

Contraceptive supplies financing: what role for donors?

A GUIDE FOR ADVOCATES



About Countdown 2030 Europe

Countdown 2030 Europe is a consortium of 15 non-governmental organizations in 12 European countries working to hold European donor governments and the European Union institutions to account for their policy and funding commitments on sexual and reproductive health and family planning.

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Executive summary

In low- and middle-income (LMI) countries, financing for contraceptive supplies comes from three sources: donors (10%), country governments (8%) and out-of-pocket spending by individuals in the private sector (82%).¹

Needs for contraceptive supplies are rising as more women and girls use modern contraceptive methods. Estimates of the difference between current spending on contraceptives and the cost of meeting projected needs of the 69 FP2020 priority countries in 2020 show a funding gap of US\$175m if current trends in contraceptive use continue. For all 135 LMI countries the gap will be US\$290m in 2020 if current trends in use continue.²

Unless donor or domestic government finance increases dramatically, most of this gap will have to be met by out-of-pocket expenditure. This is likely to increase inequity, as those least able to afford it often have to pay.

In fact, multilateral and bilateral family planning funding from European donors has been dropping during recent years. Drops have been exacerbated by exchange rate fluctuations, which reduce the amount of contraceptives that can be purchased when the US\$ is strong (procurement is done in US\$). Funding from the United States (US) has been fairly stable, but may drop in future with the reinstatement and expansion of the Mexico City Policy, the invocation of the Kemp-Kasten Amendment to cut funding to UNFPA, and other US policy developments. If European trends continue, and US funding is reduced, the future share of out-of-pocket spending will rise even further, with the resulting risks of growing inequity.

The principal challenges in contraceptive supplies financing are therefore:

- how to increase donor finance and domestic government commitments
- how to stretch limited amounts of donor and domestic government resources further
- how to decrease the inequities in out-of-pocket spending.

Stakeholders and participants in contraceptive supplies finance include: donor governments and multilaterals (particularly UNFPA); coalitions, networks and partnerships (particularly the Reproductive Health Supplies Coalition and FP2020); non-governmental organizations (NGOs); LMI country governments; the private sector (including manufacturers

and pharmacies); foundations, think tanks and research organizations.

The main global procurement agencies are UNFPA and USAID, who purchase contraceptives for their own programmes and (in the case of UNFPA) for third parties such as LMI country governments. Their prices are often the cheapest, as they procure large volumes and can negotiate lower prices as well as buy cheaper generic products. Governments, NGOs and the private sector also procure directly from manufacturers.

Initiatives to improve procurement at global level have included: better market information to avoid stock-outs and duplication; pooled procurement to reduce prices; price negotiations with manufacturers, guaranteeing volumes to enable manufacturers to optimize production costs; and smoothing volatility in orders and forward planning through bridging finance schemes. Donor funds have been used to support these initiatives, as well as for purchase of contraceptives, including supplies for emergency and humanitarian situations.



Financing modalities used by European donors include:

- bilateral
- multilateral
- multi-bilateral
- loans
- volume guarantees
- partnerships with the private sector
- pledge guarantee funds
- bridging finance mechanisms
- direct support for NGOs

Other modalities that may be applicable to contraceptive supplies financing include:

- results-based financing
- development impact bonds
- co-financing

Each modality has advantages and disadvantages, and has different potential applications, which are explored in this report.

Donors have also worked with country governments to: increase country 'ownership' of family planning programmes, which is essential for sustainability; contribute to sector-wide approaches (SWAp) and basket funds, which also strengthen country leadership; support market shaping to reduce market inefficiencies; and to promote a Total Market Approach (TMA), as a means of rationalizing service provision by different sectors. The long-term objective of universal health coverage including family planning in all LMI countries is also on the table and an important objective.

The report's recommendations focus on: achieving an impact in advocacy for increased donor finance; increasing efficiency to stretch donor funds further; improving sustainability and helping to reduce inequities. For transition countries, i.e. countries transitioning from donor funding, recommendations focus on reducing procurement costs and supporting new domestic financing initiatives.





