Closing the Gap
An advocacy strategy to increase demand-driven funding for family planning and reproductive health in Sub-Saharan Africa
June 5, 2008
Conclusions

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA
2. Country and regional analyses lead to customized advocacy strategies aimed at specific funders
3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap
Advocacy for FPRH funding may be ‘demand-driven’ or ‘supply-driven’

• Demand-driven advocacy supports funding appeals by the countries and people who use FPRH services
  – Domestic governments
  – Consumers
  – General budget support funders
  – Demand-driven-project funders

• Supply-driven advocacy supports general appeals to donor countries for overall increases in FPRH funding

Conclusions and analysis: There are two potential approaches to addressing the shortfall in FPRH funding in SSA using advocacy: supply-driven and demand-driven. Historically, FPRH supporters have largely attempted to close the gap through the former approach, advocating directly to donors in rich countries for funding increases by, for instance, calling for increases in dedicated FPRH funding. Demand-driven advocacy, on the other hand, is based on helping recipient countries justify and promote funding requests to domestic and international funding sources that reflect their FPRH needs.

Technical notes: n/a

More analysis: n/a

Sources:
Redstone Strategy Group
Conclusions and analysis: Recent estimates suggest that when all sources of FPRH funding are considered, more than half of current funding can be significantly influenced by demand-driven advocacy. Furthermore, additional donors are moving toward a system of development assistance that empowers recipient countries to set their own priorities for funding. This trend makes the need to invest in demand-driven strategies more urgent than ever. However, supply-driven funding advocacy remains important, and new opportunities may arise over time. This presentation provides a framework for developing practical demand-driven advocacy strategies to close part of Africa’s FPRH funding gap.

Technical notes: FPRH donors contribution is annual average ODA from 2000-2004. Foundations include those with country-specific investments including Buffet, MacArthur, Rockefeller, Ford, Packard, and UN. Government FPRH health spending from NIDI 2005 data. AIDS ODA includes PEPFAR and Global Fund 2007 disbursements, with variable 2-6% applied to FPRH. Private includes out of pocket spending and prepaid insurance, assuming same % FPRH as overall health by country.

More analysis: Appendix A4

Sources:


Conclusions and analysis: Efforts to quantify FPRH needs in Africa have resulted in a range of cost estimates, varying in size and scope. These range from $1.4 billion annually, based on UNFPA 2004 and WHO 2003 estimates, to the $3 billion proposed by the 2003 version of the International Conference on Population Development’s estimate.

This paper focuses on the core FPRH needs included in the $1.4 billion UNFPA/WHO estimate: delivery of contraception, counseling on family planning and reproductive health issues, and access to safe abortions and post-abortion care. This definition excludes HIV/AIDS treatment, HIV/AIDS prevention (except condom distribution), maternal health, and child health. It also excludes other less direct FPRH investments like girls’ education.

Higher estimates, such as ICPD 2003 at $3.0 billion, are wider in scope, and include broader HIV/AIDS prevention and treatment, maternal health, and research in addition to core FPRH services.

Technical notes:
UNFPA/WHO core FPRH estimate is based on cost per current and new contraceptive user to meet current unmet need for contraception, and cost per abortion care case from Johnson 2007 to eliminate unsafe abortion as estimated by the WHO.

ICPD 2006 estimate provided by Bernstein et al 2007, using estimate for drug and personnel costs (excluding overhead).

ICPD 2003 estimate is reported in UNFPA 2003b and includes HIV prevention and treatment, maternal health, and research in addition to core FPRH services.

More analysis: Appendix A5

Sources:


Conclusions and analysis: FPRH in Africa currently receives $840 million a year. Covering the $1.4 billion cost of core FPRH services would require a 70 percent increase, amounting to an additional $595 million per year.

An increase of this magnitude is possible - albeit ambitious - given that several large donors already contribute the majority of the current funding. In the league in which these donors play, $595 million is not an impossibly large amount. For example, it represents only a 2.5 percent increase in overall official development assistance (ODA) to Africa - but family planning has not been historically a significant expenditure. Some increases in funding from major donors could be achieved through demand-driven approaches, while others may rely on traditional supply-driven advocacy or a combination of the two strategies. Additionally, funding from other sources, including African governments, HIV/AIDS donors, and private consumers could supplement increases from the major international FPRH donors.

Technical notes:
Current funding: Includes FPRH ODA, foundation spending, government spending, FPRH-related AIDS ODA, and consumer spending; as described on p.4 and Appendix A4.
Core FPRH cost: Based on core FPRH UNFPA/WHO estimate from previous page. Includes cost of providing contraception to meet current unmet need and provide safe abortions. As described on p.5 and Appendix A5.
More analysis: Appendix A6

Sources:

http://www.pepfar.gov/about/82472.htm

http://www.theglobalfund.org/en/funds_raised/commitments/


First, demand-driven approaches must address recent pressures on four sources of FPRH funding

Conclusions and analysis: Over the last decade, funding for family planning in Africa declined precipitously. Meanwhile, more expensive reproductive health activities, like caring for expectant mothers and preventing infant mortality, attracted substantial funding increases. Although the result is an FPRH sector whose total funding appears to be increasing, closer inspection reveals that only certain segments have grown. Meanwhile, the core family planning services crucial to achieving good reproductive health and sustainable population growth have suffered significant losses in funding and support.

The following trends have cut into family planning funding, and slowed growth in the sector overall:

Negative FPRH donor policies: Reinstatement of the Mexico City Policy in 2001 banned US support to any foreign organization that provides abortion services, counseling, or lobbying. As a result, US family planning assistance to Africa fell from $58 million in 2001 to virtually nothing in 2004. The UK’s contributions dropped in tandem, from $70 million in 2000 to less than $2 million in 2004. Although these resources may have been shielded into other family planning-related investments like census management, research, and policy making, it is clear that core FP investments faced significant pressure. Because the UK and the US are key donors, these precipitous declines have left a large dent in total funding. To add insult to injury, other major
Donors appear to have decreased funding levels in response, perhaps in an effort to be politically sensitive to the US. Although funding for population policy and reproductive health have risen as family planning has declined, a large percentage of money in these categories is not applicable to core FPRH service goals.

**Low domestic government spending**: Few African governments prioritize spending on FPRH. Several factors drive low domestic spending, including low overall government resources, competing development priorities, political sensitivity to family planning issues, and a history of donor-dominated FPRH funding. Increased decentralization and GBS contribute to the problem. Decentralization can negatively affect FPRH funding by disrupting the traditional budget process. Roughly 30 percent of African countries are decentralized, and FPRH receives less attention in many of these countries because local planners tend to prefer to fund tangible projects like road construction. Furthermore, they are unaccustomed to budgeting for services that have historically been funded by international donors. Increased GBS as a proportion of ODA can divert ODA that was previously dedicated to FPRH, among other topics, and places control over allocation in the hands of the recipient government. In the long run, budget support may be a good tactic: it allows governments to budget according to their own priorities and helps develop local capacity. In the short run, however, FPRH has suffered. This is both because African NGOs were unprepared for the sudden shift of resources to the government, from other recipients, and because the governments themselves may not fully prioritize it for political or historical reasons.

