

# Transitions in Family Planning:

Challenges, Risks, and Opportunities Associated with Upcoming Declines in Donor Health Aid to Middle-Income Countries



Pharos  
Global Health  
Advisors





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# Preface

The world of donor aid for health is rapidly changing and will continue to evolve in the coming years, especially in middle-income countries. Donors are reducing their technical and financial support for a range of health issues including HIV, tuberculosis, malaria, and immunization, while at the same time middle-income countries are striving to invest more to preserve the gains they have made against major infectious diseases and to go further to expand coverage and impact.

This situation creates a series of acute sustainability challenges for middle-income countries as they approach transition from donor aid. Are country governments ready to take over the financial and technical leadership of these donor-backed programs? Do they have the fiscal capacity to mobilize the additional billions of dollars required to replace donor resources? Do they possess the institutions and the political leadership that will be needed? Will they assume responsibility for donor-sponsored health services directed toward politically-sensitive vulnerable and stigmatized population groups? And where does family planning, which receives US\$1.3 billion in annual donor funding, fit into this sustainability and transition landscape?

We undertook this study, sponsored by the Center for Global Development with funding from the Bill and Melinda Gates Foundation, because we were concerned that transitions in family planning might be relatively neglected by middle-income countries and donors. Our report, one of the very few to date to examine the challenges of impending transitions in family planning, bears out our initial hypothesis. Our global landscaping and case studies of Ghana, Kenya, and Bangladesh document serious impending sustainability challenges in family planning for middle-income countries and provide a set of recommended actions for country governments and their donor partners to address these challenges.

This study builds upon Pharos Global Health's leadership in health transitions and sustainability. Pharos has conducted more than a dozen country studies in Latin America, Asia, and Africa and has published a wide range of global syntheses, academic papers, and blogs on this topic. We encourage you to go to our website, [pharosglobalhealth.com](http://pharosglobalhealth.com), to access these materials.

We hope that this report catalyzes the family planning community—from local officials to global experts—to rigorously and systematically assess and plan for the sustainability and transition challenges that middle-income countries' national family planning programs will face in the coming decade. As we look to 2030, sustainability in family planning is more essential than ever to secure the health, well-being, and empowerment of millions of women, girls, and their families worldwide.



A handwritten signature in black ink, appearing to read 'R Hecht'.

Robert Hecht, President  
Pharos Global Health Advisors



# Authors & Acknowledgements

This report was prepared for the Center for Global Development (CGD) by Devyn Rigsby, Gabrielle Appleford, and Robert Hecht of Pharos Global Health Advisors. The authors thank Janeen Madan Keller, Cassandra Nemzoff, Felice Apter, Julia Kaufman, Kalipso Chalkidou, Amanda Glassman, Hannah Rees, and Cynthia Eldridge for their valuable feedback throughout the preparation of this report. Special thanks also to all interviewees who shared their time and insights for this report. Pharos and CGD are grateful to the Bill & Melinda Gates Foundation for their financial support of this research. All errors and omissions are our own.

This report design was prepared by Regina Miles of Studio RM, Inc. The photo on the cover of this report depicts a mother and her son in outside their home in the village of Srimangal, located in the Sylhet Division of Bangladesh. It was taken in February 2013.



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# Abbreviations

<b>AIDS</b>	Acquired immunodeficiency syndrome	<b>DP</b>	Development Partner
<b>ART</b>	Anti-retroviral therapy	<b>DQA</b>	Data quality audit
<b>AW</b>	All women	<b>DRC</b>	Democratic Republic of the Congo
<b>BCC</b>	Behavioral change communication	<b>DRM</b>	Domestic resource mobilization
<b>BDHS</b>	Bangladesh Demographic and Health Survey	<b>ECA</b>	Europe and Central Asia
<b>BMGF</b>	Bill & Melinda Gates Foundation	<b>eLMIS</b>	Electronic logistics management information system
<b>BTL</b>	Bilateral tubal ligation	<b>EMMS</b>	Essential medicines and medical supplies
<b>CCM</b>	Country Coordinating Mechanism	<b>ESP</b>	Essential Service Package
<b>CDoH</b>	County Department of Health	<b>EU</b>	European Union
<b>CGD</b>	Center for Global Development	<b>FFS</b>	Fee-for-service
<b>CHAG</b>	Christian Health Association of Ghana	<b>FP</b>	Family planning
<b>CHAI</b>	Clinton Health Access Initiative	<b>FP2020</b>	Family Planning 2020
<b>CHPS</b>	Community-Based Health Planning and Services	<b>FPSA</b>	Family Planning Spending Assessment
<b>CIFF</b>	Children's Investment Fund Foundation	<b>FWV</b>	Family Welfare Visitor
<b>CIP</b>	Costed Implementation Plan	<b>FY</b>	Fiscal year
<b>CSO</b>	Civil society organization	<b>GDHS</b>	Ghana Demographic and Health Survey
<b>CYP</b>	Couple-year of protection	<b>GDP</b>	Gross domestic product
<b>DAH</b>	Development assistance for health	<b>GF</b>	Global Fund
<b>DFID</b>	Department for International Development (U.K.)	<b>GFF</b>	Global Financing Facility
<b>DGFP</b>	Directorate General of Family Planning	<b>GHE</b>	Government health expenditure
<b>DGHS</b>	Directorate General of Health Services	<b>GHED</b>	Global Health Expenditure Database (WHO)
<b>DHS2</b>	District Health Information System 2	<b>GHS</b>	Ghana Health Service
<b>DHS</b>	Demographic and Health Survey	<b>GNI</b>	Gross national income
<b>DMPA-SC</b>	Subcutaneously administered depot-medroxyprogesterone acetate (Sayana Press)	<b>GoB</b>	Government of Bangladesh
		<b>GoG</b>	Government of Ghana
		<b>GoK</b>	Government of Kenya

<b>HIV</b>	Human immunodeficiency virus	<b>MoLGRDC</b>	Ministry of Local Government, Rural Development, and Cooperatives
<b>HMIS</b>	Health Management Information System	<b>MR</b>	Menstrual regulation
<b>HPV</b>	Human Papillomavirus	<b>MRM</b>	Menstrual regulation with medication
<b>HR</b>	Human resources	<b>MSB</b>	Marie Stopes Bangladesh
<b>HSS</b>	Health systems strengthening	<b>MSI</b>	Marie Stopes International
<b>HSSP</b>	Health Sector Support Program	<b>MW</b>	Married women
<b>HTA</b>	Health technology assessment	<b>NACC</b>	National AIDS Control Council
<b>ICC-CS</b>	Interagency Coordinating Committee for Contraceptive Security	<b>NASA</b>	National AIDS Spending Assessment
<b>IDA</b>	International Development Association	<b>NCD</b>	Non-communicable disease
<b>IEC</b>	Information, education, and communication	<b>NGO</b>	Non-governmental organization
<b>IHME</b>	Institute for Health Metrics and Evaluation (Washington, U.S.)	<b>NHA</b>	National Health Accounts (WHO)
<b>IPPF</b>	International Planned Parenthood Federation	<b>NHIA</b>	National Health Insurance Authority
<b>IUD</b>	Intra-uterine device	<b>NHIF</b>	National Hospital Insurance Fund
<b>JICA</b>	Japan International Cooperation Agency	<b>NHIS</b>	National Health Insurance Scheme
<b>JSI</b>	John Snow, Inc.	<b>NIDI</b>	Netherlands Interdisciplinary Demographic Institute
<b>KEMSA</b>	Kenya Medical Supplies Authority	<b>NPC</b>	National Population Council
<b>KES</b>	Kenyan shillings	<b>OBA</b>	Output-based aid
<b>KfW</b>	Kreditanstalt für Wiederaufbau (German Development Bank)	<b>OOP</b>	Out-of-pocket
<b>KOFIH</b>	Korea Foundation for International Healthcare	<b>OPM</b>	Oxford Policy Management
<b>LAC</b>	Latin America & Caribbean	<b>OPRH</b>	Office of Population and Reproductive Health
<b>LAPM</b>	Long-acting and permanent method	<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief (U.S.)
<b>LARC</b>	Long-acting reversible contraceptive	<b>PFM</b>	Public financial management
<b>LMIC</b>	Low- and middle-income countries	<b>PHC</b>	Primary health care
<b>LMIS</b>	Logistics management information system	<b>PMI</b>	President's Malaria Initiative (U.S.)
<b>LSO</b>	Logistics Support Officer	<b>PPAG</b>	Planned Parenthood Association of Ghana
<b>M&amp;E</b>	Monitoring & evaluation	<b>PPFP</b>	Postpartum family planning
<b>MC</b>	Male condom	<b>PSI</b>	Population Services International
<b>MCH</b>	Maternal and child health	<b>PSM</b>	Procurement and Supply Chain Management
<b>mCPR</b>	Modern contraceptive prevalence rate	<b>R4D</b>	Results for Development
<b>MDG</b>	Millennium Development Goal	<b>RH</b>	Reproductive health
<b>MEDS</b>	Mission for Essential Drugs and Supplies	<b>RHSC</b>	Reproductive Health Supplies Coalition
<b>MENA</b>	Middle East and North Africa	<b>RMHSU</b>	Reproductive and Maternal Health Services Unit
<b>MoH</b>	Ministry of Health	<b>RMNCAH</b>	Reproductive, maternal, newborn, child, and adolescent health
<b>MoHFW</b>	Ministry of Health and Family Welfare		

<b>SBS</b>	Sector budget support	<b>TMA</b>	Total market approach
<b>SDG</b>	Sustainable Development Goal	<b>TWG</b>	Technical working group
<b>SDM</b>	Standard Days Method	<b>UHC</b>	Universal health coverage
<b>SIAPS</b>	Systems for Improved Access to Pharmaceuticals and Services	<b>UN</b>	United Nations
<b>SMC</b>	Social Marketing Company	<b>UNFPA</b>	United Nations Population Fund
<b>SRH</b>	Sexual and reproductive health	<b>UNPD</b>	United Nations Population Division
<b>SWAp</b>	Sector-wide approach	<b>UPHCSDP</b>	Urban Primary Healthcare Services Delivery Project
<b>TA</b>	Technical assistance	<b>USAID</b>	U.S. Agency for International Development
<b>TB</b>	Tuberculosis	<b>USD</b>	U.S. dollars
<b>TFR</b>	Total fertility rate	<b>WAHO</b>	West African Health Organization
<b>THE</b>	Total Health Expenditure	<b>WB</b>	World Bank
<b>THS-UC</b>	Transforming Health Systems for Universal Coverage	<b>WHO</b>	World Health Organization
		<b>WRA</b>	Women of reproductive age



# Executive Summary

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## The FP Transition Challenge

Transition from donor aid—the process of countries shifting from dependence on outside funding and other technical assistance towards greater domestic self-sufficiency in financing and program stewardship—is a defining feature of the current global health landscape. Health transitions are occurring across a variety of donor-backed health programs, including in HIV, tuberculosis, malaria, immunization, and family planning. The roughly US \$39 billion in annual development assistance for health—including investments from major donors such as Gavi, the Global Fund, the US, the UK, and others<sup>1</sup>—is shifting from middle-income countries to the poorest nations with the highest burdens of disease. Gavi has graduated over a dozen nations from immunization support since 2014; 11 countries are expected to transition from Global Fund assistance in 2020, with 11 more by 2025; and USAID has graduated 24 nations from family planning aid. As countries see their outside funding decline, they face major challenges in financing and sustaining crucial health initiatives with their own resources. If donor funds and technical assistance are not adequately replaced, coverage of vital services for the millions of people relying on these health programs may fall.

Simultaneous declines in aid for multiple health programs—when donors pull back at the same time in several health areas such as HIV and immunization—pose particularly difficult challenges to middle-income country governments because of the competing financial, programmatic, and political pressures associated

with each transition. The complexities of multiple aid transitions are compounded by limited fiscal space for health, rising levels of international debt, limited health governance capacity, and sometimes conflicting development priorities and policy commitments.<sup>2</sup>

This report assesses the impact of simultaneous health transitions upon the sustainability and success of family planning (FP) programs in middle-income countries. Universal access to family planning is critical to the achievement of multiple Sustainable Development Goals, including those relating to women's and children's health, gender equality, and the improvement of women's economic opportunities.<sup>3</sup> Because of its benefits both within and beyond the health sector, FP has been a major focus area of international health aid for decades; donors currently contribute about US \$1.5 billion annually to FP programs.<sup>4</sup>

However, transition in family planning may be on the near- to medium-term horizon for a number of middle-income nations, especially for a group of approximately 20 lower-middle-income countries. In these countries, demand for contraception is increasing while donor assistance for FP is on the decline. At the same time, domestic co-financing for other donor-backed health programs is on the rise. Governments and their development partners must plan strategically to sustain equitable, affordable, and high-quality FP programs in the face of demographic, fiscal, political, and programmatic pressures associated with health transition.

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<sup>1</sup> IHME (2019). Financing Global Health 2018: Countries and Programs in Transition. IHME, Seattle, WA, USA.

<sup>2</sup> Yamey, G., Gonzalez, D., Bharali, I., Flanagan, K., & Hecht, R. (2018). Transitioning from foreign aid: is the next cohort of graduating countries ready? Duke University Center for Policy Impact in Global Health.

<sup>3</sup> See: <https://www.cgdev.org/sites/default/files/reproductive-choices-life-chances-new-and-existing-evidence-impact-contraception-women.pdf>

<sup>4</sup> Wexler, A., Kates, J., & Lief, E. (2019). Donor Government Funding for Family Planning in 2018. Kaiser Family Foundation.

## Study Purpose and Approach

The purposes of this study are to: (a) identify specific challenges to FP program sustainability in the context of competing fiscal and programmatic pressures across the health sector; (b) offer forward-looking, practical options for national stakeholders to manage risks associated with competing pressures of multiple upcoming health transitions; and (c) propose practical recommendations for donors to allocate resources and share responsibilities more effectively and transparently in preparation for FP program transition.

As part of the study, we reviewed the transition literature for FP and other health programs and interviewed over a dozen global FP leaders and experts (see Annex 1: Institutions Represented and Individuals Interviewed for this Report). We found that, in contrast to other major donor-backed health programs such as HIV, where considerable work has been done to analyze country transition risks and responses, there is no broadly accepted framework to assess FP transitions, and limited national assessment work has been carried out. We therefore developed and applied an analytical framework based on four dimensions of FP transition:

- 1. Financing for FP and Other Health Programs:** We assessed fiscal space, health and FP financing sources, and projected resource requirements in the context of simultaneous transitions and national health reforms including the pursuit of universal health coverage (UHC).
- 2. Procurement and Supply Chain:** We evaluated domestic capacity and mechanisms for forecasting, procurement, warehousing, and distribution of FP and other health commodities, and we identified strategies for the effective transfer of procurement and supply management to national governments.

- 3. Technical Capacity:** We examined technical assistance (TA) provided by donors to FP and other health programs in areas such as training, research and surveys, monitoring and evaluation, and quality assurance, and we proposed measures to smooth the transfer of donor-backed TA activities to national institutions.

- 4. Enabling Factors: Political Commitment to FP and Legal & Human Rights:** We reviewed national policies and laws related to FP, domestic political commitment to FP goals, and the links between FP and other development and human rights goals, which contribute to an enabling environment for individuals to access contraception.

Using data for over 25 macroeconomic, health, and FP indicators, we examined the global health and FP transitions landscape and assigned 80 low- and middle-income countries (LMICs) to one of three groups: 35 countries with high donor dependency and low likelihood of FP transition in the coming years, and thus facing few transition risks in the short to medium term; 23 countries with low donor dependency and higher per capita gross national income (GNI) and health spending, where FP and other transition is ongoing or near completion and unlikely to be very risky; and, most importantly, a group of 22 countries with moderate incomes and higher donor dependency that are facing a drawdown of donor support in the next 5-10 years, resulting in significant transition risks for FP and other health programs. Table ES.1 provides unweighted medians and ranges for six relevant FP, health, and financing indicators across the three transition categories.

**TABLE ES.1: Three country categories for FP transition risk: unweighted median and range values for six indicators**

Country Transition Category	GNI per Capita (USD)  Source: World Bank, Atlas Method (2017)	Total Fertility Rate  World Bank (2017)	Modern Contraceptive Prevalence Rate  FP2020 Annual Report (2018) & World Bank (since 2012)	Percent Unmet Contraceptive Need  FP2020 Annual Report (retrieved 2019; various years)	Share of HIV Spending from Donors  UNAIDS GAM (retrieved 2019)	Donor Expenditure on FP per WRA (USD)  IHME (2017); UN World Population Prospects (2015)
<b>Long-term, low-priority transition (n=35)</b>	<b>680</b> (280–2100)	<b>4.70</b> (2.87–7.18)	<b>19.80</b> (2.74–46.60)	<b>28.10</b> (18.30–39.80)	<b>90.5%</b> (41.3–100.0%)	<b>1.21</b> (0.02–8.37)
<b>Medium-term, higher-risk transition (n=22)</b>	<b>1525</b> (800–3570)	<b>3.23</b> (1.95–5.62)	<b>31.79</b> (2.74–65.50)	<b>24.95</b> (9.90 – 36.92)	<b>81.2%</b> (39.1–95.6%)	<b>0.73</b> (0.00–4.01)
<b>Short- to medium-term, lower-risk transition (n=23)</b>	<b>3540</b> (1790–5430)	<b>2.34</b> (1.23–4.31)	<b>45.51</b> (25.75–68.00)	<b>18.72</b> (8.54–35.30)	<b>46.1%</b> (1.8–95.7%)	<b>0.03</b> (0.00–3.58)

We then applied our analytical framework and findings from the global landscape to three country cases: Ghana, Kenya, and Bangladesh. These nations were selected because they come from the group of countries where FP transition is imminent and will likely pose significant difficulties, and because these countries illustrate the heterogeneity of transition circumstances and challenges facing this cohort. Table ES.2 below captures some of the key indicators and features of the three case study countries in relation to FP transition.

For each case study country, we conducted a literature review and interviewed experts from government, donor agencies, and non-governmental agencies (NGOs) during field visits to Ghana and Kenya and remotely for Bangladesh. We collected qualitative and quantitative data from national strategic plans, financial models and records, and health program performance reports. We synthesized our findings and identified key risks and recommendations for the three countries to manage their upcoming FP transitions.



**TABLE ES.2: Transition characteristics of the three case study countries**

	Ghana	Kenya	Bangladesh
<b>Economic and Demographic Indicators</b>			
Gross National Income per Capita	\$1,880	\$1,460	\$1,470
Women of Reproductive Age (millions)	6.9	12.1	43.5
Annual Population Growth Rate	2.19%	2.31%	1.05%
<b>Quantitative Family Planning Indicators</b>			
Modern Contraceptive Prevalence Rate	22.1%	42.7%	45.5%
Total Fertility Rate	3.93	3.79	2.08
Unmet Contraceptive Need	33.6%	20.3%	19.1%
% LAPM Methods <sup>5</sup> within Total Contraceptive Method Mix	32%	36%	15%
Donor Expenditure on FP per Woman of Reproductive Age	\$1.37	\$4.01	\$0.75
% Donor Contribution to FP Commodities	90%	51%	4%
<b>Qualitative Family Planning Indicators<sup>6</sup></b>			
Donor Involvement in Procurement & Supply TA	Strong	Moderate	Moderate
Donor Support for Enabling Environment	Strong	Strong	Strong
Political Commitment to FP	Weaker	Moderate	Strong
FP Participation in Health Transition Planning	Minimal	Minimal	Minimal
<b>Other Health Transition Indicators</b>			
% HIV Spending from Donors	63%	63%	96%
% Tuberculosis Spending from Donors	76%	52%	84%
% Malaria Spending from Donors	44%	53%	77%
% Immunization Spending from Donors	65%	77%	73%

**Sources:** World Bank, UN World Population Prospects, FP2020/Track20, IHME, UNAIDS, WHO, Ghana CIP, and Kenya CIP (See Annex 2)

<sup>5</sup> LAPMs (long-acting and permanent methods) include sterilizations, IUDs, and implants, according to FP2020.

<sup>6</sup> Categories are rated on a scale of: Minimal/Weaker; Moderate; Strong. Ratings are the authors'.

## Key Findings and Recommendations

### Global FP Transition Landscape

- **There is a group of middle-income countries under special threat from impending transition in FP and other health areas.** These countries have moderate national incomes (in the \$1500-3000 per capita GNI range), have made some progress towards contraceptive coverage goals, and are significantly dependent on donors for funding and technical assistance across a variety of health programs. Ghana, Kenya, Bangladesh are members of this at-risk group. Others include Angola, Congo Republic, Kyrgyz Republic, Vietnam, and Zambia (Table 3.4 shows the full list of countries).
- **The FP transition risks facing these countries are exacerbated by fiscal pressures caused by concurrent transitions for other global health programs.** Domestic “co-financing obligations” may increase by US \$5-10 million or more per year for each donor-supported health program, such as immunization and HIV.<sup>7</sup>
- **In the “high risk” FP transition cohort of 22 countries, there appears to be relatively less awareness and/or prioritization of this issue among most government officials and donors involved in family planning, as compared to other diseases.** As a result, FP is lagging behind other major health areas, such as HIV, tuberculosis (TB), malaria, and immunization, in terms of transition preparation.
- **Ghana’s FP indicators and FP governance capacity are weaker compared with its cohort of middle-income peers;** its unmet contraceptive need of 33.6% exceeds its modern contraceptive prevalence rate (mCPR) of 22.1%, though its method mix is relatively balanced with long-acting and permanent methods constituting about one-third of the mix.<sup>8</sup> Until 2018, the Government of Ghana did not fund FP commodities, and currently the country only pays for about 10% of the roughly \$10 million spent annually on contraceptives.<sup>9</sup> USAID and UNFPA are heavily involved in procurement and supply chain management in Ghana; donors manage commodity procurement and distribution, and support forecasting, and technical assistance.
- **Validated FP expenditure data is not available for Ghana.** In contrast to Kenya and Bangladesh, Ghana has not completed a comprehensive Family Planning Spending Assessment (FPSA), so it is not possible to assess or monitor the country’s progress towards self-financing.
- **Interviewees from Ghana’s government, partners, and civil society appeared to be the least concerned about the risks and consequences of FP transition.** This attitude may result from a lower prioritization of the transition challenge in Ghana, in part because the government and partners view full FP transition as a distant event. Ghana’s FP stakeholders and partners have not yet begun to develop a transition strategy, in contrast to other large donor-backed health programs in the country such as immunization for which transition assessments have been carried out.
- **Like Kenya and Bangladesh, Ghana faces growing fiscal pressures in health because of increasing co-financing obligations for other major programs.** By 2025, the government’s total co-

### Ghana

Of the three case study countries, Ghana is the least advanced on the FP transition continuum. Ghana has expressed its ambition to become self-reliant from donor assistance, an important first step in the transition process. However, the government has not developed concrete plans to achieve this goal in the health sector or for FP specifically.

<sup>7</sup> See, e.g.: MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future; and Gavi, 2019. Key Information on Co-financing for Bangladesh. <https://www.gavi.org/sites/default/files/document/co-financing-information-sheet-bangladeshpdf.pdf>

<sup>8</sup> FP2020, 2018. Core Indicators. FP2020 Data Dashboard. <http://www.familyplanning2020.org/data-dashboard>

<sup>9</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

financing requirements to Gavi, the Global Fund, and PEPFAR are estimated to reach US \$350 million—equal to 70% of all domestic expenditures for health in 2016.<sup>10</sup> As these fiscal obligations accumulate, they could put family planning funding at serious risk. The large infectious disease programs are also vying for inclusion in Ghana's National Health Insurance Scheme (NHIS) alongside FP. NHIS funds for FP and other primary health services may be crowded out by these competing demands, especially since the HIV, malaria, and immunization programs have strong lobbies inside the country and in the donor capitals.

To address these FP transition challenges, our report proposes several actions that Ghana and its donor partners can take, including:

- Introducing a national FP budget line and conducting FP expenditure monitoring along the lines of the Family Planning Spending Assessments being carried out in other countries;
- Developing and enforcing FP commodity co-financing requirements to ensure sustained domestic investment in FP;
- Reaching an agreement among FP stakeholders on a timeline for transitioning procurement and supply management responsibilities from donors to the government;
- Using health technology assessment more systematically to evaluate the inclusion of FP services in the NHIS benefits package;
- Developing a comprehensive health sector-wide transition strategy with input from government and partners in all major health programs, including FP; and
- Advocating for greater domestic family planning investment with senior health and financing officials by presenting the results of impact and “rate of return” modeling.

## Kenya

Kenya was at one time a leader in domestic financing and management of FP programs: the government introduced a national FP commodities budget line in 2004/05 and financed about half of all FP commodities by 2012/13.<sup>11</sup> Long-acting and permanent methods comprise over one-third of the national method mix, and this share is growing.<sup>12</sup> The national government continues to recognize and promote rights-based FP discourse. FP commodities are procured, stored, and delivered through the government-run KEMSA supply chain; unlike in Ghana, partners in Kenya provide only limited TA for these activities.

- **Devolution of power from the national government to Kenya's 47 counties in 2013 has reversed much of this earlier progress towards self-reliance in FP.** Devolution exacerbated existing regional inequalities in FP access and outcomes: while the national mCPR is 45% (all women) and unmet need is 17% (married women), some regions have mCPRs as low as 2%.<sup>13</sup> Donor TA is also concentrated in certain counties while others are poorly covered.
- **Due to a shortage of FP funding from both domestic and external sources, Kenya now faces an FP commodity crisis, with two-thirds of commodity resource needs unfunded in 2019/20.**<sup>14</sup> Domestic financing of FP commodities has decreased as counties have failed to allocate their funds to FP programs; forecasting has missed the mark because of lack of quality county-level data; and stock-outs have increasingly occurred as KEMSA refuses to distribute FP commodities to counties that have accumulated large arrears. Donors continue to supply the majority of FP program funds, with the latest FPSA showing that three-quarters of all FP spending is coming from outside sources.<sup>15</sup> Donors and the government are now developing a matching funds plan to prevent looming nationwide stock-outs and to try to return Kenya to a path towards FP sustainability and self-reliance.

<sup>10</sup> Ibid.

<sup>11</sup> FP Quantification Technical Reports, 2010-2018.

<sup>12</sup> Government of Kenya, Ministry of Health, 2017. National Family Planning Costed Implementation Plan 2017-2020. Nairobi, Kenya.

<sup>13</sup> FP2020, 2018. Core Indicators. FP2020 Data Dashboard. <http://www.familyplanning2020.org/data-dashboard>

<sup>14</sup> CHAI, 2019. Kenya FP Commodity Funding Gap Analysis 2018-2021, May 2019.

<sup>15</sup> Korir, J. and U. Kioko, 2017. Family Planning Spending Assessment FY 2014/15 – 2015/16. Center for Economic and Social Research, Nairobi, Kenya.

- **More than in the other two case study countries, health transition is recognized in Kenya as a high-priority issue**, with informants expressing concern about upcoming fiscal obligations in the health sector. Kenya still relies heavily on donor funds for multiple health programs—as of 2017, donors funded 63% of Kenya’s HIV program, for example<sup>16</sup>—yet the Global Fund and PEPFAR are actively assessing Kenya’s readiness for increased domestic funding on the path to transition. The large and increasing domestic co-financing requirements of these infectious disease programs could threaten the government’s ambitions to achieve universal access to FP and other primary health services through UHC, since HIV, TB, and malaria care currently require more resources than are available in the entire health insurance budget. The HIV program alone is estimated to absorb about US \$700 million per year, compared to the 2018 UHC budget of US \$352 million.<sup>17</sup>
- **Kenya’s National AIDS Control Council has established a technical working group to plan for transitions holistically across the health sector**, placing Kenya ahead of Ghana and Bangladesh in this regard. However, the FP program is not currently represented in this working group and thus has no voice in sector-wide transition discussions.
- Naming an FP representative to the national health transitions technical working group hosted by the National AIDS Control Council;
- Incorporating a robust mix of FP services in the national health insurance benefits package, drawing on evidence of FP demand and cost-effectiveness; and
- Improving equity in FP access across counties and among the underserved through better allocation of donor TA and the use of public-private partnerships (i.e., contracts between government and NGOs to deliver FP services in hard-to-reach situations).

### Bangladesh

Of the three case study countries, Bangladesh is most advanced along the FP transition continuum and is furthest on its way to self-reliance in FP. The government is currently funding two-thirds of annual FP program costs, including 96% of all commodities.<sup>18</sup> Like Kenya, Bangladesh manages its own national procurement and supply chain for FP with limited external TA. Due to strong, decades-long political commitment to lowering national fertility, the Bangladesh FP program has received significant prioritization and resources within the health sector.

- **However, as Bangladesh’s fertility rate reaches near-replacement levels, political will to address other longstanding programmatic challenges related to the FP enabling environment is starting to wane.** Under the current Bangladesh FP program, key vulnerable groups such as adolescents and rural and poor women lack sufficient access to FP; the Government of Bangladesh estimates that less than half of married adolescents can access FP, for example.<sup>19</sup>
- **National procurement decisions and a lack of skilled FP providers limit access to effective contraceptives in Bangladesh.** Bangladesh’s Directorate General of Family Planning has struggled to recruit and retain an adequate number of trained workers to staff FP facilities.

To address these challenges, our report offers several actions that Kenya and its donor partners can take, including:

- Re-establishing and funding a national FP budget line according to agreed-upon co-financing arrangements with donors, starting with cost-sharing between government and partners for FP commodities;
- Rebalancing the distribution of FP planning and program management responsibility between county and national levels, so that the national institutions play a larger role;

<sup>16</sup> UNAIDS, 2018. AIDSinfo: Kenya. Global AIDS Monitoring. <http://aidsinfo.unaids.org/>

<sup>17</sup> Chaitkin, M., O’Connell, M., and Githinji, J., 2017. Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Kenya. Washington, DC: Results for Development.

<sup>18</sup> Hamid, S.A., et al., 2016. Bangladesh Family Planning Spending Assessment (FPSA). Dhaka: Institute of Health Economics.

<sup>19</sup> See: <https://www.thedailystar.net/news/contraceptive-use-among-married-adolescent-girls>

Additionally, due to legal restrictions and government procurement decisions, the available method mix is skewed towards less effective short-term contraceptives. Long-acting and permanent methods (LAPMs) comprise only 15% of the Bangladesh method mix, as opposed to 32% and 36% in Ghana and Kenya, respectively.<sup>20</sup> This lack of access to effective contraception has resulted in high rates of unintended pregnancy (50%) and recourse to abortion, including unsafe abortion.<sup>21</sup>

- **While Bangladesh's basic FP procurement and distribution systems are relatively well prepared for transition, it is not clear that the government is willing to fund and manage the other complementary activities** that are crucial for expanding and sustaining the FP program's historic success. Because of the programmatic weaknesses mentioned above, donors in Bangladesh continue to provide funding and TA for FP enabling environment activities, education, program monitoring, research, quality assurance, interventions for key populations, and staff training. Informants' greatest worry as they contemplated donor withdrawal was the risk of seeing these enabling activities decline.
- **Bangladesh's long-term FP program sustainability is threatened by the looming decreases in donor funding in other parts of the health sector.** Major health programs in Bangladesh are heavily reliant on external funding. Transitions in these areas will put strong pressures on the government health budget, potentially impacting FP. For example, Gavi funded 73% of all routine immunization expenses and granted US \$93 million for immunization systems strengthening for the period 2019-2022, yet Bangladesh is scheduled to see its Gavi support end in 2026.<sup>22</sup> External funds account for 96% of HIV spending, 84% of tuberculosis spending, and 77% of malaria spending.<sup>23</sup>

Bangladesh informants were not aware of any sector-wide efforts to prepare for simultaneous increase in domestic financing requirements for these programs, including FP.

To address these challenges, our report highlights several actions for Bangladesh and its donor partners, including:

- Implementing social contracting mechanisms between NGOs and the Bangladesh Ministry of Health and Family Welfare to transfer funding responsibility for NGO-led FP TA and enabling activities from donors to the government;
- Developing a consensus-based plan for transferring funding for FP monitoring, supply chain, and quality assurance TA from donors to the government;
- Ensuring that evidence for supporting a robust contraceptive method mix (including LAPMs) in any emerging UHC scheme is fully presented to decision-makers;
- Rebuilding the training pipeline for skilled FP (especially LAPM) providers to fill vacancies in the national health system; and
- Establishing a health sector-wide transition working group with representatives from all major donor-backed health programs including family planning. Given the strength of FP in Bangladesh, FP leaders could potentially initiate and host this working group, as the National AIDS Control Council has done in Kenya.

### Cross-Cutting Recommendations

In addition to the specific proposals for the three case study countries, our report offers five cross-cutting recommendations relevant to all 22 middle-income countries in the cohort facing FP transition in the next several years. Middle-income country governments and donors can each play important roles in implementing these recommendations.

<sup>20</sup> FP2020, 2018. Core Indicators. FP2020 Data Dashboard. <http://www.familyplanning2020.org/data-dashboard>

<sup>21</sup> Guttmacher Institute, 2017. Menstrual Regulation and Unsafe Abortion in Bangladesh. Fact Sheets. <https://www.guttmacher.org/fact-sheet/menstrual-regulation-unsafe-abortion-bangladesh#fn0>

<sup>22</sup> Gavi, 2019. Key Information on Co-financing for Bangladesh. <https://www.gavi.org/sites/default/files/document/co-financing-information-sheet-bangladeshpdf.pdf>

<sup>23</sup> UNAIDS, 2018. AIDSinfo: Bangladesh. Global AIDS Monitoring. <http://aidsinfo.unaids.org/>  
World Health Organization, 2018. Global TB Database. <https://www.who.int/tb/country/data/download/en/>  
IHME, 2019. DAH Database: 1990-2018. <http://ghdx.healthdata.org/record/ihme-data/development-assistance-health-database-1990-2018>

1. **It is urgent that the 22 countries facing imminent FP transition risks develop FP transition plans,** comparable to the transition assessments and plans that are now widely completed for HIV, TB, malaria, and immunization. This recommendation aligns with current strategic thinking in the USAID and UNFPA FP programs.<sup>24</sup> (FP transition planning must also be a component of a larger health sector-wide transition planning initiative – see Recommendation 2 below.) FP transition plans should include timelines and specific co-financing requirements to transition FP commodity funding to the government, plans to transfer procurement/supply management and other technical assistance activities to national institutions if necessary, and strategies to protect vulnerable populations, ensure quality of services, and promote human rights throughout the transition period. These plans could be developed as part of existing FP strategic initiatives, such as Costed Implementation Plans (CIPs) or RMNCAH frameworks, or produced independently. Country governments need to take the lead in designing these FP transition plans, while donors can support such country-led efforts with financing and expertise.
2. **Governments and donors must promote an integrated approach to national transition planning that covers FP and other donor-backed health programs.** Currently, discussions of health transition largely take place within individual health program silos. While it is important for each health program to assess its own transition risks and readiness, transition planning and preparation must also occur across health programs. The collaborative development of a health sector-wide transition strategy would ensure that each health program's plans and goals for the timely transfer of technical capacity and financing responsibility to the national government are feasible in the context of other ongoing transitions. Similarly, when possible, governments and donors should develop health co-financing and/or matching fund agreements collectively such that the total "ask" for domestic health financing is realistic given the country's fiscal situation. A sector-wide approach to transition would also promote more coherent investments in cross-cutting systems (e.g., commodity forecasting and procurement, supply chains, and health information systems) that can efficiently sustain a range of health programs, including FP.
3. **Increased national ownership of FP and of overall health transition is imperative** to bring together and coordinate the major domestic and donor FP stakeholders, demonstrate political will for and prioritization of FP, and expand domestic funding for FP, including through co-financing or matching funds agreements. National FP leaders must also proactively join the larger national debates surrounding health transitions and the adoption of UHC, so that FP-specific priorities are considered alongside other health programs slated for transition and incorporation in UHC benefits packages. To raise this level of ownership, national FP leaders must make a strong case for the impact and cost-effectiveness of investments in FP to the health community, the Ministry of Finance, government leaders, and the general public. Donors can help to back such advocacy efforts.
4. **Donors must make their policies on FP transition more explicit and their timelines for transition more transparent and predictable,** so that countries can plan better for shifts in external support. The criteria and indicator thresholds for FP transition being used by key donors such as UNFPA, USAID, and DFID are hard to discern or unevenly applied across countries. (USAID is currently in the process of revising its FP graduation guidelines.) While major donors' long-term FP funding streams may be uncertain due to politicized replenishment and allocation processes, these organizations can do more to share medium-term plans for financial assistance and technical involvement at the country level to facilitate informed and coordinated transition planning.

<sup>24</sup> USAID, 2018. Family Planning Financing: A Framework for Addressing Strategic Opportunities. Washington, DC.



**5. A global working group on FP transition would help to coordinate, guide, and support FP transition preparedness processes at the country level and assist national FP teams as they enter into larger health sector discussions on transition.**

Composed of senior officials from transitioning countries and representatives of the leading international players in family planning, including FP2020, UNFPA, WHO, USAID, DFID, other European bilateral organizations, the World Bank, and IPPF, this working group could develop guidelines and tools

for use at country level, sponsor analytical work and planning, monitor progress, share lessons learned from FP transition, and promote knowledge sharing among national and international stakeholders. This body could also represent FP at global-level transition discussions alongside the transition working groups that already exist for other donor-backed health programs. To avoid duplication, the transition working group could be nested within existing FP task forces under FP2020 or other suitable initiatives.



# Chapter 1: Introduction

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## Problem Statement

The cohort of countries expected to transition from development assistance in the upcoming decade may have weaker economic, managerial, and technical capacity to sustain and improve upon progress in health achieved to date through partnership with donor organizations, as compared to the countries that graduated from development aid in the 2010s.<sup>25</sup> Health transition can be conceptualized as a continuum of progress towards full domestic responsibility for financing and stewardship of health programs, independent of foreign assistance.<sup>26</sup> Simultaneous decline in aid for several major donor-backed health programs poses a particular challenge to transition in this upcoming country cohort because of the competing fiscal, programmatic, and political pressures associated with multiple health transitions. Transitioning countries may have limited fiscal space for health, conflicting priorities and policy commitments within the health sector and among various development sectors, and limited capacities to maintain program infrastructure and service delivery. In this context, major donor-backed health programs are at risk for a lack of adequate funding, programmatic stewardship, and political prioritization during and after transition.

This report examines the key risks to sustaining quality family planning (FP) programs in the upcoming cohort of transitioning countries as other major donor-backed health programs simultaneously undergo transition and generate significant pressures across the health sector. Achieving universal access to quality FP services by 2030 is a key objective of the Sustainable Development Goals related to health (Goal 3) and gender equality (Goal 5).<sup>27</sup> FP empowers women and couples to make informed decisions regarding their reproductive health and contributes to desired social outcomes across a variety of sectors, such as increasing educational access, improving health outcomes, advancing women's economic opportunities, and reducing poverty.

In recognition of FP's importance in achieving development goals, FP is a major area of international health aid, with donors contributing US \$1.50 billion to FP programming in 2018.<sup>28</sup> The U.S. provided the largest share of FP funding in 2018 at 42%, and the U.K. contributed 19%. Other major donors included the Netherlands, Sweden, and Canada.<sup>29</sup> The 2018 global FP funding level represented an increase from previous years, but this was attributed primarily to U.S. disbursement patterns rather than heightened donor support for FP.<sup>30</sup> Moreover, due to changing domestic policies, sustained FP contributions from the U.S. remain uncertain.<sup>31</sup>

<sup>25</sup> Yamey, G., Gonzalez, D., Bharali, I., Flanagan, K., & Hecht, R. (2018). Transitioning from foreign aid: is the next cohort of graduating countries ready? Duke University Center for Policy Impact in Global Health.

<sup>26</sup> The Global Fund (2016). The Global Fund Sustainability, Transition, and Co-Financing Policy, Revision 1.

<sup>27</sup> SDGs 3.7, 5.6

<sup>28</sup> Wexler, A., Kates, J., & Lief, E. (2019). Donor Government Funding for Family Planning in 2018. Kaiser Family Foundation.

<sup>29</sup> Wexler, A., Kates, J., & Lief, E. (2019). Donor Government Funding for Family Planning in 2018. Kaiser Family Foundation.

<sup>30</sup> Wexler, A., Kates, J., & Lief, E. (2019). Donor Government Funding for Family Planning in 2018. Kaiser Family Foundation.

<sup>31</sup> Center for Global Development and Kaiser Family Foundation (2018). The USG International Family Planning Landscape: Defining Approaches to Address Uncertainties in Funding and Programming. Discussion summary.



As countries in the upcoming transition cohort experience increases in national incomes, they are expected to adopt greater roles in financing and stewardship of their FP programming. This process of FP transition in the upcoming cohort of LMICs poses several risks and challenges that threaten current and future gains in contraceptive quality, access, and usage. First, transitioning countries may not be able to mobilize the domestic resources necessary to fill the gap in FP financing left by exiting donors, particularly since many LMICs are heavily dependent on international funding for FP commodities and other programmatic elements. This challenge is exacerbated by competing fiscal pressures in health, particularly from simultaneous national transitions in other health areas, such as HIV/AIDS and immunization, as well as competing health priorities and policies, such as the introduction of UHC plans or other health financing reforms. Limited fiscal space for health coupled with increasing obligations for a variety of disease programs and health benefits packages may restrict domestic resources available for FP and thus translate into sub-optimal FP outcomes. Additionally, FP may not be prioritized politically or fiscally when compared with other high-profile and high-need areas in health or other development sectors, further reducing the chances of adequate domestic resource mobilization for and sustained political and social commitment to FP.

Other serious risks to transition and sustainability in FP include: limited domestic capacity for FP commodity procurement where there is a transition-related switch from international to national purchasing; weak supply chain management and quality assurance systems dependent on outside technical assistance; fragmented and inadequate monitoring and evaluation (M&E)

systems for FP program indicators and expenditures that rely heavily on donor support; limited governmental oversight of and coordination with the growing private sector for FP; a lack of home-grown institutions and practices to equip countries to make decisions in priority-setting and resource allocation; and legal and regulatory policies and social norms that fail to protect the rights of women, including adolescents.

Previous analyses of FP transitions have primarily focused upon Latin America, offering retrospective recommendations that were specific to the FP sector in this region.<sup>32</sup> This report is the first to examine FP transitions in the current fiscal environment of simultaneous health transitions and to consider transition challenges in relation to other disease programs, identifying general and FP-specific areas of country preparedness and risk.

The purpose of the study is to analyze possible future challenges in FP transitions pragmatically in order to offer forward-looking, feasible options for national policymakers to identify and manage challenges associated with competing fiscal pressures of multiple upcoming health transitions and to address specific risks within FP programming throughout the transition period. The study also aims to offer practical suggestions for donors to allocate resources and share responsibilities more effectively and transparently in preparation for FP program transition. While other international health programs, such as Gavi and the Global Fund, sponsor the development of extensive, country-level transition preparedness plans, the FP donor community does not. As such, this report's contextualized transition assessment framework and recommendations may serve as an important template for future transition analyses in the FP space.

<sup>32</sup> See, e.g., Alkenbrack & Shepherd (2005) and Bertrand, J.T. (2011).

## Methodology

In brief, our methodology for conducting this study is as follows, with more details provided in subsequent sections of the report:

- In preparation for this study, we developed a comprehensive framework to analyze family planning transitions, utilizing insight from the transition literature derived from a variety of health areas.
- We then conducted interviews with global leaders and experts in FP to refine and validate this framework (see Annex 1). These interviews also informed the Global Overview section of this report, which outlines and contextualizes the core trends and challenges relevant to FP transitions in LMICs.
- We collected data for over 25 macroeconomic, general health, and FP-specific indicators for all LMICs from various published sources to inform our country landscaping and case studies. We identified trends in the data and classified countries into three categories based on the timeframe for transition and the level of risk the countries face: those with high donor dependency but low likelihood of transition in the coming years (long-term, low-priority transition); countries currently facing a drawdown of donor support with significant transition risks over the next 5-10 years (medium-term, higher-risk transition); and countries with low donor dependency where transition should be relatively easier (short- to medium-term, lower-risk transition).
- We applied our analytical framework and global learnings to three country case studies in the second category: Kenya, Ghana, and Bangladesh. These countries were selected because they illustrate the heterogeneity of circumstances and challenges facing this medium-term transition cohort of countries, where the issue of transition is most pressing, and where FP transition planning and policy changes by country governments and donors is most urgently required.
- For each of the three countries, we conducted a review of the published literature. For Kenya and Ghana, we carried out field visits and conducted in-country interviews with 20-30 key informants in government, donor agencies, and NGOs, and we conducted remote interviews with six Bangladeshi stakeholders (see Annex 1: Institutions Represented and Individuals Interviewed for this Report). For all three countries, we gathered data from national strategic plans and other quantitative sources, including models from Avenir Health, to analyze current and projected FP expenditures and FP commodity procurement forecasts. We identified and quantified sources of domestic and external support to FP and other health programs such as HIV, TB, malaria, and immunization. Finally, we examined FP program performance within each country context. We complemented these analyses with a wide range of qualitative information from interviews on the processes, problems, strengths, weaknesses, and opportunities for positive change in the three countries to prepare for and manage family planning transition.
- We synthesized our results into a comprehensive, contextualized set of risks and associated recommendations for upcoming FP transitions in LMICs.



# Chapter 2: Analytical Framework for Family Planning Transitions

To develop a framework of analysis for FP transitions in the context of simultaneous health transitions, we conducted a literature review of transitions in FP and other health areas and interviewed twelve global experts from international donor and policy organizations specializing in health and FP. The results of this research are combined into a transition framework with a consistent set of analytical areas and guiding ques-

tions to assess country progress towards successful FP transition. This framework and report are intended to address the FP field's current lack of transition analyses in a realistic fiscal, political, and environmental context and to offer a new approach for future FP transition studies. The full framework is presented in the third section, following a review of the literature and a discussion of key trends from the global FP stakeholder interviews.

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## Review of Literature

A matrix of the 14 documents consulted for this review is presented in Table 2.1, categorized by *FP transition*, *program effectiveness*, *UHC*, and *transitions in other priority health programs*. Nearly all available studies on FP transitions were consulted;<sup>33</sup> this body of literature is small, particularly when compared with the documentation available for other major health program transitions.

The following sections describe the primary strengths and takeaways of these documents along with key areas for further analysis. Our FP framework builds upon the insights of previous researchers, engages with emerging areas of study, and fills in certain gaps within the literature, as is explained below.

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<sup>33</sup> Documents consulted were sourced from one of over 15 databases and websites, including Health Policy Plus, SHOPSPPlus, Center for Global Development, and others. The following search terms were used individually and in combination with "family planning": health financing, commodity security, sustainability, transition, effectiveness, UHC.