1. Introduction and review methodology

1.1 Background to the review

Funding for contraceptives is currently in crisis. There is a major gap between needs for funding and the resources provided by donors and country governments. While the main responsibility for ensuring access to contraceptives lies with domestic governments, donors continue to play an important role in the financing of contraceptives in low- and middle-income (LMI) countries.

The funding gap will increase in the future due to growing numbers of people in the reproductive age range and more demand for modern contraceptives in LMI countries. The gap is currently filled by out-of-pocket expenditure, which covers more than 80% of all spending on contraceptives. Out-of-pocket spending is often inequitable, with the lowest income group carrying most of the cost burden. As needs grow, and unless donor or domestic government finance increases substantially, an even larger percentage of contraceptive supplies will have to be paid for out-of-pocket.

Recent developments put global funding for supplies, and for wider sexual and reproductive health and rights, under even further strain. Changes in US policies and funding due to the reinstatement and expansion of the Mexico City Policy (or 'Global Gag Rule') and curtailment of US funding to UNFPA risk exacerbating the already substantial funding gap.

Development budgets are also under pressure in Europe, yet many European donors remain strongly supportive of sexual and reproductive health and rights in their development policies and funding. Donors provide support for supplies financing in a variety of ways, including through funding for UNFPA Supplies, direct bilateral support to country governments for the procurement of contraceptives, and funding of international non-governmental organizations (INGOs), social marketing groups and large organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which also procure contraceptives. Donor funding for contraceptive procurement is also provided through World Bank loans and projects supported through the Global Financing Facility (GFF) Trust Fund. Donors have participated in innovative financing partnerships to improve contraceptive security such as the Pledge Guarantee for Health (PGH), the Implant Access Program (IAP) for the Jadelle® and Implanon® implants, and the Sayana® Press initiative.

At national level, donor support for supplies procurement has been channelled through national public sector procurement systems, parallel private or UNFPA-managed procurement systems and basket funds set up to support supplies procurement.³

1.2 Review objective

Countdown 2030 Europe is a consortium of 15 NGOs in 12 European countries working to hold European donor governments and the European Union (EU) institutions to account for their policy and funding commitments on sexual and reproductive health and family planning. The consortium's advocacy efforts are supported by several evidence-gathering activities, including a tracking of European donor spending on sexual and reproductive health and family planning.

Countdown 2030 Europe commissioned this review to support its advocacy for contraceptive supplies finance with European donors. The objective is to provide a broad review and analysis of European donor governments' support to the financing of contraceptive supplies in LMI countries within the wider landscape of reproductive health supplies financing, and to present recommendations for future advocacy on the topic.

1.3 Methodology

The methodology was desk based. A preliminary document review collected existing information, resources and research from donor governments, UNFPA, INGOs, foundations and think tanks, advocacy organizations, coalitions and networks working in the field of contraceptive supplies financing.

Gaps in the information and areas that needed insights and analysis from experts in the field were used to draw up a generic interview guide. Skype and telephone interviews were held with 24 experts from:

- donor governments and implementing organizations
- foundations
- multilaterals
- INGOs
- coalitions, networks and advocacy groups
- think tanks and research organizations
- contraceptive manufacturers

The review was carried out in late 2017. Results, analysis and preliminary recommendations were presented to Countdown 2030 Europe members in a participatory workshop in early 2018. Feedback from the workshop discussions is included in this report.

1.4 Structure of the report

Chapter 2 of the report outlines the current context of supplies financing in LMI countries: the policy context, overall trends in donor, government and out-of-pocket finance for supplies, and estimates of funding shortfalls. Principal donors and other key actors in supplies financing are identified.

Chapter 3 discusses the policies and financing trends of European donors, and the impact of recent changes in US funding.

Chapter 4 outlines procurement processes at global and at national level and their relevance for donor financing modalities.

Chapter 5 focuses on the role of European donors in contraceptive supplies financing and the funding modalities they use, with analysis and comparison of different modalities.

