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# MAKING FAMILY PLANNING PART OF THE PRSP PROCESS:

A GUIDE FOR INCORPORATING FAMILY PLANNING PROGRAMS  
INTO POVERTY REDUCTION STRATEGY PAPERS

**JULY 2007**

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Anita Bhuyan, Maria Borda, and William Winfrey of the Health Policy Initiative, Task Order I.

The USAID | Health Policy Initiative, Task Order I, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order I is implemented by Constella Futures, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and World Conference of Religions for Peace (WCRP).

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.



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# ACKNOWLEDGMENTS

This guide was prepared by Anita Bhuyan, Maria Borda, and William Winfrey of the USAID | Health Policy Initiative, Task Order 1. The authors are indebted to the Health Policy Initiative's staff in Mali, led by Country Director Modibo Maiga, and to consultant Bakary Kante, in partnership with *Groupe Pivot/Santé Population*, for leading efforts to promote the inclusion of family planning in the country's second-generation Poverty Reduction Strategy Paper. Their efforts provided valuable lessons learned for the development of this guide. Special thanks are due to Mieke McKay and Salif Coulibaly of USAID/Mali and Tom Merrick, John May, and Tonia Marek of the World Bank for their advice and support for these efforts. The authors also wish to acknowledge the guidance and technical review provided by Michelle Prosser, Laurette Cucuzza, Jay Gribble, Nancy McGirr, William McGreevey, and Carol Shepherd of the Health Policy Initiative. Finally, we wish to acknowledge our project's cognizant technical officer, Mai Hijazi of the USAID Office of Population and Reproductive Health (OPRH) and technical advisors, Diana Prieto (OPRH) and Nithya Mani (Office of HIV/AIDS), for their technical leadership, dedication, and vision for repositioning family planning and promoting health equity.

# EXECUTIVE SUMMARY

Family planning is one of many strategies that can slow population growth and reduce demographic pressure, which can help countries lift themselves out of poverty. Reduced population sizes mean decreased burden on national expenditures for education, health, and other social services, as well as less strain on the environment and natural resources. Family planning also directly contributes to reduced infant and maternal mortality and morbidity. Satisfying the family planning needs of the poor—who often live in rural areas and in marginalized urban areas and tend to have less access to health services, higher birth rates, and higher unmet need—promotes equity, helps address the multidimensional nature of poverty, and recognizes the long-term societal changes needed to sustain economic growth at the household and national levels.

This guide is designed to help family planning champions—including civil society and NGOs, international and donor organizations, and interested government officials—and other stakeholders promote the inclusion of family planning issues and programs into Poverty Reduction Strategy Papers (PRSPs). Countries prepare PRSPs to qualify for loans and debt relief from the World Bank and International Monetary Fund (IMF). As a condition of receiving assistance, the PRSPs must outline the macroeconomic and social policies countries will adopt to alleviate poverty and, ultimately, accelerate progress toward meeting the Millennium Development Goals (MDGs). From the perspective of family planning advocates, the PRSPs can demonstrate the government’s commitment to devise, fund, and implement family planning initiatives. From the perspective of governments and PRSP planners, satisfying unmet need for family planning is an innovative approach for reducing poverty that can help countries more easily achieve a range of socioeconomic goals.

As noted throughout the guide, there are key entry points where family planning champions and their allies can participate in and influence the PRSP process, including Diagnosis, Formulation, Implementation, and Monitoring. Ideally, the initiatives included in the PRSP’s formulation will respond to the causes and consequences of poverty noted in the diagnosis of the poverty situation. Because PRSPs are broad strategy documents covering numerous sectors, they provide direction and identify priorities but are not implementation plans. Therefore, implementation of PRSPs, including family planning initiatives, must be supported by the requisite policies, plans, budgets, and human capacity development efforts, among others. Finally, the PRSP process requires preparation of annual progress reports. Family planning champions can play a role during each of these stages.

In 2006, the USAID | Health Policy Initiative, Task Order 1, teamed with an in-country NGO network, *Groupe Pivot/Santé Population* (GP/SP), to promote the inclusion of family planning into Mali’s second-generation PRSP. A first draft of the strategy had been completed when the Health Policy Initiative first became involved in the process. Given the short timeframe, the initiative provided technical and financial assistance to support a local consultant to represent GP/SP at the PRSP planning and review meetings. The experience in Mali provided several lessons learned:

- It is possible to reposition family planning as a strategic intervention that can contribute to poverty reduction. Having an organization or individual devoted to the process, that is proactive in offering suggestions and is able to follow up on needed actions, is essential.
- Early involvement is critical for raising awareness and building support for the inclusion of family planning in all aspects of the PRSP (e.g., diagnosis, objectives, policy recommendations, monitoring, etc.).



- In-country civil society capacity to advocate for family planning and, in particular, to make linkages to poverty-reduction strategies requires strengthening. In many countries, HIV/AIDS organizations may be more effective in demonstrating the impact of the epidemic on socioeconomic development. Family planning champions can learn from these organizations as well as seek to establish ties with them. Integration of FP/RH and HIV can have benefits for both constituencies.
- Family planning champions should target not only the PRSP office or unit, but also other influential stakeholders to encourage their involvement and foster a unified approach. They can find allies in civil society (e.g., women’s groups) and within the government (e.g., health ministry).
- Finally, the experiences in Mali show that using sound evidence (e.g., current population and economic data tailored to the country’s context) and presenting concise suggestions—including model or proposed language that can be incorporated into the document—can help family planning champions make a better case for inclusion in the PRSP. User-friendly computer models, described in this guide, can be used to assess country-specific contexts.

It is our hope that the guide will help users foster an enabling environment for family planning policymaking and program implementation and promote understanding of an often under-appreciated strategy for improving the lives of people living in low-income countries around the world.

# ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
APR	annual progress report
CPS	Cellule de Planification et de Statistique (Planning and Statistics Unit)
CYP	couple-years of protection
DHS	Demographic and Health Survey
DNP	Direction National de la Population (National Population Directorate)
FP	family planning
GP/SP	Groupe Pivot/Santé Population
GPRS	Growth and Poverty Reduction Strategy (Ghana)
HCNLS	Haut Conseil National pour la Lutte contre le SIDA (High National Council for the Fight Against AIDS)
HIPC	heavily indebted poor country
HIV	human immunodeficiency virus
IDA	International Development Association
IMF	International Monetary Fund
JSA	Joint Staff Assessment (of the World Bank/IMF)
JSAN	Joint Staff Advisory Note (of the World Bank/IMF)
MDG	Millennium Development Goal
MOH	Ministry of Health
NGO	nongovernmental organization
OPRH	Office of Population and Reproductive Health (of USAID)
PETS	Public Expenditure Tracking System
PRGF	Poverty Reduction and Growth Facility
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
RH	reproductive health
STI	sexually transmitted infection
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

## SECTION I: INTRODUCTION

This booklet provides guidance on integrating family planning into Poverty Reduction Strategy Papers (PRSPs). It is intended for family planning “champions” and other stakeholders involved in the PRSP process who are interested in devising innovative, multisectoral strategies to alleviate poverty.

Changes in international assistance and debt relief mechanisms are increasingly linking assistance eligibility to a country’s willingness and success in adopting economic and structural reforms—providing family planning champions both a challenge and opportunity for securing government commitment for family planning programs (Quijada et al., 2004; Greene and Merrick, 2005; Gibb Vogel, 2006). One notable change is the requirement that countries prepare PRSPs to qualify for World Bank and International Monetary Fund (IMF) concessional loans and debt relief. PRSPs are national strategy documents that delineate the macroeconomic and social policies countries will adopt to alleviate poverty and, ultimately, accelerate progress toward meeting the Millennium Development Goals (MDGs). Among these goals are to eradicate poverty and hunger, achieve universal primary education, and reduce child and maternal mortality by 2015. Attempts to tie international assistance to poverty reduction are borne out of an increasing recognition of the multidimensional nature of poverty and the impact of rising debts on a country’s ability to use aid effectively. PRSPs influence the country’s socioeconomic development planning, including decisions about how to address long-term population and demographic pressures.

Family planning is one of several avenues for reducing population growth and demographic pressure.<sup>1</sup> Reduced population sizes mean decreased burden on national expenditures for education, health, and other social services, as well as less strain on the environment and natural resources. Family planning also directly contributes to improved health in terms of reduced infant and maternal mortality and morbidity. Repositioning family planning as a key component of multisectoral poverty-reduction programs not only increases support for family planning but makes it logistically more feasible and more affordable for countries to achieve poverty reduction and related goals. In an era of international assistance that is increasingly focused on results and accountability, family planning should be seen as an essential element of PRSPs.

It is our hope that this guide will help users foster an enabling environment for family planning policymaking and program implementation and promote understanding of an often under-appreciated strategy for improving the lives of people living in low-income countries around the world. Section 2 of this guide provides an overview of the PRSPs, the key players, and the stages in the PRSP process. The importance of family planning as a critical component of poverty-reduction efforts is discussed in Section 3. The messages outlined here can provide the basis for civil society participation in promoting the inclusion of family planning in PRSPs, which is the subject of Section 4. Next, Section 5 presents a case study of efforts to integrate family planning into a PRSP, focusing on recent experiences in Mali. Section 6 provides an easy-to-use summary checklist of the booklet’s guidance and lessons learned. Finally, Section 7 lists tools, online resources, and recommended readings noted throughout the guide.

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<sup>1</sup> Other demographically important proximate determinants of fertility, beyond contraceptive use, include marriage patterns (e.g., age at marriage), duration of postpartum abstinence, duration of breastfeeding in the postpartum period, and abortion. U.S. funds are restricted from promoting or providing abortion as a family planning method.



## SECTION 2: UNDERSTANDING THE PRSP

A PRSP is a national strategy prepared by developing countries to qualify for loans and debt relief from the World Bank and IMF. In particular, it is meant to provide a link among national plans, donor support, and the outcomes needed to achieve the eight MDGs. As a strategy paper that underpins various forms of assistance, the PRSP is an important mechanism for funding national development programs, including family planning initiatives. This section provides a basic overview of the PRSP, the stages and key players involved in the PRSP process, and the current status of PRSPs. Section 4 explores in more detail how family planning champions can get involved at each stage.

### History of the PRSP

In the 1990s, in recognition of the rising debt being incurred by low-income countries and its impact on the ability of countries to lift themselves out of poverty, multilateral and donor organizations launched various initiatives to improve the effectiveness and impact of international assistance efforts. An integral component of these efforts has been to link a country's eligibility for debt relief to its commitment to reform policies and invest in economic and social programs designed to alleviate poverty. Under the Heavily-Indebted Poor Countries (HIPC) Initiative, which was launched in 1996, countries can apply for debt relief by showing how debt payments will be redirected toward accelerating reforms and strengthening commitment to reduce poverty—which is explained in the country's PRSP.

The PRSP has also become a requirement for credit, grants, and low-interest loans provided by the World Bank and IMF. The type of assistance provided depends on the country's economic situation. The World Bank's International Development Association (IDA) is concerned with reducing poverty and improving living conditions in the poorest countries. The Bank provides technical assistance as well as interest-free credit, grants, and low-interest loans to support social sectors such as education, health, and other areas, including infrastructure and communication. PRSP implementation is supported through a World Bank lending instrument called the Poverty Reduction Support Credit (PRSC).<sup>2</sup> Low-income countries can borrow from the IMF at low-interest rates through the Poverty Reduction and Growth Facility (PRGF) and Exogenous Shocks Facility (IMF, 2006).<sup>3</sup> These loans are provided on the condition that the borrowing country undertakes specific policies and measures to balance its international debt payments.

Another important trend in international assistance reforms has been an increasing emphasis on multisectoralism, both in the recognition of the various factors that contribute to poverty and in the participation of diverse sectors in the development and implementation of strategies to address those factors. In 1999, the World Bank and IMF adopted a Comprehensive Development Framework that sought to expand on the economic aspects of development by addressing the social, environmental, governance, and systems-related factors that affect development efforts. Considerations of these factors

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<sup>2</sup> The World Bank introduced the PRSC lending mechanism in 2001. PRSCs provide financial support for a government's medium-term development program (e.g., PRSP) and are given to countries eligible for IDA loans. Lending is based on the government meeting certain prior conditions, as well as achieving designated benchmarks (such as policy reforms outlined in the PRSP) after receiving assistance.

<sup>3</sup> The PRGF is the IMF's low-interest lending mechanism, introduced in 1999. It is also tied to the PRSP and is intended to support program and policy efforts within the IMF's domain of responsibility, such as macroeconomic policy reform. The Exogenous Shocks Facility provides policy and financial assistance to low-income countries facing "exogenous shocks," such as natural disasters or changing commodity prices, that could negatively affect their economies. This funding differs from other IMF emergency lending mechanisms, however, because it is designed to help countries formulate a comprehensive economic program for addressing the underlying shocks.

should be included in the PRSP. Moreover, governments must involve various ministries (not simply the Ministry of Finance), civil society partners, and development partners, including the World Bank and the IMF, as part of the PRSP process. The emphasis on multisectoralism provides family planning champions with an opportunity for encouraging the inclusion of family planning issues, programs, and indicators in the PRSPs (as discussed in Section 4).

## What Is a PRSP?

A PRSP is a strategy document that guides national development and poverty-reduction programs geared toward achieving the eight MDGs. The PRSP is intended to be updated and revised every 3–5 years. Recognizing that the proposed policies, programs, and resources will vary depending on the socioeconomic situation of the given country, the World Bank and IMF have not outlined a universal template or blueprint for a model PRSP. However, the strategies are to be guided by five principles. PRSPs should be:

- “Country-driven and -owned, predicated on broad-based participatory processes for formulation, implementation, and outcome-based progress monitoring;
- Results-oriented, focusing on outcomes that would benefit the poor;
- Comprehensive in scope, recognizing the multidimensional nature of the causes of poverty and measures to attack it;
- Partnership-oriented, providing a basis for the active and coordinated participation of development partners (bilateral, multilateral, nongovernmental) in supporting country strategies; and
- Based on a medium- and long-term perspective for poverty reduction, recognizing that sustained poverty reduction cannot be achieved overnight” (Klugman, 2002b, p. 3).

The World Bank’s *A Sourcebook for Poverty Reduction Strategies* (Klugman, 2002a)<sup>4</sup> provides guidance on designing a PRSP. The sourcebook is divided into seven major themes, including Core Techniques, (e.g., poverty measurement and analysis, development targets and costs), Crosscutting Issues (e.g., governance, participation), Macro and Structural Issues (e.g., trade policy), and Rural and Urban Poverty, among others. At a minimum, the PRSP should include a description of the participatory process used to design the strategy; a diagnosis of the country’s poverty situation; articulation of proposed policies to address or alleviate the underlying causes of poverty; and a monitoring and evaluation plan. PRSPs should also include a realistic assessment of the resources required (both internal and external) to implement the proposed policies.

