



# ALIGNING TO 2020

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How the FP2020  
Core Partners Can  
Work Better, Together

**FINAL REPORT OF THE WORKING GROUP  
ON ALIGNMENT IN FAMILY PLANNING**

Rachel Silverman  
Amanda Glassman





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This document is the final report of the Center for Global Development (CGD) Working Group on Alignment in Family Planning. The report draws from working group discussions and a series of background analyses commissioned by CGD and conducted by Fiona Duby, Victoria Fan, Karen Grepin, Sunja Kim, Marilyn McDonagh, Andrew Mirelman, Roxanne Oroxom, Rachel Silverman, and Miriam Temin. Special thanks to Roxanne Oroxom for her assistance in preparing this report. The authors are grateful to the Bill & Melinda Gates Foundation and the United Kingdom's Department for International Development for their financial support of this working group. All errors and omissions are our own.

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# Note

This report is a product of the Center for Global Development (CGD). Its content is based on the deliberations of a working group comprising mainly individuals from the aid and foundation agencies that provide funding support to family planning programs in low- and middle-income countries. Other members included representatives from the FP2020 secretariat, technical partners, civil society, academia, the World Bank, and the Center for Global Development. Members of the working group served in their individual capacities, not as official representatives of their organizations.

All members of the working group have had the opportunity to review and provide input to this report. However, working group members do not necessarily endorse all components of this report, nor do the

contents of this report constitute a policy commitment by the FP2020 secretariat or any other party. All errors and omissions are those of the authors.

This working group was funded by the Bill & Melinda Gates Foundation, the UK Department for International Development, and individual CGD funders. CGD is an independent and nonpartisan research institution. There are no conditions or limitations on CGD's independence in research, findings, conclusions, or resulting publications. Where appropriate, CGD may welcome and consider comments or views from donors, but CGD retains total discretion and final decision-making authority regarding program and project research topics, speakers, and participants in activities, and on the content of reports.



# Executive Summary

In July 2012, world leaders gathered in London to support the right of women and girls to make informed and autonomous choices about whether, when, and how many children they want to have. There, low-income-country governments and donors committed to a new partnership—Family Planning 2020 (FP2020). FP2020 set an aspirational goal—120 million additional users of voluntary, high-quality family planning services by 2020—and received commitments totaling \$4.6 billion in additional funding, including \$2.6 billion from international donors and the private sector.<sup>1</sup>

Since then, the focus countries involved in the FP2020 partnership have made significant progress. In four years, 30.2 million additional women and girls were using modern contraception—6.2 million more than would be expected based on historical trends.<sup>2</sup> Aggregate financial contributions from bilateral and foundation donors have met and exceeded initial pledges. And the number of formal political commitments from focus countries has grown steadily, reaching 38 countries in 2016.

Yet as FP2020 reaches its halfway point, and new, even more ambitious goals are set as part of the Sustainable Development Goals, gains fall short of aspirations. In mid-2016, the number of additional users was 19.2 million short of that year’s goal. Further, family planning remains relatively neglected in global health, representing a small share of development assistance for health, even as funding for other health areas

has increased in the past “golden decade” of global health.<sup>3</sup>

The midpoint of the FP2020 initiative is thus an important inflection point, offering an opportunity for family planning funders and the FP2020 partnership more broadly to take stock of progress, to reflect on the lessons of the past four years, to refine funding and accountability mechanisms, and to reallocate existing resources for greater impact.

Of course, the primary responsibility for expanding contraceptive access falls squarely on country governments. Nonetheless, donor contributions play an important role: between 2004 and 2014, donors’ per capita family planning disbursements at the country level were significantly associated with increases in the contraceptive prevalence rate, even after controlling for time trends, government effectiveness, and per capita income.<sup>4</sup> And in some countries, donors continue to finance the lion’s share of family planning program budgets: in 2015, almost the entirety of Nigeria’s family planning program was funded by donors.

With the goal of reaching as many women and girls as possible by 2020 and an eye toward the 2030 Sustainable Development Goals, the Center for Global Development (CGD) convened a working group on donor alignment in family planning in fall 2015 to see how scarce donor resources could go farther to accelerate family planning gains.

This report draws upon working group deliberations, original quantitative research, and country case studies in Kenya, Nigeria, and Uganda. As the final

1. Department for International Development (2012).

2. Family Planning 2020 (2016).

3. Fan, Kim, Oroxom, and Grepin (2016).

4. Fan and Kim (submitted for publication June 25, 2016).

product of the working group, the report analyzes the successes and limitations of family planning alignment to date, with a focus on procurement, cross-country and in-country resource allocation, incentives, and accountability mechanisms, and makes recommendations for next steps.

Key findings include the following:

- Funding has grown, but risks are on the horizon. Currency depreciations are affecting the real value of non-US donor contributions, political crises are turning donors' attention away from family planning, and changes in leadership may lead to declines in overall financing or affect its stability in the long term.
- In the aggregate, the allocation of donor resources does not closely track family planning need, measured in different ways. Each donor takes a different approach to cross-country allocation, using different criteria and processes; the resultant "priority" lists do not necessarily align with each other or the FP2020 list of 69 focus countries. Several countries consistently receive funding below their relative need: Democratic Republic of Congo, Gambia, Guinea-Bissau, Nigeria, and Somalia. Country-led costed implementation plans (CIPs) have helped set a broad direction for countries' family planning programs, with significant buy-in from country governments and civil society. However, most CIPs exhibit important limitations that constrain their utility as operational documents that can be used to optimize resource allocation decisions by country governments, donors, and other funders. During the first half of the FP2020 initiative, most CIPs did not use modeling to set realistic goals, few reflected current levels of funding or tied into other plans for the health sector, and many did not set clear priorities to clearly inform donor or other funding. Senegal offers one example of a well-designed and well-functioning CIP, with lessons for other countries, but this remains the exception, not the norm.
- Alignment of reproductive health commodity purchasing and supply chains has improved substantially under the FP2020 initiative, but the sustainability of parallel supply chains may be at risk given the volatility of aid. The United Nations Population Fund (UNFPA) is one of three major organizations supporting Nigeria's public-sector supply chain, but its supplies program is currently faced with a substantial financing gap.
- Countries have few incentives for cofinancing and some disincentives to domestic investment. As an example, domestic funding for family planning commodities in Kenya ceased following the decentralization process, but that gap was quickly and entirely filled by donors. At the time of writing, domestic funding had not returned to pre-decentralization levels.
- Finally, high-level accountability for progress and results is in place, but there is little to connect success or failure to particular streams of funding or provision, and thus it is difficult to close the accountability loop and learn lessons about what is working and what is not. Few programs in the family planning space undergo rigorous independent impact evaluation, and the results of those that do are not often shared in the public domain.

## Recommendations:

### Recommendation 1: Support more strategic and collaborative resource allocation at the country level, building on past successes and existing coordination platforms.

- The FP2020 secretariat and donors should work with countries to strengthen the utility of their CIPs and other planning and resource allocation documents. Technical support for the development of CIPs should help countries set ambitious but realistic goals for progress using modeling, clearly prioritize activities under different funding scenarios, and ensure that CIPs reflect actual funding streams and programs from donors and government, among other criteria.
- Donors should improve the transparency and predictability of their own funding decisions by sharing timely and detailed information on funding decisions with counterparts at the country level, by increasing transparency about expected resource allocations over a three- to four-year time horizon, and by ensuring that their actual and planned funding streams are clearly reflected in sector-wide planning documents.
- Donors should move beyond “business as usual” by adopting a more strategic approach to their own resource allocation.

### Recommendation 2: Create stronger incentives for greater cofinancing and performance.

- At present, donors primarily finance family planning inputs—commodities and nongovernmental organization (NGO) salaries/operational costs—with few explicit incentives for their grantees to improve the scale and quality of service delivery.
- Accordingly, the FP2020 partners should test whether the introduction of incentives—financial

and otherwise—can better align efforts and improve cofinancing and performance. Such incentives must be carefully designed to ensure respect for the principles of voluntarism and informed choice; for example, incentives should not explicitly reward the number of new family planning users but instead focus on improving measures of access, service quality, and choice. Incentives should be considered across multiple relationships: between donors and recipients, between multiple levels of government (e.g., national and subnational), and between governments or implementing partners and individual facilities.

- Donors should also test ways to increase government cofinancing and reduce the fungibility of family planning assistance, for example by considering stricter cofinancing policies, particularly in middle-income countries, or by matching fund schemes for commodity purchases.

### Recommendation 3: Enhance accountability and learning across the results chain.

- Drawing from experience elsewhere in the health sector, FP2020 funders should enhance accountability for performance among grant recipients by instituting regular independent verification of self-reported progress.
- FP2020 partners should improve the generation and utilization of evidence to inform resource allocation by requiring that at least a subset of funded programs undergo rigorous independent impact evaluations and taking steps to increase the accessibility and dissemination of existing project evaluations, potentially by creating a shared database and requiring submission of all project evaluations to the common pool.
- FP2020 partners should sustain and build upon current efforts to improve tracking and accountability for family planning expenditures.



## Chapter 1.

# Introduction: An Inflection Point on the Path to 2020

In July 2012, world leaders gathered in London to reaffirm their support for the right of women and girls to make healthy, informed, and autonomous reproductive choices through access to voluntary, high-quality family planning services. More than 70 governments, foundations, and other organizations, including 23 low- and middle-income country governments, announced financial, political, and service delivery commitments in support of a shared goal: 120 million additional users of modern contraception by 2020 across 69 of the world's poorest countries.<sup>5</sup> These commitments formed the basis of Family Planning 2020 (FP2020), “a global movement that supports the rights of women and girls to decide—freely and for themselves—whether, when, and how many children they want to have.”<sup>6</sup>

Investing in family planning is important because it benefits the users themselves, their families, and the societies in which they live. It helps reduce adolescent pregnancies, which are more likely to have complications; helps prevent the spread of HIV/AIDS by promoting the use of condoms; and reduces maternal and infant mortality, as pregnancies can be planned for the

healthiest times for mother and baby.<sup>78</sup> Family planning can also have non-health-related benefits, such as increased participation in school and the labor market.<sup>9</sup>

Now in 2016, the FP2020 partnership has reached its midpoint—and an important inflection point. The focus countries involved in the partnership have made progress. In three years, from the 2012 baseline to July 2016, 30.2 million additional women and girls became users of modern contraception—6.2 million more than would be expected based on historical trends alone.<sup>10</sup> Aggregate financial contributions from bilateral and foundation donors have met and exceeded initial pledges. And the number of formal commitments from focus countries has steadily grown, reaching 38 countries in 2016.

Yet these gains fall short of projected progress. In mid-2016, the number of additional users fell 19.2 million short of that year's goal (see Figure 1.1). And between 2012 and 2015, growth in the number of women of reproductive age exceeded the increases in family planning usage; the total number of unintended pregnancies in focus countries actually *increased*, from

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5. Family Planning 2020 (2012).

6. Family Planning 2020 (2016).

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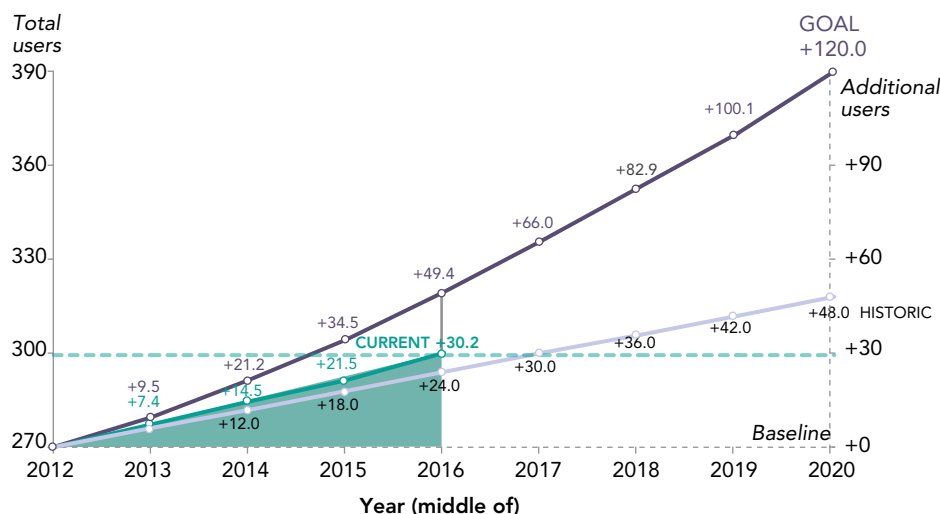
7. UNAIDS (2015).

8. Donovan and Wulf (2002).

9. Miller (2010).

10. Family Planning 2020 (2016).

**Figure 1.1.** FP2020 Progress: Ahead of Historical Trends but Short of the Goal (Millions of Modern Contraceptive Users at Year Mid-Point)



Source: Family Planning 2020. 2016. *FP2020 Momentum at the Midpoint 2015-2016*. [www.familyplanning2020.org/progress](http://www.familyplanning2020.org/progress).

47.6 to 48.8 million.<sup>11</sup> Furthermore, family planning remains relatively neglected in global health, representing a small share of development assistance for health, even as funding for other health areas has increased in the past “golden decade” of global health.<sup>12</sup>

## How Can Donors Help Accelerate Progress toward 2020—and the 2030 Sustainable Development Goal?

The midpoint of the FP2020 initiative thus represents an important inflection point, offering an opportunity for the FP2020 partnership to take stock of progress, to reflect on lessons of the past four years, to refine funding and accountability mechanisms, and to reallocate existing resources for greater impact. Now is the time to accelerate progress toward 2020 and the even

more ambitious 2030 Sustainable Development Goal (SDG) goal to “ensure universal access to sexual and reproductive health-care services, including for family planning.”<sup>13</sup>

Primary responsibility for expanding contraceptive access falls squarely on country governments. Donors alone cannot overcome many of the most significant barriers to family planning uptake in low- and middle-income countries, including deep-seated social taboos, conflict, and a lack of commitment among some governments. Ultimately, achieving the FP2020 goal will require countries to make good on the financial and political commitments made at the London Summit and in the four years since then.

Nonetheless, donor contributions can play an important role in the effort to reach as many women and girls as possible—and their investment decisions will have wide-ranging implications. Between 2004

11. Weinberger, Emmart, Srihari, Miller, and Studt (2015).

12. Fan, Kim, Oroxom, and Grepin (2016).

13. Inter-Agency and Expert Group on Sustainable Development Goal Indicators (2016).



and 2014, donors' per capita family planning disbursements at the country level were significantly associated with increases in the contraceptive prevalence rate, even after controlling for time trends, government effectiveness, and per capita income.<sup>14</sup> And in some countries, donors continue to finance the lion's share of family planning program budgets; until 2013, Malawi, one of the fastest growing countries (by population) in the world, relied exclusively on donors to finance its family planning program.<sup>15</sup> Moving forward, the family planning community should thus maintain its traditional focus on the interlinked components of supply, demand/norms, and enabling environment while continuing to evolve innovative approaches and more sophisticated frameworks. Yet family planning donors must also consider how they "do business" at different levels of their organization—and whether their own practices in allocation and use of funding are consistent with and efficient in achieving stated goals. In this report, we thus consider how the donors committed to the FP2020 partnership can better align resources with countries and among themselves toward the most effective programs and interventions to maximize progress against the 120 by 2020 headline goal.

Here, we define alignment broadly as the coherence of resources, activities, and incentives among international donors, governments, and implementing organizations to accomplish family planning goals within the context of national policies, plans, and systems. This working definition builds upon the definition of alignment proposed in the Paris Declaration on Aid Effectiveness. The Paris Declaration suggests that donors should align behind "partner countries' priorities, systems and procedures."<sup>16</sup> Similarly, this report considers how donors and accountability partners can best align behind the agreed-upon FP2020 goals and establish

coordinated and efficient allocation and accountability practices to achieve those goals within the context of countries' own national priorities, commitments to the FP2020 partnership, and financing environments. Put simply: How can donors be better partners to country governments and one another in working toward the shared FP2020 objectives?