Chapter 6 presents ideas and recommendations for contraceptive supplies financing advocacy.



2. Current context on supplies financing in low- and middle-income countries

2.1 Policy context and initiatives

Developments in the policy environment during the last several years that have implications for contraceptive supplies financing include:

- The **London Summit on Family Planning in July 2012**, co-sponsored by the United Kingdom (UK) Department for International Development (DFID) and the Bill and Melinda Gates Foundation (BMGF) in partnership with UNFPA, civil society organizations, donor and LMI country governments, private sector stakeholders and others. It agreed an objective of expanding access to family planning services and supplies to an additional 120 million women and girls in 69 priority countries by 2020. The FP2020 partnership is an outcome of the Summit. FP2020 seeks financial, political and resources commitments from donor and LMI country governments to advance rights-based family planning programmes, with a focus on country ownership and promoting family planning as a cornerstone of countries' development strategies. A second summit held in July 2017 reviewed progress. FP2020's 2016–2017 progress report showed that 39 million additional users had been reached so far.⁴
- **ICPD Beyond 2014**: 20-year anniversary review of progress on the implementation of the 1994 International Conference on Population and Development (ICPD) Programme of Action, presented to the 47th session of the UN Commission on Population and Development in 2014. The ICPD Beyond 2014 Framework of Actions affirms sexual and reproductive health and rights as central to sustainable development.⁵ Family planning is reflected as an integral part of sexual and reproductive health and rights, and has a prominent place in the objectives and indicators.
- Adoption of the **Sustainable Development Goals** (SDGs) in 2015:⁶ the SDGs propose a more integrated approach to development than their predecessor framework, the Millennium Development Goals. They set out 17 goals covering social, economic, environmental and governance dimensions of sustainable development. Sexual and reproductive health and family planning are mentioned explicitly in target 3.7 under SDG 3 ("Ensure healthy lives and promote well-being for all at all ages") and family planning is included in indicator 3.7.1 ("Proportion of women of reproductive age (aged 15–49 years) who

have their need for family planning satisfied with modern methods"). Sexual and reproductive health and reproductive rights are also covered in target 5.6 under SDG 5 ("Achieve gender equality and empower all women and girls"), and contraceptive use is mentioned explicitly in indicator 5.6.1 ("Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care").

SUSTAINABLE DEVELOPMENT GOAL TARGETS 3.7 AND 5.6

Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

- Launch of the UN's revised **Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)**⁷ in September 2015, alongside the SDGs. The World Bank and a number of donor governments set up the GFF (see section 5.2) to help ensure availability of funds to implement the strategy.

Although changes in the global policy context have repositioned family planning as an integral part of sustainable development, at the same time some countries and donors have focused their own policies more specifically on family planning itself, and on the supplies needed for family planning programmes. FP2020 itself has a specific focus on supplies, but also gives priority to capacity building and integration of family planning within health system strengthening efforts. Many of the new country commitments reflect this move to more integration.⁸

CONTRACEPTIVES AND REPRODUCTIVE HEALTH SUPPLIES

Contraceptives

Modern contraceptive methods include short-acting methods, such as male and female condoms, pills and injectables; and long-acting reversible and permanent methods, such as implants, intrauterine devices (IUDs) and male and female sterilisation.⁹

Reproductive health supplies

Hoehn et al. describe reproductive health supplies as “encompassing any material or consumable needed to provide reproductive and sexual health services – including but not limited to contraceptives, drugs, medical equipment, instruments, and expendable supplies for family planning, for prevention and treatment of sexually transmitted infections including HIV and AIDS, and for maternal health and ensuring safe delivery and postpartum care.”¹⁰

2.2 Overall trends in donor, domestic and out-of-pocket finance for contraceptive supplies

Contraceptives in LMI countries are financed by:ⁱ

- Donors (10% of the total spend). Donors include governments and private sector foundations. The 10% figure also includes spending by international institutions such as UNFPA and the World Bank.¹²
- Domestic finance (8% of the total spend). This is finance from LMI country government budgets. The 8% figure consists of spending using non-donor, non-basket fund, and non-World Bank loan revenue.¹³

- Out-of-pocket spending (82% of the total spend). The 82% figure consists mostly of out-of-pocket spending by individuals, with a small proportion representing spending by employers and insurers.¹⁴

The percentage share of each group varies between countries. Donor- and government-financed contraceptives are normally free or subsidised for users, but in the private sector retail prices are usually higher and there is little price regulation.