Countries are encouraged to build on existing policies and plans whenever possible. Uganda, for example, had prepared a Poverty Eradication Action Plan in 1997, which it revised and submitted in 2000 as its PRSP—becoming the first country to complete a PRSP. To avoid delays in seeking concessional loans and debt relief, countries can submit a less extensive interim PRSP while they prepare a full PRSP.

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<sup>4</sup> Available at <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPRS/0,,contentMDK:20175742~pagePK:210058~piPK:210062~theSitePK:384201.00.html>.

## How Are PRSPs Prepared?

For those interested in participating in and influencing the PRSP process, it is important to have a general understanding of how the process works. Figure 1 outlines the major steps involved in the formulation, implementation, and monitoring of a PRSP. The timeline for the process will vary by country. (Section 4 provides more details on how family planning champions can become involved at each stage in the process.)

The process begins with a diagnosis of the country's poverty situation, including research to identify the populations that are most affected by poverty, the various underlying causes of poverty (recognizing the multidimensional nature of the problem), and the anticipated impact of different policies and approaches on the poor and on poverty reduction. At this time, the government should also devise a participatory planning process that includes a wide range of stakeholders.

The formulation stage is generally the most time-consuming part of the PRSP process. The team charged with designing the PRSP must:

- Identify objectives given the diagnosis of the country's poverty situation;
- Devise policies that respond to the causes of poverty in the country;
- Prepare realistic estimates of the resources needed to implement the policies; and
- Outline a monitoring and evaluation plan that includes targets and indicators that correspond to the poverty diagnosis, stated objectives, and proposed policies.

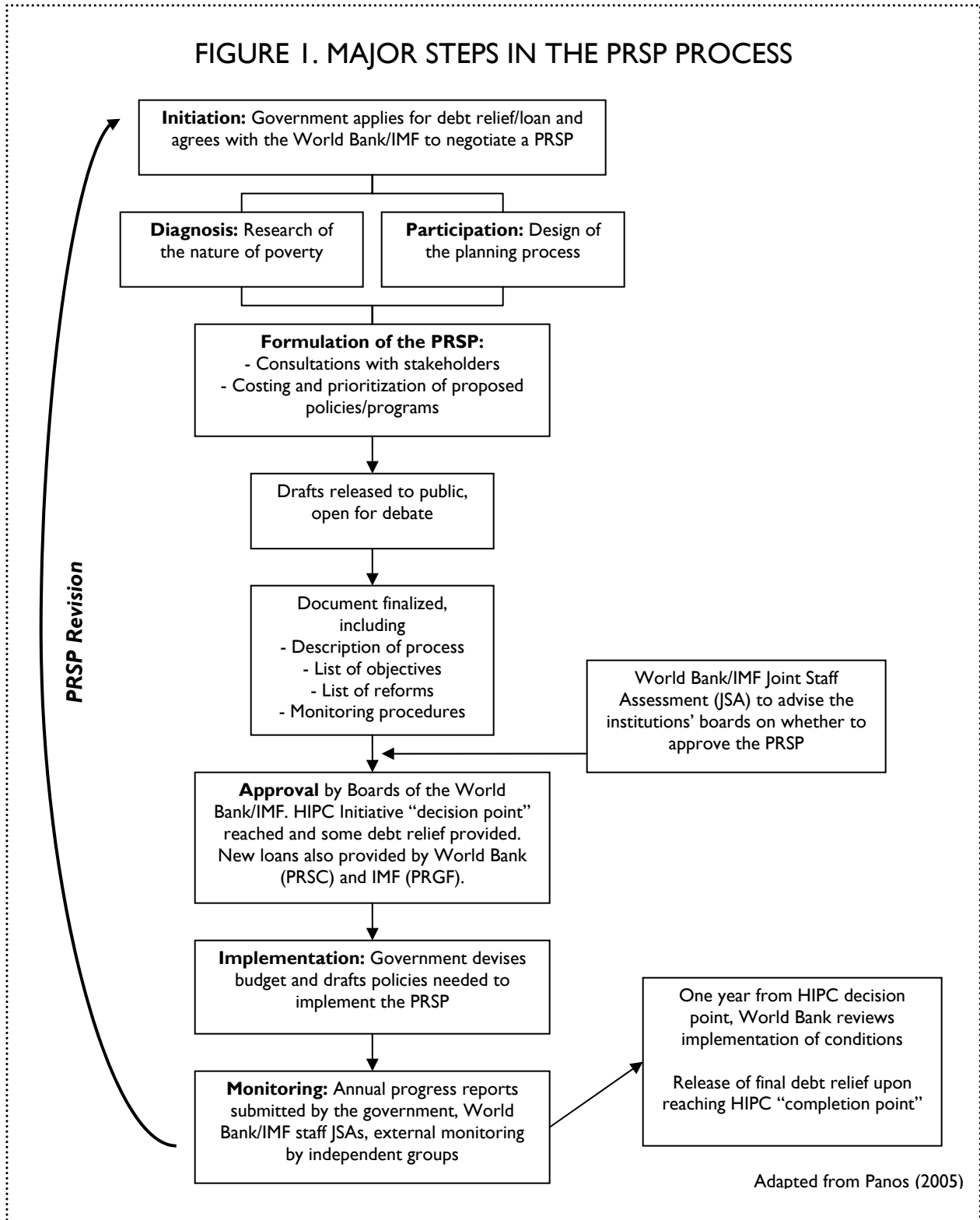
There should be a linkage and logical flow from the identification of the problems to be addressed, to the policies proposed to address them, to the indicators used to assess progress. The PRSP should also reflect prioritization of issues addressed, policies proposed, and resources required—as opposed to containing an exhaustive laundry list of policies that is impossible to fund and implement. The Ministry of Finance should review and add a medium-term expenditure plan to the final draft.

In an ideal case, a wide range of stakeholders will be involved in the formulation and review of the PRSP, as required by the PRSP guidelines. In some cases, the PRSP draft is released to the public for open discussion and comments. Open debate allows the PRSP team as well as other stakeholders to negotiate the issues that will be included in the final draft. Through technical assistance during the process and through the formal Joint Staff Assessment (JSA) of the PRSP, World Bank and IMF staff also play a significant role in ensuring that the policies proposed in the PRSP constitute a sound basis for providing assistance.

The executive boards of the World Bank and IMF determine whether to approve the strategy. Approval of the PRSP is a requirement for reaching the “decision point” of the HIPC Initiative, under which the country can receive some debt relief. Approval also enables the country to receive loans from the World Bank and IMF.

Given the broad nature of the PRSPs, the strategy papers are not implementation plans in and of themselves. To effectively implement a PRSP, the government must adopt the requisite budgets, plans, legislation, and policies and establish roles and responsibilities for managing each component—be it health, governance, or economic reform. Inclusion in the PRSP, then, is not a guarantee that the activity will be fully or effectively implemented.

**FIGURE I. MAJOR STEPS IN THE PRSP PROCESS**



Adapted from Panos (2005)

Next, countries are required to submit annual progress reports. Monitoring the impact of the initiatives contained in the PRSP requires pulling together various individual monitoring mechanisms into one



coordinated system, which can pose “substantial practical challenges” in some countries (Bedi et al., 2006). There are no set requirements of what an annual progress report should include. However, World Bank/IMF joint staff guidance on annual reports suggest that the reports should evaluate performance; outline any proposed modifications or new analysis that will affect activities in the upcoming year; and recount how the country has addressed comments from past assessments (World Bank/IMF, n.d.). The guidance also recommends that the country state how annual reporting is being used to keep relevant stakeholders informed of implementation progress. In addition to the annual reports and JSAs, external organizations may conduct independent evaluations of specific initiatives and their impact on the poor and on poverty reduction. While the focus of the PRSP is on poverty reduction (MDG #1), the country’s progress toward achieving the other MDGs is also taken into account during the monitoring and evaluation phase—especially since education, environmental, and health issues influence poverty reduction.

The results of monitoring and evaluation efforts should be tied to and inform the decisionmaking process for the next PRSP, which is to be updated and revised every 3–5 years. If a country implements a PRSP for at least one year, adopts key reforms, and demonstrates good performance (e.g., as can be documented in the annual reports), the country reaches the “completion point” for the HIPC Initiative and receives the full debt relief negotiated at the decision point.

#### ☒ **RECOMMENDED READING**

*Health in Poverty Reduction Strategy Papers (PRSPs): An Introduction and Early Experience* (Walford, 2002)

*Influencing Poverty Reduction Strategies: A Guide* (Oxfam, 2002)

“Overview” in PRSP sourcebook (Klugman, 2002b)

“Poverty Reduction Strategy Papers (PRSPs): A Rough Guide” (Bretton Woods Project, 2003)

*PRSPs: Their Significance for Health: Second Synthesis Report* (WHO, 2004)

“Who’s Richer, Who’s Poorer? A Journalist’s Guide to the Politics of Poverty Reduction Strategies” (Panos, 2005)

## Who Are the Key Players in the Process?

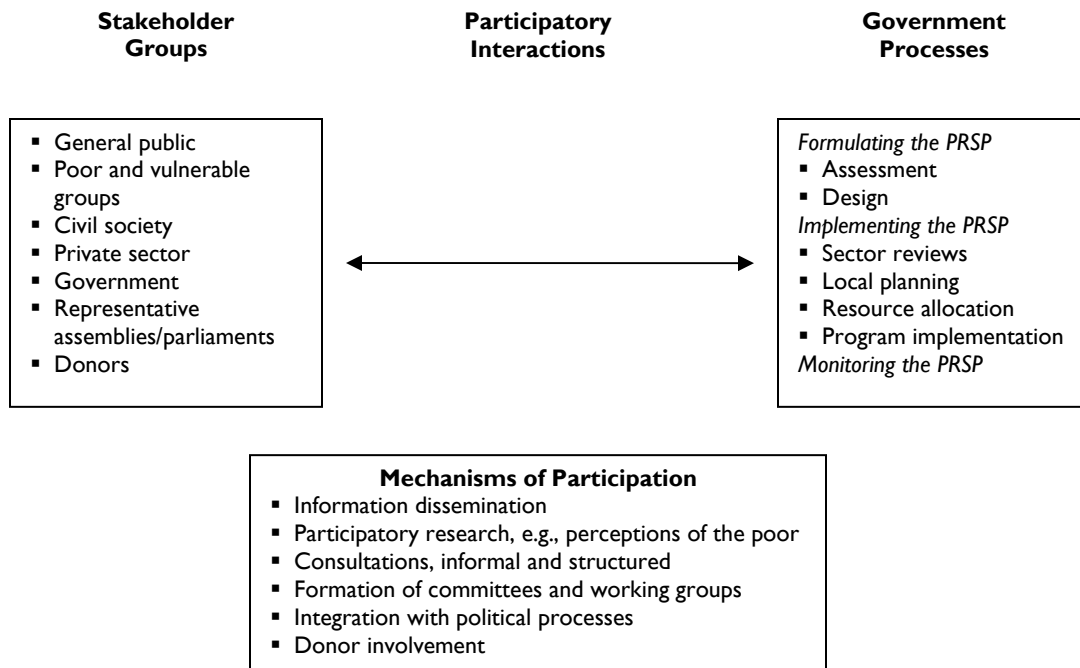
Participation is a critical component of PRSP requirements and the participatory planning process used in-country must be described in the PRSP submission. The national government is charged with establishing a mechanism for fostering participation of a diverse array of stakeholders. The Bretton Woods Project (2003) explains that “in-country arrangements have been developed at the various stages of the PRSP process,” including “ministerial or inter-ministerial committees, steering committees involving various sectors of society, thematic groups addressing crosscutting issues, monitoring multi-stakeholder groups, etc.” (p. 8). Stakeholders can include representatives from the different ministries, private business associations, civil society and NGOs, local government representatives, community leaders, donors, and groups serving the poor. Because the PRSPs deal heavily with macroeconomic policies, the Ministry of Finance generally plays a significant role in the PRSP drafting team. However, other ministry staff (e.g., health, education, labor) and civil society and private sector groups should also be included in the process

The PRSP sourcebook provides a schematic of the stakeholder groups and mechanisms of participation that can be incorporated in various stages of the PRSP process (see Figure 2). The quality and nature of participation varies greatly across countries. McGee and others (2002) suggest that while the majority of

governments have included civil society participation, the role of these groups is often “consultative,” which is defined as “participants may express views without any commitment from those inviting their participation that these views will be taken into account” (p. 7). In contrast, a more intensive form of participation would involve “joint decisionmaking,” wherein there is a commitment to take into account the views of all participants (McGee with Norton, 2000). A study by Oxfam (2004) came to a similar conclusion, suggesting that while “new spaces for dialogue have opened up in almost every country,” consultation is the model followed in most cases, not full-fledged “participation” (p. 1).

Numerous studies have also assessed the extent to which different sectors and groups are involved in the PRSP process. Some ministries or groups may have more influence depending on their type of expertise (e.g., Ministry of Finance) or on how critical their issue (e.g., HIV/AIDS) is at the time. The World Bank’s Population and Reproductive Health Cluster (2004) found that PRSP participatory processes “should give more voice to poor people and to civil society” (p. 6). An analysis of experiences in four countries revealed that the involvement of ministries of health in the PRSP processes was limited. The study suggests that the health ministries were marginalized because they lacked staff with “macroeconomic competencies” and because “influential actors in the PRSP process, such as parliamentary committees or political action groups, are commonly outside the reach of health ministries” (WHO/UNFPA, 2006, p. 4). These studies highlight the need for increased attention to participatory processes, particularly in regard to the involvement of family planning champions that could be found among civil society groups and in government health ministries and departments. They also underscore the need to better position health ministry officials vis-à-vis other influential government stakeholders and to build the capacity of both public sector and civil society health champions in terms of competencies, data, and communication skills to actively engage in the PRSP process.

FIGURE 2. PARTICIPATION IN THE PRSP PROCESSES



Source: Tikare et al. (2006)

## What Is the Current Status of PRSPs?

As shown in Table 1, each country proceeds at its own pace in the PRSP process. Countries may be drafting budgets and plans to implement a recently approved strategy or interim strategy; they may be monitoring PRSP implementation and submitting annual reports; or they may be gathering research and outlining priorities for the development of a new or next generation PRSP.

Since 2000, 51 countries have completed at least one full PRSP, while an additional 13 countries have only prepared interim PRSPs. (The IMF website<sup>5</sup> provides access to each country's interim PRSPs, full PRSPs, and annual reports. Visit this website for the most up-to-date information on each country.)

- The countries that completed their first-generation PRSPs from 2001 to 2003—such as Benin, Ethiopia, Honduras, Rwanda, and others—will need to prepare second-generation PRSPs in the near future if they are to receive additional loans or debt relief.

