Family Planning and Reproductive Health

Funding trends and FPRH indicators in Sub-Saharan Africa over the past two decades

Prepared by

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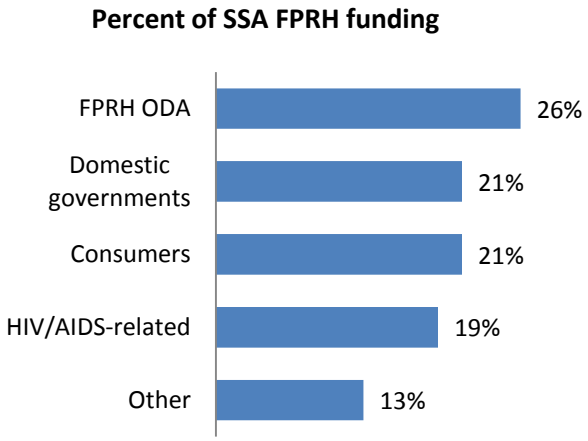
Introduction

Family planning and reproductive health (FPRH) services are crucial to supporting reproductive rights and achieving sustainable population growth in Sub-Saharan Africa (SSA). The chronically underfunded FPRH sector has seen dramatic shifts in financial support and a relative stagnation in key indicators. This document provides background data on these trends over the past two decades.

The causes for underfunding are many. Dependent on four major funding sources – FPRH overseas development assistance (ODA), domestic governments, consumers, and HIV/AIDS-related prevention funding, as shown in the Figure below – FPRH activities are competing for funds against other important sectors such as development and education. In addition, FPRH is heavily reliant on a broken funding system of donors and governments that is undergoing substantial change. The result is a drop in FPRH funding due to four distinct trends:

- Negative donor policies (e.g., global Gag Rule) and General Budget Support
- Low domestic government spending and decentralization to local government
- Low private consumer spending
- Increased funding to HIV/AIDS



Section I: Funding trends details the trends among the four key funding sources in SSA and when possible data are presented for four timeframes over the period 1987 to 2006. Additionally the data is derived from the Credit Reporting System (CRS) of the OECD, which should be taken with all due caveats. However, funding is only a means to an end.

The results of FPRH investments appear to have been generally positive. Unmet need is largely falling, contraceptive prevalence is up, and fertility and population growth rates are down. Unfortunately, recent decreases in FP funding appear to have resulted in significant stagnation of positive trends and some reversals. Additionally, although on average the indicators are positive for SSA, the indicators for specific countries vary significantly.

Section II: FPRH indicators explores these trends among FPRH outcomes. There are many potential family planning and reproductive health indicators, some *direct*, such as population growth, fertility rates, or unmet need for contraception, and some *indirect*, such as number of nurses, female education, or female labor force participation. This section provides detailed indicator trends for 16 different direct and indirect FPRH indicators and uses the most recent and best data available.

Section III: Potential interesting correlations takes it a step further and explores the potential relationship between funding and FPRH outcomes. It is important to note that the direct relationship between funding and FPRH or other outcomes is tenuous and fraught with complications. Multiple factors including donor policies (e.g., tied aid), actual activities funded, governance in recipient countries, and economic cycles can contribute to the success or failure of an investment and ultimate FPRH indicators. As a result, this document does not attempt to establish a causal relationship between funding trends and FPRH indicators. Instead, it presents the raw data and it is left to the reader to interpret the relationships for further discussion.

I. Funding trends

Overall funding from all sources

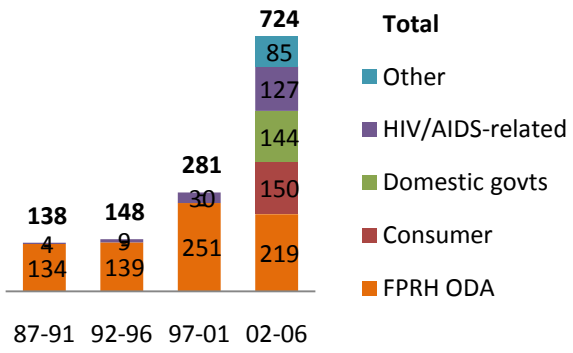
Total funding to FPRH comes from four major sources: ODA, domestic governments, consumers, and HIV/AIDS-related sources. Over the years these funding sources have waxed and waned, often changing as international priorities change, donor administrations change, and in-country dynamics and governance vary. However, improved data and flows tracking are needed to better understand historical trends in non-ODA funding. After this brief overview, the rest of this section looks at trends across the four major categories of funding.

Summary

- Total spending on FPRH is relatively higher in Southern and Eastern SSA
- FPRH ODA to SSA has climbed from 1987 to 2001, but has declined the last 5 years
- Total FPRH funding falls short of the needs in SSA, with a gap of at least $680M, see funding gap section for details
- A summary of funding by country can be found in Appendix 2

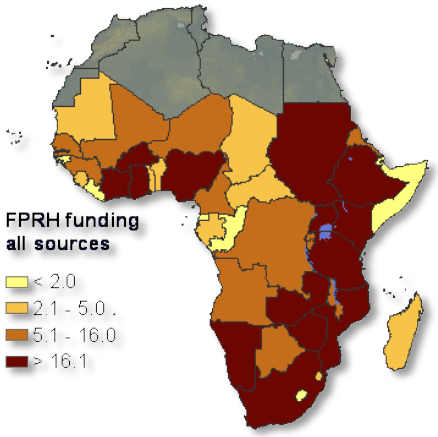
FPRH funding[1]

$M/year average to SSA, constant 2006 dollars



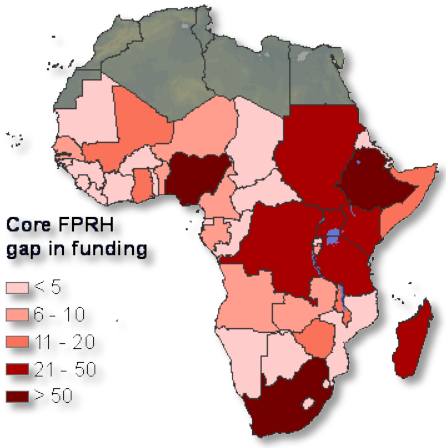
FPRH funding from all sources

$M/yr, 2002-2006 average



Funding gap (core FPRH funding est.)

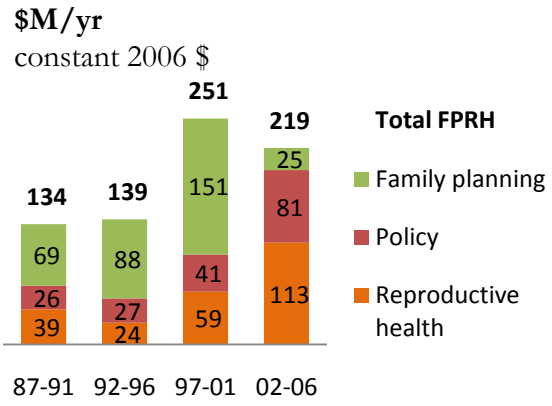
$M/yr; total gap ~$680M



[1]FPRH ODA and HIV/AIDS data are from OECD DAC data (stats.oecd.org), updated Oct 17, 2008, except for UNFPA, which is from UNFPA annual reports (www.unfpa.org/about/report). The *FPRH ODA FPRH* category includes family planning (DAC purpose code 13030), reproductive health care (13020), policy (13000, 13010, 13081), but excludes census work (~38% of policy funds based on 2005 analysis) and maternal and child health (56% of RH funds). Dollars are dollars committed, constant 2006 US dollars. Domestic government, consumer, and other spending from NIDI 2005; only current data available.

Overseas Development Assistance (ODA)

FPRH ODA to SSA from bilateral and multilateral donors climbed steadily from 1987 to 2001. However, as demonstrated in the previous section, ODA declined over the past five years. This decline was felt unevenly by the different components of FPRH: Core Family Planning (FP), Reproductive Health (RH), and policy support. FP bore the brunt of the decline, while RH and Policy Support have increased.



Several trends are likely causing these dramatic shifts in FPRH funding. First is a significant push in ODA into general budget support. Over the past ten years, the ODA field has identified several opportunities to improve the effectiveness of assistance. Specifically, experts believe that giving recipient countries more control and responsibility over the assistance they receive can both build capacity within the recipient countries and more effectively target what the country believes it needs. Unfortunately, this can also result in decreased funding for FPRH as other local governments often choose other sectors for development financing.

Another major trend is funding going to sectors driven by the Millennium Development Goals such as maternal and child health and HIV/AIDS programs. These sectors have attracted significant funding, often drawing funds away from FP, but have at times brought money into related RH activities. For the analysis below, FPRH funding does not include STD control/HIV/AIDS funding, census work, or maternal and child health.

To better highlight these trends this section is divided into the following analyses

- FPRH funding overall
- Family Planning funding
- General Budget Support
- Donor trends: Top four current FPRH donors
    - UNFPA
    - United States
    - The European Commission
    - United Kingdom

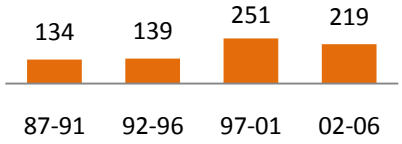
FPRH funding overall

FPRH ODA Summary

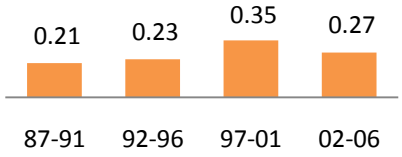
- Overall FPRH funding to SSA has declined 15% over the past 5 years, with large losses in Malawi, Zimbabwe, and Namibia
- Most countries have increased disproportionately favoring Central SSA
- Current FPRH funding is focused in East Africa and Nigeria

FPRH ODA funding[2]

$M/year average to SSA, constant 2006 dollars

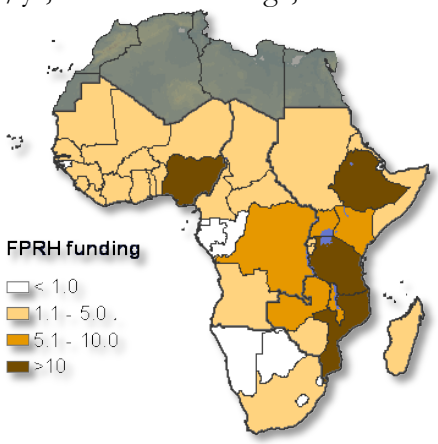


$/yr per capita to SSA, constant 2006 dollars



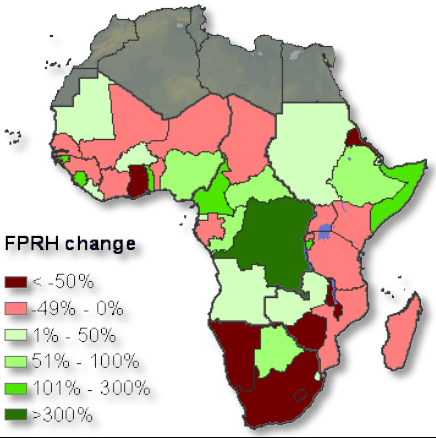
FPRH funding

$M/yr, 2002-2006 average, constant 2006 $



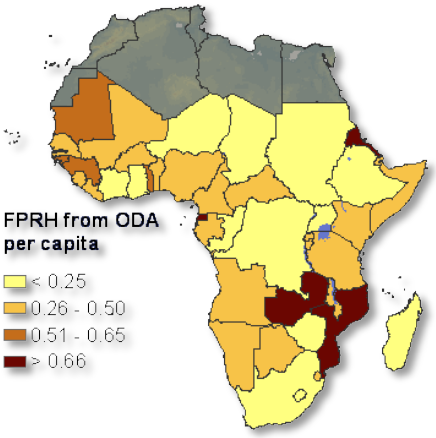
Change in FPRH

% change (02-06 minus 97-01)/(97-01)



FPRH funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $



[2] OECD DAC data (stats.oecd.org), updated Oct 17, 2008 and UNFPA 2008. Includes FP (DAC purpose code 13030), RH (13020), policy (13000, 13010, 13081), but excludes census work (~38% of policy funds based on 2005 analysis) and maternal and child health (56% of RH funds). Dollars are dollars committed, constant 2006 US dollars.

