61.8
Dominican Republic	46.3	56.4	42.2	42.4	43.9
Ecuador	52.8	54.8	48.9	43.4	61.8
El Salvador	47.5	47.1	43.6	57.7	50.8
Guatemala	42.7	36.1	43.8	47.2	46.1
Haiti	33.2	36.9	31.3	29.7	34.1
Honduras	50.3	49.4	49.1	54.5	52.0
Jamaica	62.5	72.5	56.6	68.1	59.7
Mexico	52.4	48.8	46.5	66.9	61.4
Nicaragua	47.4	44.2	46.8	49.3	51.4
Panama	54.9	53.3	52.8	51.0	62.5
Paraguay	46.4	48.3	43.4	51.9	47.6
Peru	41.0	46.8	36.0	43.9	42.3
Trinidad & Tobago	57.1	69.8	59.4	28.6	50.7
AVERAGE	49.5	51.8	46.4	49.4	52.5
WEIGHTED AVERAGE	45.8	48.4	40.4	49.3	51.1
Sub-Saharan Africa					
<i>(Anglophone)</i>					
Eritrea	37.9	33.3	38.6	44.1	39.0
Ethiopia	45.3	55.9	43.6	37.7	39.4
Gambia	50.3	53.5	52.4	46.6	44.3
Ghana	46.4	51.7	41.8	50.1	47.3
Kenya	48.7	55.8	41.0	75.8	43.5
Lesotho	50.0	48.8	48.3	49.3	55.1
Liberia	34.8	51.5	28.4	36.5	26.9
Malawi	47.8	52.6	47.5	46.4	43.6
Mauritius	60.6	64.0	58.9	63.9	58.4
Nigeria	33.6	38.1	32.9	38.9	27.6
Sierra Leone	41.1	50.3	38.6	41.7	34.8
South Africa	48.0	54.1	38.6	50.2	57.8
Swaziland	46.7	46.9	43.9	47.9	51.4
Tanzania	47.0	50.5	44.3	49.1	47.2
Uganda	50.4	63.4	47.8	47.9	41.5
Zambia	44.6	49.2	38.2	45.3	51.0
Zimbabwe	59.9	66.0	59.4	59.5	54.2
AVERAGE	46.7	52.1	43.8	48.9	44.9
WEIGHTED AVERAGE	43.0	49.5	40.0	46.1	39.9
<i>(Francophone)</i>					
Benin	35.1	42.8	31.0	40.5	31.7
Burkina Faso	45.6	49.3	41.1	50.7	47.4
Burundi	40.2	55.7	32.5	43.7	35.1
Cameroon	41.4	52.0	36.2	41.9	38.8

Chad	36.7	51.6	30.4	38.1	30.6
Congo	44.8	49.6	43.2	45.8	41.7
Congo, Democratic Republic	34.3	34.6	33.5	40.9	32.5
Côte d'Ivoire	54.4	61.1	52.3	62.3	47.1
Guinea	46.2	53.0	46.4	41.5	40.1
Madagascar	64.0	67.2	65.4	65.5	57.2
Mali	61.4	69.7	61.5	63.2	50.9
Mauritania	21.0	19.2	16.4	24.0	30.6
Mozambique	39.2	42.0	33.4	46.7	43.7
Niger	55.0	60.6	56.6	67.3	40.3
Senegal	47.5	52.4	47.1	46.2	43.2
AVERAGE	46.5	53.2	43.9	50.2	42.3
WEIGHTED AVERAGE	45.4	50.7	43.2	50.1	41.4
Global					
AVERAGE	49.3	53.5	46.3	52.1	48.8
WEIGHTED AVERAGE	56.3	62.8	54.6	59.2	51.0

ANNEX D. REGIONAL COMPONENT SCORES: 1999, 2004, 2009

Total and Four Component Scores by Region, 1999, 2004, and 2009, 61 Countries

TOTAL SCORE	2009	2004	1999
Asia	53.8	55.8	55.0
Central Asian Republics	53.3	49.1	44.3
Middle East/North Africa	54.0	50.2	47.9
Latin America	49.0	46.3	43.8
Sub-Saharan Anglophone	47.3	47.1	44.1
Sub-Saharan Francophone	45.6	42.0	38.8
GLOBAL	49.7	47.9	45.3
POLICIES			
	2009	2004	1999
Asia	58.8	61.3	62.4
Central Asian Republics	54.7	50.0	45.3
Middle East/North Africa	58.3	60.2	50.6
Latin America	50.7	47.3	47.5
Sub-Saharan Anglophone	53.0	51.7	52.6
Sub-Saharan Francophone	51.6	46.0	42.9
GLOBAL	53.8	51.8	50.3
SERVICES			
	2009	2004	1999
Asia	52.1	53.5	49.9
Central Asian Republics	49.1	44.8	40.1
Middle East/North Africa	49.7	44.5	43.6
Latin America	45.6	43.1	37.7
Sub-Saharan Anglophone	44.2	45.6	40.9
Sub-Saharan Francophone	43.2	40.7	37.2
GLOBAL	46.7	45.2	41.1
EVALUATION			
	2009	2004	1999
Asia	54.4	54.6	58.0
Central Asian Republics	59.7	50.8	39.6
Middle East/North Africa	62.2	53.8	50.6
Latin America	50.6	50.8	42.2
Sub-Saharan Anglophone	47.4	49.4	41.1
Sub-Saharan Francophone	48.7	46.5	45.8
GLOBAL	52.2	50.7	46.1

ACCESS	2009	2004	1999
Asia	51.1	53.9	54.5
Central Asian Republics	56.9	56.4	54.6
Middle East/North Africa	53.4	47.2	52.2
Latin America	52.7	49.4	52.7
Sub-Saharan Anglophone	46.5	42.9	41.1
Sub-Saharan Francophone	41.8	37.5	33.5
GLOBAL	49.5	47.1	47.4

ANNEX E: MEMORANDUM

Family Planning Program Effort in Sub-Saharan Africa, 1972–2009

John Ross
February 19, 2010

This memorandum is prepared as an addendum to the presentation to USAID staff on January 28, after which it was agreed that a look at sub-Saharan Africa alone would be useful, with particular attention to PEPFAR vs. Non-PEPFAR countries and to Anglophone vs. Francophone countries. So, we have four groups of countries, as shown in **Table 1**.