2.2.1 Donor funding

Who are the donors?

Donors are high-income country governmentsⁱⁱ and foundations. UNFPA and other international institutions are not donors. They receive donor funds themselves and channel them to governments and other recipients. The largest family planning donor (including supplies and other family planning programme spending) is the US government, followed by the UK government. During the period 2004 to 2014, the US provided 70% of all family planning funding, followed by the UK with 10% of the total and BMGF with 8%.¹⁵

The US is also by far the largest donor of contraceptive supplies. Between 2011 and 2016, the US contributed 46% of all donor-funded contraceptives in the 69 FP2020 priority countries.¹⁶

Which countries does the money go to?

Donors and other family planning stakeholders have identified priority groups for their family planning support, based on levels of need and countries' own capacity to meet those needs. USAID currently has 24 priority countries,¹⁷ UNFPA Supplies has 46 priority countries, and FP2020 has 69. All the UNFPA Supplies priority countries and the 24 USAID priority countries are included in the FP2020 group.ⁱⁱⁱ But funds also go to countries outside these priority groups.

i See Reproductive Health Supplies Coalition (2018) *Global Contraceptive Commodity Gap Analysis 2018*. Percentage figures for public sector spending (donor and domestic finance) are calculated based on three years of data (2014–2016); the out-of-pocket spending figure is based on the average annual consumption cost over the same three-year period.

ii The principal donor countries are members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC), which currently has 30 members. See OECD website, DAC members: <<http://www.oecd.org/dac/dacmembers.htm>>.

iii All the USAID priority countries except five (Afghanistan, Bangladesh, India, Pakistan and Philippines) are also included in the UNFPA Supplies priority group.

How is funding channelled to countries?

Donor funding for family planning is channelled to LMI countries through:

- multilaterals (such as UNFPA)
- direct bilateral funding of country governments
- INGOs and national NGOs

Donor funding is also the principal component of humanitarian and emergency funding for contraceptive supplies, which is usually channelled through UN agencies or INGOs. Family planning in humanitarian and emergency situations is discussed in more detail below.

What is the money spent on?

Family planning support from donors and international organizations is spent on a range of other activities as well as supplies, including family planning programming, capacity building, demand-side activities, advocacy, research and development.

Funding goes to:

- supplies
- strengthening supply chains (procurement, warehousing, distribution to service delivery facilities, information systems and monitoring and evaluation)
- improving the accessibility and quality of service provision (e.g. through training health service providers)
- raising demand for family planning
- research and development of new products
- technical support for supply chain management and strengthening
- pilot schemes for introduction and delivery of contraceptive methods
- advocacy at international, national and local levels
- strengthening of global procurement systems
- monitoring and strengthening accountability etc.

How does donor support to each country change over time?

Countries supported by USAID and UNFPA are expected to move towards more self-sufficiency in contraceptive supplies, covering a greater share of costs through domestic government expenditure. UNFPA's 'S-curve' shows how countries' needs change as their modern contraceptive prevalence rate (mCPR) grows. The need for donor support for contraceptive supplies diminishes as countries move up the S-curve, with more emphasis on capacity building for sustainability as they move towards higher mCPRs.¹⁸ Other funders use national income growth indicators to decide when to reduce or eliminate their support. The World Bank, for example, uses a specific cut-off point for preferential aid based on per capita national income.