**Low consumer spending**: Consumers in Africa spend very little on healthcare in general, and even less on FPRH, relative to the rest of the world. In Africa, the average person spends about $51 annually on health care. In contrast, other developing countries spend an average of $156 per person. As a percentage of personal income, consumer spending is quite high, but low absolute incomes in Africa limit the ability of individual consumers to fully finance FPRH services. Exacerbating this problem, access to private insurance and prepaid health plans is uncommon.

**Increased funding to HIV/AIDS**: Funding for HIV/AIDS skyrocketed in the past decade, increasing 3,200 percent since 1995 as the disease gained public attention. This international rally has been coordinated and highly effective, but has had some negative side effects, including detracting resources from less well-funded FPRH services. For instance, many nurses have moved to AIDS clinics, where they may earn up to $200 per month, compared to FPRH clinic salaries from $50 to $100 per month.

**Technical notes**: n/a

**More analysis**: Appendix A7 for details on GBS, p.4 and Appendix A4 for details on FPRH donor, government, consumer, and HIV/AIDS donor spending.

**Sources:**


http://www.pepfar.gov/about/82472.htm

http://www.theglobalfund.org/en/funds_raised/commitments/

Conclusions and analysis: Both expert interviews and analysis shows the four skills above help countries attract the highest levels of FPRH funding. Strong leadership signals commitment to FPRH and demonstrates the political will and savvy necessary to make the most out of new funding. Demonstrating need highlights a significant problem to be addressed and shows that funding to the recipient country can have a large impact. The ability to match funder priorities leads to tailored funding requests that illustrate an alignment of interests between funder and recipient country. Finally, proven planning and capacity assures funders that their money can be absorbed and spent on the sector being targeted. Countries seeking to increase FPRH funding should develop these skills in order to assure funders that their money will be put to good use. More details on the four categories of countries can be found in Appendix A8, and more details on evaluating each funding skill in a particular country can be found in Appendix A11.

Technical notes: Countries are divided into four categories, based on their current annual funding per capita and funding growth over time. We then measured the level of the proposed funding skills in each group. For details, see Appendix A8.

More analysis: Appendix A8 and A11
Sources:


Conclusions and analysis: The $595 million FPRH funding gap in Africa can be significantly narrowed through achievable increases from four main sources. To estimate the funding potential of each source, it’s necessary to first size up the current contribution from each. Then, one can set a target for each source, based on a regional funding ‘norm’. The combined contributions from each source meeting its target would close 70 percent of the funding gap.

The four key sources and their respective targets are:

**International FPRH donors:** Across Africa, donors currently contribute approximately $400 million per year to FPRH. This estimate includes ODA from bilateral and multilateral donors, spending by INGOs in SSA, and direct support from large private foundations to NGOs in SSA (in order to mitigate double counting between donors and NGOs). However, there is wide variation in the amount received by different countries. Reaching a target that brings countries with lower current ODA funding closer to the level achieved by higher-funded countries would provide an additional $115 million per year.

**African governments:** African governments currently spend $145 million per year on FPRH. If countries with low spending increased their contribution up to the current average per capita spending by African governments, an additional $180 million would
become available. The idea that developing countries can contribute significantly to funding high quality FPRH services has a long history. In 1994, the ICPD Programme of Action estimated that “up to two thirds of the costs [of attaining ICPD goals] will continue to be met by the countries themselves”. Matching the regional average for government spending falls well within this expectation.

**HIV/AIDS Donors:** HIV/AIDS donors currently spend roughly $140 million per year on FPRH-related activities, such as condom distribution. Currently, only 2 to 8 percent of funds from PEPFAR, the biggest donor, support FPRH-related prevention efforts. Raising the FPRH-related portion of funds to 8 percent in all PEPFAR recipient countries could provide an additional $85 million. Both PEPFAR and the Global Fund are increasingly emphasizing FPRH-related prevention, making this target plausible, if ambitious. The recently announced tripling of PEPFAR funding could also provide a major opportunity to increase core FPRH spending.

**Consumers:** Although FPRH may often be thought of as a strictly publicly-funded sector, consumer spending account for almost 20% of current FPRH funding in Africa, or approximately $155 million per year, including out-of-pocket expenditures and private insurance. Increases in consumer spending are limited by the realities of low personal income in many parts of Africa. However, even reaching 50 percent of the regional average of $0.14 per capita in countries with low consumer spending could amount to another $25 million per year.

**Technical notes:** Current spending is as defined on p.4 and Appendix A4. Targeted spending is defined as a level of per capita funding from a particular source, adjusted in some cases for country-specific or donor-specific factors. See Appendix A9 for details.

**More analysis:** Appendix A9

**Sources:**

Conclusions

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA

2. Country and regional analyses lead to customized advocacy strategies aimed at specific funders

3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap
Conclusions and analysis: Attracting hundreds of millions of dollars in new funding will require a strategy that takes into account both macro funding trends and the details of the unique relationships between funding source and recipients. The solution proposed is to look for the challenges and solutions that are common across the continent, then target a country, region, or topic and customize a strategy. Country-specific data on common funding pressures and fundraising are critical to building such customized strategies. The data shown above provide examples of the sort of information that is available; further details on each country are provided in the attached excel spreadsheet.

Technical notes: Each of the four fundraising skill maps represents a composite index comprised of 2-5 individual factors. An index is created for each factor by representing the score of an individual country as a percent of the maximum score; the overall index for each skill is a weighted average of the factor indices. The data for each factor and skill index can be found in the attached excel worksheet.

More analysis: Appendix A11, Strategy Summary spreadsheet

Sources:

http://www.pepfar.gov/about/82472.htm

http://www.theglobalfund.org/en/funds_raised/commitments/


The analysis identifies specific strategies that build skills to address pressures that cause a country’s funding gap.

**Conclusions and analysis:** These data can be laid into a framework for building demand-driven advocacy strategies, through which African countries can develop and demonstrate the four skills essential to increasing funding. The framework attempts to strike a balance between two opposing considerations in building demand-driven advocacy strategies. On one hand, the definition of a demand-driven strategy precludes a one-size-fits-all solution; funding advocacy that comes from within the recipient country must be specific to that country. On the other hand, the complexity of reinventing the wheel for each of dozens of countries trying to raise money from four different sources would be overwhelming.

This page shows the matrix of four skills that we have asserted can best address the six main causes of Africa’s core FPRH funding gap. The relative importance of each cause and skill will differ between countries, as will the nitty-gritty details of strategies.

However, this framework proposes baseline strategies for each combination in the matrix by drawing on the proven ideas of the many experts interviewed for this project. For example, to improve leadership in countries with high GBS, a general strategy could be to support a watchdog NGO to hold the government accountable for allocating funds to FPRH. Or, to increase the ability of a centralized government to demonstrate need, one advocacy strategy might be to work with the ministry of...
planning to document the health and economic impacts of poor FPRH services. These baseline strategies then need to be customized for a country, region, or topic.