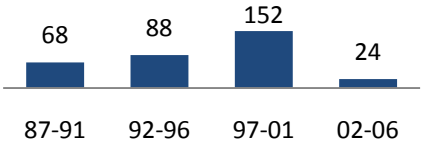
Family Planning funding (subset of FPRH)[3]

Summary

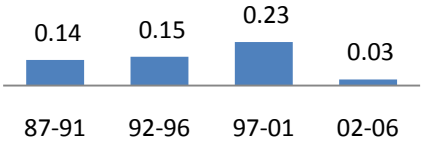
- FP funding to SSA has dropped by over 80% over the past 5 years
- The losses are relatively indiscriminate, but more massive in East and West Africa
- Total FP funding is focused in a few highly populous countries including Nigeria, Ethiopia, and Tanzania
- Per capita funding, however, appears highest in less populous countries

FP funding

$$M/year average to SSA, constant 2006 $

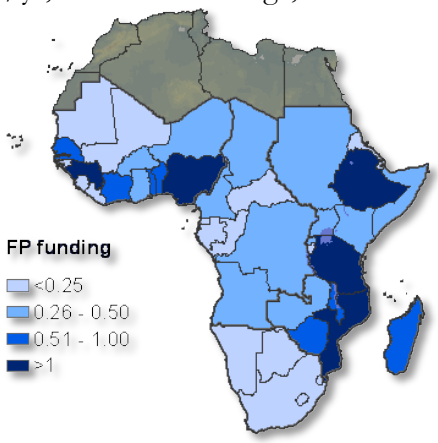


$/year per capita avg. to SSA, constant 2006 $



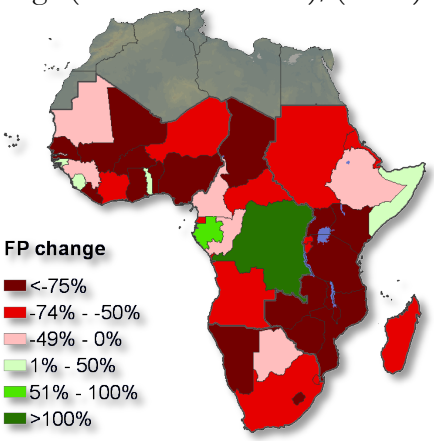
FP funding

$M/yr, 2002-2006 average, constant 2006 $



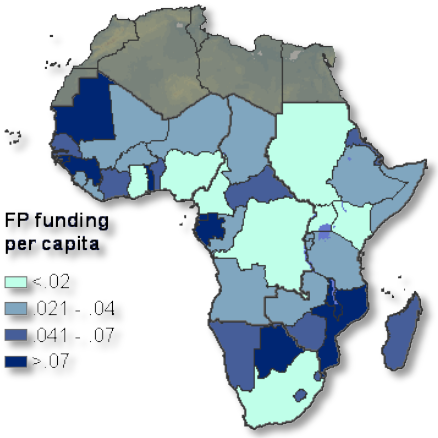
Change in FP

% change (02-06 minus 97-01)/(97-01)



FP funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $



[3] OEDC DAC 2008; UNFPA 2008.

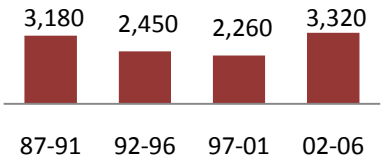
General Budget Support[4]

Summary

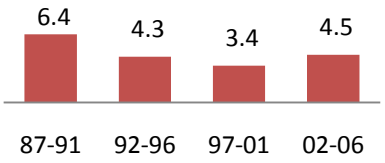
- GBS and SWAps have developed to give recipient countries more responsibility for effectively allocating development assistance
- Multilaterals and Eurpoean donors have pushed this form of funding to improve the effectiveness of development assistance
- In SSA, GBS has increased substantially over the past 5 years representing on average ~9% of all ODA to SSA
- Most increases are in Eastern SSA where governance has been improving
- FPRH funding often decreases as recipient countries under-weight it in GBS/SWAps

GBS funding

$M/year average to SSA, constant 2006 $

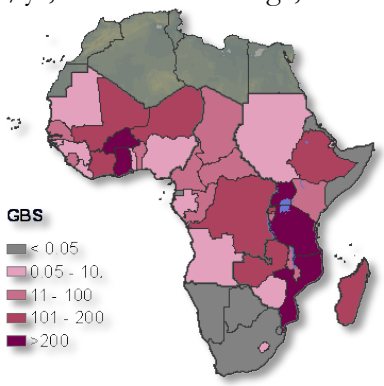


$/year per capita avg. to SSA, constant 2006 $



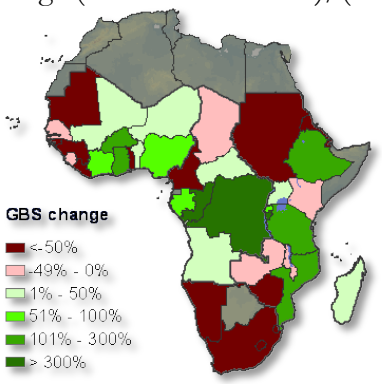
GBS funding

$M/yr, 2002-2006 average, constant 2006 $



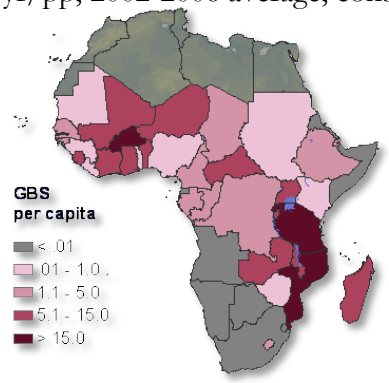
Change in GBS

% change (02-06 minus 97-01)/(97-01)



GBS funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $

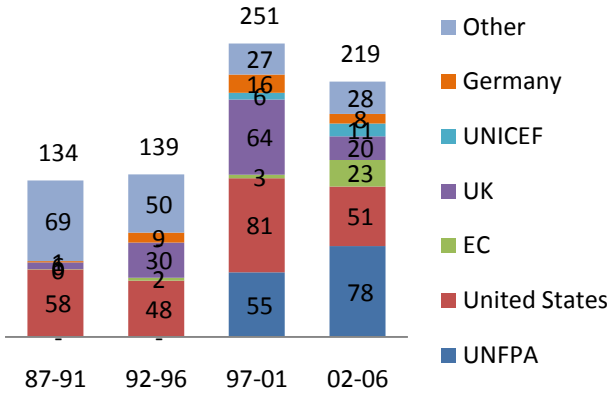


[4] OECD DAC data (stats.oecd.org), updated Oct 17, 2008. General budget support includes GBS (51010) and general health (12100).

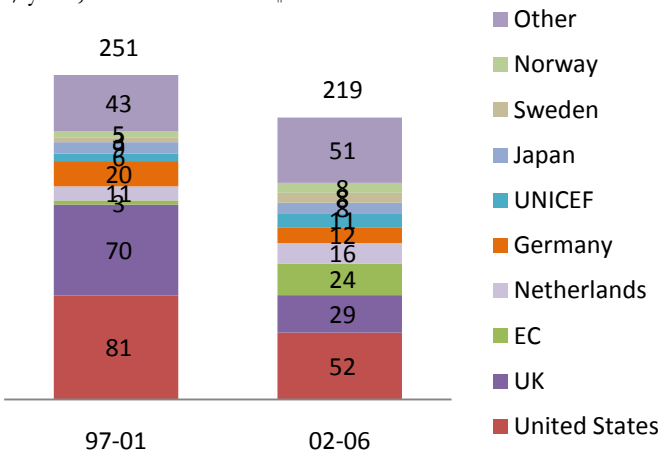
Donor trends: Top four current FPRH donors

The current top FPRH donors have dramatically shifted their support for FPRH over the last ten years as shown in the chart on the right[5]. The top four donors (UNFPA[6], U.S., EC, and U.K.) account for almost 80% of the FPRH funding, yet the US and UK significantly decreased their support in recent years. To compensate, the European Commission (EC) and UNFPA have fortunately made up for the loss. A question remains in 2009 if the new US administration will reverse previous policies and to what extent the UK might follow suit.

FPRH ODA donor trends
$M/year, constant 2006$



FPRH ODA donor trends, incorporating UNFPA donors
$M/year, constant 2006 $



In particular, the UNFPA receives its funds from several core countries. By splitting out the UNFPA into its constituent donors and incorporating that with overall ODA one gets a better sense of all the major donors. This results in a broader list of core donors and introduces important countries like the Netherlands, Sweden, and Norway who are key contributors to improving FPRH globally, albeit mostly through UNFPA.

.At this point, the UNFPA data is unavailable prior to 1997, but both analyses could be improved with additional research.

Detailed data for the top four FPRH ODA donors (UNFPA, U.S., EC, and U.K.), their trends, and focus countries are presented below.

[5] OEDC DAC 2008; UNFPA 2008; NIDI2005; WDI (Word Development Indicators) 2008.

[6] UNFPA data unavailable prior to 1997. Data obtained from UNFPA annual reports. Includes FPRH-related funds, as defined above (includes 80% of reproductive health funds, 60% of population and development funds, and 20% of gender equality and women's empowerment funds)

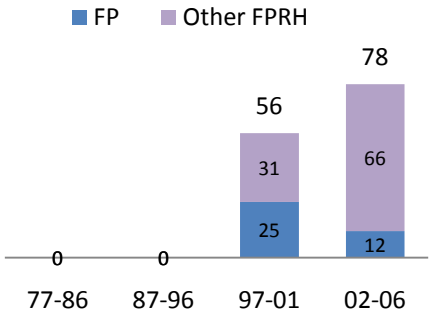
UNFPA[7]

Summary

- UNFPA is the largest funder in SSA and gives between $1-4M to most countries
- Funds have increased 40% the last 5 years
- Major donors to UNFPA include Netherlands, Sweden, Norway, UK, Japan, and Denmark. Details by donor over time can be found in Appendix 3
- Southern Africa is has seen decreased funding

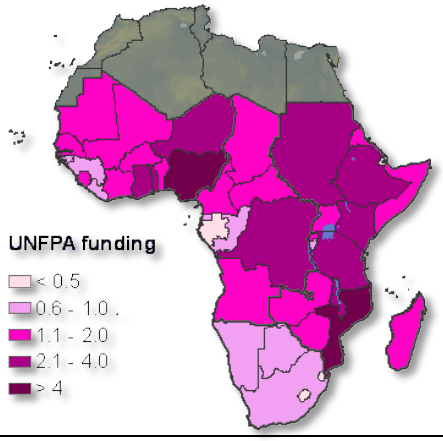
UNFPA ODA funding

$M/year average to SSA, constant 2006 $



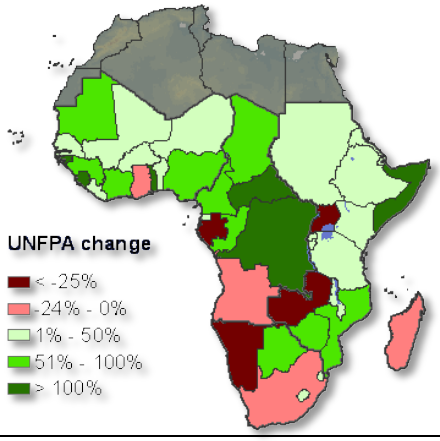
FPRH funding

$M/yr, 2002-2006 average, constant 2006 $



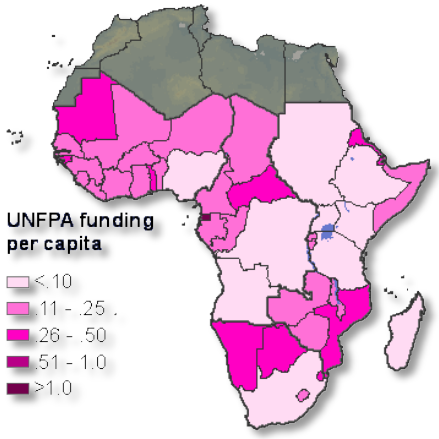
Change in FPRH funding

% change (02-06 minus 97-01)/(97-01)



FPRH funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $



[7] UNFPA annual reports from 1997-2008. Charts include donor contributions to regional Africa and SSA, where maps only show targeted aid. Maps exclude countries receiving less than $50,000/yr average

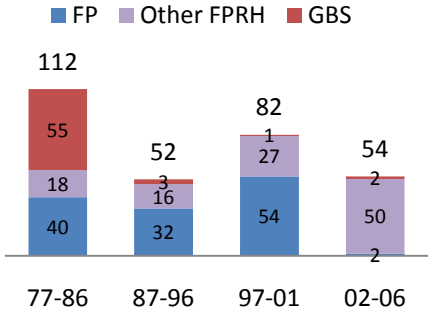
United States[8]

Summary

- The US is the second largest FPRH funder in SSA
- The US has significnatly retreated from GBS and prefers to direct its aid
- Recent funding has dropped, especially in FP, owing partially to the recent administration
- Target countries are clustered in six Eastern SSA countries and other smaller recipients

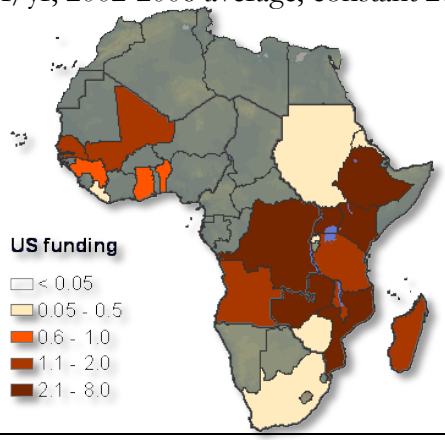
U.S. ODA funding

$M/year average to SSA, constant 2006 $



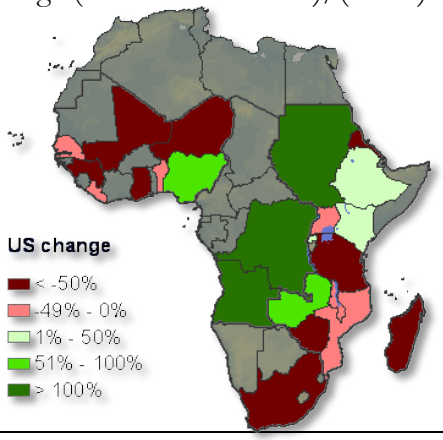
FPRH funding

$M/yr, 2002-2006 average, constant 2006 $



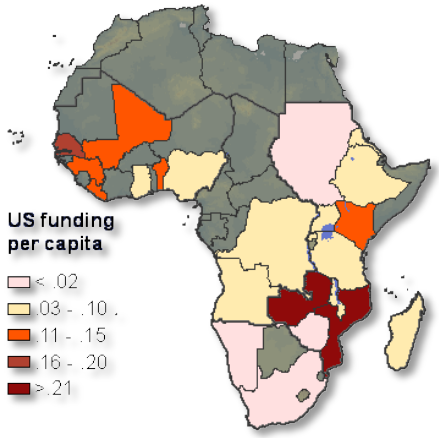
Change in FPRH funding

% change (02-06 minus 97-01)/(97-01)