Once countries 'graduate' from the priority group they receive little direct donor funding for contraceptives purchase. Governments in these graduating or transition countries may allocate loan funds from the World Bank to commodities. They may also get support from family planning programmes of large INGOs and social marketing schemes. But as well as losing direct funding for supplies purchase they lose access to concessional contraceptive prices and may also lose access to technical assistance. A sudden cut-off of support can be especially traumatic in smaller countries, particularly if a relatively high per capita national income disguises inequities in income distribution.

Donors have supported initiatives to help countries through the transition phase. In Latin American and other transition countries, USAID promoted inter-sectorial coordination mechanisms to work towards reproductive health commodity security through joint planning and coordination of procurement and distribution of supplies. The DELIVER project in Latin America and the Caribbean helped countries to set up Committees for Reproductive Health Commodity Security (Spanish acronym 'DAIA'), with participation from the public, private and NGO sectors, together with the principal donors.¹⁹ Levels of success varied between countries. UNFPA Supplies supports capacity building to strengthen national procurement and supply chains.

UNFPA, USAID and NGOs have also introduced the concept of a Total Market Approach (TMA) to help countries work towards a rational allocation of markets and resources between the public, NGO and private sectors.²⁰ A TMA

involves cooperation between public, private and NGO sectors to identify market segments, and agree which of those segments are best served by each service provider sector. The TMA defines the target market segments, roles and responsibilities of each stakeholder group.

TMAAs may include:

- research to identify the market segments
- advocacy for rational allocation of market segments to service providers
- demand creation for family planning services
- monitoring and evaluation²¹

Family planning in humanitarian and emergency aid

Donor funding for humanitarian assistance is budgeted separately from other development assistance. Figures for the total amount spent on contraceptives for humanitarian assistance are not available.

Contraceptives are included in emergency reproductive health kits for crisis situations. UNFPA, which is the principal supplier, spent US\$8.4m on reproductive health kits in 2016, but these include a range of other supplies.²²

The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) was set up in 1995 in response to the need for provision of sexual and reproductive health services in crisis settings. Its members include UN agencies, NGOs, universities and research institutes. IAWG was instrumental in setting up the Minimum Initial Service Package for Reproductive Health in Crisis Settings (MISP) soon after. Family planning is included in the MISP. During the Bosnian crisis in 1992, Marie Stopes International (MSI) developed the first pre-packaged reproductive health kit. By 1998 the first inter-agency reproductive health kits were developed by IAWG. The kits are managed by UNFPA.

There are currently 12 kits for different population levels and different stages of crisis assistance.²³ The kits are not designed for a comprehensive family planning service, and contraceptives included are appropriate for use in emergencies. They comprise male and female condoms, oral pills, injectables, IUDs and emergency contraceptives. Users procure the kits through UNFPA.²⁴

Finance for the kits is provided by UNFPA, other UN agencies, and through other multilateral and bilateral donor funds. They may also be financed through NGOs or country governments.

European donors generally have separate budgets for humanitarian aid. This finance is additional to their ongoing sexual and reproductive health and rights support.

A recent evaluation of use of the kits identified some problems of wastage and inefficient use. This was partly due to procurement of kits for emergency preparedness rather than crisis response, which may result in medicines passing their expiry dates. Procurement is sometimes based on the budget available rather than on assessed need for supplies, resulting in over-ordering. There may be import delays due to lack of registration of all products in the recipient countries (this is especially relevant for emergency contraceptives). The evaluation also stressed users' requests for more orientation and information on contraceptives for health workers in the field, and the need for training and capacity building in the national supply chains to make sure the products get to their destination quickly and are used properly.²⁵

2.2.2 Domestic government funding

Where does the money come from?

Governments fund contraceptives from tax income and through international loans, such as from the World Bank, which some countries count as domestic resources. Allocations for family planning are normally in the national health budget, and/or in regional or provincial health budgets in countries with decentralized administrative systems. Some contraceptives are also budgeted by other national ministries and agencies, such as national AIDS commissions (condom budgets) or youth ministries, which may have budgets for sexual and reproductive health activities.