In considering these questions, it is important to consider the capacities and limitations of the FP2020 partnership as an alignment mechanism. Despite leadership from a small secretariat, FP2020 is a "movement"—not a pooled fund or autonomous organization. Its potential strengths lie in its ability to convene and potentially coordinate key stakeholders, both internationally and at the country level; to increase the visibility of family planning as a health and development priority; and to track progress and hold actors accountable for meeting their commitments. But without budget authority over donors' family planning funds, FP2020 can only suggest where funds should be allocated—it cannot compel donors to align behind country or secretariat priorities. This report thus recognizes that responsibility for alignment falls largely with the individual donors themselves—not mainly with the FP2020 secretariat—and both groups are the targets of its recommendations.

## Why This Center for Global Development Working Group?

The Center for Global Development (CGD) is a Washington-based "think-and-do tank" that "works to reduce global poverty and inequality through rigorous research and active engagement with the policy community."<sup>17</sup> CGD's Global Health Policy program focuses primarily on the economics and financing of global health, with particular attention given to how donor agencies and multilateral institutions allocate, distribute, and ensure accountability for global health funds to maximize

14. Fan and Kim (2016).

15. Mbuya-Brown and Sapuwa (2015).

16. OECD (2005).

17. Center for Global Development (2016).

### Box 1.1. What about Abortion?

Induced abortion is common in the FP2020 focus countries. While hard data are scarce, a 2014 *Lancet* article estimated an abortion incidence rate of 34 per 1,000 women 15–44 years old in Africa and 36 per 1,000 women in Asia—double the estimated rate (17 per 1,000 women) in North America.<sup>a</sup> These high rates of induced abortion occur despite highly restricted legal status in all but a handful of FP2020 focus countries.<sup>b</sup> As a result, many women seek illegal and unsafe abortions from illicit abortion providers. In 2012, an estimated seven million women in low- and middle-income countries sought care for complications following unsafe abortions,<sup>c</sup> and WHO researchers estimate that unsafe abortion caused 193,000 deaths—8 percent of all mortality from maternal causes—between 2003 and 2009.<sup>d</sup> Investments in family planning can help avert abortions and related mortality by preventing unintended pregnancies; consequently, FP2020 tracks the “number of unsafe abortions averted due to modern contraceptive use” among its core indicators.<sup>e</sup>

Nonetheless, explicit consideration of abortion was outside the scope of this working group for three main reasons. First, the working group’s primary mandate was to examine alignment in family planning toward the stated FP2020 goals, and the FP2020 results framework makes no direct reference to the availability or quality of safe abortion services.<sup>f</sup> Second, the working group focused primarily on

three of the largest international donors for family planning—the United States Agency for International Development (USAID), UK’s Department for International Development (DFID), and the Bill & Melinda Gates Foundation—two of which do not fund abortion as a matter of policy. USAID is legally prohibited from supporting abortion as a method of family planning under the Helms Amendment,<sup>g</sup> and the Bill & Melinda Gates Foundation has likewise declined to dedicate funding for abortion services. (DFID has a slightly more permissive policy, allowing “support for activities to improve the quality, safety and accessibility of abortion services” in countries where abortion is legally permitted.)<sup>h</sup> Third, in large part due to its legally contentious and socially stigmatized nature, little data exist on the prevalence and provision of abortion; likewise, funding for abortion is not clearly identified in Creditor Reporting System (CRS) or other donor data. These limitations all but prohibit empirical analysis of the extent to which this funding is achieving its intended objectives.

a. Sedgh, Bearak, Susheela, Bankole, Popinchalk, Ganatra, Rossier, Gerdtz, Tunçalp, Johnson, Johnston, and Alkema (2016).

b. Center for Reproductive Rights (2014).

c. Singh and Maddow-Zimet. 2016.

d. Say, Chou, Gemmill, Tunçalp, Moller, Daniels, Gülmezoglu, Temmerman, and Alkema (2014).

e. Track20 (2016).

f. Track20 (2016).

g. Center for Health and Gender Equity (2016).

h. Gates (2014).

i. Department for International Development. (2013).

value-for-money and achieve key global health goals. Through previous working groups targeting organizations such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the United Nations Population Fund, and cross-cutting issues such as the challenge of drug resistance and the role of hospitals in low- and middle-income countries, CGD has amassed broad experience in the global health architecture and good practices for the efficient allocation and distribution of funds.

Building on this experience, and aiming to capitalize on this important inflection point for the FP2020 partnership, in September 2015, CGD convened a working group of representatives from the FP2020 secretariat, funders, accountability partners, and other key stakeholders. The objective of the working group was to consider how family planning resources could be better aligned and leveraged to accelerate progress toward the FP2020 goals, with the purpose of informing and improving practice during the second half of the FP2020 initiative. The working group discussions and recommendations targeted the FP2020 secretariat,

funders, and accountability partners, focusing on how they could better support and facilitate country governments in fulfilling their respective outcome commitments. The working group—and consequently, this report—focused narrowly on prophylactic family planning, excluding direct analysis of abortion (see Box 1.1).

Drawing upon working group deliberations, original quantitative research, and country case studies in Kenya, Nigeria, and Uganda,<sup>18</sup> this report—the final product of the working group—analyzes the successes and limitations of family planning alignment to date, with a focus on procurement, cross-country and in-country resource allocation, incentives, and accountability mechanisms. It concludes with recommendations to the FP2020 secretariat, funders, and technical and accountability partners to improve alignment during the next phase of the initiative.

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18. The Center for Global Development partnered with MannionDaniels to conduct three country case studies—in Kenya, Nigeria, and Uganda. Each case study involved a two- or three-person delegation for a week-long study visit, augmented by a literature review and secondary sources. A summary report of the country case studies, with further details on the methods used, has been published as a background paper on the CGD website.

## Chapter 2.

# Setting the Scene: FP2020 Financing at Its Midpoint<sup>19</sup>

In this chapter we summarize the current state of global family planning financing. What can we say about the trends in aggregate funding over time? Who are the largest funders, and how do they allocate and distribute their funds? How are resources allocated across countries and interventions? Who are the largest recipients—and which countries have been left behind? And what don't we know?

### The Big Picture: Family Planning Resources over Time

Substantial obstacles stand in the way of calculating the total sum of development assistance for health that supports family planning programs, including serious data limitations. However, restricting analysis to resources specifically coded as family planning does offer some insight into resource flows over time. (See Appendix 1 for full methodology and limitations; please note that our use of data from the Organisation for Economic Co-operation and Development's [OECD's] Creditor Reporting System [CRS] likely results in an underestimation of actual family resources because it does not capture family planning funding included under other health and development sectors, but enables a longer

timeline of analysis. For a more thorough estimate of aggregate donor expenditures for the period between 2012–2014, see Wexler and Kates [2015]).<sup>20</sup> Family planning funding appears to have increased substantially since 2004, both in absolute terms and as a share of total development assistance for health (Figure 2.1).

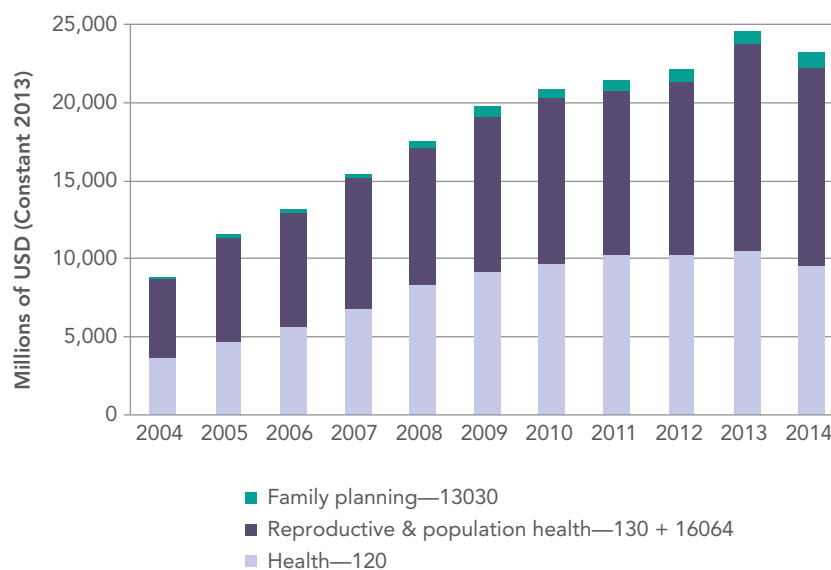
In 2014, total reported development assistance for family planning (as specified by the Creditor CRS code) totaled \$1.01 billion, compared with \$134 million in 2004. Among those captured in the data, the three largest donors—the United States, the United Kingdom, and the Bill & Melinda Gates Foundation—accounted for \$905.2 million (90 percent) of disbursements for family planning that same year. The United States is by far the largest donor, accounting for 51 percent of reported family planning expenditures. Disbursements from these three donors have increased steadily since reporting began in 2004, continuing into the post-2012 era (Figure 2.2).

Importantly, some sources of international financing for family planning are not captured by the CRS data, yet they contribute substantially to the overall landscape. According to data extracted from its website, the William and Flora Hewlett Foundation committed about \$20 million per year in 2014 and 2015

19. This chapter draws heavily from a background paper authored by Victoria Fan, Sunja Kim, Roxanne Oroxom, and Karen Grepin. The CRS data used to prepare this paper was accessed in January 2016.

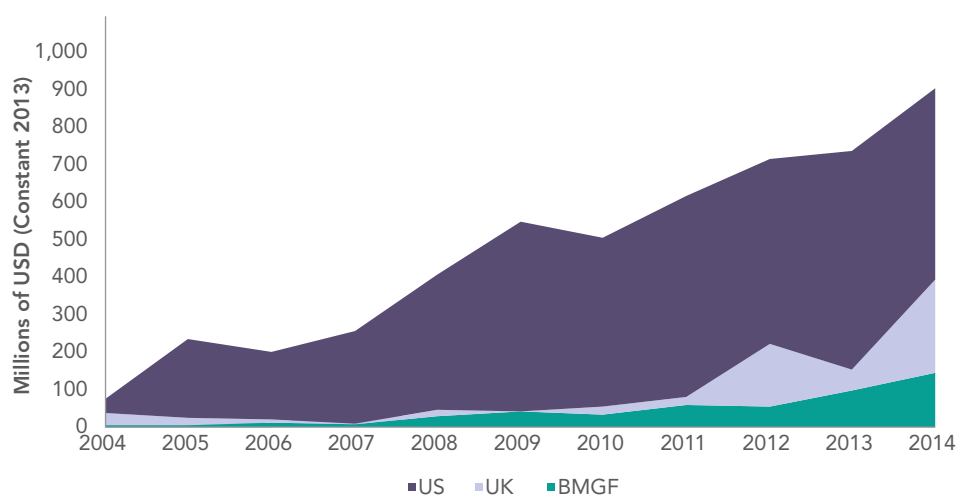
20. Wexler, Kates, and Lief (2015).

**Figure 2.1.** Disbursements for Family Planning, Reproductive and Population Health, and Other Development Assistance for Health, 2004–2014



Source: Fan, Victoria Y., Sunja Kim, Roxanne Oroxom, Karen A. Grepin. 2016. "International Funding and Need for Family Planning, 2004–14." Manuscript submitted for publication. September 14.

**Figure 2.2.** Family Planning Disbursements by the United States, UK, and Bill & Melinda Gates Foundation (BMGF)



Source: Fan, Victoria Y., Sunja Kim, Roxanne Oroxom, Karen A. Grepin. 2016. "International Funding and Need for Family Planning, 2004–14." Manuscript submitted for publication. September 14.

for family planning (and sexual and reproductive rights more broadly). The David and Lucille Packard Foundation likewise committed about \$17 million in 2015. Perhaps most importantly, the Susan Thompson Buffett Foundation does not publicly report on its expenditures but is thought to be among the largest sources of international funding for family planning.

## Who Receives International Family Planning Resources—and How Do Donors Decide?

### United States Agency for International Development (USAID)

For more than a decade, USAID has used an explicit “strategic budgeting” process to inform the allocation of family planning resources between countries. In 2003, the USAID allocation formula considered three main factors: density of population relative to arable land (adjusted by percentage of GDP in agriculture), fertility (both total fertility rate per woman and log-adjusted annual number of births), and unmet need for family planning. After adjusting for additional qualitative factors, such as perceived political commitment, performance, and absorption capacity, this process identified 13 priority countries for investment.<sup>21</sup> Under the Obama administration’s Global Health Initiative, another 11 priority countries were added to “reflect overlapping priorities/synergies with [maternal and child health].”<sup>22</sup> These 24 designated priority countries generally receive the largest funding allocations.<sup>23</sup> Several countries not designated as priority countries received more than \$5 million in 2014 disbursements (see Table 2.1 for a full list of priority countries). For example, the West Africa regional funding includes funding for the seven nonpriority countries that, together with priority countries Senegal and Niger,

comprise the Ouagadougou Partnership. In addition, 23 percent of USAID disbursements in 2014 did not specify a target country; this is predominantly funding that goes to USAID’s central Office of Population and Reproductive Health for global technical leadership, biomedical and social science research, and cross-cutting issues.

USAID typically channels its family planning (FP) funds through US NGOs (30.3 percent of FP projects

**Table 2.1. USAID Family Planning Priority Countries (2014 USAID Disbursements, US Millions)**

Original Priority Countries (2003)	Additional Priority Countries (GHI)	Other Recipient Countries/Regions > \$5 Million
Pakistan (\$28.9)	Bangladesh (\$24.2)	Global/central (\$119.1)
Tanzania (\$22.5)	Afghanistan (\$23.8)	West Africa Regional <sup>a</sup> (\$11.6)
Kenya (\$22.4)	Philippines (\$22.2)	Guatemala (\$9.5)
Ethiopia (\$20.8)	Senegal (\$13.5)	Jordan (\$9.0)
Uganda (\$19.5)	Mali (\$9.3)	Iraq (\$7.4) <sup>b</sup>
Nigeria (\$18.9)	South Sudan (\$8.4)	
India (\$12.5)	Nepal (\$7.7)	
Madagascar (\$12.0)	Mozambique (\$5.9)	
Malawi (\$10.3)	Liberia (\$5.7)	
Haiti (\$9.3)	Ghana (\$3.7)	
Democratic Republic of Congo (\$8.8)	Yemen (\$0.7)	
Rwanda (\$7.0)		
Zambia (\$5.9)		

a. The CRS data categorizes this funding as “South of Sahara”; USAID has clarified that these funds are for West Africa Regional programs. We defer here to their internal categorization.

b. Iraq family planning programs are funded from Economic Support Funds (ESF), a separate funding basket that does not use FP need as a criterion.

c. DFID support to India was discontinued in 2015.

*Sources:* Priority list of countries based on USAID Family Planning/Reproductive Health Portfolio Review April 2011. Authors’ calculations using data from Fan, Victoria Y., Sunja Kim, Roxanne Oroxom, Karen A. Grepin. 2016. “International Funding and Need for Family Planning, 2004–14.” Manuscript submitted for publication. September 14.

21. USAID (N.D.).

22. USAID (2011).

23. FP/RH activities in some countries (e.g., Pakistan, Afghanistan, Jordan and Iraq) are predominantly funded with Economic Support Funds.



initiated 2000–2014), international NGOs (21.21 percent of FP projects), and US firms (21.21 percent). Among FP projects initiated between 2000 and 2014, USAID’s top five implementing partners (by percent of all projects) have been John Snow International (9.09 percent), Management Sciences for Health (8.08 percent), Abt Associates (8.08 percent), FHI 360 (6.06 percent), and John Hopkins University (5.05 percent). The duration of USAID contracts and grant agreements is typically about five years, though the length varies by year of initiation (Figure A3.1).<sup>24</sup>

### United Kingdom’s Department for International Development (DFID)

Funding decisions for the UK’s DFID are primarily made by DFID’s country-level staff, based on a business case developed by the country office and submitted for central approval. This means that DFID in-country staff exercise broad discretion in choosing whether and how much—if anything—should be allocated to family planning programs in consultation with country government counterparts, or to health at all versus other development priorities such as agriculture or education, with the rationale that this approach is more responsive to local needs. However, funding decisions must be consistent with DFID policies and priorities and contribute to a menu of centralized DFID results targets—including an indicator for the “number of additional women using modern methods of family planning through DFID support.”<sup>25</sup>

Table 2.2 lists the 28 countries where DFID works directly, total funds coded as family planning in each country in 2014, and total development assistance for health (DAH) disbursed by DFID in each country in the same year (according to CRS data, accessed January 2016). Only 10 of the 28 countries that receive direct DFID funding saw family-planning-coded

disbursements in 2014, ranging from a low of just \$7,369 (<1 percent of DAH) in Mozambique to a high of \$11.8 million (50 percent of DAH) in Pakistan.