FPRH funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $



[8] OECD DAC data (stats.oecd.org), updated Oct 17, 2008. Dollars are dollars committed, constant 2006 US dollars. Charts include donor contributions to regional Africa and SSA, where maps only show targeted aid. Maps exclude countries receiving less than $50,000/yr average

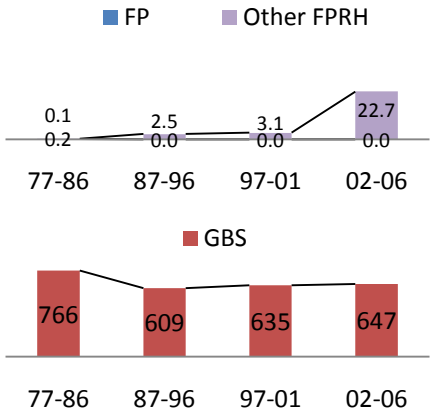
The European Commission[9]

Summary

- EC is the third largest FPRH funder in SSA
- Targeted FPRH-related funding has increased significantly over the past 5 years
- EC significantly funds GBS, but it is unclear if any of these funds go to FPRH
- EC currently targets FPRH funding to a smaller set of countries than other funders

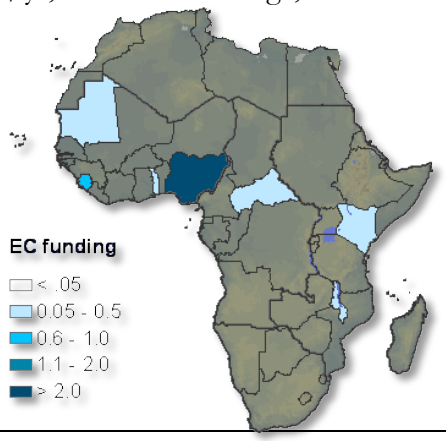
EC ODA funding

$M/year average to SSA, constant 2006 $



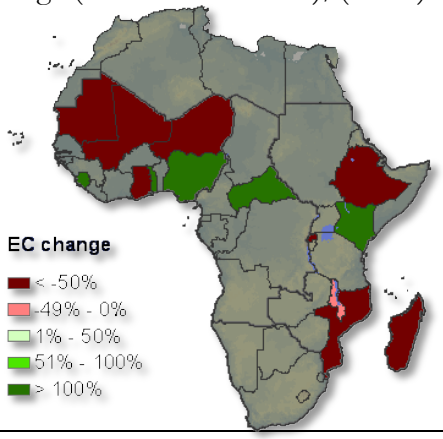
FPRH funding

$M/yr, 2002-2006 average, constant 2006 $



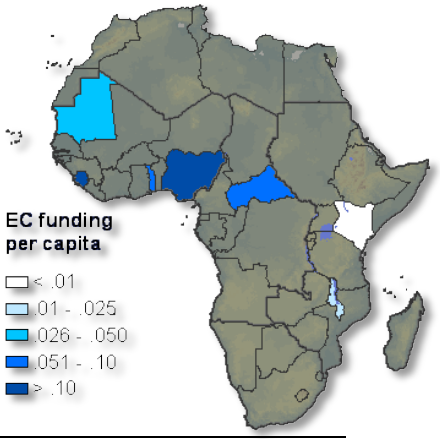
Change in FPRH funding

% change (02-06 minus 97-01)/(97-01)



FPRH funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $



[9] OECD DAC (stats.oecd.org) 2008. Dollars committed, constant 2006 US dollars. Charts include donor contributions to regional Africa and SSA; maps only show targeted aid. Maps exclude countries receiving less than $50,000/yr average

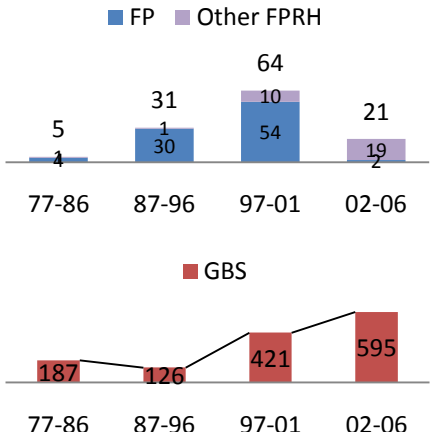
United Kingdom[10]

Summary

- UK is the fourth largest FPRH funder in SSA, and separately also contributes significantly to the UNFPA
- The UK has dramatically increased GBS over the past 5 years
- FPRH-related funding has dropped, and shifted funds away from FP
- Target countries are clustered in Eastern SSA and two Western SSA countries

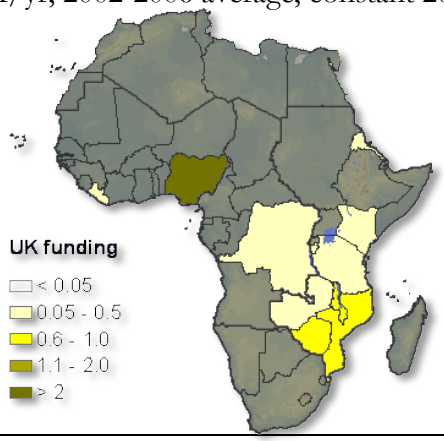
U.K. ODA funding

$M/year average to SSA, constant 2006 $



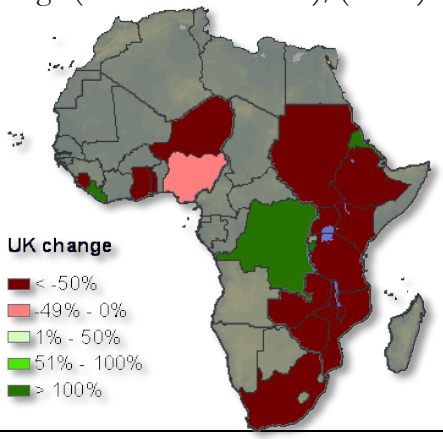
FPRH funding

$M/yr, 2002-2006 average, constant 2006 $



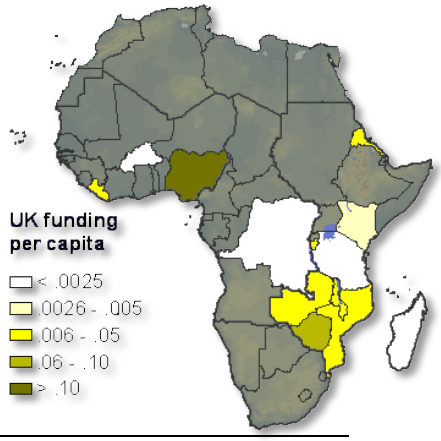
Change in FPRH funding

% change (02-06 minus 97-01)/(97-01)



FPRH funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $



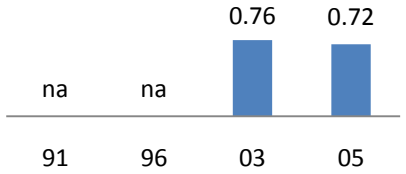
[10] OECD DAC (stats.oecd.org) 2008. Dollars committed, constant 2006 US dollars. Charts include donor contributions to regional Africa and SSA; maps only show targeted aid. Maps exclude countries receiving less than $50,000/yr average

Domestic government spending

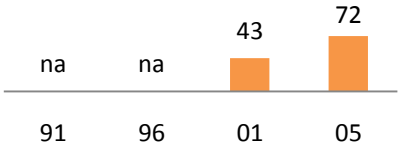
Summary

- Government spending comes mostly from health budgets and commodities line items
- Government FPRH spending has dropped slightly, where overall health spending has nearly doubled recently
- However, the magnitude of government spending is still very low, only averaging $0.65 per person on FPRH and ~$72 on average for health (median health=$26/pp)
- Increasing government spending on health and FPRH could involve gently directing GBS funds

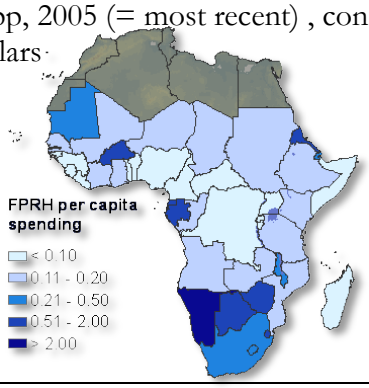
Government FPRH spending[11]
$ per person, SSA average, constant 2006 $



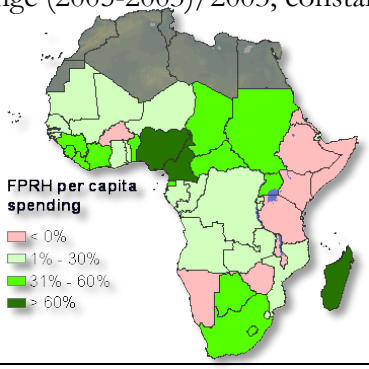
Government health spending[12]
$ per person, SSA average, current USD



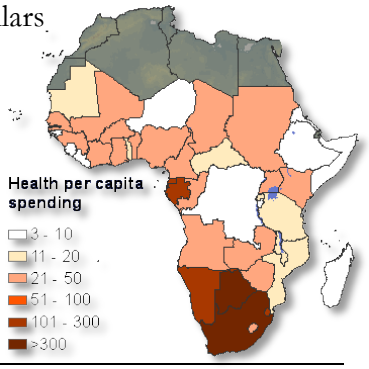
Government FPRH spending
$/pp, 2005 (= most recent) , constant 2006 dollars



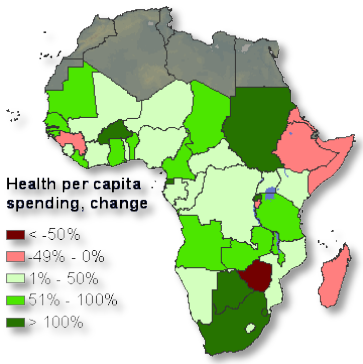
Government FPRH spending, change
% change (2005-2003)/2003, constant 2006 dollars



Government health spending
$/pp, 2005 (= most recent) , constant 2006 dollars



Government health spending, change
% change (2005-2001)/2001, constant 2006 dollars



[11] NIDI 2005, *Size and structure of worldwide funds for population and AIDS activities*. Includes family planning, reproductive health, basic research, and 5% of STD/HIV/AIDS funds as estimated by Netherlands Interdisciplinary Demographic Institute (NIDI) study. If no data available, used 0.5% (median) of health expenditures applicable to FPRH [Cape Verde, Chad, Comoros, Congo, Djibouti, Equatorial Guinea, Gabon, Buinea-Bissau, Liberia, Mali, Mauritius, Sao Tome & Principe, Seychelles, Somalia, Togo].

[12] WDI (Word Development Indicators) 2008

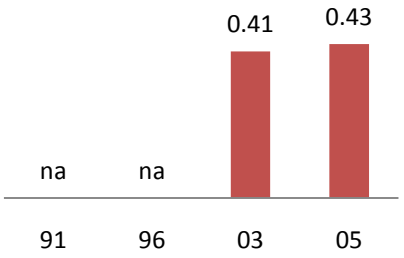
Private consumer expenditures, HIV/AIDS, and other funding

Private consumer expenditures

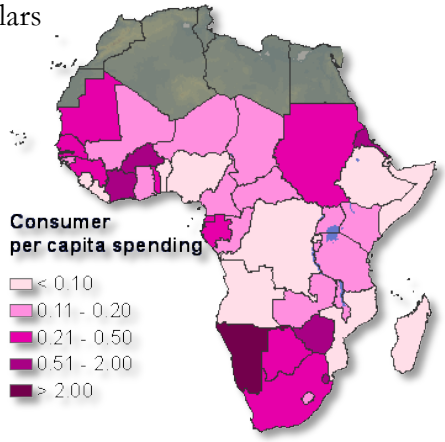
Summary

- Across SSA, the total private consumer expenditures on health is very similar to the dollar amount government spends
- However, the variation by country is great, and on average, private spending is very low, only averaging $0.43 per person on FPRH
- Increasing private spending on health could be difficult, as many in SSA have little income, but could be accomplished providing options such as prepaid plans

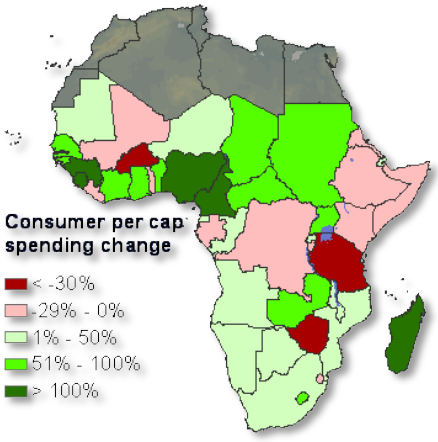
Consumer FPRH spending[13]
$ per person, SSA average



Consumer FPRH spending
$/pp, 2005 (= most recent) , constant 2006 dollars



Consumer FPRH spending, change
% change (2005-2003)/2003, constant 2006 dollars



[13] WHO 2008 *World Health Statistics*. By country, assumes ratio of private spending to government health is the same as private FPRH spending to government FPRH spending, and uses NIDI 2005 data for FPRH government spending.