Overall health spending by national governments is positively associated with economic development – there is a clear statistical relationship between the two, although there are variations between countries.²⁶ However within the health-spending envelope, it is hard work to get a specific allocation or budget line for family planning. This depends on the level of awareness of the importance of family planning in overall national development, other national priorities including emergencies, and ministry of health capacity for family planning advocacy with ministries of finance, national population councils, national development ministries and others who control national resource allocation.

Are domestic commitments growing?

Country 'ownership', demonstrated by national policy and budget commitments, is a key to the success and sustainability of family planning programmes. Since FP2020 started work, the level of commitment by country governments has grown. Of the 69 priority countries, 41 have joined the partnership since 2012.²⁷ Many of the FP2020 pledges made by these countries include specific commitments to increase resources allocated to contraceptives.

However, even when country governments have shown commitment by allocating budgets for family planning, the existence per se of a budget line does not guarantee that funds will actually be made available for contraceptives procurement. In practice, governments have other pressing priorities and may expect donors to fill the gap if there is a shortfall – donor funding can be a disincentive to domestic government funding. In Kenya for example, domestic funding of contraceptive supplies stopped during decentralization of the country's administration and donors stepped in quickly to fill the gap.²⁸

2.2.3 Out-of-pocket spending

Where does out-of-pocket spending come from?

This is by far the largest chunk of funding for contraceptives, but it is difficult to estimate its real cost. Most out-of-pocket spending is purchases of contraceptives by individuals from pharmacies, with a small proportion of out-of-pocket spending through health insurance schemes that include family planning. Actual spending depends on the price of contraceptives to users. Prices in the private sector are a lot higher than prices in the public sector in most countries and vary widely as they are set by the pharmacies and sales outlets.

Implications of out-of-pocket spending

Out-of-pocket spending is often inequitable, with the lowest income group carrying most of the cost burden. It further has important gender implications, due to women's and girls' more limited access to and control over financial resources. This is particularly stark in relation to contraceptives and other reproductive health supplies and services, which are more heavily used by women and girls. National health insurance schemes that include family planning are often only for people employed in the formal sector, leaving those in the informal sector – where women are often employed – without coverage.

As most out-of-pocket spending takes place in pharmacies, out-of-pocket expenditure is skewed towards short-term methods that can be bought over the counter (such as pills and condoms). These methods are more expensive in terms of cost per couple years of protection (CYP) than the long-acting reversible methods (IUDs and implants) and the long-acting permanent methods (male and female sterilisation). Low-income users may not be able to afford the high upfront costs of long-acting methods, which also need a service delivery infrastructure and trained health providers. The share of out-of-pocket spending is most important if the poor are excluded from donor- and government-subsidised contraceptives, and/or if funding gaps lead to lower availability of contraceptive supplies and a reduction in overall use.

Out-of-pocket spending can have some advantages for users, including:

- more privacy
- less waiting time
- availability of methods in pharmacies, often without the need to visit a health facility

Out-of-pocket spending can also be convenient and attractive for young people if they can afford it, as pharmacies and private sector service providers may be less judgemental and less affected by protocols which restrict access to public sector services for young people in some countries.

METHOD MIX

Method mix is an important factor in overall spending, due to the variation in the costs of different methods and the duration for which they offer protection. The Reproductive Health Supplies Coalition's Global Contraceptive Commodity Gap Analysis (RHSC CGA) 2018 analyses method mix in use and in cost in both the public and private sectors. It explains that method mix that reflects the number of users of each contraceptive method looks quite different from method mix that represents the consumption cost of supplies. Pills, for example, represent only one-fifth of all method use, but over 60% of consumption cost. IUDs make up 10% of use, but are only 2% in cost.²⁹

Method mix affects:

- The cost-efficiency of spending, in terms of the number of users who can be supplied for a given amount of funding. The need to maintain user choice should temper cost-efficiency considerations.
- The affordability of contraceptive supplies for users of contraception paying out-of-pocket. For example, in terms of their supplies cost, long-acting contraceptives are the most cost-efficient in terms of cost per CYP and could therefore be an attractive option for users paying out-of-pocket in the private sector. However, there are additional costs of service provision (insertion and removal of IUDs and implants). The total cost of supplies and service provision in the private sector may be out of reach for low-income users.
- The sustainability of contraceptive supplies spending once countries have to cover these costs themselves.