**TABLE 2.1: Documents consulted for literature review**

Type of Analysis	Documents Consulted
<b>FP Transition: USAID FP Graduation Reviews</b>	<ul style="list-style-type: none"> <li>• Cromer, C., Pandit, T., Robertson, J., &amp; Niewijk, A. (2004). The family planning graduation experience: Lessons for the future.</li> <li>• Alkenbrack, S., &amp; Shepherd, C. (2005). Lessons learned from phaseout of donor support in a national family planning program: the case of Mexico.</li> <li>• Bertrand, J. T. (2011). USAID graduation from family planning assistance: implications for Latin America.</li> <li>• Ávila, G., Gutiérrez, V., Corriols, M., &amp; Cole, K. (2012). USAID/Nicaragua family planning graduation strategy: final evaluation report.</li> <li>• Shen, A. K., Farrell, M. M., Vandenbroucke, M. F., Fox, E., &amp; Pablos-Mendez, A. (2014). Applying lessons learned from the USAID family planning graduation experience to the GAVI graduation process. <i>Health policy and planning</i>, 30(6), 687-695.</li> </ul>
<b>Program Effectiveness: CGD-led FP Analyses</b>	<ul style="list-style-type: none"> <li>• Silverman, R., &amp; Glassman, A. (2016). Aligning to 2020: How the FP2020 core partners can work better together. Final report of the Working Group on Alignment in Family Planning.</li> <li>• Center for Global Development and Kaiser Family Foundation (2018). The USG International Family Planning Landscape: Defining Approaches to Address Uncertainties in Funding and Programming. Discussion summary.</li> </ul>
<b>UHC: An Emerging Area of FP Study</b>	<ul style="list-style-type: none"> <li>• Fagan, T., Dutta, A., Rosen, J., Olivetti, A., &amp; Klein, K. (2017). Family planning in the context of Latin America's universal health coverage agenda. <i>Global Health: Science and Practice</i>, 5(3), 382-398.</li> <li>• Eldridge, C., &amp; Staples, M.H. (2018). A synthesis of recent learnings on the integration of family planning in universal health coverage schemes.</li> </ul>
<b>Transition in Other Priority Health Programs: Policies, Frameworks, and Analyses</b>	<ul style="list-style-type: none"> <li>• USAID, 2018. Family Planning Financing: A Framework for Addressing Strategic Opportunities. Washington, DC.</li> <li>• Aceso Global &amp; APMG Health (2017). Guidance for analysis of country readiness for Global Fund transition.</li> <li>• Gavi, the Vaccine Alliance (2018). Gavi Alliance Eligibility and Transition Policy, Version 3.0.</li> <li>• The Global Fund (2016). The Global Fund Sustainability, Transition, and Co-Financing Policy, Revision 1.</li> <li>• UNAIDS, Cambodia AIDS Authority, and Pharos Global Health Advisors (2018). Towards Ending AIDS in Cambodia: Transition Readiness Assessment.</li> </ul>

### USAID-Sponsored Studies of FP Transition

USAID was the pioneer in FP transition studies, producing the first reports in this field starting in the early 2000s. These USAID publications are concentrated on LAC nations and are almost exclusively retrospective.<sup>34</sup> Due to a lack of available data about these countries' post-graduation experiences, early reports do not draw conclusions about the effects of graduation on FP program indicators or other social outcomes. Instead, authors typically evaluate each country's FP graduation process across "common themes" of the FP program

and its environment,<sup>35</sup> offering lessons and/or recommendations for successful transition for each program element. A summary of main themes and associated lessons/recommendations is presented in Table 2.2. Many of these recommendations address important issues—such as the need for earlier initiation of transition planning involving all stakeholders—that continue to challenge current FP transitions, suggesting that donor organizations may not have fully applied these early lessons to subsequent contexts.

**TABLE 2.2: Themes of evaluation and associated lessons/recommendations from USAID FP graduation reviews**

Selected Themes of FP Graduation Evaluation	Key Lessons and/or Recommendations
<b>Domestic Funding of FP<sup>36,37,38</sup></b>	<ul style="list-style-type: none"> <li>• Governments are often unable to fulfill promises to provide free contraceptives and would be better served by adopting a total market approach (TMA) to contraceptive pricing during and after transition<sup>39</sup></li> <li>• Ensure that all FP-related staff in the MoH are funded by the domestic budget before transition</li> <li>• Domestic financial commitment to FP may be challenged by competing political priorities during and after transition</li> </ul>
<b>Contraceptive Procurement, Service Delivery, and Security<sup>40</sup></b>	<ul style="list-style-type: none"> <li>• Develop and institutionalize government-led FP procurement mechanisms at least three years before graduation so that countries complete at least one full procurement cycle prior to transitioning</li> <li>• Social marketing programs can help to expand the contraceptive market</li> <li>• Efforts to engage the commercial sector in FP procurement and provision are not always successful</li> <li>• Integration of FP into HIV and MCH programming may facilitate transition</li> </ul>
<b>M&amp;E<sup>41</sup></b>	<ul style="list-style-type: none"> <li>• Countries may need considerable M&amp;E support from donors, post-transition</li> <li>• Donors should institutionalize M&amp;E skills and funding in domestic governments before transition</li> <li>• Donors should provide ongoing TA for data utilization in MoH decision-making</li> </ul>

<sup>34</sup> See: Cromer et al. (2004), Alkenbrack & Shepherd (2005), Bertrand (2011), Avila et al. (2012).

<sup>35</sup> Cromer, C., Pandit, T., Robertson, J., & Niewijk, A. (2004). The family planning graduation experience: Lessons for the future. Submitted by LTG Associates and Social & Scientific Systems to USAID.

<sup>36</sup> Alkenbrack, S., & Shepherd, C. (2005). Lessons learned from phaseout of donor support in a national family planning program: the case of Mexico.

<sup>37</sup> Ávila, G., Gutiérrez, V., Corriols, M., & Cole, K. (2012). USAID/Nicaragua family planning graduation strategy: final evaluation report.

<sup>38</sup> Cromer et al. (2004).

<sup>39</sup> A total market approach segments the contraceptive market by income level such that every individual can access FP commodities at a price affordable to her.

<sup>40</sup> Cromer et al. (2004), Alkenbrack & Shepherd (2005), Avila et al. (2012).

<sup>41</sup> Cromer et al. (2004), Alkenbrack & Shepherd (2005), Avila et al. (2012), Bertrand, J. T. (2011). USAID graduation from family planning assistance: implications for Latin America. Bureau for Latin America and the Caribbean, USAID, 57-67.

Selected Themes of FP Graduation Evaluation	Key Lessons and/or Recommendations
<b>Equity for Special Populations</b> <sup>42</sup>	<ul style="list-style-type: none"> <li>• USAID should consider funding initiatives that serve vulnerable populations (the poor, indigenous, rural inhabitants, etc.) after graduation</li> <li>• Integration of adolescent RH programming into existing gender-based violence prevention efforts may facilitate transition</li> </ul>
<b>Coordination and Planning throughout Transition</b> <sup>43</sup>	<ul style="list-style-type: none"> <li>• Transition timelines should be lengthy</li> <li>• All stakeholders should be involved in planning for FP graduation</li> <li>• Donors need to be consistent in their messaging surrounding FP transition</li> <li>• Political will to fund quality FP programming requires ongoing advocacy from donors and civil society throughout and after transition</li> <li>• Phaseout plans should be flexible to adapt to changing environments</li> </ul>
<b>USAID Engagement Post-Transition</b> <sup>44,45</sup>	<ul style="list-style-type: none"> <li>• USAID should develop an initiative to maintain contact with graduated countries, providing a channel for continued mentorship and support if needed</li> <li>• USAID should continue to monitor FP indicators and programs in graduated countries</li> <li>• USAID should study FP graduation's effect on TFR and mCPR in the medium-term in graduated countries</li> </ul>

The strengths of the USAID transition reports include their rich qualitative detail and their application of lessons to other LAC nations approaching FP transition. All studies offer in-depth descriptions of programmatic successes and challenges before and during transition, supported by qualitative information including in-country interviews. Quantitative data is provided for key FP indicators. Later studies start to apply the lessons from a particular country or set of countries to comparable nations approaching FP transition; for example, Bertrand (2011) examines a group of three LAC nations scheduled to graduate in the early 2010s—Honduras, Nicaragua, and Paraguay—and extrapolates their “prospects and challenges of graduation” to the FP programs in three other LAC countries not yet ready for transition: Bolivia, Guatemala, and Haiti.<sup>46</sup> With this approach, the report provides more tailored and actionable recommendations for future transitioning countries.

However, the USAID FP transition analyses have some limitations. These studies generally examine only one country or region (i.e., LAC) retrospectively. Most analyses and recommendations are focused on one donor, USAID, and do not look at the transition policies and preparation of other donors, such as UNFPA and DFID, or of national governments. Moreover, these studies examine FP programming in detail but do not typically contextualize their results within broader national programs and trends. For example, while multiple reports call for increased domestic investment in FP commodity procurement, they rarely note the challenge of mobilizing additional domestic resources for FP in the face of other high-cost priorities both within and outside the health sector. When competing fiscal and/or political pressures are acknowledged, it is generally to encourage continued FP political advocacy.

<sup>42</sup> Cromer et al. (2004), Bertrand (2011), Avila et al. (2012).

<sup>43</sup> Cromer et al. (2004), Alkenbrack & Shepherd (2005), Avila et al. (2012).

<sup>44</sup> Cromer et al. (2004), Alkenbrack & Shepherd (2005), Bertrand (2011).

<sup>45</sup> See also: <https://www.cgdev.org/sites/default/files/working-itself-out-job-usaid-and-smart-strategic-transitions.pdf>

<sup>46</sup> Bertrand (2011).

Additionally, some of the recommendations of these reports do not identify actionable steps to achieve desired results. Multiple authors identify the need for increased donor coordination, for example, but do not provide concrete ideas for how to achieve this goal.<sup>47</sup> Avila et al. (2012) provide the most detailed and actionable recommendations to address challenges in Nicaragua's FP program post-graduation; for example, this study proposes that at least two staff members per FP facility be trained in the medical supplies logistics information system prior to transition.<sup>48</sup> The Avila report also includes the most quantitative data, allowing for the heightened detail of its FP program recommendations.

Overall, the initial LAC USAID transition reports establish a foundation for the field of FP transition analysis. Building upon this foundation, the present study situates upcoming FP transitions in the context of other ongoing transitions in health and increases the use of detailed, rigorous quantitative information, particularly about health financing, in assessing FP transition risks globally and at country level.

A 2014 article by Shen et al. is the first FP transition analysis that studies FP graduation in relation to other ongoing health program transitions. This article compares the FP and immunization graduation processes, applying lessons from early USAID FP graduations to upcoming Gavi transitions. One of the authors' most important points concerns differing perceptions of FP and immunization programs: *"Political leaders and communities tend to view routine immunization as an essential service, a 'right' that should be available to all. In contrast, FP programs are more controversial, with wide-ranging levels of support."*<sup>49</sup> This insight—that FP may not be a political or fiscal priority relative to other health programs throughout the process of transition—highlights the importance and urgency of studying FP transition in realistic political and social context.

Shen et al. also articulate a set of six "foci" to plan for FP graduation in countries nearing transition: *contraceptive security, advocacy & political commitment, data for decision-making, equity for special populations, the status of FP in health reform, and institutional capacity & human resources.*<sup>50</sup> The authors favor this "holistic view" of transition readiness assessment over Gavi's immunization transition policy, which considers only GNI per capita.<sup>51</sup> However, while these FP graduation foci are holistic in considering FP transition itself, they do not take into account the context of simultaneous health transitions, for example, by considering the challenge of allocating adequate domestic resources to support FP, immunization, and other donor-backed health programs such as HIV.

### **FP Program Effectiveness**

A small but growing body of FP transition literature seeks to improve the programmatic and cost-effectiveness of existing FP programs.<sup>52</sup> This shift in analysis is prompted in part by the changing political and fiscal climate in donor nations; the current U.S. administration, for example, has proposed zeroing out the budget for USAID FP assistance, and other bilateral contributions are stagnating, raising concerns about adequate resource availability for FP programs.<sup>53</sup> The growth in the FP program effectiveness literature is supported by stronger quantitative data collection in FP programming and financing. Avenir Health's Track20 initiative to improve FP M&E activities within the 69 FP2020 focus countries is in part responsible for this increase in available data.<sup>54</sup>

Two notable papers in this area from the Center for Global Development (CGD), have led new insights in FP financing and M&E. 2016 CGD report concludes that current FP program metrics are not attributable to particular interventions across the "results chain" and recommends that FP initiatives be evaluated rigorous-

<sup>47</sup> See, e.g.: Alkenbrack, S., & Shepherd, C. (2005).

<sup>48</sup> Ávila et al. (2012).

<sup>49</sup> Shen, A. K., Farrell, M. M., Vandenbroucke, M. F., Fox, E., & Pablos-Mendez, A. (2014). Applying lessons learned from the USAID family planning graduation experience to the GAVI graduation process. *Health policy and planning*, 30(6), 687-695.

<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

<sup>52</sup> See, e.g.: Silverman & Glassman (2016), Center for Global Development and Kaiser Family Foundation (2018).

<sup>53</sup> Center for Global Development and Kaiser Family Foundation (2018). The USG International Family Planning Landscape: Defining Approaches to Address Uncertainties in Funding and Programming. Discussion summary.

<sup>54</sup> Silverman, R., & Glassman, A. (2016). Aligning to 2020: How the FP2020 core partners can work better together. Final report of the Working Group on Alignment in Family Planning.



ly and independently to determine their effectiveness in terms of impact and cost, permitting evidence-based prioritization of investments.<sup>55</sup> A subsequent CGD publication observes that domestic governments do not currently have incentives (and in fact may face disincentives) to meet co-financing requests for FP; the report suggests that co-financing requirements for FP be established and bundled into an “integrated ask” for domestic government financing for all health programs.<sup>56, 57</sup>

To date, CGD’s reports have been global in scope and have examined transitions as only one challenge in the broader FP landscape. This report is intended to go further by applying the FP transition and priority-setting lens to individual countries facing declining donor support for family planning and other health programs.

### **FP and UHC**

The FP-UHC literature is still in its early stages, with two recent studies examining FP inclusion in UHC schemes more descriptively rather than analytically.<sup>58</sup> Researchers do not currently have enough data to support certain FP-UHC policies, such as demand-side financing, and evidence-based recommendations are a work in progress.<sup>59</sup> Nevertheless, as UHC schemes proliferate in LMICs, this topic constitutes an important new dimension of analysis in need of more research.

### **Transition Policies in FP and Other Donor-backed Health Programs**

Currently, no widely accepted framework, policy, or process exists to determine country readiness for FP transition. The large number of donors in FP—including UNFPA, USAID, and other bilateral agencies and NGOs, each with their own agendas and funding streams—creates a challenging environment for coordinating and applying a consistent FP transition policy. USAID has

utilized certain FP indicator thresholds to assess country readiness for transition. However, countries meeting these thresholds do not always experience USAID FP transition, sometimes due to challenging environmental factors outside the FP program.<sup>60</sup> UNFPA does not appear to have published FP transition guidelines. In contrast, other major donor-backed health programs, such as Gavi and the Global Fund, have developed and publicized analytical frameworks and/or policies that assist domestic governments and partners in assessing country readiness for transition across a consistent set of metrics.<sup>61</sup>

**USAID Approach to FP Transition.** As documented in a 2006 technical note, USAID assesses FP transition readiness based upon national FP trigger indicators: TFR less than or equal to 3.4 and mCPR greater than or equal to 48%.<sup>62</sup> Once a country meets these criteria, the USAID strategy suggests that transition should occur within six years, though revised guidelines currently under development may lengthen this transition period.<sup>63</sup> Many countries, including Peru, Sri Lanka, and South Africa, have met these targets and transitioned from USAID FP assistance.<sup>64</sup> However, others nearing or surpassing the trigger thresholds, such as Bangladesh (TFR: 2.08, mCPR: 45.5%), have not yet begun the process of transition.<sup>65</sup> Respondents suggest that such countries have remained in the USAID FP program due to considerable enabling environment challenges to their FP programs.

To account for relevant FP programmatic elements beyond TFR and mCPR, a recent CGD discussion group proposes several additional factors to consider as part of FP transition readiness assessments, including: *population share of youth, equity of FP coverage, adolescent pregnancy rates, government FP expenditures, social norms surrounding FP, and political will to create an “enabling environment” for FP.*<sup>66</sup> Incorporation

<sup>55</sup> Ibid.

<sup>56</sup> Center for Global Development and Kaiser Family Foundation (2018).

<sup>57</sup> For an innovative use of co-financing in family planning, see The Challenge Initiative: <https://tciurbanhealth.org/>

<sup>58</sup> See: Fagan et al. (2017), Eldridge & Staples (2018), Appleford & Ramarao (2019).

<sup>59</sup> Eldridge, C., & Staples, M.H. (2018). A synthesis of recent learnings on the integration of family planning in universal health coverage schemes.

<sup>60</sup> Donor respondent.

<sup>61</sup> See, e.g.: Kallenberg et al. (2016), Aceso Global & APMG Health (2017).

<sup>62</sup> Center for Global Development and Kaiser Family Foundation (2018).

<sup>63</sup> Donor respondent.

<sup>64</sup> See: <https://www.usaid.gov/global-health/health-areas/family-planning/countries#graduated>

<sup>65</sup> Donor respondent.

<sup>66</sup> Center for Global Development and Kaiser Family Foundation (2018).



of these additional factors into USAID's FP graduation strategy could improve consistency and transparency in transition. USAID is currently in the process of updating its FP graduation guidelines.

In November 2018, USAID published a new framework for FP financing designed to “provide strategic direction” for country mission staff involved in FP programming.<sup>67</sup> Drawing upon lessons from the LAC FP transitions and the emerging FP program effectiveness literature, this framework tailors suggested strategic opportunities in FP financing to a country's specific health financing maturity level and placement along the theoretical mCPR S-curve. The tactics suggested by this framework—such as increased domestic resource mobilization for FP, the incorporation of FP commodities into health insurance schemes, improved public-private partnerships and social contracting mechanisms to support national FP programs, and the development of multi-stakeholder transition plans for FP<sup>68</sup>—align with key points of investigation and elaboration in the present study.

**Gavi Approach to Immunization Transition.** In contrast to FP, the immunization space has only one major donor, Gavi, which has developed and implemented an explicit transition path to full domestic financing of immunization programs. All recipient countries classified as low-income by the World Bank contribute US \$0.20 per routine vaccine dose supported by Gavi.<sup>69</sup> When a nation reaches lower middle-income status, it enters the preparatory transition phase, during which time the domestic government's contributions for vaccine costs increase by 15% per year.<sup>70</sup> When a country's national income exceeds the Gavi threshold—currently US \$1,580—for three consecutive years, it enters the accelerated transition phase, a five-year period in which domestic contributions to immunization programs increase to 100%.<sup>71</sup>

While there are some nuances in the Gavi eligibility and transition policy to address the situation in countries with high per capita income and poor health systems and immunization performance, it is clear, predictable, and consistently applied.

#### **Global Fund Approach to HIV, TB, Malaria Transition.**

Similarly, the Global Fund (GF) has developed explicit criteria for country transition in HIV/AIDS, TB, and malaria, based upon per capita income and disease burden. Countries meeting the thresholds for transition are given early warning and provided with a final three year “transition grant” to smooth their path to self-sufficiency.<sup>72</sup> The GF is also attempting to coordinate its transition processes with other donors, especially the US Government's PEPFAR and President's Malaria Initiative. The Global Fund is increasingly encouraging countries to undertake “transition readiness assessments” at an early stage, many years prior to the projected end of GF financial support, so that plans for transition and sustainability are well in place.

The GF evaluates national programs across five core areas, as outlined by Aceso Global and APMG Health (2017): *health financing, epidemiological context, institutional environment, service delivery, and human rights & gender*.<sup>73</sup> The GF analytical framework has been applied successfully in transition readiness assessments for a variety of transitioning countries, resulting in detailed reports of contextualized country risks and actionable recommendations to prepare for transition.<sup>74</sup> These publications assist the GF and national governments in priority-setting and strategy development throughout health transitions in HIV, TB, and malaria, and this methodology serves as a useful model for the development of the analytical framework for FP transition presented below.

<sup>67</sup> USAID, 2018. Family Planning Financing: A Framework for Addressing Strategic Opportunities. Washington, DC.

<sup>68</sup> Ibid.

<sup>69</sup> See: <https://www.gavi.org/about/programme-policies/co-financing/>

<sup>70</sup> Ibid.

<sup>71</sup> See: <https://www.gavi.org/support/sustainability/eligibility/>

<sup>72</sup> The Global Fund (2016). The Global Fund Sustainability, Transition, and Co-Financing Policy, Revision 1. [https://www.theglobalfund.org/media/4221/bm35\\_04-sustainabilitytransitionandcofinancing\\_policy\\_en.pdf](https://www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf)

<sup>73</sup> Aceso Global & APMG Health (2017). Guidance for analysis of country readiness for Global Fund transition.

<sup>74</sup> See, e.g.: UNAIDS, Cambodia AIDS Authority, and Pharos Global Health Advisors, Towards Ending AIDS in Cambodia: Transition Readiness Assessment (2018); Global Fund and Pharos Global Health Advisors, Evaluación de la preparación para la transición: Colombia (2019); Aceso Global & APMG Health, Dominican Republic Country Report: Transition Readiness Assessment (2017).

## Global FP Stakeholder Interviews

We interviewed twelve FP global stakeholders from donor and research organizations (See Annex 1). The purpose of these interviews was to identify the current issues and ideas relevant to ongoing and upcoming FP transitions in order to inform our analytical framework categories and guiding questions. Twelve key findings and associated recommendations from the global informant interviews are summarized below. These findings were tested in the country case studies in this report and proved to be relevant in a number of country situations.

1. **Sustainable financing for FP requires greater domestic contribution to and management of FP resources.** Many FP funds exist off-budget, and there are few incentives for increased domestic ownership of and contribution to FP programming when donor presence in the FP space appears indefinite. Shifting FP funds on-budget would permit domestic governments to gain experience in FP fiscal management, while specific, transparent co-financing requirements and donor exit timelines would incentivize domestic investment in FP.
2. **Domestic resources for FP are significantly constrained by other simultaneous health transitions and fiscal pressures outside health.** Donors and governments must coordinate to devise realistic plans for co-financing and transition from development assistance for health across all priority programs. Continued donor assistance in priority-setting both within and outside the health sector may be required to ensure sustainable health financing during and after transition.
3. **Integration of FP within countries' universal health coverage (UHC) movements poses opportunities and risks.** FP transition planning is occurring as countries' interest in UHC grows. Many proposed UHC plans primarily aim to reduce catastrophic expenditure at the hospital level, which may lead to underinvestment in preventive and promotive care, such as FP. In this context, domestic FP financing is at risk. Additionally, more research is needed to support specific modalities of FP inclusion in UHC packages, such as fee-for-service payment for clinical FP methods.
4. **FP service provision involves a diverse set of providers, which offers challenges and opportunities.** FP services are delivered through the public, private, and NGO sectors. Transitioning countries should consider adopting the total market approach for FP, which would tailor pricing of FP services to various segments of the population based on income, unmet contraceptive need, and other factors. Growth of the private sector in particular may help fill some gaps in FP financing during transition. However, coordinating and monitoring a diverse set of FP providers may be difficult for domestic governments.
5. **Transition of procurement arrangements appears tenuous.** The current global contraceptive market involves only two main commodity procurers, USAID and UNFPA, an unsustainable long-term arrangement. Transition will require countries to move towards managing procurement themselves. However, individual countries may not receive the bulk purchasing discounts enjoyed by USAID and UNFPA, resulting in higher costs for commodities and possible risks surrounding quality of commodities obtained from uncertified manufacturers. Proposed pooled procurement mechanisms across multiple countries or regions may promote self-reliance in FP commodity procurement and assist in keeping commodity costs low.
6. **Certain donor-government practices and incentive structures are inhibiting progress toward country self-reliance.** When certain donors exit a country, some governments successfully appeal to other partners to fill commodity or other FP funding gaps rather than providing additional domestic resources. Such arrangements undermine progress towards transition; transition plans should be transparent and involve all relevant country stakeholders to prevent these situations. Additionally, partners should be more cautious in the donation of free FP commodities to national governments. The availability of free contraceptives limits the private sector's development and disincentivizes national governments in allocating program resources and designing insurance benefits packages with the long-term, "fully loaded" costs of FP in mind.

7. **The quality of available FP data is poor, particularly for FP-related expenditures, and continued donor investment in FP M&E is necessary.** It is currently difficult to monitor country progress towards FP2020 commitments because of this lack of data, but organizations like Track20 are working to support FP M&E capacity through initiatives such as the FP Spending Assessments (FPSAs). Ultimately, data should be collected at the sub-national as well as the national level to evaluate equity in program coverage. A dedicated FP M&E position in the government is necessary to sustain and further gains in FP data quality and availability.
8. **The politics of domestic financing for FP are challenging on a social and practical level.** The politics of investing in programs that are intimately tied to sex and women's autonomy are difficult to manage even in progressive contexts. In addition, the relationship between population size and government resources can create tension. For example, in federal systems when intergovernmental fiscal transfers are tied to population size, there can be a disincentive to enable women to reduce their total fertility. Donors should identify appropriate incentives for political commitment to FP programs that respect the principle of voluntary choice, such as offering a country certification for meeting a certain level of contraceptive demand.
9. **Domestic governments' priority-setting capacity is still nascent, which may result in ill-informed decision-making in health.** In the context of limited financial resources for health throughout transition, a lack of priority-setting and appropriate consideration of trade-offs may lead to implicit rationing and irrational government spending choices. While health technology assessments (HTA) can generate evidence to define cost-effective benefits packages, inform procurement, and identify appropriate pricing and provider payment schemes, many countries have not adopted HTAs or have only nascent priority-setting mechanisms in place. Prior to full transition, donors should help to institutionalize data-driven decision-making practices in the health sector.
10. **FP officials in domestic governments need greater authority and managerial capacity.** Government FP programs should have the power and the financial resources to execute FP programming decisions. Donor TA should be directed towards building domestic FP program capacity to contract with NGOs and CSOs for continued provision of FP services following transition.
11. **Tensions exist between a rights-based approach to FP and countries' fiscal constraints.** A rights-based approach to FP, which enables broad choice, is fully embraced by donors and donor financing schemes. In the context of transition, domestic governments' ability to finance staff training programs and an expansive contraceptive method mix to support the rights-based approach may be limited. Donors and governments should devise a realistic transition strategy in which a rights-based approach is optimized in the context of a country's fiscal constraints.
12. **Continued donor investment in demand generation is likely required.** For many countries facing an FP transition, contracepting is not the norm, and investment to generate demand for these products is needed to sustain FP coverage. Demand generation is typically a secondary priority for domestic governments and may require continued donor assistance.

## Analytical Framework

In contrast to other priority health programs, there is no broadly accepted framework to analyze FP transitions in the context of health systems, financing, social norms, and politics. To guide analysis in this report, we have developed a four-category FP transition framework, presented in Table 2.3. This framework builds upon the "six foci" outlined by Shen et al., the CGD discussion

group's proposed factors for assessing FP transition readiness, and the Aceso Global & APMG Health GF transition analysis categories. Guiding questions within each category are informed by the global stakeholder interviews as well as other insights from the literature review.

The four categories of analysis are: **Financing for FP and Other Health Programs**; **Procurement and Supply Chain**; **Technical Capacity**; and **Enabling Factors: Political Commitment to FP and Legal & Human Rights**. These categories are framed within country context of epidemiology, population, and development. Relevant guiding questions are shown in Table 2.3 below.

**TABLE 2.3: Analytical framework for FP transition**

Framework for Family Planning Transition Analysis   Pharos Global Health (2019)	
<p><b>I. Financing for FP and Other Health Programs</b></p> <ul style="list-style-type: none"> <li>• What is the country's overall macroeconomic and fiscal situation?</li> <li>• What are the past and present sources of FP financing, and are programs needs being met?</li> <li>• What resources are required to meet future FP program needs, and how will they be financed?</li> <li>• What other health transitions are occurring, and what are their present and future resource requirements? Who is/are responsible for financing these other programs?</li> <li>• What opportunities exist to increase cost-effectiveness and program impact in FP and other health areas?</li> <li>• What strategies or plans exist for managing transition of financial responsibility for FP and other health programs?</li> <li>• In what ways are FP and other health programs included in insurance or UHC programs, and with what consequences?</li> </ul>	<p><b>II. Procurement &amp; Supply Chain</b></p> <ul style="list-style-type: none"> <li>• What organization(s) is/are responsible for FP commodity procurement, warehousing, and distribution?</li> <li>• What FP procurement mechanism is used, and will this platform be available following transition?</li> <li>• In what ways are donors involved in FP procurement and supply chain processes? Is the government prepared to assume responsibility for donor activities in this area during transition?</li> <li>• Who oversees FP commodity forecasting? Is the government prepared to conduct its own FP forecasts?</li> <li>• What procurement and supply chain systems exist for other priority programs, and how are donors involved in those systems? Is the government prepared to assume responsibility for procurement and supply chain in other health areas?</li> <li>• Can FP and/or other priority programs be integrated into existing national procurement and supply chain processes?</li> </ul>
<p><b>III. Technical Capacity</b></p> <ul style="list-style-type: none"> <li>• What technical assistance in health is being provided for FP and other priority programs, and how can this knowledge be transferred to local institutions?</li> <li>• What is the status of the national health system? Are donors investing in HSS, and will this support continue after transition?</li> <li>• How are priorities established within and beyond the health sector? Do donors provide TA in this area, and will this support continue after transition?</li> <li>• What coordination mechanisms, strategies, or documents exist for donors, governments, NGOs, private providers, and other stakeholders in FP and health generally? Are these mechanisms actually utilized to prepare for FP/ other health transitions?</li> <li>• What M&amp;E systems exist in FP, and how are donors involved in those systems? How can M&amp;E expertise be transferred to local institutions?</li> <li>• What is the quality of the services and commodities provided? How is quality assessed?</li> </ul>	<p><b>IV. Enabling Factors: Political Commitment to FP and Legal &amp; Human Rights</b></p> <ul style="list-style-type: none"> <li>• Is the government prepared and willing to coordinate, manage, and fund the national FP program and FP-oriented CSOs and NGOs adequately?</li> <li>• Are there high-level political champions for FP?</li> <li>• What is the level of political commitment for FP compared with other health areas and other development sectors?</li> <li>• Is FP considered an important component of national development strategies?</li> <li>• Do national laws, policies, and regulations create an enabling environment for FP access and provision, including for a variety of FP methods?</li> <li>• Is access to FP equitable across the population? Are services available for key populations, including youth, rural residents, the poor, and other groups?</li> <li>• To what extent are human rights incorporated into FP policy and discourse?</li> </ul>

All framed within country context of epidemiology, population, & development

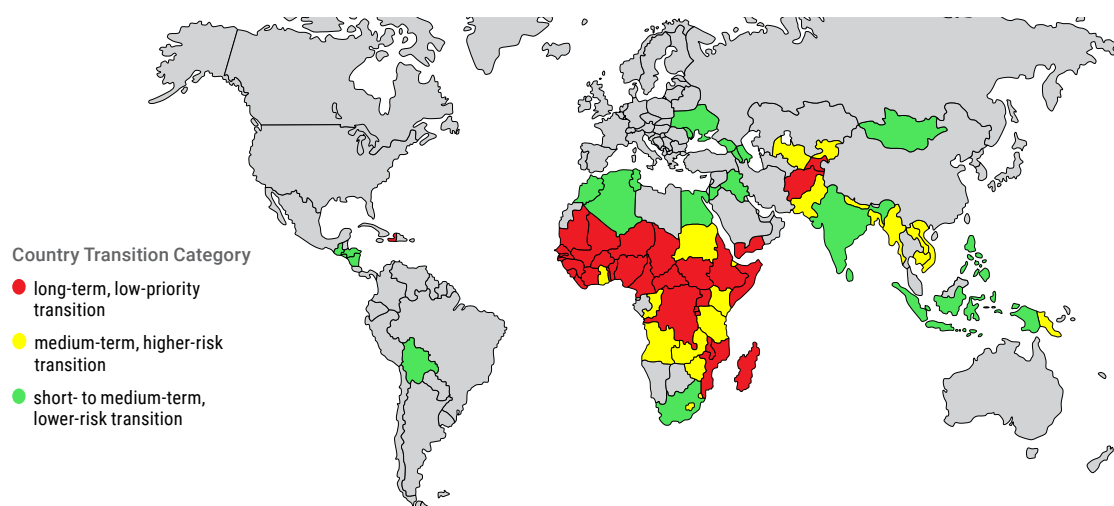
# Chapter 3: Global Landscape of Family Planning Transitions

To contextualize our three country case studies, we examined 80 low- and middle-income countries receiving international development assistance for health (DAH) in FP, including 66 of the 69 FP2020 focus nations.<sup>75</sup> When assessing LMICs across a variety of demographic, macroeconomic, fiscal, and family planning-specific characteristics,<sup>76</sup> we found considerable heterogeneity, signaling varying levels of economic, social, programmatic, and political preparedness for FP transition.

For purposes of this report, we have classified LMICs into one of three broad categories related to their readiness and ability to manage FP transition:

- countries with low incomes and high donor dependency but low likelihood of FP transition in the coming years (long-term, low-priority transition);
- countries with relatively high incomes and low donor dependency, where FP transition is already advanced and donor exit may occur soon, and should be relatively easy to manage (short- to medium-term, lower-risk transition); and
- countries with intermediate incomes and currently facing a significant drawdown of donor support with significant FP transition risks over the next 5-10 years (medium-term, higher-risk transition)

**FIGURE 3.1: Map of Eighty LMICs Categorized By Family Planning Transition Likelihood and Risk**



<sup>75</sup> All FP2020 Focus Countries, along with all other countries with GNI per capita less than US \$4100, were selected for consideration. The State of Palestine, Western Sahara, and DPR Korea are FP2020 Focus Countries but were excluded due to lack of data. Vanuatu, Kiribati, Cabo Verde, Micronesia, Tonga, Kosovo, and Samoa met the GNI per capita threshold but were excluded from analysis due to limited data.

<sup>76</sup> See Annexes 2 and 3 for full classification methodology and data. GNI per capita was selected as the primary macroeconomic indicator; TFR, mCPR, and percent unmet contraceptive need were selected as core FP and demographic indicators; and donor dependency in FP, HIV, immunization, and health generally were selected as primary fiscal/transition indicators.

Table 3.1 presents the three categories of countries, along with the median and range for each of eight family planning and health financing indicators. The countries comprising each of the three FP transition categories are presented on the map in Figure 3.1.

**TABLE 3.1: Three country categories for FP transition risk: unweighted median and range values for eight family planning and health financing indicators**

Country Transition Category	GNI per Capita (USD)	Total Fertility Rate	Modern Contraceptive Prevalence Rate	Percent Unmet Contraceptive Need	Share of HIV Spending from Donors	Share of Immunization Spending from Donors	Donor Expenditure on FP per WRA (USD)	DAH as % Current Total Health Expenditure
	Source: World Bank, Atlas Method (2017)	World Bank (2017)	FP2020 Annual Report (2018) & World Bank (since 2012)	FP2020 Annual Report (retrieved 2019; various years)	UNAIDS GAM (retrieved 2019)	WHO Immunization Financing (2017)	IHME (2017); UN World Population Prospects (2015)	WHO GHED (2016)
<b>Long-term, low-priority transition</b>	<b>680</b> (280–2100)	<b>4.70</b> (2.87–7.18)	<b>19.80%</b> (2.74–46.60%)	<b>28.10%</b> (18.30–39.80%)	<b>90.5%</b> (41.3–100.0%)	<b>76.4%</b> (24.0–99.0%)	<b>1.21</b> (0.02–8.37)	<b>26.1%</b> (5.1–53.8%)
<b>Medium-term, higher-risk transition</b>	<b>1525</b> (800–3570)	<b>3.23</b> (1.95–5.62)	<b>31.79%</b> (2.74–65.50%)	<b>24.95%</b> (9.90–36.92%)	<b>81.2%</b> (39.1–95.6%)	<b>73.2%</b> (1.0–89.0%)	<b>0.73</b> (0.00–4.01)	<b>13.3%</b> (1.2–42.5%)
<b>Short- to medium-term, lower-risk transition</b>	<b>3540</b> (1790–5430)	<b>2.34</b> (1.23–4.31)	<b>45.51%</b> (25.75–68.00%)	<b>18.72%</b> (8.54–53.30%)	<b>46.1%</b> (1.8–95.7%)	<b>6.0%</b> (0.0–94.0%)	<b>0.03</b> (0.00–3.58)	<b>1.7%</b> (0.0–5.7%)

While we believe these categories are useful in focusing attention on the countries that are most likely to transition in the coming years and those with the weakest capacity to address transition risks, it is still necessary to examine each country's characteristics individually to identify the specific risks and challenges associated with FP transition in the short- and long-terms.

The data for this global landscape were drawn from publicly available sources including the World Bank, FP2020, WHO, IHME, and UNAIDS. Each organization utilizes different data collection techniques, ranging from country self-reporting to estimation analyses derived from a variety of sources. There are inherent limitations to each reporting method. While reliable data sources for FP program indicators, such as mCPR and method mix availability, have increased due to FP2020/Track20 and other FP M&E initiatives, verified, comprehensive information about FP expenditures is not widely avail-

able. For example, only 32 countries self-report annual domestic FP spending to the WHO National Health Accounts program, and, at the time of writing, an estimation of out-of-pocket FP expenditures had only been conducted for four Family Planning Spending Assessment (FPSA) nations: Kenya, Bangladesh, Indonesia, and Senegal. A current breakdown of FP expenditures by commodities, service provision, and other activities is generally not available except in FPSA countries. This lack of financial data in the FP sector stands in contrast with the rigorous country-level financial M&E in HIV and immunization programs via the National AIDS Spending Assessments (NASAs) and required annual progress reports for Gavi. Existing FP expenditure assessments beyond FPSAs, such as the CHAI-RHSC FP Market Reports, present detailed but highly aggregated data that is not sufficient for in-depth country analyses.



**TABLE 3.2: Family planning and health financing indicators for countries in the long-term, low-priority transition category**

Country	GNI per Capita (USD)  Source: World Bank, Atlas Method (2017)	Total Fertility Rate  World Bank (2017)	Modern Contraceptive Prevalence Rate  FP2020 Annual Report (2018) & World Bank (since 2012)	Percent Unmet Contraceptive Need  FP2020 Annual Report (retrieved 2019; various years)	Share of HIV Spending from Donors  UNAIDS GAM (retrieved 2019)	Share of Immunization Spending from Donors  WHO Immunization Financing (2017)	DAH as % Current Total Health Expenditure  WHO GHED (2016)	Donor Expenditure on Family Planning per WRA (USD)  IHME (2017); UN (2015)
Afghanistan*	\$560	4.48	19.80%	28.10%	n.a.	94.0%	17.5%	\$1.89
Benin	\$800	4.91	15.38%	35.50%	71.8%	47.0%	30.5%	\$2.16
Burkina Faso	\$590	5.27	22.80%	26.70%	70.5%	72.0%	23.5%	\$0.83
Burundi	\$280	5.62	16.60%	32.96%	87.0%	89.0%	33.8%	\$1.25
Cameroon	\$1370	4.64	24.60%	32.80%	60.6%	68.0%	9.3%	\$0.74
Central African Republic	\$390	4.80	17.84%	28.80%	88.0%	94.2%	40.9%	\$0.06
Chad	\$640	5.85	5.66%	24.60%	73.1%	76.9%	14.6%	\$0.19
Comoros	\$1280	4.28	13.38%	35.73%	91.6%	92.6%	10.8%	\$3.94
Cote d'Ivoire	\$1580	4.85	22.72%	29.30%	86.6%	73.0%	15.0%	\$0.82
DRC*	\$460	6.02	11.01%	39.80%	42.7%	99.0%	43.4%	\$2.91
Eritrea	n.a.	4.06	7.12%	30.23%	91.1%	87.0%	11.7%	\$0.02
Ethiopia*	\$740	4.08	26.88%	23.90%	84.5%	59.0%	15.3%	\$3.67
Gambia	\$680	5.36	8.14%	26.17%	n.a.	72.0%	43.8%	\$0.03
Guinea	\$790	4.78	10.96%	24.70%	92.0%	n.a.	27.2%	\$8.37
Guinea-Bissau	\$660	4.56	29.70%	21.89%	88.4%	71.0%	20.3%	\$0.11
Haiti*	\$760	2.87	22.85%	38.64%	96.4%	98.0%	38.4%	\$2.25
Liberia*	\$620	4.51	33.77%	28.24%	99.4%	85.0%	30.1%	\$3.00
Madagascar*	\$400	4.13	34.80%	25.20%	41.3%	79.0%	25.1%	\$1.21

\* USAID FP Priority Country | See Annex 3 for the Color-Coding Classification Scheme

● long-term, low-priority transition range | ● medium-term, higher-risk transition range  
● short-to medium-term, lower-risk transition range

**TABLE 3.2 (continued): Family planning and health financing indicators for countries in the long-term, low-priority transition category**

Country	GNI per Capita (USD)  Source: World Bank, Atlas Method (2017)	Total Fertility Rate  World Bank (2017)	Modern Contraceptive Prevalence Rate  FP2020 Annual Report (2018) & World Bank (since 2012)	Percent Unmet Contraceptive Need  FP2020 Annual Report (retrieved 2019; various years)	Share of HIV Spending from Donors  UNAIDS GAM (retrieved 2019)	Share of Immunization Spending from Donors  WHO Immunization Financing (2017)	DAH as % Current Total Health Expenditure  WHO GHED (2016)	Donor Expenditure on Family Planning per WRA (USD)  IHME (2017); UN (2015)
Malawi*	\$320	4.51	46.60%	18.30%	97.4%	94.0%	53.8%	\$5.21
Mali*	\$770	5.97	13.48%	26.80%	100.0%	84.0%	32.7%	\$3.23
Mauritania	\$1100	4.61	9.76%	32.10%	100.0%	54.0%	8.2%	\$0.46
Mozambique*	\$420	5.18	32.55%	26.00%	97.4%	72.0%	38.1%	\$3.42
Niger	\$360	7.18	15.62%	19.80%	99.2%	68.0%	13.0%	\$1.02
Nigeria*	\$2100	5.46	13.82%	24.80%	88.7%	76.0%	9.8%	\$0.87
Rwanda*	\$720	3.81	30.02%	22.70%	90.9%	85.0%	50.6%	\$1.85
Sao Tome and Principe	\$1770	4.39	32.60%	32.02%	92.5%	35.0%	44.6%	\$0.09
Senegal*	\$1240	4.70	18.76%	25.30%	74.0%	24.0%	6.1%	\$4.28
Sierra Leone	\$510	4.36	24.79%	26.76%	99.0%	93.0%	41.0%	\$0.76
Somalia	n.a.	6.17	14.23%	29.41%	100.0%	n.a.	n.a.	\$0.22
South Sudan*	n.a.	4.77	2.74%	30.80%	90.5%	86.7%	n.a.	\$1.62
Tajikistan	\$990	3.31	20.81%	24.68%	92.0%	68.1%	5.1%	\$0.69
Timor-Leste	\$1790	5.39	15.56%	27.62%	98.8%	77.0%	31.6%	\$4.07
Togo	\$610	4.38	23.31%	34.40%	79.9%	44.0%	20.7%	\$0.06
Uganda*	\$600	5.50	27.54%	32.60%	87.0%	65.0%	40.4%	\$3.59
Yemen*	n.a.	3.89	20.43%	32.30%	71.0%	n.a.	n.a.	\$0.75
<b>AVERAGE (unweighted)</b>	<b>\$835</b>	<b>4.82</b>	<b>20.19%</b>	<b>28.56%</b>	<b>85.6%</b>	<b>74.5%</b>	<b>26.5%</b>	<b>\$1.88</b>

\* USAID FP Priority Country | See Annex 3 for the Color-Coding Classification Scheme

● long-term, low-priority transition range | ● medium-term, higher-risk transition range  
● short-to medium-term, lower-risk transition range



## Countries with Long-Term, Low-Priority Transition

Thirty-five countries in this category (see Table 3.2) are not likely to transition in FP in the coming decade, and some may not transition for several decades or longer. Their low incomes, large unmet need for contraception, and limited domestic financing allocated to FP suggests that they will remain heavily dependent on donor aid in the coming two decades. In general, these countries have a GNI per capita of less than \$1000, a total fertility rate (TFR) of greater than 4 children per woman, and a modern contraceptive prevalence rate (mCPR) of less than 25%. Unmet contraceptive need exceeds 30%. Thirty of the 35 countries are in sub-Saharan Africa, with two from Central Asia and one each from the Caribbean, the Pacific, and the Middle East. Graduation from Global Fund assistance for HIV and from the Gavi immunization program is generally not anticipated until after 2040, as most of the funding for key health programs in HIV/AIDS, tuberculosis, malaria, and immunization stems from donor aid. However, some of these countries may still find it hard to cope with even a leveling off or reduction in donor support, especially if their national budgets do not prioritize basic health services, because of population momentum: as an increasing number of individuals enter reproductive age, unmet need is anticipated to grow rapidly.

These countries which are unlikely to transition are a priority for global family planning initiatives such as FP2020 because they represent the highest level of both financial and contraceptive need. Their average fertility rate of 4.8 translates to high maternal mortality ratios that could be mitigated by increased modern contraceptive coverage. These countries rely heavily on donor assistance for health, with DAH accounting for an average of 42.5% of total health expenditure. There is no clear trend in domestic policies related to FP within this category: some countries score high on the Family Planning Policy Effort index, such as Ethiopia, while its neighbor, South Sudan, does not. This result suggests that sociocultural norms and political economies specific to each national and subnational context can dictate the level of public and political commitment to FP initiatives.

Countries in this long-term, low-priority transition category are not anticipated to undergo transitions in other major health areas in the near future. Only eight out of the 35 nations are expected to graduate from the Gavi immunization program before 2040.<sup>77</sup> Additionally, none of the countries in this category is expected to graduate from Global Fund assistance for HIV/AIDS until 2041 or later.<sup>78</sup> Expenditures for HIV, TB, malaria, and immunization are high, and funds overwhelmingly come from donors, not from national governments.

Burundi and Haiti are good examples of low-likelihood, low-priority FP transition countries. Burundi has a GNI per capita of \$280 and one of the highest TFRs in the world at 5.62, and its mCPR of 16.6% is among the lowest. Nearly 33% of WRA in the country would like to avoid pregnancy but are not currently using modern contraceptives, and the maternal mortality ratio is 712 per 100,000 live births. Burundi is also heavily dependent on donor aid in HIV and immunization; the country is not anticipated to graduate from Gavi or GF HIV assistance until after 2040. Because of these significant FP outcome and funding challenges in Burundi, continued donor involvement in FP programming for the near future is needed to improve FP indicators prior to initiating transition.

