



Among African countries, the ability and commitment to finance the costs of providing family planning and other reproductive health services varies widely. Some wealthier countries in the region can bear a greater proportion of the costs of national programs. But most countries are extremely poor, and both governments and individuals are limited in their ability to pay for services.

In Cairo in 1994, the international community set the goal of achieving universal access to basic reproductive health care by the year 2015. Africa, because of its poverty and current low base of services, faces perhaps the greatest challenge of any region in mobilizing the financial resources needed to reach this goal.

- With demand for family planning services increasing rapidly, the number of contraceptive users in Africa is projected to double between 1993 and 2000, to 33 million, then triple to 100 million by the year 2015. Millions of Africans also have a need for other reproductive health services, including STD prevention and treatment, and maternal and postabortion care. Countries also face the challenge of improving and expanding services for young people and men.
- Meeting these needs will require an enormous increase over current funding levels. To insure access to quality contraceptive services alone, spending on family planning will have to increase from an estimated \$300 million in 1993 to \$1.1 billion in the year 2000 and \$2.4 billion by 2015. Adequate provision of related reproductive health services will require at least an additional \$900 million annually by the year 2000, and \$1.4 billion by 2015. The resource gap for related reproductive health services is also large, since both governments and donors have thus far made relatively negligible investments in these services.

Mobilizing the resources to bridge this funding gap will be no easy task. It will require increased contributions from a variety of financing sources – national governments, international donors and private households – as well as concerted efforts to address current obstacles to increasing spending on reproductive health.

National Governments

Compared to governments in other regions, African governments contribute a relatively small share of total spending on family planning – only about one-fifth on average, a reflection of the low priority most African governments have given to population and family planning. Even in Kenya, where the family planning program is among the strongest in the region, in 1993 the government share of family planning program costs was only about 10 percent.

Inadequate spending on family planning and reproductive health is also a reflection of the relatively small public sector role in health care financing; African governments on average finance only one-third of all health care costs; donors cover another 20 percent, while private households pay for the remainder.

Low spending on family planning and health in general also reflects misplaced priorities. Most African governments spend more on the military than they do for health services. Furthermore, government expenditure on health is heavily tilted towards expensive curative services that benefit a relatively small group of people. Of the roughly \$2 billion that African governments spent on health care in 1990, at most only \$200 million – 10 percent – went for preventive care, including family planning and basic reproductive health services.

Moreover, many health needs compete for available primary health funds. African governments continue

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to battle long-standing and serious health problems such as diarrhea, malaria and acute respiratory infections, which together account for a third of the burden of disease in sub-Saharan Africa. Stronger government commitment is key to ensuring that family planning, HIV/AIDS and STD prevention, and other pressing reproductive health needs receive their fair share of limited resources. This is an emerging problem in Zambia, for example, where the government is integrating all special programs into a single package of basic health services.

International Donors

As a source of both financial and technical support for population programs, international donors have played a more central role in Africa than in any other developing region. Bilateral donors and multilateral development banks provide almost two-thirds of financing for African family planning services; the share in other regions ranges from just 5 percent in East and Southeast Asia to 40 percent in South Asia.

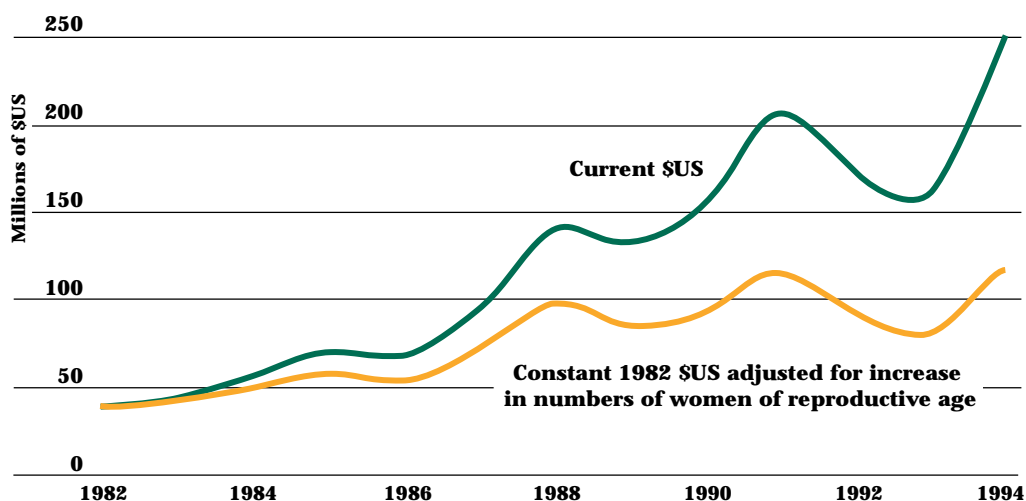
The dependence on donor population assistance is virtually uniform throughout sub-Saharan Africa. External aid represents less than half of total expenditure on contraceptive services in only 3 of 36 countries studied in 1995 – Mauritius, South Africa and Sudan.