Costs for different contraceptive methods per average unit price of UNFPA^{iv} and per CYP are shown in Table 1.

TABLE 1: AVERAGE UNIT COST OF UNFPA^{iv} AND CYP COST OF CONTRACEPTIVE METHODS IN 2016

METHOD	UNIT COST US\$	COST PER CYP US\$
Female condom	0.49	59.28
Male condom	0.03	3.64
Injectable – 3 months	0.82	3.29
Oral pills – combined	0.26	3.95
Oral pills – emergency contraception	0.35	7.02
Implant – 4 years	8.50	2.66
IUD	0.46	0.10

Source: CHAI and RHSC (October 2017) 2017 Family Planning Market Report.

The RHSC CGA also finds significant differences in method mix both in use and cost between the public and private sectors. Short-acting methods are generally more common among users purchasing their supplies from private sector providers, while long-acting methods are more common among users relying on public sector providers. Differences between public and private sector method mix in consumption cost are particularly stark. This is due to the costlier short-acting methods being more prevalent among private sector users, but also due to higher prices in the private sector. As the CGA highlights, the private sector purchase price of pill cycles, for example, is on average five times higher than the public sector price.³⁰

iv The IUD unit price is the average of the UNFPA 2016 price and USAID 2014 price. The implant unit price is the Implant Access Program price.

2.2.4 Future trends

If current trends towards use of modern contraceptives continue in future, needs for contraceptive supplies will increase. Donor finance is unlikely to rise significantly and may fall with changes in US funding (see section 3.2) and aid cuts in several European countries. Domestic government finance should rise with countries' economic growth, and with more government awareness of the important role of family planning in development, but there is competition for domestic finance and countries may give priority to the productive sectors. This means that the most likely scenario is that out-of-pocket spending will have to cover a larger share.

2.3 Estimates of funding shortfall

RHSC – Global Contraceptive Commodity Gap Analysis

The RHSC CGA 2018 provides estimates of shortfalls in contraceptive supplies funding over the coming years under the assumption of a continuation of current trends in contraceptive use.³¹ It estimates gaps for 135 LMI countries, and the subset of the 69 FP2020 focus countries.

The 2016 edition of the CGA also projected gaps for a scenario in which the FP2020 target of 120 million additional users in the 69 focus countries by 2020 is achieved, along with an acceleration of the rate of use in the remaining 66 LMI countries. Neither edition provides estimates of funding gaps for a scenario in which all unmet need for modern contraception is satisfied.

The CGA 2018 calculates the funding shortfall or 'gap' as the difference between current spending by donors, governments and individuals and the funding needed for contraceptive purchase over the coming years, under the assumption of a continuation of current trends in contraceptive use. The

amount for current spending by donors and governments is based on the average of spending over three years (2014–2016). The current spending by individuals ('private sector-individual' spending) figure represents the annual consumption cost over the same three-year period for all users of contraception who obtained their supplies from a private sector source, as well as a small amount of spending by corporate entities. It can be assumed to consist mostly of out-of-pocket spending by individuals.

Key parameters used to estimate the gap

Contraceptive costs and user prices

For the CGA 2016, out-of-pocket spending was estimated on the basis of public sector procurement prices, which are lower than private sector retail prices. The CGA 2018 applies new data on the private sector price of supplies for three methods (implant, injectable, pill), which substantially increases the share of out-of-pocket spending compared to the CGA 2016 estimates.