Haiti has a much lower TFR of 2.87, but its low GNI per capita (\$760), low mCPR (22.85%) and high unmet contraceptive need (38.64%) situate the country firmly within the in the low transition likelihood group. Haiti depends heavily on foreign assistance for health; its graduations from Gavi and the Global Fund HIV program are not expected until after 2040, and DAH accounts for over 85% of expenditures in the key disease areas of HIV, TB, malaria, and immunization. Continued external funding over the long-term will be required to sustain Haiti's FP programming.

<sup>77</sup> Silverman, R. (2018). Projected health financing transitions: timeline and magnitude. Center for Global Development Working Paper.

<sup>78</sup> Ibid.

Nations in this category are many years away from transition in FP and other health areas, but incremental transfer of responsibility for FP activities could be prudent so that eventual simultaneous graduations in numerous major disease programs do not overwhelm domestic institutional and financial capacity and result in poor outcomes for FP programs. Additionally, if

domestic policies in key donor countries result in unexpected, significant decreases in the amount of available FP funding, this group of countries—which is more reliant on external resources—will be disproportionately affected. Early and gradual transition planning in these countries can mitigate the possible risk of donor funding volatility for FP and SRH.

## Countries with Short- to Medium-Term, Lower-Risk Transition

The 23 middle-income countries in this category (see Table 3.3) should be generally well-positioned to transition from donor assistance for FP in the short- to medium-term because of their relatively high national incomes, limited donor dependence in the health sector, and more advanced status in achieving FP goals. Overall, these nations are more affluent, with an average GNI per capita of over \$3600. Their geographic distribution is varied: most are in the MENA, LAC, or ECA regions, with smaller representation from South Asia, East Asia, and Africa. They typically have a TFR less than 3, an mCPR of 40% or greater, and unmet contraceptive need of less than 20%.

Because of their higher national incomes, they are either ineligible for Gavi assistance or are transitioning from Gavi within the next five years, and only six of the 23 countries are projected to be receiving support from the Global Fund for HIV past 2030. DAH accounts for an average of only 2% of total health expenditure for these countries. A few of the countries remain dependent on

donor aid in specific disease areas, such as Ukraine (77% of HIV spending from donors) and Indonesia (57% of TB spending from donors). However, national governments in these countries contribute a large majority of the financing for HIV, TB, malaria, and immunization programs.

FP transitions in this shorter-term, lower-risk transition category can be expected to occur relatively smoothly in large part because these countries have greater financial capacity to absorb FP program costs. Their dependence on outside funding for FP is low: currently only six of the 23 countries receive more than \$1M in DAH annually for FP. Even when the donor funding is larger, it only represents a very small fraction of national FP spending. In India, for example, FP donor assistance of \$24.6M annually amounts to less than 10% of domestic public spending for family planning.<sup>79</sup> Because these countries already fund and implement most of their FP activities, reduced donor support and exit should be relatively less difficult, though not necessarily challenge-free.

<sup>79</sup> IHME DAH database, 2017; FP2020 Annual Report, 2018.

**TABLE 3.3: Family planning and health financing indicators for countries in the short- to medium-term, lower-risk transition category**

Country	GNI per Capita (USD)  Source: World Bank, Atlas Method (2017)	Total Fertility Rate  World Bank (2017)	Modern Contraceptive Prevalence Rate  FP2020 Annual Report (2018) & World Bank (since 2012)	Percent Unmet Contraceptive Need  FP2020 Annual Report (retrieved 2019; various years)	Share of HIV Spending from Donors  UNAIDS GAM (retrieved 2019)	Share of Immunization Spending from Donors  WHO Immunization Financing (2017)	DAH as % Current Total Health Expenditure  WHO GHED (2016)	Donor Expenditure on Family Planning per WRA (USD)  IHME (2017); UN (2015)
Algeria	\$3940	2.71	50.00%	n.a.	1.8%	0.0%	0.0%	\$0.00
Armenia	\$3990	1.60	28.00%	n.a.	56.0%	5.8%	1.7%	\$0.66
Azerbaijan	\$4080	1.90	n.a.	n.a.	31.1%	22.0%	0.4%	\$0.00
Bhutan	\$2660	2.02	47.36%	11.67%	n.a.	94.0%	4.8%	\$0.02
Bolivia	\$3130	2.84	32.43%	35.30%	41.4%	6.0%	3.2%	\$0.04
Egypt	\$3010	3.21	41.37%	14.02%	48.9%	0.0%	1.0%	\$0.05
El Salvador**	\$3560	2.06	68.00%	n.a.	14.3%	18.9%	2.3%	\$0.03
Georgia	\$3770	1.99	n.a.	n.a.	30.6%	3.0%	2.3%	\$0.02
Guatemala	\$4060	2.92	48.90%	n.a.	30.6%	0.0%	0.9%	\$1.93
Honduras	\$2250	2.42	44.17%	18.43%	46.9%	16.0%	3.1%	\$0.28
India*	\$1790	2.30	40.01%	19.00%	n.a.	64.0%	1.0%	\$0.07
Indonesia**	\$3540	2.34	45.51%	13.90%	57.6%	12.0%	0.4%	\$0.06
Iraq	\$4630	4.31	26.90%	26.11%	n.a.	n.a.	0.4%	\$0.00
Jordan	\$3980	3.31	37.40%	n.a.	7.4%	0.0%	5.7%	\$3.58
Moldova	\$2200	1.23	41.70%	n.a.	61.1%	26.0%	3.7%	n.a.
Mongolia	\$3270	2.71	40.31%	19.97%	40.8%	7.0%	3.9%	\$0.00
Morocco**	\$2860	2.45	58.00%	n.a.	49.5%	n.a.	0.7%	\$0.03
Nicaragua**	\$2130	2.17	52.88%	8.54%	56.5%	26.0%	4.6%	\$0.07
Philippines*	\$3660	2.89	25.75%	30.90%	56.0%	0.0%	2.2%	\$0.43
South Africa**	\$5430	2.43	47.03%	14.98%	23.5%	n.a.	1.9%	\$0.04
Sri Lanka**	\$3850	2.03	50.13%	19.50%	45.3%	n.a.	0.9%	\$0.00
Tunisia**	\$3490	2.18	50.90%	n.a.	95.7%	2.0%	0.1%	\$0.00
Ukraine	\$2390	1.37	47.80%	n.a.	77.0%	0.0%	0.8%	\$0.00
<b>AVERAGE (unweighted)</b>	<b>\$3377</b>	<b>2.41</b>	<b>44.03%</b>	<b>19.36%</b>	<b>43.6%</b>	<b>16.0%</b>	<b>2.0%</b>	<b>\$0.32</b>

\* USAID FP Priority Country | \*\* USAID FP Graduated Country | ● long-term, low-priority transition range | ● medium-term, higher-risk transition range | ● short- to medium-term, lower-risk transition range

The nations in this category are likely to experience simultaneous health graduations in the upcoming years, but they are more able to leverage domestic resources to close the comparatively narrow funding gap left by donor withdrawal.

El Salvador (2017 GNI per capita of \$3560) is an example nation within this category. It has already graduated from USAID FP assistance,<sup>80</sup> and the country's TFR of 2.06 and mCPR of 68.0% are impressive. According to IHME, El Salvador received only \$45,000 of DAH for FP in 2017, and DAH as a percentage of total health expenditure is a relatively low 2.3%.

However, there may still be challenges to sustaining FP programs in some of these countries, particularly those that struggle to address inequities in contraceptive coverage and quality and those that rely significantly on donor aid for other disease programs. The Philippines, for example, has an mCPR of 25.75% and over

30% unmet contraceptive need. Over half of the nation's expenditures on HIV and TB come from the donor aid, and transition from the Global Fund is expected within a decade. While DAH accounts for only 2.2% of overall Philippine health expenditures, the additional financial strain of HIV transition, coupled with the historical influence of religion upon the national FP political economy, may preclude adequate government resource mobilization to address the low mCPR and satisfy unmet FP need. In this case, out-of-pocket expenditures for FP could rise, exacerbating inequity of access to contraceptives by socioeconomic status.

Easy transition with sustained FP program results is not guaranteed for all countries in this category. The erosion of past gains due to financial, procurement, or policy/political factors could occur in some of these nations and might merit targeted analysis and focused action to avoid backsliding.

## Countries with Medium-Term, High-Risk Transition

The 22 LMIC countries in this category (see Table 3.4) need to be most vigilant about FP transition, since gradual declines in FP donor funding may start soon, with full transition possible in the medium term (upcoming 5-10 years), and domestic capacity to fund and sustain family planning is at serious risk.

In general, these 22 countries have intermediate incomes, with GNI per capita between \$1000 and \$3000. They typically have a TFR between 3 and 4, an mCPR between 25% and 55%, and unmet contraceptive need between 20% and 30%. Transition from Gavi is anticipated between 2025 and 2040, and from Global Fund HIV assistance between 2030 and 2040. Most countries in this group remain heavily dependent on donors to fund

HIV, TB, malaria, and immunization programs, but some have already assumed responsibility for at least a third of expenditures in two or more disease areas.

Most of the nations in this category are FP2020 focus countries because their average mCPR (32.9%) remains low, and they have significant unmet contraceptive need. However, because of their higher national incomes, they have greater capacity to take on financial responsibility for health programming. This point is reinforced by the shorter timelines for transition in immunization; all but one of the 22 countries are expected to graduate from Gavi prior to 2040, and most within the next decade.<sup>81</sup>

<sup>80</sup> See: <https://www.usaid.gov/global-health/health-areas/family-planning/countries#graduated>

<sup>81</sup> Silverman (2018).

**TABLE 3.4: Family planning and health financing indicators for countries in the medium-term, higher-risk transition category**

Country	GNI per Capita (USD) <small>Source: World Bank, Atlas Method (2017)</small>	Total Fertility Rate <small>World Bank (2017)</small>	Modern Contra- ceptive Prevalence Rate <small>FP2020 Annual Report (2018) &amp; World Bank (since 2012)</small>	Percent Unmet Contraceptive Need <small>FP2020 Annual Report (retrieved 2019; various years)</small>	Share of HIV Spending from Donors <small>UNAIDS GAM (retrieved 2019)</small>	Share of Immuniza- tion Spending from Donors <small>WHO Immunization Financing (2017)</small>	DAH as % Current Total Health Expen- diture <small>WHO GHED (2016)</small>	Donor Expenditure on Family Planning per WRA (USD) <small>IHME (2017); UN (2015)</small>
Angola	\$3570	5.62	12.50%	n.a.	83.6%	n.a.	3.6%	\$0.91
Bangladesh*	\$1470	2.08	45.50%	19.10%	95.6%	73.0%	7.6%	\$0.75
Cambodia	\$1230	2.53	30.07%	28.04%	95.3%	77.0%	18.9%	\$0.74
Congo	\$1430	4.60	26.20%	36.92%	50.8%	80.0%	3.3%	\$0.02
Djibouti	\$1880	2.79	19.03%	30.02%	90.5%	59.3%	27.8%	\$1.87
eSwatini**	\$2950	3.03	65.50%	n.a.	65.8%	7.0%	13.8%	\$3.03
Ghana*	\$1880	3.93	22.08%	33.60%	62.6%	65.0%	12.8%	\$1.37
Kenya*	\$1460	3.79	42.74%	20.30%	63.1%	n.a.	19.5%	\$4.01
Kyrgyz Republic	\$1130	3.00	28.23%	20.10%	87.1%	73.3%	3.3%	\$0.00
Laos	\$2270	2.64	36.46%	22.90%	87.7%	68.0%	18.1%	\$0.00
Lesotho	\$1210	3.04	50.44%	16.50%	57.6%	80.3%	17.3%	\$0.08
Myanmar	\$1210	2.19	32.35%	16.23%	85.0%	n.a.	5.9%	\$0.02
Nepal*	\$800	2.08	38.09%	27.60%	81.9%	73.0%	11.7%	\$1.20
Pakistan*	\$1580	3.41	20.80%	29.30%	63.7%	82.0%	4.1%	\$0.71
Papua New Guinea	\$2340	3.61	19.66%	31.42%	80.6%	89.0%	22.1%	\$0.15
Solomon Islands	\$1920	3.80	16.97%	30.45%	83.3%	56.0%	26.2%	\$0.67
Sudan	\$2380	4.47	2.74%	30.80%	65.4%	81.0%	2.2%	\$0.17
Tanzania*	\$920	4.95	31.24%	26.90%	54.7%	n.a.	36.4%	\$3.13
Uzbekistan	\$2000	2.46	46.89%	12.29%	39.1%	1.0%	1.2%	\$0.00
Vietnam	\$2160	1.95	48.42%	19.05%	68.2%	9.0%	2.3%	\$0.01
Zambia*	\$1290	4.93	35.84%	23.00%	93.3%	80.8%	42.5%	\$1.91
Zimbabwe	\$1170	3.68	51.61%	9.90%	86.4%	77.0%	25.4%	\$1.03
<b>AVERAGE (unweighted)</b>	<b>\$1739</b>	<b>3.39</b>	<b>32.88%</b>	<b>24.22%</b>	<b>74.6%</b>	<b>62.9%</b>	<b>14.8%</b>	<b>\$0.99</b>

\* USAID FP Priority Country | \*\* USAID FP Graduated Country ● long-term, low-priority transition range | ● medium-term, higher-risk transition range | ● short- to medium-term, lower-risk transition range

Many countries in this category are already in the preparatory or accelerated transition phase within the Gavi graduation program, paying a significant portion of overall immunization expenditures with domestic resources. For example, the Vietnam government contributed 91% of all immunization expenditures in 2017 and is expected to become fully self-financing in immunization by 2020. Meanwhile, other nations in this category, such as Papua New Guinea and Sudan, relied on donor support for over 80% of immunization spending in 2017 despite anticipated Gavi transitions by 2025. Six of the 22 medium-term, higher-risk FP transition countries are projected to transition from the Global Fund for HIV before 2040,<sup>82</sup> and most of them will likely experience steady declines in Global Fund support in the years leading up to full transition. Nine countries in this group finance at least one-third of total HIV expenditures with domestic resources, and 14 finance at least one-third of total malaria expenditures with domestic funding.

Health and family planning transitions over the coming decade for nations in this category will place a significant financial burden on national governments. While DAH only accounts for an average of 14.8% of total health expenditures in the 22 nations, most are still dependent on donor funding in the areas of HIV, TB, malaria, and immunization. In addition, as the three country case studies illustrate, these countries also face other problems and constraints – such as weak national procurement systems, low capacity to set priorities in health, policies and laws that inhibit access to FP services, and limited political support for family planning – that create a high risk to successful and sustained FP transition.

Ghana, Kenya, and Bangladesh are three countries within this medium-term, higher-risk country cohort that have been selected for in-depth analysis in case studies.

**Ghana** (2017 GNI per capita of \$1880) relies heavily on foreign aid for major infectious disease programs, with DAH comprising over 65% of expenditures in HIV, TB, and immunization. Although Ghana's National Health Insurance Scheme (NHIS) provides coverage for many health services and products, the system is significantly underfunded and slow to reimburse providers. Consequently, out-of-pocket expenditures account for nearly 40% of total health expenditure in Ghana, exacerbating inequality in access to health services by socioeconomic status. Ghana is facing imminent transition from Gavi, and the Global Fund has begun to assess the country's preparedness for increased domestic contribution to nations HIV, TB, and malaria programs.<sup>83</sup>

Ghana's family planning indicators remain low, with 22% mCPR and 33.6% unmet contraceptive need. High out-of-pocket FP spending and inconsistent supply of FP commodities contribute to these poor indicators. According to a 2012 National Health Insurance Authority act, family planning packages should be covered by NHIS, but this "guarantee" is not implemented in practice. One donor (DFID) has already withdrawn from direct family planning activities in Ghana, and it intends to conclude all HSS initiatives in Ghana entirely by 2022. The medium-term stances of other donors (notably USAID and UNFPA) are uncertain; though these organizations do not plan to transition from FP in Ghana in the near-term, U.S. and international funding challenges may constrain future FP activities. Much needs to be done to prepare Ghana for possible declines in external support for FP, especially as the national family planning program is likely to need additional financing in order to meet national and international FP goals. The case study in this report analyzes these challenges and examines options for enhancing Ghana's readiness to face FP transition in the context of other health transitions and reforms of the national health financing and delivery system.

<sup>82</sup> Silverman (2018).

<sup>83</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.



**Kenya** (2017 GNI per capita of \$1,460) experienced considerable gains in its FP program outcomes from the mid-2000s to the early 2010s. However, governmental devolution in 2013 placed most health financing responsibility at the county level, resulting in a reduction of political commitment to financing and stewarding FP programs along with a regression of FP indicators. The relatively high national mCPR of 42.7% masks significant regional variation in contraceptive use, and unmet need stands at 20.3%. In FY2016, approximately 75% of FP funding in Kenya came from donors, and the majority of domestic funds for FP were directed towards health worker salaries. Limited domestic financing of the FP program, particularly FP commodities, has led to a looming crisis of contraceptive stock-outs across the nation. Key FP donors in Kenya, including USAID, DFID, and the Gates Foundation, are in the process of negotiating a commodity co-financing plan with the Kenyan government to increase domestic FP funding commitments and avert the stock-out crisis.

Kenya also relies on donor assistance in other major health programs. External funds accounted for 63% of all HIV expenditures and 53% of all malaria expenditures in 2016. Transition from Global Fund assistance is not anticipated until after 2041 due to high HIV, TB, and malaria disease burdens, but full transition from Gavi is expected by 2024 based upon Kenya's increasing national income.<sup>84</sup> PEPFAR, a key HIV donor in Kenya, is also contemplating a decline in financial assistance in the near term.<sup>85</sup> As health accounts for only 7-8% of Kenya's budgetary spending, the country does not currently have the fiscal space to efficiently fund the financial gaps left by exiting donors. High-cost donor-backed health programs are only partially included in the National Hospital Insurance Fund (NHIF); for example, malaria treatment is covered, but HIV care is not, largely due to the expense of ARTs. While FP services are technically covered, consumer and provider understanding of FP inclusion in NHIF is limited. Kenya plans

to adopt a UHC scheme that is currently not designed or adequately funded to absorb the costs of major health programs, including HIV and FP, as donors transition from the country.

Kenya faces significant challenges in health financing, priority-setting, and governance that place the country's already-tenuous FP program at serious risk as transition approaches. This case study assesses these risks of transition and examines options for improving Kenya's preparedness for FP transition in the context of other health transitions and reforms of the national health financing system.

**Bangladesh** (2017 GNI per capita of \$1,470) is the most advanced of the three case study countries in its FP transition status. Due to strong, high-level political commitment to lowering national fertility, the country's FP program has witnessed great success since its inception in the 1970s. Fertility rates have dropped to near-replacement levels, and mCPR stands at 45% (married women), with unmet need at 19%. Bangladesh exceeds the USAID TFR threshold for graduation and is approaching the mCPR threshold; for this reason, USAID expects to graduate Bangladesh from FP assistance in the next decade or sooner.<sup>86</sup> Similarly, DFID and UNFPA funding for FP in Bangladesh is only assured through 2022; additional funding past that year is uncertain.<sup>87</sup> Though donors are only minimally involved in financing and procuring FP commodities in Bangladesh—the government funds 96% of FP commodities—external resources are still the primary source of funding for important complementary FP activities such as behavioral change communication, FP research and surveys, quality assurance, monitoring and evaluation, and outreach to key vulnerable populations, particularly married adolescents and the poor. Careful transition planning involving all FP stakeholders is necessary to ensure that these essential enabling environment activities are properly transferred to the national government prior to upcoming FP donor withdrawal.

<sup>84</sup> Silverman (2018).

<sup>85</sup> In-country informant.

<sup>86</sup> In-country informant.

<sup>87</sup> In-country informant.

In comparison to FP, other major health programs in Bangladesh are not as well-positioned for transition. Donor resources accounted for 96% of HIV spending, 84% of TB spending, 77% of malaria spending, and 73% of immunization spending in 2017-18. Though transition for HIV, TB, and malaria are not expected in the next decade, Bangladesh's co-financing requirements to the Global Fund will increase as its national economy grows. Moreover, Gavi is actively preparing for immunization transition in Bangladesh, and it plans to withdraw from the country entirely by 2026. The fiscal space for health in Bangladesh is exceedingly narrow; the Bangladesh health budget accounts for only 5% of the total national budget and less than 1% of GDP. As Bangladesh's domestic financing responsibilities for major infectious disease programs accumulate, and as the country attempts to address heavy reliance on OOP payments in the health sector through the adoption of a UHC scheme, adequate financial resources for the FP

program—especially enabling environment activities—may no longer be available. Despite these challenges, informants were unaware of any ongoing transition planning in FP or the health sector generally.

Bangladesh faces difficult upcoming transitions in its infectious disease programs that will put additional pressures on the already-limited national health budget. Though the FP program's basic contraceptive procurement and supply functions should experience a relatively smooth transition, the fiscal and managerial requirements of other health transitions may jeopardize FP enabling environment activities that are essential to sustaining and improving upon the program's historic success. This case study assesses these transition risks and proposes options for bolstering Bangladesh's readiness for FP transition in the context of the country's other financing and capacity challenges in the health sector.





# Chapter 4: Ghana Country Case Study

## Executive Summary

Ghana has the ambition to become self-reliant from aid, but the country has not developed concrete strategies to achieve this goal in health and specifically in family planning (FP). This situation exists despite declining aid and funding gaps in key health areas such as FP and HIV. Within the Ghanaian context, FP is not central to the national development agenda, nor are the explicit contributions of FP to other Sustainable Development Goals (SDGs) defined. The current Ghana National Development Plan does not mention reproductive health or rights and, while there are a few strong female advocates for FP within government, they alone have not generated sufficient political will on this issue.

Ghana's modern contraceptive prevalence rate (mCPR) has not accelerated relative to other sub-Saharan African countries nor in accordance with its LMIC status. Its FP performance lags behind other countries such as Kenya and Bangladesh. The country continues to have high levels of unmet need, estimated at 33.6%, which exceeds the mCPR of 22.1% (all women). While some indicators of FP access have improved, such as a reduction in rural-urban disparities in access and use of FP in some regions of the country, there remain many missed opportunities such as post-partum FP, and areas of concentrated need, both geographically and within sub-populations such as adolescents.

Current FP programming in Ghana remains highly donor dependent. While Ghana's FP2020 commitments

call for greater domestic resource allocation for FP, in practice, these funds have not materialized as expected, nor are they adequately tracked using FP expenditure surveys.<sup>88</sup> The Government of Ghana (GoG) finances only 10% of FP commodity resources (mainly in the form of warehousing and personnel costs) while donors funded all contraceptive commodities in Ghana for the period 2016-2018.<sup>89</sup> Furthermore, any additional GoG contributions to other FP program activities are not documented.<sup>90</sup> Donor contributions for FP are currently sourced from two main partners, UNFPA and USAID, which provide almost all commodity financing for the country. Additionally, Ghana relies on external partners for FP commodity procurement, supply chain management, and technical assistance for activities such as data analysis, thus increasing its vulnerability to a rapid transition away from donor aid.

While government and donor officials interviewed for this case study were aware of the possibility of FP transition, most had not considered the potential risks and challenges of transition. The leading FP donors—USAID and UNFPA—do not appear to be contemplating full exit from Ghana's FP program in the next few years, but gradual declines in FP funding alongside decreasing external resources for other health programs in Ghana could put pressure on domestic resources to fill a wider FP funding gap.<sup>91</sup> No formal FP sustainability and transition planning has begun, putting FP behind other national priority health programs in this regard.

<sup>88</sup> Ghana government and partner respondent interviews.

<sup>89</sup> In-country respondent. It is likely that this has been the case for longer, however, data was only availed for this timeframe.

<sup>90</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>91</sup> Partner respondent interviews.

Alongside FP program transition, the country also faces fiscal pressures due to other health program funding requirements. In 2017, Ghana was responsible for a total of US \$144 million in co-financing payments to support immunization, HIV/AIDS, TB, and malaria programs backed by Gavi, Global Fund, and PEPFAR. As Ghana's health financing capacity matures, its co-financing obligations are also expected to increase, reaching US \$350 million in 2025, approximately half of the total Ministry of Health budget (including donor funds) and 70% of all domestic government funds for health in 2016.<sup>92,93</sup> Whereas in the past, co-financing requirements for some priority health programs such as HIV and TB were loosely interpreted, compliance has become more rigorously measured in recent years by donors, and the consequences of defaulting include the loss of significant donor grant awards. Moreover, as Ghana approaches the formal five-year accelerated transition period with Gavi in 2021, its co-financing requirements will keep increasing. FP donors do not have similar formal arrangements for domestic co-financing, nor do they have any recourse if the GoG does not offer expected contributions.<sup>94</sup> This situation creates a serious risk for FP if Ghana fulfills its co-financing commitments to the HIV/TB/malaria and immunization donors by prioritizing funding for these other programs over FP. Additionally, if FP donors later ask Ghana to pay for a larger share of FP costs, the country may be ill-prepared to do so, both fiscally and in terms of political support for FP.

Many health programs are vying for inclusion within Ghana's National Health Insurance Scheme (NHIS) essential benefits package, which includes tertiary, secondary, and primary care, as a key transition and

financial sustainability strategy. For FP, an NHIS pilot project is ongoing to assess the feasibility of including clinical FP service using a case-based payment system; early positive results have emerged. At the same time, funding for FP in the NHIS is at risk of being crowded out by other priority programs, particularly HIV. As one interviewee stated, *"These huge disease areas with high expenditures will eat [the NHIS] up."* While FP and other vertical health programs are under consideration for integration into the NHIS, the government may also look for ways to reduce inefficiencies found within these programs and demand greater accountability for spending and performance.

This context creates a difficult environment for FP program transition in Ghana. The present case study examines the risks and challenges associated with FP transition and identifies key opportunities and areas of improvement for both donors and the national government. This report begins with an introduction to Ghana's current FP program and health financing status. It then examines in-depth the four key components of our FP transition framework: financing for FP and other health programs; procurement and supply chain; technical capacity; and enabling factors, including political commitment and legal & human rights. We conclude the case study by offering specific risks and key options for consideration to prepare Ghana for eventual transition in FP alongside simultaneous transitions in other health programs.

<sup>92</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>93</sup> Ghana MoH, 2018. Medium term expenditure framework for 2018-2021. <https://www.mofep.gov.gh/sites/default/files/pbb-estimates/2018/2018-PBB-MoH.pdf>

<sup>94</sup> See also: Silverman, R., & Glassman, A. (2016). Aligning to 2020: How the FP2020 core partners can work better together. Final report of the Working Group on Alignment in Family Planning.

## Introduction

### Country Context

Ghana has the ambition to become self-reliant from aid, but the country has not developed concrete strategies to achieve this goal in health. To transition from heavy reliance on aid, in health and other sectors, the government has adopted the “Ghana Beyond Aid” charter and strategy. However, as government respondents acknowledged, there is no clear plan for operationalizing the strategy, and it is described as more of a “philosophy.” This lack of attention to or planning for health transition persists despite declining aid and funding gaps in key health areas such as FP and HIV. Through the course of this case study, no donor or government working group focusing on self-reliance and priority health program transitions in health was identified.

FP is not central to the national development agenda nor is it politically championed. Government respondents indicated that Ghana’s strategy for transition to middle-income status is focused on developing economic sectors such as agriculture, mining and manufacturing, the benefits of which will “trickle down” to the health sector. Ghana’s 40-year development plan affirms this.<sup>95</sup> While this plan recognizes the importance of demography in development, it assumes continued rapid population growth, expecting Ghana’s 2017 population to double to 57.3 million by 2057.<sup>96</sup> The plan does not mention reproductive health or rights, nor does it make explicit the contribution of FP to other Sustainable Development Goals (SDGs). While there are strong female advocates for FP within government, they alone cannot generate necessary political will.

### History and Performance of FP Programs in Ghana

Ghana’s FP program has not accelerated relative to other sub-Saharan African countries nor in accordance with its LMIC status. In comparison to other LMICs, Ghana has high levels of unmet contraceptive need despite a long history of FP programing, which commenced in 1970, only a few years after Kenya.<sup>97</sup> The country’s

mCPR is about half of Kenya’s and its unmet need is about double. This rate of unmet need, estimated at 33.6%, has held steady in recent years, with small but not significant improvements (Box 4.1). Some government respondents suggested that these indicators might suffer from underreporting bias.

#### BOX 4.1. FP Performance Indicators

Total users	1,689,000
Additional users since 2012	601,000
mCPR (all women)	22.1%
mCPR (MW)	29%
Unmet need (MW)	33.6%
Demand satisfied (MW)	46%

Source: MoH/Track20 FP2020 performance (2019)

Ghana’s method mix is relatively balanced with an increasing share of more effective methods. Implants account for 30.7% of the method mix, followed by short-term, injectable methods (28.5%), the pill (17.4%), other modern methods (9.7%), male condom (6.1%), female sterilization (5.3%) and IUD (2.2%). Figure 4.1 provides 2015–2020 estimates of Ghana’s method mix. These projections suggest growth in the use of long-acting reversible contraceptives (LARCs) and injectables. These methods have been traditionally provided through the public sector and financed by donors; the Ghana Demographic and Health Survey (GDHS) estimated that 94% of implants, 92% of female sterilization, 90% of injectables, and 84% of IUDs were obtained or performed in public sector facilities.<sup>98</sup> Public sector provision is often done in partnership with NGO partners, such as Marie Stopes International (MSI).<sup>99</sup>

<sup>95</sup> Long-term National Development Plan of Ghana (2018–2057).

<sup>96</sup> Ibid.

<sup>97</sup> World Bank 2019, Taking stock: Financing family planning services to reach Ghana’s 2020 Goals. <http://blogs.worldbank.org/african/taking-stock-financing-family-planning-services-to-reach-ghanas-2020-goals>

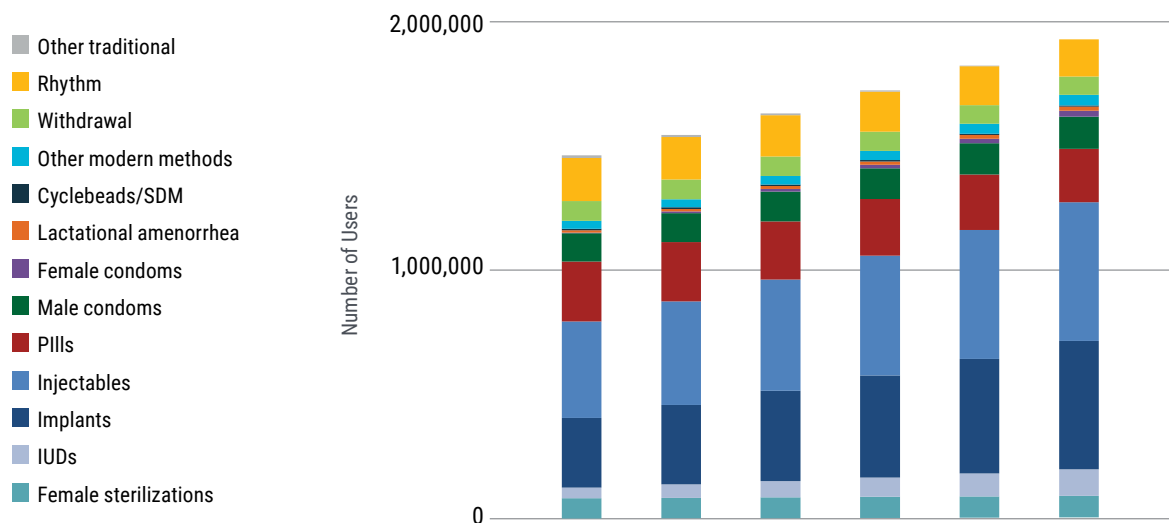
<sup>98</sup> Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. 2015. Ghana Demographic and Health Survey 2014.

<sup>99</sup> Makinen, Marty, Stephanie Sealy, Ricardo A. Bitrán, Sam Adjei, and Rodrigo Muñoz. 2011. “Private Health Sector Assessment in Ghana.” World Bank Working Paper No. 210. Washington, DC: World Bank.

Trends in FP access have improved, but missed opportunities remain. The 2015 GDHS found that more than 77.4% of women in all age groups did not discuss FP in the last 12 months when visited by a health worker or when going to a health facility.<sup>100</sup> Post-partum FP also remains low and is estimated at 4.8% and 7% at six and twelve months, respectively.<sup>101</sup> Trend analysis of consecutive GDHS data sets reveals a gradual increase in the use of modern contraceptives among rural women.<sup>102</sup> This improvement is attributed to the successes of the

Community-based Health Planning Services (CHPS) and the reproductive health (RH) NGOs which “have brought health care services to the door steps of rural residents that are affordable to families and individuals.”<sup>103</sup> These RH NGOs include MSI, Planned Parenthood Association of Ghana (PPAG), several local organizations, and the social marketing organizations GSMF International (formerly known as the Ghana Social Marketing Foundation) and DKT International.

**FIGURE 4.1: Ghana's projected method mix: 2015-2020** (Source: Ghana FP CIP, 2015)



<sup>100</sup> Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. 2015. Ghana Demographic and Health Survey 2014.

<sup>101</sup> Ghana: FP2020 Core Indicator Summary Sheet: 2017-2018 Annual Progress Report.

<sup>102</sup> Aviaiah, P.A., Dery, S., Atsu, B.K., Yawson, A., Alotaibi, R.M., Rezk, H.R., and C. Guure, 2018. BMC Women's Health. 18:141 <https://doi.org/10.1186/s12905-018-0634-9>

<sup>103</sup> Ibid.

## Health Financing in Ghana

Ghana is one of the few LMICs to take early and serious steps towards UHC. The country passed legislation for universal health insurance coverage – the National Health Insurance Scheme (NHIS) – in 2003. The NHIS started by covering vulnerable groups and was able to significantly expand enrollment as a result. Coverage has plateaued in recent years at about 40% of the population.<sup>104</sup> There has also been a clear shift from supply-side financing to demand-side financing for health, using earmarked resources to support the NHIS. However, performance of Ghana's health system is mixed. Consumer satisfaction is reportedly high, and access appears to have improved, including for the poor. However, Ghana performs worse than average on some health outcomes, including under-five, infant, and maternal mortality, compared to other countries at its level of income and health spending.<sup>105</sup> While declines were realized in child mortality indicators in the mid-2000s, under five mortality fell back to its 1990 level by 2013<sup>106</sup> and maternal mortality was declared a national emergency in 2008. Weak health outcomes are associated with a weak health system, low access to quality health services, as well as high unmet need for FP.<sup>107</sup>

Despite the country's LMIC status, fiscal space for health is constrained. As a share of gross domestic

product (GDP), total health expenditure (THE) is slightly below average for LMICs. The health budget constitutes less than 7% of the national budget.<sup>108</sup> There is very limited discretionary budget for health available after recurrent costs have been allocated. The majority of Ghana's on-budget public spending, estimated at 73%, is through the National Health Insurance Authority (NHIA).<sup>109</sup> Within the GHS, there is low budget execution and system inefficiencies, as evidenced by poor health outcomes relative to health investment. The government relies on donor funding for a significant portion of its health budget – an average of 20% over the past five years – with donor assistance concentrated in areas such as HIV (63% in 2016) and TB (76%).<sup>110,111,112</sup>

Most donor financing is concentrated on major infectious disease programs. While these programs (HIV, malaria, immunization) receive the lion's share of donor funding, international contributions for health are on a downward trajectory. Figure 4.2, based on a DFID-sponsored study, estimates future donor financing for six priority health programs through 2025, with funding declining 8% per year on average, from US \$248 million in 2017 to US \$124 million in 2025.<sup>113</sup> External financing is projected to decline most rapidly for FP (15% per annum), followed by HIV/AIDS (10% per annum).<sup>114</sup> Due to DFID's withdrawal

<sup>104</sup> Wang, H. Otoo, N. and L. Dsane-Selby. 2017. Ghana National Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review. World Bank Studies. Washington, DC: World Bank. doi:10.1596/978-1-4648-1117-3. License: Creative Commons Attribution CC BY 3.0 IGO.

<sup>105</sup> Schieber, G., Cashin, C., Saleh, K. and R. Lavado. 2012. Health Financing in Ghana. Washington, DC: World Bank. doi:10.1596/978-0-8213-9566-0. License: Creative Commons Attribution CC BY 3.0.

<sup>106</sup> Wang, Huihui, Nathaniel Otoo, and Lydia Dsane-Selby. 2017. Ghana National Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review. World Bank Studies. Washington, DC: World Bank. doi:10.1596/978-1-4648-1117-3. License: Creative Commons Attribution CC BY 3.0 IGO.

<sup>107</sup> MoH, 2015. Ghana Family Planning Costed Implementation Plan 2016 –2020, MoH, Accra, Ghana.

<sup>108</sup> MoH, 2015. Ghana Family Planning Costed Implementation Plan 2016 –2020, MoH, Accra, Ghana.

<sup>109</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>110</sup> WHO Global Health Expenditures Database in MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>111</sup> Global AIDS Monitoring Report, 2019. <http://aidsinfo.unaids.org/>

<sup>112</sup> WHO Global TB Database, 2017. <https://www.who.int/tb/data/en/>

<sup>113</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

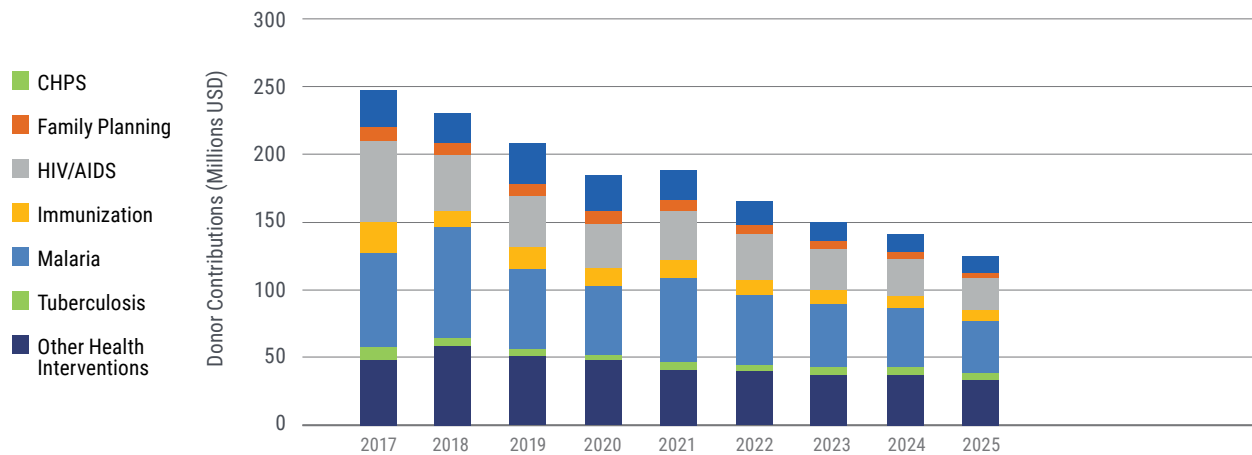
<sup>114</sup> Ibid.

<sup>115</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

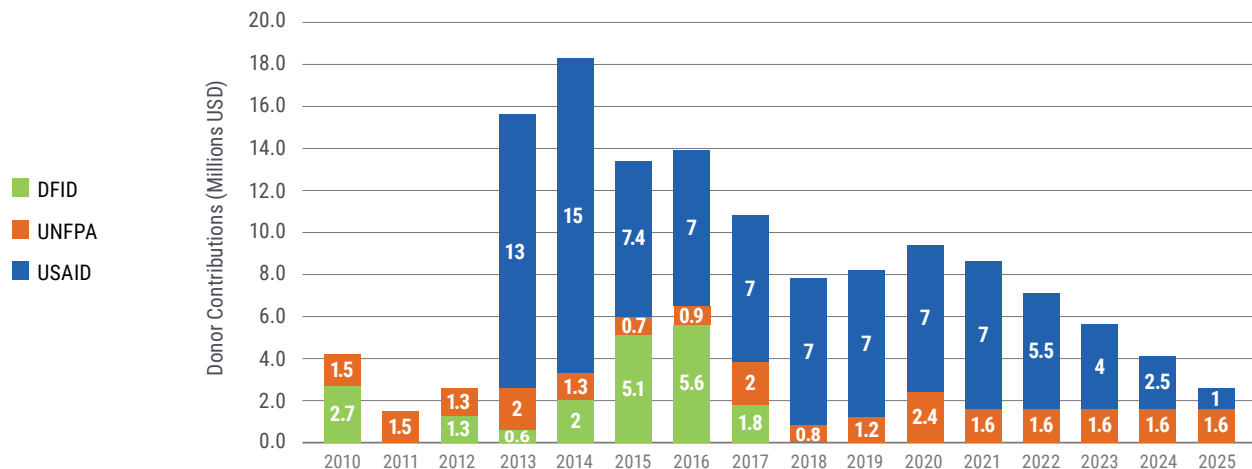
from the FP program in 2016, Ghana is already facing a scenario of reduced donor funding (Figure 4.3).<sup>115</sup> Additionally, although Ghana does not currently meet USAID thresholds for FP program transition and donor informants suggest that USAID is not actively preparing for FP

transition in-country, US funding for important FP service partners in Ghana, such as MSI and PPAG has sharply declined because, these organizations have abstained from signing the Mexico City Policy.

**FIGURE 4.2: Projected donor contributions for six priority health programs in Ghana: 2017-2025** (Source: OPM 2018)\*



**FIGURE 4.3: Figure 4.3: Estimated and projected donor contributions for FP in Ghana: 2010-2025** (Source: OPM 2018)\*



\* These estimates were prepared by OPM researchers in 2018 through extensive in-country consultations with all major health donors in Ghana. In March 2020, officials at USAID headquarters informed us that these estimated declines in US assistance for FP in Ghana through 2025 are inconsistent with current plans to maintain fairly steady funding levels to the program. In this report, we continue to cite OPM's well-researched report but acknowledge USAID's updated information.

<sup>115</sup> Center for Global Development and Kaiser Family Foundation (2018). The USG International Family Planning Landscape: Defining Approaches to Address Uncertainties in Funding and Programming. Discussion summary.

## Financing of FP and Other Health Programs

### Financing of Family Planning

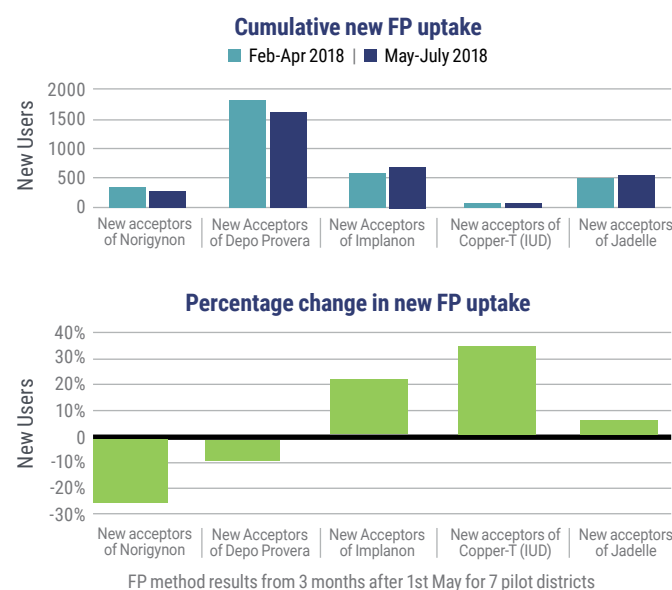
Complete and up to date information on FP financing is not available for Ghana, but what is known suggests that the program is heavily donor dependent. A recent report estimates that the government contributes around US \$1 million of a total FP expenditure of around US \$10 million<sup>117</sup> – presumably for commodities alone, since total FP funding needs are estimated at 4-5 times this amount. Donor funding comes from two main donors—UNFPA and USAID—with the West African Health Organization (WAHO) providing commodity financing and capacity building on a smaller, ad hoc basis.<sup>118</sup> DFID ended its commodity support in 2016 but continued to support FP indirectly through the Health Sector Support Program (HSSP), which concluded in 2018.<sup>119</sup>

Current government strategies for FP financing include the mobilization of additional domestic budgetary resources and the incorporation of FP clinical services in the NHIS package.<sup>120</sup> The GoG has established a dedicated budget line to finance essential health commodities, including contraceptives. However, respondents indicated that execution remains a challenge: while the GoG does “fund” FP in the budget, the money is not always disbursed in full or according to schedule. In practice, the GoG did not contribute to the direct cost of FP commodities from 2016-2018.<sup>121</sup> Only in 2019 has US \$3 million in government funding been released for the procurement of condoms, but this allocation is officially directed towards the HIV program.<sup>122</sup> Moreover, as contraceptive funding is lumped with other health programs’ commodity funds, the FP program cannot track formal government allocations and may receive varying proportions of this line item total each year.

The details of how FP clinical services may be included in the NHIS are not yet known and are largely dependent on the outcome of a pilot currently taking place. Funded by DFID and implemented by the NHIA and MSI, the pilot is testing the provision of clinical methods (permanent, long-acting, and injectable contraceptive services) under the NHIS using a case-based billing code. Preliminary actuarial analysis is promising, as is the increase in utilization of LARCs under the pilot (Figure 4.4).

**FIGURE 4.4: Total and percent change in new FP uptake by method following the initiation of the Nhis pilot**

(Source: Marie Stopes International, 2018)



<sup>117</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>118</sup> Government respondents.

<sup>119</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>120</sup> Ghana: FP2020 Core Indicator Summary Sheet: 2017-2018 Annual Progress Report.

<sup>121</sup> In-country respondent.

<sup>122</sup> Ibid.



The national FP Costed Implementation Plan (CIP) estimates that total annual FP program resource needs from 2016 to 2020 are between US \$40-50 million.<sup>123</sup> In the CIP, commodities and service delivery were estimated at 76% of the total cost, at 14% and 62% respectively. However, as a government respondent indicated, most current FP financing is off-budget, and the government “doesn’t even know how much money is spent, so it’s impossible to plan or predict costs.” Unlike some other FP2020 focus countries, Ghana has not conducted an FP spending assessment. It has completed a recent NIDI survey, but the GoG has not yet validated or released any FP financing survey results.