<sup>5</sup> Available at <http://www.imf.org/external/np/prsp/prsp.asp?view=all&sort=cty#cp>.

- Countries such as Bangladesh, Dominica, Kenya, and Lesotho completed their first-generation PRSPs in 2005/2006. Within the next couple of years, these countries will be implementing the priority activities established in their strategy documents and will submit annual progress reports.
- Twelve countries have completed second-generation PRSPs, including Cambodia, Ghana, Mozambique, Nicaragua, Tanzania, Uganda, Vietnam, and others. Again, over the next few years, these countries will focus on implementation and monitoring.
- The 13 countries with interim PRSPs will need to develop full PRSPs over the next few years if they wish to qualify for additional assistance. Countries such as Afghanistan, Haiti, Liberia, Republic of Congo, and Uzbekistan submitted interim PRSPs from 2005–2007—signaling that they may be planning to complete full PRSPs in the near future.

**TABLE I. PRSP STATUS BY COUNTRY AND BY YEAR OF APPROVAL (AS OF AUGUST 2007)**

	Country	2000	2001	2002	2003	2004	2005	2006	2007
1	Afghanistan, Islamic Rep. of							i-PRSP	
2	Albania	i-PRSP	PRSP-I						
3	Armenia		i-PRSP		PRSP-I				
4	Azerbaijan		i-PRSP		PRSP-I				
5	Bangladesh				i-PRSP		PRSP-I		
6	Benin	i-PRSP			PRSP-I				
7	Bhutan					PRSP-I			
8	Bolivia	i-PRSP	PRSP-I						
9	Bosnia and Herzegovina					PRSP-I			
10	Burkina Faso	PRSP-I					PRSP-2		
11	Burundi					i-PRSP			PRSP-I
12	Cambodia	i-PRSP		PRSP-I				PRSP-2	
13	Cameroon	i-PRSP			PRSP-I				
14	Cape Verde			i-PRSP			PRSP-I		
15	Central African Republic	i-PRSP							
16	Chad	i-PRSP			PRSP-I				
17	Comoros, Union of							i-PRSP	
18	Congo, Dem. Rep. of			i-PRSP					
19	Congo, Rep. of						i-PRSP		
20	Côte d'Ivoire			i-PRSP					
21	Djibouti		i-PRSP						
22	Dominica					i-PRSP		PRSP-I	
23	Ethiopia, Fed. Dem.	i-PRSP		PRSP-I					

	Country	2000	2001	2002	2003	2004	2005	2006	2007
	Rep. of								
24	Gambia	i-PRSP		PRSP-I					
25	Georgia	i-PRSP			PRSP-I				
26	Ghana	i-PRSP			PRSP-I			PRSP-2	
27	Grenada							i-PRSP	
28	Guinea	i-PRSP		PRSP-I					
29	Guinea-Bissau	i-PRSP							
30	Guyana	i-PRSP		PRSP-I					
31	Haiti							i-PRSP	
32	Honduras	i-PRSP	PRSP-I						
33	Kenya	i-PRSP					PRSP-I		
34	Kyrgyz Republic		i-PRSP	PRSP-I					PRSP-2
35	Lao People's Dem. Rep.		i-PRSP			PRSP-I			
36	Lesotho	i-PRSP						PRSP-I	
37	Liberia								i-PRSP
38	Macedonia, former Yugoslav Rep. of	i-PRSP							
39	Madagascar, Rep. of	i-PRSP			PRSP-I				PRSP-2
40	Malawi	i-PRSP		PRSP-I					PRSP-2
41	Mali	i-PRSP		PRSP-I					
42	Mauritania, Islamic Rep. of	PRSP-I							PRSP-2
43	Moldova, Rep. of	i-PRSP		i-PRSP		PRSP-I			
44	Mongolia		i-PRSP		PRSP-I				
45	Mozambique, Rep. of	i-PRSP	PRSP-I						PRSP-2
46	Nepal				PRSP-I				
47	Nicaragua	i-PRSP	PRSP-I					PRSP-2	
48	Niger	i-PRSP		PRSP-I					
49	Nigeria						PRSP-I		
50	Pakistan		i-PRSP			PRSP-I			
51	Rwanda	i-PRSP		PRSP-I					
52	São Tomé & Príncipe	i-PRSP					PRSP-I		
53	Senegal	i-PRSP		PRSP-I					
54	Serbia and Montenegro					PRSP-I			
55	Sierra Leone		i-PRSP				PRSP-I		
56	Sri Lanka			PRSP-I					

	Country	2000	2001	2002	2003	2004	2005	2006	2007
57	Tajikistan	i-PRSP		PRSP-I					
58	Tanzania	i-PRSP; PRSP-I						PRSP-2	
59	Timor-Leste, Dem. Rep. of						PRSP-I		
60	Uganda	PRSP-I					PRSP-2		
61	Uzbekistan, Rep. of						i-PRSP		
62	Vietnam		i-PRSP	PRSP-I		PRSP-2			
63	Yemen, Rep. of	i-PRSP		PRSP-I					
64	Zambia	i-PRSP		PRSP-I					

Note: i-PRSP = interim PRSP; PRSP-I = first-generation PRSP; PRSP-2 = second-generation PRSP

Source: IMF website: <http://www.imf.org/external/np/prsp/prsp.asp?view=all&sort=cty#cp> [accessed August 13, 2007]. Check the website for the most up-to-date information on each country.

## SECTION 3:

# WHY INCLUDE FAMILY PLANNING IN PRSPs?

From the perspective of family planning advocates, a PRSP can demonstrate the government's commitment to devise, fund, and implement family planning initiatives. Having this high-level political support will help family planning advocates coordinate with other sectors to implement multisectoral programs. From the perspective of governments and PRSP planners, satisfying unmet need for family planning is an intervention that can help countries more easily achieve a range of socioeconomic goals, including the eight MDGs (see Box 1).

While some reproductive health-related issues—such as maternal health and HIV prevention—have been elevated to MDG status and, therefore, are often included in PRSPs, family planning has not been designated as a primary goal.<sup>6</sup> Therefore, integrating family planning into a PRSP first requires fostering an understanding of how high fertility affects socioeconomic development. Stakeholders will then need to make the case that increasing access to family planning can help countries slow population growth, contributing to efforts to achieve poverty reduction and other MDGs.

Fully understanding the various links among family planning, high fertility, and poverty reduction is no easy feat, given the numerous and complex cultural, social, and economic issues involved (Merrick, 2002). High fertility, for example, may be both a cause of poverty (e.g., larger populations use up more resources) and a consequence of poverty (e.g., the poor and people living in underserved rural areas lack equitable access to family planning information and services). And family planning alone cannot bring about long-term demographic changes or reduce poverty without adequate policies to promote economic growth and provision of social services.

### BOX 1 THE MILLENNIUM DEVELOPMENT GOALS

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV, malaria, and other diseases
7. Ensure environmental stability
8. Develop a global partnership for development

With these caveats in mind, this section briefly reviews a rationale for including family planning programs in a PRSP, highlighting particular elements from the World Bank's PRSP guidelines. The section focuses on how family planning is a multisectoral issue related to poverty; how family planning can make it logistically more feasible and more cost-effective for countries to achieve poverty reduction-related results; and how improving access to family planning addresses issues of equity and accountability to the poor. This section concludes by providing examples of how countries have integrated family planning into their PRSPs to date.

A complete discussion of the interaction of high fertility, family planning, and poverty is not possible here. Stakeholders, therefore, will need to expand on the rationale presented below and tailor evidence-based data, tools, and analyses of poverty, family planning, and population dynamics to their particular

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<sup>6</sup> In 2006, the United Nations General Assembly adopted a new *target* under MDG #5, which pertains to improved maternal health. The new target, "to achieve universal access to reproductive health by 2015," is recognized as an important component of achieving the MDG of reduced maternal mortality. Under this new target, reproductive health indicators could include contraceptive prevalence rate, unmet need for family planning, availability of emergency obstetric care services, and age-specific fertility rate for the 15–19 years age group (WHO, 2005).

context. “Section 7: Tools, Online Resources, and Recommended Reading” provides additional resources that family planning champions can use to make the case for integrating family planning into a PRSP.

## The Multidimensional Nature of Poverty

World Bank guidance calls on countries to recognize the “multidimensional nature of the causes of poverty and measures to attack it” as well as articulate a “long-term perspective for poverty reduction, recognizing that sustained poverty reduction cannot be achieved overnight” (Klugman, 2002a, p. 3). By considering population issues and the role of family planning in national development, PRSP planners and stakeholders can demonstrate their understanding of the various facets of poverty and their appreciation of the strategies needed to sustain progress over the long term.

Family planning is a multisectoral issue related to poverty for two primary reasons: 1) high fertility is one of the non-economic factors that affects poverty and economic development at societal and household levels; and 2) reduced fertility, brought about by improving access to and use of family planning, alleviates the burden on a range of services across sectors. The following points illustrate how fertility and/or family planning can influence short- and long-term socioeconomic development in various sectors.

- **Impact of low fertility at the national level.** Research shows that high fertility can impede economic growth (Birdsall et al., 2001; Singh et al., 2004). Countries with high “population pressure”<sup>7</sup> or with rapidly growing populations may not be able to meet the large education-, labor-, health-, and infrastructure-related demands of the population. Population growth also affects the environment and raises concerns about food security, safe drinking water, and availability of arable land (Leisinger et al., 2002).

Reducing fertility can help alleviate poverty and stimulate economic growth. For example, a 2001 study explored the impact of reduced fertility on poverty in 45 countries (Eastwood and Lipton, 2001). The study estimated that reducing the birth rate by 5 births per 1,000 during the 1980s would have reduced the average national incidence of poverty from 18.9 percent in the mid-1980s to 12.6 percent in the mid-1990s.

Countries that experience a falling birth rate and invest in socioeconomic development during this period can take advantage of a demographic dividend (Merrick, 2002). For a short period of time, declining birth rates can result in an improved dependency ratio, with an increasing number of productive adults relative to the number of young and elderly dependents. The demographic dividend is realized if countries respond with appropriate policies and the resources that would have been required to meet the needs of a larger number of dependents “are released for investment in economic development and family welfare” (Ross, 2004, p. 1). Research suggests that countries in East Asia and, to some extent, Latin America have benefited from this demographic dividend over the last four decades (Mason and Lee, 2004).

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<sup>7</sup> Population pressure refers to the number of people in relation to the natural and financial resources of a given territory (May, 2005).



- **Impact of low fertility at the household level.** High fertility strains the resources of low-income households and hinders their ability to escape poverty. For example, improved educational opportunities promote economic advancement, yet children’s attendance in school is negatively associated with the number of siblings they have. Larger families tend to keep children out of school, particularly girls, when they have limited resources (UN Millennium Project, 2006).

A reduced family size can translate into higher average income per capita. As the UNFPA notes, “A family of a certain size may be below the poverty line, but with one less member may rise above the poverty threshold” (2004, Chap. 2, p. 3).<sup>8</sup> With more resources available per person, families are better able to afford educational-, health-, and nutrition-related expenses for their children. A smaller family may also be in a better position to save money for emergency use (e.g., a catastrophic illness, such as HIV or malaria), thereby avoiding going deep into debt or selling off assets (e.g., land, property, cattle) that are essential for the family’s economic survival.

The World Bank’s guidelines for interim PRSPs note that “[i]ll-health, malnutrition, and high fertility are three main reasons why households become or remain poor” (Soucat et al., 2000, p. 3). Satisfying unmet need for family planning is an intervention that can reduce fertility and lead to health benefits for mothers and children. Pregnancy- and childbirth-related complications, such as hemorrhage, infection, and complications from abortion, account for 13 percent of the global disease burden among women ages 15 to 44 (Cohen, 2004). Mortality and morbidity among mothers consequently affects the health and nutrition of children. Access to contraceptives, however, enables women to delay, space, or limit pregnancies, which reduces their exposure to high-risk pregnancies. Women who space or limit births are also more likely to enter or stay in school and have improved opportunities for income-earning employment.

These examples touch on a few of the ways in which fertility and family planning bear on the poverty level and economic development of countries and households. Several other issues should also be explored, depending on the country context. Family planning champions can play an important role in gathering data on and thoughtfully articulating the potential of family planning to decrease poverty.

## A Results Orientation

A country’s ability to qualify for permanent debt relief under the HIPC Initiative and future World Bank/IMF loans and assistance now depends on the extent to which the country shows results—in terms of reducing poverty, accelerating reforms, and achieving the goals outlined in the PRSPs and international consensus agreements, such as the MDGs. In particular, the World Bank’s PRSP sourcebook states that national poverty-reduction strategies should be “results-oriented, focusing on outcomes that would benefit the poor” (Klugman, 2002a, p. 3).

Increasing access to family planning makes it logistically more feasible and less expensive for countries to achieve their objectives. In the long term, satisfying unmet need for family planning leads to slower population growth, thereby enabling governments to expand social services to a smaller population. Egypt provides an example of how investments in family planning led to less pressure on the country’s social sector spending levels. If Egypt had not invested in family planning programs from 1980 to 2005 to the extent that it did, the country would have 12 million more inhabitants and 84 percent of those people would have been under the age of 15, contributing to increased need for health and education expenditures (Moreland, 2006). Analysis shows that Egypt, in 2005, would have needed to spend an

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<sup>8</sup> For specific webpage, please see: <http://www.unfpa.org/swp/2004/english/ch2/page3.htm>.

additional US\$880 million on education and an additional US\$18 million on early childhood immunizations if the country had not invested in family planning (see Box 2). Cumulative savings over the 25-year period are estimated at US\$6.4 billion for education and US\$137 million for childhood immunizations.