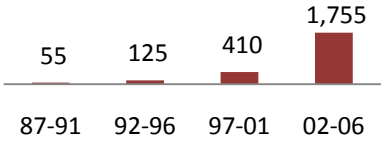
HIV/AIDS funding[14]

Summary

- Funding for HIV/AIDS has risen dramatically over the past five years due substantially to commitments from the US/PEPFAR and international donors (Global Fund to fight AIDS, TB, & Malaria)
- On average, 4-5% of HIV/AIDS funds go toward prevention, which aligns with FPRH goals
- Further alignment of FPRH programs with HIV/AIDS prevention could direct more of existing funds to FPRH needs

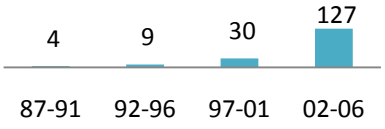
HIV/AIDS funding

$M/year average to SSA, constant 2006 $



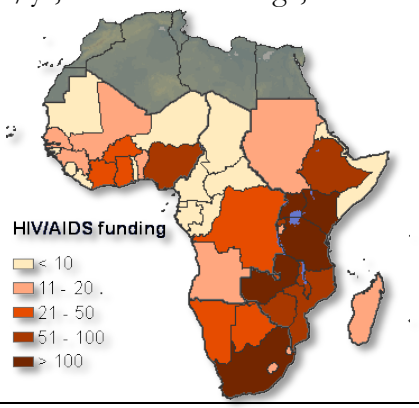
Prevention HIV/AIDS funding[15]

$M/year avg to SSA, estimate, constant 2006 $



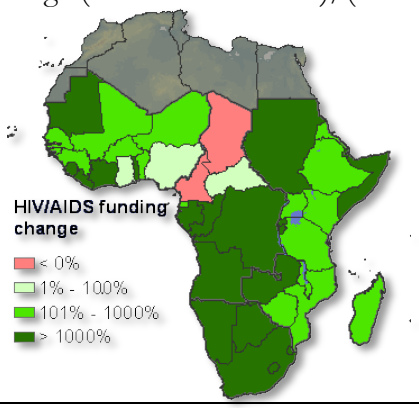
HIV/AIDS funding

$M/yr, 2002-2006 average, constant 2006 $



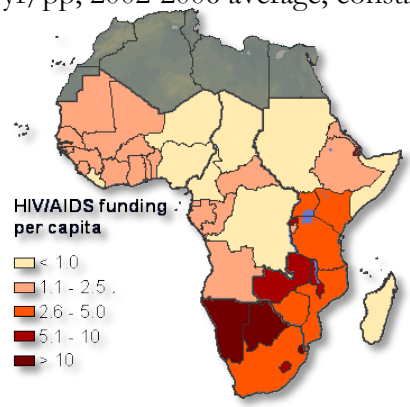
Change in HIV/AIDS funding

% change (02-06 minus 97-01)/(97-01)



HIV/AIDS funding per capita

$/yr/pp, 2002-2006 average, constant 2006 $



[14] ODA purpose code 13040: STD control including HIV/AIDS

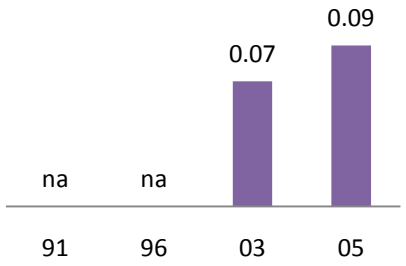
[15] Estimates for SSA are 4.5% of total AIDS funding based on assuming percent of PEPFAR and GF 'other prevention' dollars are applicable to FPRH (excludes prevention related to PMTCT, abstinence, blood safety, injection safety). On average, 4.1% in 2007 went to 'other prevention,' though the amount varied by country up to 5.8%.

Other funding: NGOs and foundations

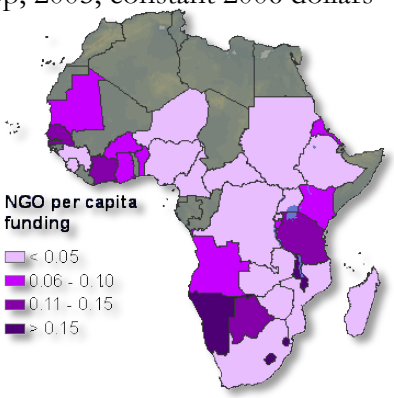
Summary

- NGOs and foundations provide additional funding for FPRH in SSA
- Funding is increasing, and in recent years new foundations have shown interest in SSA

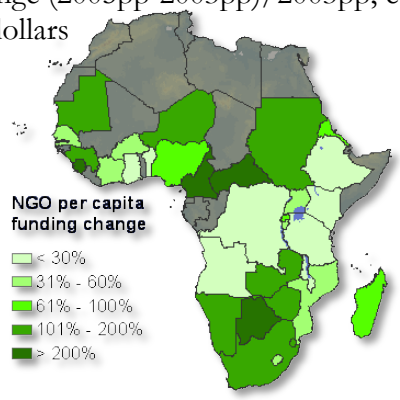
NGO FPRH spending[16]
$ per person, SSA average



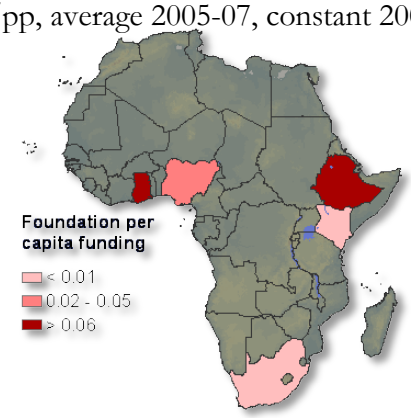
NGO FPRH funding
$/pp, 2005, constant 2006 dollars



NGO FPRH spending, change
% change (2005pp-2003pp)/2003pp, constant 2006 dollars



Foundation FPRH funding
$/pp, average 2005-07, constant 2006 dollars



Foundation estimate based on Hewlett, Packard, UN Foundation, MacArthur, and Buffet grants or estimates

[16] NIDI 2005, *Size and structure of worldwide funds for population and AIDS activities*. Includes family planning, reproductive health, basic research, and 5% of STD/HIV/AIDS funds as estimated by Netherlands Interdisciplinary Demographic Institute (NIDI) study.

Funding gap (preliminary)

Summary

- Current funding from aid, domestic government, consumers, NGOs and foundations falls short of meeting core FPRH needs in SSA
- Even meeting core FPRH needs would require an increase of ~$680 M/year to SSA, more than doubling the current levels
- The largest funding gaps are in Eastern SSA, and expand into Middle and Western SSA as FPRH funding estimates increase

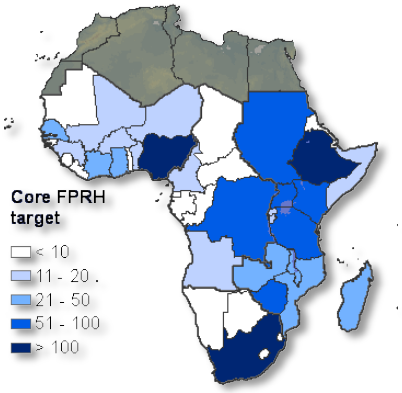
Core FPRH cost estimate[17]

- Cost of current contraceptive use
- Costs to meet unmet need
- Costs to provide safe abortions for currently unsafe abortions[18]

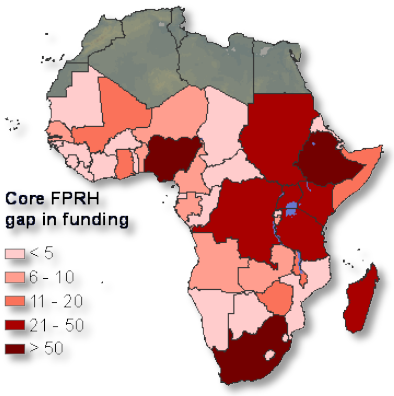
Higher FPRH cost estimate

- Based on meeting ICPD 2003 goals[19] (average of 2005 and 2010 estimates)
- Includes core FPRH needs and reproductive health services

Core FPRH funding needed, estimate
$M/yr



Funding gap (core FPRH funding est.)
$M/yr; total gap ~$680M

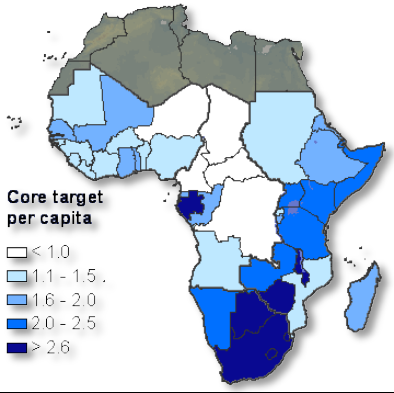


[17] Guttmacher 2004 *Assessing Costs and Benefits of Sexual and Reproductive Health Interventions.* UNFPA 2003: *Country Profiles for Population and Reproductive Health: Policy Development and Indicators 2003*. World Health Organization 2007, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*. Johnston 2007 *Reducing the costs to health systems of unsafe abortion: a comparison of four strategies,* Journal of Family Plann Reprod Health Care 2007: **33**(4).

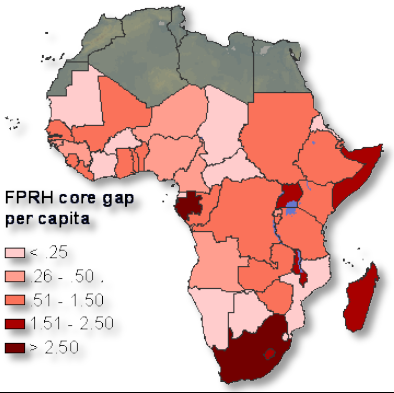
[18] Note: does not include cost savings of reduced unsafe abortions to health care system

[19] UNFPA 2003: *Country Profiles for Population and Reproductive Health: Policy Development and Indicators 2003*.

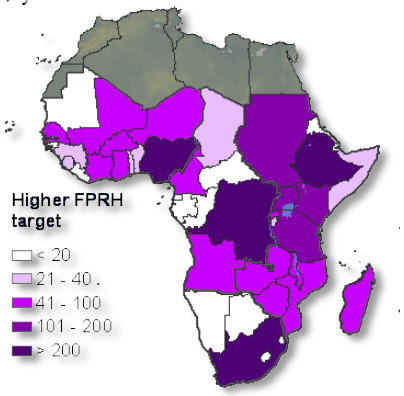
Core FPRH funding per capita, estimate $/yr/pp



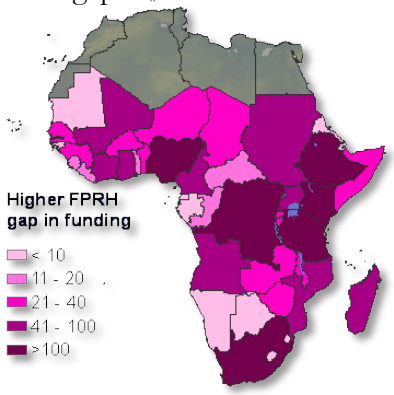
Funding gap per capita (core FPRH funding est.) $/yr/pp;



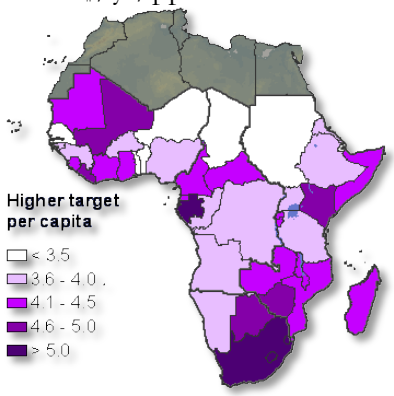
Higher FPRH funding, estimate $M/yr



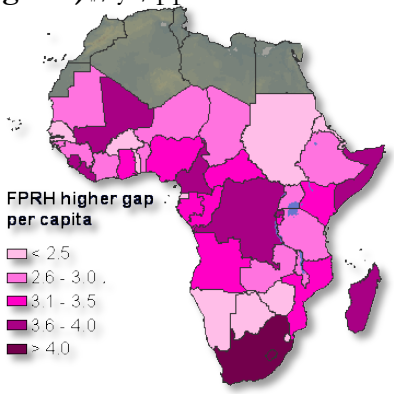
Funding gap (higher FPRH funding est.) $M/yr; total gap ~$2.3B



Higher FPRH funding per capita, estimate $/yr/pp



Funding gap per capita (higher FPRH funding est.)$/yr/pp



II. FPRH-related indicators

Family planning and reproductive health have many types of indicators, some direct and some indirect. Below, the following indicators and their change over time are presented. Most of the FPRH indicator data are from World Development Indicator data (World Bank), 2008[20] and other data sources are noted below.

- Direct indicators
    - Population size and growth rates
    - Fertility rates, total and adolescent
    - Contraceptive prevalence, unmet need for contraception
    - Maternal mortality
    - Abortion legal status, unsafe abortions

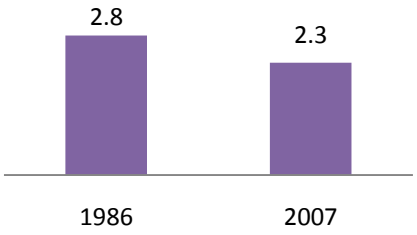
- Indirect indicators
    - Physicians, nurses, and midwives
    - Female education (persistence to grade 5)
    - Labor force participation and gender equity
    - Urban population
    - Prevalence of HIV

[20] World Development Indicators, 2008. Data are presented for four timeframes: 2007, 2001, 1996, 1991, and 1986, linked to the latest time period of the funding analysis presented above. If data were unavailable for the given year, the most recent going backward in time over the previous 5 years were used (with the exception that if the most recent 6 years wasn't available, the data from the most recent of the past 11 years were used).