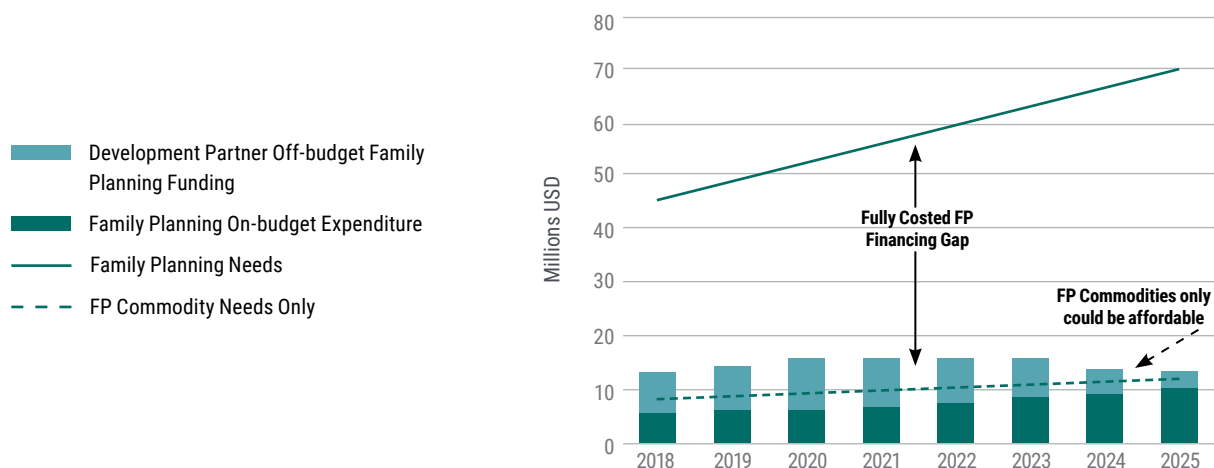
Projected FP resource requirements are available in Ghana through 2025. However, these do not appear to be officially recognized by the GoG, nor are they reflected within domestic planning. Analysis by Oxford Policy Management (OPM) estimates that fully costed FP resource needs would total US \$46 million in 2018, rising to US \$70 million in 2025 (Figure 4.5).<sup>124</sup> This

amount includes all program costs categorized into seven areas: demand creation; service delivery; contraceptives; contraceptive security; policy and enabling environment; financing; and stewardship, management, and accountability. GoG on-budget financing and development partner (DP) funding are primarily directed towards commodity procurement and delivery, and their current funding levels are considered “significantly lower than the fully costed needs.”<sup>125</sup>

### **Fiscal Challenges of Simultaneous Health Transitions**

Declines in donor funding for HIV, TB, malaria, and immunization are taking place concurrently in Ghana. This process is not well choreographed among donors, or between donors and government. As stated in the OPM report, development partners “do not all have similar or aligned transition plans, if they have plans at all.”<sup>126</sup> However, indicators of impending transition include a reduction in the number of donors funding health, shrinking donor allocations, and stronger conditions around domestic co-financing.

**FIGURE 4.5: FP Financing Gap Projections (million USD)** (Source: OPM, 2018)



<sup>123</sup> Government of Ghana. 2015. Accra: Ghana Health Service. 2015. Washington, DC: Futures Group, Health Policy Project. Ghana Family Planning Costed Implementation Plan.

<sup>124</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>125</sup> Ibid.

<sup>126</sup> Ibid.



Some long-standing donors have recently left the Ghanaian health sector, including the European Union and the Danish International Development Agency, with more donors anticipated to transition out of health and of aid to Ghana in general.<sup>127</sup> For example, DFID, which has provided over 10% of external health financing in Ghana since 2010, intends to depart from direct health sector assistance in 2019 and from all health-related TA activities by 2022.<sup>128</sup> According to OPM, USAID anticipates a reduction in all health activities in Ghana starting in 2021, and Gavi expects Ghana to become fully self-financing in immunization by 2027 (Table 4.1).<sup>129</sup>

Co-financing payments are an opportunity to ensure

domestic financial sustainability, but current program estimates suggest a very large increase in required domestic funding in the next few years. Gavi, the Global Fund, and PEPFAR have incorporated significant co-financing requirements into their grant packages to prepare the country for national “ownership” of health programs and to promote sustainable financing. In 2019 alone, Ghana’s expected co-financing requirements include US \$3.5 million to Gavi, US \$227.2 million to the Global Fund, and US \$8.3 million to PEPFAR.<sup>131</sup> Moreover, for the period 2019-2025, Ghana’s co-financing requirements will total over US \$2 billion.<sup>132</sup> Whereas informants described loose monitoring and enforcement of co-financing requirements in the past,

**TABLE 4.1: Timeline of donor health aid withdrawal in Ghana through 2027** (Source: OPM, 2018)<sup>130</sup>

Donor	FP	HIV/AIDS	Immunization	Malaria	TB	Health TA
<b>DFID</b>	Ended 2017; some TA ongoing to 2022			Ends 2019		Ends 2022
<b>Gavi</b>			Accelerated transition begins 2021; full transition by 2027			
<b>Global Fund</b>		Medium/long-term		Medium/long-term	Medium/long-term	
<b>JICA</b>		Ended 2016				Medium/long-term
<b>KOFIH</b>						Medium/long-term
<b>UNFPA</b>	Medium/ long-term	Low-level aid ongoing				
<b>USAID</b>	Expected to decline starting 2021*	Expected to decline starting 2021		Expected to decline starting 2021		Medium/long-term
<b>World Bank</b>		Ended 2015		Ended 2014		Medium/long-term
<b>WHO</b>		Medium/long-term	Medium/ long-term	Medium/long-term	Medium/long-term	Medium/long-term

\* See page 41 for updated information from USAID headquarters regarding future US financing of the Ghana FP program.

<sup>127</sup> Ibid.

<sup>128</sup> Ibid.

<sup>129</sup> Ibid.

<sup>130</sup> See Annex 5 for full OPM data.

<sup>131</sup> Ibid.

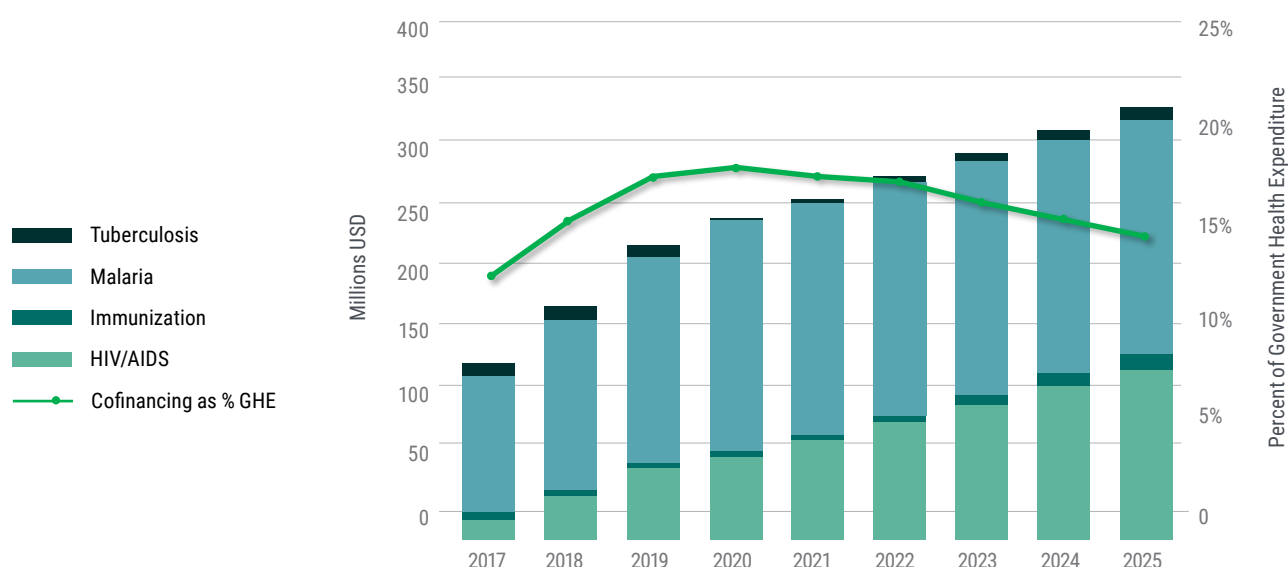
<sup>132</sup> Ibid.

particularly for the Global Fund, current consequences of defaulting on co-financing agreements have become more severe, resulting in losses of and delays in grant funding. According to an informant, the Global Fund is now paying greater attention to Ghana's co-financing commitments as spelled out in official letters and has reduced recent grant awards due to noncompliance. Total co-financing projections for HIV/AIDS, TB, malaria, and immunization through 2025 are presented in Figure 4.6. The GoG is estimated to require a US \$206 million increase in annual domestic financing from 2017 to 2025, which will also coincide with a US \$124 million decline in external financing.<sup>133</sup> In comparison, total domestic government expenditure on health in 2016 was approximately US \$523 million.<sup>134</sup> Thus, the GoG must allocate approximately US \$729 million, or 1.4 times its 2016 domestic health budget, simply to maintain 2016 health expenditure levels while meeting co-financing arrangements in 2025. To cover lost donor

funds, the 2025 GoG must further increase its health expenditures to US \$853 million, or 1.6 times its 2016 domestic health budget.

Ghana's ability to mobilize expanded resources for co-financing is not ensured. Domestic funding of the immunization program has already run into payment difficulties.<sup>135</sup> At present, only 10% of government health funds are earmarked for the MoH to satisfy co-financing requirements,<sup>136</sup> which does not meet the 15-20% GHE requirement illustrated in Figure 4.6. As a result, many major disease areas are lobbying for a special earmarked tax or levy to fund their program.<sup>137</sup> However, additional health taxes are viewed as "*not fair for Ghanaians*" (Government respondent), with the implication that priority health programs need to be more accountable for current funding before seeking more resources through new levies.

**FIGURE 4.6: Ghana's projected co-financing requirements: 2017-2025** (Source: OPM, 2018)



<sup>133</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future. See Annex 5 for full data.

<sup>134</sup> Ghana MoH, 2018. Medium term expenditure framework for 2018-2021. <https://www.mofep.gov.gh/sites/default/files/pbb-estimates/2018/2018-PBB-MoH.pdf>

<sup>135</sup> Ibid. Based on OPM interviews with Gavi and MOH, co-financing requirements have been in arrears since 2016.

<sup>136</sup> Government respondents.

<sup>137</sup> Government respondent.

### **UHC, FP, and Other Priority Health Programs**

Priority health program transition is situated within broader discussions on UHC. UHC is not a new concept for Ghana. Starting with the Alma Ata “Health for All Movement,” the country adopted the Ghana Primary Health Care Strategy in the late 1970s and early 1980s; strengthened District Health Systems in the 1990s; introduced and scaled up the CHPS starting in 2000; and established the NHIS in 2003. However, *“despite the near universal acceptance of the UHC concept among the majority of stakeholders in the health sector, there remains no consensus over what Ghana needs to do to achieve UHC, nor the clear goal and targets.”*<sup>138</sup> The UHC Roadmap, currently in draft form, is intended to provide needed consensus and chart a course toward achieving UHC by 2030.

The NHIS is the GoG’s primary strategy for moving to UHC and reaching infectious disease program sustainability,<sup>139</sup> but this plan will be challenging to implement. The UHC Roadmap outlines plans to consolidate the gains made with reproductive, maternal, neonatal, child and adolescent health (RMNCAH) and communicable diseases and integrate them into the overall health system, funded by the NHIS. As the Roadmap indicates, vertical disease programs were the hallmark of the Millennium Development Goals (MDGs); they now require integration as part of “SDG thinking” to ensure their sustainability. However, the NHIS has significant challenges; it is in deficit as claims have outpaced revenue, and delayed contributions from the NHIS levy exacerbate this issue. This uncertain funding scenario has impacted the efficiency of both NHIA internal operations and health provider activities, since both lack incentives to be cost-effective. NHIS coverage remains low, estimated at 40% of the total population in 2014 with large variations regionally in coverage as well as amongst the informal sector and the poor.<sup>140</sup>

While GoG policy assumes that infectious disease programs will transition to NHIS and be integrated with other health services, the prospects for full integration are questionable. Currently, NHIS policies and donor funding practices reinforce vertical service delivery.<sup>141</sup> For example, the Global Fund pays NHIS premiums for HIV-positive individuals to access opportunistic infection treatment in NHIS-accredited facilities, but these same patients must seek anti-retroviral therapy (ART) from HIV clinics because ART drugs are excluded from the NHIS benefit package.<sup>142</sup> Ghanaian policymakers have expressed doubts about the HIV program’s proposed inclusion of ART services within the NHIS: previously, the HIV program enjoyed large amounts of donor funding, but now they *“claim they’re broke and want to be included in NHIS...if we’re not careful, these huge disease areas with high expenditures will eat us up.”* In contrast, another government respondent acknowledged that while the NHIS cares about costs, *“they [the NHIA] must listen to government verdict: if government [e.g., the MoH or Ministry of Finance] says it’s included, then it is.”* None of the respondents mentioned formal processes for priority-setting within the NHIS benefits package, although an actuarial study was ongoing at the time of writing. In addition, Ghana has started to engage with health technology assessments as a means of moving towards more evidence informed policy decisions.<sup>143</sup>

Within this milieu, FP may have a better chance of being included under NHIS for several reasons: it is not viewed as a vertical program as it is integrated in the GHS; it does not entail large expenditures such as those for HIV; and its future inclusion in the NHIS is implicit based upon the clinical FP pilot implemented with the support of MSI and DFID.

<sup>138</sup> MoH, 2019. Overview of the UHC Roadmap for Ghana For Discussion at the Health Summit 2019. MoH, Accra, Ghana.

<sup>139</sup> Ibid.

<sup>140</sup> Wang, H. Otoo, N. and L. Dsane-Selby. 2017. Ghana National Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review. World Bank Studies. Washington, DC: World Bank. doi:10.1596/978-1-4648-1117-3. License: Creative Commons Attribution CC BY 3.0 IGO.

<sup>141</sup> UHC2030 International Health Partnership, 2019. Perspective from Health Programs on Sustainability and Transition from External Funding. Report of a meeting held at Chateau de Penthes Geneva, Switzerland, May 2019.

<sup>142</sup> The NHIA reported that the NHIS currently pays for opportunistic infection treatment and lab tests performed using HIV kits (which are donated, so this practice is considered “double-dipping”). The NHIS does not support ART.

<sup>143</sup> See: <https://www.idsihealth.org/blog/ghanas-minister-of-health-launches-the-national-hta-steering-committee-and-calls-for-hta-institutionalisation-in-the-country/>

## Procurement and Supply Chain

### Organization of Health Delivery Systems

Ghanaian health structures have been organized to improve decentralized management and service delivery. Institutionally, the health sector is stewarded by the MoH, which is responsible for policymaking and monitoring and evaluation (M&E) of progress in achieving sector targets. The Ghana Health Service (GHS), established in 2001, is responsible for planning and management of health services and provides decentralized authority to Regional and District Health Services.

As part of the GHS, the Community-Based Health Planning and Services (CHPS) was started as a pilot in 1994 to improve PHC access. To date, it is estimated that there are 3,175 functional CHPS zones and 1,410 functional CHPS compounds, employing around 15,900 Community Health Nurses.<sup>144</sup> The CHPS delivers a comprehensive package of PHC services but is overburdened. PHC services include maternal and reproductive health, neonatal and child health services (including immunization), minor ailments, and health education. There have been changing definitions of the basic package of CHPS interventions, particularly in relation to infectious disease programs, which has added to the burden of frontline workers. Not all CHPS zones are considered functional; only 74% have an operating site, only a half have either a functioning vaccine fridge or a cold box, and only 41% have trained Community Health Officers to provide services.<sup>145</sup> Issues with CHPS functionality as well as an expanding service package may reduce these facilities' capacity to provide quality FP services, and these challenges may be further exacerbated through transition because of the program's heavily reliance on donor funding. For example, decline in external funds for

health may negatively impact the contraceptive method mix, particularly the provision of LARCs, given the GoG's reliance on donors for commodities, training and, in some cases, service delivery (e.g. through NGO-supported outreach).

The GHS mandate and structure do not adequately engage the private sector. Only the Christian Health Association of Ghana (CHAG), a network of 302 faith-based health facilities, has been integrated within the GHS, while other for-profit and not-for-profit providers, including MSI and PPAG, operate at the periphery of the health system.<sup>146</sup> Therefore, with the exception of CHAG, the private sector is largely excluded from access to subsidized commodities, accreditation, and the GHS supervision structure.<sup>147</sup> This situation exists despite significant private sector involvement in PHC activities, including the provision of one-third of FP services in Ghana.<sup>148</sup> The private sector also plays a role in the supply of FP commodities. For example, GSMF International is the largest private sector supplier of contraceptives in Ghana and has a distribution network of more than 4,000 outlets across the country.<sup>149</sup>

Most FP services provided in the private sector are short-term methods. This situation may reflect a lack of access to LARC commodities among private providers, except for those supported through social franchising and social marketing programs. Pharmacies and chemical sellers also provide over-the-counter FP methods, such as pills, condoms, and emergency contraception, primarily in urban areas.

<sup>144</sup> Rowan, A., Gesuale, S., Husband, R. and K. Longfield, 2019. Integrating Family Planning into Primary Health Care in Ghana: A Case Study. Washington, DC: Results for Development.

<sup>145</sup> Rowan, A., Gesuale, S., Husband, R. and K. Longfield, 2019. Integrating Family Planning into Primary Health Care in Ghana: A Case Study. Washington, DC: Results for Development.

<sup>146</sup> Ibid.

<sup>147</sup> Rowan, A., Gesuale, S., Husband, R. and K. Longfield, 2019. Integrating Family Planning into Primary Health Care in Ghana: A Case Study. Washington, DC: Results for Development.

<sup>148</sup> Ibid.

<sup>149</sup> MoH, 2015. Ghana Family Planning Costed Implementation Plan 2016 –2020, MoH, Accra, Ghana.

<sup>150</sup> Government respondents.

### Procurement and Supply Chain for FP and Other Major Health Programs

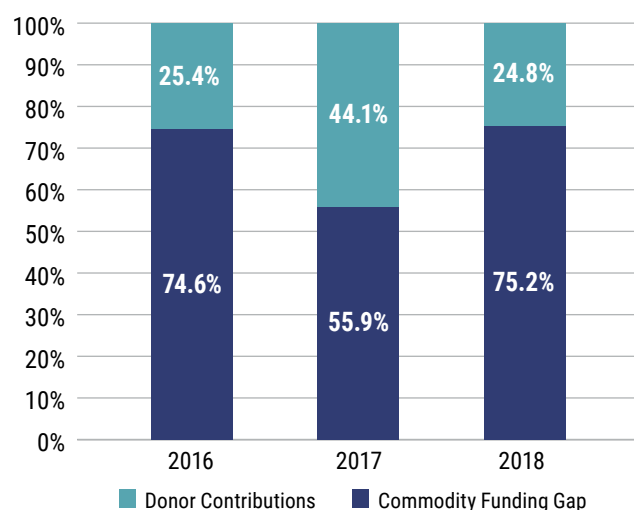
The GHS is responsible for the procurement and distribution of essential medicines and medical supplies (EMMS), including FP commodities. The EMMS supply chain receives external support through the USAID Global Health Procurement and Supply Chain Management (PSM) project.<sup>150</sup> Chemonics, the implementing partner for the PSM project, acts as the procurement agent for all USAID-funded commodities, including for FP. The project also provides TA for the national supply chain system, covering warehousing, distribution, information, logistics, and capacity building. The FP supply chain currently uses a private sector warehousing system funded by the PSM project.<sup>151</sup> When transition occurs, the GoG may choose not to contract private sector warehouses or may find that the cost of private contracting is not affordable, creating serious risks to the FP supply chain.

Forecasting and quantification of FP commodities is done at national level under the leadership of the GHS. There is an Interagency Coordinating Committee for Contraceptive Security (ICC-CS) chaired by the National Population Council. The ICC-CS meets quarterly to review stock status and coordinate forecasting, procurement, and supply across partners. The ICC-CS has a supply plan showing what items are coming into the country, when they arrive, and who is funding them. From 2016-2018, external donors funded all contraceptive commodities in Ghana.<sup>152</sup> (In this period, the GoG contributed in-kind resources for commodity-related expenditures such as warehousing and personnel costs. Starting in 2019, the GoG is reportedly begun contributing to the direct cost of commodities.<sup>153</sup>) Donor funding of FP commodities helps to ensure consumer choice of contraceptive method in the public sector.<sup>154</sup> However, choice in the private sector is considered limited, particularly for LARCs. Additionally, private providers (except for CHAG) use a separate FP commodity procurement system, which contributes to difficulties in making accurate contraceptive forecasts for the entire country.<sup>155</sup>

FP commodity financing fluctuates from year to year but reportedly does not result in significant stock-outs because consumption projections are not realized. In-country respondents reported that, in 2016, 74.6% of the forecast commodity resource requirements were supplied by donors, leaving a 25.4% annual commodity funding gap. In 2017, only 55.9% of projected resource requirements were filled by donors, due to UNFPA funding shortfalls and DFID's departure. In 2018, this figure increased to 75.2% (Figure 4.7). On average over this period, 31.5% of projected annual commodity resources went unfunded, representing between US \$2 million and US \$3.6 million per year.

**FIGURE 4.7: FP Commodity Financing Gap: 2016-18**

(Source: Country Informant)



Despite these large shortfalls in financing, the country does not run out of commodities. This result may be due to two factors: overestimated demand and unmet need. Government and partner respondents favored the former explanation; as noted by a respondent, “By mid-year, when the forecast is reviewed, the assumptions used for consumption are not realized.” Interviewees did not suggest that the lack of stock-outs (despite

<sup>151</sup> Partner respondent.

<sup>152</sup> In-country respondent.

<sup>153</sup> In-country respondent.

<sup>154</sup> MoH, 2015. Ghana Family Planning Costed Implementation Plan 2016 – 2020, MoH, Accra, Ghana.

<sup>155</sup> Ibid.

commodity funding gaps) was the result of unmet demand. However, given Ghana's 33.6% rate of unmet contraceptive need, this could be a significant contributing factor to the annual discrepancy between forecast and realized consumption. The fact that stock-outs at the central and regional levels are avoided despite large annual commodity funding gaps may also explain why the GoG is hesitant to contribute domestic resources for commodities. Where stock-outs do exist at health facilities, they are considered "artificial" due to maldistribution (i.e., over- and under-supply at service delivery points).<sup>156</sup>

Procurement and supply chains for other priority health programs – HIV and TB – also remain vulnerable as part of transition. Currently, all program commodities are integrated within the EMMS except for HIV and TB which are managed separately.<sup>157</sup> As highlighted by WHO's analytical work, stock-outs of HIV and TB drugs have occurred not because of a lack of funding, but because these medicines are transported along separate but near-identical vertical supply chains, resulting in unnecessary, delay-inducing duplication of delivery efforts.<sup>158</sup> There are plans in place as part of Global Fund transition to look at integration of HIV and TB within the

EMMS.<sup>159</sup> However, according to one respondent, the timing of the Global Fund transition assessment coincided with government elections and political change. As reported, this work towards HIV/TB integration was viewed as part of the previous administration and was not embraced.

There are practical systems challenges with the inclusion of commodities and distribution costs within the NHIS. Health facilities use part of their NHIS reimbursement to pay for EMMS from the GHS regional stores. However, bottlenecks occur in practice because payment of EMMS costs depends on reimbursement from the NHIS, which is often significantly delayed. There are also challenges with the inclusion of donor-funded commodities in the NHIS. Commodity costs should not be reimbursed by the insurance system if they are already paid for by donors, but some health facilities have sought full reimbursement for donor-provided malaria commodities as well as contraceptives included in the FP pilot.<sup>160</sup> In addition, the NHIS has no intention of being involved in commodity procurement; as stated in an interview with NHIS officials, *"Someone has to buy it, then we will reimburse."*

## Technical Capacity

As an FP2020 pledging country, Ghana has committed to improved FP program data collection and utilization. At the national level, this M&E initiative is primarily supported by the Track20 project,<sup>161</sup> which works with FP2020 countries to train dedicated FP M&E officers. Track20 and other partners support the GHS's efforts to improve FP data quality and its utilization in decision-making and priority-setting. TA in this area has mainly focused on program performance and not financing, as FP2020 has yet to report verified expenditure data for Ghana. Internally generated FP program data are utilized in the ICC-CS and other technical working groups in order to build consensus on commodity forecasting, FP2020

progress, and technical interventions.<sup>162</sup> Data analysis estimates unmet need and monitors FP outcomes for specific vulnerable sub-groups such as adolescents. However, not all government respondents were convinced of FP data accuracy; some suggested that Ghana's relatively weak FP program indicators were the result of underreporting.

FP logistics data are also improving but require ongoing TA. The flow of contraceptive information and data from service delivery points through the system is weak. At the national level, stock monitoring and reporting are routine, but stock information coming from devolved

<sup>156</sup> MoH, 2015. Ghana Family Planning Costed Implementation Plan 2016–2020, MoH, Accra, Ghana.

<sup>157</sup> Government respondent.

<sup>158</sup> UHC2030 International Health Partnership, 2019. Perspective from Health Programs on Sustainability and Transition from External Funding. Report of a meeting held at Chateau de Penthes Geneva, Switzerland, May 2019.

<sup>159</sup> Government respondent.

<sup>160</sup> Government respondent.

<sup>161</sup> <http://www.track20.org>.

<sup>162</sup> Government respondents.



levels of the health system is incomplete, unreliable, and delayed.<sup>163</sup> The FP-CIP notes that routine reporting of stock levels and performance monitoring of the supply chain remain inadequate, with gaps in accountability and responsibility across agencies. Additionally, with

multiple stakeholders involved in supply chain activities, coordination and sharing of data on contraceptive supply remain insufficient.<sup>164</sup> The required TA to address these issues currently comes from donors and thus represents another area of risk in transition.

## Enabling Factors: Political Commitment to FP and Legal & Human Rights Risks

It is an FP2020 priority to increase political commitment for FP, but the results in Ghana to date are mixed. Ensuring that financing and service availability do not preclude access to FP services constitutes an important component of political commitment. To achieve this goal, as mentioned above, the government has approved a dedicated budget line to finance essential health commodities, including contraceptives, and is currently in the process of piloting access to clinical FP services in the NHIS benefit package. This strategy complements national efforts to ensure that health financing reforms in the country are oriented towards attainment of UHC. Ghana has also been included in the Global Financing Facility (GFF) for women, children and adolescents, following the replenishment event in 2018. The GFF will provide an opportunity for additional investment in FP which could be oriented towards sustainability and transition, but the GFF will entail mainly external funding and may not translate into larger domestic commitments.

Ghana does not have high-level political champions of FP. The most senior political officials in Ghana are generally not aware of any specifics regarding the national FP program, including its major challenges and weaknesses. Individuals tasked with development planning tend to focus on other sectors such as infrastructure rather than the health sector, and the contribution of FP to achieving social and economic goals is not recognized or discussed publicly. A few FP advocates—primarily women—hold positions of prestige in government and civil society, and they are actively seeking to elevate the issue of FP to a national priority. However, they have not been able to recruit other senior politicians, especially senior male officials, to become champions of this cause. This situation exists despite recognition of rapid population growth as a



A young mother and her child receive care at a community health clinic in Ghana. Photo: USAID/Ghana, 2018.

development issue within the Long-term National Development Plan of Ghana (2018-2057).

Unmet need is high in Ghana, suggesting that reproductive rights are not realized for all women and girls. Only 47% of married women's FP needs are currently being met, of which 39% is satisfied by modern methods.<sup>165</sup> Unmet need is about the same in urban and rural areas at 26% and 28% respectively.<sup>166</sup> However, there are distinct regional patterns to FP use, with mCPR ranging from 32% in Volta region to 11% in Northern region.<sup>167</sup> Adolescent girls aged 15-19 have the highest unmet need for FP at 51%.<sup>168</sup> This level of unmet demand frequently results in unwanted pregnancy or recourse to abortion, including unsafe abortion. It is estimated that

<sup>163</sup> MoH, 2015. Ghana Family Planning Costed Implementation Plan 2016 –2020, MoH, Accra, Ghana.

<sup>164</sup> Ibid.

<sup>165</sup> Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. 2015. Ghana Demographic and Health Survey 2014.

<sup>166</sup> Ibid.

<sup>167</sup> Ibid.

<sup>168</sup> Ibid.

22% of girls under 18 and 39% of women under 20 have had a pregnancy,<sup>169</sup> which is high compared to other sub-Saharan African nations. Informants indicated that Ghana's laws and regulations surrounding adolescent contraceptive use are sufficiently enabling, and the high rates of teenage pregnancy result more from cultural norms, social practices, and provider biases. In particular, respondents pointed to the widespread belief among Ghana's adolescent girls (as well as their families and male peers) that teenage motherhood is an essential component of womanhood. The individual and societal challenges of adolescent pregnancy are recognized by some advocates within and outside government, but this issue has not been central to the wider development agenda, political discussions, or financing decisions.

Client OOP expenditure is ubiquitous in Ghana and contributes to FP inequities. OOP expenditure in Ghana is higher than or about the same as in other countries with similar per capita incomes, and it is twice the threshold recommended by the WHO.<sup>170</sup> OOP expenditure affects access to a range of health services, including FP. While FP is supposed to be free in the public sector,

it is estimated that nearly all public sector clients do make some form of payment for FP.<sup>171</sup> Thus FP service charges “deviate from the official government subsidized FP service rates.”<sup>172</sup> If the NHIS FP pilot is scaled, NHIS-accredited private providers would also offer free clinical FP methods. This change would require provider and consumer education so that co-payments are not introduced or paid for clinical FP services.

A Ghanaian study showed that women's type of earnings has a bearing on use of modern contraceptives with women who earn a cash income more likely to use modern contraceptives as compared to women who are not paid or paid in-kind.<sup>173</sup> These results suggest that women's financial dependence and lack of income may limit use of modern contraceptives. However, these financial barriers do not seem to be recognized or prioritized by Ghanaian officials amidst the many other barriers to contraceptive use, such as consumer knowledge, women's concerns about side effects, physical access to services, religious and cultural norms, and provider bias.

<sup>169</sup> Ibid.

<sup>170</sup> Schieber, G., Cashin, C., Saleh, K. and R. Lavado. 2012. Health Financing in Ghana. Washington, DC: World Bank. doi:10.1596/978-0-8213-9566-0. License: Creative Commons Attribution CC BY 3.0.

<sup>171</sup> Stover, J. and R. Chandler, 2017. Expenditures on Family Planning in FP2020 Focus Countries in 2015. Track20 Project for the International Family Planning Expenditure Tracking Advisory Group.

<sup>172</sup> <https://ghana.unfpa.org/en/news/taking-stock-financing-family-planning-services-reach-ghanas-2020-goals>.

<sup>173</sup> Aviiisah, P.A., Dery, S., Atsu, B.K., Yawson, A., Alotaibi, R.M., Rezk, H.R., and C. Guure, 2018. BMC Women's Health. 18:141 <https://doi.org/10.1186/s12905-018-0634-9>.



## Summary of Risks and Key Options for Consideration

Key options for consideration to improve Ghana's readiness for FP transition are summarized in Table 4.2 below and explained in detail in the remainder of this section.

**TABLE 4.2: Key options for consideration to improve Ghana's readiness for FP transition**

Transition Risk Area	Key Options for Consideration
<b>Financing of FP and Other Health Programs</b>	<ul style="list-style-type: none"> <li>• Incorporate learnings and include FP clinical services in the NHIS benefits package as validated through actuarial analysis and the pilot program</li> <li>• Develop realistic cost estimates for the FP program and use these to guide planning and budgeting</li> <li>• Introduce a centralized FP budget line at the national level with ring-fenced funding</li> <li>• Introduce FP co-financing arrangements and clear timescales for transition of donor financing for FP to domestic financing</li> <li>• Conduct and publish annual FP expenditure analysis including OOP expenditure</li> <li>• Develop the Ghana GFF investment case so that it is prioritized, affordable, and realistic and so it addresses sustainability and transition of FP and other RMNCAH services</li> <li>• Align externally supported programs with domestic policies and incentives as part of UHC, so that silos are eliminated, inefficiency is reduced, and national ownership is enhanced</li> </ul>
<b>Procurement and Supply Chain</b>	<ul style="list-style-type: none"> <li>• Develop more precise forecasts so that FP requirements are accurate and drive domestic commitments, and pinpoint the cause of continued discrepancies in projected versus realized consumption</li> <li>• Develop timeframes and milestones for transitioning support for procurement and supply chain management</li> <li>• Build domestic capacity for private supply chain contracting or integrate the current supply chain into the national system, building off what already exists</li> <li>• Include the private sector within commodity forecasts in order to improve their accuracy, and encourage the private sector to increase participation in commodity procurement and supply</li> <li>• Monitor FP supply at service delivery points to rectify "artificial" stockouts and improve reporting</li> </ul>
<b>Technical Capacity</b>	<ul style="list-style-type: none"> <li>• Develop a comprehensive and practical health transition strategy that is led by the GoG and includes all major health donors/programs, including FP</li> <li>• Introduce more systematic use of HTA governance, processes, and analytics to inform design of benefits packages and build FP technologies and services into the HTA program and UHC benefits package</li> <li>• Transfer FP data analysis and survey skills to national institutions</li> </ul>
<b>Enabling Factors</b>	<ul style="list-style-type: none"> <li>• Improve FP service access in under-served regions and for the poor and adolescents through public-private-partnership (e.g. contracting out to NGOs)</li> <li>• Publicize the availability of free FP services through the NHIS and enforce rules prohibiting the collection of user fees at NHIS-affiliated facilities</li> <li>• Using the demographic dividend as an organizing framework, elevate the societal and economic benefits of FP to make rights more central to the discourse of FP programming as inputs to advocacy and policy dialogue at all levels of government</li> </ul>

### **Financing Risks and Options for Consideration**

Ghana needs more money for health, which is assumed to come from the NHIS. Ghanaian respondents indicated that sustainable financing of FP—and other major health programs—would likely come through the NHIS. However, the NHIS is not currently prepared to support these programs. There is a need to address ongoing challenges with NHIS's financial solvency and stability while developing a sustainable, evidence-based benefits package. There is also need for greater efficiency in both the NHIA and the GHS and adoption of priority setting mechanisms, given fiscal constraints.

Respondents also expressed the desire for greater accountability of the high-cost infectious disease control programs (including HIV, TB, and malaria) before consideration of their inclusion within the NHIS, as these programs have been perceived as bloated or over-funded. (This is likely not the case at present, but the perception may have been more accurate when there were many well-funded bilateral and multi-lateral donors contributing to these disease programs.) Ongoing political debates about donor-backed health programs' accountability could delay the incorporation of FP within the NHIS. Moreover, although FP will not impose the same large financial burden on NHIS as other programs such as malaria, FP does not have the same lobbying power as the other disease programs. More needs to be done by the FP community in Ghana to elevate the importance of FP service inclusion in the NHIS. The argument for inclusion could be reinforced by evidence from other countries supporting the incorporation of FP within national health insurance schemes (Box 4.2).

Ghana also needs more health impact for money, but specific strategies to improve efficiency in the health sector have yet to be identified. There are inconsistencies between the central management of vertical programs and the devolved service delivery system under the GHS. Within the NHIS, there are reportedly ineffective gatekeeper and referral systems as well as misaligned provider payment incentives that limit the role of the NHIA as a strategic purchaser.<sup>174</sup> However, government and partner respondents did not identify specific actions or plans to improve efficiency in health

spending despite the clear need for such initiatives across all health programs, including FP.

The biggest financing risk for FP is that declining donor funding will not be replaced by domestic funding. While this risk applies to all priority health programs, it is of particular concern for FP. No precise, evidence-based cost estimates or expenditure assessments for the total FP program exist, making it difficult for policymakers to plan and allocate resources effectively. Currently, FP external financing is heavily reliant on just two donors. Annual donor contributions fluctuate, but the two main partners—USAID and UNFPA—have historically stepped in to compensate for lost funding from exiting organizations (such as DFID). However, OPM projects that the rate of reduction in FP donor funding in Ghana—15% per annum in the coming years—will be greater than in other priority programs. Additionally, the other donor-backed

#### **BOX 4.2. FP in UHC**

Integration of FP into UHC-oriented efforts has been suggested as a possible way to improve FP access and use as well as provide sustainable FP financing, especially where external financing has transitioned. A study conducted by Fagan et al. (2017) examined FP within UHC schemes (e.g., social health insurance) in nine Latin American and Caribbean (LAC) countries, concluding that:

- FP services have been relatively well-integrated into UHC-oriented schemes in LAC countries.
- Enrollment in government-supported insurance schemes (rather than reliance on free provision through public health facilities) was associated with improved access to and uptake of modern FP methods.
- **Among the poorest quintile of women, insured women had a modern contraceptive prevalence rate 16.5 percentage points higher than those who were uninsured.**

<sup>174</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

health programs have explicit co-financing obligations, which FP does not, meaning that there is no immediate financial consequence for the GoG to not fund FP, while there is a consequence for other programs. This may result in an increase in OOP expenditure for FP as cost is passed on to the consumer, given that FP is considered an optional, not required health service. To address this serious financing dilemma, it is recommended that a dedicated national FP commodity budget line be introduced and clinical FP methods be included within the NHIS. Additionally, explicit co-financing arrangements and clear timelines for transition of FP financing, alongside accountability mechanisms, should be developed by the GoG and donors, in a similar way as other major health programs have done.

### **Procurement and Supply Chain Transition Risks and Options for Consideration**

Weak FP forecasts have reduced pressure on the GoG to finance commodities. Overestimated contraceptive consumption estimates have lowered the urgency of domestic contributions to FP commodities. Forecast assumptions have been based on need, but much of this need continues to be unmet through the public sector, while a lack of data from the private sector limits understanding of total commodity requirements. More precise forecasts are urgently needed so that FP requirements are accurate and drive domestic commitments.

Procurement and supply chain processes are improving but rely heavily on external support. As noted in the OPM study, *“Transition is much more than reduced external financing and increased domestic requirements: logistical, organizational, and administrative responsibilities will also need to be transferred to government.”*<sup>175</sup> The OPM study identified some of these areas and recommended that timeframes need to be applied to each development partner and program to plan for transition of these additional functions. This recommendation is critically important for FP and other priority programs.

To ensure the sustainability of FP commodities, the GoG must begin to fund contraceptives. The Ghana FP CIP recommended greater investment by the government in commodity security and called on the private sector to participate more significantly in FP commodity procurement, distribution, sales, and promotion. To date, no clear targets for contraceptive security have been agreed. It is recommended that a contraceptive security plan be developed and operationalized as soon as possible, including the development of milestones and monitoring mechanisms.

### **Technical Capacity Risks and Options for Consideration**

There have been several pieces of health transition work undertaken in Ghana, but sector-wide coordination and policy dialogue still need to be improved. USAID/Health Policy Plus hosted a conference on sustainable FP financing in Accra in January 2018;<sup>176</sup> but in-country informants did not identify any follow-up work that had occurred on this topic since that time. The DFID-commissioned OPM study on major health program transitions referenced in this case study is the most comprehensive work in this field, analyzing transitions in six heavily donor-reliant health programs.<sup>177</sup> Other transition studies have been supported by the Global Fund and Gavi.<sup>178</sup> WHO also conducted analytical work to support the government in addressing inefficiencies within vertical health programs, specifically examining areas of duplication across HIV, TB, malaria, and RMNCAH.<sup>179</sup> The OPM and WHO analyses highlighted that the donor-by-donor piecemeal approach to transition is not effective, as systemic issues need to be addressed. Overall, while many individual transition studies have been completed in Ghana, it is recommended that a comprehensive health transition strategy be developed and coordinated between government and donors across program areas, including FP.

FP transition must be contextualized within broader NHIA financing reforms and the movement towards UHC. This approach should define actions to improve

<sup>175</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>176</sup> Presentations and notes from this conference can be found at: <http://www.healthpolicyplus.com/FP-SSA.cfm>

<sup>177</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<sup>178</sup> Ibid.

<sup>179</sup> The Pharos team was unable to access this document; however, this work was reported in UHC2030, Reflections on Country Context.

the coherence among externally supported health programs and align them with national policies and financing streams in the NHIS and the proposed UHC scheme.<sup>180</sup> As one government respondent noted, this task will require investments in change management as much as in health services.

Ghana's FP M&E capacity remains weak. The GoG has pledged to improve data collection and utilization in decision-making. However, FP M&E programs are heavily reliant on donor funding and expertise. Ghana has also yet to report verified FP expenditure data, a core FP2020 indicator, suggesting that the country's financial M&E capabilities are limited even with ongoing investments in TA. The GoG and partners must coordinate the transfer of M&E skills to national institutions and health officials, continuing to build capacity in this area.

### ***Enabling Factors Risks and Options for Consideration***

The Ghana political economy does not favor rights-based appeals for FP. While the right to FP is recognized within health, this concept does not resonate with government officials responsible for overall budgeting and finance. Some of these officials felt that FP was not as high a priority as other programs, such as immunization, because contraception is viewed as an optional, individual choice. While the general perception of contraceptive use as voluntary aligns with the rights-based approach, high unmet need in Ghana suggests that many women

cannot exercise their rights to FP. Greater understanding of and measures to address the continuum of unmet need, desire to use FP, autonomy of choice and access to quality FP free from provider bias are required. Additionally, there seems to be little awareness of the social and economic benefits of FP and its contribution to the SDGs. It is recommended that these social/economic arguments and evidence be more strongly articulated and presented to government decision-makers in health and finance in order to accelerate FP policy commitments.

The contribution of OOP to FP inequities is underrecognized and may be exacerbated by transition. A reliance on OOP expenditures already exists for FP and may contribute to high unmet need found within the country and in specific sub-populations. It is estimated that OOP expenditure in Ghana will account for a large share of the financing for FP over the next three years.<sup>181</sup> This form of financing should be closely monitored, as it may increase with transition and result in greater inequities in contraceptive access. The ongoing NHIS FP pilot holds promise and could help secure FP rights and affordability, particularly for LARCs, throughout transition. The GoG should publicize the free FP services available in public-sector clinics and enforce rules prohibiting unofficial user fees charged by NHIS-affiliated FP service providers.

<sup>180</sup> Schieber, G., Cashin, C., Saleh, K. and R. Lavado. 2012. Health Financing in Ghana. Washington, DC: World Bank. doi:10.1596/978-0-8213-9566-0. License: Creative Commons Attribution CC BY 3.0.

<sup>181</sup> RHSC, 2018. Global Contraceptive Commodity Gap Analysis 2018. Brussels: Reproductive Health Supplies Coalition.



# Chapter 5: Kenya Country Case Study

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## Executive Summary

If transition is understood as a continuum and not a destination, then donor support for FP is in transition in Kenya. However, timelines for the decline in external FP resources and technical assistance are uncertain, and the Government of Kenya (GoK) has not developed a national strategy to address the challenges of transition in FP and other priority health programs. In the context of a looming FP commodity crisis in the country, the present lack of transition preparation on the part of both government and donors poses a serious threat to the FP program's continued operation.

There are clear indicators of donors' desire to transfer FP financing and stewardship to the GoK, including emphasis on mobilizing domestic resources for FP commodities through the development of match fund and sliding scale initiatives. These arrangements would see government assume greater responsibility for commodity security in the coming five years, concomitant with a significant decline in donor support for FP commodities. If the GoK is unable to meet commitments to these co-financing initiatives, adequate funding for Kenya's FP commodities may be in jeopardy.

Kenya's national FP program results are considered successful. The country has surpassed its FP2020 target of 58% modern contraceptive prevalence rate (mCPR). However, this national mCPR, while high by regional and donor transition standards, masks significant disparities found within the country; mCPR ranges from 2% in northern Kenya to nearly 80% in the central part of the country. Governmental devolution, which

commenced in 2013, has done little to correct for FP disparities and may have diluted technical support for FP, as partners have concentrated efforts and resources at the county level without commensurate engagement at the national level, where FP is technically stewarded. As Kenya transitions from donor financing, gaps in technical capacity at county level are likely to be exacerbated. Moreover, geographic disparities in mCPR, driven in large part by varying social norms and county-level commitment to FP, may increase without donor-funded demand creation and political engagement activities.

The GoK recognizes FP as an essential component of the national development agenda, and it has made policy commitments to this effect. Both the Vision 2030 social pillar and the national health policy (2014-2030) commit to ensuring increased reproductive health rights and access to reproductive health services for all women and couples, including the poor and vulnerable. However, GoK's policy commitments do not make explicit the societal and economic benefits of FP, nor is FP politically championed, despite being constitutionally upheld. Not since the Moi government of the 1980s has there been high-level political support for FP.<sup>182</sup> If FP lacks a major political champion, it is vulnerable to de-prioritization and de-funding throughout the transition process.

Other major donor-backed health programs – HIV, malaria, TB, and immunization – are also a decrease in the number of donors and total funding in the last several years. These donor resources have not been

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<sup>182</sup> AFIDEP, 2012. Assessment of Drivers of Progress in Increasing Contraceptive use in sub-Saharan Africa: Case Studies from Eastern and Southern Africa. African Institute for Development Policy (AFIDEP), Nairobi, Kenya.

replaced by domestic financing in any significant way; however, GoK has made deliberate efforts to protect essential program commodities, such as anti-retroviral and anti-malarial medicines, through their positioning as strategic commodities at national level. FP commodities have not yet benefited from similar protection. As Kenya experiences multiple health transitions, FP may not be prioritized in the context of competing high-impact infectious disease programs. The significant funding requirements for these other programs may seriously constrain domestic resources available for the FP program.

Alongside health program transitions, Kenya has ambitions to achieve 100% universal health coverage (UHC) by 2022. Priority programs, including FP, have been incorporated within Kenya's UHC Roadmap, but only partially, with the assumption that donor financing will continue to fund commodities in the near-term. This arrangement is in recognition of the fact that resource requirements for the HIV program alone, for example, far exceed the full budget for the entire UHC agenda (Box 5.1). From some respondents, there is a sense that some infectious disease program budgets are inflated and their vertical governance structures inefficient. This perception has hindered constructive dialogue about health transition within government.

This context creates a difficult environment for FP program transition in Kenya. The present case study examines the risks and challenges associated with transition and identifies key opportunities and areas of improvement for both donors and the national govern-

ment. This report begins with a background of Kenya's current characteristics in politics, society, and health. It then examines in-depth the four key components of our FP transition framework: Financing for FP and Other Priority Programs; Procurement and Supply Chain; Technical Capacity; and Enabling Factors for FP, including political commitment and legal & human rights. We conclude the case study by offering specific risks and key options for consideration to prepare Kenya for its upcoming transitions in a variety of health programs.