## **BOX 2**

## **EGYPT'S FAMILY PLANNING INVESTMENTS MADE A DIFFERENCE**

### **Education**

- Pre-university enrollment would have totaled 21 million versus 16 million in 2005
- Education costs would have reached US\$3.51 billion compared to US\$2.63 billion

### **Immunizations**

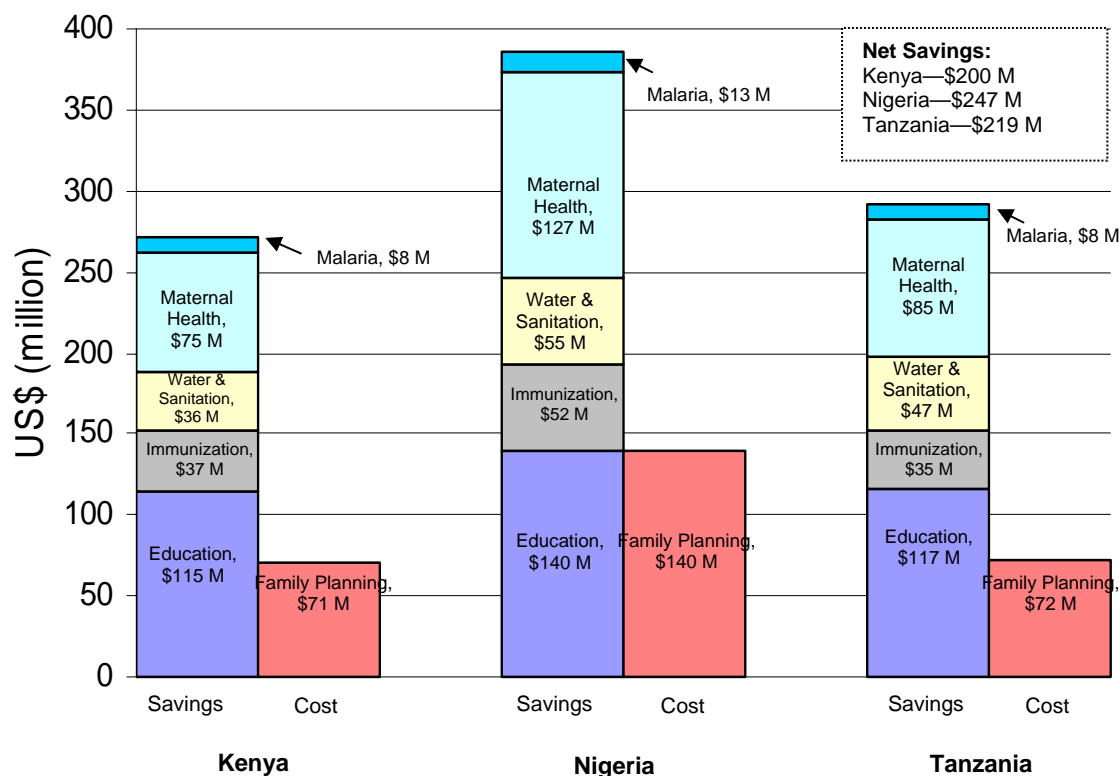
- An additional 1 million infants would have required immunizations in 2005
- Early childhood immunization costs would have totaled US\$49.7 million compared to US\$31.4 million

A recent benefit-cost analysis of the contribution of family planning to achievement of the MDGs further demonstrates the overall savings countries can enjoy by investing in family planning programs (Moreland and Talbird, 2006). The analysis focused on selected targets of five MDGs (relating to primary education, child immunization, maternal health, water and sanitation, and insecticide-treated nets for malaria) in 16 sub-Saharan African countries. The benefits from satisfying unmet need for family planning (as measured by savings in achieving selected MDG targets) outweighed the extra costs for family planning in all countries. Savings ranged from US\$2.03 for every dollar spent on family planning in Ethiopia to US\$6.22 in Senegal. Figure 3 presents the overall potential savings that could be achieved in three countries: Kenya, Nigeria, and Tanzania. The estimated net savings in reaching the selected MDG targets, after satisfying unmet need for family planning, ranged from US\$200–\$247 million per country.

By reducing the costs for meeting a range of goals related to poverty alleviation—such as expanding primary education, preventing the spread of malaria, improving water and sanitation, and reducing the disease burden related to maternal mortality and morbidity—family planning can help countries free up additional resources that could be invested in socioeconomic development. With smaller populations to serve and more resources available to meet their needs, it will be logistically more feasible for countries to achieve results.

Computer modeling tools listed in Section 7, such as BenCost and Allocate, can help family planning advocates and policymakers estimate the level of resources needed to achieve various outcomes. The methodology for the MDG analysis is also described in Section 7.

**FIGURE 3. COMPARISON OF THE COSTS FOR SATISFYING UNMET NEED FOR FAMILY PLANNING AND SAVINGS INCURRED IN ACHIEVING SELECTED TARGETS OF THE MDGs**



Source: Data derived from Moreland and Talbird (2006)

## Equity Issues and Accountability to the Poor

The 2004 *World Development Report* (World Bank, 2003) highlights the theme of “Making Services Work for Poor People.” It notes that studies have increasingly confirmed that, paradoxically, it is the wealthier groups who benefit from government healthcare spending, not the poor. Moreover, the poor may not be aware of policies designed to help increase access to reproductive healthcare services, such as user fee exemption schemes for the poor, or they may be subject to informal fees charged by providers (Sharma et al., 2005a; Sharma et al., 2005b). These factors necessitate putting the poor at the center of service provision to improve access, quality, and affordability.

This new orientation is reflected in the PRSP process. Whether referring to the multi-faceted and long-term dimensions of poverty, the need for partnerships and participation, or a results orientation, the focus of the PRSP is on meeting the needs of the poor, which raises issues of equity and accountability. The World Bank’s interim PRSP guidelines argue that:

A more complete view of poverty includes deprivations from not only money income, but also human development, financial and physical security, expanding opportunities and especially participation in key aspects of social life ... Responsiveness of the health sector to the needs of the poor and accountability to social goals are therefore essential (Soucat et al., 2000, p. 4).

Beyond the macroeconomic indicators of progress that countries must strive to attain, PRSPs and annual reports are judged on the extent to which countries introduce policies and reforms specifically designed to meet the needs of the poor.

If governments target resources for the poor, satisfying their unmet need for family planning is one intervention that can make a significant difference in the lives of the poor. Fertility and family planning are aspects of health that exhibit significant disparities between the rich and the poor. The UNFPA *State of the World Population Report 2004* summarizes data from 56 countries as follows:

- “[P]oorer women have children at younger ages;
- Wealth-based health inequities are greater for safe motherhood, adolescent fertility, contraceptive use, and total fertility than for infant mortality;
- Poor women have more children throughout their lives than wealthier women;
- Poor countries have a heightened risk of maternal, infant, and child death and illness, and poor women in all countries face higher risks than others; [and]
- Use of family planning, particularly of modern methods, is higher in richer segments of society” (UNFPA, 2004, Chap. 2, p. 3).<sup>9</sup>

These differences are influenced by several factors, including that the poor face greater obstacles in accessing services (e.g., costs for services and transportation, less accessible service locations, limited information about service options). While several of the macroeconomic and structural reforms typically included in PRSPs can be seen as benefiting society as a whole, increasing access to family planning—with its emphasis on allocating resources for the poor and satisfying unmet need—is an intervention that promotes equity and accountability specifically for meeting the needs of the poor.

## What Is the Current Status of Family Planning within the PRSPs?

In the ideal case, PRSPs that fully include family planning will analyze population and family planning issues in the poverty diagnosis section; identify improved access to family planning as a national priority; outline components of effective family planning policies and programs; include costing plans that address family planning services and a budget line-item in the expenditure framework; and incorporate family planning-related monitoring and evaluation indicators to track progress.

A World Bank assessment looking at the broader issue of population<sup>10</sup>, reproductive health<sup>11</sup>, and adolescent health content found that 17 out of 21 PRSPs analyzed included a discussion of the relationships among these issues and poverty (Population and Reproductive Health Cluster, 2004). While most PRSPs included policies related to reproductive health, child health, and HIV and other sexually

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<sup>9</sup> For the specific webpage, please see: <http://www.unfpa.org/swp/2004/english/ch2/page3.htm>.

<sup>10</sup> In the study, “population” refers to population-level factors such as population growth rate, life expectancy, age structure, and urbanization.

<sup>11</sup> The study uses the definition of “reproductive health” found in the International Conference on Population and Development, Section 7.2, and includes access to family planning, safe motherhood programs, and STI prevention and treatment.

transmitted infections (STIs), 12 PRSPs included adolescent health and only seven included population policies. Moreover, less than 6 percent of the policies across these categories specified an implementing institution, a timeline for key activities, and a budget. Seven PRSPs included contraceptive prevalence rate as an indicator in the poverty diagnosis, and seven included it as a target in the monitoring and evaluation plan. In addition, only the HIV and population policies were deemed as having a “significant multisectoral component”—but, even in these two categories, only about one-third of the policies were classified as multisectoral.

What do the PRSPs say about family planning specifically? A content analysis of 45 PRSPs found that “15 country PRSPs did not mention family planning, 19 mentioned family planning without reference to implementation details, and 11 PRSPs mentioned family planning noting details related to financing, logistics, commodities, quality of service, and/or specific awareness raising campaigns” (Borda, 2005) (See Box 3). The countries that had an established history of considering the needs of the poor in their existing national family planning policies and programs were the ones most likely to also include family planning in their PRSPs. Examples of some specific family planning-related references in PRSPs finalized by 2005 are reviewed below:

- The second-generation PRSP in Vietnam,<sup>12</sup> approved in 2004, analyzes the relationship between poor households and high birth rates and considers “implementation of family planning and reduction of the birth rate to be one of the important steps to poverty reduction.”
- Guyana’s 2002 PRSP<sup>13</sup> mentions the need to “increase school programs on sexual and reproductive health” within the Communicable Diseases section. However, no specific actions or plans are described on how to integrate sexual and reproductive health within the educational system.
- Ghana’s first-generation PRSP in 2003<sup>14</sup> details family planning program elements related to financing, logistics, and provision of high-quality services. The PRSP includes a section titled “Population Management” that discusses the relationship between high fertility and poverty and noted the importance of “improving service delivery and awareness creation on choices and benefits.” The PRSP also acknowledges the need for “increasing literacy and incomes of women, improving service delivery and effectively providing access to information on choices.” To increase access to family planning, the PRSP calls for decentralizing “counseling services and sale of contraceptives.” Furthermore, the budget estimate includes US\$39.9 million for population management for 2003–2005.
- Azerbaijan provides an extensive description of family planning program implementation in its 2003 PRSP.<sup>15</sup> The PRSP includes a section on the “Protection of Population’s Reproductive Health,” describing the Program on Reproductive Health and Family Planning. This section describes the provision of improved access to services for “families living far from cities and hospitals, including refugees and [internally displaced populations], poor and low-income people.” It specifically refers to equipment and contraceptives distributed in seven centers. In addition, the PRSP discusses “making joint efforts to integrate FP/RH centers established by international organizations.” The budget includes US\$600,000 to provide “access to contraceptives from reliable supply systems.”

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<sup>12</sup> Socialist Republic of Vietnam. 2003. *The Comprehensive Poverty Reduction and Growth Strategy*. Hanoi: Socialist Republic of Vietnam.

<sup>13</sup> Government of Guyana. 2002. *The Guyana Poverty Reduction Strategy Paper*. Georgetown: Government of Guyana.

<sup>14</sup> Republic of Ghana. 2003. *Ghana Poverty Reduction Strategy 2003–2005*. Accra: Republic of Ghana

<sup>15</sup> Republic of Azerbaijan. 2003. *State Programme of Poverty Reduction and Economic Development 2003–2005*. Baku: Republic of Azerbaijan.

**Countries with PRSPs that do not mention family planning**

- Albania
- Armenia
- Democratic Republic of Congo
- Djibouti
- Georgia
- Honduras
- Kyrgyz Republic
- Lesotho
- Mali
- Republic of Congo
- Sierra Leone
- Tanzania
- Uganda
- Yugoslavia
- Zambia

**Countries with PRSPs that do mention family planning but do not provide programmatic details**

- Benin
- Burkina Faso
- Cameroon
- Cape Verde
- Chad
- Ethiopia
- Gambia
- Guinea
- Guyana
- Lao People's Democratic Republic
- Madagascar
- Malawi
- Mongolia
- Mozambique
- Niger
- Rwanda
- Senegal
- Sri Lanka

**Countries with PRSPs that include specific details about family planning, such as financing, logistics, quality of service, and/or awareness-raising campaigns**

- Azerbaijan
- Bangladesh
- Côte d'Ivoire
- Ghana
- Mauritania
- Nepal
- Nicaragua
- Pakistan
- Tajikistan
- Yemen
- Vietnam

## SECTION 4:

# INTEGRATING FAMILY PLANNING INTO THE PRSP: STEP BY STEP

This section provides step-by-step guidance on how family planning champions can work to integrate family planning issues, analyses, and approaches throughout the PRSP process. It is written mainly for civil society or NGO stakeholders but also provides information that may be of use to government officials or donor groups that wish to foster an innovative, multisectoral approach to poverty reduction through the inclusion of family planning initiatives.

The section begins by providing guidance on getting started and designing an advocacy strategy. Four broad stages, taken from Figure 1 (see page 6), are then explored: Diagnosis, Formulation, Implementation, and Monitoring. While these stages are discussed in separate subsections below, they will overlap in practice. Moreover, given the country-specific nature of the PRSP and the variations in which groups are involved, what issues are addressed, and how strategies are formulated, the guidance given below is of a general nature and should be adapted to the country's unique experience. Where relevant, we have highlighted tools and other resources that stakeholders can use to advocate for increased attention to family planning issues. These tools, online resources, and recommended readings are presented in Section 7.

## I. Getting Started

As mentioned in Section 2, each country proceeds at its own pace, with the PRSP expected to be revised every 3–5 years. The first step for family planning champions will be to determine their country's stage in the process. Is the government compiling background analyses to inform the development or revision of a PRSP? Is it meeting with various stakeholder groups to identify objectives and strategies? Is it adopting laws, budgets, and regulatory frameworks to implement strategies? Is it submitting annual reviews on the PRSP's impact? Knowing the stage in the process and the individual or group that is leading the effort will help family planning champions identify their best course of action.

To have the most influence and active participation, interested stakeholders should become involved in the process as early as possible, which could be a challenge given the cyclical nature of the process. Ideally, family planning champions should contact the committee or unit in charge of the PRSP process at least a year before the strategy expires or is due for revision. In many cases, the PRSP unit will be led by the country's Ministry of Finance. The PRSP unit is in charge of inviting stakeholders to consultations; however, it may not necessarily invite family planning organizations or representatives. Family planning champions, therefore, should take the initiative to communicate with the PRSP unit. As a starting point, the in-country World Bank office can provide information about the PRSP unit.

In getting started, family planning champions may wish to consider the following questions:

- ***What skills or resources does your group need to make the best case for integrating family planning into the PRSP?*** Family planning stakeholders should ensure that they have the requisite capacity to make a strong case in support of family planning. Particular skills that could aid in this endeavor include advocacy, strategic planning, and public speaking skills, as well as capacity to use computer models and data analysis techniques. It would be beneficial to explore the extent to which in-country groups and partners or international donors can support needed training and

capacity development. In addition, Section 7 provides recommended readings and online resources regarding family planning and poverty issues.

- **Who are your target audiences?** The primary audiences, first and foremost, are the committee(s) or unit(s) charged with developing the PRSP. Those involved in the process may vary, depending on the task at hand, such as analyzing the poverty situation, setting objectives and policies, proposing budgets, and formulating monitoring plans. Beyond those who are directly involved, there may be secondary audiences—such as particular parliamentarians or officials from the health, women’s affairs, agricultural, or other ministries—that influence individuals directly responsible for writing the strategy. It is important to learn who the key decisionmakers are at each stage.