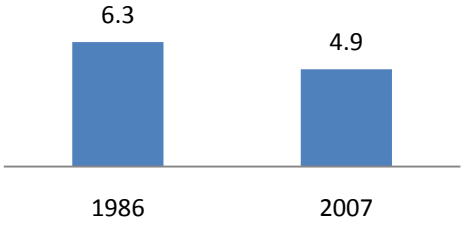
FPRH Indicator Summary

FPRH indicators[21] throughout Sub-Saharan Africa have been improving over the past 20 years. Growth rates and fertility rates have been dropping, and contraceptive prevalence, girls' education, and FPRH capacity (e.g. physicians) have been on the rise. However, many challenges remain, as population is still growing (over 800 M in 2007, growth rates are still over 2%), and many highly populous countries such as Congo, Sudan, Kenya, Nigeria, and DRC have a combination of increasing growth rates, high TFRs, high adolescent fertility rates, and/or high levels of unmet need.

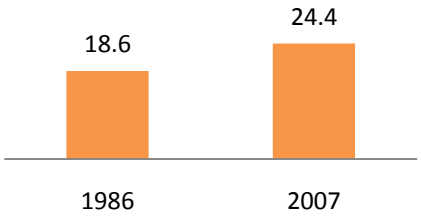
Population growth
% average SSA



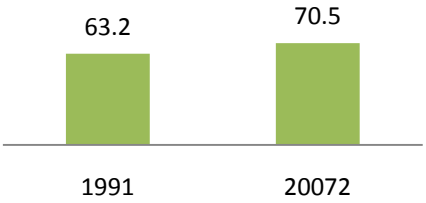
Total Fertility Rate
Births per woman



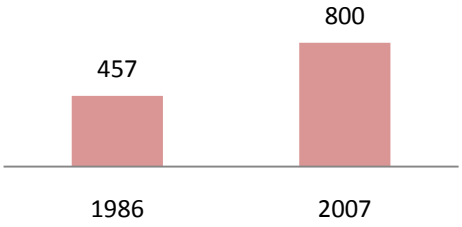
Contraceptive prevalence rate
% of women(15-49)



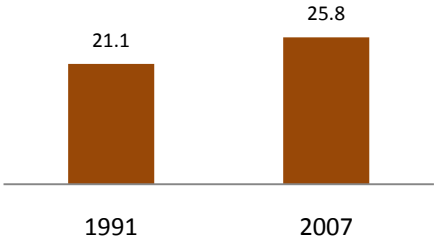
Female primary education
% of cohert, perist. to grade 5, SSA average



Population
M total, SSA



Unmet need
% of married women, ages 15-49



[21] World Development Indicators 2008

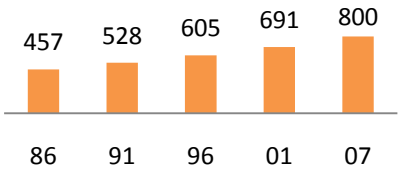
Direct indicators

Population size and growth rates[22]

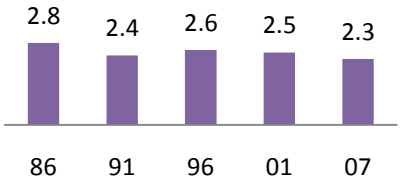
Summary

- Population size in SSA has continued to grow to 800 M in 2007
- Growth rates are dropping , but are still over 2% in most countries
- Highly populous countries such as Nigeria and Ethiopia have seen significant drops in growth rates
- However, some populous countries, such as Congo, Sudan, and Kenya have seen increases in growth rates

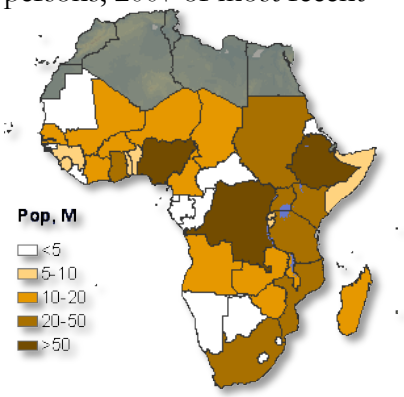
Population
M total, SSA



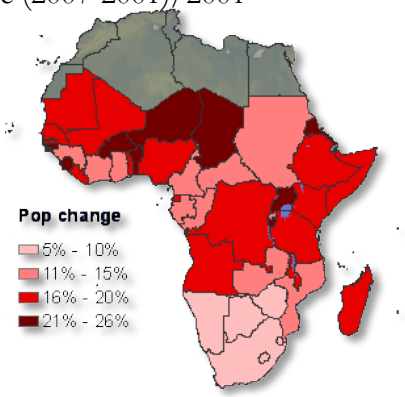
Growth
% average SSA



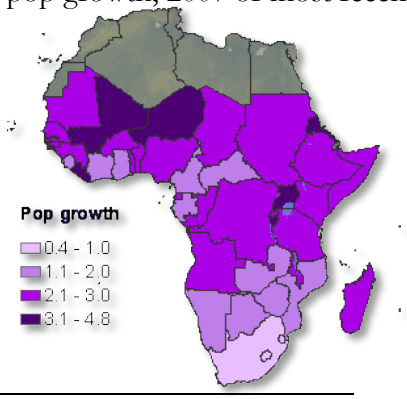
Population
M persons, 2007 or most recent



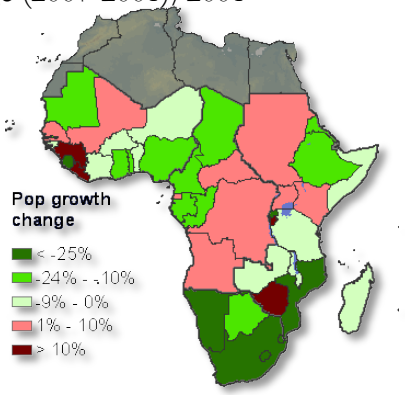
Population, change
% change (2007-2001)/2001



Population growth
% pop growth, 2007 or most recent



Population growth, change
% change (2007-2001)/2001



[22] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

Fertility rates, total and adolescent[23]

Summary

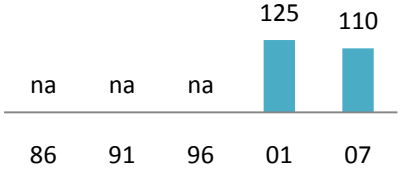
- Fertility rates are declining down to the current average of 4.9 births per woman
- However, over half of the countries in SSA have TFR's greater than 5.0
- Adolescent fertility rates are also declining, though the values vary greatly from a low of 34 births per 1,000 adolescent girls in Swaziland to over 220 in the DRC. Population momentum is a large component of overall growth in SSA.

Total Fertility Rate

Births per woman, SSA average

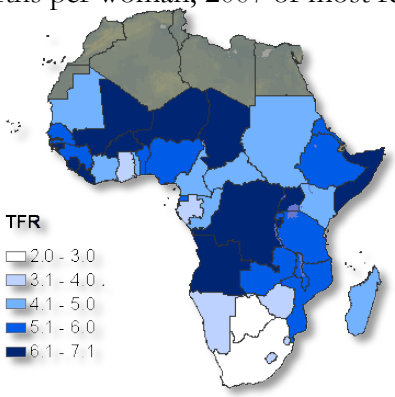
Adolescent fertility rate

Births per 1,000 women ages 15-19, SSA avg.



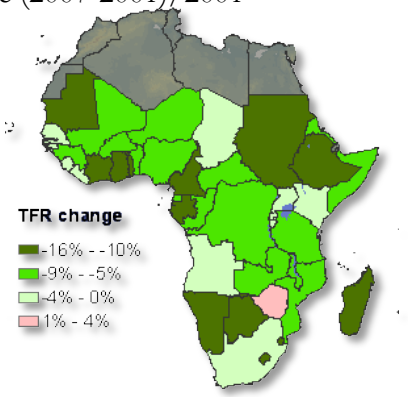
TFR

Births per woman, 2007 or most recent



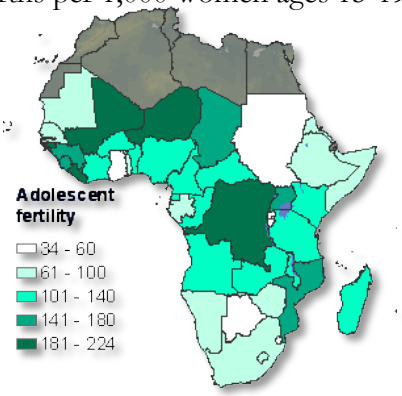
TFR, change

% change (2007-2001)/2001



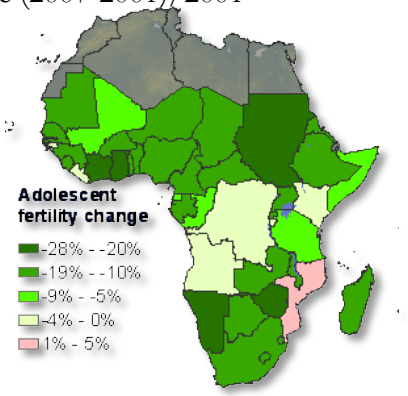
Adolescent fertility

Births per 1,000 women ages 15-19, 2007



Adolescent fertility, change

% change (2007-2001)/2001



[23] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

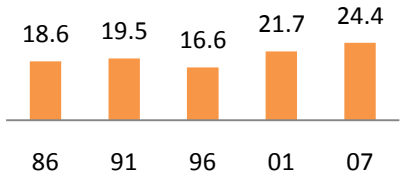
Contraceptive prevalence, unmet need for contraception[24]

Summary

- Contraceptive prevalence rates are rising, and have seen significant growth since 1996. Countries such as South Africa and Zimbabwe stand out with CPRs >60%
- However, CPR is still only ~24% on average, with the lowest CPR in Chad at only 2.8%. CPR's have declined across Central and Western SSA significantly
- Unmet need has remained relatively stagnant over the past 10 years, though has seen some improvements in Eastern, Southern, and Western SSA

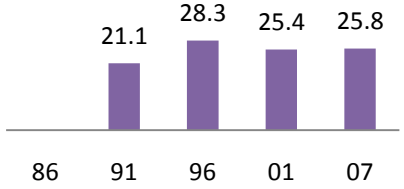
Contraceptive prevalence rate

% of women, ages 15-49, SSA average



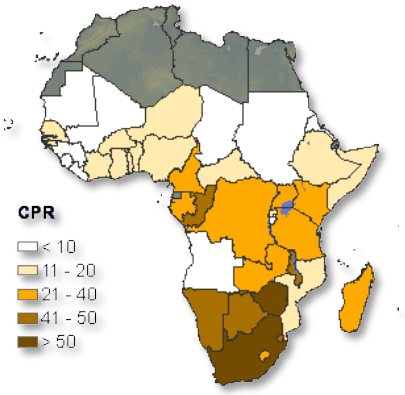
Unmet need

% of married women, ages 15-49, SSA average



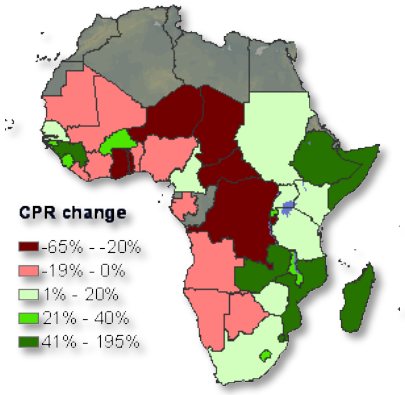
CPR

% of women, ages 15-49, 2007 or most recent



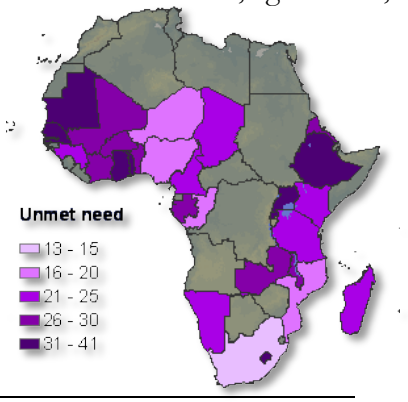
CPR, change

% change (2007-2001)/2001



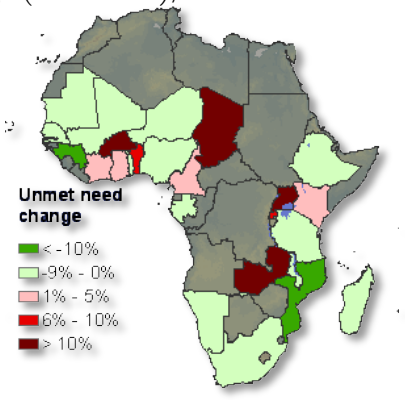
Unmet need

% of married women, ages 15-49, 2007



Unmet need, change

% change (2007-2001)/2001



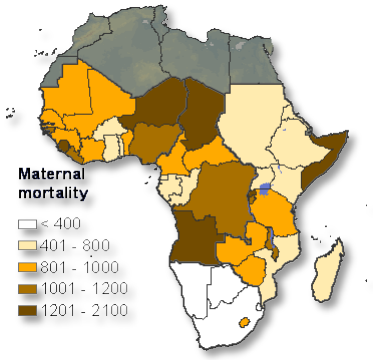
[24] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

Maternal mortality[25]

Summary

- Maternal mortality is very high in SSA, on average 830 deaths per 100,000 live births (relative to ~13 in the U.S.)
- Southern and Eastern Africa have shown the lowest rates, but are still quite high
- Data are unavailable for timeframes other than 2005

Maternal mortality
Deaths per 100,000 live births, 2005



Abortion legal status, unsafe abortions

Summary

- Abortion for any reason is prohibited in many SSA countries and almost all other countries have multiple restrictions on the conditions in which abortion is allowed
- The incidence of unsafe abortions is quite high, and highest is Eastern SSA
- Estimated deaths from unsafe abortions are almost 31,000 persons[26]. One of every 150 procedures leads to death compared to one for every 85,000 procedures in developed countries[27]

Legality of abortion[28]
2007 or most recent

Unsafe abortions[29]
Incidence per 1000 women 15-44, 2003

[25] World Development Indicators, 2008

[26] World Health Organization (WHO). 1998 Unsafe abortion. Global and regional estimates of incidence of and mortality due to unsafe abortion; WHO 2003 Safe abortion:Technical and policy guidance for health systems.