Notably, DFID reporting to the CRS excludes a large portion of its actual family planning investments. Many general health programs that are not coded as family planning do indeed contain a significant family planning component, and all but six of the DFID direct recipients had nonzero disbursements for health in 2014. In addition, these numbers exclude some cross-cutting investments that would also benefit family planning outcomes, such as grants for health systems strengthening. For example, the CRS database records the Democratic Republic of Congo as having zero family planning expenditures from DFID in 2014, but \$75.4 million in general health aid. Yet DFID’s Development Tracker suggests that family planning comprises about 8 percent of the budget for a large health sector program in the Democratic Republic of Congo, with total FY 2014–15 expenditures of £30.4 million (US \$43.8 million), implying expenditures of about £2.4 million (US \$3.5 million) in family planning.<sup>26</sup>

DFID also has several “central programs” for family planning, which are selected and administered by DFID’s London headquarters. Funding for these programs would typically be included within the “unallocated/unspecified” portion of DFID disbursements (see Table A2.1). DFID pledged to reach at least 10 million additional users of modern family planning by 2015 in *The UK’s Framework for Results for Reproductive, Maternal and Newborn Health in the Developing World* report, published in 2010. The goal was also echoed in their 2011–2015 Business Plan, alongside a commitment to focus on delaying first pregnancy and providing services to women who want them.<sup>27</sup> At the London Summit, DFID committed to reaching 24 million additional users between 2012 and 2020, a goal that is currently being reflected across its business planning processes.<sup>28</sup>

24. United States Agency for International Development. 2016. Foreign Aid Explorer Dashboard. Accessed June 9. <https://explorer.usaid.gov/aid-dashboard.html>.

25. Department for International Development (2014).

26. Development Tracker (2016).

27. Department for International Development (2011).

28. Department for International Development (2012).

<b>Country</b>	<b>Total DFID FP Disbursements (\$)</b>	<b>Total DFID disbursements, all health (\$)</b>	<b>FP disbursements as portion of all health disbursements (%)</b>
Afghanistan	—	—	—
Bangladesh	—	47,172,271	0
Burma	—	—	—
Democratic Republic of Congo	—	75,414,953	0
Ethiopia	—	121,971,906	0
Ghana	2,112,960	44,539,420	5
India <sup>a</sup>	9,890,710	80,779,819	12
Kenya	10,103,883	42,004,041	24
Kyrgyzstan	—	—	—
Liberia	—	—	—
Malawi	8,595,161	29,587,396	29
Mozambique	7,369	14,938,180	<1
Nepal	2,770,730	61,655,398	4
Nigeria	—	116,199,860	0
Occupied Palestinian Territories	—	—	—
Pakistan	11,756,793	23,357,912	50
Rwanda	—	2,427,640	0
Sierra Leone	—	11,288,581	0
Somalia	—	39,854,573	0
South Africa	—	14,703,892	0
Sudan	—	—	—
South Sudan	—	25,294,879	0
Tajikistan	—	276,348	0
Tanzania	9,393,917	28,049,355	33
Uganda	8,553,360	51,278,748	17
Yemen	—	8,527,180	0
Zambia	7,842,897	29,753,200	26
Zimbabwe	—	52,741,972	0
Unallocated/Unspecified	178,851,436	760,512,578	24

a. DFID support to India was discontinued in 2015.

Source: Authors' calculations using data from Fan VY, Kim S, Oroxom R, Grepin KA. 2016. "International Funding and Need for Family Planning, 2004–14." Manuscript submitted for publication. September 14.



## The Bill & Melinda Gates Foundation

As a private entity, the Bill & Melinda Gates Foundation enjoys maximum flexibility in its ability to allocate funds across countries and programs, in line with the priorities of its co-chairs and to a lesser extent its trustees. Its disbursements for family planning are significant, totaling \$143 million in 2014, according to CRS data. The foundation funds a broad range of multicountry and cross-cutting projects, focusing on accountability mechanisms for the FP2020 commitments, donor and recipient engagement, medical innovations, implementation research, and the improvement of data collection and monitoring systems. It also makes sizable investments in country-level service delivery in a small selection of countries—India, Nigeria, Indonesia, Pakistan, Ethiopia, Kenya, and the Democratic Republic of Congo are listed as focus geographies in the foundation’s family planning strategy outline.<sup>29</sup> India and Nigeria have seen the largest commitments since 2012 (see Table A2.2). According to CRS data, 38 percent of Gates Foundation commitments since 2012 did not specify country recipients; the remainder were coded as specific countries or regions. However, the latter category also includes substantial funding to cross-cutting accountability mechanisms that operate in part at the country level, for example, the PMA2020 and Track20 initiatives.

## Other Donors

In addition to the aforementioned donors, many European countries also provide funding for family planning and reproductive health services. From 2004 to 2014, Germany and Norway provided the next greatest amounts of resources for family planning: \$192 million and \$79 million, respectively. Although the World Bank is not a top-three donor, it did launch the Global Financing Facility in 2015, which will focus on

improving reproductive, maternal, newborn, child, and adolescent health. Figure 2.3 provides a more detailed breakdown of the top 20 donors to family planning from 2004 to 2014.

## On the Horizon: An Uncertain Funding Environment

Aggregate funding flows suggest positive trends in family planning expenditures over time. Yet recent developments since 2014 have introduced significant questions about funding in the coming years. The major sources of uncertainty are threefold.

First, substantial depreciation of donor currencies versus the US dollar since the 2012 summit has reduced the effective value of European and other non-American funding sources (Figure 2.4). This is particularly relevant for international institutions that use the US dollar as their working currency, most notably the United Nations Population Fund (UNFPA). The recent post-referendum drop-off in the pound is of particular concern given the importance of UK funding.

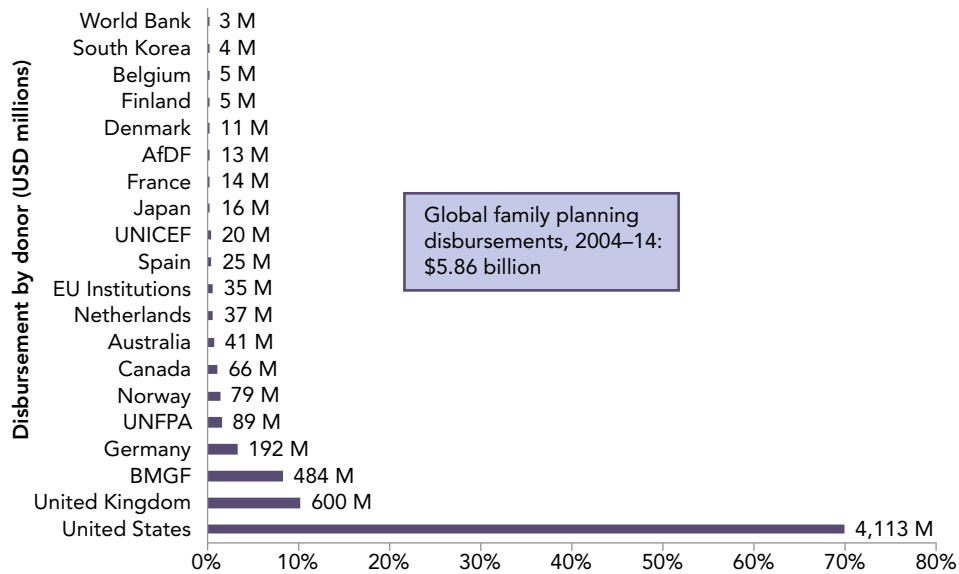
Second, political developments in donor countries may put family planning budgets at risk. Several European countries are facing substantial pressure to reallocate foreign aid funds to deal with the ongoing refugee crisis; Sweden, for example, expects to cut foreign aid programs by 30 percent in 2016.<sup>30</sup> In the United Kingdom, fallout from the Brexit vote continues to introduce funding uncertainty; the incoming Theresa May government has reiterated its commitment to the 2015 Conservative manifesto, which includes family planning but contains no explicit reference to FP2020.<sup>31</sup> The upcoming presidential and congressional elections in the United States also represent a significant source of uncertainty; a new administration and/or congressional majority may be more or less willing to prioritize international family planning assistance versus other development priorities or domestic investments.

29. Bill & Melinda Gates Foundation (2016).

30. Swedish International Development Agency (2012).

31. Conservatives (2015).

**Figure 2.3.** Cumulative Donor Shares in Global Family Planning Disbursements, 2004–2014



Source: Fan, Victoria Y., Sunja Kim, Roxanne Oroxom, Karen A. Grepin. 2016. “International Funding and Need for Family Planning, 2004–14.” Manuscript submitted for publication. September 14. UNFPA figures refer only to core (assessed) funds, excluding direct/earmarked bilateral spending.

Third, the World Bank’s newly formed Global Financing Facility (GFF) offers a novel window for low- and lower-middle income countries to access financing for family planning alongside other reproductive, maternal, newborn, adolescent, and child health services, with links to International Development Association (IDA) funding—but cannot compel investments in family planning absent government demand.<sup>32</sup> For now, the extent to which governments will use GFF funds in support of family planning thus remains unclear. Additional donor commitments to the GFF will likewise increase the overall pool of funds available for family planning, and the GFF could represent an important opportunity to firmly embed family planning within the continuum of care. Yet if donors reallocate from direct support of family planning to support of

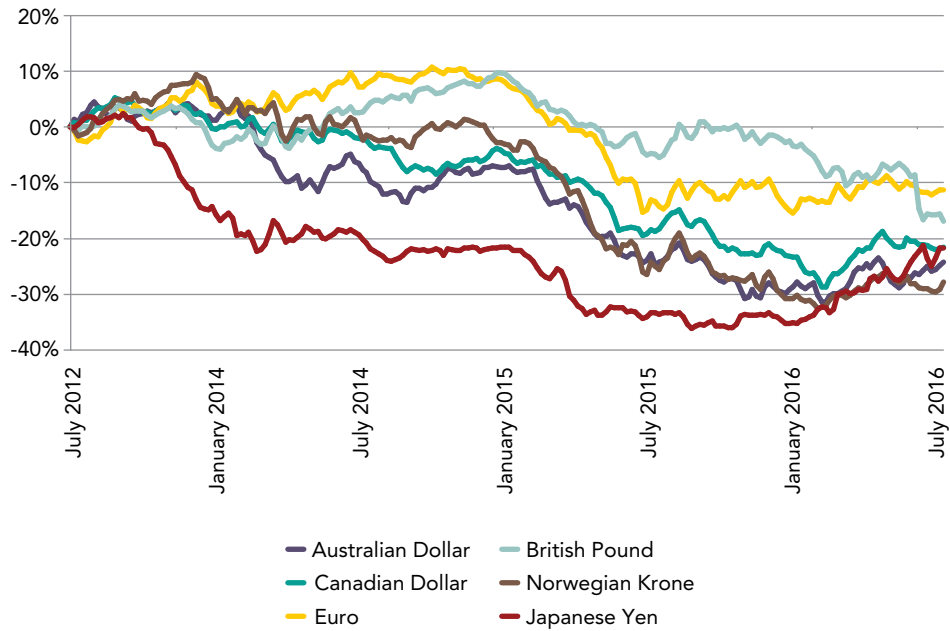
the GFF, their family planning dollars may be “diluted” by support for other interventions—potentially representing a net drop in total family planning financing. Thus, the full effect of the GFF on the overall financing landscape remains uncertain, with both significant upside potential and downside risk.

The full effects of these developments will become clear only in the coming years, but cause for concern exists presently. The UNFPA Supplies program, which provides more than a quarter of all contraceptives used by women and girls in the FP2020 focus countries, is currently facing a substantial funding gap due to exchange rate fluctuations and a fall-off in donor contributions (Figure 2.5).<sup>33</sup> Without corresponding funding increases from other sources, global contraceptive supply security could potentially be put in jeopardy.

32. Global Financing Facility (2015).

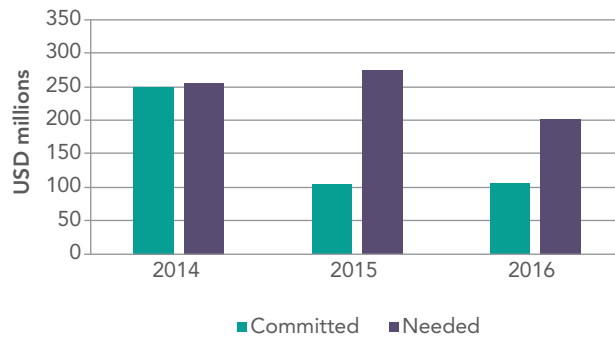
33. United Nations Fund for Population Activities (2014).

**Figure 2.4.** Exchange Rate Depreciation vs. US Dollar since July 1, 2012



Source: OANDA. 2016. Historical Currency Exchange Database. Accessed August 16. <https://www.oanda.com/solutions-for-business/historical-rates/main.html>. Compiled from OANDA weekly data.

**Figure 2.5.** UNFPA Supplies Committed vs. Needed 2014–2016



Source: Glassman, Amanda. 2016. "Failing to Deliver on Family Planning? Funding in Crisis." Center for Global Development Global Health Policy Blog, May 19. <http://www.cgdev.org/blog/failing-deliver-family-planning-funding-crisis>; updated following private communication with Jennie Greaney on September 21, 2016.

## Conclusion

International resources for family planning have increased steadily since 2004, with three donors—the United States, United Kingdom, and the Bill & Melinda Gates Foundation—accounting for the lion’s share of publicly reported funding. However, recent

and upcoming global developments, including currency depreciation, political upheaval in donor countries, and the introduction of the GFF, have introduced substantial risks for the future funding outlook. Better data are needed to fully understand the distribution of family planning resources across countries and priorities.

## Chapter 3.

# FP2020 Alignment: Important Success, but Room to Grow

In this chapter, we draw on cross-country analysis, working group discussions, and country case studies to analyze the degree to which FP2020 mechanisms are working effectively to align attention, resources, and efforts toward the FP2020 goals. We focus on four areas: allocating financial resources across and within individual countries, aligning commodity purchasing and supply chains, creating incentives and an enabling environment for countries' domestic investments, and creating a strong accountability environment to ensure partners and implementers are following through on their commitments with high-quality services.

### **Allocating Financial Resources across and within Countries**

To achieve the shared FP2020 goals, donors must align their funding and effort, both across the set of eligible FP2020 focus countries and within each focus country. In this regard, FP2020 or individual donor mechanisms have had a mixed track record, achieving some important success but falling short in other respects.

#### **Cross-Country Allocations**

In practice, it is difficult to evaluate whether the current distribution of funding across FP2020 focus countries is efficient. Limited evidence is available on the relative effectiveness of spending in different country settings.

In lieu of such information, we can only assess the distribution of funding vis-à-vis measures of family planning need—and the appropriate measure of need may itself vary depending on each donor's perspective. For example, some donors define the neediest countries as those with the lowest contraceptive prevalence; others prioritize countries with high unmet need or a high rate of maternal mortality. For each of those measures, donors could prioritize countries in absolute terms (e.g., the greatest number of maternal deaths) or on a relative basis (e.g., the highest maternal mortality ratio). Each metric is defensible but implies a different prioritization across countries and thus a different assessment of whether funding is sensibly distributed. Our understanding of current funding flows is itself hampered by the data limitations described in Appendix 2, including our inability to fully account for the contribution of countries' domestic financing. Finally, we recognize that non-need criteria appropriately play an important role in determining allocations, so a misalignment between need and funding may not, in and of itself, represent an inefficiency (see further discussion below).