#### BOX 5.1.

The 2018 Kenyan UHC budget was KES 37 billion (US \$352 million). For one year, this full amount would fund:

- 36% of total HIV resource needs, OR
- 88% of all ARTs, OR
- 72% of current domestic expenditure on HIV, TB, malaria, and FP, OR
- 100% of total resource needs for TB, malaria, and FP with only KES 7.8 billion (US \$73.2 million) left over to support all other health programming, including care for HIV, cancers, and NCDs



## Introduction

### Country Context

Kenya's political and demographic context is marked by transition. Transition is underpinned by Kenya's new Constitution, ratified in 2010, which created a decentralized system of government wherein two of the three arms of government, the legislature and the executive, were devolved to the 47 counties. This change was driven by a political push to address real and perceived long-term political challenges of marginalization and inequitable resource allocation at the county level.<sup>183</sup> The country's demography is also in transition in absolute terms, with population growth estimated at 2.7% per annum, and spatially, through increasing population concentration in cities and towns across the country. Kenya's population is youthful, with the 15-35-year age group contributing about two-thirds of Kenya's adult population.<sup>184</sup>

Kenya achieved lower-middle income country (LMIC) status in 2015. The economy and capacity to mobilize development resources through taxation is projected to continue to grow in the medium term.<sup>185</sup> Alongside economic growth, health is a core feature of the development agenda, with a target of 100% UHC by 2022. Primary health care (PHC) and the removal of financial barriers for the poor and indigents are prioritized within this agenda. Despite Kenya's LMIC status, it is estimated that 46% of Kenyans live below the poverty line, with 30% classified as indigent.<sup>186</sup>

### History of FP Programs in Kenya

After almost a decade of stagnation—dating from the early 2000s—the modern contraceptive prevalence rate (mCPR) has accelerated in Kenya. The national mCPR increased more than 10% over the 5 years to 2014, the date of the last Demographic and Health Survey (DHS).<sup>187</sup> Recent data (Box 5.2) indicate that Kenya has achieved its FP2020 goal of 58% modern contraceptive use by married women (MW). However, this statistic masks regional disparities, with some counties reporting an mCPR as low as 2% and others as high as 76% (Figure 5.1).<sup>188</sup> Of critical note, there has been no change in the teenage pregnancy rate, with nearly one in five (18%) adolescents (15-19-years) having started childbearing due to early marriage, high unmet need for contraception, and poor access to contraceptive services among youth.<sup>189</sup>

#### BOX 5.2. FP Performance Indicators

Total users	6,052,000
Additional users	1,951,000
mCPR (all women)	45%
mCPR (MW)	61%
Unmet need (MW)	17%
Demand satisfied (MW)	78%

Source: MoH/Track20 FP2020 performance (May 2019)

<sup>183</sup> Tsofa, B, Goodman, C, Gilson, L and S. Molyneux, 2017. International Journal for Equity in Health (2017) 16:169 DOI 10.1186/s12939-017-0663-2.

<sup>184</sup> Government of Kenya, Ministry of Health, 2016. Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework, Ministry of Health, Nairobi, Kenya.

<sup>185</sup> Dutta, A., T. Maina, M. Ginivan, and S. Koseki. 2018. Kenya Health Financing System Assessment, 2018: Time to Pick the Best Path. Washington, DC: Palladium, Health Policy Plus.

<sup>186</sup> Government of Kenya, Ministry of Health, 2012. Kenya Draft Health Financing Strategy, Report of an External Review. Commissioned by the Ministry of Medical Services, Nairobi, Kenya.

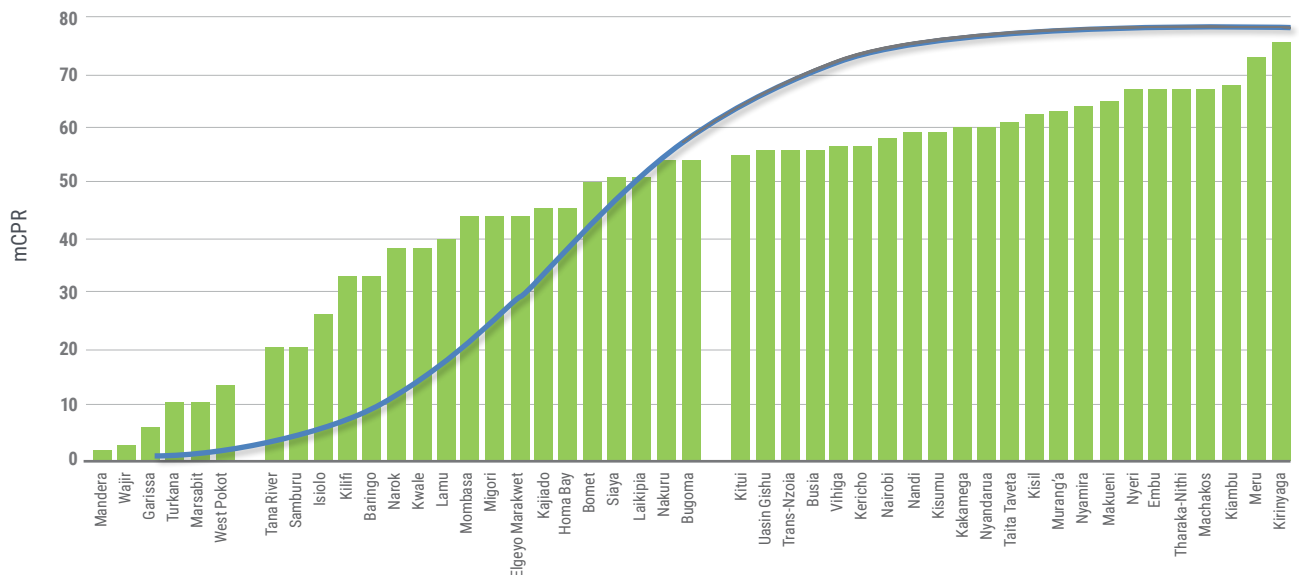
<sup>187</sup> Government of Kenya, National Bureau of Statistics, 2015. Kenya Demographic and Health Survey 2014. Nairobi, Kenya.

<sup>188</sup> Government of Kenya, National Bureau of Statistics, 2015. Kenya Demographic and Health Survey 2014. Nairobi, Kenya.

<sup>189</sup> Government of Kenya, National Bureau of Statistics, 2015. Kenya Demographic and Health Survey 2014. Nairobi, Kenya.



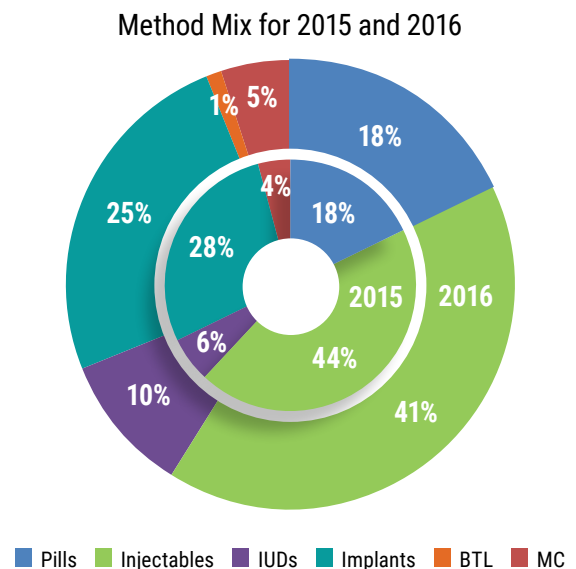
**FIGURE 5.1: mCPR by Kenya county, superimposed on the theoretical S-curve of mCPR growth** (Source: Track20, 2019)



Kenya's FP method mix is relatively balanced with an increasing share of more effective methods. While injectables are the dominant method, long-acting reversible contraceptives (LARCs) are increasingly popular and growing as a proportion of the method mix. Figure 5.2 provides an overview of the contraceptive method mix for 2015 and 2016, showing that LARCs have remained a consistently demanded service and constitute just over one-third of the overall method mix. The FP program has also been promoting post-partum FP, although uptake remains low with 18% of women using FP at six months post-partum. There have also been concerted efforts to increase the number of youth-friendly service delivery points; however, these remain patchy, and data regarding their performance are not available.

Kenya has a vibrant NGO and private sector for FP, which has contributed to the success of the FP program. Several large service delivery partners operate in Kenya, including Marie Stopes International (MSI), Population Services Kenya (PSK), and the International Planned

**FIGURE 5.2: Kenya method mix estimates for 2015 and 2016** (Source: MoH, 2017)



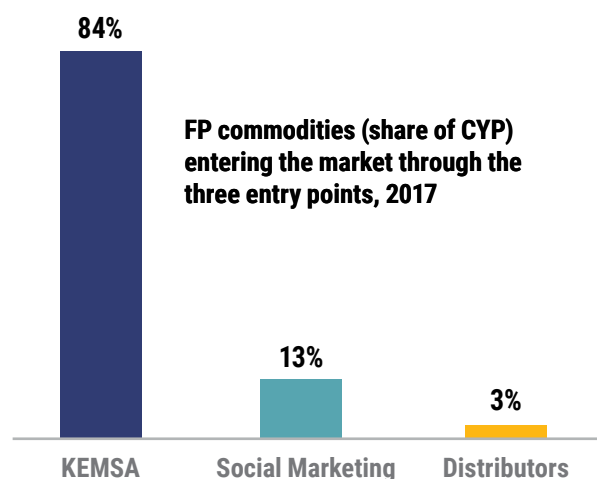
Parenthood Federation (IPPF) affiliate. Combined, these providers deliver a large share of couple years' of protection (CYPs); MSI, for example, delivered 1,400,000 service CYPs in 2018, or approximately one-quarter of Kenya's FP service market. MSI and PSK have large social franchising networks that are supported to deliver reproductive and FP services. These providers are increasingly integrated into county health services, they provide monthly service data which is reflected in the DHIS2, and they are able to access government commodities for free through county stores. PSK and DKT also play a significant role in social marketing, complementing public sector provision of FP commodities (via KEMSA) and the commercial sector. Figure 5.3 shows the proportionate share of FP commodities (using CYPs) from the three suppliers. Of note, Kenya's commercial sector share for FP has grown by 31% over two years (2017 and 2018), dominated by emergency contraception.<sup>190</sup>

### Health Financing in Kenya

Despite the high status accorded to health within Kenya's development agenda, the GoK does not accord commensurate resources. With devolution, there has been little change in fiscal prioritization of health, which, in aggregate, has held steady at approximately 7–8% of the government budget since 2014.<sup>191</sup> This figure falls below the averages of 12% for sub-Saharan Africa, 14% for low-income countries,<sup>192</sup> and the Abuja Declaration target of 15%. Figure 5.4 provides estimates of GoK actual budgetary spending on health and health as a percentage of total approved GoK budget. Although the counties allocate an increasing share of their budgets to

**FIGURE 5.3: FP commodities share of CYPs**

(Source: Palladium and IQVIA, 2018)



health, there have been concurrent decreases in national government's budget for health, meaning little gain in the total budget for health.

Most health expenditure in Kenya comes from domestic resources, both government and household. Government financing for health has increased as a proportion of THE from 27% in 2009/10 to 33% in 2015/16. Over the same period, donor resources have declined as a percentage of THE from 32% in 2009/10 to 22% in 2015/16. External spending on health has also declined in absolute terms, from KES 64.1 billion in 2012/13 to KES 53.2 billion in 2015/16.<sup>193</sup> Household OOP contri-

<sup>190</sup> Palladium and IQVIA, 2018. Current Family Planning Market Conditions in Kenya: Baseline 2018 interim findings (presentation). The commercial sector excludes social marketing and subsidized products. It includes wholesalers and retailers.

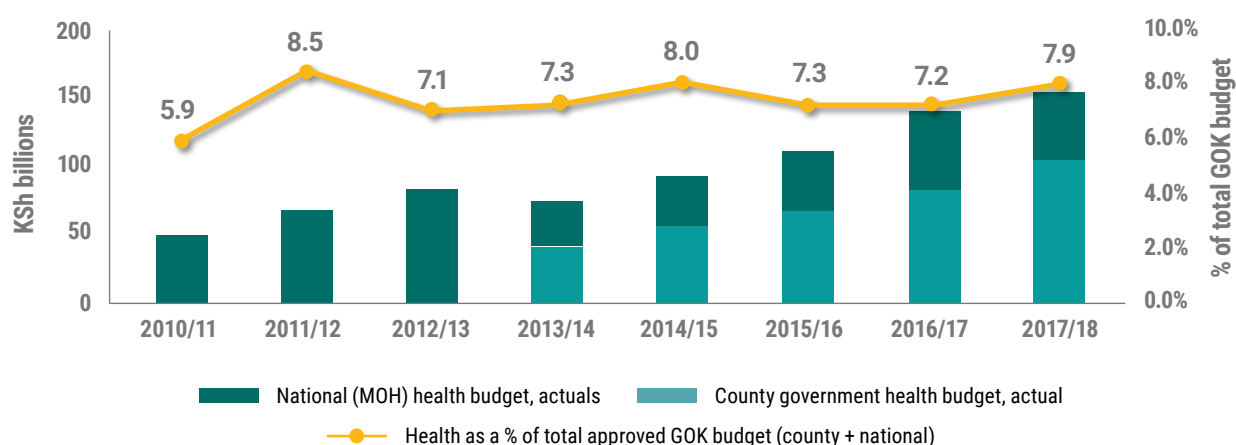
<sup>191</sup> Ministry of Health, 2018. National and County Health Budget Analysis FY 2016/17. Nairobi, Kenya: Ministry of Health, Government of Kenya. [http://www.healthpolicyplus.com/ns/pubs/6138-6239\\_FINALNationalandCountyHealthBudgetAnalysis.pdf](http://www.healthpolicyplus.com/ns/pubs/6138-6239_FINALNationalandCountyHealthBudgetAnalysis.pdf).

<sup>192</sup> World Bank. 2017. Health Nutrition and Population Statistics. The World Bank Databank. <http://databank.worldbank.org/data/reports.aspx?source=health-nutrition-and-population-statistics>.

<sup>193</sup> Dutta, A., T. Maina, M. Ginivan, and S. Koseki. 2018. Kenya Health Financing System Assessment, 2018: Time to Pick the Best Path. Washington, DC: Palladium, Health Policy Plus.

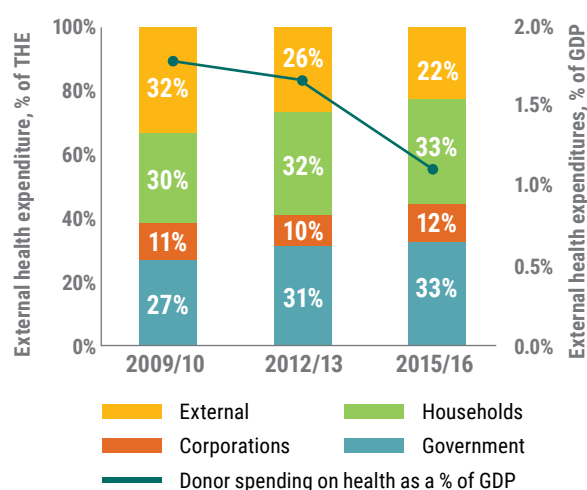
**FIGURE 5.4: GoK actual budgetary spending on health and health as a percentage of total approved GoK budget**

(Source: GoK, 2018, in Dutta et al., 2018)



bution to THE has increased from 30% in 2009/10 to 33% in 2015/16 (Figure 5.5).<sup>194</sup> Donor resources are directed towards the health development budget, which covers non-recurrent programmatic and capital costs. Within this budget, most donor funds are allocated to HIV, reproductive health, immunization, and health systems support. In contrast, the government (national and county) contribution to the health development budget, including these priority programs, is only 36.6%.<sup>195</sup> At the county level, most of the health budget (72% in FY 2015/16 to 79% in FY 2016/17<sup>196</sup>) is allocated to recurrent expenditures for personnel. This proportion has risen since 2015/16, largely due to increases in the wage bill. County spending on personnel leaves few resources available for non-salary components of health programs, including reproductive health and FP.

**FIGURE 5.5: External Spending as a Percentage of THE and GDP** (Source: MoH 2017, in Dutta et al., 2018)



<sup>194</sup> Dutta, A., T. Maina, M. Ginivan, and S. Koseki. 2018. Kenya Health Financing System Assessment, 2018: Time to Pick the Best Path. Washington, DC: Palladium, Health Policy Plus.

<sup>195</sup> Ministry of Health, 2018. National and County Health Budget Analysis FY 2016/17. Nairobi, Kenya: Ministry of Health, Government of Kenya. [http://www.healthpolicyplus.com/ns/pubs/6138-6239\\_FINALNationalandCountyHealthBudgetAnalysis.pdf](http://www.healthpolicyplus.com/ns/pubs/6138-6239_FINALNationalandCountyHealthBudgetAnalysis.pdf).

<sup>196</sup> Ibid.

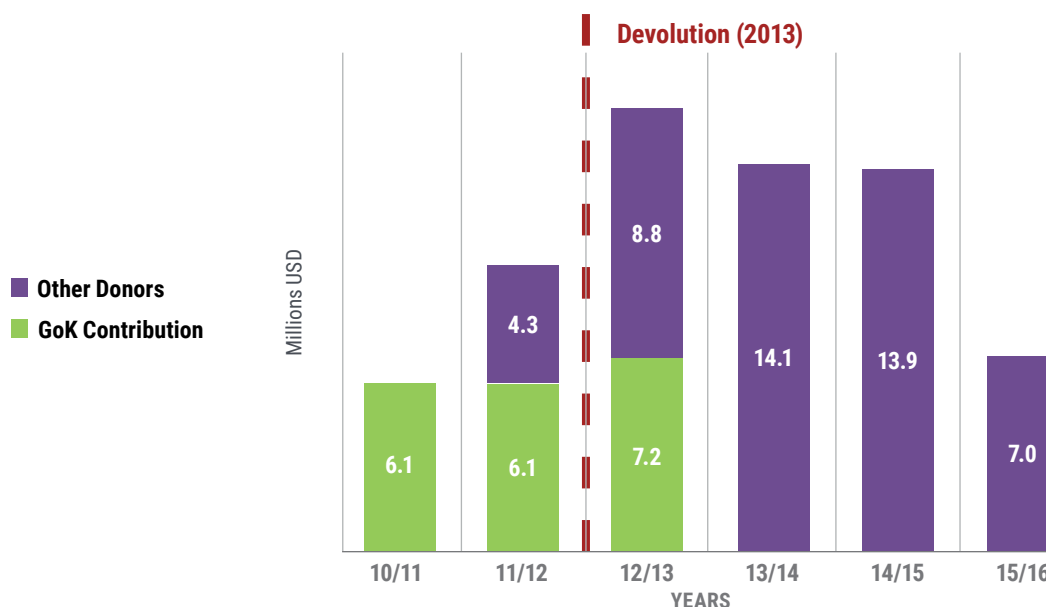
## Financing of FP and Other Health Programs

### Historical FP Financing: 2010-2017

Prior to devolution, government-led commodity security was considered a pillar of Kenya's success in FP expansion.<sup>197</sup> A budget line, ring-fenced for commodities, was introduced in the 2004/05 fiscal year and heralded a shift away from sole reliance on donor funding. With devolution in 2013, responsibility for financing of FP commodities was transferred to county governments, and the national budget line effectively became defunct. However, counties failed to assume responsibility for purchasing commodities. Changes in the predominant source of FP financing are reflected in Figure 5.6,<sup>198</sup> with a clear "reverse" transition from domestic to donor financing observed when health budgets were devolved to counties. After 2013, donors covered almost all FP commodity costs.

The Kenya FP Spending Assessment (FPSA) for fiscal years 2014/15 – 2015/16 estimated total FP expenditures and tracked the sources of domestic and donor funding for FP services and commodities.<sup>199</sup> Excluding OOP expenditures, total domestic and partner FP spending in Kenya in 2014/15 was \$73M USD, and total spending in 2015/16 was \$70M. From 2014-2016, FP expenditure accounted for approximately 2% of total health expenditure and 0.1% of GDP.<sup>200</sup> In 2015-16, the majority of funds (62.3%) was spent on human resources, administration, and professional development, with commodity costs for implants (9.5%) and injectables (7.5%) accounting for the second- and third-largest shares.<sup>201</sup> IEC and other FP commodities rounded out total spending.

**FIGURE 5.6: Kenya FP commodity funding 2010-2016 (\$' million)** (Sources: FP Quantification Technical Reports 2010-2018; FP Dashboard)



<sup>197</sup> Government of Kenya, Ministry of Health, 2017. National Family Planning Costed Implementation Plan 2017-2020. Nairobi, Kenya.

<sup>198</sup> CHAI, 2019. Kenya FP Commodity Funding Gap Analysis 2018-2021, May 2019.

<sup>199</sup> Korir, J. and U. Kioko, 2017. Family Planning Spending Assessment FY 2014/15 – 2015/16. Center for Economic and Social Research, Nairobi, Kenya.

<sup>200</sup> Korir, J. and U. Kioko, 2017. Family Planning Spending Assessment FY 2014/15 – 2015/16. Center for Economic and Social Research, Nairobi, Kenya.

<sup>201</sup> Ibid.

According to the FPSA, donors contributed nearly 75% of all FP funds in Kenya from 2014-2016. International NGOs and foundations, particularly USAID, DFID, UNFPA, and BMGF, constituted the main financing sources (Figure 5.7). County departments of health came second due to salary expenditures for health workers; not one county had a direct budget allocation for FP.<sup>202</sup>

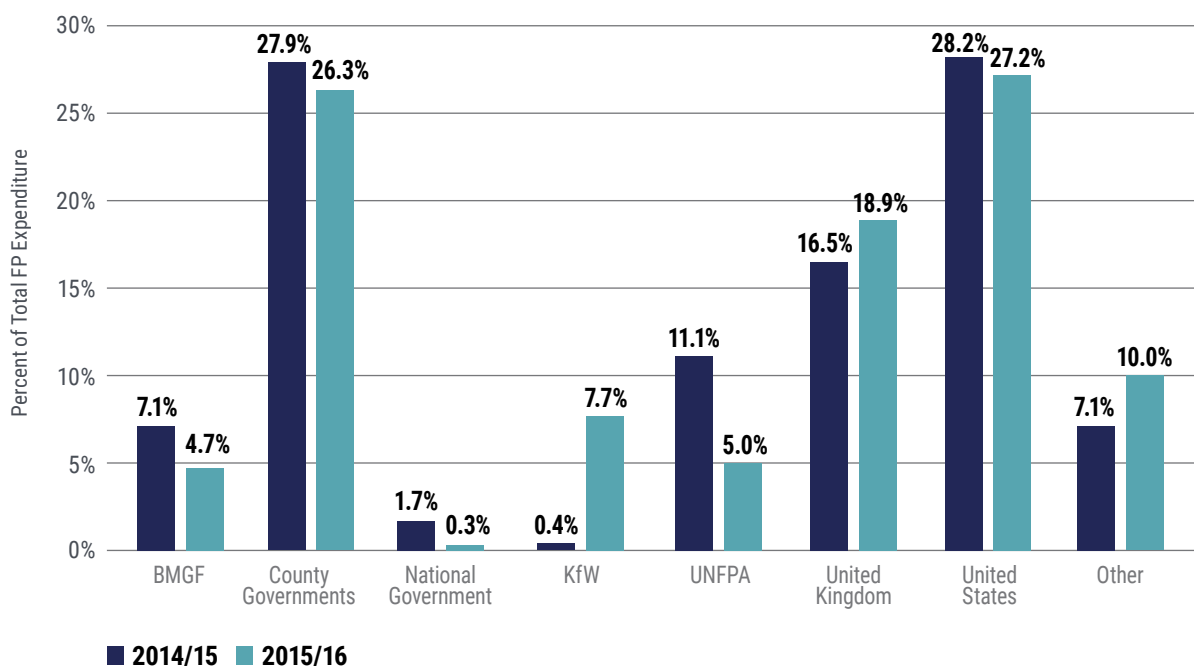
The FPSA did not gather information about household OOP spending on FP and recognized this as a critical area for future study. Subsequent Track20 analyses estimated that Kenya's OOP spending for FP in 2016 was \$3.7M USD, accounting for 5% of total annual FP expenditure. However, this figure is almost certainly an underestimate given recent growth in Kenya's commercial FP sector.<sup>203</sup> The commercial sector, comprising wholesalers and retailers, largely provide over-the-

counter FP products, such as oral contraceptive pills, emergency contraceptives, and condoms, which are paid for OOP.

### Current Status of FP Financing

Since the 2016 FPSA was conducted, there has been a reduction and concentration of donor financing for the FP program. While a timeline has not been formally established, donors have started the process of departure. This is evidenced by a gradual reduction in the number of donors supporting health, including FP, writ large. One notable departure in 2017 was the German government, which previously provided support for FP commodities and co-financed the Output-Based Aid (OBA) program with the GoK.<sup>204</sup> Currently, Kenya has five main donors that support the national FP program: BMGF, USAID, DFID, UNFPA, and the World Bank. The World Bank has

**FIGURE 5.7: FP spending by financing source, Kenya: 2014-16** (Source: FPSA, 2017)



<sup>202</sup> Ibid.

<sup>203</sup> Palladium and IQVIA, 2018. Current Family Planning Market Conditions in Kenya: Baseline 2018 interim findings (presentation).

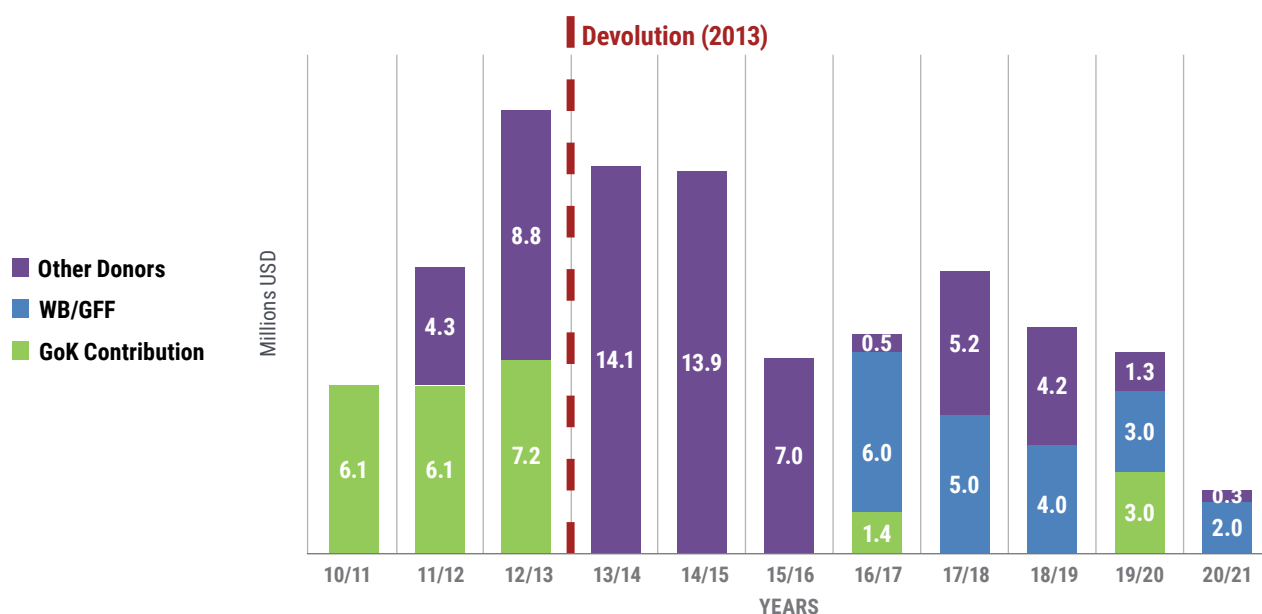
<sup>204</sup> Financed through the Kreditanstalt für Wiederaufbau (KfW), the OBA program provided subsidized high-quality safe motherhood, clinical family planning and gender violence recovery services to a population of approximately three million poor people in selected districts (now counties) in Kenya over four phases, from 2006-2017.

stepped into a larger role in FP financing in Kenya since 2016-17. Notably, the growth in GoK contributions in 2019/20 reflects new World Bank THS-UC allocations for FP, which are considered domestic expenditures as the project is partly funded through a loan<sup>205</sup> (Figure 5.8). For some donors, there also is now a greater “prescriptiveness” in how funds are programmed, signaling that grant-based aid is increasingly viewed as complementary to FP mainstream programming. For example, donors such as DFID have maintained bilateral funding for FP; however, their aid comes with a clear prescription that it is directed towards vulnerable groups, such as adolescents, people living with disability, and residents of marginalized counties within Kenya, where mCPR is below the national average.

The main emphasis of GoK financing is focused on two key areas – service delivery and commodities. Govern-

ment respondents were mainly concerned with gaps in commodity financing, while health worker salaries were considered funded as a main line item in county budgets. While government respondents recognized the importance of other FP program aspects, such as demand creation, community outreach, and capacity building, there was an implicit assumption that partners would continue to support these areas. Despite this perception, implementing partner projects are viewed as transient – “*there today, gone tomorrow*” (Government respondent)—and their absence is not being planned for. There was the sense among government respondents that financing for FP and other major health programs was “... *luxurious costing based on donors, but this will not be possible with government resources.*” It is therefore likely that transition will focus on these two main cost drivers, and not on other program areas.

**FIGURE 5.8: Kenya FP commodity funding 2010-2020 (\$' million)** (Sources: FP Quantification Technical Reports 2010-2018; FP Dashboard)



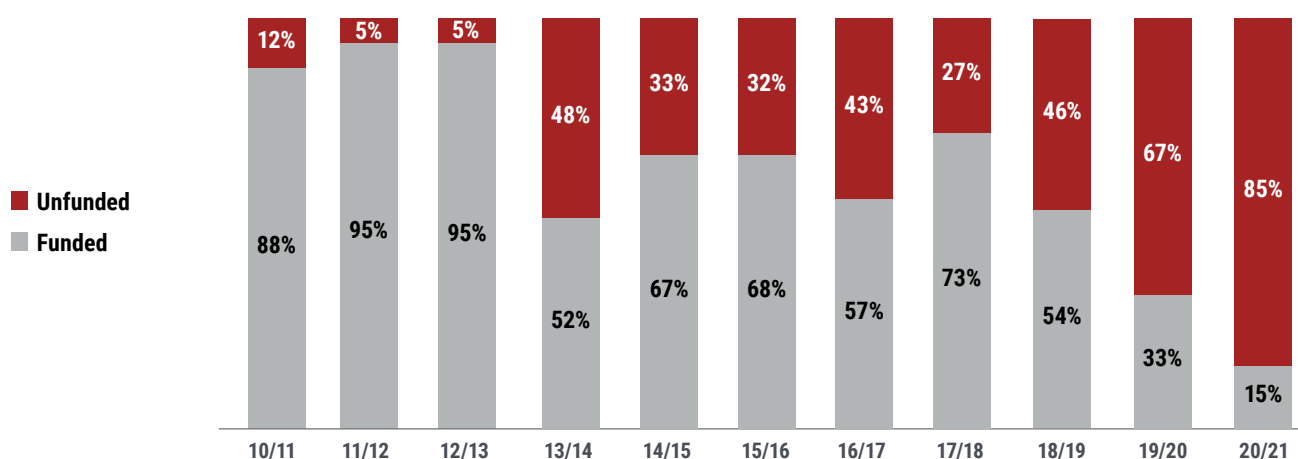
<sup>205</sup> The THS-UC is financed through a combination of the International Development Association (IDA) Credit of US \$150 million; a grant of US \$40 million from the GFF; and a grant of US \$1.1 million from the Japan Policy and Human Resources Development Fund.

## Future FP Financing Needs

**Commodities.** The main driver of commodity insecurity in Kenya is the growing contraceptive financing gap. This gap has widened due to a reduction in domestic financing for commodities since devolution in 2013 as well as an increasing total number of modern method users, driven by Kenya's youthful population. Currently, it is estimated that US \$27.2 million is needed to cover

the commodity funding gap from 2019/20 to 2020/21. Figure 5.9 shows the proportion of commodity financing that is unmet (in red) vis-à-vis projected requirements from 2010/11 through to 2020/21 along with a table of total resource requirements and funding gaps in this period.

**Figure 5.9: Commodity funding gap analysis in Kenya** (Sources: CHAI 2019; FP Quantification Technical Reports 2010-2018; FP Dashboard)



Requirement (USD)	6.9M	10.9M	16.8M	27.3M	20.8M	10.4M	14.0M	14.0M	14.7M	21.7M	14.9M
Funding Available (USD)	6.1M	10.4M	16.0M	14.1M	13.9M	7.1M	7.9M	10.2M	8.2M	7.1M	2.3M
Funding Gap (USD)	0.8M	0.5M	0.8M	13.2M	6.9M	3.3M	6.1M	3.8M	6.5M	14.6M	12.6M

At present, donors are focusing specifically on Kenya's future commodity resource needs given the imminent commodity financing crisis. Three key FP donors – USAID, DFID, and the Gates Foundation<sup>206</sup> – have presented the Ministry of Health (MoH) with a proposal for addressing the current crisis. This plan proposes a match fund with a sliding scale that would see donor support decrease over time as domestic support increases. While the proposed arrangement is still being worked out between donors and the MoH, it would take effect in 2019/20 and last for five years. This plan is

intended to curb annual “emergency” requests from the MoH for FP commodity financing. As one respondent noted, this is the “most coordinated action the donors have taken to date. Previously, GoK would shop around until a donor agreed to fund [the commodities].” While details of the arrangement are still being negotiated, it appears that donor financing for commodities will decline gradually from around 60% of total spending in the first year until the Kenya Government takes over 100% of commodity costs at the end of the five-year period.

<sup>206</sup> The Gates Foundation is not considered a main source of financing for commodities although this may change in future.



**Overall FP Program Resource Needs.** Official resource projections for FP are available in Kenya, but only through 2020. The national FP CIP (2017-2020) estimated total funding requirements for the four years of the CIP at KES 30.80 billion (US \$305 million) with a projected funding gap of KES 8.41 billion (US \$83 million). In the CIP, commodities and service delivery were estimated at almost 80% of total resources required: 52% and 27%, respectively. (The 2016 FPSA revealed that, in practice, about 62% of funds were directed towards human resources.) At the time that the FP CIP was developed, it was also assumed that most domestic resources

(89%) would come from county budgets. However, while counties have continued to finance health worker salaries, funding for FP commodities has not materialized as expected.

Our colleagues at Avenir Health have modeled FP resource needs in Kenya through 2030 (Table 5.1). These have been projected using UNDP<sup>207</sup> estimates of modern method users and mCPR growth in Kenya. These values are approximately in line with the CIP projections through 2020: US \$75.6 million for 2019 and US \$76.7 million for 2020.

**TABLE 5.1: Projected Kenya FP Resource Requirements: 2019-2030** (Source: Avenir Health for Pharos Global Health)<sup>208</sup>

Year	Modern method users	Resource needs (USD millions)	mCPR projections (percent)
2019	4,695,800	\$81.5	62.1
2020	4,841,900	\$84.1	62.6
2021	4,995,400	\$86.7	63.1
2022	5,145,300	\$89.3	63.5
2023	5,301,900	\$92.0	64.0
2024	5,452,000	\$94.7	64.4
2025	5,605,300	\$97.3	64.8
2026	5,751,600	\$99.9	65.2
2027	5,898,400	\$102.4	65.5
2028	6,043,600	\$104.9	65.8
2029	6,195,500	\$107.6	66.2
2030	6,336,700	\$110.0	66.5

<sup>207</sup> United Nations, Department of Economic and Social Affairs, Population Division (2018). Estimates and Projections of Family Planning Indicators 2018. New York: United Nations.

<sup>208</sup> See Annex 4 for full projection methodology.

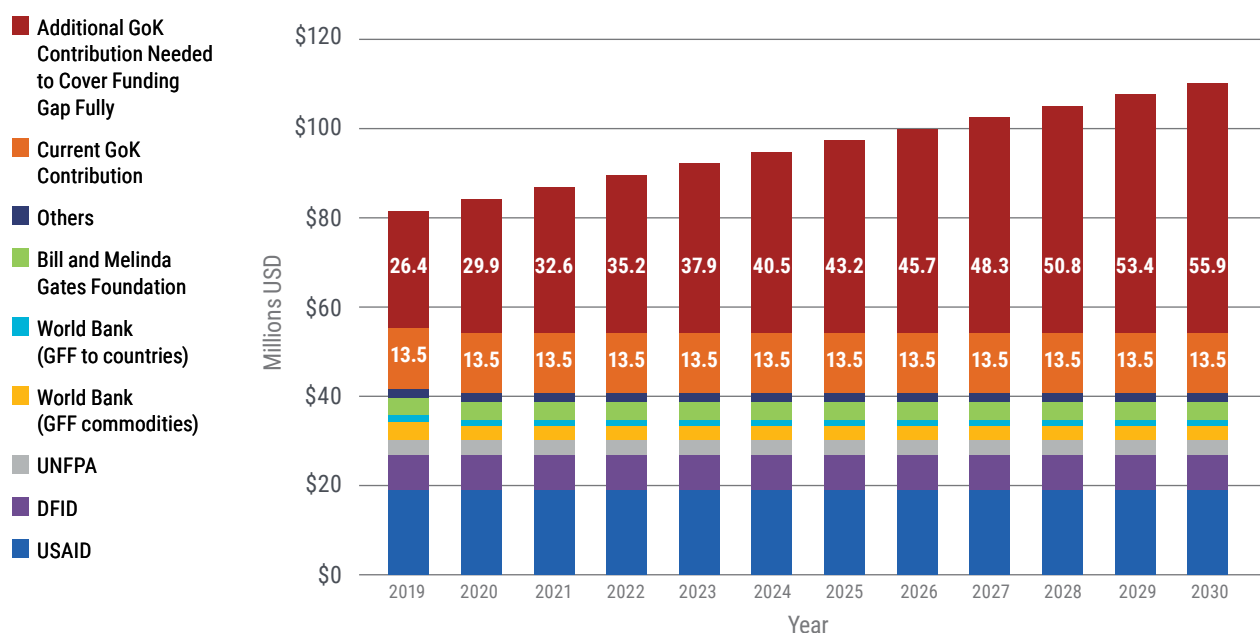
As the number of modern method users grows, Kenya's FP resource requirements will also increase. To keep up with population growth and to reach an mCPR of 66.5% by 2030, the Avenir projections above suggest that overall FP spending will have to grow by over 50% in the coming decade, from US \$81 million in 2019 to over US \$110 million annually in 2030. This growth will put pressure on domestic spending and especially on county and central budgets, assuming that donor contribution will level off and/or decline in the coming years.

In a best-case scenario of constant donor funding in the next decade, GoK's total contribution must increase five-fold to cover all FP program costs by 2030. In scenarios of declining donor contributions, GoK's expenditure requirements increase further. The 2017-2020 CIP estimates that donors will contribute approximately US \$40 million to the FP program in 2020, while national and county governments will contribute US \$13.5 million.

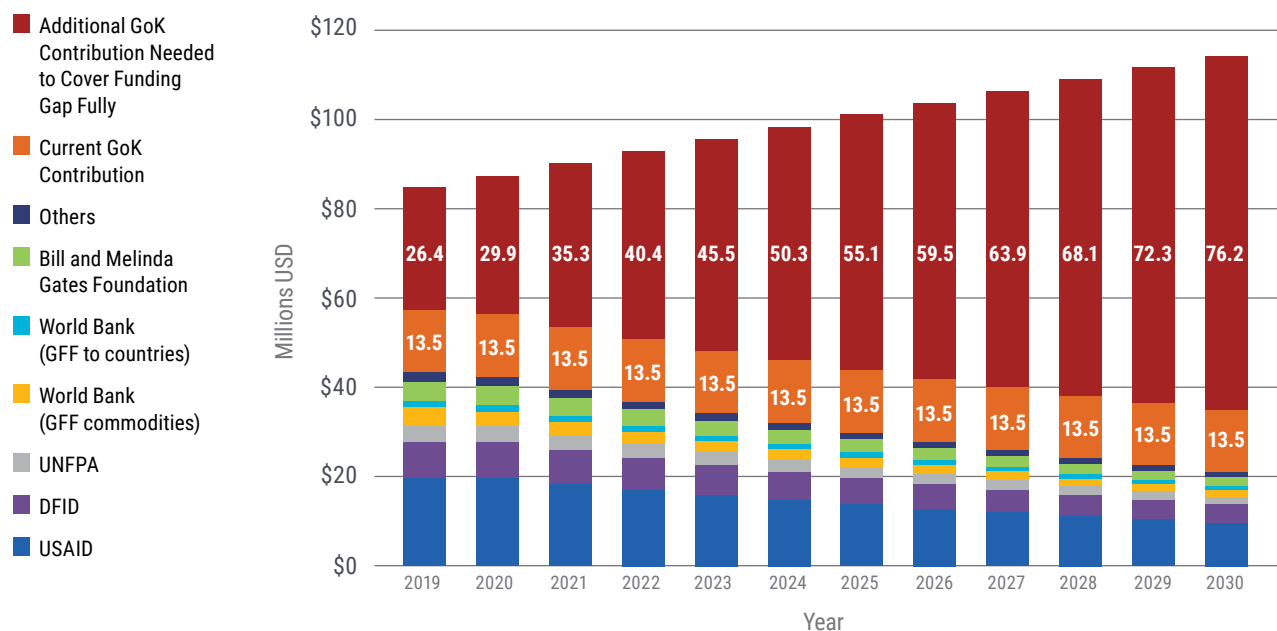
Thus, according to Avenir's estimate of total program resource needs, Kenya faces a shortfall of about US \$30 million for FP in 2020. Under the CIP's assumption that donor funds hold constant at about US \$40 million annually, by 2030, the GoK must spend US \$69.4 million (\$13.5 million in current GoK contributions plus an additional \$55.9 million to meet program resource needs) to cover all program costs, more than five times the amount it currently contributes (Figure 5.10). However, this value is most likely an underestimate of domestic resource requirements, since donors have already indicated their intention to decrease contributions to Kenya's FP program through the development of a sliding scale matching funds program. If, instead, donor funds decline by 50% from 2020-2030, the GoK must contribute US \$89.7 million to cover all FP program costs, over 6.5 times its current expenditure (Figure 5.11).

**FIGURE 5.10: Projected FP resource requirements in Kenya assuming constant donor funds: 2019-2030**

(Source for 2019/20 expenditures: Kenya CIP, 2017-2020)



**FIGURE 5.11: Projected FP resource requirements in Kenya assuming a 50% reduction in donor funds over ten years: 2019-2030** (Source for 2019/20 expenditures: Kenya CIP, 2017-2020)



### Fiscal Challenges of Simultaneous Health Transitions

Transitions in priority health programs beyond FP are taking place concurrently but without clear timelines of donor exit. Other health programs grappling with transition include HIV, TB, malaria, and immunization. This process is not well choreographed among donors, or between donors and government, in part because projected funding requirements and domestic-donor cost sharing amounts are not established for priority health programs in the medium term. Estimated resource needs are available for HIV, TB, and malaria only through 2020. A notional figure for HIV of KES 80-85 billion (US \$685-728 million) per annum was estimated to “stimulate discussion” but is acknowledged to be imprecise as an estimate of future revenue requirements.<sup>209</sup> According to the authors of the estimates, these figures are an upper-bound, “as donor funds may not require shilling-for-shilling replacement”

due to health financing reforms and harnessed efficiencies within the health system.<sup>210</sup> However, specific measures to improve health systems efficiency have not been articulated or agreed upon. Equally, the authors note that health requirements could change and sustaining current coverage rates may require increased investment.

In the past several years, Kenya has experienced a concentration and reduction of donor financing for other priority health programs. Currently, HIV, TB, and malaria external resources come from three donors – the Global Fund, USAID, and the World Food Programme – whereas before these programs enjoyed a diverse bilateral donor base. Moreover, funds from these three donors were reduced from KES 4,043 million in FY 2015/16 to KES 3,549 million in FY 2016/17, a decrease of 12.2%.<sup>212</sup> The Global Fund has started to assess GoK

<sup>209</sup> Chaitkin, M., O’Connell, M., and Githinji, J., 2017. Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Kenya. Washington, DC: Results for Development.

<sup>210</sup> Chaitkin, M., O’Connell, M., and Githinji, J., 2017. Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Kenya. Washington, DC: Results for Development.

<sup>212</sup> Ministry of Health, 2018. National and County Health Budget Analysis FY 2016/17. Nairobi, Kenya: Ministry of Health, Government of Kenya. [http://www.healthpolicyplus.com/ns/pubs/6138-6239\\_FINALNationalandCountyHealthBudgetAnalysis.pdf](http://www.healthpolicyplus.com/ns/pubs/6138-6239_FINALNationalandCountyHealthBudgetAnalysis.pdf)

readiness for increased domestic co-financing,<sup>213</sup> and the U.S. Government anticipates a decline in funding for Kenyan HIV/AIDS, TB, and malaria programs within the next five years.<sup>214</sup> Immunization and related health systems support received KES 2,600 million (US \$25.2 million) from Gavi in FYs 2015/16 and 2016/17, and the GoK provided KES 700 million (US \$6.8 million) and KES 410 million (US \$4 million) in domestic co-financing for immunization in FYs 2015/16 and 2016/17.<sup>215</sup> Gavi, the main donor in immunization, initiated plans for transition but reportedly had to defer by several years due to challenges with devolution and its impact on co-financing. (Vaccination coverage rates also suffered as part of devolution.) However, as of 2019/20, Kenya is again in the Gavi preparatory transition phase and is expected to enter the accelerated transition phase in 2022/23.<sup>216</sup>

Kenya is still in the process of developing strategies for priority program transition. As HIV is by far the largest health program to transition, the National AIDS Control Council (NACC) is leading the effort to establish a technical working group (TWG) for health transitions. The TWG would advise on domestic resource mobilization (DRM) to address needs across priority programs. The creation of this group was an explicit request from other sections of government, such as the Treasury, to develop a holistic, not piecemeal, picture of DRM requirements: *“Why are you thinking vertically, why not health in general?”* (Government respondent). Transition is not a new discussion for the HIV program; according to a government respondent, as early as 2008 during the global economic crisis, transition in HIV was raised given the vulnerabilities associated with the program’s heavy reliance on DAH.<sup>217</sup> When Kenya was subsequently reclassified as a LMIC in 2015, NACC developed a policy position paper which outlined what transition would mean in terms of financing and commodities for treatment and testing.<sup>218</sup>

## UHC, FP, and Other Priority Programs

FP is included in Kenya’s national insurance policy, but this program has room for significant improvement. FP services are split between capitation and fixed-fee-for service (FFS) under the National Hospital Insurance Fund (NHIF). Currently, all methods are included under capitation except for permanent methods, which are under FFS. In practice, the inclusion of FP within the NHIF national scheme is not well understood by providers or consumers and therefore may not facilitate utilization.<sup>219</sup> Additionally, permanent methods are only covered for individuals on corporate or civil servant contracts with the NHIF. NHIF membership coverage is estimated at only 20% of the total population and is particularly low among informal sector workers and indigents, where most of the unmet need for FP is likely to exist. (Unmet need in Kenya is greatest among uneducated, poor, married women in rural locations.) Therefore, at present, the NHIF does not improve access to FP or expand the method mix.