[27] Population Action International. 2001. The PAI report card.

[28] Center for Reproductive Rights, http://www.reproductiverights.org/pub_fac_abortion_laws.html.

[29] World Health Organization 2007. "Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003" 5th Edition

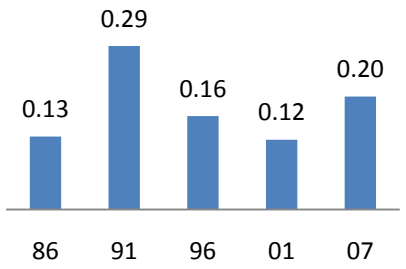
Indirect indicators

Physicians, nurses, and midwives[30]

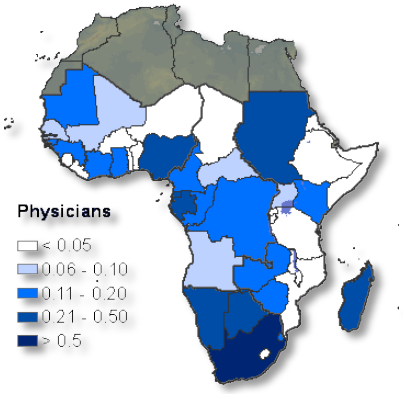
Summary

- After falling for 15 years, the number of physicians per 1,000 persons in SSA is again rising, increasing by 36% over the past 5 years
- However, in some countries (e.g. Tanzania), physicians are not prevalent and have dropped over the past 5 years
- Nurses and midwives augment FPRH capacity in some countries. Their trends generally follow those of physicians

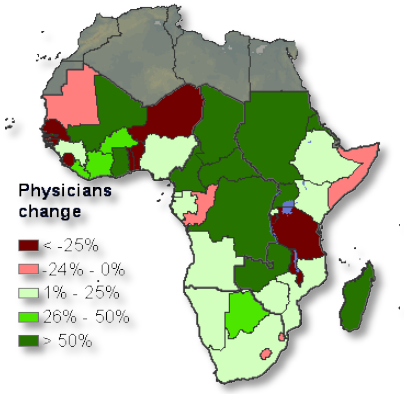
Physicians
Number per 1,000 people, SSA average



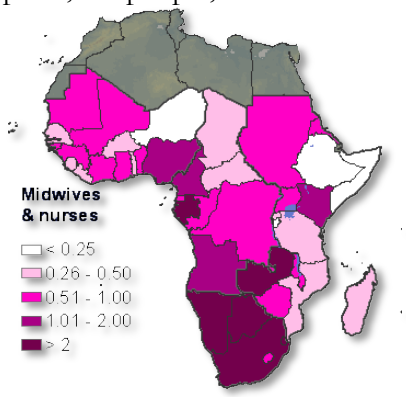
Physicians
Number per 1,000 people, 2007



Physicians, change[31]
% change (2007-2001)/2001



Nurses and midwives
per 1,000 people, 2007 or most recent



(Nurses and midwives change data not available)

[30] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

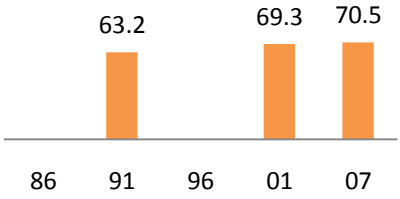
[31] For 26 countries (mostly middle and western SSA), change taken from 2007 vs. 1996, as 2001 data was unavailable.

Female education [32]

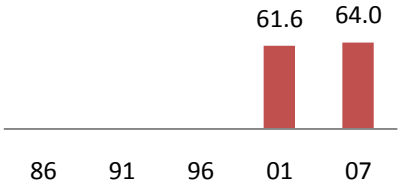
Summary

- More girls completing school can be an indicator of future demand
- On average, the percentage of girls completing primary school is rising, as is girls' progression to secondary school
- Girls education is relatively stronger in Southern and Eastern Africa. For example, in Botswana, Ethiopia, and South Africa, over 90% continue to secondary school
- However, primary completion is quite low, and is falling in many countries. Continuation onto secondary school is also very low in many countries, below 60% in 19 countries

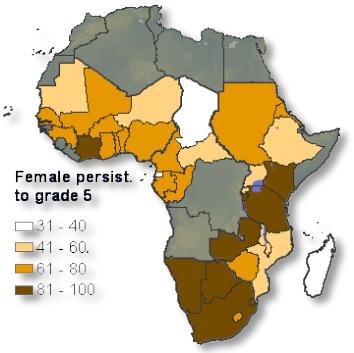
Female persistence to grade 5
% of cohert SSA average



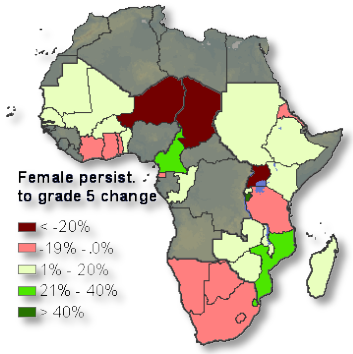
Female progression to secondary school
%, SSA average



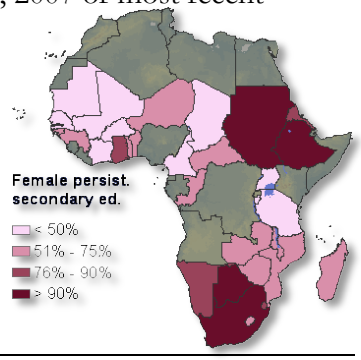
Female persistence to grade 5
% of cohert, 2007 or most recent



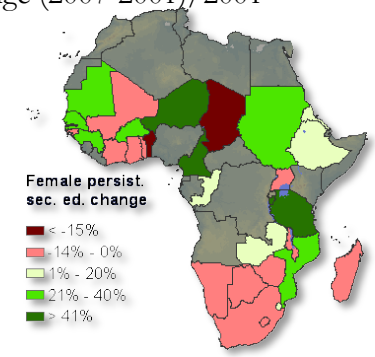
Female persistence to grade 5, change[33]
% change (2007-2001)/2001



Female progression to secondary school
%, 2007 or most recent



Female prog. to secondary school, change
% change (2007-2001)/2001



[32] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

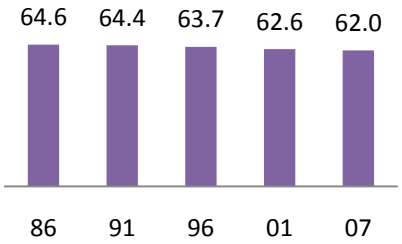
[33] Central African Republic, Congo, Guinea, and Kenya are changes from 1991 to 2007, as other data is unavailable

Labor force participation and gender equity[34]

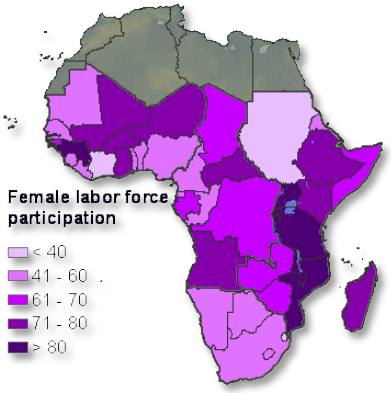
Summary

- Some countries show outstanding female labor force participation, including Burundi, Tanzania, Malawi and Mozambique
- However, on average labor force participation by women has been declining over the past 20 years, with only 5 out of 48 countries showing increases >0.5%
- Gender equity in select countries is quite low in SSA

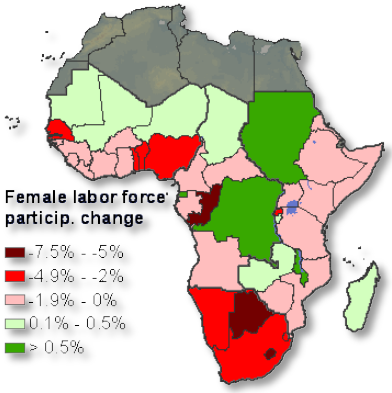
Female labor force participation
% of female population, age 15-64



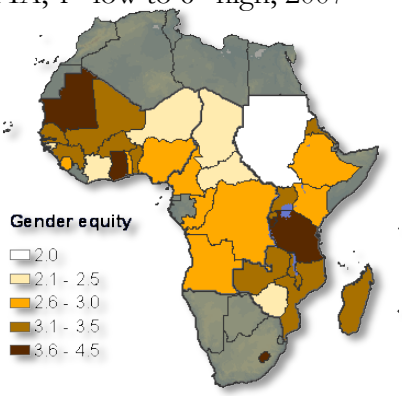
Female labor force participation
2007 or most recent



Female labor force participation, change
% change (2007-2001)/2001



Gender equity
CPIA, 1=low to 6=high, 2007



Gender equity definition[35]

Gender equity is one of the 16 Country Policy and Institutional Assessment (CPIA) factors, assessing the extent to which the country has enacted and put in place institutions and programs to enforce laws and policies that:

(a) promote equal access for men and women to human capital development [primary completion and access to secondary education, access to health care during delivery and to family planning, and adolescent fertility rate]

(b) promote equal access for men and women to productive and economic resources [labor force participation, land tenure and property and inheritance rights]

(c) give men and women equal status and protection under the law [individual and family rights and personal security (violence against women, trafficking, or sexual harassment) and political participation]

[34] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

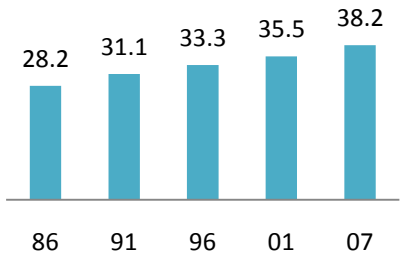
[35] Change over time unavailable from World Development Indicators

Urban population[36]

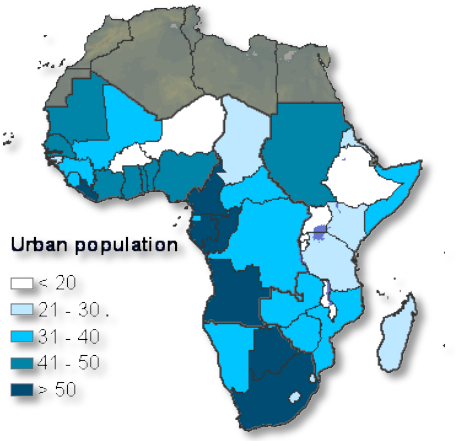
Summary

- Urbanization has been occurring steadily over the past few decades
- As more people move into the cities, opportunities arise for potentially more cost effective FPRH services
- However, even with urbanization, between 90% and 40% of the population in almost all countries currently live in rural areas

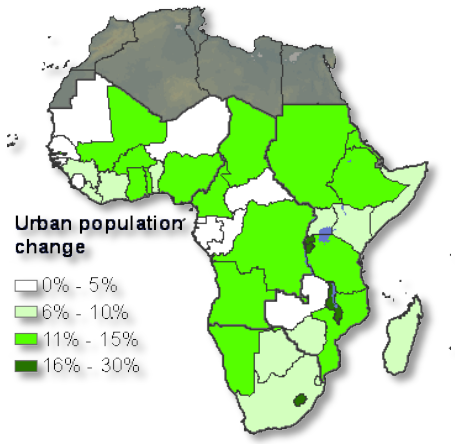
Urban population
% of total, SSA average



Urban population
2007 or most recent



Urban population, change
% change (2007-2001)/2001



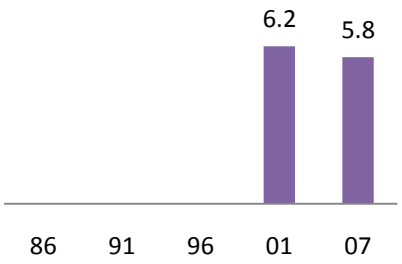
[36] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

Prevalence of HIV[37]

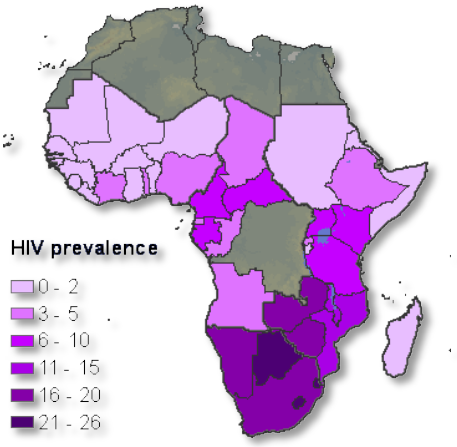
Summary

- On average, the prevalence of HIV is decreasing
- However, prevalence is still very high, especially in Southern SSA countries and is still increasing in many SSA countries
- Prevention related to HIV and FPRH services could be further integrated, improving FPRH access, particularly where HIV prevalence is high

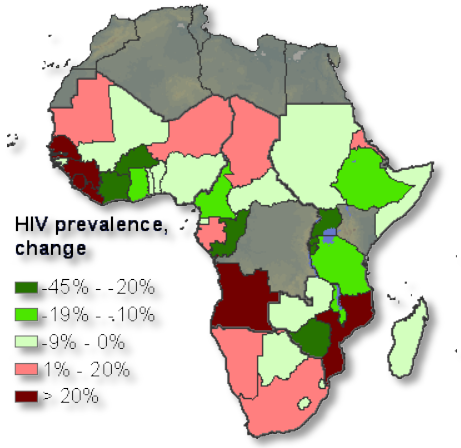
HIV prevalence
% of total population, SSA average



HIV prevalence
% of total population, 2007



HIV prevalence, change
% change (2007-2001)/2001



[37] World Development Indicators, 2008, using most recent of previous 5 years if data unavailable for given year

III. Interesting potential correlations

Based on the data from the previous sections, the following sets of maps attempt to highlight potential relationships between funding levels and FPRH indicators. One should expect that higher levels of funding result in positive results for FPRH. In many cases this is true and in some it is not.