**Technical notes:** n/a

**More analysis:** Appendix A12

**Sources:**
Redstone Strategy Group
Conclusions and analysis: Tanzania provides an example of how to develop country-specific strategies. Because funding from the domestic government and the FPRH-related portion of HIV/AIDS ODA are currently low, demand-driven strategies to raise funding from these sources should be a priority. To a lesser extent, Tanzania may also be able to increase funding from FPRH donors. Consumer spending already exceeds SSA norms, and is unlikely to provide much room for growth. Tanzania scores comparatively well on all of the four skills that contribute to successful fundraising. However, it scores lowest on leadership and demonstrated need, so focusing on improving these two skills could help increase funding. In developing demand driven strategies, it may also be useful to know that Tanzania’s government is relatively decentralized, and that a high percentage of ODA is channeled through GBS.

Technical notes: n/a

More analysis: Appendix A12

Sources:

<http://www.pepfar.gov/about/82472.htm>
http://www.pepfar.gov/about/82472.htm

<http://www.theglobalfund.org/en/funds_raised/commitments/>
http://www.theglobalfund.org/en/funds_raised/commitments/


Thus, advocacy in Tanzania should focus strategies on these specific funding pressures and required skills.

<table>
<thead>
<tr>
<th>Funding pressures</th>
<th>Required skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low FPRH donor spending?</td>
<td>Institutionalize accountability to prioritize FPRH at district level</td>
</tr>
<tr>
<td>Low domestic government spending?</td>
<td>Focus on high population districts where need is more acute</td>
</tr>
<tr>
<td>• Increased decentralization</td>
<td>Support creation of a watchdog NGO (Haki-Elimu-type)</td>
</tr>
<tr>
<td>• High GBS</td>
<td>Demonstrate need for transitional funding during shift to GBS from UK, EC, Netherlands</td>
</tr>
<tr>
<td>Low AIDS % FPRH?</td>
<td>Work with TACAIDS to extend Kikwete’s HIV interest into FPRH</td>
</tr>
<tr>
<td>Low consumer spending?</td>
<td>Develop media campaign on AIDS/FPRH linkages</td>
</tr>
</tbody>
</table>

**Conclusions and analysis:** Based on the scores, generalized strategies can help direct country-specific interviews to determine specific strategies needed to address the funding pressures and required skills. Above are just a few examples of customized versions of baseline strategies based on interviews that could lead to increases in spending in a country like Tanzania.

**Technical notes:** n/a

**More analysis:** n/a

**Sources:**


These strategies could fill 80% of Tanzania’s funding gap

Funding would come from changes at four main sources

• **FPRH donors**: US and UNFPA have strong potential for funding increases, but high GBS lowers potential for UK and EC

• **Government**: TZ currently has low spending and should more than double

• **AIDS donors**: Integrating additional prevention into AIDS activities could direct more of AIDS funds to FPRH

• **Consumers**: Relatively high current consumer spending means opportunity is low

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**Conclusions and analysis:** Targeting the funding sources as described earlier could fill up to 80% of Tanzania’s funding gap going from $48M per year to $74M per year. Fundraising efforts could focus primarily on increasing government spending and directing more funding from HIV/AIDS donors toward FPRH-related activities. Secondarily, more funds can be raised from FPRH donors, especially the UNFPA and US. Because consumer spending is already above the norm for SSA, the funding model assumes no potential for increases from that source.

**Technical notes:** Current and targeted funding are Tanzania-specific versions of the analysis shown on p.9.

**More analysis:** For details on the methodology see pp. 4,5,9 and Appendices A4,5,9. For Tanzania-specific data, see “Strategy model” tab in spreadsheet.

**Sources:**


Conclusions

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA
2. Country and regional analyses lead to customized advocacy strategies aimed at specific funders
3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap
Conclusions and analysis: The first step of implementation is to identify high-priority countries, regions, and topics. The example analysis can help narrow the range of potential priorities by showing a rough country-level expected value calculation. Potential benefit is based on the size of the surmountable funding gap and level of FPRH need in each country. Likelihood of success includes factors such as having a strong president and capable NGOs to help drive a funding package, and low political risk based on governance indicators. The results of these analyses show that countries in East Africa, or the whole region, could be priorities for demand-driven funding efforts. However, an initiative could also focus on topics like decentralization and GBS which are important factors in funding in East Africa, or on helping all countries in SSA improve their ability to demonstrate need and make demand-driven cases.

Technical notes: Potential target regions are determined using the five factors shown on the left. For country-specific data, see Appendix A17.

More analysis: Appendix A17

Sources:


Conclusions and analysis: Armed with a realistic fundraising plan and measurable goals, FPRH supporters can move into the implementation phase of demand-driven advocacy. Coordinating action and ensuring commitment from key players is crucial to implementation success.

Recommendations for implementation follow two initial steps:

Assemble a project team: Implementing demand-driven advocacy through a project team can ensure coordination between - and commitment from - key players. Typically, such a team might include the government(s) of the target country or region, lead funders, and a lead in-country NGO. Other stakeholders whose input is valuable, but who are less directly or critically involved, can be included through a larger working group.

Use the project team to drive coordinated action: Each member of the project team will have an important role to play in making demand-driven advocacy successful. Government involvement signals credible commitment to potential funders. It also provides a channel through which to implement skill-building projects to improve leadership, demonstration of need, and so on. A lead in-country NGO should be skilled in advocacy and familiar with country or regional conditions. It can implement and coordinate advocacy efforts, and assist the government in skill-building. The
involvement of supportive funders encourages buy-in from potential funding sources, and builds a link with donor countries. Other stakeholders to involve in the working group might include secondary in-country NGOs, donor-country NGOs, researchers, and representatives of parallel efforts in other countries. The team can then refine the baseline strategies identified by the model through in-country interviews and more country-specific research. Finally, a team should set fundraising goals, likely based on the targets set in this document, establish measures of success, and start implementing.

**Technical notes:** n/a

**More analysis:** n/a

**Sources:**
Redstone Strategy Group
Over time, the Program will know it is successful when more money is raised that ultimately improves FPRH

### Conclusions and analysis:
Over time, the success of demand-driven funding advocacy efforts can be tracked through intermediate and ultimate outcomes in a logic model. Initially, positive outcomes will include improvements in fundraising skills, which result in more money being raised for core FPRH services from a variety of sources. Ultimately, efforts should result in money being well spent on FPRH services and noticeable improvements in FPRH outcomes in target regions.

### Technical notes:
 n/a

### More analysis:
 n/a

### Sources:
Redstone Strategy Group
Slide 1

Closing the Gap
APPENDIX 1
For practitioners

THE WILLIAM AND FLORA HEWLETT FOUNDATION

June 5, 2008
Appendix

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA
2. Country and regional analysis leads to customized advocacy strategies aimed at individual funders
3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap
A4. Foundation funding currently provides ~$37M to SSA

Private foundation spending mainly in 5 countries
$M/year, average 2005-2007

- $23M
- $7M
- $7M
- $0.3M
- $0.2M

Ethiopia
Nigeria
Ghana
Kenya
South Africa

- Foundation spending counts only grants for FPRH services in a specific country and not grants to international NGOs or non-core FPRH activities
- Grants from foundations spending over $10M/year on FPRH are included
- Hewlett, Rockefeller, and Gates are not included because they give general support rather than country-specific grants

Note: Estimates of spending by the Buffet Foundation are rough approximations

Sources:
A4. NGOs currently provide ~$47M to SSA

Domestic NGO expenditure based on NIDI data
NGO spending $M, 2005

Sources:
A4. HIV/AIDS donors currently provide ~$140M in FPRH-related funding to SSA