Noting these analytical limitations and caveats, it is nonetheless evident that current cross-country allocation practices have not consistently aligned funding with family planning need. To illustrate, Fan et al. calculate the difference between a country's ranking as determined by family planning disbursements per

capita received and a country's ranking as determined by family planning need (Figures 3.1a–d). Need is measured using four different metrics: the maternal mortality ratio, the percentage of women using modern contraceptives, the population growth rate, and a gender inequality index score.<sup>34</sup>

Countries with a negative rank difference have a higher need rank compared with their aid rank. If relative need and relative funding were perfectly aligned, all countries would sit along the red horizontal line. Countries studied are limited to those of priority for FP2020, USAID, and/or DFID. The size of the circle in the figures reflects the level of domestic funding for health per capita.

Though each measure results in a different set of rankings, none of the four metrics is clearly correlated with countries' relative family planning funding. Further, it is clear that a handful of countries have experienced relative neglect in terms of family planning funding, consistently receiving funding well below their relative need. Across all four measures, five countries—the Democratic Republic of Congo, Gambia, Guinea-Bissau, Nigeria, and Somalia—have rank differences between need and funding in the bottom 10 percent of the distribution. Seven countries—Cote d'Ivoire, Republic of Congo, Eritrea, Ethiopia, Sudan, Chad, and the Central African Republic—finish in the bottom 25 percent of distribution of rank differences on at least three of the four measures.<sup>35</sup>

However, discrepancies between relative need, as measured in this analysis, and relative funding do not necessarily indicate inefficiency or misalignment. Some of the neglected countries—Somalia, for example—are challenging operating environments; donors may assess that family planning investments will have limited impact in settings where basic security is lacking. Other countries—for example, Ethiopia and the Democratic Republic of Congo—are likely to have substantial

family planning investments that are not captured in the database because they are funded through the government and nondisaggregated DFID programs. In yet another set of countries—particularly middle-income countries like Nigeria—relative “underfunding” is likely to reflect donors' legitimate reservations about continued expenditures of external resources without commensurate government spending and political commitment.

Nonetheless, the consistent discrepancies across multiple metrics suggest that real underlying differences do exist. The FP2020 secretariat does not have standing to direct resource allocation across countries, and donors themselves vary in their approach to cross-country allocation, as described in the previous chapter. Only USAID has an explicit priority-setting mechanism to allocate family planning resources across countries, but its list of priority countries differs to some extent from FP2020's list of 69 focus countries. Likewise, DFID operates in only a small subset of the FP2020 countries; its own set of countries with bilateral programs (across all sectors), developed long before the start of the FP2020 initiative and based on different criteria, also excludes the Republic of Congo, Chad, and Cote d'Ivoire, among other countries that appear relatively underfunded in the above analysis.

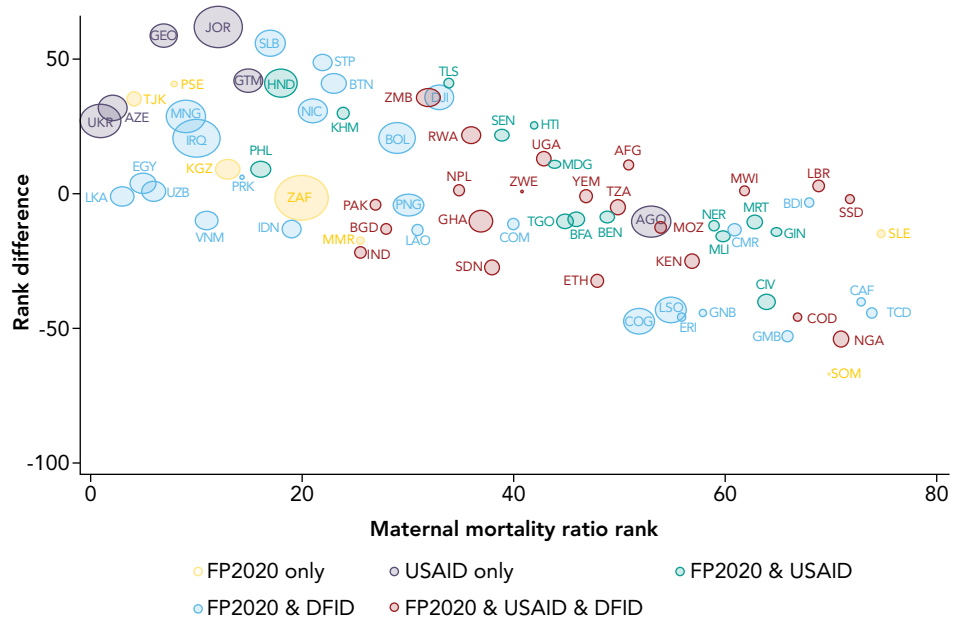
### Allocation within Countries

Within its target countries, several mechanisms introduced under the FP2020 umbrella are intended to help align funding and effort behind the FP2020 goals. Most notably, FP2020 has encouraged its focus countries, in coordination with and supported by the FP2020 donors, to develop family-planning-specific costed implementation plans (CIPS). According to the FP2020 secretariat, CIPs are “multi-year actionable roadmap[s] designed to help governments achieve their family planning goals,” enabling governments to “prioritize family planning interventions; detail key activities and outline a roadmap for implementation;

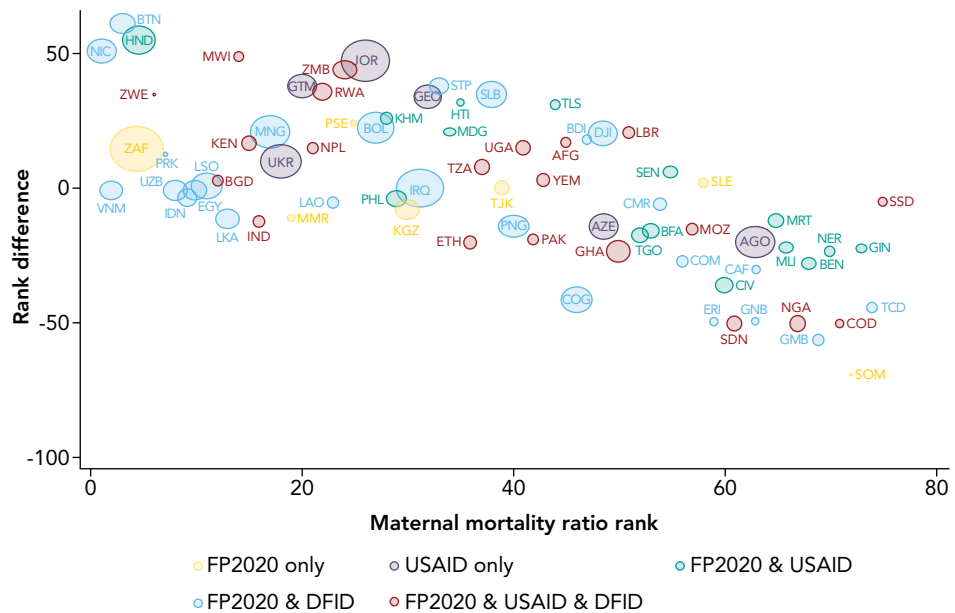
34. Fan, Kim, Oroxom, and Grepin (2016).

35. Fan, Kim, Oroxom, and Grepin (2016).

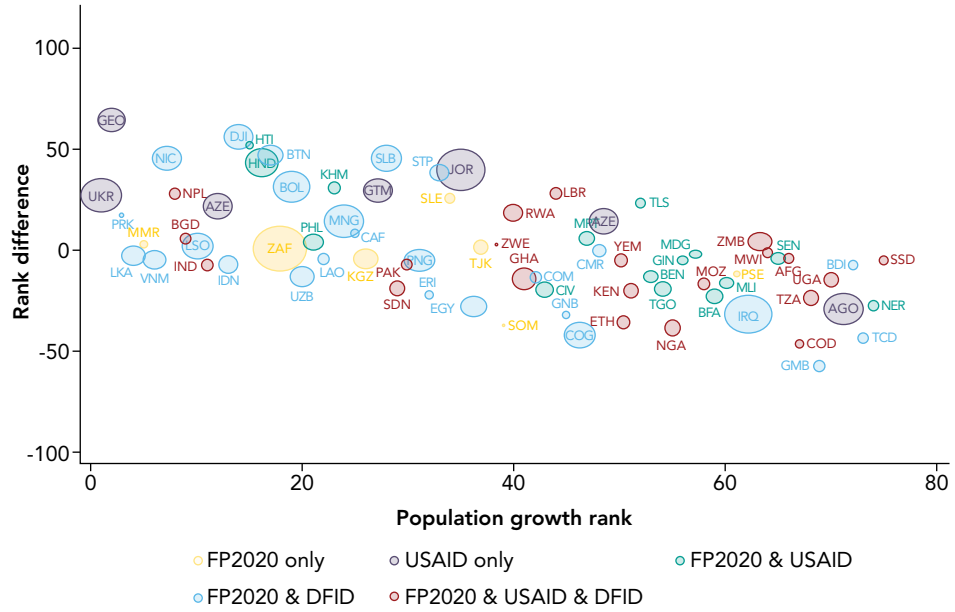
**Figure 3.1a.** Rank Difference vs. Maternal Mortality Ratio Rank



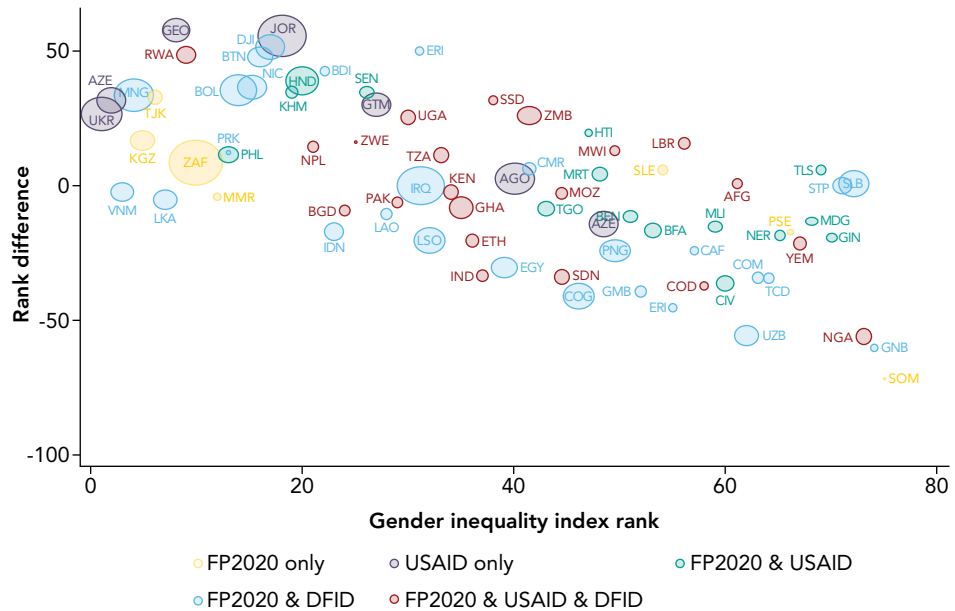
**Figure 3.1b.** Rank Difference vs. Percentage of Women Using Modern Contraceptives Rank



**Figure 3.1c. Rank Difference vs. Population Growth Rank**



**Figure 3.1d. Rank Difference vs. Gender Inequality Index Rank**



Source: Fan, Victoria Y., Sunja Kim, Roxanne Oroxom, Karen A. Grepin. 2016. "International Funding and Need for Family Planning, 2004–14." Manuscript submitted for publication. September 14.



estimate the impacts of interventions; forecast costs and make strategic allocation decisions; mobilize resources to meet gaps; monitor progress; [and] unify stakeholders around one focused family planning strategy.”<sup>36</sup> In each country, the CIP is intended to serve as the unifying, government-owned family planning strategy, guiding both donor and national investments.

The introduction of country-owned family planning strategies, with shared buy-in from donors and other stakeholders, is a welcome contribution of the FP2020 partnership. Across all three country case studies, and particularly in Nigeria and Uganda, government, donor, and civil society officials cited the CIP favorably as the overarching framework for national family planning efforts and noted the role the CIP played in raising the visibility of family planning and generating broad stakeholder buy-in. (In Kenya, however, most stakeholders agreed that devolution had rendered the 2012 CIP largely obsolete.) In theory, such documents may be

a powerful tool in aligning funding behind the FP2020 goals. In practice, however, the first round of CIPs analyzed for this report—those completed between 2010 and 2015—have varied substantially in their real utility as guides for resource allocation. Common limitations of the CIPs are threefold but interrelated.

First, most of these CIPs set aspirational rather than realistic targets, with no basis in rigorous modeling (Box 3.1) or historical trends; as a result, even their full and effective implementation will not necessarily (and in some cases, definitively not) lead to achievement of the CIP goals within the designated timeline. The disconnect between the actual activities and cost figures on the one hand, and the monitoring framework on the other, sets up countries—and thus the entirety of the FP2020 partnership—for failure. For example, Nigeria’s 2014 CIP suggests that Nigeria aims to more than double its all-methods contraceptive prevalence rate (CPR) by 2018, with an increase from 15 to 36 percent.<sup>37</sup> Yet many

36. FP2020 (2016).

37. Federal Government of Nigeria (2014).

### Box 3.1. How Rigorous Modeling Can Inform Resource Allocation

Epidemiological and economic modeling can be powerful tools to inform resource allocation and accelerate progress toward the FP2020 goals. Family planning leaders have long drawn from a large arsenal of Excel- and other computer-based modeling tools for these purposes, each with slightly different capabilities and use cases. These tools fall into two primary baskets. The first category is the “advocacy models”—that is, models intended to drive investments in family planning by illustrating the costs of population growth or the expected economic and health returns from family planning investments. These models include the RAPID model, which projects the demographic,

infrastructure, and economic consequences of different population scenarios;<sup>a</sup> the DemDiv model, which calculates the demographic, economic, and health impacts resulting from different family planning, education, and economic investment scenarios;<sup>b</sup> and the ImpactNow model, which estimates the extent to which achieving a set CPR or unmet need goal in the short term will avert unintended pregnancies, unsafe abortions, maternal and child deaths, and associated costs.<sup>c</sup> The second category is the “planning models” intended to inform resource allocation and costing. The FamPlan model calculates the number and cost of service delivery and commodity needs to meet a

*(continued)*

### Box 3.1. Continued

preset fertility or mCPR goal and then extrapolates the economic and health impacts of achieving it.<sup>d</sup> The GAP Tool likewise projects a country's funding and commodity needs to reach a preset goal and compares current funding levels with the projected need (based on service delivery costs alone).<sup>e</sup>

Recently, Avenir Health has completed an initial version of a new family planning model, FP Goals.<sup>f</sup> (For now, the model is proprietary and not available online; this section draws from limited publicly available information.) Unlike previous family planning models, FP Goals allows the user to project the expected increase in mCPR that will result from a given package of interventions, including public sector, private sector, system strengthening, and demand generation activities; when run multiple times, the model thus enables the user to compare different scenarios and prioritize the most effective interventions. This empowers countries to set realistic goals for mCPR growth and select a relatively efficient intervention package—both of which can greatly improve strategic planning. Yet even this new model has important limitations. First, as its creators caution, the model considers mCPR growth as its only outcome; it excludes consideration of quality of services, equity, or norm changes—all of which are important to family planning donors. Second, the tool does not automatically optimize the “best” mix of interventions to increase mCPR. Instead, it relies on the user to enter multiple scenarios and manually compare them—and it is always possible that the “best” intervention mix will be one that the user did not consider.<sup>g</sup> Third, and relatedly, the model does not project the expected cost for implementing any given intervention mix, nor does it allow the user to optimize resources within a limited budget constraint or easily project the amount of progress that could be attained given a budget increase.

Given these limitations, current modeling capacity for family planning lags behind recent advances in other fields, most notably HIV. For example, the Optima Model developed by Wilson et al. allows a user to “calculate the optimal allocation of resources to different program areas to address the specific objectives of either (a) reducing new infections, HIV-related deaths, disability-adjusted life years, or a combination thereof; or (b) minimizing costs associated required to achieve specific targets.”<sup>h</sup> An important factor is the introduction of costing data, which allows the user to consider the costs and feasibility of multiple scenarios and to optimize spending under its existing budget constraints. For example, the simulation presented in Figure B3.1 for Georgia from the World Bank and the Optima Consortium shows that reallocation of the existing budget to an optimal intervention mix could avert 15.5 percent of additional new infections and 36 percent of additional deaths.<sup>i</sup> It also provides the necessary information to advocate for additional funding by illustrating the expected impact and guiding policymakers on the best use of the next dollar of funding.