Family planning advocates also need to determine where their primary and secondary audiences stand on the issue (e.g., whether or not they support increased family planning efforts), as well as how they feel about working with civil society. Advocates may need to spend considerable time building relationships before getting the opportunity to have input into the PRSP process.

- **Are there any individuals or groups within the government or other sectors that could serve as allies in the effort to integrate family planning into the PRSP?** Other stakeholders—women’s groups, associations of health professionals, government officials, faith-based organizations serving the poor, HIV/AIDS organizations, and sustainable development advocates, among others—could share similar or related interests as family planning organizations. Networking with such groups can help present a united front and further demonstrate the multisectoral nature of family planning issues.

#### ⊕ RECOMMENDED READING

*Networking for Policy Change: An Advocacy Training Manual* (POLICY Project, 1999)

*Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit* (POLICY Project, 2005)

## 2. Developing an Advocacy Approach

To integrate family planning into a PRSP, interested stakeholders essentially must “advocate” for its inclusion. Advocacy involves “a set of targeted actions directed at decisionmakers in support of a specific policy issue” (POLICY Project, 1999, p. III-2). Advocates not only raise awareness of a particular policy issue, but they also encourage support and commitment for a particular action in response to the identified issue. In this case, family planning champions must educate the PRSP unit and other audiences about the relationships among high fertility, family planning, and poverty. They must then propose sound strategies for satisfying unmet need for family planning and demonstrate the impact of these strategies on poverty reduction.

Effective advocacy involves several steps, including outlining advocacy goals and objectives, identifying target audiences, collecting relevant data and information, designing messages and strategies, implementing the action plan, and monitoring advocacy efforts. Given that several guides and resources on advocacy have already been published, these steps are not recounted here (see Recommended Reading). In terms of the PRSP process, the messages, strategies, and target audiences may differ depending on the stage in the process, which is explored more fully below.



## RECOMMENDED READING

*Advocacy for Population and Reproductive Health: An Introductory Manual for Advocates and Trainers—Part I: Preparing the Ground Work* (Aradeon, 2000)

*Advocacy Tools and Guidelines: Promoting Policy Change* (Sprechmann and Pelton, 2001)

*Meeting the Need: Strengthening Family Planning Programs* (PATH and UNFPA, 2006)

*Networking for Policy Change: An Advocacy Training Manual* (POLICY Project, 1999)

*Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit* (POLICY Project, 2005)

“Why Family Planning Matters.” *Population Reports XXVII* (2, July) (Population Information Program, Center for Communication Programs, The Johns Hopkins School for Public Health, 1999)

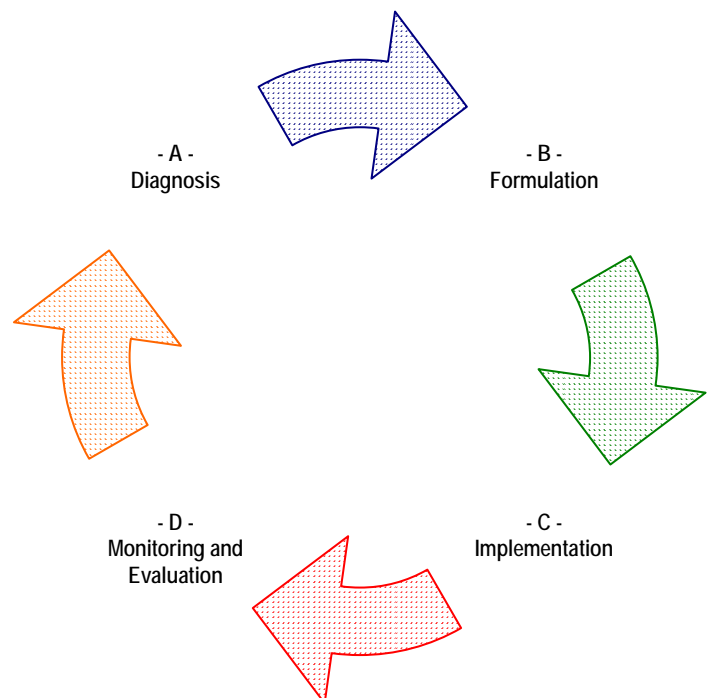
### 3. Diagnosing the Problem

Figure 4 presents the major stages in the PRSP process where family planning champions have an opportunity to influence the process. The first phase is Diagnosis. Each PRSP must include a description of the country’s poverty situation, touching on the poverty status of the population, what groups constitute the poor, the underlying causes of poverty, and the effects of poverty across sectors.

It is important that individuals with expertise in health, development, population, and family planning take part in the poverty analysis phase because future policy and budget decisions will be based on this analysis. At this stage, family planning champions could seek opportunities to serve on a working group to explore a particular topic; compile data and prepare background papers to inform decisionmaking (for an example, see May et al., 2004); and give advocacy presentations to influential stakeholders or partners. Through these efforts, family planning advocates can:

- Prepare fact sheets, background papers, or presentations that demonstrate the impact of population dynamics and high fertility on national or household income, education, health, food

FIGURE 4. MAJOR STAGES IN THE PRSP PROCESS: OPPORTUNITIES FOR ACTION



security, the workforce, the status of women and girls, and other sectors (for an example, see the RAPID Model described in Section 7);

- Conduct mapping exercises to determine where the poor reside and what barriers they face in accessing family planning and reproductive health services;
- Assess the extent of unmet family planning needs, particularly among the poor; and
- Explore the link between family planning and the MDGs, including impact on poverty reduction, child and maternal health, and prevention of infectious diseases (for an example, see the MDG Presentation described in Section 7).

#### ☒ RECOMMENDED READING

*Achieving the Millennium Development Goals: The Contribution of Fulfilling the Unmet Need for Family Planning* (Moreland and Talbird, 2006)

*Adding It Up: The Benefits of Sexual and Reproductive Health Care* (Singh et al., 2003)

*Nourrir, éduquer et signer tous les Nigériens : La démographie en perspective* (May et al., 2004) (English summary included)

*Reducing Poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health and Rights* (UNFPA, 2005)

“Chapter 18: Health, Nutrition, and Population” In PRSP Sourcebook (Claeson et al., 2002)

## 4. Formulating the PRSP

The Formulation Phase is intimately connected to the Diagnosis Phase because policies included in the PRSP should respond to the issues identified earlier. Moreover, the PRSP should include a strong monitoring and evaluation plan that incorporates indicators to measure the implementation and impact of each approach. A review of population and reproductive health issues in 21 PRSPs found many examples of “policies that ‘float’ without connection to either poverty diagnosis or targets” (Population and Reproductive Health Cluster, 2004, p. 10).

Keep in mind that family planning can be incorporated into the PRSP as its own strategy or policy area, or as part of a supportive activity for other policy areas. Family planning has been shown to play a key role, for example, in reducing maternal mortality and infant/child mortality and the number of people affected by infectious diseases, such as HIV—all of which are MDGs and are, therefore, already likely to have support among the PRSP planners. To help make the case for the adoption of family planning as a priority in the formulation of the PRSP, family planning champions can:

- Conduct an analysis of current family planning and reproductive health laws and policies and identify any gaps that should be addressed in the PRSP;
- Prepare fact sheets, briefs, and policy recommendations related to family planning issues and poverty reduction;
- Use a computer model, such as RAPID (described in Section 7), to demonstrate the social sector impacts of reducing population growth;
- Use a computer model, such as FamPlan (described in Section 7), to estimate the level of resources needed to satisfy unmet need for family planning so that these estimates can be included in budget proposals;

- Highlight the level of resources saved in meeting the MDG targets by satisfying unmet need (as in the MDG Presentation described in Section 7); and
- Prepare market segmentation studies to inform the development of strategies to target and better use resources to meet the family planning needs of the poor.

Governments are required to set up a plan for active, multisectoral participation in the Formulation Phase, though participation may vary in terms of type and degree. As noted above, the PRSP unit may not necessarily invite all groups to participate in the process and, therefore, family planning champions must be proactive in seeking opportunities to become involved. Some possible opportunities for participating in the process include:

- Serving on the team that reviews the progress of the previous PRSP;
- Serving on the PRSP drafting team;
- Serving on consultative groups or committees that advise the drafting team;
- Providing technical assistance in drafting family planning and reproductive health objectives, policies, and indicators;
- Preparing model language for inclusion in the strategy document; and
- Reviewing drafts prepared by the drafting team.

If direct participation in the process is limited or to augment direct participation, family planning champions can also:

- Convene meetings with high-level officials or other stakeholders who can influence the drafting team;
- Promote mechanisms for the poor or otherwise disenfranchised to have their voice heard in the process (e.g., facilitate their participation; conduct and disseminate focus group research on the experiences of the poor); and
- Raise awareness of family planning and poverty linkages through the media and other public venues.

The Formulation Phase—though shorter in duration than the implementation and monitoring phases—is likely to be a time- and labor-intensive endeavor, because this is the point where the objectives and primary approaches of the country’s national development plan are determined. If a family planning organization or network is interested in influencing the PRSP process, it is imperative to have one or two individuals dedicated to the PRSP process so that they can attend meetings and play an active role in following up on needed actions.

In formulating the PRSP, family planning champions should work to ensure that:

- Population and family planning issues are included in the poverty diagnosis;
- Family planning-related objectives are clearly established;
- Family planning is adopted as a key poverty-reduction strategy;
- Effective policies and approaches to satisfying family planning needs, particularly for the poor, are outlined;
- A budget line-item for family planning is included if it does not already exist; and
- Family planning indicators are included in the monitoring plan.

Ghana’s second-generation PRSP provides a good example of how population and family planning issues can be incorporated throughout the document (see Box 4).

**Poverty Diagnosis**

- Population growth influences economic growth and sustainable social development
- High fertility has resulted in a high dependency ratio with a large youthful population
- The population growth rate continues to outstrip provision of social services and infrastructure

**Policy Objectives**

- Promote access to and utilization of family planning services
- Educate the youth on sexual relationships, fertility regulation, adolescent health, marriage, and child-bearing
- Promote sexual health and delayed marriage and child-bearing
- Promote compulsory and universal birth registration as a basic right and population management measure
- Promote the integration of HIV/AIDS into sexual and reproductive health programs
- Strengthen the multisectoral, multi-disciplinary institutional coordination, collaboration, and networking for population management

**Proposed Strategies**

- Decentralize counseling services; strengthen the family planning component of maternal health delivery; and promote the sale of contraceptives through community agents
- Promote FP/RH education in formal and informal and out-of-school training programs to prepare the youth for responsible parenthood
- Scale up effective implementation of the Adolescent Reproductive Health Policy
- Ensure availability of and accessibility to family planning services to all who seek such services, including youth-friendly services
- Educate the population at community levels on health, social, and demographic values of family planning
- Build the capacity of the National Population Council and partner agencies for the integration of population concerns in the Growth and Poverty Reduction Strategy (GPRS)

**Monitoring and evaluation**

- Integrate population variables into the GPRS at the national, regional, and district levels and improve the population database for the GPRS
- Promote participatory monitoring and evaluation, including participation of the poor, through mechanisms such as Citizen's Report Cards and the African Peer Review Mechanism
- Ensure that timely information is available in the right form to meet the needs of stakeholders, including development partners

Source: National Planning Development Commission. 2005. *Growth and Poverty Reduction Strategy (GPRS-II) (2006–2009)*. Accra: Republic of Ghana.

### ⊕ RECOMMENDED READING

*A Review of Population, Reproductive Health, and Adolescent Health and Development in Poverty Reduction Strategies* (Population and Reproductive Health Cluster, 2004)

*Banking on Reproductive Health: The World Bank's Support for Population, the Cairo Agenda, and the Millennium Development Goals* (Global Health Council, 2004)

"Chapter 4: Development Targets and Costs" In PRSP Sourcebook (Christiaensen et al., 2002)

*Designing Health & Population Programs to Reach the Poor* (Ashford et al., 2006)

*The Policy Circle: A Framework for Analyzing the Components of Family Planning, Reproductive Health, Maternal Health, and HIV/AIDS Policies* (Hardee et al., 2004)

*PRSPs: Their Significance for Health: Second Synthesis Report* (WHO, 2004)

*Influencing Poverty Reduction Strategies: A Guide* (Oxfam, 2002)

## 5. Implementing the PRSP

The PRSP is an important indication of a country's commitment to social sector investment priorities and can be used to encourage support for initiatives outlined in the strategy. However, inclusion of a policy or activity in the PRSP does not mean it will be implemented. The PRSP is generally a wide-ranging strategy that touches on different sectors. Given this, any proposal contained in the document must be supported by a sequence of actions, such as strengthening political will, adopting a national policy or law, appointing a group or agency to lead implementation, allocating and approving a budget for the activity, conducting the necessary capacity building and training to roll out the policy, and so on.

Therefore, efforts to link family planning and poverty reduction do not end with the completion of the PRSP. The role of family planning champions in the Implementation Phase will differ depending on the type of organization or individual they are, such as an NGO, an international donor agency or international NGO, an association of health professionals, or a government official. NGOs and healthcare providers will likely be engaged in service provision; private sector groups should adopt workplace policies that support their workers' reproductive health-related needs; donors can provide technical and financial assistance for implementing national strategies; and government officials will be involved in several aspects of funding and managing policy directives.

To facilitate effective implementation, family planning champions help ensure that the government and other implementing partners are accountable for the commitments made in the PRSP. Some possible activities at this stage could include:

- Conducting an analysis of current family planning and reproductive health laws and policies and how they compare to the PRSP strategy;
- Encouraging policy reforms or modifications where necessary;
- Convening, or calling for the establishment of, multisectoral stakeholder groups to coordinate implementation;
- Using the FamPlan Model to estimate the resources required to meet family planning-related goals in the PRSP and advocate for adequate budget allocations; and
- Understanding the place of family planning/reproductive health in Ministry of Finance budgeting as well as the Public Expenditures Tracking System (PETS).<sup>16</sup>

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<sup>16</sup> The PRSP and HIPC are steppingstones toward Ministry of Finance commitment of at least partial support for an increase in spending for social programs. The spending is checked via the PETS. Spending on family planning/reproductive health can often be supported by donor assistance other than the World Bank and IMF. These other sources count as raising money to justify HIPC debt relief. Effective family planning champions should be aware of such opportunities to make themselves a valuable partner in the PRSP process.