Current breakdown of AIDS ODA
Average percent of PEPFAR $, 2007*

<table>
<thead>
<tr>
<th>Activity</th>
<th>100%</th>
<th>$2.2B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment and care</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>FPRH-related prevention</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>PMTCT, abstinence, blood</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>FPRH-related prevention</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Current AIDS funding directed to FPRH-related prevention totals ~$140M $M/yr (countries not shown <$0.5M/yr)

* Based on 2007 Country Operating Plan in 15 focus countries. PMTCT: prevention of mother-to-child transmission. FPRH-related is other prevention measures

Sources:
A4. Domestic governments currently provide ~$145M for FPRH in SSA

Government FPRH spending

US per capita FPRH spending in 2005

Note: Seychelles ~$6.5/pp, Namibia ~$15/pp

Sources:
A4. Consumers currently spend ~$155 on FPRH in SSA

Sources:

A5. FPRH cost estimates for SSA include different packages of services

ICPD, 2006 SRH (Bernstein)
- Cost of personnel and supplies for:
  - Family planning
  - Non-HIV STI prevention
  - Newborn/safe delivery and antenatal care
  - Obstetric complications and other maternal care

ICPD, 2003 (UNFPA)
- Cost based on meeting unmet need in 2015 for:
  - Family planning
  - RH and safe motherhood
  - Diagnosis and prevention of STIs including HIV
  - Data analysis and research

Core FPRH (UNFPA & Guttmacher Institute)
- Regionally adjusted per user cost of supplies, labor, overhead, and hospitalization to provide contraceptive services to:
  - Current users
  - Women with current unmet need
  - Cost of safe abortion and post-abortion care
    - Average of the cost per case in liberal and restrictive legal contexts
    - Provides care for all unsafe abortions

MDGs 4 and 5 (Millennium Project - not show in presentation)
- Cost of the package of health services required to:
  - Reduce under-5 mortality by two thirds
  - Reduce maternal mortality by three quarters
  - Does not include HIV MDG goal

Sources:


A5. Costs to provide core FPRH services under the UNFPA/WHO estimate vary by country

Cost of core FPRH services
• Basic FPRH costs include contraceptive services and abortion care
• Estimate was chosen as a target for fundraising because it:
  • Provides a baseline for critical FP and RH services
  • Can be replicated easily and compared across countries
  • Represents a reasonable middle ground between high and low cost estimates

Sources:


A6. A regional analysis shows substantial differences in the funding gap in different parts of SSA

<table>
<thead>
<tr>
<th>Source</th>
<th>SSA total</th>
<th>East</th>
<th>West</th>
<th>South</th>
<th>Middle</th>
<th>Tanzania</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS ODA</td>
<td>1434</td>
<td>137</td>
<td>89</td>
<td>51</td>
<td>101</td>
<td>165</td>
</tr>
<tr>
<td>Government</td>
<td>598</td>
<td>145</td>
<td>98</td>
<td>51</td>
<td>101</td>
<td>165</td>
</tr>
<tr>
<td>Private</td>
<td>154</td>
<td>154</td>
<td>154</td>
<td>154</td>
<td>154</td>
<td>154</td>
</tr>
<tr>
<td>FPRH ODA, NGOs, Foundations</td>
<td>400</td>
<td>270</td>
<td>89</td>
<td>48</td>
<td>150</td>
<td>120</td>
</tr>
</tbody>
</table>

**Funding gap**

- SSA total: 70%
- East: 65%
- West: 40%
- South: 150%
- Middle: 120%
- Tanzania: 70%

**Private**

- SSA total: 70%

**Sources:**


A6. The importance of sources in filling the gap varies, but government plays a large role in all

**Sources:**


http://www.pepfar.gov/about/82472.htm

http://www.theglobalfund.org/en/funds_raised/commitments/

<http://www.oecd.org/dataoecd/50/17/5037721.htm>


A6. The funding gap varies widely between countries

Funding gap
Difference between current and needed annual funding, $M

Increasing size of gap

SSA country

Sources:
A7. FP ODA has decreased relative to RH and Policy, but only funds for core FPRH services are counted

FP has fallen off as RH and Policy have increased in SSA

- FP funding has decreased, while RH and Policy have increased, but not all goes to core FPRH services
- ODA estimates only include core FPRH, which translates into:
  - 100% of FP
  - 62% of Policy
  - 44% of RH
- ODA estimates also include SSA regional funds and the SSA portion of least developed countries (LDCs) funds

Notes: Policy includes population/development policies; census work, vital registration; migration data; demographic research/analysis; reproductive health research, unspecified population work. Family planning includes counseling, information, education and communication activities, delivery of contraceptives, capacity building and training. Reproductive health care includes promotion of reproductive health; prenatal and postnatal care; prevention and management of consequences of abortion; safe motherhood activities

Sources:
A7. GBS is increasing in many countries in SSA

Percent GBS vs. all ODA

Increase to 00-04 avg.
1995-99 average*

SSA country
Increasing GBS

*If 00-04 average is lower than 1995-99 average, 00-04 average shown

Sources:
A8. Analysis of funding skills first maps SSA countries according to funding per capita and funding growth.

Funding per capita

Weighted funding growth*

0.0
0.1
1.0
10.0
100.0
1,000.0

$0.1
$1.0
$10.0

Nigeria
DRC
Ethiopia
Sudan
Burundi
Zimbabwe
Ghana
Angola
South Africa
Somalia
Zambia
Mozambique
Eritrea
Equatorial Guinea
Sao Tome &
Principe
Cape Verde
Mali
Congo, R.
Togo
Mauritius
Chad
Malawi
Kenya
Cameroon
Seychelles

Population under 5M

Guinea
Madagascar
Namibia

* [Percent change in funding from 2000 to 2004 vs. 1995 to 1999 X (country population in millions)^2]/1000 to mitigate effect of big changes in small countries

Thresholds at $2/pp and weighted growth of 8. Funding does not include AIDS

Sources:
A8. Next, countries are divided into four categories according to their funding characteristics

**Increasing**
- Burundi
- Cote-d’Ivoire
- DRC
- Ethiopia
- Gabon
- Ghana
- Niger
- Somalia
- South Africa
- Sudan

**Higher**
- Angola
- Guinea-Bissau
- Lesotho
- Mozambique
- Nigeria
- Rwanda
- Sierra Leone
- Uganda
- Zambia
- Zimbabwe

**Lower**
- Botswana
- Burkina Faso
- Cameroon
- Chad
- Congo, Republic
- Gambia
- Kenya
- Mauritius
- Namibia
- Seychelles
- Swaziland
- Togo

**Static**
- Benin
- Cape Verde
- Central African Republic
- Comoros
- Djibouti
- Equatorial Guinea
- Eritrea
- Guinea
- Liberia
- Madagascar
- Malawi
- Mali
- Mauritania
- Sao Tome and Principe
- Senegal
- Tanzania

**Sources:**
More analysis: Further details on calculations for each skill are in Appendix A11 and attached spreadsheet.

Note: Levels based on 3-5 country analyses for each characteristic. H=high, MH=medium-high, M=medium, ML=medium low, L=low

Leadership:
Countries with strong leadership on FPRH issues attract more funding than countries with weaker FPRH leadership. Commitment by senior politicians signals a desire to pursue high quality FPRH services and make the most out of funders’ contributions. Leadership can be showcased through public statements by high-profile figures or through concrete commitments of resources, such as through domestic budgets. Leaders of countries with higher funding routinely speak out about population issues. For instance, Rwandan president Paul Kagame articulately criticizes overpopulation, linking it to some of his country’s political and economic ills and calling for immediate action.