The introduction of the FP Goals model is a welcome first step toward using more rigorous mathematical modeling to inform FP resource allocation. The family planning community should continue to build on this promising development to strengthen the modeling tools at its disposal, particularly through the introduction of cost data and a budget constraint.

a. Futures Institute (N.D.).

b. Health Policy Project (2015).

c. Health Policy Project, USAID, and Marie Stopes International (2014).

d. Futures Institute (N.D.).

e. Health Policy Project (N.D.).

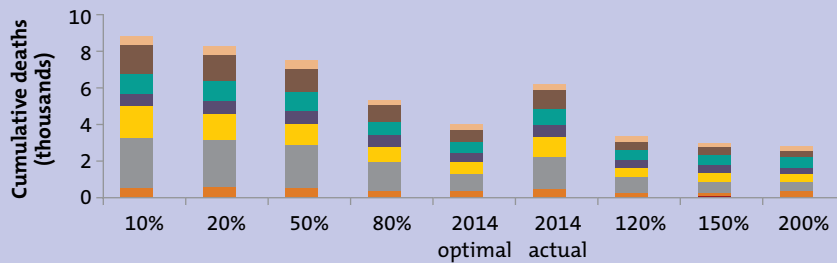
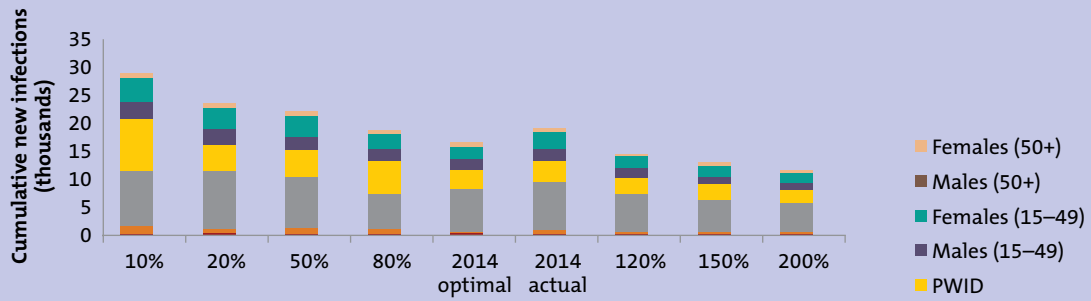
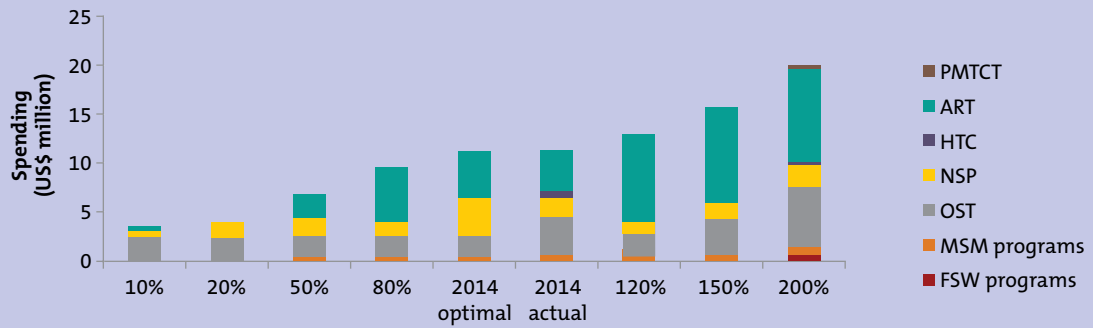
f. Avenir Health/Track20. FP Goals at <http://www.track20.org/pages/resources/FPGoals>.

g. Track20 (2016).

h. Optima. (N.D.).

Box 3.1. Continued

Figure B3.1. Optimized Allocations to Minimize HIV Incidence and Deaths by 2030 at Different Budget Levels (2014 Budget)\*



Note: Populated Optima model for Georgia; only optimized costs are scaled, non-optimized spending remains at current levels.

Note: PMTCT stands for Prevention of Mother-to-Child Transmission, ART stands for antiretroviral therapy, HTC stands for HIV testing and counseling, NSP stands for needle-syringe programs, OST stands for opiate substitution therapy, MSM stands for men who have sex with men, FSW stands for female sex workers, PWID stands for people who inject drugs, and MSMW stands for men who have sex with men and women.

Source: World Bank. 2016. Optimizing Investments in Georgia's HIV Response. Washington, DC: World Bank. <https://openknowledge.worldbank.org/handle/10986/24966>.

family planning stakeholders in the country agreed that this rate of increase is impossible even under the best of circumstances; Nigeria has thus far shown limited national progress toward its goal, even as impressive local increases have been observed in the six cities targeted by the Gates-funded Urban Reproductive Health Initiative.<sup>38,39</sup> Uganda's CIP, likewise, commits to increasing its modern contraceptive prevalence rate (mCPR) from 26 percent in 2011 (the most recent data at the time of its writing) to 50 percent in 2020<sup>40</sup>—a rate of increase that many stakeholders believe is unrealistic.

Second, the activities and costing laid out in most of the early CIPs typically do not correspond with real-world funding levels, modes of funding, or other health-sector strategy documents. As a result, most of these CIPs are also not trackable; it is nearly impossible to relate actual funding flows from donors and government to the categories and priorities set out within the documents. In Uganda, for example, the CIP costings omit overhead costs for international implementing partners and does not account for existing donor funding flows. A 2015 gap analysis exercise undertaken in Uganda by the Health Policy Project indicates enormous gaps within noncommodity funding buckets, suggesting that the overall costing was not realistic given the existing funding environment (Figure 3.2).<sup>41</sup> Yet their results clearly do not capture all funding available. For example, in 2015 the gap analysis indicates that less than \$1 million was allocated in Uganda for service delivery and access; but according to the UK development tracker, DFID disbursements to a Marie Stopes–led service delivery consortium alone totaled more than £4 million in FY 2015–16.<sup>42</sup> Nonetheless, this highlights the challenges in tracking the CIP against donors' actual modes of investment and existing funding environment. Relatedly, many CIPs

fail to adequately reflect or account for subnational or devolved structures for allocation and administration of health-sector funds, a particular problem in decentralized countries Kenya and Nigeria. More broadly, they typically lack in-depth discussion of how funds will be allocated between geographic areas.

Third, most of these CIPs essentially present a “wish list” of activity categories rather than a prioritized, detailed blueprint for achieving realistic progress against family planning indicators. As a result, donors can pay lip service to aligning behind one of the broad CIP priorities while continuing to fund according to their own priorities. Likewise, new donors to the family planning space struggle to identify the next activity that should be covered with an additional injection of funds; this also hampers advocacy and resource mobilization. For example, in GFF negotiations, some stakeholders reported that the absence of a prioritized list of activities hindered their ability to advocate for the inclusion of family planning within the GFF investment case.

A potential example of a well-functioning CIP can be seen in Senegal. In addition to listing broad activities and subactivities as other countries did, Senegal's CIP also outlined priority actions by region and potential for change. For example, for the region of Diourbel, where the target population is highly religious and limited in access to family planning messages, the CIP called on implementers to “palliate the lack of information, insisting on health advantages (non-economical), and adapt materials, especially in Wolof, and transcription to Arabic.”<sup>43</sup> Further, Senegalese officials leveraged their national CIP to encourage all 76 districts to develop their own family planning targets and plans. The plans' progress and challenges, including financing problems, are regularly monitored.<sup>44</sup> However, even the Senegalese plan suffered from some of the limitations described above; most notably, the CIP set an aspirational target

38. FP2020 (2015).

39. Measurement, Learning, & Evaluation (MLE) Project. (2015).

40. Ministry of Health, Uganda (2014).

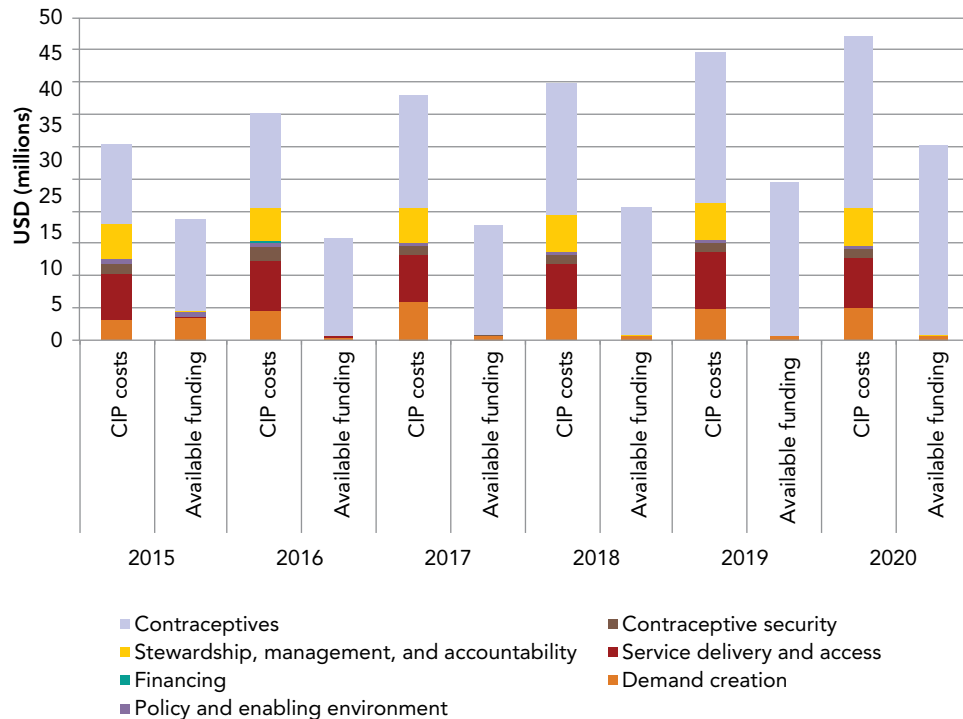
41. Zlatunich and Couture (2015).

42. Department for International Development. Development tracker.

43. Republic of Senegal Ministry of Health and Social Welfare, Division of Reproductive Health (2012).

44. Knowledge for Health (2015).

**Figure 3.2.** Uganda Gap Analysis, 2015



Source: Zlatunich, Nichole, and Taryn Couture. 2015. 2015 Gap Analysis for Uganda Family Planning Costed Implementation Plan, 2015–2020. Washington, DC: Health Policy Project. [http://www.healthpolicyproject.com/pubs/840\\_UgandaCIPbrief.pdf](http://www.healthpolicyproject.com/pubs/840_UgandaCIPbrief.pdf).

of 27 percent mCPR (for married women) by 2015 and 45 percent by 2020, compared with a baseline of just 12 percent in 2012. (According to DHS data, Senegal had achieved a 21.2 percent mCPR among married or in-union women by 2015—a significant improvement, but still well short of the highly ambitious goal.)<sup>45</sup>

Given the absence of clear, detailed guidance and prioritization on activities from within these early CIPs, donors have largely pursued business-as-usual approaches to their own allocation based on precedent, discretion, and to some degree their perceived

comparative advantage. These allocations are rarely based on modeling, and in some cases are made with little reference to data and evidence. At times, this can lead to implausible assumptions or strategically questionable investment decisions. For example, interviews with Kenyan stakeholders suggested that for one large grant from a major donor, the projected number of additional users to be served by the project was greater than the total population of nonusing women of reproductive age in the target areas. (The targets were later revised downward, but only after the grant had been awarded.)

45. Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal] and ICF International (2015).

The FP2020 secretariat and its partners have learned from these early experiences, and the most recent CIPs—those completed or under development in 2016—reflect an evolving approach. These CIPs place a stronger emphasis on activity-based costing; priority-setting given different funding scenarios; performance management; subnational allocation; and the use of modeling to set more realistic goals, although there is still substantial variation across countries. Drawing from effective practice in Senegal, the FP2020 partnership has also begun providing countries with technical assistance to support the implementation of CIPs completed prior to 2016.<sup>46</sup>

Overall, CIPs have helped set a broad strategic direction for countries' family planning programs and raised their visibility, and more recent CIPs have begun to address the problems evident in the earlier round. Nonetheless, more rigor is needed to align funding behind the most effective strategies to quickly and equitably increase family planning access.

46. Martyn Smith, Managing Director of FP2020, notes: "The first CIP was developed in Tanzania for the period 2010 - 2015. Since that time, 27 national and sub-national CIPs have been developed with a further 11 under development, and the CIP approach and products have evolved greatly to ensure that they are more focused and actionable. Detailed activity roadmaps, activity-based costing, and clear priority setting have become part of the standard approach being adopted by technical assistance partners and countries working on CIP development and implementation. Examples of the evolution of the CIP process include: The newest CIPs currently being developed and revised starting in 2016 have a stronger focus on performance management to strengthen execution of the plans, to align funding behind the most effective strategies to quickly and equitably increase family planning access, and to implement a partnership approach to CIP development to strengthen the capabilities of countries to execute their CIPs ... A number of countries with CIPs developed prior to 2016 will also be provided with technical assistance to support execution, which is based on evidence from Senegal ... In response to the additional complexities that come with devolution, more focus has been placed on developing subnational CIPs for large countries with decentralized health systems like Nigeria and Pakistan. In addition more emphasis has been placed during the CIP development process in working with Governments to use modeling to set ambitious but realistic goals as was done recently in Ghana/ CIPs that make clear which of the proposed strategies should be prioritized in the face of resource shortages include Zambia, Uganda, Malawi and Ghana. The Uganda CIP is a particularly good example of a plan with clear linkages to other relevant health strategies." Personal correspondence, 23 September 2016.

## Aligning Commodity Purchasing and Supply Chains

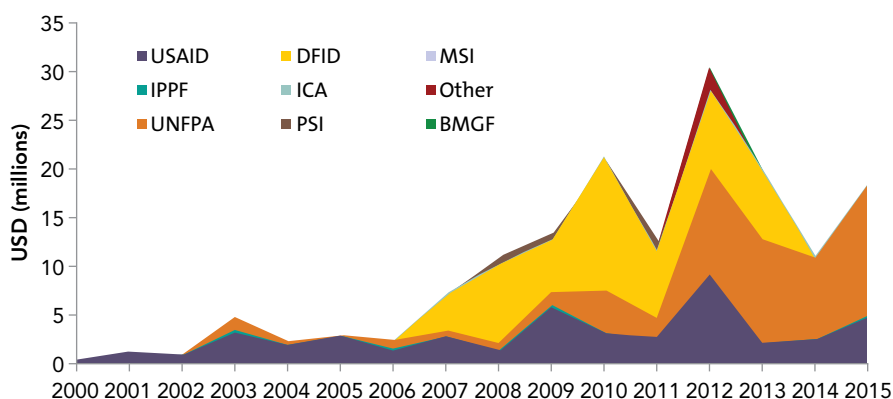
One area of apparent success for the FP2020 partners has been better alignment of commodity purchasing and supply chains. In all three countries profiled for this report, stakeholders report that joint procurement mechanisms have improved since the launch of FP2020, helping supply a steadier stream of commodities to countries, subnational units, and sometimes facilities—though these improvements cannot necessarily be attributed to FP2020 itself, and some improvements predate the initiative. In some cases, donors have eschewed national supply chains in favor of parallel, donor-controlled systems, potentially leaving supply security at risk in public facilities.

In Kenya, following a successful regime of technical assistance, all donors have aligned their commodity procurement and distribution through Kenya's national system, the Kenya Medical Supplies Agency (KEMSA). KEMSA is an autonomous state corporation tasked with procuring, storing, and distributing medical supplies, including contraceptive commodities. The establishment of a joint procurement mechanism with participation from all donors, exclusively using national systems, represents a major success for alignment with important implications for sustainability. However, difficulties in the procurement and distribution system have emerged due to poor planning by the national government during the decentralization process, particularly the devolution of family planning funding to counties without the existence of financing or distribution mechanisms to ensure consistent supplies—requiring donors to at least temporarily plug the financial gap, and at times leading to stockouts at the facility level. Supporting the government of Kenya to design and implement a sustainable, sensible commodity supply system in the context of decentralization represents an important next step.