Since the early 1980s, the volume of population assistance to Africa has increased notably. After adjusting for inflation, grant aid for population programs in Africa tripled between 1984 and 1994; meanwhile, Africa's share of global population assistance jumped from 12 to 25 percent. Population aid to Africa in 1994 totaled \$252 million, an increase of more than 50 percent over 1993. Figures for 1995 show another large increase, to \$361 million; however, part of this rise appears to reflect the use of a broader definition for population assistance.

Donor support has been concentrated in a relatively few African countries. Kenya and Nigeria have consistently been among the top three population aid recipients in Africa, each receiving on average over \$15 million per year between 1985 and

FIGURE 19

Trends in Population Assistance to Sub-Saharan Africa



SOURCES: UNFPA. *Global Population Assistance Report, 1994*. New York: UNFPA, 1996; United Nations. *World Population Prospects: The 1996 Revision*. New York: United Nations, 1996.

1994. However, in terms of aid per woman of reproductive age, many of the smaller countries in Africa, for example, Swaziland and the Gambia, have received relatively high amounts – over \$4 per woman compared to between \$2 and \$4 in larger countries such as Kenya, Ghana and Uganda.

Using the same measure, many African countries also receive greater amounts of assistance than most other developing countries. For example, Bangladesh, the world's largest recipient of population funds, receives about \$3 per woman; other large beneficiaries such as Indonesia, India and Pakistan all receive less than \$1 per woman.

Bilateral Donors

The **United States** has been the most important source of donor funding for population programs in Africa. U.S. bilateral population assistance, managed through the U.S. Agency for International Development (USAID) and its network of private technical assistance agencies, accounts for roughly half of all population aid to Africa; between 1989 and 1996, U.S. funding for family planning activities in the region rose from \$72 million to \$127 million.

In a number of African countries, the United States has provided consistently high levels of support. U.S. population assistance to Kenya, for example, averaged \$16 million a year between 1991 and 1996. The United States has shown significant levels of commitment in Nigeria (\$12 million a year) and Ghana (\$7 million a year). Fifteen of 20 USAID country offices fund major population and health programs; 14 support HIV/AIDS prevention activities. Beyond its financial importance, USAID – through its network of technical agencies – has been the only donor with the breadth and depth of expertise to provide hands-on assistance to all key elements of national family planning programs. It has been responsible for much of the progress in African countries to date.

Yet U.S. leadership on population issues in the region is in danger of slipping.

- Major cuts in overall U.S. population funding threaten to harm efforts in Africa, as well as elsewhere. Global U.S. family planning funding was cut by 35 percent between 1995 and 1996; 1997 budgets rose slightly, but are still 30 percent below 1995 levels.

- USAID has greatly reduced the number of countries in Africa to which it provides comprehensive assistance. Nine field missions – mostly in West Africa – were closed between 1994 and 1996. A regional effort in West Africa provides limited continued support to population programs in four countries – Burkina Faso, Cameroon, Côte d'Ivoire and Togo – where USAID has closed field missions. It is too soon to say, however, whether this arrangement will prove effective. The agency withdrew from Niger in 1997, and expects to withdraw from Zimbabwe and Guinea-Bissau within five years. Staff cuts, combined with mission closings, have reduced the number of USAID population and health experts in the field by over one-third and have left some country programs without adequate technical oversight.

- Because of disagreement over the pace of democratization, in 1997 USAID slashed its support to Kenya by half – just as demand for family planning was skyrocketing. The cuts have affected NGO programs the most; support to some NGOs has already ended, and funding for others will be phased out.

In recent years, **Germany** has emerged as an important donor to population programs in Africa, although on a smaller scale than the United States. In 1995, Germany gave roughly \$70 million to fund family planning and reproductive health

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programs in 22 African countries. Substantial, further increases in German population assistance appear unlikely, however, in light of recent cutbacks in foreign aid.

Like Germany the **United Kingdom** has expanded its population assistance in Africa, and funded programs in 12 African countries in 1995. In 1996, the United Kingdom donated \$27 million for family planning and reproductive health projects in the region.

Many other bilateral donors provide support to population programs in Africa in a smaller way. Finland, the Netherlands and Sweden work in a few selected countries. Four of 12 priority countries under Japan's Global Initiative in Population and AIDS are in sub-Saharan Africa, although Japan provides very little direct support to family planning service delivery. The European Union is moving to expand its population aid to Africa, but is still very new to the sector. Despite its strong links to former French colonies, France has provided virtually no support to family planning efforts in the region; it has, however, provided limited assistance for AIDS prevention efforts.