Nevertheless, one must remember that correlations between funding and any development indicator are wrought with many potential issues. For example, if governance in a given country is bad, high aid funding may not make its way into services for the population. Or if money is spent on services and activities that take time to develop, there may be a lag between when the funding occurs and when a given indicator changes. The list goes on and on and the debate continues in the literature.

No matter how you look at it, it is hard to argue that if more money is raised and it is focused on being better spent on FPRH that positive results should follow in resource poor environments. As a result, for discussion purposes we highlight *interesting potential correlations* below including:

- **FPRH funding and CPR:** higher funding appears to be correlated with higher CPR
- **FPRH funding and TFR:** higher funding appears to be correlated with higher TFR
- **Government health spending and nurses:** more government funds appear to be correlated with more nurses
- **Government health spending and unsafe abortion:** more government funding appears to be correlated with fewer unsafe abortions

Additional trends will be developed as these materials are shared with FPRH partners.

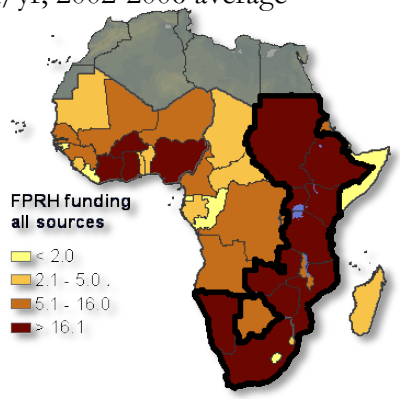
FPRH funding and CPR

- The most highly funded countries (e.g. those with total FPRH funding from all sources>$16M/year) on average have a positive benefit on CPR, with CPRs rising. This trend is highlighted in the first two maps below using the dark black outline

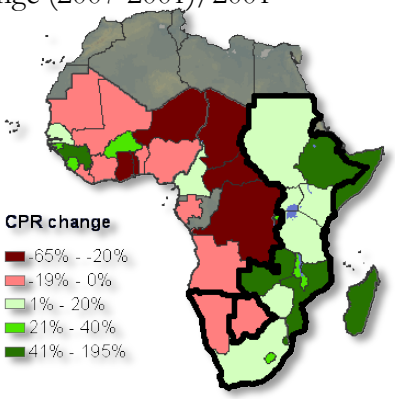
- Countries with higher per capita funding levels tend to have higher levels of CPR, shown in the second set of two maps below, highlighted with black

- Funding for contraceptives is likely measurable in CPR in the very near-term as supplies get distributed

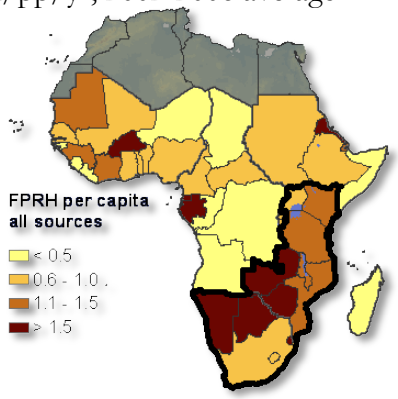
FPRH funding from all sources[38]
$M/yr, 2002-2006 average



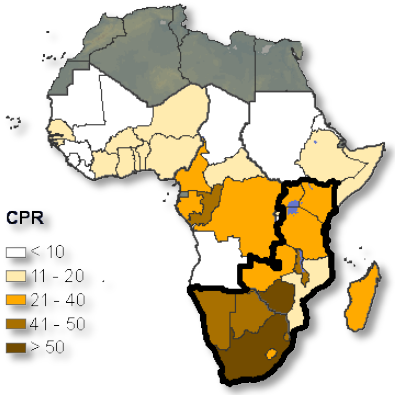
CPR, change
% change (2007-2001)/2001



Per capita FPRH funding from all sources
$M/pp/yr, 2002-2006 average



CPR
2007 or most recent

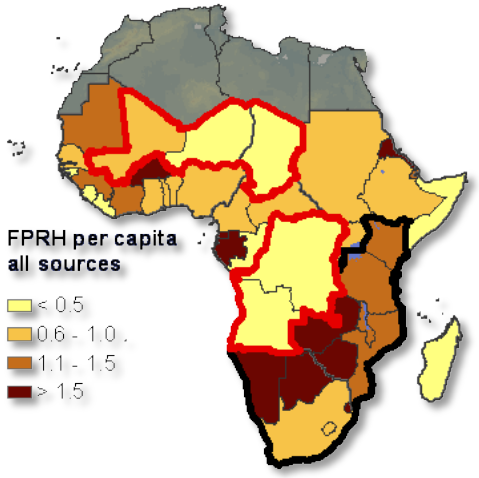


[38] Sources: OEDC DAC 2008; UNFPA 2008; Netherlands Interdisciplinary Demographic Institute (NIDI)2005; WDI (Word Development Indicators) 2008.

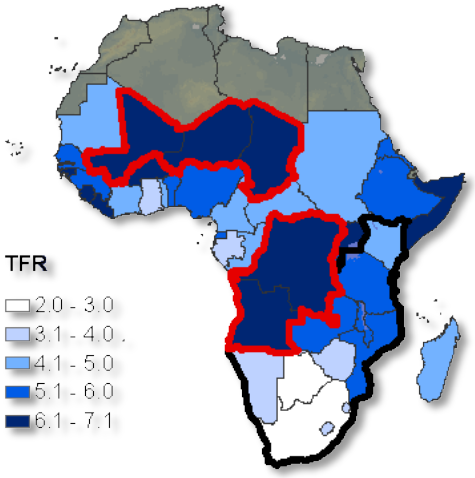
FPRH funding and TFR

- Countries with the lowest per capita funding tend to have higher total fertility rates, highlighted in the two maps below using the red outline
- Alternatively, countries that spent more on FPRH tend to have lower TFRs highlighted in black outline
- Are funders avoiding tougher cultural or political circumstances?

FPRH funding/pp from all sources[39]
$M/pp/yr, 2002-2006 average



TFR[40]
2007 or most recent



[39] Sources: OEDC DAC 2008; UNFPA 2008; Netherlands Interdisciplinary Demographic Institute (NIDI)2005; WDI (Word Development Indicators) 2008.

[40] World Development Indicators, 2008

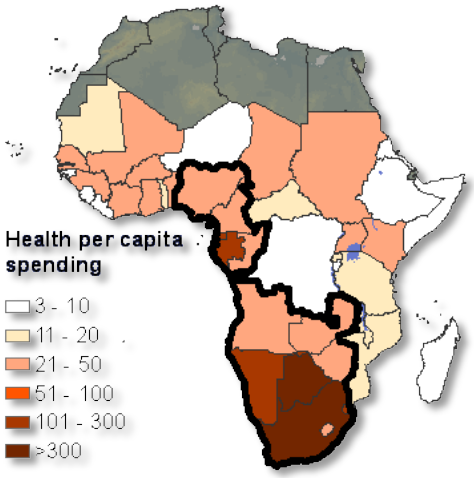
Government health spending and nurses

- Governments that spend more on health and FPRH tend to have a higher number of physicians, midwives and nurses, leading to more services for their populations. This trend is highlighted in the dark black outline

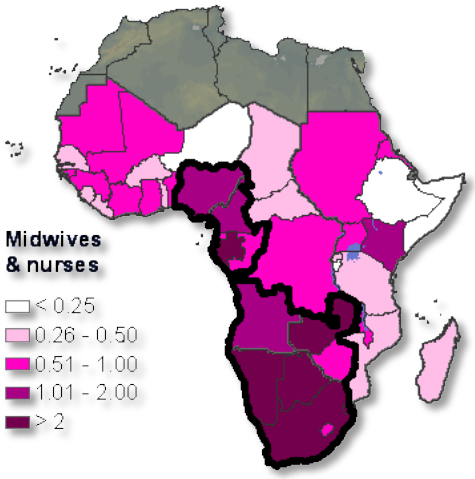
- The correlation with nurses is lower between GBS, ODA FPRH, and total FPRH spending

- Are nurses a good proxy for government investment in health care and infrastructure?

Government health spending[41]
$M/pp/yr, 2002-2006 average



Nurses and midwives[42]
2007 or most recent (mostly 2004)



[41] Netherlands Interdisciplinary Demographic Institute (NIDI)2005; WDI (Word Development Indicators) 2008, WHO 2008.

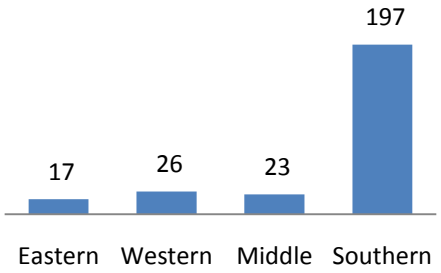
[42] World Development Indicators, 2008

Government health spending and unsafe abortions

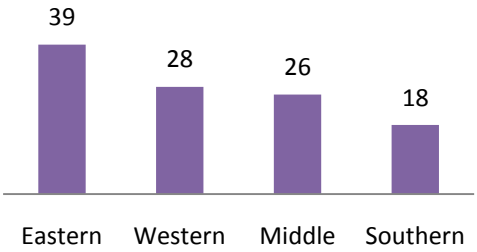
- Governments that spend more on health and FPRH tend to have a lower incidence of unsafe abortions, especially in Southern SSA.

- The legality of abortion of course also affects these trends, but improved health and overall FPRH as a result of more spending can lead to lower incidence of unwanted preganancies leading to unsafe abortions

Government health spending[43]
$/pp/yr, 2002-2006 (sum spending by region/sum population by region, excluding South Africa)



Unsafe abortions[44]
Incidence per 1000 women 15-44, 2003



[43] Netherlands Interdisciplinary Demographic Institute (NIDI)2005; WDI (Word Development Indicators) 2008, WHO 2008.

[44] World Health Organization 2007. "Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003" 5th Edition

Appendix 1: Sub-Saharan African countries

As a reference point, a map of SSA is provided below.

Appendix 2: Funding summary by source

Funding by SSA country by source and FPRH gaps are shown in the two tables below.

FPRH funding	Total FPRH spending from all sources	FPRH ODA	UNFPA ODA	U.S. ODA	EC ODA	UK ODA	Domestic government spending	Private consumer spending	HIV/AIDS-related funding	NGOs, Foundation funding
TOTAL	$724	$219	$72	$51	$23	$20	$144	$150	$127	$85
Country	**Total FPRH spending from all sources**	**FPRH ODA**	**UNFPA ODA**	**U.S. ODA**	**EC ODA**	**UK ODA**	**Domestic government spending**	**Private consumer spending**	**HIV/AIDS-related funding**	**NGOs, Foundation funding**
Unit	$M/yr	$M/yr	$M/yr	$M/yr	$M/yr	$M/yr	$M/yr	$M/yr	$M/yr	$M/yr
ANGOLA	$8.1	$4.6	$1.5	$1.5	$0.0	$0.0	$1.7	$0.4	$0.3	$1.1
BENIN	$5.7	$3.2	$1.7	$1.0	$0.0	$0.0	$0.4	$0.4	$0.8	$0.9
BOTSWANA	$6.4	$0.9	$0.9	$0.0	$0.0	$0.0	$1.7	$0.2	$2.8	$0.8
BURKINA FASO	$28.5	$4.1	$1.6	$0.0	$0.0	$0.0	$10.9	$11.1	$1.0	$1.3
BURUNDI	$5.9	$2.4	$0.9	$0.0	$0.0	$0.2	$0.5	$1.6	$0.9	$0.6
CAMEROON	$11.2	$4.8	$1.9	$0.0	$0.0	$0.0	$1.2	$3.2	$1.0	$1.0
CAPE VERDE	$1.1	$0.6	$0.5	$0.0	$0.0	$0.0	$0.3	$0.1	$0.2	$0.0
CENTRAL AFRICAN REP.	$3.8	$1.9	$1.5	$0.0	$0.3	$0.0	$0.4	$0.6	$0.5	$0.4
CHAD	$5.4	$1.9	$1.6	$0.0	$0.0	$0.0	$1.1	$1.7	$0.7	$0.0
COMOROS	$0.5	$0.4	$0.4	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
CONGO, DEM.REP.	$10.9	$6.6	$2.8	$2.5	$0.0	$0.1	$0.6	$2.4	$0.7	$0.6
CONGO, REP.	$2.0	$0.6	$0.6	$0.0	$0.0	$0.0	$0.6	$0.6	$0.2	$0.0
COTE D'IVOIRE	$21.3	$3.0	$2.0	$0.0	$0.0	$0.0	$2.9	$8.9	$3.9	$2.6
DJIBOUTI	$0.9	$0.4	$0.3	$0.0	$0.0	$0.0	$0.2	$0.1	$0.2	$0.0
EQUATORIAL GUINEA	$1.5	$0.9	$0.8	$0.0	$0.0	$0.0	$0.5	$0.1	$0.0	$0.0
ERITREA	$10.8	$4.2	$1.3	$0.2	$0.0	$0.1	$2.8	$3.1	$0.2	$0.4
ETHIOPIA	$70.5	$14.0	$3.1	$4.7	$0.0	$0.0	$7.8	$4.7	$17.2	$26.7
GABON	$3.1	$0.4	$0.2	$0.0	$0.0	$0.0	$1.8	$0.8	$0.1	$0.0
GAMBIA	$1.3	$0.7	$0.4	$0.0	$0.0	$0.0	$0.1	$0.0	$0.3	$0.2
GHANA	$19.6	$4.0	$2.4	$1.0	$0.0	$0.0	$2.3	$3.2	$1.3	$8.8