The NHIF offers variable coverage of other infectious disease areas. HIV/AIDS services are not covered under the NHIF due to the high annual cost of ARTs (about US \$420 per person per year). Not considering economies of scale and program efficiency costs, it would cost Kenya KES 42 billion (US \$400 million) to keep 1,00,000 HIV-positive Kenyans alive each year.<sup>220</sup> (UNAIDS estimates that between 1.3M and 1.9M Kenyans were living with HIV in 2018.<sup>221</sup>) Malaria treatment is currently included in the NHIF under capitation for outpatient services and in-patient care for more serious disease episodes.

Increasingly, FP and other infectious disease program transition plans are situated within broader discussions on UHC. Kenya’s Big Four agenda (2012)<sup>222</sup> positioned UHC as a flagship program, which *“reignited the story of [priority program] transition and sustainability linked*

<sup>213</sup> Chaitkin, M., O’Connell, M., and Githinji, J., 2017. Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Kenya. Washington, DC: Results for Development.

<sup>214</sup> Partner respondent.

<sup>215</sup> Ministry of Health, 2018. National and County Health Budget Analysis FY 2016/17. Nairobi, Kenya: Ministry of Health, Government of Kenya. [http://www.healthpolicyplus.com/ns/pubs/6138-6239\\_FINALNationalandCountyHealthBudgetAnalysis.pdf](http://www.healthpolicyplus.com/ns/pubs/6138-6239_FINALNationalandCountyHealthBudgetAnalysis.pdf)

<sup>216</sup> Gavi Co-Financing Sheet: Kenya, 2019.

<sup>217</sup> Interview with government respondent.

<sup>218</sup> Interview with government respondent.

<sup>219</sup> Appleford, G., and Owino, E. January 2018. National Hospital Insurance Fund tariffs – what are the effects on Amua Franchise business? African Health Markets for Equity, Marie Stopes International.

<sup>220</sup> NACC, 2018 (Feb). Achieving Universal Health Coverage by Leveraging the Infrastructure Sector to Reduce New HIV Infections and Enhance Domestic Financing for Health. Policy Brief, NACC, Nairobi, Kenya.

<sup>221</sup> UNAIDS Estimates 2019.

<sup>222</sup> <https://big4.president.go.ke/>. Other Big Four priority projects include affordable housing, food security and enhanced manufacturing.

to UHC” (Government respondent). UHC has become a platform for developing the health sector more broadly. UHC-related plans include converting the NHIF into a social health insurance<sup>223</sup> program and consolidating existing managed schemes into one essential benefits package, based on available resources (and not rationed at point of delivery). GoK intends to leverage productivity and efficiency gains in resource utilization to gradually achieve UHC. According to one government respondent, there are competing priorities within the UHC agenda: on one hand, the demand side financing through the NHIF is seen as the vehicle for addressing OOP and catastrophic expenditure, while the MoH is also pushing for the removal of user fees and supply side financing, seeking to “sort it all out” through UHC. Of note, a UHC pilot is currently taking place in four counties, and this program does not currently incorporate major infectious disease care or the NHIF package. This proposed UHC model is solely focused on supply-side financing through the public sector, which would reduce the role of the NHIF and its opportunities for strategic purchasing.

Kenya’s UHC roadmap<sup>224</sup> only partially includes major infectious disease programs because of high program costs, traditionally funded by donors. While FP, HIV, TB, and malaria services are considered essential, they are

not factored into UHC program costs. Limited funding of these programs’ commodity requirements is in recognition that financial requirements for priority programs, particularly for HIV, are more than what is budgeted for the entire UHC agenda. Table 5.2 presents the total cost of four priority health programs in 2018: KES 132.4 billion (US \$1.27 billion), of which KES 51.3 billion (US \$497 million) is currently funded by the GoK. Anticipated annual costs of ARTs alone exceed KES 42 billion (US \$400 million), while, in comparison, the entire UHC budget for 2018 was estimated at KES 37 billion (US \$352 million). As noted by one government respondent, “The amount allocated for UHC is not enough – priority programs will wipe out UHC.” However, there is recognition in the UHC Roadmap that priority program costs will need to be absorbed, given that they are major contributors to Kenya’s disease burden and drivers of other ill-health costs. Novel partnerships and financing strategies are being explored, including leveraging the private sector and exploration of development impact bonds for health.

A political economy surrounds major donor-backed health program inclusion in UHC plans. There is currently a lack of urgency to identify domestic sources of funding for priority programs, including FP, as they are considered to be already financed by donors in the

**TABLE 5.2: Summary table of priority health program resource needs and expected domestic expenditures in 2018**

Health Program Area	2018 Total Resource Need (KES millions)	2018 Expected Domestic Funding (KES millions)	2018 Expected Donor Funding (KES millions)	2018 Unmet Resource Need (KES millions)
HIV	103,205	33,094	61,912	8,199
Malaria	14,747	14,456	6,313	(surplus of 6,022)
Tuberculosis	6,555	2,398	2,433	1,724
Family Planning	7,899	1,366	4,292	2,241
<b>Total</b>	<b>132,406</b>	<b>51,314</b>	<b>74,950</b>	<b>6,142</b>

(Sources: Chaitkin et al., 2017 for HIV, TB, Malaria; Kenya CIP, 2017-2020 for FP)

<sup>223</sup> Government of Kenya, Ministry of Health, 2012. Kenya Draft Health Financing Strategy, Report of an External Review. Commissioned by the Ministry of Medical Services, Nairobi, Kenya.

<sup>224</sup> Government of Kenya, Ministry of Health, 2018. Roadmap towards Universal Health Coverage in Kenya 2018–2022. Ministry of Health, Nairobi, Kenya.

medium term. Additionally, some respondents suggest that the MoH may not be able to present a sufficiently compelling case for increased domestic resources at the expense of other arms of government, as skepticism exists around the costing of large health program needs, particularly for HIV.<sup>226</sup> As noted by one government respondent, *“Good plans can be made [for UHC and priority program transition], but they need the buy-in of politicians well as other line ministries such as the Ministry of Finance...at the moment, we are having a discussion with ourselves [only in the health sector].”*

Inefficiencies associated with vertical governance and management of major infectious disease programs may mean that these programs need to look inwards to identify cost-saving mechanisms before gaining greater buy-in from government for increased domestic resources. This situation also affects FP, as government wants to address health requirements holistically. However, at present, the FP community is not playing a significant role in broader national health transition discussions.

## Procurement and Supply Chain

As part of devolution, the Constitution bestowed upon Kenya’s 47 counties responsibility for managing health services. The national government retains leadership in developing health policy and regulation, as well as managing national referral facilities. County departments of health (CDoH) steward most of Kenya’s public and private facilities within their jurisdiction. The health system as a whole is characterized as one of increasing demand for healthcare alongside inadequate funding, underdeveloped infrastructure, and shortages in both human resources for health and essential drugs and medical supplies, with significant variation in barriers across regions and counties.<sup>227</sup> The small and medium enterprise private sector, particularly those not in social franchise networks, remains unorganized and disconnected from the broader FP market. While devolution was viewed as a *“unique window of opportunity to address long-standing inequities and inefficiencies in the health sector,”*<sup>228</sup> in practice, there have been significant challenges with its implementation, particularly regarding human resource management and essential medicines and medical supplies (EMMS). Limited physical access to adequate medical facilities, trained providers, and appropriate supplies—particularly in rural and remote areas—inhibits many Kenyans’ ability and right to realize fertility intentions through FP.

KEMSA is the government body responsible for procurement, warehousing, and distribution of EMMS, including for the FP program. KEMSA was created in 2000 after the GoK transformed the medical supplies coordinating unit into a parastatal organization with a mandate to manage the forecasting, procurement, warehousing, distribution, and inventory control for EMMS for the public sector. (The faith-based sector uses the separate MEDS system.) Before KEMSA’s establishment, parallel logistics systems for various programs existed, resulting in poor inventory control at service delivery points and inadequate inventory reporting.<sup>229</sup> At present, FP rides on the KEMSA EMMS supply chain, while other priority programs, such as HIV, TB and immunization, retain separate systems.

FP commodities’ inclusion within the KEMSA system may ease the supply chain transition, but threats to commodity procurement remain. KEMSA is responsible for the warehousing and distribution of all FP commodities, regardless of their procurement source, based on agreed forecasting and quantification requirements developed by government, donors, and implementing partners. Since donors do not contribute any funds or personnel to KEMSA beyond specific TA engagements, this arrangement may improve the sustainability of the FP supply chain during transition. However, FP commodity procurement is still at risk throughout transition due

<sup>226</sup> Chaitkin, M., O’Connell, M., and Githinji, J., 2017. Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Kenya. Washington, DC: Results for Development.

<sup>227</sup> Government of Kenya, Ministry of Health, 2012. Kenya Draft Health Financing Strategy, Report of an External Review. Commissioned by the Ministry of Medical Services, Nairobi, Kenya.

<sup>228</sup> Government of Kenya, Ministry of Health, 2016. Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework, Ministry of Health, Nairobi, Kenya.

<sup>229</sup> AFIDEP, 2012. Assessment of Drivers of Progress in Increasing Contraceptive use in sub-Saharan Africa: Case Studies from Eastern and Southern Africa. African Institute for Development Policy (AFIDEP), Nairobi, Kenya.



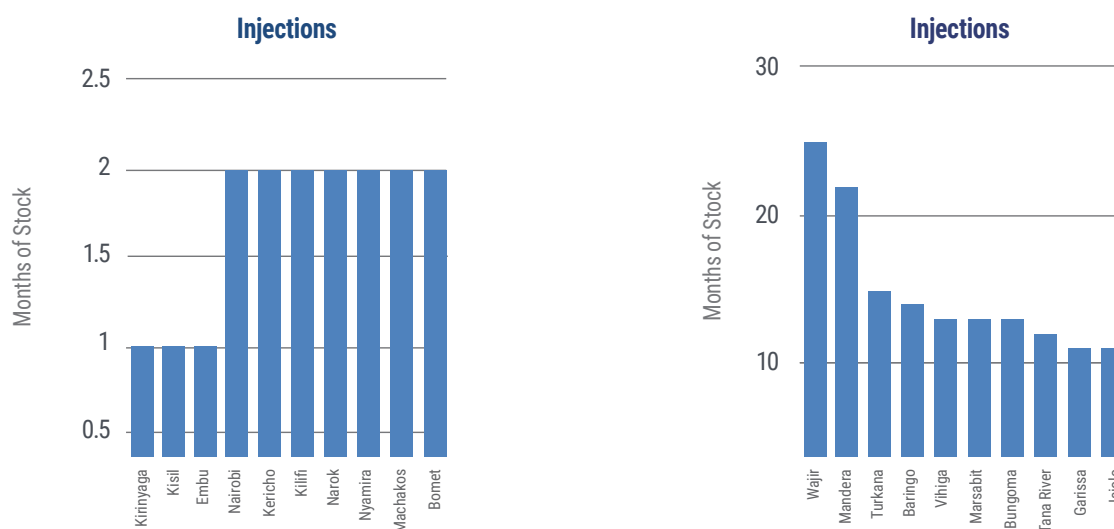
to GoK's heavy reliance on external donor funds for FP commodities, as described above in Part 2: Financing. Moreover, KEMSA only procures FP commodities funded by the World Bank and the GoK; other donors order contraceptives through UNFPA, and USAID utilizes its own global procurement mechanism. FP transition would therefore require an increase in KEMSA's procurement volume and responsibility, assuming that the GoK has the resources to cover FP commodity funding gaps.

The FP supply chain also suffers from devolution-specific problems, including weak forecasting and large county debts that must be resolved prior to achieving a successful program transition. Despite the counties' ostensible ownership of and financial responsibility for FP programming, county officials are not significantly involved in FP forecasting; KEMSA officials and donor partners, including USAID, the World Bank, DFID, and UNFPA, oversee this process at the national level. Quantification is broken down by county and is sometimes based on current reported consumption or, more often, demographic projections. Given the national forecasting officials' lack of county contextual information, such as challenges with seasonal access to health centers, health worker strikes, and the construction or closure of medical facilities, one partner noted that *"most of the time the forecast is wrong, and you find yourself with*

*more commodity than you need, or sometimes with less."* The lack of county involvement in FP commodity forecasting contributes to many stakeholders' belief that commodity procurement—alongside commodity financing—should be the domain of the Kenyan national government. Such an arrangement would also eliminate the current issue of large county debts to KEMSA. These debts must be serviced before KEMSA distributes any further products, including FP commodities, to the debtor counties, contributing to stock-out crises in many regions.

Donor exit from FP would likely exacerbate existing weaknesses and bottlenecks found within the EMMS chain, particularly with respect to supply chain monitoring and management. CHAI has supported KEMSA and the Reproductive and Maternal Health Services Unit (RMHSU) with data analytics to understand FP commodity availability at service delivery points. These data indicate that many counties and facilities regularly grapple with stock-outs of popular methods, such as implants and injectables, while other counties are over-supplied with commodities (Figure 5.12).<sup>230</sup> Without continued assistance and investment in FP supply chain monitoring to correct deficiencies in forecasting and stock management, this problem is likely to intensify further.

**FIGURE 5.12: Ten counties with the highest and lowest aggregate facility month of stock (stock on hand) for injectable contraceptives** (Source: National Contraceptives Report, June 2019)



<sup>230</sup> Ministry of Health, Reproductive and Maternal Health Services Unit. National Contraceptives Report, June 2019.





A medical officer with patients and families outside of the Kangagetet Dispensary in Turkana County, Kenya, 2004.

Procurement and supply chains for other priority programs – HIV, TB and immunization – remain vulnerable as part of transition. KEMSA operates these programs’ vertical warehousing systems, which are heavily supported with donor funding and partner TA. For example, UNICEF has been contracted by Gavi to support vaccine supplies and distribution and continues to retain this function. KEMSA has recently assumed

responsibility for procurement for all US Government- and Global Fund-funded commodities for HIV and TB, but “historical challenges” related to KEMSA leadership and governance remain, and bureaucratic delays hinder procurement and stock availability.<sup>231</sup> This KEMSA-led arrangement in HIV and TB contrasts with the independent procurement systems utilized by USAID and UNFPA for FP.

## Technical Capacity

### **Technical Assistance for HSS and Priority-Setting**

There is fairly limited and uneven technical assistance (TA) specifically targeted to FP in Kenya, but the FP program currently benefits from significant donor investments in health systems strengthening (HSS). There have been a range of TA and HSS initiatives to address managerial and technical gaps found within CDoH management and service provision. As part of the World Bank-Global Financing Facility (GFF) project, a Multi-Donor Trust Fund has been established which finances TA to selected counties and addresses HSS building blocks such as planning and budgeting, monitoring and evaluation, and supply chain management. USAID “Afya” [health] programs fund HSS initiatives alongside priority programs including HIV, TB, malaria, and FP. There are also a range of Gates Foundation partners specifically addressing FP in several counties;

these partners support budget advocacy, data visualization, supply chain strengthening, and demand- and supply-side interventions for specific vulnerable sub-populations such as adolescents. Overall, donor withdrawal from TA initiatives would compromise gains in HSS across the country, including strategic planning and M&E initiatives that benefit the FP program.

Partners providing TA tend to work directly with a preferred set of counties; there is little to no coordination of county TA through the national MoH. This arrangement results in “patchy” support; some counties have several partners providing TA, while other counties have few.<sup>232</sup> TA for FP is not necessarily targeted to the weakest-performing counties; partners may instead prefer to fund a select set of counties that have demonstrated efficiency and are generating results in

<sup>231</sup> Ibid.

<sup>232</sup> Appleford, G. and P. Emmert, 2019. Transforming Health Systems for Universal Care: Annual budget and workplan analysis and implications for family planning. Avenir Health case study.

their FP programs.<sup>233</sup> While many counties with poorer FP performance already suffer from a lack of partner investment, donor transition from FP would jeopardize funding for interventions in counties that have demonstrated greater efficiency in and/or commitment to FP, since the GoK is not planning to replace TA support from these partner initiatives.

Devolution has weakened technical support for priority-setting and stakeholder coordination within FP, which may worsen through the process of transition. Devolution coincided with the first national FP costing implementation plan (CIP) (2012-2016), the launch of FP2020, and Kenya's "Revitalizing Long-acting Reversible Contraception (LARC) Strategy." As one partner respondent indicated, although the national FP CIP became somewhat irrelevant due to devolution, *"partners did coordinate around this."* The current national FP CIP (2017-2020) is viewed as more of a "reference material," as it is not being used to plan, finance, or monitor FP programming in any significant way. In its place, several partners have supported CDoH to develop bespoke county FP CIPs. Just under half of counties (18 of 47) have these county-level CIPs, and there are divergent views on how useful these documents are, as they neither assist in prioritizing FP interventions nor guide counties on future transition and sustainability. Furthermore, one respondent indicated that the county FP CIPs may have contributed to donors' assumption that counties would finance FP commodities: *"Devolution brought confusion, including for commodity security. Development partners assumed [the county] government was there"* (Partner respondent). Presently, GoK technical knowledge for priority-setting and government-donor coordination is weak and diluted across the counties (Health technology assessment (HTA) has recently been introduced to support priority setting.) Kenya requires strong donor and national investment in evidence-based financial planning, realistic program priority-setting, and transparent strategy development for FP that includes all stakeholders throughout the transition process to ensure the FP program's viability.

However, donors' continued funding of personnel for TA and other supportive activities across health programs generates challenges of its own. For example, in Nairobi county alone, almost two hundred staff are funded

off-budget through HIV program donors. According to government respondents, the salaries and stipends paid to these individuals *"are totally off what the government can afford"* and will create major issues for absorption as partner programs exit. In government respondents' view, there have been no arrangements made for HR transition, including within the FP program. "Bad habits" have been formed; for example, a per diem and "conference package" culture has mushroomed within select counties that enjoy heavy donor investment for FP and other priority programs. This issue was raised previously by the Head of Public Service and needs to be addressed to manage program costs and employee expectations across all health programs throughout the transition process.

### Data

As a member of FP2020, Kenya has committed to improving FP data availability and utilization with the support of multiple implementing partners. At the national level, this effort is primarily supported by the Track20 project,<sup>234</sup> which works with FP2020 pledging countries to train dedicated FP M&E officers. These individuals are supported to play a leading role in building consensus around estimates for annual reporting on FP progress to FP2020. The Track20 initiative has enabled greater consistency in the quality and availability of FP data in Kenya. Other national M&E support comes from CHAI, which aids in data visualization and analytics related to commodity supply. UNFPA also contributes periodic surveys on topics such as commodity supply, supply chain functionality, and FP financing using the NIDI methodology. TA for data appears to be better coordinated than for other components of the FP program, partly due to fewer partners working in this area. Additionally, most assistance is targeted specifically at the national government level because FP data belongs to and is housed within the national health management information system (HMIS). At the county level, various partners support data quality audits (DQAs); some audits are for FP specifically, while others take a more holistic approach to RMNCAH. Donor assistance drives most FP M&E activities in Kenya, and the quality of data available for use in decision-making is at considerable risk throughout transition unless donors and/or the government continue to invest in this area.

<sup>233</sup> Appleford, G. and P. Emmert, 2019. Transforming Health Systems for Universal Care: Annual budget and workplan analysis and implications for family planning. Avenir Health case study.

<sup>234</sup> <http://www.track20.org>

## Enabling Factors: Political Commitment to FP and Legal & Human Rights Risks

In the face of competing fiscal demands in the health sector, including multiple health program transitions and UHC expansion, the GoK has yet to make FP a national political priority by allocating increased domestic resources to FP programming. This unfulfilled priority is made even more urgent in the face of significant shortfalls in financing for FP commodities. However, the GoK has been in this position before: while the government made early progress in committing to population policies in the 1960s, and in FP service provision during the 1970s and 1980s, political support, financial resources, and FP services subsequently declined in the 1990s.<sup>235</sup> This change occurred in the context of shifting international attention and official development assistance for health (DAH) to HIV and AIDS programs during the 1990s and into the 2000s.<sup>236</sup> The GoK was slow to resume its investment in FP programming; only when mCPR stagnated and TFR started to increase for some population segments<sup>237</sup> did the government introduce a national budget line for FP commodities in the 2005/06 and subsequent national budgets.<sup>238</sup> However, GoK contribution has declined considerably since devolution in 2012/13 (see Figure 5.8). Moreover, FP is not high on the political agenda in Kenya; the topic is rarely discussed in a public setting, and the program lacks political champions. GoK's willingness to finance and steward the Kenyan FP program after donor departure is therefore uncertain.

GoK's low prioritization of FP is also reflected in its limited implementation of financial sustainability initiatives recommended in the national FP CIP (2017-2020). The current CIP identified sustainability in financing as a key pillar of the national FP strategy. This pillar was developed in recognition of the GoK's dependency on donors in FP and the unpredictability of future donor financing. However, little has been done to implement the CIP's sustainability-related recommendations, which include increasing domestic financing through diversifying funding sources and strengthening advo-

cacy for funding from multiple sources, including the county treasuries. The CIP also recommends adopting a total market approach (TMA) within the FP commodity market, reviewing the government's policy to provide free FP commodities to private health centers, including the full method mix in the National Hospital Insurance Fund (NHIF), and harnessing new funds through the World Bank-GFF THS-UC project. The government has not implemented most of these initiatives. In fact, a respondent noted that the plan had become more of a reference material, alongside the county FP CIPs: *"After the launch, who is referring to it?"* At present, the GoK is not following through on its own financial and programmatic recommendations within FP; stronger political commitment to developing a sustainably financed FP program is a requirement for successful transition.

Beyond the FP CIP, there is an RMNCAH investment framework,<sup>239</sup> developed in 2016, to guide transition. This framework correctly diagnoses that the health sector has traditionally focused on inputs, with weak linkages between health financing and performance. The investment tagline is "smart, scaled-up, and sustained financing." With 230 immediate actions recommended, however, the framework is too dense for reasonable prioritization and implementation of strategic initiatives. Moreover, the recommendations are very broad and lack specific plans for fulfillment, as evidenced by the following four actions pertaining to health financing, sustainability, and transition:

- Develop the national health financing strategy;
- Link donor financing to domestic financing at national and country levels for RMNCAH;
- Institutionalize a performance-based framework; and
- Scale up performance-based and demand-side financing, relevant to the Kenyan context.

<sup>235</sup> Chimbwete and Zulu 2003 in Crichton, J. 2008. Changing fortunes: analysis of fluctuating policy space for family planning in Kenya, *Health Policy and Planning* 2008;23:339–350 doi:10.1093/heapol/czn020.

<sup>236</sup> Cleland et al. 2006 in Crichton, J. 2008. Changing fortunes: analysis of fluctuating policy space for family planning in Kenya, *Health Policy and Planning* 2008;23:339–350 doi:10.1093/heapol/czn020.

<sup>237</sup> The 2003 DHS results revealed a stall in fertility decline at 4.8 in 1998–2003, and fertility rose for women who had not completed primary education.

<sup>238</sup> Crichton, J. 2008. Changing fortunes: analysis of fluctuating policy space for family planning in Kenya, *Health Policy and Planning* 2008;23:339–350 doi:10.1093/heapol/czn020.

<sup>239</sup> Government of Kenya, Ministry of Health, 2016. Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework, Ministry of Health, Nairobi, Kenya.

In addition to the deficiencies described above, it is unclear how the framework is being used to guide prioritization or investment in FP or other RMNCAH interventions. None of the respondents consulted for this case study mentioned the framework or any of the recommended immediate actions. This guide for FP and other RMNCAH transitions appears to have been superseded by the UHC agenda (see Part 2: Financing).

Women's reproductive rights are acknowledged by political officials and government policies, but they are not always realized. Despite recognition of reproductive rights within key GoK policy documents, 18% of women of reproductive age have an unmet need for FP; this figure is higher in rural areas (20%) than urban areas (13%) and is also higher for women with lower levels of education and household wealth.<sup>240</sup> Age also inhibits access to contraception, as adolescents and youth may face biases and stigma in accessing FP services and may choose to forgo contraception or use over-the-counter methods (such as emergency contraception) as a result. At 18%<sup>241</sup>, the adolescent pregnancy rate is high in Kenya, compared to other sub-Saharan African nations. The teen pregnancy rate also varies widely between counties—ranging from 6% to 40%<sup>242</sup>—and poses a significant threat to development and aspira-

tions of young girls, as well as the country. Additional investment in programming for vulnerable populations is required to achieve equity in FP access. However, these groups may not be prioritized in a transitioning FP environment that lacks donor financial support and political advocacy for vulnerable populations.

The Kenyan political economy does not favor “special attention” to key health programs such as FP. The current GoK's interest is in UHC, which should include priority programs. However, emphasis on domestic financing for UHC may make the essential benefits package vulnerable to political and financial pressures, such as a lack of funding for FP commodities, and privilege clinical over public health interventions.<sup>243, 244</sup> Additionally, less powerful groups, such as poor women, who have higher health needs and lower financing capabilities than men, may not be prioritized or adequately served in a UHC system.<sup>245</sup> A partner respondent supported this view, stating that FP is considered a “women's issue.” This narrow frame of reference does little to garner political support, nor does it capitalize upon societal and economic benefits of FP. FP's relationship with the demographic dividend is not adequately harnessed, and rights are not central to the discourse of health financing in Kenya.

<sup>240</sup> Government of Kenya, National Bureau of Statistics, 2015. Kenya Demographic and Health Survey 2014. Nairobi, Kenya.

<sup>241</sup> Ibid.

<sup>242</sup> Ibid.

<sup>243</sup> Hill, PS, 2018 Primary health care and universal health coverage: competing discourses? *The Lancet*. Vol.392, Number 10156.

<sup>244</sup> Schmidt, H, Gostin, LO, and EJ Emanuel, 2015. Public health, universal health coverage, and Sustainable Development Goals: can they coexist? *Lancet* 2015; 386: 928–30.

<sup>245</sup> Witter, S, Govender, V, Ravindran, TKS and R Yates, 2017. Minding the gaps: health financing, universal health coverage and gender. *Health Policy and Planning*, 32, v4–v12 doi: 10.1093/heapol/czx063.



## Summary of Risks and Key Options for Consideration

Several key “candidate” recommendations to improve Kenya’s readiness for FP transition, alluded to above, are summarized in in Table 5.3 below.

**TABLE 5.3: Key options for consideration to improve kenya’s readiness for FP transition**

Transition Risk Area	Key Options for Consideration
<b>Financing of FP and Other Health Programs</b>	<ul style="list-style-type: none"> <li>• Develop realistic cost estimates for the FP program and use these to guide planning and budgeting</li> <li>• Re-introduce a centralized FP budget line at the national level with ring-fenced funding for commodities</li> <li>• Finalize and implement an FP commodity co-financing plan agreed upon by donors/GoK and systematically monitor performance</li> <li>• Secure an FP representative position at ongoing UHC discussions to advocate for inclusion of prioritized FP commodities and services under any new UHC scheme</li> <li>• Conduct and publish annual FP expenditure analysis including OOPs with assistance from Track20</li> </ul>
<b>Procurement and Supply Chain</b>	<ul style="list-style-type: none"> <li>• Forecast FP commodity resource requirements through 2030</li> <li>• Resolve county debts to KEMSA so that these do not delay EMMS shipments</li> <li>• Improve county FP commodity forecasting to address over- and under-supply</li> <li>• Monitor FP commodity supply chain to reduce stockouts and improve real-time reporting</li> </ul>
<b>Technical Capacity</b>	<ul style="list-style-type: none"> <li>• Transfer FP data analysis/survey skills to national institutions</li> <li>• Build FP technologies and services into an HTA program and definition of UHC benefits package and bolster local capacity for HTA/priority setting</li> <li>• Appoint FP representatives to the transition/sustainability Technical Working Group to assist in planning for Kenya’s health transitions holistically</li> <li>• Ensure that health transition planning is completed jointly with other programs such that FP transition needs are universally acknowledged and budgeted</li> </ul>
<b>Enabling Factors</b>	<ul style="list-style-type: none"> <li>• Improve FP service access in under-served counties and for poor and adolescents through public-private partnerships (e.g. contracting out to NGOs)</li> <li>• Integrate donor-dependent disease programs and FP more fully into primary health care so that silos are eliminated, inefficiency is reduced, and national ownership is enhanced</li> <li>• Address poor/perverse incentives related to heavy reliance on per diems and conference packages to improve the affordability of FP and other health activities</li> <li>• Increase NHIF coverage among the rural poor and ensure that a robust FP method mix is covered for all members</li> <li>• Make explicit the societal and economic benefits of FP, harness the demographic dividend, and make rights more central to the discourse of FP financing in Kenya – as inputs to advocacy and policy dialogue</li> </ul>

### **Financing Risks and Options for Consideration**

The GoK's heavy dependence on external funding in FP and other high-cost health programs, coupled with the perception that donor money for health will continue in the foreseeable future, presents a significant challenge to appropriate fiscal planning for FP transition. Kenya has not developed cost estimates for its FP or major infectious disease programs past 2020, and national strategic plans for transition are still in the early development phase. The NACC-led TWG for transition and the donor-led FP match fund and sliding scale proposal represent important first steps to devising a comprehensive financial transition strategy for FP and other health programs, but further coordination between the GoK and donors in preparation for anticipated declines in external funding for health is necessary. Additionally, domestic and donor advocates for FP must take part in ongoing discussions with other major health programs to ensure that FP is incorporated sufficiently into any emerging UHC scheme. Total annual expenditure for FP is estimated to increase to over US \$110 million by 2030, but this cost is a small fraction of the estimated US \$730 million-plus currently required to fund HIV/AIDS, TB, and malaria programs each year. If Kenya were to take greater responsibility in financing its various health programs in the face of declining donor funds, FP's relatively modest share in the national health budget is at risk of being subsumed under the enormous resource requirements of these competing high-cost, high-priority infectious disease programs.

Inadequate government investment in health programs may increase the risk for increased household OOP and catastrophic health expenditure. Household OOP spending is already a major concern for malaria service delivery, accounting for 36% of total malaria expenditure.<sup>246</sup> While less concerning in the short term (given current levels of donor support), malaria and other health services are at high risk for increases in OOP spending in the context of donor transition.<sup>247</sup> This also holds true for FP. As Kenya reorganizes its health financing func-

tions, it will be important that priority health services such as FP are effectively included in benefits packages and related UHC schemes, particularly for vulnerable populations such as poor women and adolescent girls.

While there is recognition of the need for mixed donor-domestic financing models, these may be constrained by public financial management (PFM) systems. The size of the ARV program in Kenya was recently estimated to be six times higher than that of the entire budget for the NHIF.<sup>248</sup> Therefore, providing HIV treatment services as part of an essential benefits package may necessitate channelling donor funding into the country's financing schemes. This arrangement may prove problematic due to weak PFM systems in terms of efficient and timely money flows as well as transparency in accounting and reporting.<sup>249</sup> Additionally, contracting mechanisms for NGOs and the private sector to support service delivery, particularly for vulnerable groups, are not developed. Only one pilot in one county is currently taking place to test this model of N60 engagement, and this initiative has been fraught with political interference and bureaucratic challenges.<sup>250</sup> This pilot is nonetheless an important first step and could set a precedent for government contracting of FP services or supportive activities, such as demand creation or capacity building.

### **Procurement and Supply Chain Risks and Options for Consideration**

Because FP rides on EMMS and not a parallel vertical system, transition in FP supply chain management should be easier than for other health programs that have separate systems. KEMSA's central role in procurement, warehousing, and distribution should also not be greatly affected by transition, though it must take on greater responsibility in the volume of FP commodities procured, adding to the strain of PFM systems. However, with support from donors, concerted effort and funds have already been invested into strengthening the supplies authority's capacity, and its effectiveness is evidenced by donor utilization of KEMSA's systems.

<sup>246</sup> Ministry of Health 2015 in Chaitkin, M., O'Connell, M., and Githinji, J., 2017. Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Kenya. Washington, DC: Results for Development.

<sup>247</sup> Ibid.

<sup>248</sup> UHC 2030 International Partnership, 2019 (May). Perspectives from Health Programmes on sustainability and transition from external funding. Report of a meeting held at Chateau de Penthes Geneva, Switzerland.

<sup>249</sup> UHC 2030 International Partnership, 2019 (May). Perspectives from Health Programmes on sustainability and transition from external funding. Report of a meeting held at Chateau de Penthes Geneva, Switzerland.

<sup>250</sup> Living Goods is contracted by Isiolo County to deliver community-based services on the county's behalf for four years (the contract was signed in 2018).

While transition risks associated with FP procurement and the supply chain should be manageable, existing inefficiencies must be remedied. In particular, over- and under-supply of FP commodities to counties and between service delivery points should be addressed by improving commodity utilization reporting rates, which are currently low, and developing better forecasts. Ongoing and future TA for these functions should target efficiency, given that this is a major focus of Kenya's health policy and DRM strategy.

### **Technical Capacity Risks and Options for Consideration**

Technical capacity and stewardship of FP programming has been diluted through devolution. The GoK already has a redundancy of national-level plans, such as the national FP CIP and the RMNCAH investment case. However, due to devolution, partners have also introduced county-level FP CIPs in some but not all counties, which do little to aid prioritization or prepare for transition. TA has also shifted to become more systems-oriented. With transition, there is the risk that technical gaps and stewardship may be diluted further and that comprehensive priority-setting will continue to be neglected.

There is limited communication and planning for transition. This gap exists between different arms of government, at both national and county level, as well as between government and partners. There is an opportunity to address this issue through the DRM TWG being formed under the leadership of NACC. The TWG is focused on DRM—to obtain “more money for health”—but it should also seek “more health for money,” given real and perceived inefficiencies found within the major infectious disease programs. If these issues are not attended to concurrently, domestic resources for FP and other priority programs may not be adequate or adequately considered.

Partners are also not designing programs for eventual transition. It emerged from interviews that most part-

ners are not approaching transition as a continuum, in which transition milestones are built into implementation. (WHO refers to this as designing with the end in mind.) Moreover, donor timelines for exit are unclear. A continuum approach would help to set expectations with the counties, as “*we can't continue to program as before, with large budgets*” (Government respondent). Since co-financing arrangements have not been developed for FP as they have for other priority health programs funded by the Global Fund, PEPFAR, and Gavi<sup>251</sup>, there is a risk that responsibility for FP programming will not shift gradually over time or in an expected manner, but rather in abrupt changes to donor funding levels for which the GoK is not prepared.

### **Enabling Factors Risks and Options for Consideration**

The GoK has not sustained political and bureaucratic commitment to the FP program. Waning national commitment to FP can lead to stagnation in programmatic implementation and can also undermine the likelihood that political and bureaucratic actors create new policies and strategies to adapt to changing contexts, such as shifts in external funding trends.<sup>252</sup> This situation has happened to Kenya's FP program before, during the HIV/AIDS pandemic of the 1990s. Lessons from past experiences in FP underfunding are important for understanding the political economy of current simultaneous transition scenarios.

The contribution of OOP expenditure to FP inequities is underrecognized and may be exacerbated by transition. Globally, it is estimated the OOP expenditure will account for most of the financing for FP over the next three years.<sup>253</sup> In Kenya, there is a lack of comprehensive data to estimate OOP expenditure for FP and reproductive health more generally.<sup>254</sup> This form of financing requires monitoring, as it may increase with transition and result in greater inequities, including recourse to unsafe abortion and unwanted pregnancy, with potentially catastrophic consequences for the individual, her family, and the health system.<sup>255</sup>

<sup>251</sup> Exceptions to this are The Challenge Initiative sites in Kenya. The Challenge Initiative is an innovative program led by Johns Hopkins University that requires local government co-financing to scale up FP programs.

<sup>252</sup> Crichton, J. 2008. Changing fortunes: analysis of fluctuating policy space for family planning in Kenya, *Health Policy and Planning* 23:339–350 doi:10.1093/heapol/czn020.

<sup>253</sup> RHSC. 2018. *Global Contraceptive Commodity Gap Analysis 2018*. Brussels: Reproductive Health Supplies Coalition.

<sup>254</sup> Sidze, EM, Pradhan, J, Beekink, E, Maina, TM and BW Maina (2013). Reproductive health financing in Kenya: an analysis of national commitments, donor assistance, and the resources tracking process, *Reproductive Health Matters*, 21:42, 139-150, DOI: 10.1016/S0968-8080(13)42738-6.

<sup>255</sup> Appleford, G. and S. Ramarao, 2018. *Health financing and family planning in the context of Universal Health Care: connecting the discourse*. Population Council, New York.





# Chapter 6: Bangladesh Country Case Study

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## Executive Summary

The Bangladesh FP program has witnessed great success in the national expansion of contraceptive use and decline in total fertility. This achievement is due in part to governmental leaders' strong commitment to the FP program since its inception in the 1970s, as well as the international FP donor community's involvement in Bangladesh. However, while Bangladesh has succeeded in reducing fertility rates to near-replacement levels in recent years, national contraceptive coverage has plateaued, highlighting remaining inequities in access to quality family planning. These programmatic challenges—including a deficiency of FP services for vulnerable groups such as adolescent girls and the urban and rural poor, a lack of skilled FP providers, and limited access to effective long-acting and permanent methods (LAPM) of contraception—could be exacerbated as donor support for Bangladesh's FP program continues to decline in the coming years.

The FP program in Bangladesh started the process of transition in the early 2000s: while donors funded and procured all contraceptive commodities prior to the period 1998–2002, the Government of Bangladesh (GoB) has gradually contributed increasing domestic resources, often in the form of World Bank (WB) loans, to FP. As of 2016, the GoB financed 66% of its US \$340 million FP program, including nearly 96% of all commodities.<sup>256</sup> Donors such as USAID have transferred most procurement and supply chain management activities to the GoB's Directorate General of Family Planning (DGFP) or other domestic stakeholders. The basic systems of financing, procuring, and supplying contraceptive

commodities, particularly short-term methods, are well established in Bangladesh and are likely prepared for a relatively smooth transition. This situation places the Bangladesh FP program in a privileged position compared to other countries in the “medium-term, higher-risk transition” category such as Ghana and Kenya as well as the other major donor-backed health programs approaching transition within Bangladesh itself.

However, donors continue to provide significant TA to the Bangladesh FP program, particularly in its most vulnerable programmatic areas. Donors fund 98% of enabling environment initiatives, including behavioral change communication (BCC) campaigns; 99% of FP-related research; 90% of M&E activities; and 95% of training and capacity building endeavors.<sup>257</sup> Some TA directly supports contraceptive procurement and supply, including technical support for the FP electronic logistics management information system (eLMIS) and assistance in commodity forecasting and planning. Other TA activities help to build a conducive environment for individuals to access FP: improving quality of care across the FP system, expanding access to long-acting contraceptives especially among vulnerable populations, building public demand for FP, training skilled FP (particularly LAPM) providers, and conducting pilot programs and cost-effectiveness studies to inform policy advocacy. It is not clear that the GoB is financially prepared or politically motivated to take on these additional initiatives and expenses. As described by an informant, many FP officials in the government and NGO sectors have become “*complacent*” in the face of stag-

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<sup>256</sup> Hamid, S.A., et al., 2016. Bangladesh Family Planning Spending Assessment (FPSA). Dhaka: Institute of Health Economics.

<sup>257</sup> Ibid.

nating FP indicators because of the program's historical success in fertility reduction, and they may not prioritize addressing these ongoing weaknesses in the system. However, without domestic investment in important enabling environment activities, existing vulnerabilities in the national FP program could be exacerbated during and after transition, possibly resulting in a reduction of access to a robust FP method mix as well as a decline in the quality of services available. As one interviewee stated, *"We have been able to reach the low-hanging fruit now, but if the government does not take responsibility for the broader program during transition, we may lose many of the gains we have achieved."*

Despite widespread recognition that donor funds for health are declining in Bangladesh, informants were not aware of a coordinated government- or donor-led effort to plan for transition, either within the FP program or more broadly across the health sector. Preparation for transition has become a major concern for other donor-backed health programs such as immunization. Gavi plans to withdraw fully from Bangladesh by 2026, and it is preparing for this transition earlier and more intensively than it has in peer Southeast Asian countries due to Bangladesh's unusually challenging "double dose of transition" in immunization.<sup>258</sup> By 2026, the GoB must take on not only US \$67 million in annual vaccination expenses (about 8% of domestic government health expenditures in 2017)<sup>259</sup> but also the salaries of the "significant" number of immunization workers currently funded by Gavi.<sup>260</sup> This large, looming Gavi graduation may generate a fiscal crunch for other health programs, including FP. Other transition-related challenges for the health sector include expected increases in co-financing requirements to other global health mechanisms like the Global Fund, as well as the loss of eligibility for International Development Association (IDA) grants and IDA's most favorable loan terms due to the growing national economy. While the Bangladesh FP program has numerous committees for stakeholder coordination that could begin to plan for these upcoming tran-

sition-related concerns, this issue does not appear to be prioritized in these fora or in the health sector more broadly.

Beyond transitions, Bangladesh faces additional challenges in the health sector that will place pressure on health delivery systems and financing for FP in the coming decade. Bangladesh seeks to achieve universal health coverage (UHC) by 2030, an ambitious endeavor given the nation's health insurance coverage rate of 1% in 2017.<sup>261</sup> Additionally, climate change and urbanization have introduced new diseases to the country and exacerbated current weaknesses in health; recent devastating outbreaks of dengue fever and chikungunya, as well as endemic seasonal cholera outbreaks related to flooding, illustrate this concern.<sup>262</sup> In this context, and considering the country's already-narrow fiscal space for health, Bangladesh's FP program may not be prioritized for funding beyond the amount necessary to maintain basic contraceptive procurement and supply. Thus, a donor transition in FP may reduce or eliminate funding for M&E, forecasting, BCC, evidence generation, staff training, method mix development, quality assurance, and other enabling environment activities. Fearing this outcome, one informant had a request for FP donors: *"You can stop donating your money, but don't get out of the country. Stay and help with TA; that is what is needed."*

The remainder of this case study examines the challenges associated with transition in Bangladesh's FP program with an emphasis on the technical assistance and enabling environment risks that are most likely to materialize during transition. This report begins with a general overview of Bangladesh's relevant country characteristics and then examines the four key components of our FP transition framework: Financing for FP and Other Priority Programs; Procurement and Supply Chain; Technical Capacity; and Enabling Factors for FP. We conclude the case study by offering key options for consideration to prepare Bangladesh for its upcoming FP transition.

<sup>258</sup> Informant interview.

<sup>259</sup> World Health Organization: Southeast Asia, 2017. Health Financing Profile 2017: Bangladesh. <https://apps.who.int/iris/rest/bitstreams/1092340/retrieve>

<sup>260</sup> Informant interview.

<sup>261</sup> Government of Bangladesh Health Economics Unit, 2014. Framework for monitoring progress towards UHC in Bangladesh. Dhaka: Ministry of Health and Family Welfare. [http://heu.gov.bd/pdf/UHC\\_indicators%20FINAL.pdf](http://heu.gov.bd/pdf/UHC_indicators%20FINAL.pdf)

<sup>262</sup> Mutsuddy, P., Tahmina Jhora, S., Shamsuzzaman, A. K. M., Kaisar, S. M., & Khan, M. N. A., 2019. Dengue situation in Bangladesh: An epidemiological shift in terms of morbidity and mortality. *Canadian Journal of Infectious Diseases and Medical Microbiology*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6431455/>

## Introduction

### Country Context

Bangladesh is one of the most populous and densely populated countries in the world. Its July 2019 population estimate exceeded 161 million people, the eighth highest in the world.<sup>263</sup> Excluding small city-states and island nations, Bangladesh is the world's most densely populated country, with approximately 1,240 people per square kilometer.<sup>264</sup> The current population is young; individuals aged 0 to 24 comprise 46% of the total population.<sup>265</sup> The percentage of urban residents has more than doubled since the 1980s and currently stands at 37%.<sup>266</sup> Although the country's previous rapid population growth rate has slowed, reaching 1.1% in 2018,<sup>267</sup> total population is expected to peak around 190 million in 2050 before beginning to decline.<sup>268</sup>

Bangladesh became a lower-middle-income country in 2015, and its 2018 GNI per capita was \$1,750.<sup>269</sup> Bangladesh has exceeded the GNI per capita eligibility threshold for IDA grants (US \$1,175 in FY2020) and is currently borrowing from the World Bank on blend credit terms, meaning that its interest rates are higher and repayment periods are shorter.<sup>270</sup> Additionally, due to improvements in economic and social indicators, the UN anticipates that Bangladesh will graduate from "Least Developed Country" status in 2024.<sup>271</sup> Though the number of Bangladeshis living in poverty decreased by 44% from 1991 to 2016,<sup>272</sup> about 14% of the population still lived below the international poverty line of US \$1.90 per person per day in 2017.<sup>273</sup>

### FP Program Context

Family planning has long been a political priority in Bangladesh. The country's modern FP program was established in the late 1970s under the Ministry of Health and Population Control, which was later rebranded as the Ministry of Health and Family Welfare (MoHFW).<sup>274</sup> A primary purpose of the GoB's FP program, as suggested by the ministry's initial name, was to slow the nation's rapid population growth through the expansion of contraceptive use. Since the program's inception, FP as a means to achieve replacement-level fertility rate has remained a top political and fiscal priority in Bangladesh. The 3rd Health, Population, and Nutrition Sector Development Plan (2011-2016) called for a replacement-level fertility by 2016.<sup>275</sup> While this goal was not achieved, per the GoB's most recent Health, Nutrition, and Population Strategic Investment Plan/Global Financing Facility Investment Case in 2016, FP continues to be a primary focus of both domestic and donor investment in the health sector.<sup>276</sup>

While Bangladesh's FP program has historically seen great success, the country's FP indicators have plateaued in the past decade. Due to strong FP commitments from national leaders and international donors, the Bangladesh TFR declined drastically from 6.4 births in 1975 to 2.3 births in 2011.<sup>277</sup> Contraceptive prevalence increased from less than 10% in the 1970s to 43% (modern methods, married women) in 2012.<sup>278</sup> However, in the past decade, mCPR (all women) has remained

<sup>263</sup> U.S. Census Bureau, 2019. World Population. <https://www.census.gov/popclock/print.php?component=counter>

<sup>264</sup> World Bank, 2018. Population Density. The World Bank DataBank. <https://data.worldbank.org/indicator/EN.POP.DNST>

<sup>265</sup> U.S. Central Intelligence Agency, 2019. Bangladesh. The World Factbook. <https://www.cia.gov/library/publications/the-world-factbook/geos/bg.html>

<sup>266</sup> <https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?locations=BD>

<sup>267</sup> World Bank, 2018. Urban Population. The World Bank DataBank. <https://data.worldbank.org/indicator/SP.POP.GROW>

<sup>268</sup> U.N. Population Division, 2019. Bangladesh Total Population Probabilistic Estimates. World Population Prospects. <https://population.un.org/wpp/Graphs/Probabilistic/POP/TOT/50>

<sup>269</sup> World Bank, 2019. Bangladesh Overview. World Bank: Where We Work. <https://www.worldbank.org/en/country/bangladesh/overview>

<sup>270</sup> World Bank, 2019. Borrowing Countries. IDA. <http://ida.worldbank.org/about/borrowing-countries>

<sup>271</sup> World Bank, 2019. Bangladesh Overview. World Bank: Where We Work. <https://www.worldbank.org/en/country/bangladesh/overview>

<sup>272</sup> Ibid.