In Nigeria as well, all donors except USAID have aligned their funds behind a single, UNFPA-managed



**Figure 3.3.** Value of Contraceptive Shipments by Source of Funding, Nigeria, 2000–2015



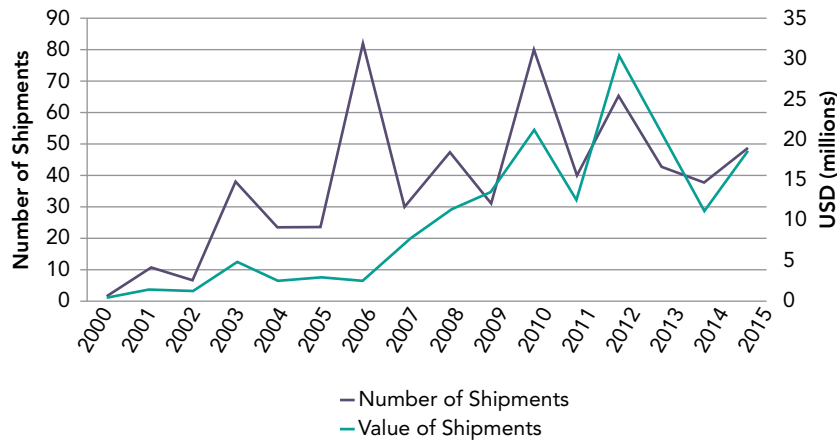
Source: Data from Reproductive Health Interchange, analysis by Andrew Mirelman.

contraceptive procurement system and supply chain system for the public sector, which coordinates commodity procurement and distribution from the national level to states and local government authorities. The system is financed through a basket fund supported by the UK Department for International Development (DFID), the Canadian International Development Agency (CIDA) and UNFPA. Stakeholders perceive that this arrangement (agreed to in 2011, prior to the start of FP2020) has led to large improvements in the reproductive health commodity supply chain and that government and donors contributed to these efforts. Figure 3.3 shows the value of contraceptive shipments by funding source from 2000 to 2015. The increase in the contribution from UNFPA since 2011 illustrates how the basket fund has become the dominant procurement source (it is managed by UNFPA). The figure also shows fewer funding sources since 2014, indicating lower levels of fragmentation. One potential result is an increasing stability of purchasing, as indicated by greater correlation between the number of contraceptive commodity shipments and their total value (Figure 3.4), suggesting a possible

increase in predictability. Evidence shows that the flow of commodities to service delivery points has also improved. Data from 2014 suggest that almost 80 percent of service delivery points had stocked contraceptive commodities in the past three months,<sup>47</sup> though some stakeholders express skepticism that services were actually available at all times. However, the reliance on a small number of donors for financing of the entire public-sector supply chain leaves Nigeria vulnerable to supply insecurity in the event of donor funding cuts.

In Uganda, all donors except UNFPA have withdrawn their support from the public-sector supply chain, citing perceptions of corruption and inefficiency at the National Medical Stores. Instead, they have aligned their funding behind a parallel procurement system, the Alternative Distribution Mechanism (ADM), which is managed by the nonprofit Uganda Health Marketing Group and provides free contraceptive commodities to nonprofit, for-profit, and faith-based facilities throughout Uganda. Stakeholders (e.g., NGOs

47. Federal Government of Nigeria and United Nations Population Fund (2015).

**Figure 3.4.** Number and Value of Shipments, Nigeria 2000–2015

Source: Data from Reproductive Health Interchange, analysis by Andrew Mirelman.

and faith-based groups) report general satisfaction with the services and continuity of supply provided by the ADM; this is an important enabling factor for the wide network of social franchises and NGO clinics operating in Uganda. NGO facilities also report frequent “sharing” of commodities with public facilities in order to resolve frequent public-sector stockouts. However, even if the decision to invest in a private supply chain makes sense in this context, the general neglect of the public sector caused by the out-migration of donors represents a serious concern—particularly since the ADM cannot directly stock public facilities. According to the 2011 DHS, 47 percent of Ugandan contraceptive users obtain supplies from public-sector facilities;<sup>48</sup> without supply security and method choice in public clinics, many women will be excluded from accessing family planning. Local reporting suggests that stockouts and highly restricted method choice have already become common in public facilities.<sup>49</sup> The situation in pub-

lic clinics could become even more serious if funding cuts at UNFPA lead it to dial back support to National Medical Stores.

### Creating Incentives and an Enabling Environment for Countries’ Domestic Investments

FP2020 partners have strongly emphasized the importance of country commitments and domestic resource mobilization for meeting the FP2020 goals. Yet despite this focus, the partnership has not yet been able to effectively leverage donor funding to increase countries’ domestic investments.

First, donors have created few explicit incentives for country cofinancing of family planning. Unlike other large global health funders—for example, Gavi, the Vaccine Alliance, and the Global Fund—none of the large family planning financiers require countries to cofinance donor investments with domestic funds. As a result, domestic budgets may sensibly prioritize funding for vaccines, HIV, malaria, and tuberculosis—requisite

48. Uganda Bureau of Statistics (UBOS) and ICF International Inc. (2012).

49. Bangirana (2016).



cofinancing to access donor funds for those disease areas—over line items for family planning, which may be seen as optional and financed by donors even if countries fail to chip in. Indeed, countries may rightly fear that increases in domestic expenditure—particularly for commodities—will result in equally large decreases in donor financing for those same line items, prompting a redistribution of those funds to other countries. The inverse also holds; countries correctly believe that donors will step in, at least in the short term, to plug commodity gaps if domestic funding falls. The belief that donors will rescue countries from commodity insecurity creates moral hazard; countries believe that they can cut family planning funding without assuming the risk for stockouts as a result.

In Kenya, for example, domestic funding for family planning commodities evaporated following the rushed decentralization process; donors, as expected, reacted by fully funding commodities in the interim. (This is not to say that Kenyan government officials cut commodity funding knowingly, under the expectation that donors would step in; however, the presence of donors, and their interest in maintaining supply security, relieved any pressure on the government to immediately restore funding. Indeed, domestic funding has not yet been renewed at pre-decentralization levels.) A similar situation emerged in Nigeria; after the national government failed to ensure full disbursement of its existing \$3 million line item for family planning in 2014 and 2015 (or to disburse the additional \$8.35 million per year committed by the Nigerian government at the 2012 London Summit), UNFPA stepped in to fill the resultant gap in 2015. Several bilateral donors in Nigeria have considered changing the rules of engagement to ensure the commitment of the Nigerian government before the release of funds; however, no donors have yet followed through on these threats, in part because they reasonably fear disastrous consequences for health if they do so.

Second, donor investments in family planning advocacy and accountability mechanisms at the international, national, and local levels do not yet appear to have resulted in significant domestic spending increases or even the disbursement of previously promised annual expenditures. These investments are intended to create a positive enabling environment for family planning programs over a long-term time horizon. Yet many donors acknowledge hope that advocacy and accountability programs will also generate “wins” within a shorter time frame by creating incentives for country officials to fund family planning with domestic resources, among other policy goals (for example, task shifting to enable more rapid rollout of SayanaPress, a new injectable contraceptive that is easy to administer with minimal training).

The theory of change at least partially undergirding these investments suggests that country and subnational policymakers will be persuaded by local civil society groups to substantially increase funding allocations, and that the accountability created by advocacy groups will incentivize them to deliver on their family planning commitments. No rigorous evaluation of these efforts is ongoing or planned (where rigor implies use of study designs that construct a convincing counterfactual). In the short term and at the anecdotal level, these investments have seen important, if modest, returns. Advocates have achieved some important policy changes; in Nigeria, for example, advocacy efforts resulted in a new policy allowing community health extension workers to administer long-acting reversible contraceptives. Advocacy and accountability efforts have also generated modest but locally significant budget allocations for family planning in some settings; for example, budget advocacy programs appear to have helped secure the first-ever budget allocation for family planning in Kenya’s Kitui county (\$162,000 for FY 2015–16) and a 17 percent increase in Malawi’s contraceptive budget

for 2015–16 (to \$164,745 USD).<sup>50</sup> At the national level in Kenya, advocacy of a broad range of local and international organizations has helped secure a partial reinstatement of central funding for commodity procurement in FY 2015–16.

Thus far, however, examples of increased domestic resource allocations for family planning are relatively few—and the subsequent allocations have been small in absolute terms relative to overall funding needs or the scale of donor investments. In Nigeria, for example, despite substantial investment by donors in advocacy and accountability measures, the Federal Ministry of Health has not made good on its commitment to spend additional \$8.35 million per year on family planning; indeed, in 2015 it actually failed to disburse any of its preexisting \$3 million budget allocation. Even at the local level, only one of 36 states (Lagos) has disbursed any money specifically earmarked for family planning.<sup>51</sup> And in Kenya the restored funding for family planning commodities totaled just \$1.3 million for FY 2015–16, far below the \$8 million per year that the government of Kenya was funding pre-devolution. Although welcome steps in the right direction for long-term sustainability, these marginal increases in funding (following dramatic reductions) make little dent in the overall short-term financing picture.

More broadly, although the arguments are well developed in publications like the World Bank's 2004 *Making Service Delivery Work for the Poor*,<sup>52</sup> little and mixed empirical evidence is available on the effectiveness of civil society advocacy and accountability initiatives as a means to increase public funding for a given use or to enhance the quality or productivity of service delivery. Within reproductive health and family planning, a 2014 review by the Population Council noted the limited (though potentially encouraging) evidence base and “the need for more rigor in articulating and

evaluating [social accountability] interventions.”<sup>53</sup> The particular design and scale of the initiative likely matters to the outcome, as well as the baseline quality of government and precedent for civil society organizations (CSOs) to influence the budget or policy process. In any case, such strategies are likely to require a longer-term time frame to be effective.<sup>54</sup>

Overall, advocacy efforts have improved the enabling environment for family planning at the country level, but they have not yet generated substantial increases in country investments. By themselves, these efforts cannot substitute for the urgent action needed to address the uncertain donor funding environment for service delivery and commodities, particularly the shortfall in funding for the UNFPA supplies program discussed in the previous chapter.

## Building Stronger Accountability for Results

Across the results chain, different measurement strategies are required to support accountability efforts to ensure that the FP2020 partnership—and its constituent countries, funders, implementers, and programs—are fulfilling their financial and programmatic commitments. At different stages across the results chain, different data and measures answer different questions (Figure 3.5), from financing (Are we honoring financial commitments for FP investment?) through service and commodity provision (To what degree are FP services serving those they intend to reach?) to impact (Are maternal and infant mortality rates dropping? Is gender equity improving?).

Current data verification and accountability mechanisms within the FP2020 partnership have enhanced the ability of the family planning community to monitor progress and hold itself accountable *in aggregate* across the various stages of the results chain. At the financing stage, the FP2020 secretariat monitors the

50. PAI (2016).

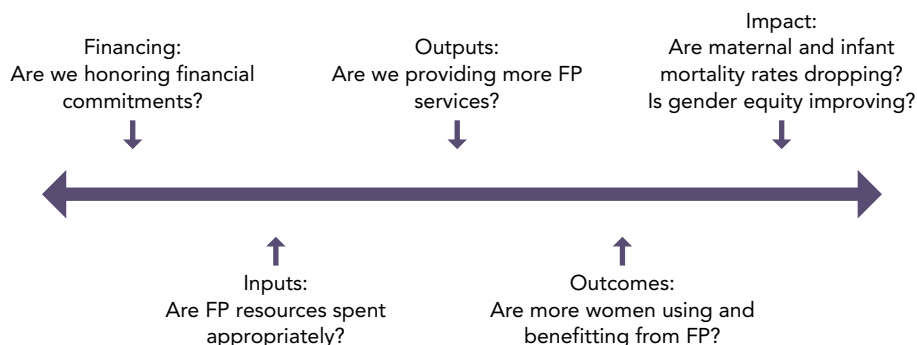
51. Federal Government of Nigeria (2014).

52. The World Bank (2004).

53. Boydell and Keesbury (2014).

54. Devarajan, Khemani, and Walton (2014).

**Figure 3.5.** Accountability across the Results Chain



Source: Authors.

overall level of resources available for family planning programs. However, as discussed in previous chapters and below, important gaps still exist in financial tracking. At the output stage, Avenir Health's Track20 project works directly with country governments to improve routine collection and analysis of family planning data;<sup>55</sup> the program has helped focus countries to improve their health management information systems and produce annual estimates for family planning service delivery (primarily outputs). In addition, the Performance Monitoring and Accountability 2020 (PMA2020) program, run by the Johns Hopkins Bloomberg School of Public Health, conducts regular household- and facility-level surveys in 10 participating countries. These frequent surveys monitor population-level trends in contraceptive uptake, unmet need, and method mix (outcomes); they also assess service readiness at a sample of facilities. And with some regularity, demographic and health surveys measure changes in reproductive and child health outcomes, for example, the maternal and infant mortality rates (impact); they also provide data on contraceptive prevalence, unmet need, and ideal family size for those countries excluded from the PMA2020 umbrella.

Although this *collective* measurement and accountability is important, it does not currently translate into sufficient *attributable* measurement and accountability for whether specific countries, service provider organizations, health facilities, or investments are achieving their programmatic objectives and delivering on their commitments. Without attributable measurement and accountability, it is impossible to know which investments are making a difference, to reallocate investments from poorly performing to more effective programs, or to use lessons learned and best practices to inform future program design. In this way, the attributable accountability vacuum impedes learning within the FP2020 partnership and slows the pace of progress.

For the early stages of the results chain, some attributable measurement and accountability exists; the FP2020 secretariat monitors whether individual countries and donors are fulfilling their financial commitments, and individual donors exercise financial oversight over grantees to ensure that funds are spent appropriately by requiring regular audits of larger grants. Even here, however, financial tracking is limited, data on countries' domestic family planning expenditures are scarce, and donors do not necessarily track or follow the flow of funds to specific subregions or interventions.

55. Track20/Avenir Health (2016).

Further down the results chain, attributable accountability can be thin. Donors typically rely on grantees to self-report their outputs and outcomes, without independent verification to ensure that reported results are accurate. (DFID hires independent evaluators to assess grantees' annual progress; the methodology varies and can at times include some validation of grantees' self-reported data.)<sup>56</sup> Donor field offices are typically understaffed and overstretched; just a few dedicated staff members are responsible for management of many grants, leaving limited bandwidth for routine grant oversight in the field. Very few family planning programs undergo rigorous, independent impact evaluation to assess whether they have made a difference for the health, economic, or empowerment status of women and girls—or even whether they have helped bend the curve on family planning uptake.

Gaps in attributable accountability are common in global health and international development programs more broadly, sometimes creating perverse incentives for implementers to misreport administrative data. For example, Sandefur and Glassman document over-reporting of diphtheria-tetanus-pertussis vaccination coverage in administrative data relative to independent survey data across several African countries, potentially driven by incentives offered by Gavi, the Vaccine Alliance.<sup>57</sup> Better performance verification to improve accountability for results is feasible and already being done well in sub-Saharan African contexts, including end-use verification by the President's Malaria Initiative and independent verification associated with the World Bank's Health Innovation Trust Fund (now the Global Financing Facility).

Taken together, at times and to varying extents (depending on the donor and specific field office, among other factors), this can leave an accountability vacuum for implementers, who may not be subject to rigorous oversight of their outputs or impact and may thus feel little external pressure to improve their approach to operations.

## Conclusion

This chapter has set out key achievements and challenges in aligning donor funding to FP2020 goals along four key dimensions. First, resource allocation across countries is done on a donor-by-donor basis, reflecting different priorities and processes and leaving some key countries under-allocated; within individual countries, CIPs are not yet suited to real-world resource optimization. Second, alignment of reproductive health commodity purchasing and supply chains has improved substantially under the FP2020 initiative, but sustainability of parallel supply chains may be at risk given volatility of aid. Third, countries face few explicit incentives for cofinancing and some disincentives to domestic investment. Finally, high-level accountability for progress and results is in place, little exists to connect success or failure to particular streams of funding or provision, and thus it is difficult to close the accountability loop and learn lessons about what is working or not.

56. See general description ([https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/67344/HTN-Reviewing-Scoring-Projects.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67344/HTN-Reviewing-Scoring-Projects.pdf)) and methodology section of an indicative report from Kenya: <https://devtracker.dfid.gov.uk/projects/GB-1-202547/documents>.