## RECOMMENDED READING

“PRSP Implementation and Monitoring” In *Reducing Poverty or Repeating Mistakes?* (pp. 32-39) (Sanchez and Cash, 2003)

## 6. Monitoring PRSP Implementation

The Monitoring Phase coincides with the Implementation Phase of the strategy. In the 3–5 years in between approval of the PRSP and submission of the next PRSP, governments must prepare and submit annual progress reports (APRs) to the World Bank and IMF. Unlike the Formulation Phase, the government is not required to include widespread participation in the preparation of APRs. Family planning champions should establish contact and seek to collaborate with the group in charge of compiling the APRs, which could be the PRSP Unit or another unit within a government ministry or national statistics institute. Civil society involvement in PRSP monitoring, to date, has taken on various forms:

... it includes performing monitoring activities (whether as part of the PRS monitoring system or independently), participating in monitoring committees and working groups, providing analysis and policy advice, and interpreting and disseminating monitoring outputs to the general public (Bedi et al., 2006, p. XXII).

As the APRs review progress to date and help set the direction for the upcoming year, it will be important to ensure that family planning issues and outcomes are reflected in the APRs. Ideally, population and family planning indicators—such as total fertility rate, contraceptive prevalence rate, and unmet need for family planning—have been included in the monitoring plan during the strategy’s formulation.

Section 7 lists online resources that provide national-level monitoring data; however, additional studies of particular regions or programs may be needed. Monitoring the impact of policies on family planning and, ultimately, a reduction in the total fertility rate is a significant challenge, especially in the short term. Significantly increasing contraceptive use and reducing population growth are outcomes that require time. Moreover, annual tracking data may be limited because large-scale household surveys, such as the Demographic and Health Surveys (DHS), are not conducted in every country or every year. A further challenge will be to determine the extent to which family planning efforts are meeting the needs of the poor and underserved rural populations, as opposed to the population as a whole. An increase in contraceptive prevalence among the wealthiest quintiles or among urban populations will not achieve the goal of reducing poverty and alleviating the burden on poor, rural households as may be envisioned in the PRSP.

In the interim, to address these challenges, family planning champions will need to consider both quantitative and qualitative data as well as information on both processes and outcomes. For example: Has the government allocated a budget to support programs to satisfy unmet family planning needs? Has a policy been adopted that outlines which groups are eligible for government-subsidized services? Have healthcare personnel been trained in new guidelines? Do the poor know what services are available, including subsidized or free services for the poor? Are programs reaching their intended beneficiaries? If not, then why are they not reaching the intended beneficiaries?

The Monitoring Phase will flow into the Diagnosis Phase for the next PRSP, and the cycle will begin again if the country is interested in seeking additional loans and debt relief. As new data become

available, family planning champions should update their briefs, presentations, talking points, and other advocacy materials to inform the next round of decisionmaking.

#### # RECOMMENDED READING

*Beyond the Numbers: Understanding Institutions for Monitoring Poverty Reduction Strategies* (Bedi et al., 2006)

“Chapter 3: Monitoring and Evaluation” In PRSP sourcebook (Prennushi et al., 2002)

*Designing Health & Population Programs to Reach the Poor* (Ashford et al., 2006)





## SECTION 5:

# CASE STUDY: MALI

In mid-2006, the USAID | Health Policy Initiative, Task Order 1,<sup>17</sup> initiated efforts to promote the inclusion of family planning in Mali's poverty reduction strategy. Mali was a suitable candidate to pilot test this effort given the presence of a strong health NGO network in the country, the approaching expiration of Mali's current PRSP, and the demographic and socioeconomic factors facing the country.

In 2001, Mali's estimated total fertility rate was 6.8. Among currently married women, more than one-quarter had unmet need for family planning (28.5%) and only 5.7 percent were using modern contraceptive methods (with 8.1% using any method).<sup>18</sup> In 2005, the country had an estimated population size of 13.5 million and an annual population growth rate of 3 percent.<sup>19</sup> Nearly 7 out of 10 (68%) inhabitants live in rural areas and an estimated 64 percent of the total population lives below the national poverty line. These factors suggested that Mali's national development efforts could benefit from strategies that link family planning and poverty-reduction initiatives.

The PRSP activity, described below, involved identifying a local civil society partner to help champion the inclusion of family planning in the PRSP, as well as raising awareness of key opinion leaders and development partners. The lessons learned from this activity have been used to inform the development of this guide.

## Mali's PRSP-I

The Government of Mali submitted its first PRSP in 2003. The strategy received a limited credit from the World Bank for specific activities. The 2003 PRSP was built on three pillars:

- Institutional development and improved governance and participation;
- Human development and strengthening access to basic social services; and
- Development of infrastructure and support for key productive sectors.

The strategy's section on access to social services included a strong, integrated argument for improved health. Population and demographic issues were noted as having an impact on the country's ability to improve living conditions, but the strategy did not specifically mention their effect on economic growth. Population was also mentioned as an issue that needed to be addressed in order to reduce inequities. The PRSP monitoring plan did identify total fertility rate and contraceptive prevalence rate as indicators. However, while the PRSP noted the need to slow population growth, it did not specifically mention family planning as a health service that needed attention.

## Institutional Framework for the PRSP Process

The PRSP Unit within the Ministry of Finance (*Cellule de Cadre Stratégique de Lutte contre la Pauvreté*) manages the overall coordination of Mali's PRSP process, including formulation, implementation, and

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<sup>17</sup> Referred to hereafter as the Health Policy Initiative.

<sup>18</sup> See ORC Macro, Measure DHS STATcompiler. Available at [www.statcompiler.com](http://www.statcompiler.com) [accessed February 1, 2007].

<sup>19</sup> See World Bank, World Development Indicators Database. Available at <http://devdata.worldbank.org/external/CPProfile.asp?CCODE=MLI&PTYPE=CP> [accessed February 2, 2007].

monitoring. Until September 2006, the PRSP Unit had a staff of only four people seconded from other parts of the Ministry of Finance. Beginning in September, the office expanded to include a staff of about 20 people. As part of the PRSP-I, the Malian government established five additional mechanisms to help guide the PRSP process (Government of Mali, 2002).

1. **Policy Committee.** The Prime Minister is the chairperson of the Policy Committee, also known as the Orientation Committee. The committee comprises nine additional ministers and seven civil society representatives. This committee was tasked with meeting quarterly to provide high-level policy guidance throughout the PRSP process. However, during the first PRSP, the committee typically met only twice a year at most, limiting its leadership and effectiveness.
2. **Joint Committee.** This committee brings together Malian and international development partners. It is chaired by the Minister of Finance and includes representatives from civil society, the private sector, women's groups, development partners (financial and technical), and the Ministry of Planning. The committee deliberates on PRSP implementation issues and calls on additional ministries as needed (e.g., health, education).
3. **Technical Committee.** During the first PRSP, 11 thematic working groups were established under the Technical Committee. The working groups include representatives from the government, civil society, and development partners. The groups undertook research or commissioned background reports on various topics, such as macroeconomic framework, rural development and natural resources, and health and population.
4. **Steering Committee.** Based on the information provided by the working groups, the Steering Committee leads efforts to analyze the country's situation as the basis for devising policy recommendations in the PRSP. The committee includes the chairpersons of the thematic working groups and other development partners. During preparation of the first PRSP, the committee met about once every two months.
5. **Technical Secretariat.** The Technical Secretariat is led by the National Planning Department and is responsible for facilitating implementation of the PRSP.

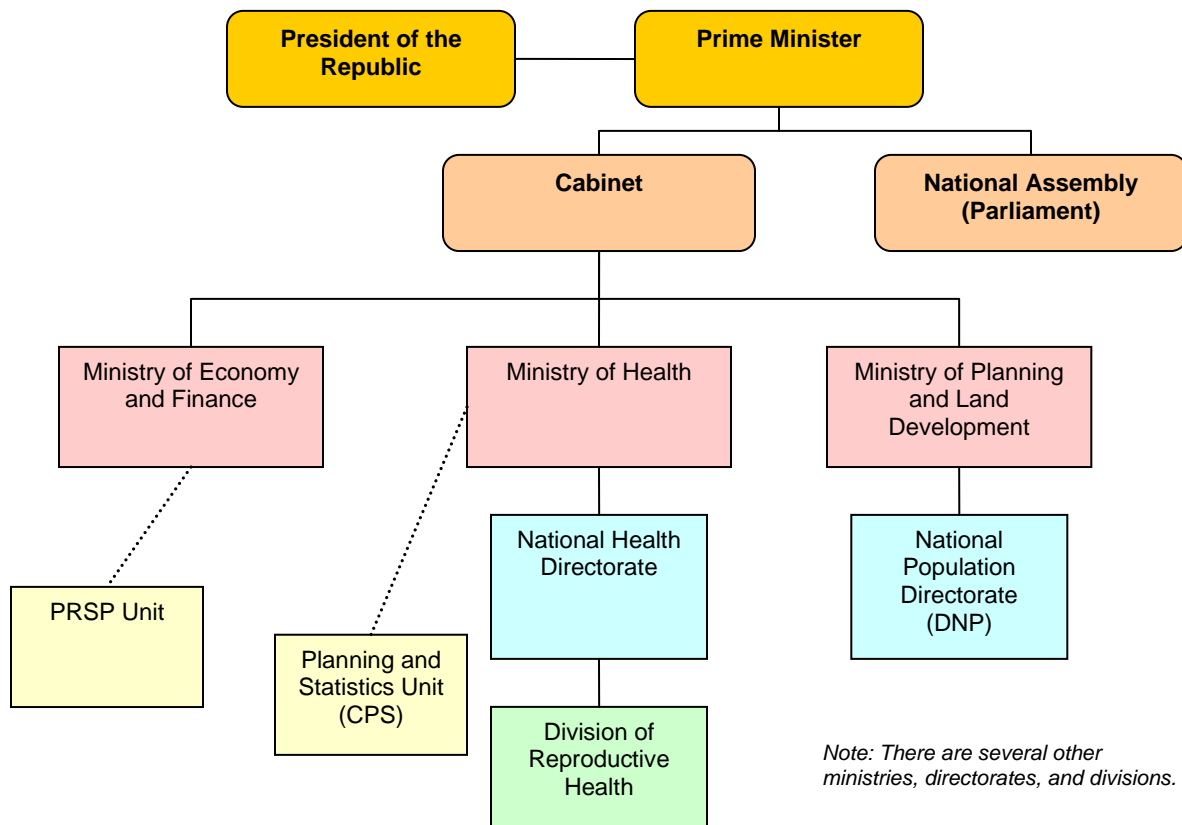
## Mali's PRSP-II

With the impending expiration of the country's first PRSP at the end of 2006, the steering committee and the PRSP Unit initiated a process to prepare the second-generation poverty reduction strategy. Unlike the first PRSP in Mali, the new PRSP will be accompanied by direct budget support via a World Bank Poverty Reduction Support Credit. In January 2006, the government invited approximately 100 people to a launch meeting. Participants decided to reduce the number of thematic groups down to six *ad hoc* groups. The groups and the organizations assigned to lead the groups are as follows:

- Evaluation of PRSP I (*Observatoire de Développement Humaine Durable*)
- Analysis of sectoral policy (PRSP Unit)
- Elaboration of growth strategy (Chamber of Commerce and Industry)
- Macroeconomic framework (Ministry of Finance)
- Budgetary framework (Budget Directorate)
- Group for decentralization and spatialization (Territorial Administration)

These groups included relevant stakeholders from ministries and civil society as well as domestic and international consultants with additional expertise. Each group prepared a report on their topic area, drawing upon group members working full-time on the activity.

FIGURE 5. MALI'S GOVERNMENT STRUCTURE



## Potential Allies for Family Planning Efforts in Mali

Mali's national government includes various ministries whose functions are categorized into directorates and then divisions—each with different levels of authority (see Figure 5). The Ministry of Health (MOH) and the National Population Directorate (*Direction Nationale de la Population*, DNP) of the Ministry of Planning have historically been the principal advocates for population issues within the Malian government. However, these entities approach population issues from somewhat different vantage points and with keen interest in maintaining authority over their respective areas. The MOH addresses population growth issues via the provision of family planning services. The primary planning document for the MOH is not the PRSP, but the *Programme de Développement Socio-Sanitaire* (PRODESS)—and family planning is one of many key interventions contained in the PRODESS.<sup>20</sup> The DNP views the issue

<sup>20</sup> The PRODESS, now in its second phase, is a 10-year sector-wide approach for health and social welfare. It is coordinated with a range of other social and economic plans, including the PRSP. The program was launched in 1998 following a two-year process of consultations with stakeholders, including local communities and women. The PRODESS focuses on five themes: reinforcing solidarity and fighting inequities; alleviating poverty; strengthening social protection; strengthening institutions; and human resource capacity building.

primarily as needing to bring population growth into balance with the country's resources. While the DNP believes that population growth requires management, it considers family planning services to be a level of detail that does not need to be included in the PRSP. The result of these different approaches is that there is no unified government leadership or strong government advocate for a multisectoral response to improve the uptake of and access to family planning.

Both the MOH and the DNP had representatives involved in the preparation of Mali's second-generation PRSP. The MOH delegated a representative from its planning and statistics office (*Cellule de Planification et de Statistique*, CPS) to the sectoral policy *ad hoc* group. It is worth noting that members of the Division of Reproductive Health, which oversees family planning, were not involved in the process. The DNP had delegates who served on the *ad hoc* group that assessed the success of the first PRSP. The MOH representative argued for implementation of the far-reaching PRODESS, while the DNP representatives emphasized implementation of the National Population Policy.

In terms of civil society advocates, NGOs in Mali have traditionally had limited capacity with regard to addressing family planning issues. In contrast to family planning, the need to address HIV/AIDS has received both political commitment and donor funding, which has helped to strengthen capacity of NGOs in this sector. As shown in Box 5, HIV/AIDS-related NGOs mobilized and met with key stakeholders before the process of preparing the second-generation PRSP began. They were also aided by having resources available (e.g., to sponsor learning tours, to hire a consultant, to conduct independent research).

## First Draft of PRSP-II

The 2003 PRSP and the reports from the six *ad hoc* groups were assessed during a meeting in June 2006. Following the meeting, the government tasked a consulting group with writing the first draft of the second-generation PRSP document. The group included both in-country and international consultants. During the process, the consulting group engaged several high-level officials from previous government administrations, including the former Minister of Finance and the former Minister of Territorial Administration. A draft dated August 4, 2006, was released to relevant PRSP stakeholders for review. In terms of the population and family planning issues addressed, a content analysis revealed the following:

- The assessment of the 2003 PRSP indicated that health and population objectives were met.

### **BOX 5** EFFECTIVE ADVOCACY: LEARNING FROM HIV/AIDS ORGANIZATIONS

HIV/AIDS was given great priority in the various drafts of the PRSP in Mali. In the most recent PRSP draft, the response to the HIV epidemic is cited as a priority intervention on a par with improvement of food security, improving basic social services, administrative reform, and others. It is also cited as a cross-cutting issue, along with gender, population, and territorial management. HIV is mentioned throughout the diagnostic of poverty.