The entire series of seven rounds of the research, from 1972 to 2009, caught 42 countries at one time or another in the sub-Saharan region. In 2009, 32 of those countries were included, and those are the ones in Table 1.

The best way to compare the positions of these four groups in 2009, for the Total Score, is in **Figure 1**. The midpoints are nearly the same, in the mid 40s to high 40s, but the figure highlights the considerable diversity within every group. That, in turn, suggests more attention to individual cases, with inputs from staff who know the local situations. (Moreover some anomalies exist in the scores, as with improbably high readings for Tanzania and Uganda in 1999 and Niger in 2009; see **Table 2**.)

Most PEPFAR countries are in the Anglophone group; only three are in the Francophone group (and Rwanda is missing in 2009). The pattern for Anglophone-PEPFAR is nearly identical to Anglophone-NonPEPFAR if we discount the two high points for Zimbabwe and Mauritius.

The time trends in **Figure 2**, top two panels, also suggest some similarity between the two Anglophone groups: in 1994, both Total scores were at 50, and the changes to 2009 were not much different.

The two Francophone groups (bottom two panels) also agree with each other, though at lower levels than the Anglophone groups. They were below 40 in 1994 and rose to about 45 by 2009. (In the PEPFAR group, Rwanda is missing from the line in 1994 and 2009, but the trend is similar when re-done with only the other two countries every year.)

Information for all 42 countries for all years 1972–2009 appears in Table 2.

Trends for the Four Components in the Four Geographic Groups, 1982–2009

The trends in **Figure 3** provide a closer look at the major types of effort. There are five panels, first for the Total Score, then for each of the four components. (As in Figure 2, the break between 1994 and 1999 signals the change in methodology and the likely discontinuity.) (All numerical values are in **Table 3**.)

Total Scores: First, a glance at the Total Scores (top panel) shows the sharp rise from 1982 to 1989 to the 1999 level, which was basically sustained from then on. The Anglophone group is highest, above the Francophone group; however, the latter rose after 1999 to close the gap to the other lines. The positions of the PEPFAR and Non-PEPFAR groups are very close (though below PEPFAR does better in 2009 on Services and a little better on Access).

Note that the Non-PEPFAR group contains nearly all of the Francophone group, along with a smaller number of Anglophone countries.

Policy Scores: In 2009, Policy scores exceed Total scores; in fact, in all analyses, Policy scores rank higher than the other components, suggesting that it is considerably easier to declare favorable policies than to implement them. (That however does not mean that favorable policy determinations, with real intent, emerge without considerable effort.) All groups rose slightly after 2004. The Anglophone group's policies fell after 1999; it is unclear why. Interestingly, the Francophone group rose to close the gap to the other groups.

Services and Access Scores: In 2009, both Services and Access scored only at about 40 to 45 percent of maximum effort. In the last five years, Services have been flat, while Access has improved a little. As with the other components, it is unclear why the Anglophone group fell after 1999; for Access, the PEPFAR group also fell, partly because nearly all of PEPFAR is Anglophone. The Francophone group has improved somewhat since 1999.

The 1982 to 1994 trends are interesting: first the sharp rises, then the wide disparities in 1994 that closed thereafter. Methodologically, it is curious that after the 1994/1999 discontinuity scores jumped for Services, Access, and Evaluation, but not for Policies. Therefore, Total scores also jumped, here in sub-Saharan Africa—though the average Total scores for all countries (all regions) fell.

Evaluation scores (M&E) come from only three of the 30 indicators and can fluctuate more than the other components do. However, the trends here are quite similar to those seen above: the groups cluster fairly closely in 2009. They do so at about half of maximum effort. The Anglophone group declined from 1999 to 2004, as did the PEPFAR group.

Effort Patterns Across the Thirty Individual Scores

The comparisons in **Figure 4** (two panels) contrast PEPFAR vs. Non-PEPFAR countries for the Anglophone sector, and second, contrast all Anglophone vs. all Francophone countries. All 30 scores are shown, together with the averages for the Total and four Component Scores (5 leftmost points).

Comparison of PEPFAR and Non-PEPFAR Profiles for Anglophone countries: The first chart shows the very similar profiles for PEPFAR and Non-PEPFAR countries within the Anglophone group. (In the Francophone group, there are only two countries in 2009).

PEPFAR does slightly worse overall, but the main deficiencies are under Services, where it especially falls down on its administrative structure, training program, personnel performing their tasks, and logistics. It also suffers from less involvement of the civil bureaucracy, on community-based distribution, and on postpartum programs. These all pertain to actual implementation features, a cluster that may signal a harder hit by HIV on the health ministries in certain member countries. Or, are there other explanations?

Comparison of Anglophone and Francophone Countries: The patterns of these two groupings are surprisingly close. Anglophone has a slight advantage (see five averages to the left), but both Total means are disappointingly low, below 50 percent. Anglophone does better on the level of program leadership but worse on leadership statements; it does better on community-based distribution but worse on CSM. It has a slight but consistent advantage on the same cluster of implantation features discussed above, of administrative structure, training, personnel, and logistics. It is also stronger on sterilization.

But mainly, the two groups differ little in the effort they give to each of the 30 types of effort.

All these group comparisons are enlightening, even when they show unexpected similarities. They help for general planning and resource allocations, and they give a context for examining a particular country. Local program actions, however, must be based on additional information and management judgment.

Table 1. 2009 Total Scores for Four Groups, Ordered by Size

We have scores on 42 countries for the period 1972–2009, though some countries are missing data in some years. This table shows the 32 countries with data for 2009, which include all of the largest countries and a high percentage of the total population of the region.