57. Sandefur, Justin, and Amanda Glassman (2014).

## Chapter 4.

# Recommendations to Accelerate Progress

The FP2020 midpoint presents an important opportunity for the FP2020 partners to take stock, learn from the past four years, and make changes in how they do business to accelerate progress toward 2020 and beyond. Based on the findings in Chapter 3, we lay out three recommendations to strengthen alignment within the FP2020 partnership for the years ahead.

### 1. Support more strategic and collaborative resource allocation at the country level, building on successes and existing coordination platforms.

FP2020 coordination mechanisms, particularly the costed implementation plans (CIPs), offer a useful platform for improving the strategic allocation and alignment of family planning resources. Yet as we describe in the previous chapter, current allocation mechanisms suffer from important limitations, hampering coordination and slowing the potential pace of progress. To improve alignment, donors and the FP2020 secretariat can take the following concrete steps to support more strategic and collaborative resource allocation at the country level, building off successes and existing platforms. First, the FP2020 secretariat and donors should work with countries to strengthen the utility of their CIPs and other planning and resource allocation

documents. These are country-owned documents, with broad stakeholder involvement; donors must be careful to avoid coopting or unduly distorting countries' own planning and budgeting processes. Nonetheless, to the extent that donors and the FP2020 secretariat are already providing technical guidance and support in developing these documents, they must ensure that their support is consistent across countries and based in good practice. Specifically, we propose that technical support emphasize the following core principles for CIPs or other operational planning and budgeting documents while being careful to sustain country ownership of the process and resultant document. Goals should:

- Be ambitious but realistic for progress using modeling (particularly the appropriate use of the range of modeling tools described above, including the recently completed FP Goals model, with the addition of a budget constraint scenario);
- Be clearly prioritized under different funding scenarios; they should not be a “laundry list” of all possible interventions;
- Reflect actual funding streams and programs from donors and government;
- Be easily trackable, meaning financial gaps are easily identifiable;

- Feature an annual performance monitoring process that includes a review of existing resources, gaps, and priorities;
- Account for decentralization of financing and service delivery, where applicable; and
- Be consistent with and incorporated into other health-sector and planning documents, for example the GFF investment case.

Second, donors should take steps to improve the transparency and predictability of their own funding decisions. While most donors report to the CRS, to the International Aid Transparency Initiative (IATI), or through their own websites (or some combination of all three), the data reported in these formats are neither timely nor granular enough to support resource allocation decisions and coordination at the country level. Donors should therefore ensure that their counterparts within the country government and other donor organizations—and ideally the broader public—receive timely, detailed information about all funding decisions, including geographic scope and interventions/activities. In addition, donors should work to enhance predictability and forward planning by increasing transparency about expected resource allocations over a three- to four-year time horizon—noting caveats related to overall budget uncertainty. Finally, through active and transparent engagement in the CIP development process, donors should also ensure that their actual and planned funding streams are clearly reflected in sector-wide planning documents, enabling countries to engage in more accurate tracking and gap analysis, and better-informed prioritization. Overall, this improved transparency would enhance coordination, prevent wasteful duplication, and better facilitate an open, strategic conversation about resource allocation.

Third, donors should seek tighter coordination with each other, drawing on best practices such as the Ouagadougou Partnership. This partnership, encompassing

nine countries in West Africa, includes participation from all major technical and financial partners, including the French Development Agency and Ministry of Foreign Affairs, USAID, the Bill & Melinda Gates Foundation, the Hewlett Foundation, UNFPA, and the West African Health Organization, all of whom share full information on their respective funding and activities.<sup>58</sup> A coordination unit housed in Dakar regularly convenes donors and key stakeholders, coordinates support to countries in developing and implementing costed implementation plans, tracks progress in each country, and facilitates learning and exchange both within and beyond the partner countries.<sup>59</sup> Aspects of this approach could be replicated in other countries and/or regions with substantial multistakeholder investments. FP2020 itself has begun to convene workshops with the express intent of developing action plans to implement priorities based on CIP.<sup>60</sup>

Finally, donors should move beyond “business as usual” by adopting a more strategic approach to their own resource allocations, both across and within individual countries, and aligned with the country-owned CIPs. With support from the FP2020 secretariat, donors should regularly and collectively analyze cross-country funding trends; where such exercises suggest relative underfunding of some countries without an underlying rationale, they should consider the establishment of funding mechanisms to direct additional donor investment to the neediest areas, helping to promote equity. (According to the FP2020 secretariat, similar discussions are already taking place in the wake of three regional focal point workshops.) Regular data

58. Ouagadougou Partnership (2016).

59. Ouagadougou Partnership (2016).

60. According to Beth Schlacter, Executive Director of FP2020: “This year the FP2020 secretariat in partnership with UNFPA, USAID, and other stakeholders convened three focal point workshops that resulted in action plans to implement country FP priorities based on the CIPs or national plans. These workshops were held in Bali, Kampala, and Abidjan with focal points from 37 countries, and the secretariat is now structured to follow up with country focal points throughout the year to support implementation of agreed priority activities.”



analysis and strategic reallocation is perhaps even more important at the country-level, where funding decisions are largely made by in-country staff. In Kenya, for example, enormous disparities in family planning access persist across subnational regions, wealth quintiles, and age groups; donors should respond with due attention to allocation shifts or the mobilization of new resources that can be directed toward neglected geographic areas or to population groups with the greatest need. And in countries like Uganda, valid concerns about corruption have led donors to all but abandon the public sector. It is understandable that in such cases donors will not fund the public sector directly; even so, they should devote greater attention to strengthening public-sector management and service delivery, for example, by strengthening capacity to contract.

## 2. Create and test stronger incentives for greater cofinancing and performance.

At present, the FP2020 partnership suffers from a poor incentive environment across donors, implementing partners, country governments, and individual service providers. Donors primarily finance family planning inputs—commodities and NGO salaries/operational costs—with few explicit incentives for their grantees to improve the scale and quality of service delivery. Country governments, meanwhile, can face an explicit disincentive to maintain or increase their investments; they may (correctly) perceive that donors will cut their own contributions in response to higher country allocations or, conversely, that donors will step up to fill gaps and ensure contraceptive security/continuity of services in the face of budget cuts, creating moral hazard. Subnational governments often see little benefit to spending on family planning versus other more visible priorities; in Kenya, anecdotal reports suggest that county governments may even be explicitly encouraging population growth to increase their relative power and budgetary

allocation from the central government. And with limited resources, individual health facilities often deprioritize family planning (and other preventive care) or fail to offer appropriate counseling or method choice.

Accordingly, the FP2020 partners should test whether the introduction of incentives—financial and otherwise—can better align efforts and improve cofinancing and performance. Such incentives should be considered across multiple relationships: between donors and recipients; between multiple levels of government (e.g., national and subnational); between governments or implementing partners and individual facilities; and between civil society, service providers, and multiple levels of government. Experimentation should include both “carrots” (public praise or bonuses for outstanding service delivery and access gains) and “sticks” (penalties or publicity for poor performance). And the design of incentive programs should draw inspiration from successful programs elsewhere in the sector. In Argentina, for example, the Plan Nacer program created a structured set of incentives between the national and provincial governments, offering reward payments based in part on the extent to which provinces improved the health of mothers and young children; a rigorous evaluation showed the program was associated with a 74 percent decrease in neonatal mortality within large hospitals.<sup>61</sup> And in Nigeria, an innovative program from the Bill & Melinda Gates Foundation offered public recognition and a \$500,000 grant to the governors of states who succeed in improving routine immunization past a predefined threshold, helping to mobilize increased political will to achieve polio elimination.<sup>62</sup> Importantly, any incentives intended to improve performance must be carefully designed to ensure respect for the principles of voluntarism and informed choice, and full compliance with

61. Gertler, Giovagnoli, and Martinez (2014).

62. Solina Health (2016).

legal strictures such as the United States Tiahrt Amendment.<sup>63</sup> This has important implications for the choice of indicator(s) that should be tracked and incentivized; for example, incentives should not explicitly reward the number of new family planning users. Instead, incentives should focus on improving measures of access, service quality, and choice. For example, at the country or local level, donors could track and reward the percentage of women with accurate knowledge about family planning and/or knowledge about how to access family planning, the percentage of users who received adequate counselling on method choice and side effects, or the percentage of facilities stocked with and offering multiple method choices. And at the facility level, results-based financing programs could reimburse providers based on the range of family planning methods available or the number of family planning counseling sessions provided, adjusted by a measure of patient satisfaction—whether or not that patient ultimately decides to begin use of contraception.<sup>64</sup> Such data should also be shared publicly, empowering civil society to hold government, implementers, and service providers to account.

Donors should also test ways to increase government cofinancing and reduce the fungibility of family planning assistance. For example, donors could consider implementation of stricter cofinancing policies, particularly in middle-income countries, or matching fund schemes for commodity purchases. Gavi offers one instructive example: receipt of its support is contingent upon meeting cofinancing requirements, which start at \$0.20 per dose in low-income countries and gradually rise, ultimately reaching 100 percent as countries graduate from Gavi support. Countries that default on Gavi cofinancing requirements face a series of clearly articulated, escalating penalties, potentially

culminating in a full loss of Gavi support.<sup>65</sup> Donors could consider a similarly scaled cofinancing policy for family planning commodities, with expected contributions starting at a fixed price per couple year of protection (CYP) and gradually rising with income to reach 100 percent of the bulk purchase price. This approach would offer several potential benefits. First, donors would incentivize greater country investments in family planning, as donor funding would complement country investments in a predictable way—not substitute for country investments, as is currently the case. Second, countries would be able to undertake forward planning about their expected cost burden over time, allowing them to allocate budgets accordingly. Finally, by setting cofinancing requirements as a fixed price or proportion per CYP (versus the commodity purchase price), countries may be more inclined to invest equally in a range of contraceptive methods, counteracting the common bias against purchasing long-acting methods, which have higher up-front purchase costs but longer-term benefits.

In partnership with countries, donors could also explore innovative financing partnerships to incentivize longer-term performance and sustainability. One strategy could be that donors and country governments pay into a joint trust fund, securing investments over a longer time horizon. For example, the International Finance Facility for Immunization (IFFIm) locked in donors with legally binding funding commitments over a time horizon of up to 20 years, helping Gavi ensure a predictable long-term revenue stream.<sup>66</sup> Especially in middle-income countries, donors could also consider tying their support to the policy changes needed to ensure long-term sustainability and access, for example, inclusion of family planning in countries' universal health coverage benefit plans. As is already ongoing, donors should pair these more aggressive strategies with continued support

63. USAID (2013).

64. Eichler Seligman, Beith, and Wright (2010).

65. Gavi, the Vaccine Alliance (2016).

66. Pearson, Clarke, Ward, Grace, Harris, and Cooper (2011).



to local partners and stakeholders who can advocate for local governments to prioritize FP by providing funding and improving policies that demonstrate commitment and ownership of FP programs.

### 3. Enhance accountability and learning across the results chain.

FP2020 partners can take several concrete steps to fill the accountability deficits described in Chapter 3 and enhance learning across the results chain. Recommendations focus on improving three kinds of data: programmatic and performance data, evaluation data, and expenditure data.

First, drawing from experience elsewhere in the health sector, FP2020 funders should enhance accountability for performance among grant recipients by instituting regular independent verification of self-reported progress. Independent verification seeks to validate the self-reported results of individual grantees and to assess service readiness and quality in at least a random sample of service delivery points; it has become standard practice for many global health funders. Family planning funders can take inspiration from the constituent programs of the World Bank's Health Results Innovation Trust Fund (HRITF), which conduct robust independent verification to inform results-based payments; PEPFAR's Site Improvement through Monitoring System (SIMS), a census of supported facilities intended to ensure "that all Implementing Partners are providing services according to PEPFAR standards and fulfilling cooperative agreements [and] grants";<sup>67</sup> and the US President's Malaria Initiative's End Use Verification tool, which surveys a random sample of facilities to assess stocks, case management, and health worker capacity.<sup>68</sup>

Second, FP2020 partners should improve the generation and utilization of evidence to inform resource allocation. Contraception is clearly an efficacious technology, but little rigorous evidence is available to inform the choice and design of delivery strategies. FP2020 partners should require that at least a subset of funded programs undergo rigorous independent impact evaluations, helping the family planning community to identify the most (and least) effective and cost-effective strategies for reducing unmet need, increasing user satisfaction, empowering women and girls to make autonomous choices about contraceptive uptake, and promoting healthy birth spacing. In addition, many existing project evaluations have been withheld from the public domain; others are released informally as gray literature but remain difficult to access due to their exclusion from searchable databases or resource repositories. As a result, funders often reinvent the wheel, inadvertently replicating ineffective project design without reference to prior experience. (So-called youth corners are a frequently cited example; they remain common despite clear evidence of their ineffectiveness.)<sup>69</sup> Donors should thus take steps to increase the accessibility and dissemination of existing project evaluations, potentially by creating a shared database and requiring submission of all project evaluations to the common pool. With better evidence, and with existing evidence more accessible in the public domain, funders will be better equipped to direct their funding away from "zombie programs"—interventions that are known not to work but continue to receive funding because of political pressure or inertia, such as "youth corners" at service delivery points.

Third, FP2020 partners should sustain and build upon current efforts to improve family planning data. This also includes tracking and accountability for family planning expenditures—both by country governments and external funders—to assess the impact of

67. Birx (2016).

68. USAID, Deliver Project (2010).

69. Zuurmond, Geary, and Ross (2012).

different funding trends and scenarios at the national level. Already, UNFPA, the Kaiser Family Foundation, and the Netherlands Interdisciplinary Demographic Institute (NIDI) are working to improve tracking of countries' domestic expenditures on family planning; donors should continue to support this important work and push for its release in the public domain. FP2020 partners should also advocate for WHO to make the family planning module mandatory under its System of Health Accounts (SHA) and provide WHO with requisite resources for the module's completion.

(Family planning is currently an optional module; just two countries—Burkina Faso and the Democratic Republic of Congo—completed and publicly released the results for 2013.)<sup>70</sup> Donors should also take steps to address the problems with their own coding of family planning programs within the CRS (as described in Appendix 2), most importantly by assigning the relevant portion of broader reproductive health programs to the family planning purpose code.

70. Weinberger, Emmart, Srihari, Miller, and Studt (2015).

Area	Issue	Response & Responder
Allocation of resources across and within countries	Cross-country allocation practices have not consistently aligned funding with family planning need.	With support from the FP2020 secretariat, donors should regularly and collectively analyze cross-country funding trends; where such exercises suggest relative underfunding of some countries without an underlying rationale, they should consider the establishment of funding mechanisms to direct additional donor investment to the neediest areas, helping promote equity.
	Most CIPs set aspirational targets with no basis in rigorous modeling or historical trends.	The FP2020 secretariat and donors should work with countries to ensure that CIPs and other planning and resource allocation documents set ambitious but realistic goals for progress using modeling.
	Activities and costings laid out in most CIPs do not correspond with real-world funding levels, modes of funding, or other health-sector strategy documents.	Donors should ensure that their counterparts within the country government and other donor organizations—and ideally the broader public—receive timely, detailed information about all funding decisions, including geographic scope and interventions/activities.  Donors should ensure that their actual and planned funding streams are clearly reflected in sector-wide planning documents.  Donors should work to enhance predictability and forward planning by increasing transparency about expected resource allocations over a three- to four-year time horizon—noting caveats related to overall budget uncertainty.
	Most CIPs essentially present a “wish list” of activity categories rather than a prioritized, detailed blueprint for achieving realistic progress against family planning indicators; new donors to the family planning space struggle to identify the next activity that should be covered.	The FP2020 secretariat and donors should work with countries to ensure that CIPs are clearly prioritized under different funding scenarios, ideally using rigorous modeling; they should not be a “laundry list” of all possible interventions.  The FP2020 secretariat and donors should work with countries to ensure that CIPs are easily trackable, meaning financial gaps are easily identifiable.  The FP2020 secretariat and donors should work with countries to ensure that CIPs are consistent with and incorporated into other health sector and planning documents, for example, the GFF investment case.