Strong leaders in higher-funded countries also put their money where their mouths are, allocating more money to health budgets, and by extension to FPRH, than leaders in other countries.

Demonstrated need:
By international standards, almost all African countries have extremely high need for improvement in FPRH services. But given limited resources, many funders want to send their money where the need is highest. Not surprisingly, therefore, the most funding goes to countries that have demonstrated the greatest needs, as measured by the following indicators:

Population: Population in higher-funded countries averages 24 million people, while lower-funded countries have only 5 million people.
Population density: Higher-funded countries squeeze in an average of 100 people per square kilometer, while an average kilometer in lower-funded countries holds about 60 people.
Fertility rates: Women in higher-funded countries have 5.8 children per woman on average, while in lower-funded countries they have 4.2.
Maternal health: In higher-funded countries 10 women per 1,000 die in childbirth, compared to 5 in lower-funded countries.

This is not to suggest that countries with lower funding have no need for more FPRH money. Rather, it implies that countries with better average indicators could attract funding by documenting and communicating high needs where they occur. Highlighting specific issues or regions, such as slums or rural districts with disproportionately high fertility rates, can help funders look beyond the averages and draw targeted funding. The key skill is not having high needs, but demonstrating that need in a way that informs and compels funders.

Matching funder priorities:
In most funding relationships, it is incumbent on the requesting party to show the funder an alignment of interests. Countries that understand donor priorities are able to accurately tailor funding requests, and thus receive more money than countries that don’t.

In the FPRH sector, donors tend to focus on different topics. These observed preferences fall into three categories:
Population policy: EC, US, and UNICEF
Family planning: UK
General FPRH: UNFPA

From 2000-2004, the four main funders with demonstrated preferences (excluding UNFPA) provided 68 percent of the funding received by higher-funded countries. In contrast, they provided only 22 percent of the funding received by the lowest-funded countries (Figure 6). This suggests that the highest-funded countries successfully appealed to deep-pocketed donors and aligned their requests with the donors’ priorities.

Nurturing diplomatic relationships with key decision-makers and keeping open lines of communication can go a long way in helping tailor funding requests. They can also increase the chances of a positive response by building confidence and trust between funders and recipient countries.

Planning and capacity:
Funders know that sheer quantity of funding doesn’t count for much if it is not put to good use. Countries with a proven ability to plan and capacity to implement strong FPRH programs attract substantial funding by assuring funders that their money will be well-spent.
This skill can be measured in part by past ability to absorb funding. Higher-funded countries have historically used a greater fraction of their resources. For instance, during the most recent UNFPA funding cycle, higher-funded countries spent a larger percentage of their allocated funding, suggesting a greater ability to effectively absorb and administer aid.

Countries with existing channels for spending funds, such as established public or non-profit programs that could absorb new money, also do well. The presence of strong NGOs can be particularly important if the government lacks capacity, easing funder concerns about the ability to use funding.

Sources:

A9. Setting targets for FPRH donor funding

FPRH donor opportunity = (Target per capita - current funding per capita) * Population

**Current funding**
- FPRH ODA estimates are taken from the OECD Development Assistance Committee (DAC) database
- Only “core FPRH” spending is included, amounting to a different percentage for each DAC category:
  - Family planning (DAC purpose code 13030) - 100%
  - Reproductive health care (13020) - 44%
  - Population policy and admin. mgmt (13010) - 62%
- Current spending is modeled as the annual average of core FPRH ODA received between 2000-2004, totaling ~$316M for SSA. An additional ~84M from private foundations and NGOs is also included.
- SSA regional and least developed countries (LDCs) funds are allocated in the same way as country-specific ODA

**Targets**
- Target per capita levels reflect funding levels in high performing countries within SSA
- Only targets for 5 top FPRH donors to SSA are considered
- Targets adjusted, per next slide, to:
  - Reflect priority, or focus, countries of specific donors with conservative assumptions for non-priority countries
  - Reflect trends to support GBS on a country-by-country basis

Sources:
** Using Highs for US, UK, and EC, average of Highs and Static for UNFPA and UNICEF; reduced to 75% for UNFPA, EC, and UNICEF.

** FPRH total (current and requested) for all countries except Nigeria are below 10%; for US, for countries with >$2M total FPRH, targets remain below threshold of 20% excluding Nigeria (~40% of ODA). For UK, for countries with >$2M total FPRH, targets remain below threshold of 20% excluding Madagascar (~30% of ODA) and Cote D’Ivoire (50%)

Sources:

A9. Setting targets for domestic government funding

**Government opportunity = (Target per capita - current per capita) * Population**

### Current FPRH spending

- Estimates of government FPRH expenditure are drawn from NIDI 2005
- Data based on:
  - Reports from in-country experts
  - Projections based on regression analysis of past expenditure
  - Total government expenditure on FPRH is ~$145M in SSA

### Targets

- Target domestic government expenditure is modeled as the average of the median and average of spending across SSA
- This is equal to $0.47 per capita per year
- Target limited to remain below 15% of health budget overall*
- 29 SSA countries currently spend less than this target amount

* Limited countries who can still meet overall targets through other sources are Ethiopia, Guinea, and Guinea-Bissau. Limited countries above this target, where strategies would focus on increasing the health budget are Burundi and DRC

Sources:
A9. Governments could increase FPRH spending to a mid-level target of $0.47/pp

Target = $0.47/pp = average of (median $0.14/pp and average $0.80/pp)

Note: Seychelles ~$6.5/pp, Namibia ~$15/pp

Sources:
A9. Setting targets for HIV/AIDS donor funding

**HIV/AIDS opportunity = (Target prevention % - Current prevention %) * Current HIV/AIDS ODA**

**Current HIV/AIDS ODA from three sources**
- PEPFAR funds to 13 SSA focus countries in 2007
- Global Fund funds to SSA countries in 2007
- AIDS-related ODA to other SSA countries, average from 2000-2004
  - STD control including HIV/AIDS (purpose code 13040)
  - Social mitigation of HIV/AIDS (16064)
- Current FPRH-related prevention efforts are only 2-8% of PEPFAR funds. Where allocation of funds was unavailable, assumed average of 4.1%
- Current FPRH-related spending by HIV/AIDS donors is ~$140M

**Targets**
- Target 8% of AIDS funds going to FPRH-related prevention
- PEPFAR and the Global Fund are increasing the focus on FPRH-related prevention funding requests and is prioritizing prevention (e.g. Malawi ~$2M/yr, Rwanda ~$6M/yr)

Sources:
A9. Setting targets for consumer spending

Target consumer expenditure is modeled as 50% of the average level across SSA. This is equal to $0.14 per capita per year. Because increasing consumer spending relies on reaching individuals rather than a single decision-maker, it may be more difficult to achieve this target. Some countries may also be limited in their ability to reach this target by lower income or higher inequality.