	Group 1 A (P)		Group 2 A (NP)	
Nigeria	33.6	Liberia	34.8	
Zambia	44.6	Eritrea	37.9	
Ethiopia	45.3	Sierra Leone	41.1	
Tanzania	47.0	Ghana	46.4	
South Africa	48.0	Swaziland	46.7	
Kenya	48.7	Malawi	47.8	
Uganda	50.4	Lesotho	50.0	
		Gambia	50.3	
		Zimbabwe	59.9	
		Mauritius	60.6	
	Group 3 F (P)		Group 4 F (NP)	
Mozambique	39.2	Mauritania	21.0	
Cote d'Ivoire	54.4	Congo, DR	34.3	
		Benin	35.1	
		Chad	36.7	
		Burundi	40.2	
		Cameroon	41.4	
		Congo	44.8	
		Burkina Faso	45.6	
		Guinea	46.2	
		Senegal	47.5	
		Niger	55.0	
		Mali	61.4	
		Madagascar	64.0	

A: Anglophone; F: Francophone; (P): PEPFAR; (NP): Non-PEPFAR

Figure I. 2009 Total Scores, Four Groups of Countries
 (Note diversity within each group)

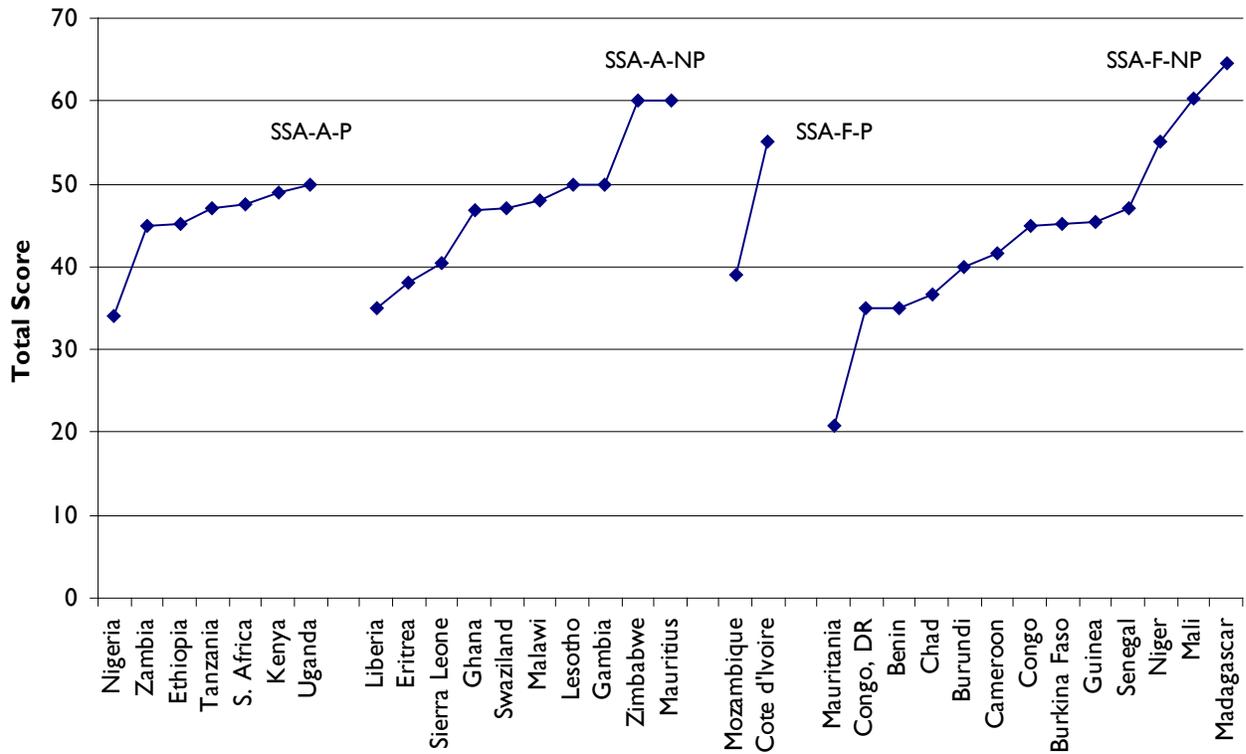


Figure 2. Group Total Scores

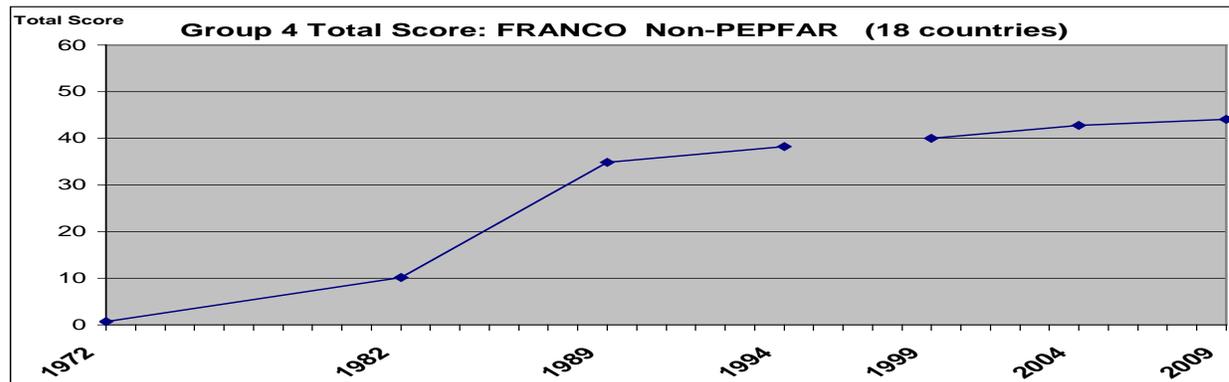
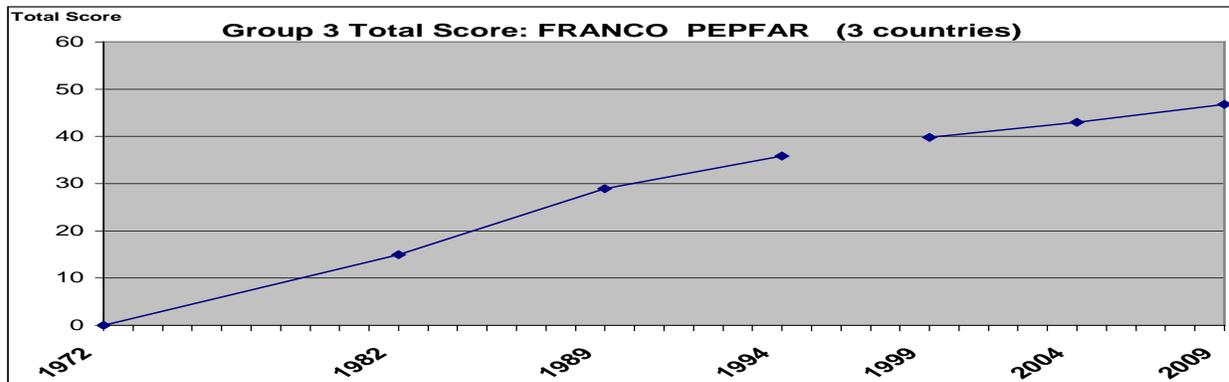
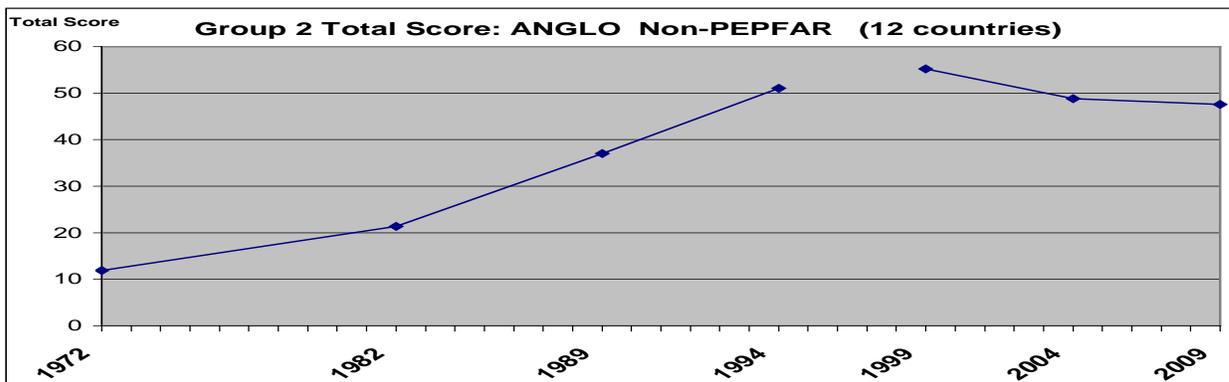
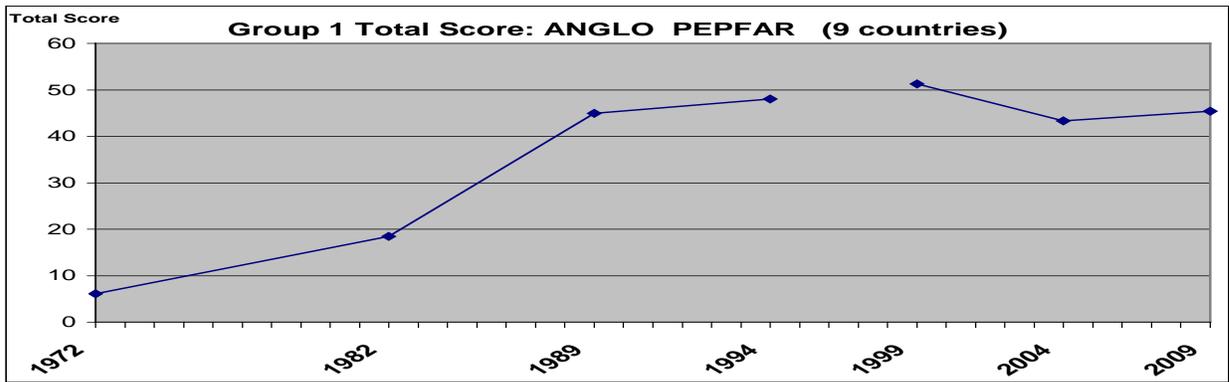
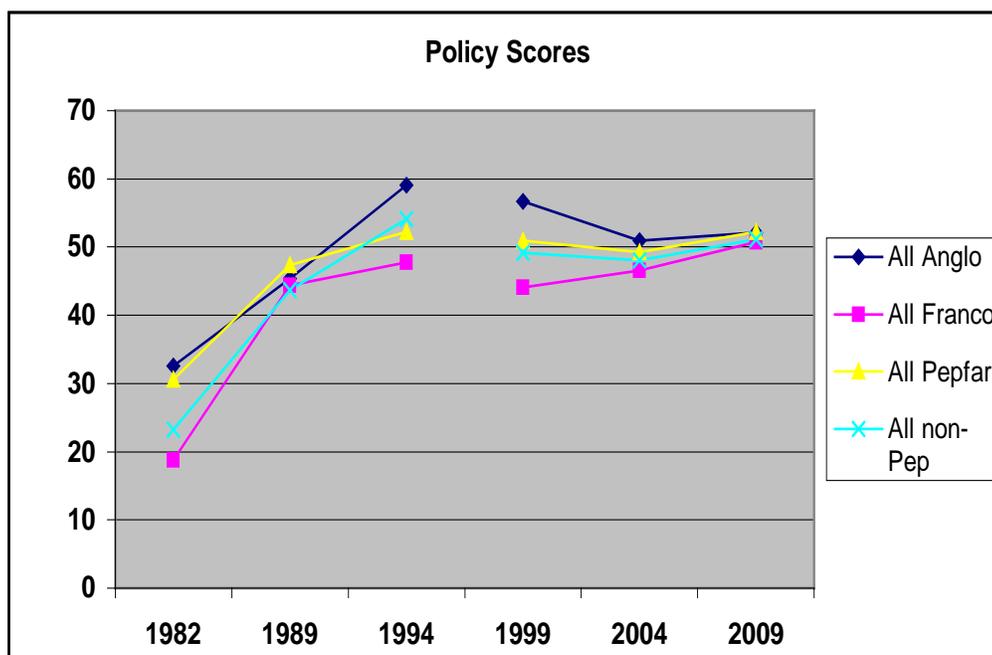
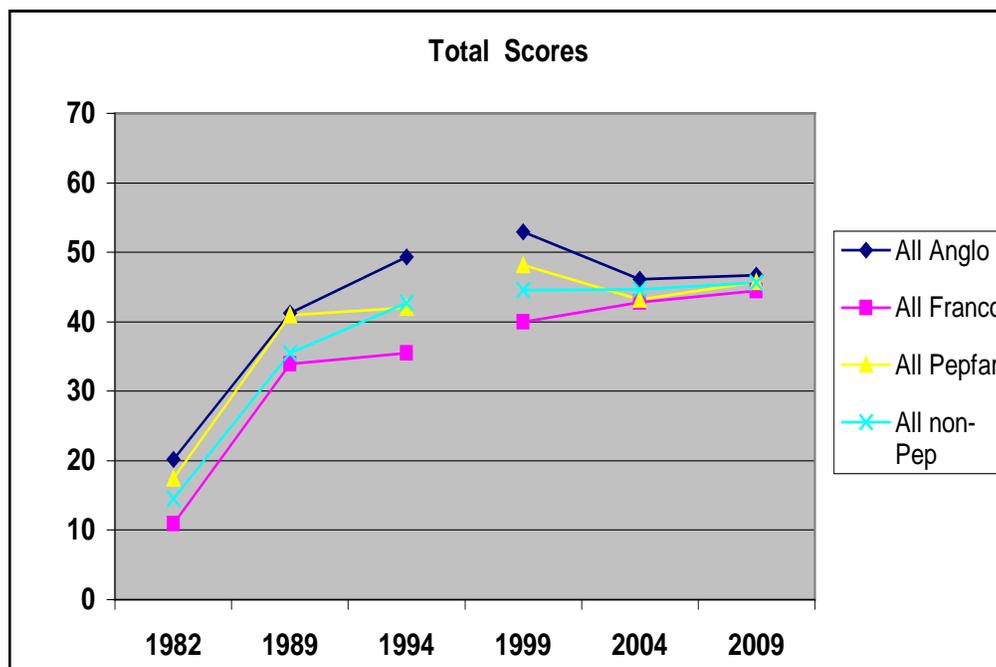