Multilateral Donors

The **United Nations Population Fund (UNFPA)** is the only population donor with a presence in virtually every African country. The Fund provides about one-quarter of total population grant assistance to sub-Saharan Africa. Roughly a third of country program allocations go to Africa; in 1995, UNFPA support for the region totaled \$73 million – double the 1993 level.

However, prospects for increased UNFPA funding remain uncertain. Although Africa is likely to receive a greater share of funds under the Fund's new system for allocating resources, UNFPA's overall income plateaued in 1996 and – due to losses from

exchange rate fluctuations – fell by about five percent in 1997.

Moreover, because its resources are spread relatively thin among many countries, the impact of UNFPA programs in any particular country has been limited. In 1996, UNFPA budgets for 30 countries in the region were under \$2 million annually. The thinness of the Fund's professional field staff has further limited the effectiveness of UNFPA programs in Africa.

Relative to the important role the **World Bank** has played in supporting population programs in other regions – especially in Asia – the Bank's efforts in Africa have been disappointing. Until the early 1980s, Kenya was the only country in Africa receiving World Bank loans for population. Since then, lending has risen substantially; between 1990 and 1996 the Bank committed about \$70 million per year for population and reproductive health programs in 28 African countries. Still, this amount represents only about one-fifth of the Bank's total lending in the sector, and lending for population in recent years is down considerably from levels achieved in 1990 and 1991.

Except in a few countries, the Bank is moving away from stand-alone family planning projects such as those previously supported in Kenya, Niger and Nigeria. Moreover, the Bank is increasingly placing higher priority on health financing and sector reform over direct support for family planning and reproductive health services. Although this shift in lending strategy may help countries improve the overall efficiency and effectiveness of health services, the change in the Bank's focus has diminished its leadership in the family planning and reproductive health field in Africa. This trend is further exacerbated by the inadequate numbers of Bank staff with expertise in reproductive health, especially at the field level.

The **International Planned Parenthood Federation (IPPF)** is an important source of funds for national

family planning associations in Africa. IPPF provided \$17 million to its African member associations and other private groups in 1995 – almost 60 percent of their total funding. As in the case of UNFPA, the share of IPPF resources going to Africa – currently about 30 percent – is expected to increase as the agency implements new funding guidelines. Still, a recent large fall in IPPF income threatens future levels of assistance to Africa

Private Households

Consumers in Africa, as elsewhere, are willing to pay for quality curative health care services. Indeed, private African households account for almost half of all health care expenditures, including outlays of close to one billion dollars annually on drugs alone. But it is unclear how much consumers are ready to pay for family planning and other preventive reproductive health services. African households pay about 15 percent of family planning costs, a proportion higher than in most Asian countries, but only about a third of the share consumers pay in some other developing regions.

In varying degrees, almost all African countries have now instituted user fees in public sector facilities as a way of increasing revenues to help cover the cost of health care services. Yet, so far, these efforts have fallen short of expectations. On average, cost recovery programs have generated only 3 to 5 percent of recurring health costs, rather than the expected 20 percent.

The degree to which family planning services are included in cost recovery efforts in Africa varies considerably. In Ghana, the government charges for most health services, including family planning. Kenya and Senegal do not charge for contraceptives, although there is a small user fee for a clinic visit.

It is unclear how charging for contraceptives affects the use of family

planning services. Program managers often express concern that charging for contraceptives – especially in fledgling programs and in rural areas where people have little cash – can discourage family planning use. Most evidence, however, indicates that charging small amounts for contraceptives does not significantly dampen demand for services. One indication that some people are willing to pay for contraceptives is the growth of social marketing programs. However, many of these programs continue to provide contraceptives at prices far below market rates.

A further sign of the willingness of consumers to pay for health services is the success of the Bamako Initiative, a region-wide effort in part aimed at improving the availability of drugs in rural clinics. Participating local communities purchase essential drugs from governments or donors, then charge community members a modest fee and use the proceeds to support a revolving fund to ensure adequate drug supplies. However, the community drug committees which manage these revolving funds typically do not yet value contraceptives, and prefer to purchase antibiotics and other essential curative drugs.

Issues in Program Finance

Boosting Levels of Population Assistance

Total donor assistance to population programs in Africa appears to have risen substantially in 1994 and 1995, in part reflecting the stimulus to donor country commitments provided by the ICPD. However, the picture for 1996 and beyond suggests that the international community faces a serious challenge in maintaining this rate of increase. A number of donor countries are cutting back their population assistance because of overall

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reductions in development assistance budgets. Income levels for UNFPA and IPPF dropped significantly in 1997. Should the stagnation in overall donor assistance continue, the donor community will be hard pressed to meet the ICPD's year 2000 goal of \$5.7 billion in population assistance in constant 1993 dollars, a large share of which is required to respond to the enormous needs in Africa.