FPRH funding	Total FPRH spending from all sources	FPRH ODA	UNFPA ODA	U.S. ODA	EC ODA	UK ODA	Domestic government spending	Private consumer spending	HIV/AIDS-related funding	NGOs, Foundation funding
GUINEA	$10.3	$5.0	$1.0	$1.0	$0.0	$0.0	$0.6	$3.4	$0.7	$0.6
GUINEA-BISSAU	$1.1	$0.9	$0.6	$0.0	$0.0	$0.0	$0.1	$0.1	$0.0	$0.0
KENYA	$39.7	$10.3	$2.5	$5.1	$0.3	$0.1	$3.6	$3.9	$17.9	$4.1
LESOTHO	$2.1	$0.4	$0.3	$0.0	$0.0	$0.0	$0.4	$0.3	$0.3	$0.8
LIBERIA	$1.9	$1.4	$0.8	$0.4	$0.0	$0.1	$0.2	$0.2	$0.1	$0.0
MADAGASCAR	$5.8	$3.4	$1.3	$1.9	$0.0	$0.0	$0.6	$0.2	$0.6	$0.9
MALAWI	$17.3	$5.5	$2.5	$1.3	$0.2	$0.5	$5.8	$1.2	$2.6	$2.2
MALI	$8.8	$5.0	$1.5	$1.7	$0.0	$0.0	$1.6	$1.9	$0.3	$0.0
MAURITANIA	$4.3	$1.9	$1.4	$0.0	$0.1	$0.0	$1.0	$0.5	$0.4	$0.5
MAURITIUS	$2.5	$0.1	$0.1	$0.0	$0.0	$0.0	$1.4	$1.1	$0.0	$0.0
MOZAMBIQUE	$27.1	$14.1	$5.6	$4.9	$0.0	$1.0	$2.5	$0.5	$8.6	$1.3
NAMIBIA	$53.1	$0.8	$0.7	$0.0	$0.0	$0.0	$32.2	$13.4	$5.9	$0.8
NIGER	$7.1	$3.1	$2.3	$0.0	$0.0	$0.0	$1.4	$1.3	$0.6	$0.7
NIGERIA	$96.3	$55.5	$5.1	$9.0	$20.5	$17.0	$6.1	$14.4	$9.9	$10.4
RWANDA	$7.4	$2.7	$1.4	$0.4	$0.0	$0.0	$0.6	$0.2	$3.3	$0.6
SAO TOME & PRINCIPE	$0.3	$0.3	$0.2	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SENEGAL	$12.3	$4.4	$1.6	$2.0	$0.0	$0.0	$1.8	$3.3	$1.1	$1.7
SEYCHELLES	$0.3	$0.0	$0.0	$0.0	$0.0	$0.0	$0.2	$0.1	$0.0	$0.0
SIERRA LEONE	$3.3	$2.4	$1.2	$0.0	$1.0	$0.0	$0.2	$0.1	$0.3	$0.3
SOMALIA	$3.0	$2.2	$1.7	$0.0	$0.0	$0.0	$0.3	$0.4	$0.0	$0.0
SOUTH AFRICA	$47.0	$1.6	$0.6	$0.3	$0.0	$0.0	$12.1	$16.6	$12.4	$4.2
SUDAN	$25.0	$3.7	$2.5	$0.4	$0.0	$0.0	$6.6	$13.1	$0.1	$1.5
SWAZILAND	$3.3	$0.4	$0.4	$0.0	$0.0	$0.0	$1.2	$0.5	$0.6	$0.5
TANZANIA	$42.4	$13.5	$3.7	$2.2	$0.0	$0.1	$7.2	$6.8	$9.8	$5.2
TOGO	$6.3	$3.5	$3.0	$0.0	$0.3	$0.0	$0.6	$1.9	$0.3	$0.0
UGANDA	$20.5	$5.4	$1.7	$2.4	$0.0	$0.0	$1.2	$1.5	$10.6	$1.7
ZAMBIA	$18.8	$8.2	$1.2	$6.8	$0.0	$0.1	$2.1	$1.1	$6.6	$0.9
ZIMBABWE	$37.5	$3.0	$1.5	$0.3	$0.0	$0.9	$14.1	$18.3	$1.3	$0.7

FPRH funding gap	Total FPRH spending from all sources	Core FPRH Cost	Higher FPRH Cost	Gap in funding, assuming core FPRH cost	Gap in funding, assuming higher FPRH cost
TOTAL	$724	$1,340	$3,015	$683	$2,336
		0			
Country	Total FPRH spending from all sources	Core FPRH Cost	Higher FPRH Cost	Gap in funding, assuming core FPRH cost	Gap in funding, assuming higher FPRH cost
Unit	$M/yr	$M/yr	$M/yr	$M/yr	$M/yr
ANGOLA	$8.1	$15.7	$55.9	$7.6	$47.8
BENIN	$5.7	$11.5	$26.9	$5.8	$21.2
BOTSWANA	$6.4	$6.6	$8.6	$0.2	$2.2
BURKINA FASO	$28.5	$17.0	$49.2	$0.0	$20.8
BURUNDI	$5.9	$12.7	$32.0	$6.8	$26.0
CAMEROON	$11.2	$17.2	$74.6	$6.0	$63.4
CAPE VERDE	$1.1	$2.0	$2.8	$0.8	$1.7
CENTRAL AFRICAN REP.	$3.8	$3.9	$17.4	$0.1	$13.6
CHAD	$5.4	$4.9	$34.1	$0.0	$28.7
COMOROS	$0.5	$2.1	$3.4	$1.5	$2.9
CONGO, DEM.REP.	$10.9	$54.3	$222.7	$43.4	$211.7
CONGO, REP.	$2.0	$5.9	$13.3	$4.0	$11.3
COTE D'IVOIRE	$21.3	$25.9	$74.4	$4.6	$53.1
DJIBOUTI	$0.9	$1.7	$2.3	$0.7	$1.4
EQUATORIAL GUINEA	$1.5	$0.8	$2.1	$0.0	$0.5
ERITREA	$10.8	$6.6	$15.5	$0.0	$4.7
ETHIOPIA	$70.5	$136.2	$274.4	$65.7	$203.9
GABON	$3.1	$10.0	$7.1	$6.9	$4.0
GAMBIA	$1.3	$2.2	$5.1	$0.9	$3.8
GHANA	$19.6	$36.3	$92.1	$16.7	$72.5
GUINEA	$10.3	$12.6	$33.4	$2.3	$23.1
GUINEA-BISSAU	$1.1	$1.6	$5.4	$0.5	$4.3
KENYA	$39.7	$82.8	$156.5	$43.1	$116.8
LESOTHO	$2.1	$5.6	$11.3	$3.5	$9.2

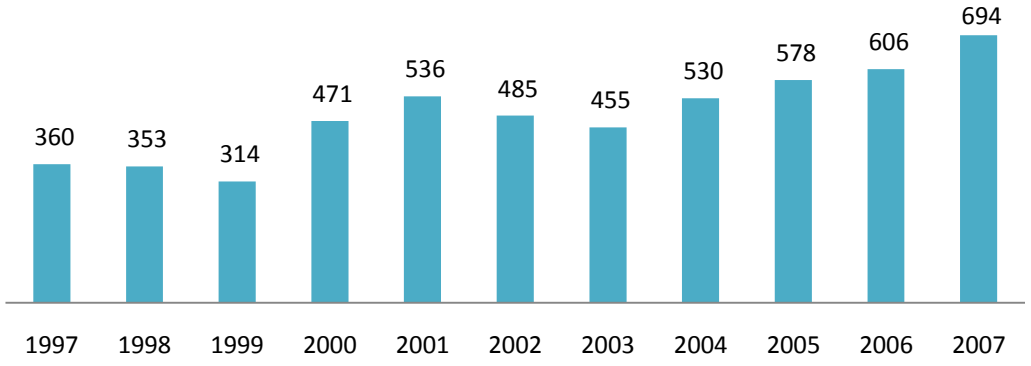
FPRH funding gap	Total FPRH spending from all sources	Core FPRH Cost	Higher FPRH Cost	Gap in funding, assuming core FPRH cost	Gap in funding, assuming higher FPRH cost
LIBERIA	$1.9	$3.8	$15.3	$1.9	$13.4
MADAGASCAR	$5.8	$33.7	$78.1	$28.0	$72.4
MALAWI	$17.3	$36.8	$51.9	$19.5	$34.5
MALI	$8.8	$19.0	$51.5	$10.2	$42.7
MAURITANIA	$4.3	$4.2	$12.0	$0.0	$7.7
MAURITIUS	$2.5	$6.0	$9.4	$3.5	$6.9
MOZAMBIQUE	$27.1	$29.5	$88.0	$2.5	$61.0
NAMIBIA	$53.1	$4.5	$7.9	$0.0	$0.0
NIGER	$7.1	$12.6	$44.8	$5.4	$37.7
NIGERIA	$96.3	$153.3	$545.2	$57.0	$448.9
RWANDA	$7.4	$11.9	$40.1	$4.5	$32.7
SAO TOME & PRINCIPE	$0.3	$0.4	$0.6	$0.0	$0.3
SENEGAL	$12.3	$20.0	$40.2	$7.7	$27.8
SEYCHELLES	$0.3	$0.2	$0.4	$0.0	$0.0
SIERRA LEONE	$3.3	$6.1	$22.1	$2.8	$18.8
SOMALIA	$3.0	$16.8	$34.5	$13.8	$31.5
SOUTH AFRICA	$47.0	$209.7	$249.6	$162.7	$202.6
SUDAN	$25.0	$53.7	$111.7	$28.6	$86.6
SWAZILAND	$3.3	$2.9	$6.0	$0.0	$2.8
TANZANIA	$42.4	$80.3	$149.6	$37.8	$107.2
TOGO	$6.3	$9.5	$20.9	$3.2	$14.6
UGANDA	$20.5	$68.9	$103.5	$48.4	$82.9
ZAMBIA	$18.8	$28.0	$48.0	$9.2	$29.2
ZIMBABWE	$37.5	$52.6	$62.9	$15.2	$25.4

Appendix 3: UNFPA donors

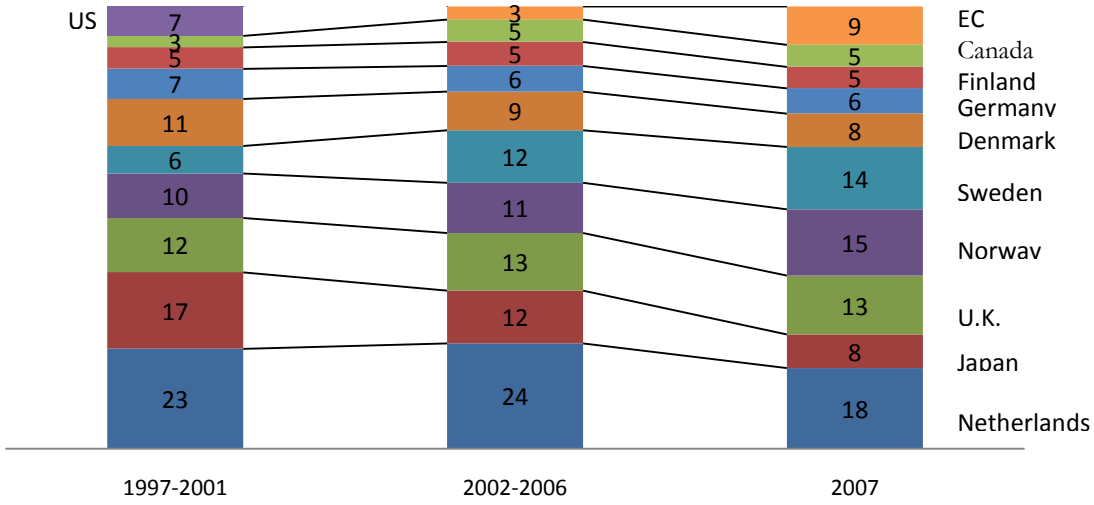
UNFPA is the largest donor to FPRH in Sub-Saharan Africa. As a multilateral, the UNFPA receives funds from many different donor countries. Below are funding sources for total UNFPA income (not just for SSA), and analysis of where the money came from for the period 1997 through 2007. Data is from UNFPA annual reports[45].

Total UNFPA income

$M, constant 2006 dollars



UNFPA income by top 10 sources



[45] UNFPA annual reports (www.unfpa.org/about/report). 1997-2006. UNFPA data unavailable prior to 1997