Consumer opportunity = (Target per capita – current per capita) * Population

Current consumer spending
- Estimates of private out-of-pocket spending on FPRH use method from NIDI 2005*
- Uses country data available for ratio of out-of-pocket health spending to government spending
- Assumes ratio is the same for FPRH as for health
- Uses government expenditure reported by WHO and ratios to estimate out-of-pocket expenditure
- Total private spending includes $120M from out-of-pocket spending and $35M from prepaid plans

Targets for out-of-pocket spending
- Target consumer expenditure is modeled as 50% of the average level across SSA
- This is equal to $0.14 per capita per year
- Because increasing consumer spending relies on reaching individuals rather than a single decision-maker, it may be more difficult to achieve this target
- Some countries may also be limited in their ability to reach this target by lower income or higher inequality

* This same method is applied to estimate spending on prepaid insurance plans

Sources:
A9. Current consumer spending could increase to 50% of SSA average

Consumer spending
Out-of-pocket FPRH spending per capita, average 2000-2004

Target = $0.14/pp
= 50% of average

SSA country

Sources:
Appendix

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA

2. Country and regional analysis leads to customized advocacy strategies aimed at individual funders

3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap
A11. FPRH donor focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on FPRH donors

- Angola
- Benin
- Burkina Faso
- Burundi
- Cameroon
- Cape Verde
- Chad
- Comoros
- Congo, Rep.
- Cote d’Ivoire
- Djibouti
- Equatorial Guinea
- Eritrea
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mali
- Mauritania
- Mauritius
- Niger
- Nigeria
- Rwanda
- Sao Tome & Principe
- Senegal
- Seychelles
- Sierra Leone
- Somalia
- South Africa
- Sudan
- Swaziland
- Tanzania
- Togo
- Uganda
- Zimbabwe

Sources:
A11. Government focus is important in countries where >10% of targeted new funds come from that source.

Countries that should focus on domestic government:

- Angola
- Benin
- Burundi
- Cameroon
- Chad
- Central Africa Republic
- Comoros
- Congo, Rep.
- Cote d’Ivoire
- Ethiopia
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Mali
- Mauritania
- Mozambique
- Niger
- Nigeria
- Rwanda
- Senegal
- Sierra Leone
- Somalia
- South Africa
- Sudan
- Tanzania

Sources:
A11. HIV/AIDS donor focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on HIV/AIDS donors

- Botswana
- Burkina Faso
- Central Africa Republic
- Congo, Rep.
- Côte d’Ivoire
- Djibouti
- Equatorial Guinea
- Eritrea
- Ethiopia
- Gabon
- Gambia
- Guinea-Bissau
- Kenya
- Lesotho
- Malawi
- Mali
- Mauritania
- Mozambique
- Namibia
- Niger
- Rwanda
- Sao Tome & Principe
- South Africa
- Swaziland
- Tanzania
- Togo
- Uganda
- Zambia
- Zimbabwe

Sources:
A11. Consumer focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on consumers
- Angola
- Benin
- Lesotho
- Madagascar
- Malawi
- Mozambique
- Sierra Leone

Sources:
A11. US focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on the US
- Burkina Faso
- Cape Verde
- Equatorial Guinea
- Ethiopia
- Gabon
- Mauritius
- Sao Tome & Principe
- Seychelles
- Sudan
- Zimbabwe

Sources:
UNFPA focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on the UNFPA
- Burkina Faso
- Congo, Rep.
- Ethiopia
- Gabon
- Guinea
- Malawi
- Mali
- Mauritius
- Nigeria
- Somalia
- Sudan
- Tanzania
- Zimbabwe

Sources:
A11. UK focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on the UK

- Angola
- Burkina Faso
- Burundi
- Cameroon
- Cape Verde
- Comoros
- Congo, Rep.
- Djibouti
- Equatorial Guinea
- Eritrea
- Gabon
- Gambia
- Ghana
- Guinea
- Lesotho
- Liberia
- Mauritania
- Mauritius
- Sao Tome & Principe
- Senegal
- Seychelles
- Somalia
- Sudan
- Swaziland
- Togo

Sources:
A11. UNICEF focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on UNICEF
• Cape Verde
• Seychelles

Sources:
A11. EC focus is important in countries where >10% of targeted new funds come from that source

Countries that should focus on the EC

- Cape Verde
- Equatorial Guinea
- Eritrea
- Gabon
- Mauritius
- Sao Tome & Principe
- Seychelles

Sources:
Where GBS is high, advocacy to encourage government to direct GBS funds to FPRH is important

High
Benin
Burkina Faso
Burundi
Cape Verde
Chad
Comoros
Cote d’Ivoire
Djibouti
Ethiopia
Ghana
Guinea
Guinea-Bissau
Kenya
Madagascar
Malawi
Mali
Mozambique
Niger
Rwanda
Sierra Leone
Tanzania
Togo
Uganda
Zambia

Low
Angola
Botswana
Cameroon
Congo, Rep.
Equatorial Guinea
Eritrea
Gabon
Gambia
Guinea
Lesotho
Liberia
Mauritania
Mauritius
Namibia
Nigeria
Sao Tome & Principe
Senegal
Somalia
South Africa
Sudan
Swaziland
Zimbabwe

Sources:
The level of decentralization determines the best place to focus government advocacy efforts

Sources:

USAID FPRH priority countries have a special opportunity to raise funds from the US

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Graduation Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congo, Dem. Rep.</td>
<td>Angola</td>
<td>South Africa</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Benin</td>
<td></td>
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<tr>
<td>Ghana</td>
<td>Guinea</td>
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<td>Kenya</td>
<td>Sudan</td>
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<td>Madagascar</td>
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<td>Malawi</td>
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<tr>
<td>Mali</td>
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<td>Mozambique</td>
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<td>Nigeria</td>
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<td>Rwanda</td>
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<td>Senegal</td>
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<tr>
<td>Tanzania</td>
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<tr>
<td>Uganda</td>
<td></td>
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<tr>
<td>Zambia</td>
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</tr>
</tbody>
</table>

First tier countries are likely to receive a greater share of USAID resources than Tier 2 (a larger group of countries in the world) and graduation tier countries are on track to no longer receive USAID assistance.

Sources:
DFID tends to focus its resources in bilateral focus countries, to a lesser degree in bilateral countries, and to the least extent in multilateral countries where it expects significant contribution from other donors.