Improving Effectiveness of External Assistance

With population aid levels in danger of stagnating or even falling, improving the effectiveness of donor assistance has become even more important. Some of the major areas in need of strengthening include the following.

- **Building national capacity.** The technical assistance provided by expatriate health and family planning professionals has been of enormous importance to the development of African population programs. Yet, it has often been at the expense of building African capacity to manage programs. In their eagerness to get population programs off the ground quickly, donors have not drawn enough on African resources, nor have they done enough to create effective local policy and service delivery institutions. Especially in the public sector in Africa, institutions remain weak and human capacity limited, diminishing the long run effectiveness of population programs and hampering the capacity of the health system as a whole to function efficiently with minimal external aid.
- **Donor coordination.** Governments, lacking adequate managerial and technical capacity, often do not take enough of a leadership role in donor coordination. Greatly differing donor styles and systems are frequently counterproductive to

effective implementation of national programs. Donors have made some progress in improving collaboration and consultation in the design of projects, but the lack of in-country technical staff often leads to poor coordination during implementation and fragmented, wasteful efforts.

As population programs have come to encompass other reproductive health services in addition to family planning, coordination has become more complex. Kenya hosts 20 official donor agencies working in population and health. In the past, donors held fairly effective bimonthly population coordination meetings; now that these meetings deal with broader reproductive health programs, participants find it difficult to maintain the same depth of discussion that took place when the donor group addressed only family planning issues.

- **Promoting sustainable programs.** In the context of heavy reliance on external donor assistance, the ability of African governments to maintain programs after the termination of donor funding is a crucial issue. Donor cutbacks are occurring despite dramatic projected increases in resource needs; a 1995 study in Kenya shows yearly family planning financing requirements almost doubling from \$23 million in 1993 to \$43 million in 2000. The abrupt withdrawal of USAID assistance has posed a major setback in Kenya and several other countries.

Sustainability of NGO Services

The cutbacks in USAID funding also raise the issue of the sustainability of NGO programs. In many African countries, NGOs have been heavily dependent on donor support. Meanwhile, government policies often constrain the ability of NGOs to recover costs through client fees. In Kenya, for

example, the government has required that family planning services be free, limiting the ability of NGOs to charge for services and their sustainability.

NGO program managers also express concern that raising fees will cause their clients to shift to cheaper, public sector services or discontinue contraceptive use. Because cost-recovery is particularly difficult in the poor areas served by community-based distribution programs, these programs are especially vulnerable to the withdrawal of donor support. However, a study in Kenya found that 82 percent of clients in communities served by outreach workers were willing to pay for family planning services; a very few clients said they would stop contraceptive use altogether if asked to pay a minimal amount.

The Kenyan government is now reconsidering its policy on charging for services in light of shrinking donor support to NGOs. Meanwhile, most community-based family planning programs in Kenya are moving towards charging for services as a way of recovering some costs, including such strategies as instituting small, annual “membership” fees.

The Importance of Donors in Contraceptive Supply

Donor financial support has been crucial in the purchase and management of contraceptive supplies for use in family planning and STD prevention programs in Africa. The potential for domestic production of contraceptives is extremely limited, and most African countries cannot afford to pay for imported contraceptives. External technical assistance has also played an important role in strengthening contraceptive distribution systems.

However, donors appear to be losing interest in supplying contraceptives. Sweden has sought to shift its longstanding financial support for oral contraceptives in Kenya to other reproductive health activities. USAID’s

role in contraceptive supply has been crucial – it has been the major source of technical expertise in strengthening overall supply management systems, and has a central procurement system with a strong track record of providing adequate supplies of contraceptives to countries in a timely manner. USAID’s pullback in several West African countries has reportedly left contraceptive supply systems in disarray – just when contraceptive prevalence is starting to rise in some of these countries.

The Potential of the Private, Commercial Sector

Although for the foreseeable future the vast majority of Africans will remain extremely poor, with limited ability to afford even low-cost health services, there are opportunities for the private, commercial sector to serve a larger share of wealthier family planning clients. Rising incomes, the growing application of means testing at public sector facilities, and more favorable government attitudes towards commercial sector health activities are all key ingredients to making this gradual shift.

Nevertheless, important barriers continue to limit the private, commercial sector’s engagement in reproductive health and family planning. Because few Africans have formal sector jobs, most are not covered through employer health insurance schemes. Legal and regulatory barriers inhibit private, commercial health activities in many countries. In Zimbabwe, for example, qualified nurse-midwives outnumber doctors more than four to one; because of cumbersome regulations, however, few are in private practice. Moreover, most public health care systems continue to provide highly subsidized services to clients regardless of income level, thus hampering the development of private health care markets.

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