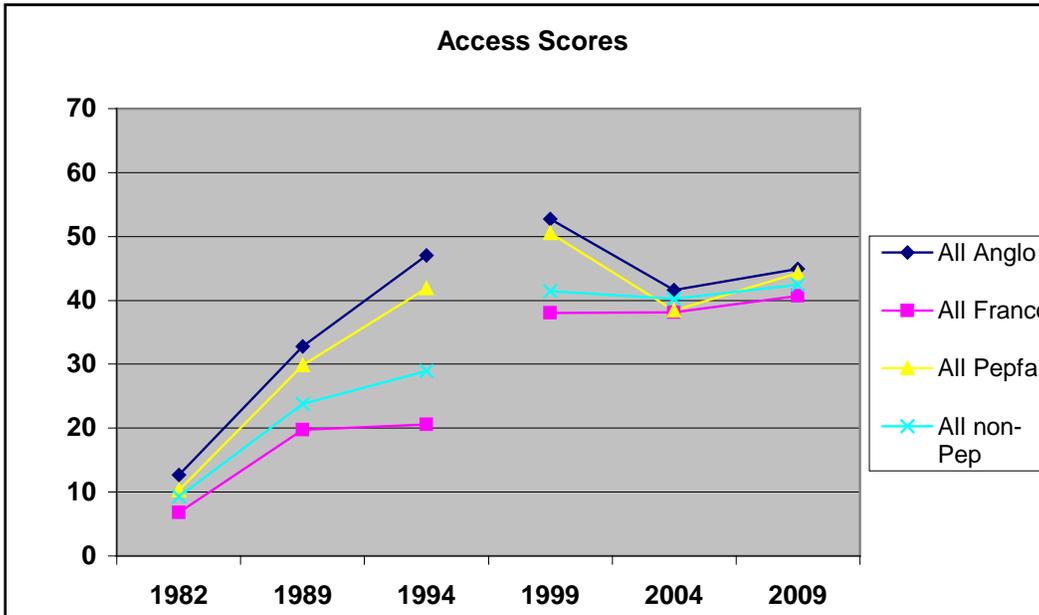
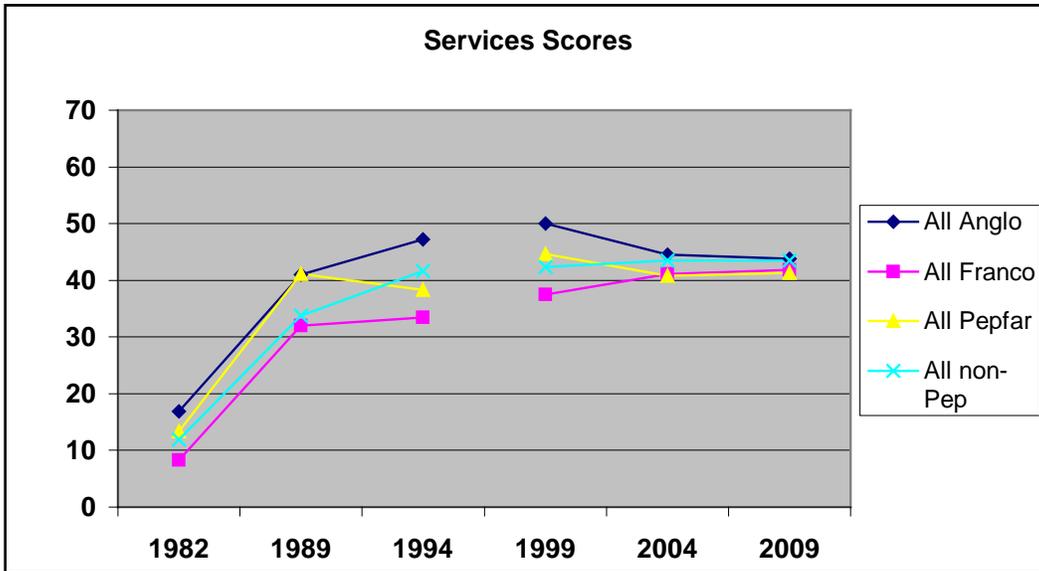
Table 2. Total Scores, All Years, All 42 Countries