Sources:
A11. FPRH leadership score is based on health spending and public commitment to FPRH

Notes: Details for calculation of index are in attached excel worksheet

Sources:
http://www.populationaction.org/

A11. Demonstrating high need score is based on pop size and density, TFR, and maternal mortality

High
- Burundi
- Congo Democratic Republic
- Kenya
- Angola
- Benin
- Burkina Faso
- Cameroon
- Central African Republic
- Chad
- Congo Republic
- Cote d’Ivoire
- Equatorial Guinea
- Ethiopia
- Guinea
- Ethiopia
- Guinea-Bissau

Medium
- Angola
- Benin
- Burkina Faso
- Cameroon
- Central African Republic
- Chad
- Congo
- Guinea
- Guinea
- Guinea

Low
- Botswana
- Cape Verde
- Comoros
- Djibouti
- Eritrea
- Gabon
- Lesotho
- Madagascar
- Mauritius
- Namibia
- Sao Tome & Principe
- Seychelles
- South Africa
- Sudan
- Swaziland
- Zimbabwe

Notes: Details for calculation of index are in attached excel worksheet

Sources:
<https://publications.worldbank.org/register/WDI?return%5furl=%2fextop%2fsubscriptions%2fWDI%2f>


A11. Matching funder priorities score is based on funding and level of priority from major donors

<table>
<thead>
<tr>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Cote d’Ivoire</td>
<td>Gabon</td>
</tr>
<tr>
<td>Congo,</td>
<td>Djibouti</td>
<td>Gambia</td>
</tr>
<tr>
<td>Democratic</td>
<td>Equatorial</td>
<td>Lesotho</td>
</tr>
<tr>
<td>Republic</td>
<td>Guinea</td>
<td>Libera</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Guinea-Bissau</td>
<td>Mauritania</td>
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<tr>
<td>Ghana</td>
<td>Guinea-Republic</td>
<td>Mauritius</td>
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<tr>
<td>Madagascar</td>
<td>Haiti</td>
<td>Namibia</td>
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<td>Mali</td>
<td>Senegal</td>
<td>Niger</td>
</tr>
<tr>
<td>Mauritania</td>
<td>Sierra Leone</td>
<td>Sao Tome &amp;</td>
</tr>
<tr>
<td>Rwanda</td>
<td>Slovenia</td>
<td>Principese</td>
</tr>
<tr>
<td>Senegal</td>
<td>Sudan</td>
<td>Seychelles</td>
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<tr>
<td>Sierra Leone</td>
<td>Togo</td>
<td>Somalia</td>
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<tr>
<td>Zimbabwe</td>
<td>Togo</td>
<td>Swaziland</td>
</tr>
</tbody>
</table>

Notes: Details for calculation of index are in attached excel worksheet

Sources:
A11. Strong planning and capacity score is based on pop policies, UNFPA history, and NGO presence

**High**
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cameroon
- Cape Verde
- Central African Republic
- Chad
- Cote d’Ivoire
- Georgia
- Ghana
- Guinea
- Kenya
- Lesotho
- Madagascar
- Malawi
- Mali
- Mozambique
- Namibia
- Niger
- Nigeria
- Rwanda
- Senegal
- South Africa
- Tanzania
- Togo
- Uganda
- Zambia
- Zimbabwe

**Medium**
- Angola
- Congo, Republic
- Eritrea
- Ethiopia
- Mauritania
- Sierra Leone
- Comoros
- Congo, Democratic Republic
- Djibouti
- Equatorial Guinea
- Gabon
- Guinea
- Guinea-Bissau
- Liberia
- Mauritius
- Sao Tome & Principe
- Seychelles
- Somalia
- Sudan
- Swaziland

**Low**
- Angola
- Congo, Republic
- Democratic Republic
- Djibouti
- Equatorial Guinea
- Gabon
- Guinea
- Guinea-Bissau
- Liberia
- Mauritius
- Sao Tome & Principe
- Seychelles
- Somalia
- Sudan
- Swaziland

Notes: Details for calculation of index are in attached excel worksheet

Sources:

A12. Sources and strategies

**Country Characteristics**

- Leadership
- Demonstrated need
- Match funder priorities
- Planning and capacity

<table>
<thead>
<tr>
<th>FPRH donors</th>
<th>Levels low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic government spending low</td>
<td>Centralized</td>
</tr>
<tr>
<td></td>
<td>Decentralized</td>
</tr>
<tr>
<td></td>
<td>High GBS</td>
</tr>
<tr>
<td>AIDS donors</td>
<td>% FPRH low</td>
</tr>
<tr>
<td>Private</td>
<td>Spending low</td>
</tr>
</tbody>
</table>
A12. FPRH donors priority granting strategies

**Leadership**
- Take advantage of leadership in donor groups or on FPRH issues
- Establish a presence in donor working groups to prioritize FPRH
- Provide evidence-based marketing linking increased funding to better FPRH outcomes
- Educate NGOs and government on trends in FPRH funding
- Create funding package that targets requests to donor priorities and works with the government
- Build capacity of BINGOs (IPPF) to do advocacy in country and regionally
- Foster relationships between government, NGOs, and key donor representatives
- Strengthen advocacy and leadership capability of UNFPA to work with countries on funding packages
- Market success stories to donors
- Train NGOs to write better proposals based on donor processes and priorities
- Build capacity of BINGOs (IPPF) to do advocacy in country and regionally
- Foster relationships between government, NGOs, and key donor representatives
- Strengthen advocacy and leadership capability of UNFPA to work with countries on funding packages

**Demonstrated need**

**Match funder priorities**

**Planning and capacity**

**Sources:**
A12. FPRH donors geographic focus and in-country questions

Focus geographically where the potential is higher, for instance...

• Is there a strong health development partners group (DPG)? Does it have an FPRH sub-group?
• Which donors are health leads?
• How strong is information transfer between NGOs and donors? Do any NGOs sit on the DPG?

Target priorities of key donors
Percent of funds to type of investment, average 2000-2004

<table>
<thead>
<tr>
<th></th>
<th>Policy</th>
<th>FP</th>
<th>RH</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>71</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>UNFPA</td>
<td>37</td>
<td>23</td>
<td>40</td>
</tr>
<tr>
<td>UK</td>
<td>73</td>
<td>25</td>
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<tr>
<td>UNICEF</td>
<td>67</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>EC</td>
<td>87</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Helpful in-country questions

- Is there a strong health development partners group (DPG)? Does it have an FPRH sub-group?
- Which donors are health leads?
- How strong is information transfer between NGOs and donors? Do any NGOs sit on the DPG?

Sources:
A12. Centralized government priority granting strategies

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Demonstrated need</th>
<th>Match funder priorities</th>
<th>Planning and capacity</th>
</tr>
</thead>
</table>
| • Advocate to the President through other supportive heads of state  
• Advocate to health minister through regional organizations  
• Create national media attention and accountability through a watchdog NGO  
• Showcase strong FPRH leadership in other countries  
• Network FPRH supporters across different areas of domestic government (e.g. MoH, MoP) | • Demonstrate concrete benefits (health, economics) of FPRH to President and MoF  
• Improve health data systems to identify districts and topics with greatest need  
• Showcase opportunities to extend successful local programs | • Support the Health Minister or MoH staff to be more effective advocates for FPRH in the budget process  
• Disseminate materials on the cost-saving benefits of FPRH within the MoF and MoP (e.g. RAPID) | • Prioritize a package of 3 essential FPRH interventions  
• Promote south-south knowledge transfer, showcasing countries with successful programs  
• Improve budgeting and disbursal systems  
• Create accountability for national leadership in MoH, etc through a watchdog NGO |