<sup>273</sup> World Bank, 2018. Bangladesh: Reducing Poverty and Sharing Prosperity. Results Briefs. <https://www.worldbank.org/en/results/2018/11/15/bangladesh-reducing-poverty-and-sharing-prosperity>

<sup>274</sup> Larson, A., & Mitra, S. N. (1992). Family planning in Bangladesh: An unlikely success story. *International Family Planning Perspectives*, 123-144. <https://www.jstor.org/stable/pdf/2133539.pdf?refreqid=excelsior%3Aa21ade119c458ad42b2e9b7d4fc1417a>

<sup>275</sup> Ahmed, S., & Islam, W., 2015. Bangladesh Costed Implementation Plan, 2016-2020. Dhaka: Ministry of Health and Family Welfare.

<sup>276</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>277</sup> World Bank, 2017. Total Fertility. The World Bank DataBank. <https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=BD>

<sup>278</sup> FP2020, 2018. Core Indicators. FP2020 Data Dashboard. <http://www.familyplanning2020.org/data-dashboard>

steady at around 45%, and unmet need has hovered around 19% for married women. Unmet need is particularly high in certain key populations, especially adolescents. Due to the widespread practice of child marriage in Bangladesh, the national adolescent fertility rate (83 births per 1000 adolescent girls aged 15-19) is nearly double the global average of 42.<sup>279</sup> Disparities in FP access and outcomes also exist regionally—the eastern divisions of Sylhet and Chittagong have higher fertility rates and lower CPRs than Dhaka or the western divisions—and by income, as poorer women tend to have larger families.<sup>280</sup> Box 6.1 presents relevant FP indicators for Bangladesh.

### BOX 6.1. FP Performance Indicators

Total users	21,205,000
Additional users	2,637,000
mCPR (all women)	45.5%
mCPR (married women)	56.8%
Unmet need (MW)	19%
Demand satisfied (MW)	75%

Source: Track20 FP2020 Core Indicators (2018)

Bangladesh's method mix strongly favors less effective short-term contraceptives that are prone to discontinuation, leading to unintended pregnancies and pregnancy termination. Short-term methods, including injectables, pills, and male condoms, comprised 85% of all contraceptives used in 2014.<sup>281</sup> IUDs and implants accounted for less than 5% of the total, with sterilizations rounding

out the mix. Discontinuation, particularly for short-term methods, remains high, at rates of 25% for injectables, 34% for pills, and 40% for condoms.<sup>282</sup> As a result of the reliance on short-term methods and high discontinuation rates, about half of all pregnancies in Bangladesh are unintended.<sup>283</sup> Menstrual regulation (MR), a type of induced abortion permitted under current GoB regulations, therefore plays a large role in Bangladesh FP: up to 60% of all unintended pregnancies in Bangladesh are terminated.<sup>284</sup> Guttmacher Institute estimates that 430,000 MR procedures were performed in Bangladesh health facilities in 2014, and an additional 1.2 million induced abortions occurred outside of health centers, including in unsafe conditions, in that year.<sup>285</sup>

The private and NGO sectors are also involved in health service delivery in Bangladesh, especially for FP. FP NGOs have a long history in Bangladesh, and the private and social marketing sectors are growing. NGO service delivery partners include the Family Planning Association of Bangladesh (an IPPF affiliate active since 1953) and Marie Stopes Bangladesh (MSB, founded in 1988).<sup>286</sup> Local urban governments frequently contract NGOs to provide health services in their cities, and NGOs are also active in hard-to-reach rural areas. In the social marketing space, the aptly named Social Marketing Company (SMC), a non-profit firm, is the national leader. According to the 2014 Bangladesh Demographic and Health Survey (BDHS), 34% of all modern method users in Bangladesh use SMC-branded contraceptives, including 62% of all condoms, 44% of pills, and 18% of injectables.<sup>287</sup> The company is currently expanding into the LARC and self-administration market, offering a branded implant and IUD along with Sayana Press (DMPA-SC).<sup>288</sup> SMC also oversees and promotes its trademark Blue Star and Pink Star networks of private providers who are trained in LAPM provision.<sup>289</sup> Several NGOs operate smaller FP social marketing programs; MSB runs an MR medica-

<sup>279</sup> World Bank, 2017. Adolescent Fertility. The World Bank DataBank. <https://data.worldbank.org/indicator/sp.ado.tfrt>

<sup>280</sup> Ahmed, S., & Islam, W., 2015. Bangladesh Costed Implementation Plan, 2016-2020. Dhaka: Ministry of Health and Family Welfare.

<sup>281</sup> FP2020, 2018. Core Indicators. FP2020 Data Dashboard. <http://www.familyplanning2020.org/data-dashboard>

<sup>282</sup> Ibid.

<sup>283</sup> Guttmacher Institute, 2017. Menstrual Regulation and Unsafe Abortion in Bangladesh. Fact Sheets. <https://www.guttmacher.org/fact-sheet/menstrual-regulation-unsafe-abortion-bangladesh#fn0>

<sup>284</sup> Ibid.

<sup>285</sup> Ibid.

<sup>286</sup> See: <http://www.fpab.org.bd/HOME> and <https://mariestopes.org/where-we-work/bangladesh/>

<sup>287</sup> SMC Enterprise, Ltd., 2017. Social Marketing Company Annual Report 2016-17. Dhaka.

<sup>288</sup> Social Marketing Company, 2019. Our Brands: Contraceptives. [https://www.smc-bd.org/products/search\\_brand\\_product?cat\\_id=4](https://www.smc-bd.org/products/search_brand_product?cat_id=4)

<sup>289</sup> Social Marketing Company. Our Programs: Pink Star Program. <https://www.smc-bd.org/pink-star-program-ppp->

tion social marketing program, for example.<sup>290</sup> Additionally, contraceptives are readily available for purchase at pharmacies, and the number of private practitioners in the FP space is growing. OOP payments at these private providers accounted for approximately 12% of total FP expenditures in 2016.<sup>291</sup> The private for-profit FP sector is mostly unregulated with varying quality.<sup>292</sup>

### Health Financing and Governance Context

While the GoB contributes two-thirds of all fiscal resources for FP, its overall health expenditure indicators are poor. As a share of the national budget, MoHFW allocations have declined from over 6% in FY11 to 4.9% in FY20. The national health budget as a share of GDP has remained stagnant at just under 1%, far below the WHO target of 5% and the GoB's own Seventh Five Year Plan target of 1.12%.<sup>293</sup> OOP payments account for approximately 63% of total health expenditures.<sup>294</sup> Bangladesh has a low tax-to-GDP ratio (about 9% in 2016),<sup>295</sup> leading to significant challenges in translating economic growth into increased government revenue for health and other development sectors.<sup>296</sup>

The division of responsibility for public-sector health systems among various government entities impedes effective integration of health service delivery in Bangladesh. The MoHFW is divided among several directorates, two of which are most relevant to FP: the Direc-

torate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP).<sup>297</sup> The DGHS is responsible for providing a variety of health services, including labor and delivery care, in hospitals and local health complexes. The DGFP focuses specifically on FP service delivery, including at the community and household level. Although many opportunities exist to integrate DGHS and DGFP activities, such as postpartum FP (PPFP) provision following deliveries at district hospitals, there is little coordination between the two directorates.<sup>298</sup> According to partner informants, DGFP and DGHS staff who jointly run community clinics “don’t talk to each other.” Additionally, the Ministry of Local Government, Rural Development, and Cooperatives (MoLGRDC) is responsible for the provision of urban primary healthcare.<sup>299</sup> There is minimal coordination between the MoHFW and the MoLGRDC.<sup>300</sup> Partner NGOs—not the government—generally run urban health clinics through the Urban Primary Healthcare Services Delivery Project (UPHCSDP).<sup>301</sup> Challenges in urban PHC delivery include poor infrastructure, inadequate financial investment, limited monitoring and supervision, and a lack of trained providers.<sup>302</sup> As more Bangladeshis move to urban areas beyond the reach of the MoHFW’s public-sector health system, the many weaknesses of the UPHCSDP system may intensify at the same time that donor resources for health decline.

<sup>290</sup> Marie Stopes Bangladesh, 2019. Social Marketing: Ensuring Access to All. <https://www.mariestopes.org.bd/who-we-are/social-marketing/>

<sup>291</sup> Hamid, S.A., et al., 2016. Bangladesh Family Planning Spending Assessment (FPSA). Dhaka: Institute of Health Economics.

<sup>292</sup> Informant interview.

<sup>293</sup> Bangladesh Ministry of Finance, 2019. Bangladesh FY20 Health Sector Issues. Powerpoint presentation.

<sup>294</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>295</sup> World Bank, 2018. Tax Revenue as % GDP. The World Bank DataBank. <https://data.worldbank.org/indicator/GC.TAX.TOTL.GD.ZS>

<sup>296</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>297</sup> Twesigye, G., et al., 2017. Strengthening Governance in Procurement in Bangladesh. USAID/SIAPS Technical Brief.

<sup>298</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>299</sup> Ibid.

<sup>300</sup> Ahmed, S., & Islam, W., 2015. Bangladesh Costed Implementation Plan, 2016-2020. Dhaka: Ministry of Health and Family Welfare.

<sup>301</sup> Ahmed, S.M., et al., 2015. Bangladesh Health System Review. Health Systems in Transition. WHO: Asia Pacific Observatory on Public Health Systems and Policies. [https://www.researchgate.net/publication/281843396\\_Bangladesh\\_Health\\_System\\_Review](https://www.researchgate.net/publication/281843396_Bangladesh_Health_System_Review)

<sup>302</sup> Ahmed, S., & Islam, W., 2015. Bangladesh Costed Implementation Plan, 2016-2020. Dhaka: Ministry of Health and Family Welfare.



## Financing of FP and Other Health Programs

### Historical FP Financing

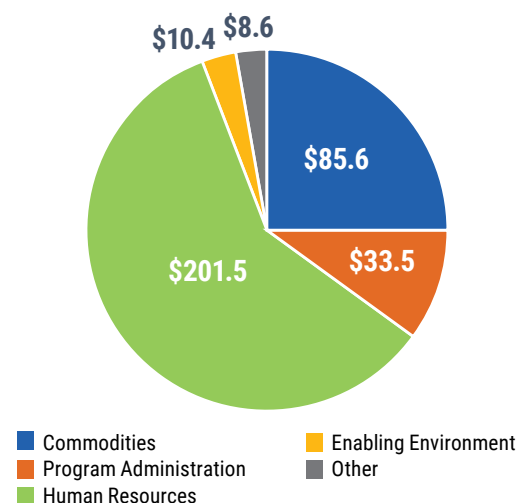
Donors funded nearly all contraceptives in Bangladesh until the introduction of the health sector-wide approach (SWAp) financing scheme in the country in 1998.<sup>303</sup> The 1998-2002 Bangladesh SWAp was the first of its kind worldwide, and its purpose was to pool donor and domestic resources to provide essential health services, including FP, to women and the poor.<sup>304</sup> As part of the SWAp, the GoB was required to contribute domestic funding (in the form of World Bank loans) towards the FP program and specifically the purchase of FP commodities. By the end of the first SWAp, in 2002, the GoB financed 16% of FP commodities with WB loans, and donors contributed the remaining 84% of resources.<sup>305</sup> In subsequent SWAp iterations, the GoB has contributed an increasing percentage of total SWAp funding, up to 78% of all resources in the 2011-2016 program.<sup>306</sup> As GoB SWAp contributions have risen over the past 20 years, domestic funding for FP commodities and other FP program activities has also increased.

### Current FP Program Expenditures

Bangladesh FP expenditures in 2016 totaled US \$340.4 million. According to the 2016 Family Planning Spending Assessment (FPSA) for Bangladesh, the GoB contributed US \$224.6 million, or 66% of total FP expenditures. Donors contributed US \$52.7 million, or 15.5% of the total. USAID was the largest FP donor, contributing about half of the overall funds from international partners. Other international donor groups included DFID, UNFPA, the EU, and KfW (the German Development Bank). Independent NGO funds constituted 6.5% of total spending. SMC was the largest financier of the NGO sector by far, contributing US \$21.3 million of the NGOs' US \$22 million total. Finally, out-of-pocket (OOP) expenditures (US \$41.2 million) at pharmacies and private providers constituted 12.1% of the total.

Human resources (HR) accounted for the majority of total Bangladesh FP expenditures, followed by commodities (Figure 6.1). According to the 2016 FPSA, total expenditure on human resources for the FP program was US \$201.5 million, or 59.2% of the total program cost. Commodities totaled 25% of spending, with most funds directed towards pills and condoms. 9.8% of funds were spent on program administration, and 3.1% on enabling environment activities, including advertising and professional development.<sup>307</sup>

**FIGURE 6.1: Breakdown of 2016 FP expenses by category (millions UDS)** (Source: Bangladesh FPSA, 2016)



Donors disproportionately funded enabling environment activities, research, and program administration, while the GoB funded most commodities and two-thirds of HR costs (Figure 6.2). Donors also funded about 90% of M&E activities and 95% of training and capacity building initiatives, subsections of the program administration category.<sup>308</sup> Most donor funds were channeled through FP-related NGOs: \$42.1 million of the US \$52.7 million in donated FP funds were directed to NGOs, US \$6 million

<sup>303</sup> Chawla, D., et al., 2003. Bangladesh Contraceptive Market Segmentation Analysis. USAID/JSI: DELIVER Project.

<sup>304</sup> KfW, 2005. Ex-post Evaluation of the Bangladesh Health and Population Sector Program.

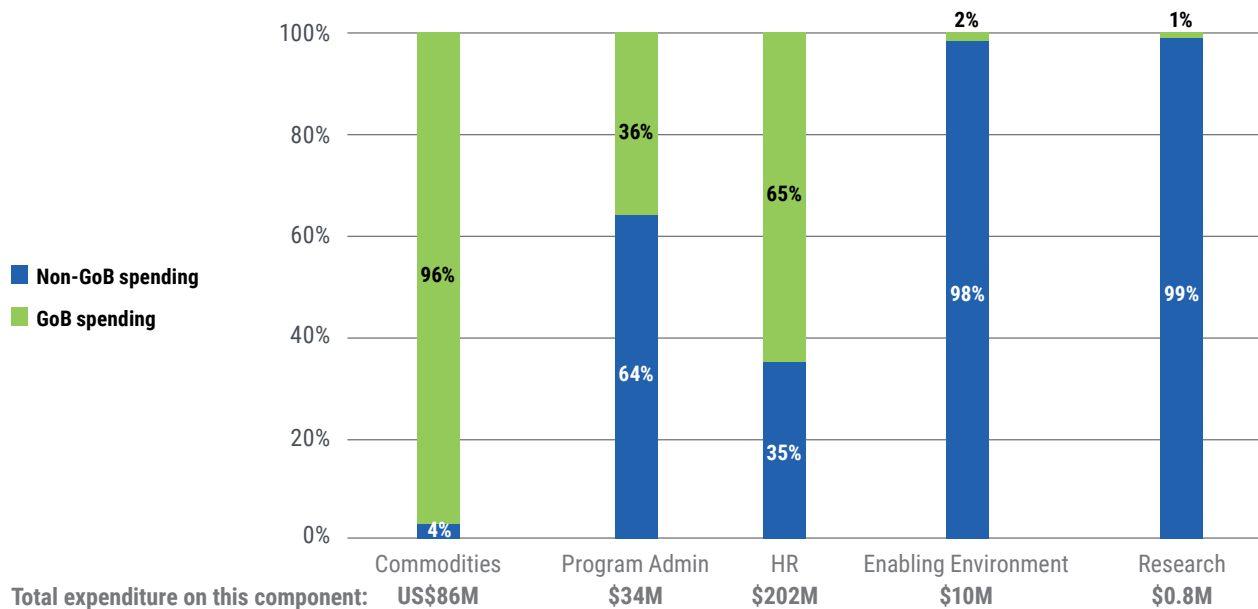
<sup>305</sup> Chawla, D., et al., 2003. Bangladesh Contraceptive Market Segmentation Analysis. USAID/JSI: DELIVER Project.

<sup>306</sup> World Bank/IDA, 2017. Independent Evaluation of the Bangladesh Health Sector Development Program. Implementation Completion Report Review. <http://documents.worldbank.org/curated/en/114181528922648368/pdf/Bangladesh-BD-Health-Sector-Development-Program.pdf>

<sup>307</sup> Hamid, S.A., et al., 2016. Bangladesh Family Planning Spending Assessment (FPSA). Dhaka: Institute of Health Economics.

<sup>308</sup> Ibid.

**FIGURE 6.2: Funding sources of selected FP programmatic areas in Bangladesh** (Source: FPSA, 2016)



was provided directly to the DGFP, and the remaining US \$4.5 million was channeled through the MoLGRDC to support FP in urban settings.<sup>309</sup>

### Projected Trends in FP Financing

External funding for FP is expected to decline in the next decade due to Bangladesh's increasing national income and its achievement of threshold fertility and contraceptive coverage targets. UNFPA has received funding from DFID and other donors to support Bangladesh FP operations only through 2022.<sup>310</sup> USAID officials report that Bangladesh is a top candidate, along with India, for FP graduation in the next 5-10 years, as both country's FP indicators have approached or exceeded target transition thresholds.<sup>311</sup> Domestic politics in donor countries has also resulted in a decline in NGO-led FP programming in Bangladesh. For example, with the U.S.'s re-statement of the Mexico City Policy, USAID no longer

funds NGOs, such as MSB, that provide abortions in addition to other FP services.<sup>312</sup> As a result, MSB was forced to close some of its Bangladesh clinics in 2017, the year of this policy's reenactment,<sup>313</sup> and cut back on other national programming, such as the provision of LAPMs in government hospitals.<sup>314</sup>

Projections by Avenir Health suggest that, under the assumption of current mCPR growth trends, total annual FP resource requirements will increase by about US \$30 million by 2030. Estimates for the number of modern method users and mCPR are sourced from UNPD.<sup>315</sup> (Note: Bangladesh's official CPR target is 75% by 2021, which will likely not be achieved; the GoB has not stated a goal for mCPR.)<sup>316</sup> As demonstrated in Table 6.1, Bangladesh's FP resource requirements will increase as its population of modern method users expands, though mCPR growth is expected to slow over the next

<sup>309</sup> Hamid, S.A., et al., 2016. Bangladesh Family Planning Spending Assessment (FPSA). Dhaka: Institute of Health Economics.

<sup>310</sup> Informant interview.

<sup>311</sup> Informant interview.

<sup>312</sup> Informant interview.

<sup>313</sup> Kaiser Family Foundation, 2019. The Mexico City Policy: An Explainer. KFF Global Health Policy. <https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/>

<sup>314</sup> Informant interview.

<sup>315</sup> United Nations, Department of Economic and Social Affairs, Population Division (2018). Estimates and Projections of Family Planning Indicators 2018. New York: United Nations.

<sup>316</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)



**TABLE 6.1: Projected Bangladesh FP resource requirements: 2019-2030** (Source: Avenir Health for Pharos Global Health)

Year	Modern method users	Resource needs (USD millions)	mCPR projections (percent)
2019	21,818,900	\$357.6	57.4
2020	22,158,600	\$363.2	57.8
2021	22,461,700	\$368.1	58.1
2022	22,797,000	\$373.6	58.5
2023	23,052,100	\$377.8	58.7
2024	23,296,100	\$381.8	58.9
2025	23,458,100	\$384.4	59.1
2026	23,612,600	\$387.0	59.3
2027	23,755,400	\$389.3	59.6
2028	23,796,100	\$389.9	59.8
2029	23,784,300	\$389.8	59.9
2030	23,804,000	\$390.1	60.2

decade. Bangladesh is approaching the peak of the theoretical mCPR S-curve, the point at which the growth in the number of modern method users plateaus. Therefore, its FP resource requirements will grow over time with a moderately increasing number of contraceptive users, but resource needs will not increase as greatly as in other countries, such as Ghana, which currently have higher rates of unmet contraceptive need and are farther from the S-curve plateau.

If donors have completely exited the Bangladesh FP program by 2030, the GoB's expected annual expenditure for FP will be US \$165.5 million greater than total domestic FP spending in 2016, an increase of 74%. To contextualize these values, the GoB has contributed an average of US \$655 million annually to fund all components of its essential service package (ESP) from 2017-22.<sup>317</sup> The ESP includes not only FP services but also maternal and child health (MCH), nutrition, non-communicable diseases (NCDs), and basic communicable disease treatment, and FP is intended to comprise less than 5% of total ESP costs.<sup>318</sup> However, in 2022, the final

year of the 4th Health, Nutrition, and Population Sector Development Plan, Avenir's projected FP costs would make up 57% of the GoB's contributions to the ESP and 37% of the total budget allocated to the ESP, including donor resources. Without increased resources from the GoB or a new commitment of donor funds, the FP program and/or other essential health services will likely be underfunded.

### ***Fiscal Challenges of Simultaneous Health Transitions***

The GoB has developed several strategic plans for the health sector, but specific health transition planning is lacking among all major donor-backed health programs. There are a variety of sector-wide strategic plans for health, including the Seventh Five Year Plan (2016-2020), the 4th Health, Nutrition, and Population Strategic Investment Case (2016-2021), and a Health Care Financing Strategy (2012-2032) to achieve UHC.<sup>319</sup> However, according to informants, transition planning has occurred on an ad-hoc, donor-driven, and program-specific basis.

<sup>317</sup> Akhter, S., et al., 2018. Resource Gap for Public Sector Provision of the Essential Service Package in Bangladesh, 2017-2022. Rockville, MD: Health Finance and Governance Project, Abt Associates.

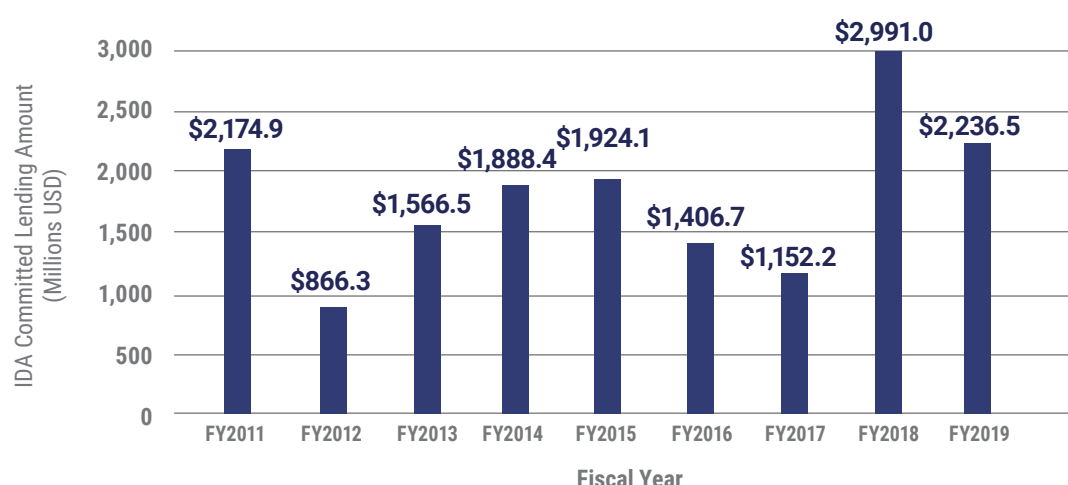
<sup>318</sup> Ibid.

<sup>319</sup> Government of Bangladesh Health Economics Unit, 2014. Framework for monitoring progress towards UHC in Bangladesh. Dhaka: Ministry of Health and Family Welfare. [http://heu.gov.bd/pdf/UHC\\_indicators%20FINAL.pdf](http://heu.gov.bd/pdf/UHC_indicators%20FINAL.pdf)

As stated previously, financing for health programs in Bangladesh utilizes a sector-wide approach (SWAp) that combines funds from the GoB and international partners. The previous (3rd) SWAp cost approximately US \$6.5 billion from 2011-2016, with the GoB contributing 78% of these funds. (US \$488 million, or about 10%, of GoB contributions were in the form of IDA loans.)<sup>320</sup> Projected costs for the 4th SWAp (2016-21) range from US \$10.7 billion to US \$15.0 billion.<sup>321</sup> The World Bank oversees international partner contributions to the SWAp via a pooled Multi Donor Trust Fund. SWAp funds are used to support a variety of health programs, including FP, MCH, NCD care, nutrition, and communicable disease control for HIV, TB, and malaria.

External contributions to the health sector's SWAp are on the decline. Bangladesh's GNI per capita exceeded the IDA eligibility limit for two consecutive years in 2017-18, and the country is currently in "gap" status with the organization, resulting in higher interest rates and shorter repayment periods for World Bank loans.<sup>322</sup> IDA grants and low-interest loans have been an essential component of health financing in Bangladesh, particularly for urban health programs.<sup>323</sup> In 2017, for example, the WB provided the GoB with \$500 million in IDA credit and granted \$15 million from the GFF to support health systems management and delivery, especially in vulnerable regions in Bangladesh, through 2023.<sup>324</sup> Figure 6.3 presents the total amount of IDA credits and grants distributed to Bangladesh since FY2011.<sup>325</sup>

**FIGURE 6.3: IDA committed lending amounts to Bangladesh: 2011-2019** (Source: World Bank, 2019)



<sup>320</sup> World Bank/IDA, 2017. Independent Evaluation of the Bangladesh Health Sector Development Program. Implementation Completion Report Review. <http://documents.worldbank.org/curated/en/114181528922648368/pdf/Bangladesh-BD-Health-Sector-Development-Program.pdf>

<sup>321</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>322</sup> IDA, 2019. Bangladesh: World Bank Lending. <http://ida.banquemoniale.org/debt/bangladesh>

<sup>323</sup> Informant interview.

<sup>324</sup> World Bank, 2017. IDA Project Appraisal Document: Bangladesh Health Sector Support Project. <http://documents.worldbank.org/curated/en/509301501466454241/pdf/BANGLADESH-HSSP-PAD-07112017.pdf>

<sup>325</sup> IDA, 2019. Bangladesh: World Bank Lending. <http://ida.banquemoniale.org/debt/bangladesh>

Donor funds for Bangladesh's other major health programs are also expected to decrease in the coming years. Gavi expects that the GoB will fully fund its immunization program by 2026 despite the GoB's reliance on external funds for 73% of immunization costs in 2017 (see Box 6.2).<sup>326, 327</sup> Analysis by Silverman suggests that Bangladesh will remain eligible for GF assistance for TB and malaria through 2040, with HIV transition complet-

ed by 2038.<sup>328</sup> However, GF allocations are determined in part by national income, and Bangladesh's economic growth will translate into lower future GF grants and higher co-financing requirements for all three diseases, which are all heavily dependent on donor funds at present: external funding accounted for 96% of HIV spending, 84% of TB spending, and 77% of malaria spending in Bangladesh.<sup>329, 330, 331</sup>

## BOX 6.2. Financing the Immunization Transition in Bangladesh.

Per Gavi's immunization transition timeline, Bangladesh is expected to enter the accelerated transition phase in 2021 and become fully self-financing in 2026. In 2017, the GoB contributed about US \$24 million, or only 27% of all resources required for routine immunization. Thus, the GoB must take on at least an additional US \$67 million in annual immunization spending by 2026. These significant impending financial obligations for immunization have impacted the GoB's calculus in introducing new vaccines, according to informants. Previously, the GoB would introduce new vaccines based on epidemiological need, but the government is now heavily considering the cost of new vaccines (such as HPV) when deciding whether to roll out a new program.

Informants also described Bangladesh's challenging *"double dose of transition"* in immunization financing: Gavi currently supports significant portions of the immunization workforce and contributes to HSS initiatives along with directly financing vaccines. In addition to Gavi's annual contributions to the immunization program, which have reached a maximum of US \$81.4 million annually since 2015, the current Gavi HSS grant to Bangladesh, which funds some of the immunization workforce as well as TA initiatives like cold chain optimization, amounts to US \$93 million for 2019-2022. The terms of this grant require that the GoB assume the costs of the Gavi-supported health workforce by 2022 to prepare for transition. Informants stated that any future Gavi HSS grants, if awarded, would be small (no more than US \$12 million) and could not continue to support health worker salaries. In sum, the \$67 million in direct immunization costs plus the approximately \$31 million in HSS financing per year represents an additional \$100 million in annual domestic spending requirements, or about one-eighth of the Bangladesh's total domestic government health expenditure in 2017.

Taking responsibility both for vaccine costs and for immunization staff salaries will pose a significant challenge for Bangladesh in the next decade. According to informants, the GoB's reliance on Gavi support for health workforce compensation is unusual among countries approaching transition and has resulted in earlier and more intensive Gavi involvement in immunization transition planning efforts. According to donor informants, these efforts are significantly hindered by Bangladesh's limited fiscal space for health.

<sup>326</sup> Gavi, 2019. Key Information on Co-financing for Bangladesh. <https://www.gavi.org/sites/default/files/document/co-financing-information-sheet-bangladeshpdf.pdf>

<sup>327</sup> WHO, 2018. Immunization Financing Indicators: Bangladesh. [http://apps.who.int/immunization/programmes\\_systems/financing/data\\_indicators/maps/](http://apps.who.int/immunization/programmes_systems/financing/data_indicators/maps/)

<sup>328</sup> Silverman, R., 2018. Projected health financing transitions: timeline and magnitude. Center for Global Development Working Paper. <https://www.cgdev.org/publication/projected-health-financing-transitions-timeline-and-magnitude>

<sup>329</sup> UNAIDS, 2018. AIDSinfo: Bangladesh. Global AIDS Monitoring. <http://aidsinfo.unaids.org/>

<sup>330</sup> World Health Organization, 2018. Global TB Database. <https://www.who.int/tb/country/data/download/en/>

<sup>331</sup> IHME, 2019. DAH Database: 1990-2018. <http://ghdx.healthdata.org/record/ihme-data/development-assistance-health-database-1990-2018>

## FP and Universal Health Coverage

Bangladesh has set the ambitious goal of achieving universal health coverage (UHC) by 2030.<sup>332</sup> In 2017, less than 1% of the population was covered by insurance, and 10% of households faced catastrophic OOP expenditures.<sup>333</sup> The GoB has developed a monitoring framework to evaluate progress towards UHC,<sup>334</sup> but significant improvements in health delivery and financing capacity must be made before UHC attainment is realistic.<sup>335</sup>

FP, a component of the MoHFW's Essential Service Package (ESP), is already free at all public facilities.<sup>336</sup> NGOs are also not permitted to charge for commodities obtained through the DGFP supply system, though some do charge small service fees.<sup>337</sup> Additionally, the DGFP offers a "client compensation" program that reimburses transport and food costs as well as lost wages for women who undergo an LAPM procedure.<sup>338</sup> According to informants, FP would "*absolutely*" continue to be

fully covered under any UHC program, but total UHC costs may force difficult decisions that limit a robust FP method mix. According to the country's Health Care Financing Strategy, the GoB expects the health budget as a percent of the national budget to increase from 5% in 2012 to 15% in 2032 in preparation for UHC. (Currently, the health budget still sits at 5% of the national budget, and the country is not on track to meet its target of 12% by 2021.)<sup>339</sup> As the GoB's financial obligations in the health sector grow with the introduction of UHC—and if ambitious health financing targets are not met—officials may be faced with tough choices, such as prioritizing cheaper health services and commodities. In FP, this could result in the GoB's preferential funding of short-term methods and IUDs over more expensive but increasingly popular LAPMs like single-rod implants, especially if donors are no longer funding LAPM training and demand generation programs.<sup>340</sup>

## Procurement and Supply Chain

The DGFP is principally responsible for financing, procuring, and supplying FP commodities in Bangladesh and has generally managed these tasks well in the past several years. In this regard, Bangladesh is well ahead of its "medium-term, higher-risk" transition category peers. The Logistics & Supply Unit in the DGFP has been responsible for FP commodity procurement since the first Bangladesh SWAp in 1998-2002, when the GoB began funding contraceptives with WB loans.<sup>341</sup> According to contemporaneous reports, the procurement transition in the early 2000s was "problematic," since the GoB did not have experience purchasing contraceptives

through the IDA procurement procedure.<sup>342</sup> However, USAID supported the GoB's FP commodity procurement process throughout the SWAp transition period in order to build domestic capacity in this area; the GoB now conducts this task without heavy external TA.<sup>343</sup> As noted in Part 2, the GoB currently finances 96% of all commodities and is thus responsible for procuring the vast majority of commodities that enter the country. Informants reported that there have not been major commodity stock-outs at the national level, except in 2017, when a fire destroyed large commodity stocks in the central Dhaka warehouse.

<sup>332</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>333</sup> Government of Bangladesh Health Economics Unit, 2014. Framework for monitoring progress towards UHC in Bangladesh. Dhaka: Ministry of Health and Family Welfare. [http://heu.gov.bd/pdf/UHC\\_indicators%20FINAL.pdf](http://heu.gov.bd/pdf/UHC_indicators%20FINAL.pdf)

<sup>334</sup> Ibid.

<sup>335</sup> Government of Bangladesh Health Economics Unit, 2012. Health Care Financing Strategy, 2012-2032. <http://socialprotection.gov.bd/wp-content/uploads/2017/03/HCF-Strategy-Bd-2012-2032.pdf>

<sup>336</sup> Informant interview.

<sup>337</sup> Rahaim, S., et al., 2011. Bangladesh: Private Sector Assessment of LAPMs. Washington: USAID/SHOPS.

<sup>338</sup> Measure Evaluation, 2014. The Future of LAPMs of Contraception in Bangladesh. Chapel Hill, NC: USAID/Measure Evaluation.

<sup>339</sup> Government of Bangladesh Health Economics Unit, 2012. Health Care Financing Strategy, 2012-2032. <http://socialprotection.gov.bd/wp-content/uploads/2017/03/HCF-Strategy-Bd-2012-2032.pdf>

<sup>340</sup> Informant interview.

<sup>341</sup> JSI, 2011. Delivering Family Planning One Village at a Time. Washington, DC: USAID DELIVER.

<sup>342</sup> Chawla, D., et al., 2003. Bangladesh Contraceptive Market Segmentation Analysis. USAID/JSI: DELIVER Project.

<sup>343</sup> JSI, 2011. Delivering Family Planning One Village at a Time. Washington, DC: USAID DELIVER.

Donors do not fund and/or procure contraceptives for Bangladesh except in unusual, emergent circumstances. Following the 2017 central warehouse fire, some partners donated commodities to prevent national stock-outs: MSB funded and procured IUDs, and major international donors such as USAID and UNFPA supported procurement of condoms and injectables.<sup>344</sup> Additionally, when the GoB was unable to procure single-rod implants due to the manufacturer's ineligibility for WB funds, UNFPA and DFID stepped in to donate these popular commodities to the GoB.<sup>345</sup> However, such cases of heavy donor involvement in procurement are increasingly rare; the DGFP is generally successful in funding and procuring adequate stocks of contraceptives for the country.

The DGFP conducts forecasts centrally with input from district officials, but this process relies on ongoing donor TA. According to an informant, forecasting was formerly conducted only at the national level. Now, local administrators estimate contraceptive use in their districts, and these data feed into the national forecasting process. However, local officials must be properly trained to upload usage data to the USAID-supported national online system, an area in which multiple partner informants stated that ongoing donor TA is required. USAID also supports FP forecasting at the national level. USAID grant recipient SIAPS (Systems for Improved Access to Pharmaceuticals and Services) has been active in Bangladesh FP forecasting since the early 2010s, developing two five-year commodity forecasts (2012-2016 and 2017-2022) with the DGFP and assisting in the formation of a Forecasting Working Group that meets annually to review contraceptive usage data and plan for upcoming procurements.<sup>346</sup>

Many FP commodities are already manufactured in Bangladesh, which may help to promote sustainability in

procurement throughout transition. Multiple domestic manufacturers produce short-term contraceptive methods such as condoms and pills. However, Bangladesh's LAPM production capability is still in a nascent stage. Implants are procured from foreign manufacturers, but DFID is supporting an initiative with SMC to improve domestic IUD manufacturing capabilities that would further improve national FP program sustainability.<sup>347</sup>

GoB policies related to FP procurement and supply likely influence the low national uptake of LAPMs, and transition may further reduce LAPM access in Bangladesh. The method mix currently funded and procured by the GoB favors short-term, less effective methods. IUDs and implants combined accounted for only 7.5% of total FP commodity expenditure in 2016, while condoms accounted for 12.3% and pills for 43%. As one informant stated, *"The government justifies its limited funding of LAPMs by saying that few women use these methods. But the low supply of LAPMs is partially responsible for their limited use."* At present, donors fund demand generation initiatives for LAPMs and train LAPM providers, but the GoB may not take on these responsibilities during and after transition (see Part 4: Technical Capacity).<sup>349</sup>

The Bangladesh FP supply chain has historically been heavily donor dependent, but the DGFP has institutionalized many supply chain responsibilities in recent years. Starting in 1988, Jon Snow, Inc. (JSI), funded by USAID, provided substantial TA to the FP supply chain in Bangladesh, including the streamlining of warehousing systems and the development of a logistics management information system (LMIS) for the FP program. However, by the end of JSI's involvement in Bangladesh FP in 2012, the GoB was managing all major FP procurement and supply chain activities, including storage, distribution, and operation of the LMIS.<sup>350</sup> Despite this progress, ongoing TA is still required for the training of

<sup>344</sup> Informant interview.

<sup>345</sup> Informant interview.

<sup>346</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>347</sup> Government of Bangladesh Health Economics Unit, 2014. Framework for monitoring progress towards UHC in Bangladesh. Dhaka: Ministry of Health and Family Welfare. [http://heu.gov.bd/pdf/UHC\\_indicators%20FINAL.pdf](http://heu.gov.bd/pdf/UHC_indicators%20FINAL.pdf)

<sup>348</sup> Ibid.

<sup>349</sup> Government of Bangladesh Health Economics Unit, 2012. Health Care Financing Strategy, 2012-2032. <http://socialprotection.gov.bd/wp-content/uploads/2017/03/HCF-Strategy-Bd-2012-2032.pdf>

<sup>350</sup> Giashuddin, M.S., & Kibria, M.G., 2017. Bangladesh National Family Planning Commodities Forecasting, 2017-22. Arlington, VA: SIAPS for USAID.

<sup>351</sup> Informant interview.

<sup>352</sup> Hamid, S.A., et al., 2016. Bangladesh Family Planning Spending Assessment (FPSA). Dhaka: Institute of Health Economics.

<sup>353</sup> Informant interview.

<sup>354</sup> JSI, 2011. Delivering Family Planning One Village at a Time. Washington, DC: USAID DELIVER.

government procurement and logistics officers in new technology, logistics troubleshooting, and the piloting of new strategies to improve efficiency, such as the use of barcoding in warehouses.<sup>351</sup>

Procurement and supply chain management has been identified as a key weakness in other major donor-backed health program transitions in Bangladesh. According to a December 2017 audit by the Global Fund, supply chain gaps constituted a key risk for Bangladesh's HIV, TB, and malaria programs.<sup>352</sup> The TB program in particular struggles with effective procurement and supply; on average, 74% of anti-TB medicines were held at the port of entry for 52 or more days as they awaited clearance. Moreover, while the FP program maintains a robust network of warehouses, the TB and malaria programs lack necessary warehousing and monitoring infrastructure to protect medication quality.<sup>353</sup> Insufficient stock information at the local level has resulted in inefficient allocation of resources sub-nationally and the expiry of unused medications. In 2015, for example, TB program medications and commodities worth US \$1.1 million expired due to improper subnational allocation.<sup>354</sup>

Procurement and supply challenges in infectious disease areas are compounded by a lack of ownership of and accountability for these major health programs. Management responsibility for these programs is divided among the GoB, GF principal and sub-recipients such as BRAC, and other NGOs involved in infectious disease control at the local level. As opposed to the established DGFP supply chain governance structure, "there is no dedicated entity responsible for the overall supply chain of the TB commodities."<sup>355</sup> In the immunization program, Gavi is heavily involved in procurement and supply of vaccines. Gavi procures vaccines directly through UNICEF, supports the supply chain via the Cold Chain Equipment Optimization Platform, and funds salaries of surveillance officers at the local level.<sup>356</sup> Informants indi-

cated that Bangladesh's heavy reliance on Gavi's immunization systems support is unusual among Southeast Asian countries approaching Gavi graduation and has prompted the organization to initiate transition planning in Bangladesh earlier than usual. In sum, while there is room for improvement and ongoing donor TA in the FP program's procurement and supply processes, they are evidently at a more advanced stage than those of other major health programs.

Finally, quality of medications and commodities remains a major supply concern across all health programs in Bangladesh. While all commodities financed through the SWAp must be purchased from prequalified suppliers to ensure product quality, independent domestic manufacturers and sellers are not subject to these regulations.<sup>357</sup> In the FP program specifically, many commodities and medications sold in the private sector are manufactured domestically. A 2016 Bangladesh maternal health market report noted that Bangladesh's Directorate General of Drug Administration, the national quality control body, was understaffed and lacked the necessary resources to regulate health products within the country, suggesting that "many health products on the market in Bangladesh may be of poor or unknown quality."<sup>358</sup> Informants anecdotally confirmed this concern. One interviewee stated that complications from MR with medication (MRM)—either due to medication quality or improper use—was one of the top reasons for women to seek care at reproductive health clinics. For this reason, MSB supports quality control testing for a domestic MR medication producer and runs a call center to assist Bangladeshi women in the proper use of MR medications.<sup>359</sup> The extent of MSB's quality assurance initiatives for MRM—just one example of partner involvement in Bangladesh's medical quality control—illustrates this ongoing challenge in health, including in the FP program.

<sup>351</sup> JSI, 2011. *Delivering Family Planning One Village at a Time*. Washington, DC: USAID DELIVER.

<sup>352</sup> Global Fund Office of the Inspector General, 2017. *Audit Report: Global Fund Grants to Bangladesh*. Geneva: The Global Fund. [https://www.theglobalfund.org/media/7089/oig\\_gf-oig-17-027\\_report\\_en.pdf?u=636727911750000000](https://www.theglobalfund.org/media/7089/oig_gf-oig-17-027_report_en.pdf?u=636727911750000000)

<sup>353</sup> Ibid.

<sup>354</sup> Ibid.

<sup>355</sup> Ibid.

<sup>356</sup> Informant interview.

<sup>357</sup> Seaver, E., et al., 2016. *Stronger markets, increased access to essential maternal health supplies: Advocacy recommendations for Bangladesh*. PATH, R4D, & RHSC.

<sup>358</sup> Seaver, E., et al., 2016. *Stronger markets, increased access to essential maternal health supplies: Advocacy recommendations for Bangladesh*. PATH, R4D, & RHSC.

<sup>359</sup> Informant interview.



## Technical Capacity

### **Quality and Training of Service Delivery Personnel**

There is a distinct lack of skilled FP providers in Bangladesh, particularly for LAPMs, contributing to the national stagnation of FP indicators and constituting a risk throughout transition. Recently, there have been numerous required retirements among DGFP Family Welfare Visitors (FWVs), who are trained in IUD insertion. The GoB has not been able to fill these vacancies,<sup>360</sup> and informants estimated that 30% of public-sector FP staff positions are currently vacant. As a result, IUD insertion at the local level is often either unavailable or performed by an unpracticed provider, contributing to dissatisfaction with this method. Doctors are also not well trained in LAPM provision and report a lack of confidence in providing LAPM services.<sup>361</sup> Recent donor initiatives, such as the USAID Mayer Hashi project, have attempted to address this issue by funding LAPM trainings for medical professionals. Outcomes of these programs are mixed at best.<sup>362</sup> Additionally, in the past several years, NGOs such as MSB have stepped in to provide LAPM services in government health centers lacking a confident public provider. However, as external funds for this program declined, MSB has been forced to cut back on its services, and the GoB has yet to address this gap either by directly funding MSB's work with domestic resources or by employing and training more public-sector LAPM providers. This lack of skilled public-sector FP providers—and the GoB's apparent difficulties in hiring and training new FP workers—was identified as a major transition risk by nearly all donor and partner informants.

### **Monitoring and Evaluation**

Donors have supported the development of a robust eLMIS for the FP program and transferred stewardship of this system to local stakeholders, though limited ongoing training and TA is likely required. The MoHFW's

Supply Chain Management Portal offers up-to-date web reports of contraceptive stocks at multiple levels of the warehousing system as well as a “procurement tracker” to monitor order progress.<sup>363</sup> The information from the eLMIS is used to conduct forecasts, evaluate procurement and supply chain weaknesses, and identify sites of impending stock-outs.<sup>364</sup> JSI (funded by USAID) supported the development of the eLMIS and trained government officials in its proper and timely use. Skilled logistics support officers (LSOs) are the key personnel for the eLMIS's maintenance and troubleshooting; JSI transferred management of LSOs to a local NGO in 2009.<sup>365</sup> However, informants suggested that donor TA still remains necessary for continued training of FP eLMIS managers from the local to the national level.

The GoB has improved its FP indicator and expenditure data availability and usage with the significant support of FP2020 partners. Bangladesh was one of only four FP2020 countries to complete an FPSA in the mid-2010s, detailing GoB, donor, NGO, and OOP expenditures for FP in the country. Avenir Health implemented this project as part of Track20, using funds from the Gates Foundation.<sup>366</sup> The GoB has also reported core FP indicators to the FP2020 program using data from the 2014 BDHS, which was supported by USAID. However, multiple informants expressed concerns with BDHS data quality. Because Bangladeshi women may seek FP services from an array of public, private, and NGO providers, it is possible that FP acceptors are double-counted in contraceptive use surveys. One informant suggested that a nationwide electronic medical record system may be the next step to monitoring individuals' healthcare activities across a variety of providers. Additional TA is likely required to sustain and improve FP indicator data collection.

<sup>360</sup> Rahaim, S., et al., 2011. Bangladesh: Private Sector Assessment of LAPMs. Washington: USAID/SHOPS.

<sup>361</sup> Ibid.

<sup>362</sup> Rahman, M., et al., 2016. The Mayer Hashi Large-Scale Program to Increase Use of Long-Acting Reversible Contraceptives and Permanent Methods in Bangladesh: Explaining the Disappointing Results. An Outcome and Process Evaluation. *Global Health: Science and Practice*, 4 (Supplement 2), S122-S139.

<sup>363</sup> See: <https://scmpbd.org/>

<sup>364</sup> See: <https://scmpbd.org/index.php/dgfp-logistics-tools#lmis>

<sup>365</sup> JSI, 2011. Delivering Family Planning One Village at a Time. Washington, DC: USAID DELIVER.

<sup>366</sup> Hamid, S.A., et al., 2016. Bangladesh Family Planning Spending Assessment (FPSA). Dhaka: Institute of Health Economics.