In Mali, HIV/AIDS-related interest groups organized early and effectively. For example, before the first meeting of the PRSP steering committee, the High National Council for the Fight Against AIDS (HCNLS, *Haut Conseil National pour la Lutte contre le SIDA*) sponsored the attendance of representatives from the Ministry of Finance, the PRSP Unit, and the Budget Office at a workshop in Johannesburg, South Africa. The purpose of the regional workshop was to discuss the interactions between HIV/AIDS and poverty. The HCNLS followed up on this by employing a consultant who followed the PRSP process from beginning to end and highlighted the impact of HIV in each aspect of sectoral policies. In addition, the HCNLS sponsored an independent background paper on the economic costs of HIV/AIDS in Mali.

- In the same section, rapid population growth was recognized as a factor that makes it difficult for youth to find employment.
- The document said that cross-cutting issues, such as population, were addressed in the sectoral policy analysis.
- The estimates provided in the macroeconomic growth section assumed that population growth would be reduced.
- The section titled “Population” dealt primarily with implementation of the Population Policy of 2005–2009, noting its cross-cutting nature and the need to follow the investment plan outlined in the policy.<sup>21</sup>
- Along with gender and environment, population was mentioned as a cross-cutting issue that needed to be addressed.

Notably lacking in the initial draft of the new PRSP were the following:

- Specific mention of family planning;
- Specific mention of addressing demographic pressure or population growth as a factor in reducing poverty; and
- Details about how population could be integrated as a cross-cutting issue across sectors.

## Mobilization of Civil Society to Advocate for Family Planning

When the Health Policy Initiative’s PRSP activities began in Mali, the PRSP process had been underway for about eight months. A key lesson learned is the importance of becoming involved in the process early on, well before the actual planning and drafting of the PRSP takes place. In this case, earlier involvement in Mali would have provided the opportunity to further build local capacity to advocate for family planning and poverty-related linkages.

Responding to the tight timeframe, following the release of the first draft of the 2006 PRSP, USAID/Mali and the Health Policy Initiative met with *Groupe Pivot/Santé Population* (GP/SP) to discuss integration of family planning into the PRSP final draft. GP/SP was selected as a local partner because it is an umbrella organization that represents Malian NGOs from a range of health, education, and other sectors. The organization’s health section alone includes about 200 members.

At an initial meeting with 28 key civil society representatives in August, the Health Policy Initiative presented background information on the impact of population growth on national development (using the RAPID Model) and on the role of family planning in meeting the MDGs (using the MDG presentation). Key findings are shown in Box 6. A smaller working group of seven members was constituted to devise a strategy for better incorporation of family planning into the next draft of the PRSP. Members of the group included representatives from the Association of Health Centers, Coordinating Body of Women’s Associations, the Federation of NGOs, GP/SP, and the Health Policy Initiative.

### BOX 6

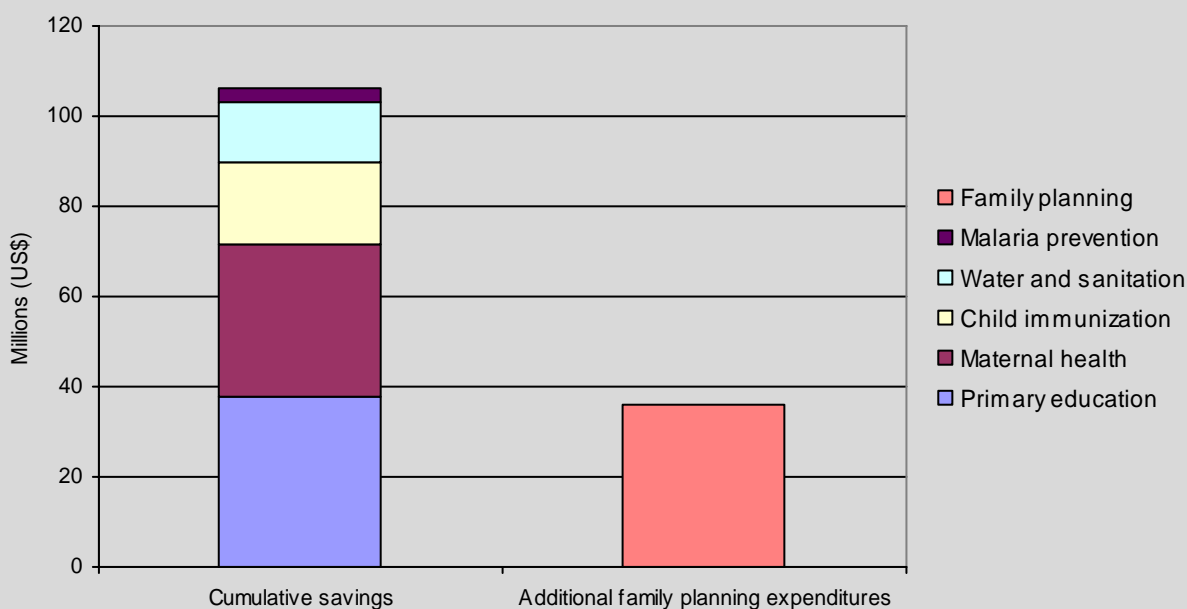
### MAKING THE CASE FOR FAMILY PLANNING IN MALI

The RAPID Model and MDG presentation demonstrate the contribution of family planning to achieving Mali’s socioeconomic development goals:

<sup>21</sup> The Population Policy contains 10 objectives. The third objective is to control demographic growth. Most of the strategic interventions are elements of an effective family planning program.

- Current total demand for family planning among married women is 36.6% (current users [8.1%] plus those with unmet need [28.5%])
- Satisfying total demand for family planning would:
  - Decrease total fertility from 6.8 births per woman to 4.3
  - Reduce the total projected 2025 population from 23.1 to 18.9 million
  - Reduce infant deaths in 2025 from a projected 121,000 to 36,000
  - Reduce maternal deaths in 2025 from a projected 6,240 to 1,860
- Satisfying unmet need for family planning would require an estimated \$35.8 (in addition to what would be spent to maintain current levels of contraceptive use). However, by slowing population growth, satisfying unmet need for family planning would also ease health and education expenditures during the MDG period (2005–2015), resulting in a total savings of \$106.3 million (\$70.5 million net savings) (see Figure 6).

**FIGURE 6. CUMULATIVE SAVINGS IN ACHIEVING SELECTED MDG TARGETS IN MALI, 2005-2015**



- \$37.9 million saved on cumulative costs for achieving universal primary education
- \$33.5 million saved on cumulative costs for addressing maternal health
- \$18.5 million saved on cumulative costs for providing measles immunization
- \$13.2 million saved on cumulative costs for providing safe water and sanitation
- \$3.2 million saved on cumulative costs for providing insecticide-treated nets to prevent malaria

In early September, the working group met to prepare for a meeting with the PRSP Unit. The group outlined recommendations for improving the status of family planning in Mali. Among the recommendations were:

- Improve family planning services to satisfy unmet need;
- Encourage demand for family planning services;
- Reduce costs for family planning services;
- Assure financing for family planning commodities;
- Raise the institutional stature of reproductive health within the MOH; and
- Foster dialogue between the government and partners.

Given that the PRSP process was underway and there was a need to move quickly to advocate for the inclusion of family planning, the Health Policy Initiative provided financial assistance to hire a consultant to represent GP/SP and the working group. Having a person with advocacy skills, knowledge of the issues, and adequate time to dedicate to the PRSP process is essential. The consultant, a Malian with experience in economics and rural development, introduced himself to the PRSP Unit, proactively sought out information on dates of civil society meetings, and reviewed drafts of the PRSP. He met with the small working group and the PRSP Unit on several occasions over a 4–6 week period. This consistent presence ensured that family planning remained on the PRSP agenda. At the same time, Health Policy Initiative staff met with PRSP stakeholders to further discuss family planning.

## Second Draft of PRSP-II

On August 25, a second draft of the 2006 PRSP-II was released for review. There were a few minor changes to the document, somewhat elevating the importance of addressing demographic issues. For example:

- The introduction contained a sentence stating that reducing poverty requires slowing population growth.
- In a section on strategic orientations, a paragraph was added emphasizing the importance of taking demographic factors, including population growth, into account.
- In the discussion of gender and health, the draft mentioned that access to information about family planning is important.
- The monitoring and evaluation framework contained several indicators relating to family planning and population, including total fertility rate, population growth rate, and use of family planning services.

## Ongoing Advocacy Efforts

The impetus for the changes in the two August drafts is not entirely clear, but they do highlight the importance of reaching out to various target audiences and potential allies. In August, GP/SP and its consultant had not yet begun their advocacy efforts. However, Health Policy Initiative staff and others had begun an education process on the impact of population growth on poverty and economic growth. Among those contacted by the Health Policy Initiative was the director of the PRSP Unit. Also, the PRSP Unit itself held several one-on-one meetings with prominent stakeholders. It is possible that one or more of the stakeholders mentioned the need to more prominently discuss population issues. The first two additions above are similar to the outlook often espoused by the DNP. The mention of family planning in

relation to gender was possibly the result of the strong effort by gender advocates to include the input of women in the process.

On September 1, the Health Policy Initiative's Country Director made a presentation combining the RAPID presentation and the MDG presentation to the Secretary General of Mali (a chief advisor to the President), USAID officials, and religious leaders. After the presentation, the Secretary General and other participants asked in-depth questions concerning the correlation between economic development and family planning. The participants asked further questions about the content of the MDGs and strategies to be implemented and the implications for religious leaders in relation to family planning. To the extent that members of PRSP Unit were aware of the presentation and are influenced by the Secretary General, this presentation may have had an impact on future revisions of the strategy document.

In mid-September, the PRSP Unit convened intensive meetings involving government and civil society stakeholders. A number of advocates of population and family planning issues attended. Among these advocates were a representative from the Dutch Embassy, the MOH delegate, DNP officials, the consultant representing GP/SP, and other civil society groups. The representatives from the Dutch Embassy and the MOH advocated for additional components on family planning and on nutrition. The representatives from the DNP argued for better incorporation of population elements.

The PRSP Unit organized four commissions (or working groups) for intensive discussion at the September meeting that focused on:

- Macroeconomic, budget, and financing framework;
- Follow up and consolidation of structural reform;
- Infrastructure and productive sector; and
- Reinforcement of social sectors.

The consultant representing GP/SP participated in the commission on the social sectors. Other participants in the social sector commission included representatives from the health ministry's CPS and the Dutch Embassy. The representative from the DNP represented the interests of population issues, in general.

In serving on the social sectors commission, the consultant representing GP/SP offered concise, specific examples of how family planning could be strengthened throughout the PRSP. His initial suggestion of inserting a paragraph on describing an effective family planning program was rejected. The rationale for rejection was that the PRSP was not a place to describe programs or projects described elsewhere (in this case, the PRODESS and/or the National Population Policy). The consultant shifted his strategy toward offering specific instances or sentences where improvements in family planning content could be made. For example, he suggested the following:

- Advocacy for population issues should be done with not only decisionmakers, but also opinion leaders;
- Unmet need for family planning should be addressed in the document; and
- Family planning should be among the health services where reduced user fees should be investigated.

The consultant, along with representatives from the DNP, lobbied to retain family planning and population indicators in the monitoring and evaluation framework. They were told that the number of indicators for the entire PRSP would be reduced to about 20 and that indicators relating to the MDGs would have priority.



## Third Draft of PRSP-II

On October 4, a third draft of the PRSP-II was released. As the document moved toward completion, greater discussion of family planning and population growth was evident. For example:

- One of the two major objectives for the PRSP is economic growth. In the description of this objective, the document states that slowing population growth is necessary to improve income distribution and reduce poverty.
- The concluding sentence of the section describing poverty states that one of the causes of the high level of poverty is lack of attention to reducing population growth.
- The section on assessing success of the first PRSP now states that all health objectives, except for family planning, were met.
- In the section on estimates of per capita income projections, there is further emphasis on the importance of reducing population growth in the analysis of poverty.
- Early in the sectoral policy section, there is a statement that although population is a cross-cutting issue, it is placed in the sectoral policy section to further emphasize its importance.
- In the section on improving social sectors, advocacy is expanded to include opinion leaders.
- In the section on priority interventions, the subsection on social sectors includes the need to address the unmet need for family planning.
- The subsection on sectoral policy for the health sector mentions the need to control costs to the poor for family planning.

The greatly reduced monitoring and evaluation framework, however, lacked several indicators relating to population growth, fertility, and family planning use. A table of indicators, dated December 15, 2006, included only couple-years of protection (CYP)<sup>22</sup> as an indicator for measuring the stated objective of strengthening family planning services at community health centers and referral health centers. According to the table, the goal is to have half of the community and referral health centers operational by 2007, and then have all of the centers operational by 2008.

## Lessons Learned

As this guide is being written, the final PRSP document is being drafted by the PRSP Unit. After finalization, it will be submitted to the National Assembly. While the National Assembly does not vote on the PRSP, it does serve as a reference document for the budget law that will be passed by the Assembly.

While Mali's 2006 PRSP does not necessarily represent an ideal case of strong inclusion of family planning, the process of advocating for family planning highlighted a number of lessons learned.

- First and foremost, this exercise demonstrated that it is possible for civil society to participate in the PRSP process and to reposition family planning as a national intervention that can contribute to poverty reduction. Having a family planning champion devoted to the process, who was proactive in offering suggestions and following up on needed actions, was essential. This is evidenced, in particular, by the fact that all of the specific mentions of family planning—except the assessment of the achievement of family planning under the first PRSP—correlate to the suggestions made by the consultant for GP/SP.

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<sup>22</sup> CYP is defined as a measure representing the total number of years of contraceptive protection provided by a method. For each method, the CYP is calculated by taking the number of units distributed and dividing that number by a factor representing the number of units needed to protect a couple for one year.

- Early involvement, however, is also essential. Getting involved in the process in Mali as stakeholders were reviewing the 2003 PRSP and analyzing issues for inclusion in the 2006 PRSP would have provided more time to raise awareness and build support for the inclusion of family planning in all aspects of the PRSP (e.g., diagnosis, objectives, policy recommendations, monitoring, etc.).
- Having a civil society group in place with particular interest in family planning is needed to facilitate active participation in and follow-up of the preparation and implementation of the PRSP. In-country civil society capacity to advocate for family planning and, in particular, to make linkages to poverty-reduction strategies requires strengthening. In this case, with the limited timeframe, it was not possible to build the capacity of a member within the GP/SP and, therefore, the Health Policy Initiative provided assistance to hire an experienced consultant to serve as a constant presence during the formulation process.
- HIV/AIDS organizations have been more effective in demonstrating the impact of the epidemic on socioeconomic development. Family planning champions can learn from these organizations as well as seek to establish ties with these groups. Integration of FP/RH and HIV can have benefits for both constituencies.
- Family planning champions can find allies in civil society (e.g., women’s groups) and within the government. In the case of Mali, a potential strong ally for family planning, the MOH Division for Reproductive Health, was not actively involved in the PRSP process. Moreover, the MOH and Ministry of Planning staked out their own terrain in terms of approaches to population issues. Therefore, family planning champions may need to not only target the PRSP office or unit but also other influential stakeholders to encourage their involvement and foster a unified approach.
- Finally, the experiences in Mali show that using sound evidence tailored to the country’s context and presenting concise suggestions—including model or proposed language that can be incorporated into the document—can help family planning champions make a better case for inclusion in the PRSP.