Sources:
A12. Decentralized government priority granting strategies

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Demonstrated need</th>
<th>Match funder priorities</th>
<th>Planning and capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support the FP Unit in the MoH to become a budget champion</td>
<td>• Customize district-level marketing packages (e.g. RAPID) to show concrete local benefits of FPRH</td>
<td>• Train mid-level officials to understand the budget process and fight for funding</td>
<td>• Provide a budgeting template to planners</td>
</tr>
<tr>
<td>• Institutionalize incentives to prioritize FPRH at the district level</td>
<td></td>
<td>• Prioritize a package of 3 essential FPRH interventions</td>
<td>• Train local planners to use pro-FPRH budget templates</td>
</tr>
<tr>
<td>• Support a watchdog NGO to track progress at all levels of government</td>
<td></td>
<td>• Promote south-south knowledge transfer, showcasing successful programs</td>
<td>• Prioritize a package of 3 essential FPRH interventions</td>
</tr>
<tr>
<td>• Network government FPRH supporters (e.g. district planners, mayors, service providers)</td>
<td></td>
<td></td>
<td>• Promote south-south knowledge transfer, showcasing successful programs</td>
</tr>
</tbody>
</table>

Sources:
A12. Decentralized and centralized government in-country questions

Decentralized country questions
- Are any local leaders already sympathetic to FPRH or related topics?
- Are there any required budget items or reported statistics for FPRH?
- Who drives the budgeting process (e.g., is the budget built bottom-up?)
- What tactics are effective in budgeting?
- Is there access to information?
- Are there FPRH watchdog groups?
- Is there an essential health package including priority FPRH interventions?
- Do public funds disbursals reach recipients in a timely manner?
- Do planning documents reach a practical level of detail and prioritization?

Centralized country questions
- Are any leaders already sympathetic to FPRH or related topics?
- What best influences specific leaders (e.g., media, parliament, donors)
- What is the current political cycle and regime (e.g., lame duck president?)
- Who drives the budgeting process (e.g., is the budget built top-down?)
- What tactics are effective in budgeting?
- Is there access to information?
- Are there FPRH watchdog groups?
- Is there an essential health package including priority FPRH interventions?
- Do public funds disbursals reach recipients in a timely manner?
- Do planning documents reach a practical level of detail and prioritization?

Sources:
A12. High GBS priority granting strategies, geographic focus and in-country questions

Granting strategies
- Same strategies for relevant level of government, and...
- Advocate to the Health donor working group to pressure the government to allocate more GBS money to FPRH
- Demonstrate need for transitional funding during the shift to GBS, especially to donors such as UK, EC, and Netherlands
- Improve financial systems to smooth the transition to budget support
- Train governments on how to fund NGOs

Helpful in-country questions
- Which donors give GBS but traditionally support targeted FPRH funding?
- How does the government allocate donor money to service providers, esp. NGOs?

Sources:
### A12. HIV/AIDS priority granting strategies and in-country questions

#### Leadership
- Advocate to head of HIV/AIDS Country Coordinating Mechanism (CCM) to include FPRH integration in proposals
- Demonstrate concrete benefits of FPRH for HIV-AIDS prevention

#### Demonstrated need

#### Match funder priorities
- Support CCMs to develop AIDS funding proposals with a strong FPRH component
- Support south-south transfer of best practices in requesting FPRH in GF and PEPFAR proposals
- Regional coordination of PEPFAR and GF recipient advocacy to increase percent of funds allocated to FPRH
- Align HIV-prevention efforts with FPRH goals
- Develop general guidelines for FPRH integration into Global Fund requests (e.g., Aidspan Children GF Proposal Guide)
- Support south-south transfer of best practices in integrating FPRH and HIV-AIDS services

#### Planning and capacity
- Has a GF HIV/AIDS proposal been approved? Any with FPRH integration?
- Is the country a PEPFAR focus country?
- Are there FPRH supporters within the CCM?
- Do service providers have training and support in both FPRH and HIV/AIDS?

#### Focus geographically
where HIV prevalence is higher and prevention focus is lower

---

**Sources:**
A12. Private spending priority granting strategies and in-country questions

Focus geographically where private spending is low

Granting strategies
- Same strategies for 7-10 centralized government, plus...
  - Leadership
    - Advocate to cultural and religious leaders to promote FPRH
  - Demonstrated need
    - Demonstrate concrete benefits (health, economics) of FPRH to individuals
  - Match funder priorities
    - Institute effective cost recovery program where appropriate
    - Expand social marketing and media campaigns
    - Expand health insurance to include FPRH
  - Planning and capacity
    - License informal shops and pharmacies to sell contraceptives
    - Create or revitalize CBDs to reach rural and isolated communities
    - Increase public-private partnership (PPP) service provision

Helpful in-country questions
- Is there a realistic PPP program?
- Are contraceptives available outside government clinics?
- Is there widespread demand for services?
- Are cultural attitudes a barrier to increased demand?
- Is there a public cost-recovery strategy?

Sources:
A13. Efforts in Tanzania focus on GBS, decentralization, FPRH AIDS funding, leadership, and regional need

GBS is extremely high in Tanzania
% GBS versus all ODA

Tanzania is becoming decentralized

Funding per HIV capita is low

And PEPFAR FPRH % is low
% PEPFAR funds for FPRH in 2005

The President has the mandate of the people
% vote, recent elections <2007

And his party controls the National Assembly
% vote, recent elections <2007

Regional TFR needs could appeal to donors
TFR

Or regional unmet need
% unmet need for contraception

Sources:

Appendix

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA

2. Country and regional analysis leads to customized advocacy strategies aimed at individual funders

3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap
A17. Characteristics of priority countries

Strong president

Capable NGOs

Sources:

A17. Characteristics of priority countries

Low political risk  
High FPRH need  
Large money gap

Sources:

<https://publications.worldbank.org/register/WDI?return%5furl=%2fextop%2fsubscriptions%2fWDI%2f>

A17. To implement, begin by identifying high-priority countries, regions, and topics

High priority countries
- Ethiopia
- Kenya
- Uganda
- Rwanda
- Tanzania
- Zambia
- Madagascar
- Mozambique
- South Africa
- Ghana

Sources:
Redstone analysis
### Strategy Model

<table>
<thead>
<tr>
<th>Country</th>
<th>Region</th>
<th>Leadership, matching funder priorities.</th>
<th>Funding skills to improve</th>
<th>Funding pressures*</th>
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</table>

**Technical notes:**

- **Strategies:** Strategies are recommended if the funding skill is currently at less than 30% or if the funding source has the potential to contribute at least 10% of total achievable new funding.
- **Funding skills:** Details on funding skills are on the "Funding skills" tab.
- **Funding pressures:** Details on funding pressures are on the "Funding pressures" tab.
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### Technical Notes

- **Funding skills:** 14
- **Funding skills:** 16
- **UNFPA funds used:** 33
- **UNFPA funds used:** 57
- **% funding from former colonial power:** 66
- **% funding from former colonial power:** 100
- **% funding from US, UK, and EC:** 25
- **% funding from US, UK, and EC:** 63
- **% funding from former colonial power:** 10
- **% funding from former colonial power:** 63
- **% funding from other donors:** 38
- **% funding from other donors:** 17

### Data Sources

- http://www.uneca.org/eca_programmes/food_security_and_sustainability/programm...
- http://www.minbuza.nl/en/developmentcooperation/Themes/Development,reproduction...
- From USAID
- From OECD DAC 2006.
- From OECD DAC 2006.
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<th>% of increase coming from donors</th>
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<td>Current funding pressures ($/pp by source)&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Current annual per capita funding from each major funding source. Cells in red have funding levels below the target set for that source and country. For details, see Appendix A4.</td>
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