	1972	1982	1989	1994	1999	2004	2009
ANGLO-PEPFAR							
Botswana	na	26.5	74.9	65.8	na	na	na
Ethiopia	-	6.2	32.0	38.3	38.7	37.1	45.3
Kenya	20.0	28.1	57.6	55.8	49.6	na	48.7
Namibia	na	na	10.8	42.5	51.8	54.3	na
Nigeria	6.7	12.8	43.2	41.7	50.3	41.1	33.6
South Africa	na	na	61.9	55.8	47.4	46.0	48.0
Tanzania	10.0	22.3	41.7	47.5	71.2	44.7	47.0
Uganda	-	17.1	33.1	44.2	61.1	43.0	50.4
Zambia	-	16.4	49.2	40.8	39.9	36.9	44.6
Means	6.1	18.5	44.9	48.1	51.2	43.3	45.4
ANGLO-NonPEPFAR							
Eritrea	na	na	na	na	na	na	37.9
Gambia	na	26.0	na	na	na	50.2	50.3
Ghana	10.0	17.8	52.1	52.5	52.6	55.5	46.4
Lesotho	-	13.9	45.1	43.3	55.5	46.7	50.0
Liberia	10.0	21.6	na	na	na	38.4	34.8
Malawi	-	5.8	16.5	44.2	44.5	50.1	47.8
Mauritius	66.7	68.3	69.5	74.2	74.0	na	60.6
Sierra Leone	-	16.1	35.5	46.7	na	na	41.1
Somalia	-	9.6	0.8	na	na	na	na
Sudan	10.0	7.5	20.2	29.2	55.7	na	na
Swaziland	na	na	na	na	na	39.3	46.7
Zimbabwe	10.0	27.3	56.4	67.5	48.9	61.6	59.9
Means	11.9	21.4	37.0	51.1	55.2	48.8	47.6
FRANCO-PEPFAR							
Cote d'Ivoire	-	5.5	16.3	38.3	52.0	38.3	54.4
Mozambique	-	16.4	27.3	33.3	23.4	55.0	39.2
Rwanda	-	23.0	43.3	-	44.0	35.7	na
Means	-	15.0	29.0	23.9	39.8	43.0	46.8
FRANCO-NonPEPFAR							
Angola	-	na	39.4	24.2	na	na	na
Benin	10.0	11.4	28.5	37.5	30.3	53.4	35.1
Burkina Faso	-	4.3	45.1	na	46.0	58.3	45.6
Burundi	-	10.5	40.3	na	na	41.5	40.2
Cameroon	-	8.4	34.2	49.2	35.5	41.1	41.4
Central African Rep.	-	10.3	42.2	40.0	39.3	47.4	na
Chad	-	6.9	19.5	26.7	25.3	28.9	36.7
Congo	-	15.3	36.1	27.5	35.5	25.9	44.8
Congo, DR	na	12.9	28.3	na	na	31.6	34.3
Gabon	na	na	na	na	47.7	na	na
Guinea	-	4.5	39.6	50.0	48.2	45.8	46.2
Guinea-Bis	na	13.6	28.5	35.8	na	na	na
Madagascar	-	8.6	40.3	32.5	33.7	47.7	64.0
Mali	-	11.3	37.6	45.0	59.3	52.6	61.4
Mauritania	-	3.5	20.8	31.7	19.1	40.1	21.0

Niger	-	4.6	38.4	45.8	35.6	26.3	55.0
Senegal	-	22.7	43.7	50.8	52.0	46.1	47.5
Togo	-	13.9	29.7	na	52.7	54.7	na
Means	0.7	10.2	34.8	38.2	40.0	42.8	44.1