### **Stakeholder Coordination: TA and Strategic Planning**

As described throughout this case study, many partners provide TA to the Bangladesh health sector and the FP program in particular. Because donor and NGO funds disproportionately support M&E, forecasting, staff training, logistics management, FP-related research, and quality control, these programs would be at significant risk during and after transition. International organizations involved in FP TA include USAID, DFID, BMGF, UNFPA, Avenir Health, and others. Box 6.3 describes DFID's FP-related TA involvement in greater detail.

Bangladesh has the committee structures in place to support stakeholder coordination and planning for FP transition, but transition is not currently a priority on these agendas. According to a partner informant, the FP2020 Country Engagement Working Group, designed to convene a wide variety of government and civil society FP stakeholders, *"has become dormant."* FP donors and the government meet at a monthly consortium to improve coordination, but informants who attend these meetings did not recall any FP transition-related planning or discussion. Other bodies include the National Technical Committee on FP, which advises the DGFP on private sector and NGO coordination, and the National Task Force on Reproductive Health, in which donors and the government review progress of the national sexual and reproductive health (SRH) program. These bodies meet infrequently, and informants did not indicate that they currently focus on FP transition or broader transition in the health sector. Similarly, informants from other health areas did not know of any transition planning underway for the health sector generally. However, the existence of this robust set of health and FP-specific committees provides a strong foundation for possible transition planning and coordination in the future.

### **BOX 6.3. DFID's Ongoing FP-Related TA in Bangladesh.**

DFID currently sponsors two technical assistance programs focusing on FP in Bangladesh:

- **Better Health in Bangladesh (£88 million):** half of these funds are provided directly to the SWAp pooled funds to support the health sector and HSS, and the other half supports FP TA. DFID has partnered with UNFPA to strengthen supervision and monitoring of district FP providers and work with the Obstetrical and Gynecological Society of Bangladesh to improve private-sector FP provision.
- **Improving Quality and Access to FP Services (£5 million):** implemented by Ipas. This program operates within the DGHS to improve FP integration with general health services. Their initiatives include PPFP promotion in district hospitals and the standardization of post-MR care in DGHS facilities. Through this program, Ipas is present at nearly 50% of all DGHS facilities.

Additionally, DFID's Strengthening Midwifery in Bangladesh program trains midwives in FP, specifically PPFP provision. Beyond these large TA programs, DFID assists in the introduction and expansion of new contraceptives like DMPA-SC with UNFPA, helps to fund SMC, and supports an ongoing initiative to produce IUDs domestically in Bangladesh.

## Enabling Factors: Political Commitment to FP and Legal & Human Rights Risks

### Political Commitment to Family Planning

Leaders in Bangladesh are strongly committed to the national FP program primarily as a means to reach stated TFR goals; these goals are not linked explicitly to women's empowerment and rights. The GoB's FP program features prominently in national health and development plans: Bangladesh's 2016-21 Strategic Development Plan for the health sector called for additional investments in FP to achieve a national TFR of 1.7 by 2021.<sup>367</sup> A partner informant stated that the GoB's political will on this issue was formidable, in part due to the hierarchical authority structure of the DGFP and MoHFW: *"When someone in leadership says something [in the FP program] needs to happen, a lot gets done."* However, as one informant stated, because TFR has trended downwards in the past several years, some government and NGO officials *"think that [they] have done [their] job, so [they] don't need to work too hard to improve CPR or remove misconceptions about family planning."* The informant cited other factors, such as urbanization and women's entrance into the workforce, that have contributed to the decline in TFR while CPR and other FP program outcomes have stagnated. Moreover, rights-based FP discourse is not prevalent in Bangladesh. As one informant stated, *"the government is a bit apprehensive"* to make the explicit connection between FP and the achievement of SDGs related to women's empowerment and rights, partially because officials do not want to provoke the religious sector. However, the informant continued, the GoB demonstrates its commitment to the FP program in its budget allocations and other enabling policies, such as the permission of MR.

Despite the popularity of the FP program among GoB officials, there is little evidence of political will to address ongoing issues with the FP program that may be exacerbated during transition, including administrative redundancy and poor program governance. Informants indicated that officials from both the DGFP and the DGHS were strongly opposed to any integration mecha-

nism that may reduce overlap and waste between these two departments. Additionally, interviewees described a system of FP management that lacks accountability and transparency: *"Governance is the problem in the public sector; there is weak supervision and lots of points for corruption to happen."* National FP officials rarely visit regional facilities, political relationships complicate FP remediation efforts in poor-performing districts, and local managers are often reluctant to report any financial or commodity irregularities for fear of retaliation. With donor funds and TA available, some of these domestic governance problems are currently mitigated, but resource waste due to managerial inefficiencies will become more urgent when the GoB is responsible for financing and stewarding its FP program fully.

### Enabling Legal Environment and Key Populations

The GoB imposes some legal restrictions on FP provision that preclude many women from accessing the full FP method mix, constituting a rights risk for key populations such as adolescent girls.<sup>368</sup> Bangladesh has the fourth-highest prevalence of child marriage in the world, with 22% of girls married by age 15 and 59% by age 18.<sup>369</sup> However, in 2013, the GoB estimated that only 47% of married adolescent girls had access to contraceptives.<sup>370</sup> By law, only married individuals can seek contraceptives at public facilities; unmarried individuals may only receive FP information.<sup>371</sup> This policy is problematic for newlywed adolescents—a group with a fertility rate double the global average<sup>372</sup>—because they are less able to access contraceptives prior to their wedding day. Additionally, effective, reversible contraceptives like IUDs are restricted to women who have at least one child, forcing youths to choose from less effective methods such as condoms and pills that are frequently misused or discontinued. Advocacy from the domestic and international FP community has loosened restrictions on FP access in recent years, however: IUD insertion and sterilization previously required significant postpartum waiting peri-

<sup>367</sup> Ministry of Health and Family Welfare, 2016. Health, Nutrition, and Population Strategic Investment Plan, 2016-2021. Dhaka: Government of Bangladesh. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Bangladesh-Investment-Case.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Bangladesh-Investment-Case.pdf)

<sup>368</sup> Rahaim, S., et al., 2011. Bangladesh: Private Sector Assessment of LAPMs. Washington: USAID/SHOPS.

<sup>369</sup> Girls Not Brides Bangladesh, 2018. Child Marriage in Bangladesh. <https://www.girlsnotbrides.org/child-marriage/bangladesh/#stats-references>

<sup>370</sup> See: <https://www.thedailystar.net/news/contraceptive-use-among-married-adolescent-girls>

<sup>371</sup> Informant interview.

<sup>372</sup> World Bank, 2017. Adolescent Fertility. The World Bank DataBank. <https://data.worldbank.org/indicator/sp.ado.tfrt>



A family planning worker in Bangladesh displays the health commodities she brings to clients. Photo: JSI/USAID DELIVER.

ods, and spousal/familial consent is no longer required for women 18 and older to undergo MR. Without donor- and NGO-driven evidence generation activities and policy advocacy, ongoing FP rights risks—especially for vulnerable adolescent girls—may not be resolved.

Other administrative regulations related to FP provider qualifications also limit FP access, and some donors and NGOs are advocating for policy reforms in this area as well. In Bangladesh, only doctors are allowed to insert implants, even though nurses and midwives regularly perform this service in other countries.<sup>373</sup> Family welfare assistants, who administer immunizations, are not permitted to provide the first dose of injectable contraceptives.<sup>374</sup> Moreover, public facilities that provide free FP services close in

the early afternoon, forcing many working women to pay OOP for contraceptives at for-profit vendors. Donors have funded pilot programs and research studies to encourage the government to change some of these policies; UNFPA partnered with the DGFP to study whether family welfare assistants could be trained in first-dose injectable screening and delivery, for example.

Overall, donors disproportionately finance initiatives supporting the Bangladesh FP program's key populations, including youths, LAPM acceptors, the urban poor, and rural residents. As described above, NGOs such as MSB fill gaps in LAPM provision at public facilities, particularly in remote areas. Donor funds that previously supported this initiative are no longer available, and the GoB has stalled a social contracting arrangement with MSB to continue these services.<sup>375</sup> Donors also fund training and capacity building of FP providers to improve quality of care, counseling, and confidence in LAPM provision across the public-sector health system. Moreover, the urban poor rely on healthcare, including FP, managed through the MoLGRDC. According to informants, IDA grants and loans finance a large proportion of urban health initiatives, which are operated by NGOs. As Bangladesh exits IDA eligibility and urban health NGOs no longer receive this consistent funding stream, the urban poor may lose access to FP and other primary care services. Finally, youth access to FP services is a focal point of donor engagement in Bangladesh. DFID and UNFPA have sponsored pilot programs to increase youth awareness of and access to FP services, and USAID funds FP BCC campaigns that encourage delayed childbirth and birth spacing, particularly for adolescent brides.<sup>376</sup> These examples are a small subset of the donor-sponsored FP initiatives for key populations, which would all be at risk—along with the vulnerable populations they serve—during transition.

<sup>373</sup> Rahaim, S., et al., 2011. Bangladesh: Private Sector Assessment of LAPMs. Washington: USAID/SHOPS.

<sup>374</sup> Informant interview.

<sup>375</sup> Informant interview.

<sup>376</sup> Informant interview.

## Summary of Risks and Key Options for Consideration

A set of suggested actions to improve Bangladesh's readiness for FP transition is summarized in Table 6.2 below and explained in detail in the remainder of this section.

**TABLE 6.2: Key Options for consideration to improve Bangladesh's readiness for FP transition**

Transition Risk Area	Key Options for Consideration
<b>Financing of FP and Other Health Programs</b>	<ul style="list-style-type: none"> <li>• Build the GoB's social contracting capacity to facilitate transition of FP NGO and TA funding from donors to government</li> <li>• Secure an FP representative position at ongoing UHC discussions to advocate for inclusion of FP commodities and services (especially higher-cost long-acting reversible and permanent methods) under any emerging UHC scheme</li> </ul>
<b>Procurement and Supply Chain</b>	<ul style="list-style-type: none"> <li>• Transfer commodity forecasting and planning responsibilities and knowledge to domestic institutions</li> <li>• Increase GoB quality control capacity to assess FP and other health commodities in both the private and public sector at various points along the supply chain</li> <li>• Investigate possible points of integration of DGFP and DGHS activities throughout the health governance structure</li> <li>• Host regular meetings for procurement and supply officials in the health sector to share best practices and knowledge across major donor-backed programs</li> </ul>
<b>Technical Capacity</b>	<ul style="list-style-type: none"> <li>• Develop a comprehensive and practical health sector-wide transition strategy that is led by the GoB and includes all major health donors/programs, including FP</li> <li>• Prioritize FP-specific transition planning and discussion during national FP committee meetings</li> <li>• Building off the 2016-2020 CIP, conduct a comprehensive assessment of all donor-funded TA activities in the Bangladesh FP program and develop a consensus-based plan for transitioning these responsibilities to the GoB</li> <li>• Transfer FP data analysis and survey skills to national institutions</li> <li>• Transfer eLMIS M&amp;E skills to national institutions and local government officials</li> <li>• Rebuild the training pipeline for FP workers to fill vacancies in the health system</li> </ul>
<b>Enabling Factors</b>	<ul style="list-style-type: none"> <li>• Conduct a comprehensive assessment of all donor-funded enabling environment activities in the Bangladesh FP program and develop a consensus-based plan for transitioning these responsibilities to the GoB</li> <li>• Improve FP (especially LAPM) service access in under-served regions and for the poor and adolescents, including through public-private partnerships</li> </ul>



### ***Financing Risks and Options for Consideration***

The Bangladesh government contributes a majority of funding for its national FP program. This demonstrated domestic financial commitment will help to smooth the financial transition from donor assistance. However, most GoB funding is directed toward commodities (especially short-term methods) and human resources. FP stakeholders should begin to plan for a reduction in donor funds for other programmatic areas, especially for TA and enabling environment initiatives (see below). While the DGFP builds its capacity to manage these programs independently, it can engage in social contracting arrangements with NGO partners—whose FP initiatives are generally internally or donor-funded at present—as an intermediate step towards transition. Donors can help the GoB build this social contracting capacity.

Bangladesh and its partners are in the early stages of UHC planning. FP representatives (both government officials and external advocates) can play an important role in the UHC planning process to ensure that a robust FP method mix continues to be free of charge and widely available under any health insurance program.

### ***Procurement and Supply Chain Risks and Options for Consideration***

The DGFP already funds most procurement and supply chain activities, placing Bangladesh in an advantageous position for FP transition as compared with many peer countries. The FP program's procurement and supply capacity is also more advanced than those of other major health programs in the country; FP officials can share this expertise with procurement and supply officers from other national programs like TB in regular health sector-wide meetings. Tighter connections between the FP program and other health areas may also improve integration of the DGFP and DGHS, reducing inefficiencies and waste. The MoHFW and partners should review the health governance structure to identify and address specific points of overlap or missed opportunities for integration between these two directorates.

Ongoing donor TA is the biggest transition risk for FP procurement and supply. Donors are involved in funding and overseeing FP forecasting and planning activities; this responsibility and knowledge should be transferred to national institutions prior to full donor withdrawal. Donors and NGOs also support quality control initiatives for medications and health commodities that should be transitioned to the MoHFW to ensure quality of FP products during and after transition.

### ***Technical Capacity Risks and Options for Consideration***

Donors and partners are heavily engaged in capacity building and TA in the Bangladesh FP program, particularly for staff training and M&E/eLMIS activities. In preparation for transition, the DGFP should reinvigorate its staff training pipeline to fill the approximately 30% of FP positions that are currently vacant. Furthermore, prior to full donor withdrawal, all M&E and eLMIS skills should be transferred to national institutions. This process is underway for the eLMIS, but M&E of FP expenditure and program indicators still rely on external TA and funding.

The FP transition planning process should involve a wide range of stakeholders; the Bangladesh FP community's many committees would be an appropriate place to begin this discussion and planning. With the assistance of donors, the designated FP transition coordinating body could identify all ongoing TA activities and develop a plan to transfer these responsibilities to the government. This FP-specific transition committee could also take part in, and even lead, broader health sector-wide transition planning discussions for all major donor-backed programs in Bangladesh. Given the country's limited fiscal space for health, increases in co-financing obligations for immunization, HIV, TB, and malaria as well as the loss of IDA eligibility may have serious consequences for the GoB's ability to fund FP and other primary healthcare programs. A comprehensive transition plan would map out anticipated fiscal and programmatic changes due to donor withdrawal and identify appropriate measures to replace these donor activities.

### ***Enabling Environment Risks and Options for Consideration***

Because donors are the principal funders of enabling environment activities in Bangladesh, comprehensive transition planning should include a prioritized assessment of partner initiatives and financing in this area as well as a consensus-based timeline for the transfer of enabling environmental activity management and funding to the GoB. The transition of activities for vulnerable populations should receive special attention; social contracting of NGOs to provide FP to the urban poor, rural residents, youths, and other underserved groups may be appropriate as an intermediate step towards transition (see Financing Risks). National FP committees would be a useful venue to begin this planning and evaluation.



# Conclusions

Based on the three country case studies and our broader landscaping of countries facing possible reductions in donor support for FP in the medium to long term, we have identified several key transition challenges relevant to all countries in this cohort that should be addressed with urgency in FP transition analyses and planning. These include:

1. Limited prioritization of and preparation for the impending FP transition challenge among both domestic governments and FP donors, especially as compared with the transition preparation efforts ongoing in other donor-backed health programs
2. A lack of mechanisms to stimulate and enforce domestic family planning investment, such as FP matching funds arrangements with donors and/or dedicated national budget lines for FP commodities
3. Increasing domestic co-financing requirements for other global health programs—such as HIV, TB, malaria, and immunization—that squeeze the available fiscal space for health, which otherwise could be tapped to expand domestic funding for family planning
4. Low participation of the FP community thus far in nascent health sector-wide transition planning efforts
5. Lack of study of the cost-effectiveness of FP within an HTA framework, the results of which could help to justify the inclusion of a broad range of FP services within Universal Health Coverage benefits packages
6. Uncertain capacity of the national public and private sectors to finance and manage procurement of FP commodities—especially more effective, longer-acting contraceptives—as donors withdraw, possibly limiting contraceptive choice
7. Continued reliance on donors for assistance in FP program M&E, surveys, and studies
8. Varying levels of political commitment to family planning that could jeopardize FP program financing and sustainability over time

However, salient differences exist in each case study country's stage of transition preparedness and primary programmatic risks, suggesting that transition plans and strategies should be customized to the specific situation in each country.

Of the three case study countries, **Kenya's** government is most aware of the broader challenge of health transition and is also the most advanced in its overall health transition planning. The National AIDS Control Council is leading a sector-wide technical working group on health transitions; however, the FP community in Kenya is not yet involved in this group. Kenya's domestic share of FP spending, at about a quarter of total expenditure in 2016, exceeds the Government of Ghana's proportional contribution but is far behind Bangladesh, which pays for about 66% of its FP activities with domestic funds. The Government of Kenya demonstrated strong political commitment to the FP program in the 2000s and early 2010s by allocating increasing domestic resources to contraceptives, but devolution of power to Kenya's 47 counties in 2013 has eroded the nation's progress

towards FP self-reliance. Kenya's capacity to procure contraceptives through the national KEMSA supply system is strong, but the decentralized system of county-level FP commodity financing responsibility has led to major reductions in domestic financial allocations for FP. As a result, nationwide contraceptive stockouts are looming, and the government and FP donors are urgently working to address this crisis. Kenya will face a heavy fiscal crunch in health in the next few years as donors pull back in areas like HIV, malaria and immunization, where major global programs spend more than a billion dollars per year. These financial pressures from other transitions may make it harder for FP to secure increased domestic resources.

In contrast, there is lower recognition within **Ghana's** government of the health transition challenge, even though Ghana's expected annual domestic funding obligations to global health programs are expected to more than double from 2017 to 2025. Among the donor-backed health programs in the country, the FP program in Ghana appears less aware of the transition challenge, in part because the major FP donors and national government in Ghana have not prioritized the issue. Ghana is also the least advanced of the three case study countries in its FP procurement and supply capacity, relying more on international partners to procure contraceptives and oversee a network of private warehouses and distributors. Ghana began directly funding contraceptives with domestic resources in 2018, but only at a level of about 10% of the total cost. Sustained domestic investment in FP is uncertain, as no FP co-financing or matching funds schemes are currently being developed in Ghana, and fiscal pressures in the health sector are likely to intensify as co-financing requirements to other global health mechanisms increase from US \$150 million in 2017 to US \$350 million by 2025. However, Ghana has improved its forecasting, procurement, and provision of effective, long-acting contraceptives, which now account for more than one-third of the contraceptive mix in Ghana. Kenya's share of long-acting contraceptives is also about one-third of the method mix, while in Bangladesh this proportion is just 15%. Although Ghana's senior leadership does not currently champion the FP program and its wider benefits to health and society, some younger government and civil society officials are beginning to elevate FP as a priority both in the health sector and in the country's overall development.



A nurse discusses family planning and post-natal care with a client in Nyamebekyere, Ghana. Photo: Karen Kasmauski/USAID.

**Bangladesh's** government has strongly promoted and prioritized the national family planning program as a means to lower fertility since the 1970s. This long-standing political commitment to FP may partly explain the country's relative preparedness for FP transition as compared with the other two case study countries. Bangladesh is currently funding two-thirds of its national FP program with domestic resources and thus has lower dependence on FP donors as compared with Kenya and Ghana. The Government of Bangladesh covers 96% of the cost of the country's FP commodities and manages its own FP supply chain, which was previously a focal point of donor investment. In Bangladesh, transition preparation to date is mostly donor-driven and program-specific. Gavi, for example, has initiated immunization transition planning in the country in preparation for Bangladesh's anticipated graduation in 2026. However, informants in Bangladesh did not identify any FP-specific or health sector-wide working groups devoted to transition, despite the existence of numerous FP committees and working groups in the country. Upcoming transition in immunization (where Gavi is contributing around \$100 million a year for childhood vaccination and health systems improvements) and increases in co-financing requirements for other disease control



programs may exert major fiscal pressure on domestic financing for health, making it difficult for Bangladesh to achieve self-sufficiency in FP. In this context, key FP enabling environment activities currently supported by donors—including education campaigns, FP provider training, quality assurance, and initiatives targeting vulnerable populations such as youths—will likely be most at risk in Bangladesh.

The previous chapters contain a number of proposed actions that countries and donors can take to prepare for and manage FP transitions according to the unique contexts of Ghana, Kenya, and Bangladesh. Among these, there are five common actions that all 22 middle-income countries at greatest FP transition risk—as well as their major FP donors—should strongly consider. In short, these countries and their partners should:

1. **Carry out national FP transition assessments and develop FP transition plans.** Country governments should lead this analysis and planning process, while donors can contribute financing and expertise.
2. **Integrate the national FP transition plan into a larger health sector-wide sustainability and transition strategy,** including clear and achievable goals and timelines for increased domestic financing and program stewardship, developed collaboratively by stakeholders from all the major donor-backed health programs in the country.
3. **Make a strong case to national leaders and the public for prioritizing FP** to ensure that it is included in health transition planning and that domestic resources are allocated to the FP program from

national budgets and national health insurance financing pools. National FP leaders should highlight the expected impact and cost-effectiveness of FP investments as an argument to build national commitment to the program. Donors can help to support these analytic and advocacy efforts.

4. **Improve the transparency and timely communication of FP donor transition policies and declines in funding.** FP donors should articulate and communicate their criteria for triggering transition and their timelines for decreasing financial and technical assistance more explicitly in order to facilitate informed and coordinated transition planning among national governments and their partner organizations.
5. **Develop a global working group on FP transition to support country-level planning and promote knowledge sharing across national contexts.** This group, possibly nested within an existing FP global task force, could help to create tools and guidelines for transition assessments, sponsor analytical work, and assist national FP teams as they engage in larger health sector-wide discussions surrounding transition.

By improving policies, processes, and national capacities to plan for and manage transition, forward-looking country governments and their donor partners can ensure that family planning programs are sustained and strengthened over the coming decade, and that they offer quality services to improve the health and well-being of hundreds of millions of women and their families around the globe.

# Annexes

## Annex 1: Institutions Represented and Individuals Interviewed for this Report

Institution	Individual Interviewed
<b>GLOBAL INFORMANTS</b>	
<b>Avenir Health</b>	Rudolph Chandler, Senior Economist Emily Sonneveldt, Director of the Center of M&E and Advocacy John Stover, Vice President & Founder
<b>FP2020</b>	Martyn Smith, Managing Director
<b>Gavi, the Vaccine Alliance</b>	Juliette Puret, Senior Program Manager, Immunization Financing and Sustainability Anthony Swan, Senior Program Manager, Immunization Financing and Sustainability
<b>HP+/Palladium</b>	Arin Dutta, Senior Economist
<b>Kaiser Family Foundation</b>	Jennifer Kates, Director of Global Health & HIV Policy
<b>NIDI</b>	Karin Vrijburg, Researcher
<b>UNFPA</b>	Ben Light, Senior Policy Adviser for FP and Reproductive Health Commodity Security
<b>USAID</b>	Ellen Starbird, Director, OPRH Linda Cahaelen, Health Development Officer, OPRH Marguerite Farrell, Private Sector Health Team Leader, Global Health Bureau, OPRH
<b>World Bank</b>	Brendan Hayes, Health Specialist at the Global Financing Facility
<b>GHANA INFORMANTS</b>	
<b>Global Fund Ghana CCM</b>	Cecilia Senoo, Chair
<b>Ghana AIDS Commission</b>	Kyeremeh Atuahene, Acting General Director
<b>Ghana National Population Council</b>	Leticia Adelaide Appiah, Executive Director
<b>Ghana Health Service</b>	Yaa Asante, FP Program Manager Angela Boateng, FP M&E Officer Claudette Diogo, FP Logistics Officer Daniel Osei, Deputy Director of the Policy, Planning, Monitoring, and Evaluation Division
<b>Marie Stopes Ghana</b>	Anne Coolen, Country Director
<b>Ministry of Health</b>	Joycelyn Azeez, Pharmacy Chief Program Officer

Institution	Individual Interviewed
Ministry of Planning	George Gyan-Baffour, Minister of Planning
National Development Planning Commission	Felix Addo-Yobo, Acting Director of the Development Division; Sustainable Development Goals Coordinator
NHIS	Lydia Dsane-Selby, CEO
Office of the Senior Minister	Eric Yeboah, Research Advisor
Planned Parenthood Association of Ghana	Abena Adubea Acheampong, Executive Director
R4D	Chris Atim, Senior Program Director of Health Systems and Financing
UNFPA	Dela Gle, Reproductive Health Specialist Ismail Ndifuna, Reproductive Health Specialist
USAID Ghana	Rebecca Fertziger, Deputy Office Director, Office of Health, Population, and Nutrition Felix Osei-Sarpong, Public Health Specialist, Office of Health, Population, and Nutrition
USAID Global Health Supply Chain Program/ Chemonics	Afua Aggrey, Maternal and Child Health/Family Planning Lead Deogratius Kimera, Country Director
<b>KENYA INFORMANTS</b>	
CHAI	Gerald Macharia, Vice President, East and Southern Africa
CIFF	Julia Greenland, Manager, Adolescent Sexual Health
Council of Governors	Meshack Ndolo, Health Advisor
DFID Kenya	Tessa Mattholie, Health Advisor
JSI	Judith Anyona, inSupply Program Manager
Kilifi County	Vincent Idura, Kilifi County Director of Health
Ministry of Health	Isabel Maina, Division of Health Care Financing, Department of Policy, Planning & Healthcare Financing Nancy Njeru, Department of Universal Health Coverage
Nairobi County	Lucina Koyio, Nairobi County Director of Health
National AIDS Control Council	Regina Ombam, Deputy Director, HIV Investments
Population Council	Timothy Abuya, Researcher
PS Kenya	Joyce Wanderi, CEO
UNFPA	Dan Okoro, Program Specialist, Sexual and Reproductive Health and Rights & Maternal Health
USAID Kenya	Sheila Macharia, Senior Health Advisor

Institution	Individual Interviewed
<b>BANGLADESH INFORMANTS</b>	
DFID Bangladesh	Shehlina Ahmed, Health and Population Advisor
FP2020 Bangladesh	Abu Jamil Faisel, Civil Society Organizations Focal Point
Gavi, the Vaccine Alliance	Samuel Muller, Senior Country Manager, Asia-Pacific
Marie Stopes Bangladesh	Masrurul Islam, Country Director
UNFPA Bangladesh	Abu Sayed Hasan, Sexual and Reproductive Health Technical Officer
USAID Bangladesh	Alia El Mohandes, Senior Family Planning Advisor

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## Annex 2: Global Landscape Full Data Table

The full data table—containing over 30 macroeconomic, demographic, health financing, and FP-specific indicators—for the 80 LMICs studied as part of this report’s landscaping can be accessed via the following link:

<https://www.dropbox.com/s/923ja7dnaawhyj6/Pharos%20CGD%20FP%20Transitions%20Landscaping%20Table.xlsx?dl=0>

### Annex 3: Classification Methodology to Determine Readiness for Family Planning Transition

Table A.1 shows the FP transition preparedness category classification scheme for the LMICs included in this report. The three categories are structured such that approximately 1/3 of all values fall within each of the three categories. Some long-term and short-term categories may include more than 1/3 of all countries due to outliers. The long-term, low-priority categorization for GNI per capita is determined by the World Bank definition of a low-income country, and the short- to medium-term, lower-risk categorizations for TFR and mCPR are determined by the current USAID FP graduation thresholds. The shading in Table A.1 corresponds to the color-coding of characteristics in Table 3.2-Table 3.4.

**Table A.1: Categorization Scheme for LMIC FP Transition Preparedness**

Characteristic	Long-Term, Low-Priority Transition	Intermediate-Term, High-Risk Transition	Short- to Medium-Term, Lower-Risk Transition
<b>GNI per capita (USD)</b>	<1000	1000-3000	>3000
<b>TFR</b>	>4	3.4-4	<3.4
<b>mCPR</b>	<25%	25-48%	>48%
<b>Unmet contraceptive need</b>	>30%	20-30%	<20%
<b>GF HIV Graduation Year</b>	2041+	2030-2040	Before 2030 or not eligible
<b>Gavi Graduation Year</b>	2041+	2025-2040	Before 2025 or not eligible
<b>Donor Dependency</b>	Does not meet Middle or High criteria	At least 2 major disease areas* in which DAH <66% total expenditure	At least 3 major disease areas* in which DAH <66% total expenditure OR At least 2 major disease areas* in which DAH <50% total expenditure
<b>Other notes</b>	Cannot have three "green" ratings		Cannot have three "red" ratings

\* Disease areas include: HIV, TB, Malaria, Immunization. FP is not included due to the lack of verified data for total FP expenditure for many countries. A "major" disease area depends on country context.

A majority (at least 4 of 7) characteristics in one category determines a country's classification, unless the country's characteristics are 4L, 3H, or 3L, 4H, in which case the overall categorization is intermediate-term, high-risk transition. If characteristics are tied between any two categories because of missing data, overall rating is intermediate-term, high-risk transition. Any categorization using this formula should be contextualized within other national statistics and circumstances to ensure accuracy.



## Annex 4: Avenir Health Methodology for Projecting FP Resource Needs through 2030

FP resource projections through 2030 for Kenya and Bangladesh were determined via the following methodology.

### Number of modern method users:

The number of modern method FP users (married or in union) annually from 2019-2030 was obtained for each country from the UN Department of Economic and Social Affairs, Population Division.<sup>377</sup>

Country	Year	Number of Modern Method Users (married or in union)	Country	Year	Number of Modern Method Users (married or in union)
Bangladesh	2019	21,818,900	Kenya	2019	4,695,800
	2020	22,158,600		2020	4,841,900
	2021	22,461,700		2021	4,995,400
	2022	22,797,000		2022	5,145,300
	2023	23,052,100		2023	5,301,900
	2024	23,296,100		2024	5,452,000
	2025	23,458,100		2025	5,605,300
	2026	23,612,600		2026	5,751,600
	2027	23,755,400		2027	5,898,400
	2028	23,796,100		2028	6,043,600
	2029	23,784,300		2029	6,195,500
	2030	23,804,000		2030	6,336,700

<sup>377</sup> United Nations Department of Economic and Social Affairs, Population Division, 2018. Estimates and Projections of Family Planning Indicators 2018. New York: United Nations. [https://www.un.org/en/development/desa/population/theme/family-planning/cp\\_model.asp](https://www.un.org/en/development/desa/population/theme/family-planning/cp_model.asp).

### Expenditure per modern method user:

Total FP expenditure in FY2016 was obtained from the Bangladesh and Kenya Family Planning Spending Assessments.<sup>378,379</sup> The number of modern method users in 2016 was obtained from the UN Department of Economic and Social Affairs, Population Division. Total 2016 FP expenditure was divided by total modern method users in 2016 to determine expenditure per modern method user in each country.

Country	FP Expenditures in 2016 by Source (Millions USD)					2016 Total FP Expenditure (USD)	Modern Method Users in 2016	Expenditure per Modern Method User
	Donor	Domestic	NGOs	Other	OOP			
Bangladesh	52.7	224.5	22	0	41.2	340,400,000	20,770,000	\$16.39
Kenya	44.23	18.6	0.15	6.86	3.7	73,540,000	4,236,000	\$17.36

### Total FP resource needs:

Total FP resource needs were estimated by multiplying the number of modern method users for each year 2019-2030 by the expenditure per modern method user in each country.

Country	Year	FP Resource Needs (USD)	Country	Year	FP Resource Needs (USD)
Bangladesh	2019	\$357,590,446	Kenya	2019	\$81,522,458
	2020	\$363,157,797		2020	\$84,058,859
	2021	\$368,125,310		2021	\$86,723,729
	2022	\$373,620,549		2022	\$89,326,101
	2023	\$377,801,389		2023	\$92,044,789
	2024	\$381,800,310		2024	\$94,650,633
	2025	\$384,455,332		2025	\$97,312,031
	2026	\$386,987,436		2026	\$99,851,904
	2027	\$389,327,788		2027	\$102,400,457
	2028	\$389,994,821		2028	\$104,921,233
	2029	\$389,801,431		2029	\$107,558,326
	2030	\$390,124,295		2030	\$110,009,660

<sup>378</sup> Abdul Hamid, S. et al., 2018. Family Planning Spending Assessment in Bangladesh, FY 2015-16. Institute of Health Economics, University of Dhaka.

<sup>379</sup> Korir, J., and Kioko, U, 2017. Family Planning Spending Assessment in Kenya, FY 2014/15 - 2015/16. Centre for Economic and Social Research, Nairobi.

### Limitations:

Resource needs were calculated with the assumption that the 2016 expenditure per modern method user remains constant through 2030. This assumption is an oversimplification, and two important limitations of this assumption emerged from the case studies.

In Kenya, due to the trimming of all health budgets throughout the process of transition, it is possible FP expenditure per user will decrease in the coming decade. Government respondents indicated that donor health budgets are based on “luxurious costing... [that] will not be possible with government resources.” As domestic governments transition into the primary FP financing role, national health officials may be forced to trim the FP budget of its perceived “luxury” to fund other priorities within and outside the health sector. Decreases in cost per modern method user may also be realized with improved health system efficiency as various donor-backed parallel health delivery systems are integrated under domestic stewardship.

In Bangladesh, the cost per modern method user assumes a method mix that is heavily skewed towards cheaper, short-term methods. If LARCs increase as a share of the method mix in the next decade—as current forecasts predict to varying degrees<sup>380</sup>—then the cost per user may increase.

Additionally, this methodology is inadequate for projecting FP resource needs in Ghana because of the lack of validated FP expenditure data for the country. Analyses using limited data from the 2016-2020 Ghana FP CIP, unvalidated NIDI assessments, or other incomplete sources produce unrealistic underestimates.

<sup>380</sup> SIAPS, 2017. Bangladesh National Family Planning Commodities Forecasting, 2017-22.

## Annex 5: OPM External Financing and Co-Financing Trends and Projections for Ghana: 2010-2025

Table A.2 presents estimated donor expenditure by health area from 2010-2017 and projected donor expenditures by health area from 2018-2025. Projections were based on interviews with donor officials. Full methodology for estimations and projections of donor expenditures can be found in Annex A of the OPM report.<sup>381</sup>

**TABLE A.2: Actual and projected donor expenditure by health area in Ghana, 2010-2025**

<b>All nine donors</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>178</b>	<b>152</b>	<b>226</b>	<b>283</b>	<b>206</b>	<b>234</b>	<b>232</b>	<b>248</b>	<b>229</b>	<b>207</b>	<b>185</b>	<b>188</b>	<b>165</b>	<b>151</b>	<b>141</b>	<b>124</b>
CHPS	1.1	3.2	3.2	11.2	11.2	17.7	19.2	27.9	20.7	30.3	26.3	20.9	17.4	15.2	13.7	12.2
FP	4.2	1.5	2.6	15.6	18.2	13.2	13.9	10.7	7.8	8.2	9.4	8.6	7.1	5.6	4.1	2.6
HIV/AIDS	35.4	50.1	43.9	58.5	22.2	41.9	34.2	59.2	41.9	37.9	33.1	37.2	33.0	29.9	27.9	24.8
Immunization	5.8	25.5	38.7	34.5	24.6	27.6	22.2	21.5	10.9	16.1	12.7	12.2	11.7	10.6	9.5	8.3
Malaria	88.7	30.8	62.2	98.4	59.0	82.3	74.3	69.2	81.9	58.4	50.6	62.7	51.8	46.7	43.7	37.4
TB	6.2	0.9	17.1	7.5	3.4	4.9	5.4	9.9	6.2	5.0	4.1	5.1	4.7	4.6	4.8	4.7
SBS	12.7	14.7	14.8	14.5	11.8	0.2	6.9	4.9	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>DFID</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>47.4</b>	<b>16.2</b>	<b>16.7</b>	<b>18.0</b>	<b>48.5</b>	<b>27.4</b>	<b>28.9</b>	<b>22.9</b>	<b>17.0</b>	<b>5.1</b>	<b>3.1</b>	<b>2.6</b>	<b>2.2</b>	<b>1.2</b>	<b>1.0</b>	<b>0.8</b>
CHPS	0.0	0.0	0.0	0.0	0.0	2.0	1.7	9.8	6.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FP	2.7	0.0	1.3	0.6	2.0	5.1	5.6	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HIV/AIDS	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Immunization																
Malaria	23.3	0.1	2.0	0.0	16.2	5.6	8.5	1.1	1.3	1.4	0.0	0.0	0.0	0.0	0.0	0.0
TB																
SBS	12.7	12.9	13.0	12.7	10.0	0.2	5.1	4.9	2.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Gavi</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>6.9</b>	<b>33.0</b>	<b>39.2</b>	<b>40.9</b>	<b>25.1</b>	<b>22.9</b>	<b>21.0</b>	<b>15.6</b>	<b>9.1</b>	<b>14.3</b>	<b>9.5</b>	<b>9.0</b>	<b>8.5</b>	<b>7.4</b>	<b>6.3</b>	<b>3.1</b>
CHPS																
FP																
HIV/AIDS																
Immunization	3.0	22.4	35.3	30.7	20.4	22.9	17.0	16.3	5.7	10.9	7.5	7.0	6.5	5.4	4.3	3.1
Malaria																
TB																
SBS																

<sup>381</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.

<b>GF</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>57.3</b>	<b>35.2</b>	<b>63.4</b>	<b>113.6</b>	<b>26.4</b>	<b>81.0</b>	<b>65.4</b>	<b>92.2</b>	<b>90.3</b>	<b>57.8</b>	<b>45.9</b>	<b>64.7</b>	<b>56.1</b>	<b>55.5</b>	<b>58.8</b>	<b>56.8</b>
CHPS																
FP																
HIV/AIDS	20.6	34.4	21.9	38.4	8.4	27.7	22.5	42.5	25.7	20.7	16.8	21.1	19.5	19.1	19.9	19.5
Immunization																
Malaria	30.6	0.0	24.6	67.8	14.8	48.6	37.7	39.9	52.4	28.9	22.4	34.6	28.6	28.5	30.6	29.3
TB	6.0	0.8	17.0	7.4	3.2	4.7	5.2	9.8	6.1	4.9	4.0	5.0	4.6	4.5	4.7	4.6
SBS																
<b>JICA</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>4.0</b>	<b>9.8</b>	<b>25.3</b>	<b>9.9</b>	<b>8.8</b>	<b>6.9</b>	<b>8.7</b>	<b>13.4</b>	<b>13.8</b>	<b>13.8</b>	<b>13.8</b>	<b>13.8</b>	<b>13.8</b>	<b>13.8</b>	<b>13.8</b>	<b>13.8</b>
CHPS	1.1	3.2	3.2	3.2	3.2	3.2	3.2	3.3	1.5	1.5	1.5	1.5	1.5	1.0	1.0	1.0
FP																
HIV/AIDS	0.3	0.1	1.1	1.1	0.7	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Immunization																
Malaria																
TB																
SBS	0.0	1.8	1.8	1.8	1.8	0.0	1.8	0.0	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>KOFIH</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>0.1</b>	<b>0.1</b>	<b>1.7</b>	<b>3.6</b>	<b>7.0</b>	<b>5.6</b>	<b>6.0</b>	<b>4.0</b>	<b>4.0</b>	<b>3.4</b>	<b>3.4</b>	<b>1.3</b>	<b>1.1</b>	<b>1.0</b>	<b>1.1</b>	<b>1.1</b>
CHPS	0.0	0.0	0.0	0.0	0.0	0.0	1.8	1.8	1.8	1.8	1.8	0.4	0.4	0.2	0.2	0.2
FP																
HIV/AIDS																
Immunization																
Malaria																
TB																
SBS																
<b>UNFPA</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>4.2</b>	<b>3.2</b>	<b>2.7</b>	<b>3.1</b>	<b>6.8</b>	<b>6.3</b>	<b>5.0</b>	<b>4.5</b>	<b>4.1</b>	<b>4.1</b>	<b>4.1</b>	<b>4.1</b>	<b>4.1</b>	<b>4.1</b>	<b>4.1</b>	<b>4.1</b>
CHPS																
FP	1.5	1.5	1.3	2.0	1.3	0.7	0.9	2.0	0.8	1.2	2.4	1.6	1.6	1.6	1.6	1.6
HIV/AIDS	0.0	0.0	0.1	0.1	0.1	0.1	0.5	0.5	0.0	1.0	0.1	0.0	0.0	0.0	0.0	0.0
Immunization																
Malaria																
TB																
SBS																

<b>USA</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>47.0</b>	<b>44.8</b>	<b>53.4</b>	<b>74.0</b>	<b>69.5</b>	<b>60.4</b>	<b>74.1</b>	<b>70.9</b>	<b>70.9</b>	<b>70.9</b>	<b>70.9</b>	<b>70.9</b>	<b>59.4</b>	<b>47.9</b>	<b>36.5</b>	<b>25.0</b>
CHPS	0.0	0.0	0.0	8.0	8.0	7.5	7.5	7.0	7.0	7.0	7.0	7.0	5.5	4.0	2.5	1.0
FP	0.0	0.0	0.0	13.0	15.0	7.4	7.4	7.0	7.0	7.0	7.0	7.0	5.5	4.0	2.5	1.0
HIV/AIDS	13.0	15.0	20.3	18.0	11.5	12.2	10.9	15.9	15.9	15.9	15.9	15.9	13.2	10.4	7.7	5.0
Immunization																
Malaria	34.0	29.8	32.0	28.5	28.0	28.0	28.0	28.0	28.0	28.0	28.0	28.0	23.0	18.0	13.0	8.0
TB																
SBS																
<b>World Bank</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>5.6</b>	<b>3.1</b>	<b>16.3</b>	<b>12.3</b>	<b>5.8</b>	<b>14.4</b>	<b>13.3</b>	<b>14.3</b>	<b>12.3</b>	<b>28.3</b>	<b>24.3</b>	<b>12.0</b>	<b>10.0</b>	<b>10.0</b>	<b>10.0</b>	<b>10.0</b>
CHPS	0.0	0.0	0.0	0.0	0.0	5.0	5.0	6.0	4.0	20.0	16.0	12.0	10.0	10.0	10.0	10.0
FP																
HIV/AIDS	1.2	0.3	0.3	0.6	1.3	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Immunization																
Malaria	0.7	0.7	3.5	1.9	-0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TB																
SBS																
<b>WHO</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
<b>Health (USD M)</b>	<b>5.7</b>	<b>6.3</b>	<b>7.0</b>	<b>7.7</b>	<b>8.4</b>	<b>9.0</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>	<b>9.7</b>
CHPS																
FP																
HIV/AIDS	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Immunization	2.8	3.1	3.4	3.8	4.2	4.7	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2
Malaria	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
TB	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
SBS																

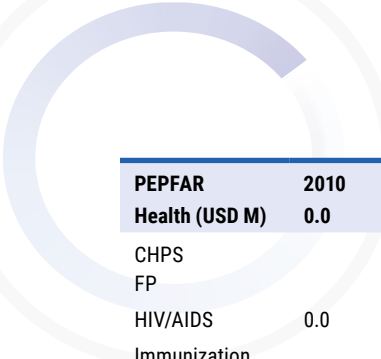


Table A.3 presents estimated GoG co-financing requirements by health area from 2010-2017 and projected co-financing requirements by health area from 2018-2025. Only Gavi, the Global Fund, and USA/PEPFAR require domestic co-financing. Projections were based on interviews with donor officials. Full methodology for estimations and projections of donor expenditures can be found in Annex A of the OPM report.<sup>382</sup>

**TABLE A.3: Actual and projected co-financing requirements by health area in Ghana, 2010-2025**

<b>Total Health (USD M)</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
	<b>1.1</b>	<b>0.7</b>	<b>2.3</b>	<b>2.1</b>	<b>2.3</b>	<b>117.2</b>	<b>174.2</b>	<b>144.3</b>	<b>190.2</b>	<b>239.0</b>	<b>260.3</b>	<b>276.7</b>	<b>294.8</b>	<b>313.2</b>	<b>331.9</b>	<b>350.5</b>
CHPS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HIV/AIDS	0.0	0.0	0.0	0.0	0.0	7.5	13.7	18.0	38.3	61.5	69.3	82.5	97.2	111.9	126.6	141.3
Immunization	1.1	0.7	2.3	2.1	2.3	3.7	3.3	6.3	4.2	3.5	4.1	4.8	5.7	7.0	8.5	9.9
Malaria	0.0	0.0	0.0	0.0	0.0	105.7	157.0	111.2	137.6	167.4	186.0	186.9	187.7	188.5	189.3	190.1
TB	0.0	0.0	0.0	0.0	0.0	0.3	0.2	8.8	10.1	6.7	0.8	2.5	4.2	5.9	7.5	9.2
SBS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Gavi Health (USD M)</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
	<b>1.1</b>	<b>0.7</b>	<b>2.3</b>	<b>2.1</b>	<b>2.3</b>	<b>3.7</b>	<b>3.3</b>	<b>6.3</b>	<b>4.2</b>	<b>3.5</b>	<b>4.1</b>	<b>4.8</b>	<b>5.7</b>	<b>7.0</b>	<b>8.5</b>	<b>9.9</b>
CHPS																
FP																
HIV/AIDS																
Immunization	1.1	0.7	2.3	2.1	2.3	3.7	3.3	6.3	4.2	3.5	4.1	4.8	5.7	7.0	8.5	9.9
Malaria																
TB																
SBS																
<b>GF Health (USD M)</b>	<b>2010</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>2025</b>
	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>113.5</b>	<b>167.7</b>	<b>132.4</b>	<b>177.7</b>	<b>227.2</b>	<b>247.9</b>	<b>263.5</b>	<b>279.2</b>	<b>294.9</b>	<b>310.6</b>	<b>326.3</b>
CHPS																
FP																
HIV/AIDS	0.0	0.0	0.0	0.0	0.0	7.5	10.5	12.4	30.0	53.1	61.0	74.2	87.4	100.5	113.7	126.9
Immunization																
Malaria	0.0	0.0	0.0	0.0	0.0	105.7	157.0	111.2	137.6	167.4	186.0	186.9	187.7	188.5	189.3	190.1
TB	0.0	0.0	0.0	0.0	0.0	0.3	0.2	8.8	10.1	6.7	0.8	2.5	4.2	5.9	7.5	9.2
SBS																

<sup>382</sup> MoH and Oxford Policy Management, 2018. A roadmap for sustainability and transition from external finance: mapping donor and domestic financing for the health sector in Ghana and planning for the future.



PEPFAR	2010	11	12	13	14	15	16	17	18	19	20	21	22	23	24	2025
Health (USD M)	0.0	0.0	0.0	0.0	0.0	0.0	3.2	5.6	8.3	8.3	8.3	8.3	9.8	11.3	12.8	14.3
CHPS																
FP																
HIV/AIDS	0.0	0.0	0.0	0.0	0.0	0.0	3.2	5.6	8.3	8.3	8.3	8.3	9.8	11.3	12.8	14.3
Immunization																
Malaria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TB																
SBS																