#### 📌 **RECOMMENDED ONLINE RESOURCES**

To find additional country-specific case studies of the PRSP process, please visit:

- African Learning Group on the Poverty Reduction Strategy Papers  
<http://www.uneca.org/prsp/>
- Afriline: Poverty Reduction Strategies Monitoring Participation  
<http://www.afriline.net/prsp.html>
- Eldis: Watching the Poverty Reduction Strategies Process  
<http://www.eldis.org/poverty/prsp.htm>

## SECTION 6:

# FAMILY PLANNING AND PRSP CHECKLIST

Below is a checklist to help integrate family planning into a PRSP. It summarizes the key points from Section 4 and lessons learned from the Mali case study as discussed in Section 5. The points outlined below are provided as suggestions, not chronological steps, given that the opportunities for civil society participation will vary based on the particular country context. Additionally, countries creating their first-generation PRSP may not have formed some of the organizational structures (e.g., PRSP Unit, working groups) that are mentioned below.

## 1. Getting Started

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### **Know the process**

Contact the unit or committee in charge of the PRSP process, generally housed within the Ministry of Finance. Early involvement in the process is critical.

Determine your country's stage in the PRSP process. PRSPs are typically revised every 3–5 years.

### **Assess your strategic position**

Address any training or resource gaps within your organization that will help you make the best case for family planning (e.g., public speaking skills, data analysis skills).

Consider building strategic alliances with like-minded organizations (e.g., women's groups, children's health advocates, HIV/AIDS groups, health professionals, etc.).

## 2. Developing an Advocacy Approach

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### **Prioritize objectives and audiences**

Outline goals and objectives of the advocacy (e.g., to integrate family planning issues, policies, budget items, and indicators into the PRSP).

Identify target audiences (e.g., PRSP Unit, Ministry of Health personnel, parliamentarians, etc.). Remember that the messages, strategies, and target audiences may differ depending on the stage in the process.

### **Design your advocacy strategy**

Prepare an implementation plan, including responsibilities and timelines.

Collect relevant information and data.

Design advocacy messages to target PRSP decisionmakers (e.g., focusing on the relationships among high fertility, family planning, and poverty reduction; the impact of satisfying unmet need for family planning).

Monitor your family planning and PRSP advocacy efforts.

### 3. Diagnosing the Problem

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#### Document the problem you seek to address through the PRSP process

Each PRSP begins with a description of the country's poverty situation. Compile data to inform decisionmakers on the relationships among population growth, poverty, unmet need for family planning, and access for the poor.

Prepare background papers, fact sheets, briefs, and policy recommendations related to family planning issues and poverty reduction.

Conduct an analysis of current family planning and reproductive health laws and policies and identify any gaps that should be addressed in the PRSP.

Prepare market segmentation studies to inform the development of strategies to target and better use resources to meet the family planning needs of the poor.

#### Communicate the results of the assessment of the problem

Give advocacy presentations to influential PRSP stakeholders or partners.

Serve on the working group(s) that will assess the previous PRSP and the current poverty situation in the country.

Raise awareness of family planning and poverty linkages through the media and other public venues.

Use computer models to demonstrate the social sector impacts of reducing population growth.

### 4. Formulating the PRSP

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#### Influence those writing or approving the PRSP

Convene meetings with high-level officials or other stakeholders who can influence the drafting team.

Promote mechanisms for the poor to have their voice heard in the process.

#### Participate in the writing and review process

Provide technical assistance in drafting objectives, policies, and indicators.

Prepare model language for inclusion in the strategy document.

Serve on the PRSP drafting team or on consultative committees that advise the drafting team.

Review drafts prepared by the drafting team.

### 5. Implementing the PRSP

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#### Engage groups to follow implementation

Ensure that the government and implementing partners are accountable for the commitments made in the PRSP.

Convene, or call for the establishment of, multisectoral stakeholder groups to coordinate implementation.

**Mobilize information for implementation**

Conduct an analysis of current family planning and reproductive health laws and policies and how they compare to the PRSP strategy. Encourage policy reforms or modifications where necessary.

Use computer models to estimate the resources required to meet family planning-related goals in the PRSP and advocate for adequate budget allocations.

## 6. Monitoring PRSP Implementation

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**Participate in the annual PRSP review process**

Annual progress reports are submitted each year. Ensure that family planning indicators (e.g., total fertility rate, contraceptive prevalence rate, unmet need) are included in monitoring and evaluation plans.

Contact the PRSP Unit to become involved in a monitoring committee.

**Conduct independent assessments**

Consider conducting your own research to provide advice to the PRSP monitoring group or to disseminate to the general public.

Given the challenges in increasing family planning use and reducing population growth in the short-term (e.g., the 3-5 years between each PRSP), some questions that can shed light on progress in achieving family planning goals are:

- Has the government allocated a budget to support programs to satisfy unmet family planning needs?
- Has a policy been adopted that outlines which groups are eligible for government-subsidized services?
- Have healthcare personnel been trained in the new guidelines?
- Do the poor know what services are available, including subsidized or free services for the poor?
- Are programs reaching their intended beneficiaries (e.g., poor or rural groups)? If not, why?

## 7. Final Thoughts

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**Get involved early in the process**

Early involvement is critical for building support for the inclusion of family planning in all phases of the PRSP process.

**Be prepared for the long haul**

The PRSP process, particularly at the formulation stage, can be labor-intensive. Ensure that you have an organization, or individual(s) within the organization, that will be dedicated to the process and proactive in following up on needed actions.

**Learn from your peers**

Repositioning family planning explicitly as a poverty-reduction strategy is a somewhat new endeavor. In many countries, the links between HIV/AIDS and socioeconomic development have been more clearly established. Family planning champions can learn from HIV/AIDS organizations as well as seek to establish ties with them. Integration of FP/RH and HIV can have benefits for both groups.

**Don not overlook potential allies**

Family planning champions should target not only the PRSP office or unit, but also other influential stakeholders to encourage their involvement and foster a unified approach. They can find allies in civil society (e.g., women's groups, child health advocates) and within the government (e.g., health ministry, parliamentarians).

**Always back up your arguments with strong evidence**

Using sound evidence (e.g., current population and economic data tailored to the country's context) and presenting concise suggestions—including model or proposed language that can be incorporated into the document—can help family planning champions make a better case for inclusion in the PRSP.

## SECTION 7:

# TOOLS, ONLINE RESOURCES, AND RECOMMENDED READING

Accurate, up-to-date, country-specific data are essential for effective advocacy. PRSPs are designed to address the unique poverty-related issues of the given country. Family planning champions will have a greater chance of success if they can adapt the general arguments presented in this guide to their own country's situation. The tools and resources outlined below provide advocates with country-specific, family planning-related data and customizable computer models as well as further reading on the linkages between family planning and poverty.

## Policy Advocacy and Planning Tools

### *User-friendly Computer Models*

Through its health policy technical assistance efforts, USAID has supported the development of user-friendly computer models that can be used to assess country-specific contexts. The models can be used to raise awareness of family planning and reproductive health issues; foster policy advocacy and dialogue; evaluate different strategies and their impact; and estimate the level of resources required to meet a particular policy goal.

The models, some of which have been referenced throughout this guide, are grouped together in a computer software package known as SPECTRUM. The SPECTRUM software package is a set of policy models that make use of a unified set of Windows-based commands that can be easily learned. Four of the family planning-related models are presented in Table 2. Each model includes a detailed user manual that not only describes how to use the software but also includes sections on data sources, interpreting and using the results, a tutorial, and a description of the methodology. Data can be presented as easy-to-use charts in reports or PowerPoint presentations. SPECTRUM is available for free online at [www.healthpolicyinitiative.com/index.cfm?id=software](http://www.healthpolicyinitiative.com/index.cfm?id=software).

**TABLE 2. ADVOCACY AND STRATEGIC PLANNING COMPUTER MODELS AVAILABLE IN THE SPECTRUM SUITE**

<b>Model</b>	<b>Description</b>
<b>RAPID</b>	RAPID projects the social and economic consequences of high fertility and rapid population growth for such sectors as labor, education, health, urbanization, and agriculture. This program is used to raise policymakers' awareness of the importance of fertility and population growth as factors in social and economic development.
<b>FamPlan</b>	FamPlan projects family planning requirements needed to reach national goals for addressing unmet need or achieving desired fertility. It can be used to set realistic goals and to plan for the service expansion required to meet program objectives. The program uses assumptions about the proximate determinants of fertility and the characteristics of the family planning program (method mix, source mix, discontinuation rates) to calculate the cost and the number of users and acceptors of different methods by source. Various strategies can be simulated as a way to evaluate alternative methods of achieving program goals.

Model	Description
<b>DemProj</b>	DemProj projects the population for an entire country or region by age and sex, based on assumptions about fertility, mortality, and migration. A full set of demographic indicators can be displayed for up to 50 years into the future. Urban and rural projections can also be prepared.
<b>BenCost</b>	This model compares the monetary cost of family planning programs to the monetary benefits in terms of reduced levels of social services required at lower levels of fertility. Benefits are defined as savings in government expenses on social services. BenCost allows planners to add the cost of health, education, and other social services to population projections created with the DemProj and FamPlan models. BenCost can be used to study the long-term economic costs and benefits to society resulting from changes in family planning programs.
<b>Allocate</b>	Allocate is a tool that examines the linkages and interactions between three main areas of a comprehensive reproductive health action plan: family planning, safe motherhood, and post-abortion care. The purpose of Allocate is to determine the interactive impacts of decisions about funding levels. It summarizes output from other SPECTRUM models on one summary screen. Allocate then provides a mechanism to re-allocate and/or increase budgets for each of the various areas, with resulting effects shown on the summary screen.

## MDG Presentation

The USAID | Health Policy Initiative and its predecessor, the USAID-funded POLICY Project, have developed a methodology for assessing the impact of family planning on achieving the MDGs. This methodology calculates the net costs saved in meeting selected MDG targets after satisfying unmet need for family planning. Moreland and Talbird (2006), who conducted the analysis for 16 sub-Saharan African countries, describe the methodology as follows:

The benefit-cost study was based on selected targets of five of the eight MDGs, using a modeling approach. In the sections that follow, we first review the demographic momentum facing the selected countries and the levels of unmet need for family planning and of unintended and mistimed pregnancies. Then we present two population projection scenarios—one based on a continued modest increase in contraceptive prevalence and the other based on meeting current levels of unmet need. We also estimate the extra cost of meeting the unmet need for family planning. Following these sections, we discuss analyses and scenarios based on five MDG models in the areas of education, child survival, maternal health, malaria, and water and sanitation. Considerable research was conducted and is reported to document the basis for projecting the cost implications of meeting various MDG targets. Lastly, we compare the costs of family planning to the reduced costs of meeting the five MDGs' targets, using a benefit-cost framework (p. 1).

The spreadsheets are not as user-friendly as the computer models described above and are not currently available online. However, MDG briefs have been developed for all 16 African countries included in the original study (Burkina Faso, Cameroon, Chad, Ethiopia, Ghana, Guinea, Kenya, Madagascar, Mali, Niger, Nigeria, Rwanda, Senegal, Tanzania, Uganda, and Zambia). They can be downloaded at





[http://www.usaid.gov/our\\_work/global\\_health/pop/techareas/repositioning/index.html#mdg](http://www.usaid.gov/our_work/global_health/pop/techareas/repositioning/index.html#mdg). PowerPoint presentations are being prepared for additional countries as requests and needs arise. To date, presentations have been prepared for Malawi, as well as Dominican Republic, El Salvador, Guatemala, Peru, and Nicaragua (which are in Spanish). They may be made available upon request from the Health Policy Initiative.

## Online Resources

The online resources below can be used to obtain country-specific data, documents, and case studies. Some sites are also included that provide general information on the PRSPs and MDGs.

- African Learning Group on the Poverty Reduction Strategy Papers  
<http://www.uneca.org/prsp/>
- Afriline: Poverty Reduction Strategies Monitoring Participation  
<http://www.afriline.net/prsp.html>
- DOLPHN: Data Online for Population, Health, and Nutrition  
<http://dolphn.aimglobalhealth.org/>
- Eldis: Watching the Poverty Reduction Strategies Process  
<http://www.eldis.org/poverty/prsp.htm>
- IMF: Data and Statistics  
<http://www.imf.org/external/data.htm>
- IMF: PRSP Portal  
<http://www.imf.org/external/np/prsp/prsp.asp>
- MEASURE Demographic and Health Surveys  
<http://www.measuredhs.com/>
- Population Reference Bureau: Datafinder  
<http://www.prb.org/datafind/datafinder7.htm>
- SPECTRUM Software Suite  
<http://www.healthpolicyinitiative.com/site/software.cfm>
- UN Millennium Development Goals Home  
<http://www.un.org/millenniumgoals/>
- UN MDG Indicators  
<http://mdgs.un.org/unsd/mdg/Default.aspx>
- UNDP: Human Development Reports  
<http://hdr.undp.org/>
- UNDP: MDG Toolkit  
<http://mdgtoolkit.undg.org/>

- UNDP Resource Sheet: Poverty Reduction Strategies—Perspectives from Civil Society  
<http://www.undp.org/partners/cso/publications/brochure.pdf>
- UNFPA: Indicators/Policy Developments Search  
<http://www.unfpa.org/worldwide/>
- UNICEF: Monitoring the Situation of Children and Women  
<http://www.childinfo.org/>
- World Bank: Data and Research  
<http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/0,,menuPK:476823~pagePK:64165236~piPK:64165141~theSitePK:469372,00.html>
- World Bank: Poverty and Reproductive Health Country Studies  
<http://wbln0018.worldbank.org/HDnet/hddocs.nsf/vtlw/8FC90D3546E938CE85256DE9005A248C>
- World Bank: PovertyNet  
<http://www.worldbank.org/poverty>
- World Bank: PRSP Sourcebook  
<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPRS/0,,contentMDK:20175742~pagePK:210058~piPK:210062~theSitePK:384201,00.html>
- World Health Organization: Database on Health in PRSPs  
<http://www.who.int/hdp/database/index.aspx>
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<http://www.who.int/statistics/en/>

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