Figure 3. (Five Panels) Time Trends by Component and Country Groups





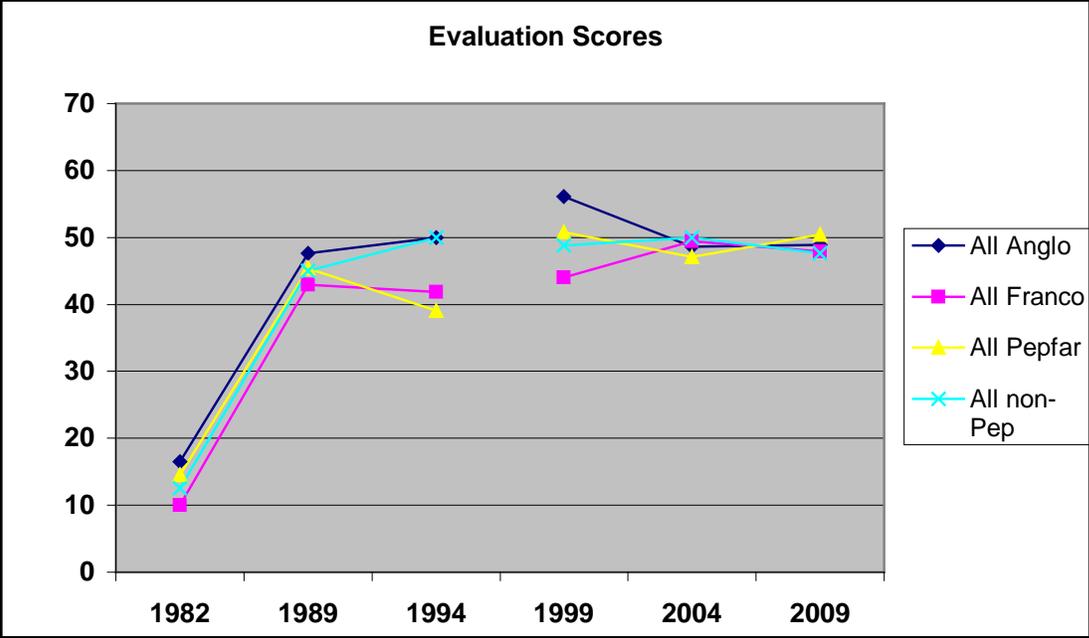
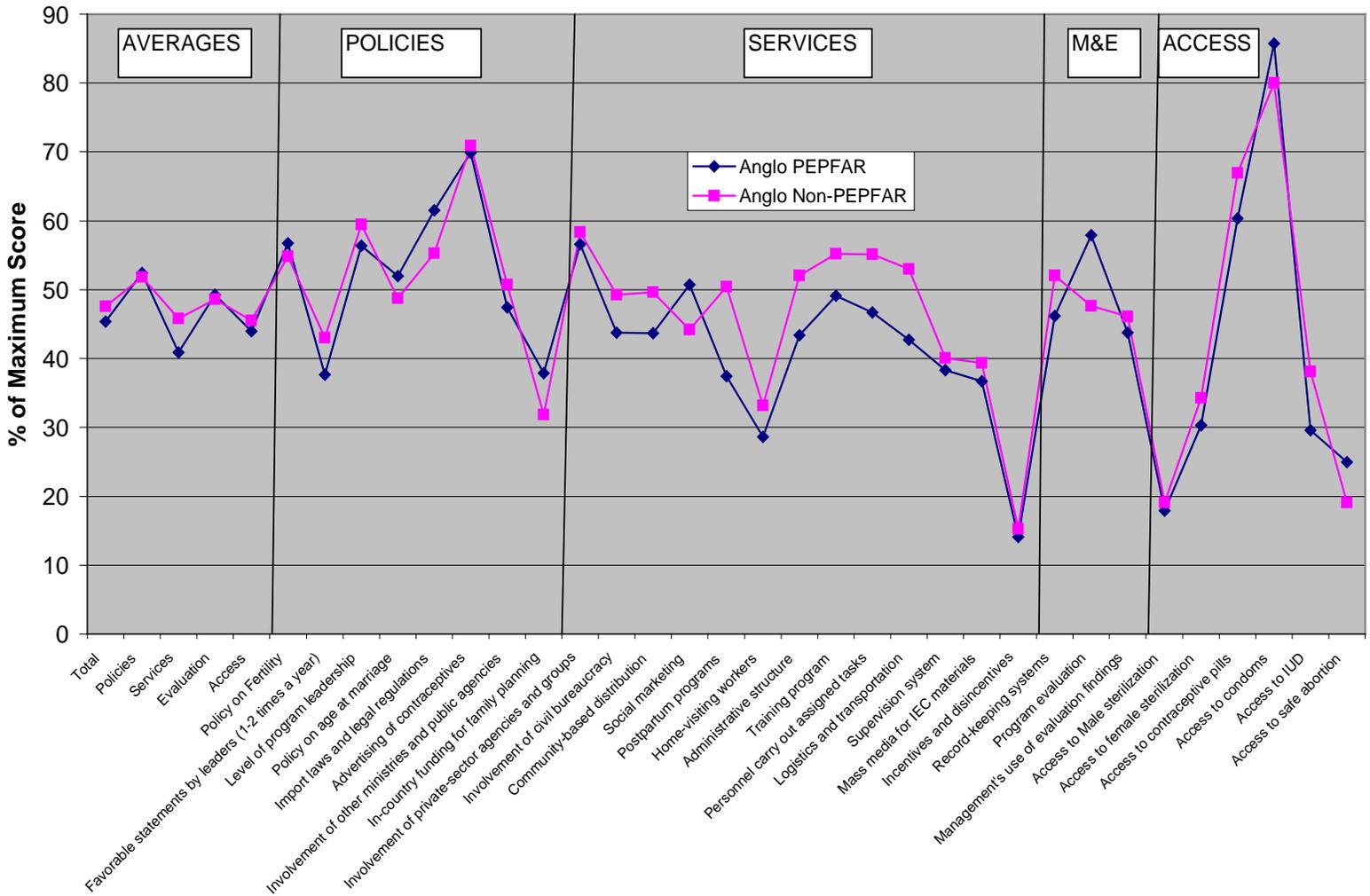
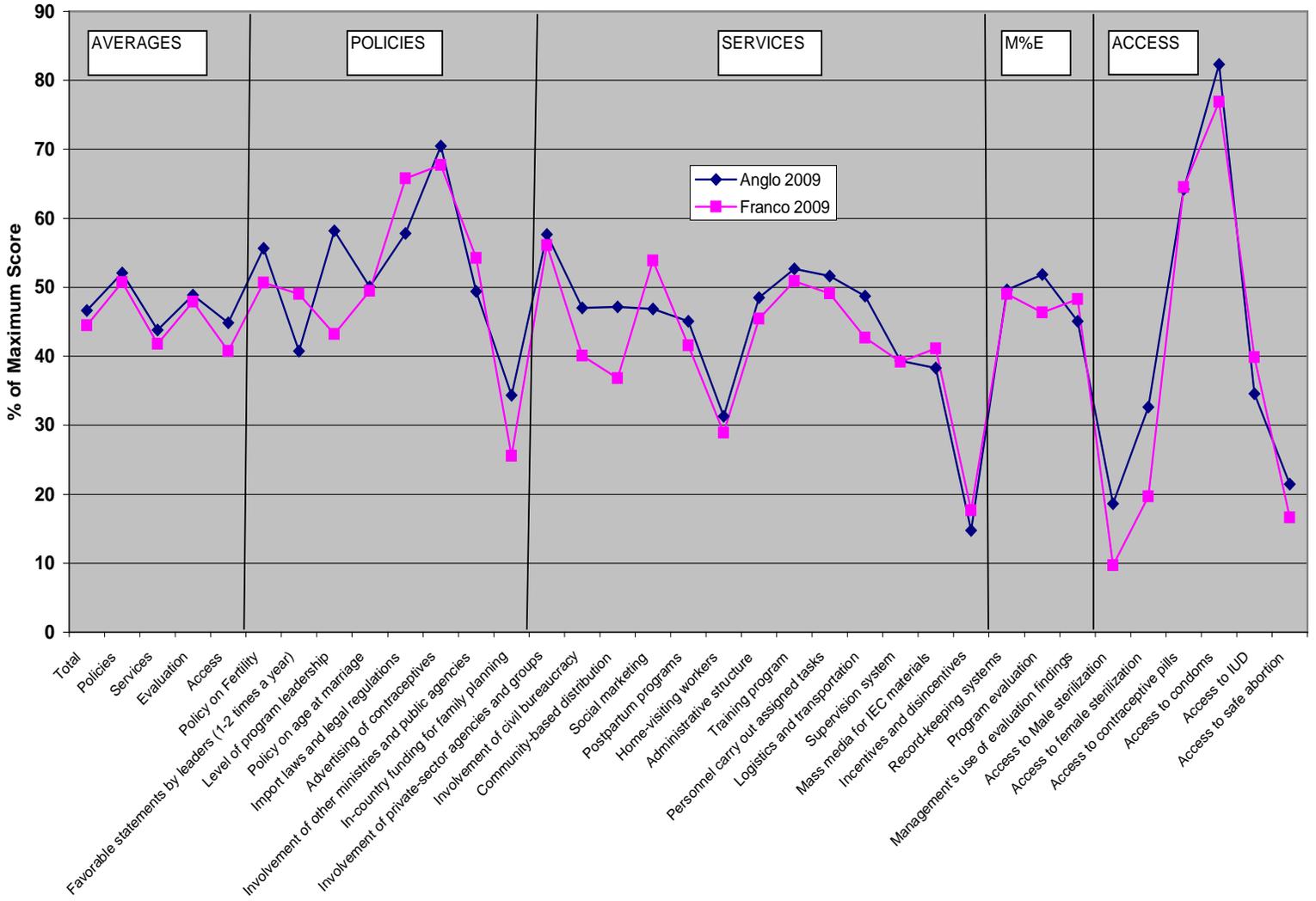