(continued)

Area	Issue	Response & Responder
	Given the absence of clear, detailed guidance and prioritization on activities from within the CIP, donors largely pursue business-as-usual approaches to their own allocations based on precedent, discretion, and—to some degree—their perceived comparative advantage. These allocations are rarely based on modeling and, in some cases, are made with little reference to data and evidence.	<p>Donors should seek tighter coordination with each other, drawing on best practices such as the Ouagadougou Partnership.</p> <p>Donors should move beyond “business as usual” by adopting a more strategic approach to their own resource allocations, both across and within individual countries, and aligned with the country-owned CIPs.</p>
Creating incentives and an enabling environment for countries’ domestic investments	Donor funding has not been leveraged to increase countries’ domestic investments and may have created disincentives for country cofinancing.	<p>FP2020 partners should experiment with “carrots” (public praise or bonuses for outstanding service delivery and access gains) and “sticks” (penalties or publicity for poor performance) to improve incentives for performance and cofinancing, drawing from experience elsewhere in the health sector. Such incentives must be carefully designed to ensure respect for the principles of voluntarism and informed choice; for example, incentives should not explicitly reward the number of new family planning users but instead focus on improving measures of access, service quality, and choice.</p> <p>Donors should consider implementation of stricter cofinancing policies, particularly in middle-income countries, or matching fund schemes for commodity purchases.</p> <p>In partnership with countries, donors could also explore innovative financing partnerships to incentivize longer-term performance and sustainability.</p>
Building a strong accountability environment	<p>The family planning community is unable to hold specific investments, individuals, or institutions accountable for achieving their objectives or delivering on commitments.</p> <p>Resource allocation is hampered by a lack of rigorous and widely disseminated evidence on the most effective delivery strategies.</p>	<p>Drawing from experience elsewhere in the health sector, FP2020 funders should enhance accountability for performance among grant recipients and contractors by instituting regular independent verification of self-reported progress. FP2020 partners should require that at least a subset of funded programs undergo rigorous independent impact evaluations to help the FP community identify the most and least effective and cost-effective strategies.</p> <p>Donors should increase the accessibility and dissemination of existing project evaluations, potentially by creating a shared database and requiring submission of all project evaluations to the common pool.</p>
	Data on family planning financing—both among donors and country governments—suffers from serious limitations, hampering analysis.	<p>FP2020 partners should sustain and build upon current efforts to improve tracking and accountability for family planning expenditures by continuing to support data collection on family planning financing by UNFPA, the Kaiser Family Foundation, and NIDI, and push for the public release of their findings.</p> <p>FP2020 partners should advocate for WHO to make the family planning module mandatory under its System of Health Accounts (SHA) and provide requisite resources for the module’s completion.</p> <p>Donors should improve their coding of family planning projects within the CRS to achieve consistency between data sources and ensure family planning resources are fully accounted for.</p>

# Appendix 1.

The FP2020 goal—120 million additional users by 2020—is highly ambitious. According to documents released at the time of the summit, the goal was based on two factors: an analysis of historical change in modern contraceptive prevalence rates (mCPR) in the FP2020 focus countries and countries’ own national targets for increasing family planning access and uptake. To meet the aggregate goal, all 69 focus countries would need to increase their mCPR by an average of 1.4 percentage points per year—a rate of increase that only a quarter of focus countries had historically achieved. A majority of the 69 focus countries had previously seen rates of increase less than half a percentage point per year, and an unweighted average from the 10 most populous countries suggested that mCPR had actually been decreasing in the years prior to FP2020.<sup>71</sup> Notably, even this highly ambitious goal stopped well short of the increases implied by countries’ national plans, which would have totaled 185 million additional users between 2012 and 2020.<sup>72</sup>

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71. London Summit on Family Planning (2012).

72. Brown, Druce, Bunting, Radloff, Koroma, Gupta, Siems, Kerrigan, Kress, and Darmstadt (2014).

The current trajectory exceeds historical trends but falls short of the original ambition. The original target-setting process included a ramp-up period between 2012 and 2015 during which low performers could gradually increase their rates of progress; nonetheless, all countries—even those with the lowest historical growth rates—were expected to average at least 1.3 percentage point increases per year during that period.<sup>73</sup> According to estimates released in 2015 by FP2020, six of the 69 focus countries achieved this average annual growth rate—and these six countries were historically medium- or high-growth countries projected to achieve at least 1.8 percentage points growth per year during that period, although none did. Across all 69 countries, median annual growth was just 0.6 percentage points. In many of the largest focus countries, such as Bangladesh, Egypt, India, and Indonesia, mCPR grew 1 percentage point or less between 2012 and 2015—not surprising given the high existing prevalence rates in these countries (see Table A1.1).<sup>74</sup>

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73. Brown, Druce, Bunting, Radloff, Koroma, Gupta, Siems, Kerrigan, Kress, and Darmstadt (2014).

74. Weinberger, Emmart, Srihari, Miller, and Studt (2015).

<b>Table A1.1. Historical and Actual Growth Rates in mCPR (All Women) in Selected Countries</b>			
<b>Country</b>	<b>Estimated mCPR, 2012 (%)</b>	<b>Estimated mCPR, 2015 (%)</b>	<b>Growth Rate (Percentage Points) Per Year</b>
Mozambique	16.5	24.2	2.6
Malawi	38.8	43.2	1.5
Ethiopia	22.2	26.2	1.3
Minimum projected growth rate to reach FP2020 goal: 1.3%			
Kenya	35.4	39.1	1.2
Senegal	12.5	15.8	1.1
Kyrgyzstan	24.0	26.6	0.9
Republic of Congo	23.0	25.5	0.8
Uganda	21.0	22.6	0.5
Philippines	23.1	24.4	0.4
Indonesia	44.3	44.9	0.2
Indonesia	44.3	44.9	0.2
Egypt	53.6	53.9	0.1
Bangladesh	42.2	42.3	0.0
Vietnam	43.9	43.5	-0.1

*Source:* Weinberger, Michelle, Priya Emmart, Shipra Srihari, Nina Miller, and Erika Studt. 2015. FP2020 Commitment to Action: Measurement Annex 2015. Washington, DC: Family Planning 2020. Washington: FP2020; growth rate calculated by authors.

## Appendix 2.

We draw upon three primary data sources to analyze the distribution of family planning funds: the OECD's creditor reporting system (CRS), which catalogs flows of official development assistance; the International Aid Transparency Initiative (IATI) database; and the online grant databases provided by the Bill & Melinda Gates Foundation and the United Kingdom's Department for International Development (DFID). Together, these sources provide mostly complete data for 2004–2014, and partial information for 2015 and 2016.

However, all of this data suffers from important limitations. These limitations constrain our ability to know where family planning is allocated, whether those allocations respond rationally to different measures of family planning need, and whether they are optimally aligned to maximize progress against FP2020 objectives. For these reasons, the results and findings presented later in the chapter are best interpreted as suggestive estimates for the state of family planning financing at the FP2020 midpoint.

The first problem is in determining exactly which funds are used to support family planning programs. The CRS database includes a specific family planning purpose code; however, it also includes a separate, more general category for “reproductive and population health.” It is likely that a significant portion of family planning resources is coded under this more general category, lumped together with other investments in reproductive health, such as HIV. Indeed, some donors refuse on principle to separate family-planning-specific investments from their integrated investments in sexual

and reproductive health. And even nonfamily planning investments can help improve family planning outcomes, such as HIV prevention programs, girls' education, and investments in the health system and workforce.

Second, different data sources report family planning resource flows in different ways. The CRS database reports disbursements in a given calendar year, which typically differs from the fiscal years used by donor governments. In contrast, individual donor databases (e.g., donor websites) typically report only on planned budgets, usually in aggregate over the course of a multiyear project; where disbursements are reported, they are typically categorized and organized by fiscal year. For these reasons, data are not necessarily comparable across multiple sources. Even where data are reported in a similar format, our efforts to validate the data across different databases suggested major discrepancies in reporting.

Finally, and perhaps most importantly, the analysis in this report does not account for all resources supporting family planning programs in low- and middle-income countries, particularly the resources that country governments allocate to family planning from their own domestic budgets. These important data are not currently available for most countries, although a consortium of organizations, including the Kaiser Family Foundation, Avenir Health, the Netherlands Interdisciplinary Demographic Institute (NIDI), and UNFPA, is currently working to improve its quality, comprehensiveness, and availability. The analysis also excludes resources from some private sources, for

example, the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, and the Susan Thompson Buffett Foundation. (The latter foundation does not publicly report on its expenditures but is thought to be among the largest sources of international funding for family planning.) Last, the analysis does not include private out-of-pocket spending on

contraception. Without comprehensive data on countries' domestic expenditures and all private sources of funds, it is not possible to know the total sum of funds supporting family planning programs in any individual country or across low- and middle-income countries in aggregate.

## Appendix 3.

**Table A3.1.** DFID Centrally Allocated Programs with Family Planning Components > £1 million, in Implementation as of May 2016

Program Name	Program Description	Years	Budget for FP Component, GBP millions (USD millions)	Countries/Regions Targeted	Recipient Organization(s)
Multicountry support for increased access to reproductive health, including family planning	To ensure that a reliable supply of contraceptives and life-saving medicines is available to improve reproductive, maternal and sexual health in the poorest countries.	2013–2020	£294.6 (\$390.7)	Developing countries, unspecified	United Nations Population Fund
Family Planning 2020: Monitoring and Accountability at Global and Country Level	To deliver and meet FP2020 financial and other commitments for enabling 120 additional million girls and women to realize their rights to voluntary family planning by 2020 by holding governments and service providers to account.	2013–2020	£10.5 (\$13.9)	Developing countries, unspecified	United Nations Foundation
Health: Preventing Maternal Deaths from Unwanted Pregnancies	Reduced recourse to unsafe abortion and increased use of family planning for women (especially marginalized and young)	2011–2017	£18.6 (\$24.7)	Africa, regional, Asia, regional, Nigeria, Sierra Leone	Consortium led by Marie Stopes International and including Ipas and DKT
Newborn, Women and Children—Saving Lives through Access to Essential Health Commodities	To contribute to the Reproductive, Maternal, Newborn and Child Health Trust Fund to support high-burden countries to scale up availability and access for the essential health commodities.	2014–2016	£15.0 (\$19.9)	Developing countries, unspecified	United Nations Population Fund
Somali Health and Nutrition Programme (SHINE) 2016–2021	Improve the health of Somalis which leads to improved human development and economic development outcomes for Somalia.	2015–2021	£13.8 (\$18.3)	Somalia	Not specified
Preventing Maternal Deaths in Eastern and Southern Africa programme (PreMDESA)	To increase the availability of robust evidence and proven innovations relating to sexual and reproductive health (SRH) and the improved awareness of, access to, and uptake of family planning and SRH services across the East and Southern Africa (ESA) region, with a focus on women and adolescent girls.	2015–2018	£4.6 (\$6.1)	Africa, regional	United Nations Population Fund

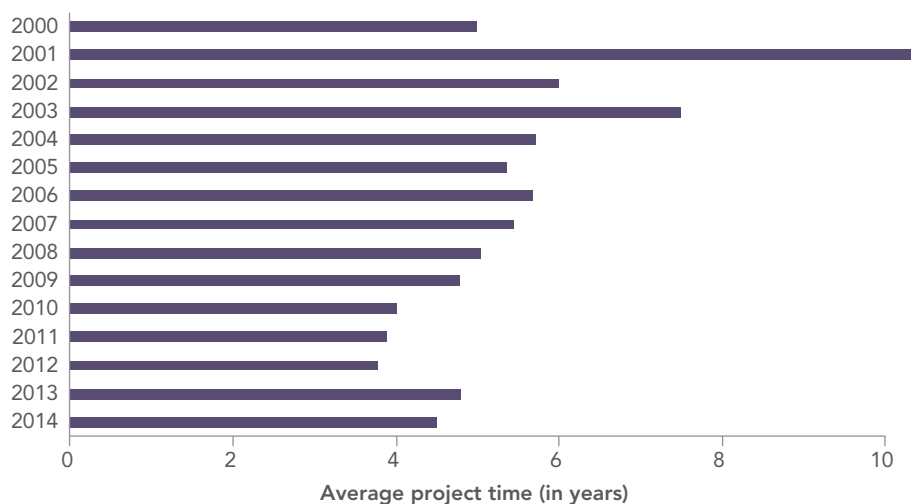
(continued)



Table A3.1. Continued					
Program Name	Program Description	Years	Budget for FP Component, GBP millions (USD millions)	Countries/Regions Targeted	Recipient Organization(s)
To update Estimates of Global Unmet Need and Costs of Providing Universal Reproductive Maternal and Neonatal Health (RMNH)	To provide evidence on the costs and benefits of meeting unmet needs for reproductive, maternal, and neonatal health and the use of the evidence-based case for increased investments and improved policies for meeting these needs in developing countries.	2012–2020	£3.9 (\$5.2)	Developing countries, unspecified	Guttmacher Institute
International Development Support Project	To engage with China on developmental issues on international poverty reduction in order to develop a shared agenda on innovative activities that expose aid practitioners to new and effective approaches to international development.	2012–2018	£1.6 (\$2.)	China	Assorted organizations

Source: Extracted from DFID Development Tracker in June 2016 and augmented following correspondence with DFID staff. US dollar values calculated by authors using the exchange rate as of September 12, 2016.

**Figure A3.1.** Contract Length for USAID Family Planning Projects by Year of Initiation, 2000–2014



Source: USAID. N.D. Foreign aid explorer. Accessed June 13, 2016.

**Table A3.2.** Largest FP Investments from the Bill & Melinda Gates Foundation, Commitments 2012–2015

Grantee	Purpose	Total Amount (\$)	Years
International Bank for Reconstruction and Development	To contribute to the Global Financing Facility (GFF) in Support of Every Woman, Every Child	75,000,000	2015–2020
CARE	To support the Bihar government in accelerating progress toward achieving maternal, newborn, and child mortality reduction goals; improving nutrition and family planning outcomes; and improving coverage, quality, and equity of health services	47,152,599	2013–2018
The University of Manitoba	To reduce the adverse health and development outcomes to families, mothers, newborns, and children by achieving high reach, coverage, and quality of effective interventions and services for health (maternal, neonatal, and child health; family planning and nutrition in communities and at health facilities); and agriculture and financial inclusion	45,240,209	2013–2018
Johns Hopkins University	To sustain resources for quality family planning programs, contribute to universal access to reproductive health services, Millennium Development Goal 5b, and the vision of the London Summit on Family Planning	43,572,727	2012–2018
Johns Hopkins University	To promote accountability	40,099,124	2013–2018
Family Health International	To support a clinical trial comparing HIV incidence and contraceptive benefits in women using three family planning methods in four sub-Saharan African countries	26,999,993	2015–2019
Family Health International	To develop and introduce, through a strong focus on global partnerships, new and strategically important contraceptives to provide quality affordable and acceptable products for those most in need	22,504,065	2013–2018
JSI Research & Training Institute, Inc.	To contribute toward sustainably improving health practices within communities and the primary-level health-care system through the application of innovative solutions that are informed by evidence-based best practices	21,959,315	2015–2019
Johns Hopkins University	To eliminate supply and demand barriers to family planning in order to increase contraceptive use in Nigeria	18,000,000	2015–2018
Avenir Health, Inc.	To build essential capacity to enable global and country-level annual reporting of contraceptive use and related estimates in a standard and systematic manner, building accountability platforms, and tracking FP2020 resources and commitments	15,692,825	2013–2018
Population Services International	To meet the contraceptive needs of adolescents aged 15–19 by using a user-centered design and youth-driven approach in the three project countries of Ethiopia, Nigeria, and Tanzania	15,000,000	2015–2019

Source: Extracted June 2016 from <http://www.gatesfoundation.org/How-We-Work/Quick-Links/Grants-Database>.

# Notes

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**Table 2.1**

- a. The CRS data categorizes this funding as “South of Sahara”; USAID has clarified that these funds are for West Africa Regional programs. We defer here to their internal categorization.
- b. Iraq family planning programs are funded from Economic Support Funds (ESF), a separate funding basket that does not use FP need as a criterion.
- c. DFID support to India was discontinued in 2015.

**Table 2.2**

- a. DFID support to India was discontinued in 2015.

**Box 3.1**

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