Table 3. 2009 Scores by Component and Group

	Year	All Anglo	All Franco	All PEPFAR	All Non-PEPFAR	ALL SSA
TOTAL						
	1982	20.2	10.9	17.4	14.5	15.3
	1989	41.2	34.0	41.0	35.5	37.3
	1994	49.4	35.5	42.0	42.7	42.4
	1999	53.0	40.0	48.1	44.6	45.8
	2004	46.1	42.8	43.2	44.7	44.2
	2009	46.7	44.4	45.7	45.6	45.6
POLICY						
	1982	32.6	18.8	30.6	23.2	25.3
	1989	45.4	44.4	47.4	43.7	44.9
	1994	59.0	47.7	52.2	54.1	53.4
	1999	56.7	44.1	50.9	49.1	49.8
	2004	50.9	46.5	49.3	48.1	48.5
	2009	52.1	50.7	52.2	51.1	51.4
SERVICES						
	1982	16.9	8.2	13.3	11.9	12.3
	1989	41.0	32.0	41.1	33.7	36.1
	1994	47.2	33.4	38.3	41.6	40.3
	1999	50.0	37.5	44.7	42.3	43.1
	2004	44.5	41.1	40.8	43.4	42.6
	2009	43.8	41.8	41.3	43.4	42.9
EVALUATION						
	1982	16.5	10.0	14.5	12.6	13.1
	1989	47.6	43.0	45.4	45.0	45.1
	1994	50.0	41.8	39.1	50.0	45.9
	1999	56.1	44.0	50.8	48.8	49.5
	2004	48.7	49.4	47.1	50.0	49.1
	2009	48.9	47.9	50.4	47.6	48.4
ACCESS						
	1982	12.7	6.8	10.3	9.3	9.6
	1989	32.8	19.7	29.8	23.8	25.7
	1994	47.1	20.5	41.9	28.9	33.8
	1999	52.7	38.0	50.6	41.4	44.6
	2004	41.6	38.1	38.4	40.2	39.7
	2009	44.9	40.7	44.3	42.4	42.9

Figure 4. (Two Panels) Comparison of Anglo PEPFAR and Anglo Non-PEPFAR 2009 and Comparison of Anglo and Franco 2009





ANNEX F. MEAN* SCORES FOR PROGRAM JUSTIFICATIONS, EMPHASES ON SPECIAL POPULATIONS, INFLUENCES, AND QUALITY, 81 COUNTRIES, BY REGION

	All	Asia	Central Asia	Latin America/ Caribbean	Middle East/North Africa	Anglo-phone Africa	Franco-phone Africa
JUSTIFICATIONS							
Reduce population growth	69.8	80.0	30.2	29.9	66.5	59.1	51.2
Enhance economic development	69.2	74.4	67.8	43.0	66.6	63.9	63.1
Reduce unmet need	78.2	80.6	80.1	79.3	69.0	71.5	67.2
Reduce nonmarital adolescent childbearing	62.7	63.3	80.5	62.8	39.6	63.1	76.3
Improve women's health	83.3	83.2	91.1	83.3	82.6	82.2	84.6
Improve child health	78.0	77.0	87.5	75.4	80.8	80.1	83.4
Avoid unwanted births	83.3	84.3	86.5	84.9	78.8	78.8	79.8
EMPHASES ON SPECIAL POPULATIONS							
The poor	66.8	71.4	50.9	66.4	63.7	49.7	49.1
Rural population	70.0	76.6	59.9	53.5	72.5	51.4	48.1
Unmarried youth	38.3	34.8	59.1	50.5	28.5	45.2	52.9
Postpartum women	59.0	59.8	74.6	56.9	63.1	48.5	58.9
Postabortion women	52.2	52.6	69.1	53.0	45.9	47.3	55.3
INFLUENCES							
Changes in donor funding	-3.7	-5.0	32.2	-2.7	-5.9	-6.9	4.4
Changes in domestic funding	14.2	15.4	33.7	-1.7	22.3	11.3	12.5
Decentralization	31.7	32.7	25.9	9.8	34.3	44.9	34.0
Integration with other health services	49.1	48.9	73.1	38.3	52.5	50.6	54.2
Incorporation with reproductive health	54.1	54.9	73.2	49.8	49.1	51.7	53.4
HIV/AIDS programs	38.7	41.7	54.2	33.2	34.4	15.6	51.2
QUALITY	53.8	56.0	51.5	44.8	60.8	45.6	48.6

*All scores weighted for regional populations.
Note: Negative scores indicate detrimental effects.

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