The CGA calculates commodity costs for the six most prevalent contraceptive methods, i.e. male and female sterilisation, implants, IUDs, injectables, pills and male condoms (for contraceptive use only), and a seventh miscellaneous category, representing the least used methods. Its estimates only include the costs of the contraceptive commodities themselves and associated clinical supplies. They do not include costs of service provision. For surgical sterilisation, the CGA uses the cost of a surgical kit of consumables. In the case of long-acting reversible contraceptives and sterilisation, the total service delivery cost is a lot higher than the actual commodities.

Method mix

Method mix has a major impact on overall costs and on the share financed from each source, due to differences in the cost of methods. The CGA 2018 analyses method mix by use and by cost overall, and disaggregated for the public and private sectors.

Size of the gap

Table 2 shows current spending on supplies in the 135 LMI countries and in the 69 FP2020 priority countries, and the projected spending gap for each group in 2020 if current trends in contraceptive use continue.

TABLE 2: SIZE OF THE CONTRACEPTIVE SUPPLIES FUNDING GAP IN 2020, ASSUMING DONOR, GOVERNMENT AND INDIVIDUAL SPENDING IN THE PRIVATE SECTOR STAYS AT THE CURRENT LEVEL

COUNTRIES	CURRENT ANNUAL SPENDING IN US\$	GAP IN 2020 IN US\$
All 135 LMI countries	2.55bn	290m
69 FP2020 priority countries	1.03bn	175m

Source: RHSC (2018) *Global Contraceptive Commodity Gap Analysis 2018*.

Table 3 shows the current shares of spending from donors, governments and individuals. If donor and government funding does not increase dramatically beyond current spending levels, most of the funding gap will have to be covered by out-of-pocket spending of individuals, which will further increase their already substantial spending shares.

TABLE 3: CURRENT SHARES OF SPENDING

COUNTRIES	ACTUAL % SHARE
All 135 LMI	
Donors	10%
Domestic governments	8%
Individuals	82%
69 FP2020 priority countries	
Donors	24%
Domestic governments	13%
Individuals	63%

Source: RHSC (2018) *Global Contraceptive Commodity Gap Analysis 2018*.

Guttmacher – Adding It Up

Guttmacher's *Adding It Up 2017* provides estimates of the costs of fully meeting the contraceptive needs of women in developing regions in 2017.³² It calculates that, as of 2017, about 671 million women in developing regions were using modern contraceptives, while 214 million women had an unmet need for modern contraception, meaning that they wanted to avoid pregnancy but were not using a modern contraceptive method.

It estimates the current annual cost of contraceptive services in developing regions, covering the 671 million women currently using modern contraception, as US\$6.3bn, including both direct and indirect costs. It suggests that expanding and improving services to meet all women's needs for modern contraception in developing regions would cost US\$12.1bn per year, including direct and indirect costs.

The cost estimates for direct costs include not only the costs of commodities and supplies themselves, but also costs related to personnel time, and information and counselling associated with contraceptive services. Indirect costs cover programme and systems costs such as costs related to infrastructure improvements, training of personnel, and commodity supply systems.

UNFPA Supplies funding gap

UNFPA Supplies calculated its own financing gap for its programmes in its 46 priority countries. Estimations were based on projections of need, donor commitments and negotiations in the pipeline. The total financing gap for the period 2017–2020 was estimated to be US\$700m.³³

2.4 Principal donors and other stakeholders involved in supplies financing and procurement

This section outlines the principal donors and stakeholders involved in family planning and contraceptive supplies.

2.4.1 Donors

The US is by far the largest donor for family planning programmes, and also for contraceptive supplies.

In the period 2004–2014, the US share of all family planning programme support was US\$4.1bn, a huge 70% of the total. The largest European donor was the UK, with US\$600m or 10% of the total, followed by Germany, Norway, the Netherlands, the EU institutions and Spain, with smaller contributions from France, Denmark, Finland and Belgium with a combined contribution of just over US\$400m, or 7% of the total.³⁴

Donor spending on contraceptives in the 69 FP2020 priority countries can be tracked for the period 2011–2016 with data from the Clinton Health Access Initiative (CHAI) and RHSC *2017 Family Planning Market Report*. Donor contributions were less skewed, but the US was still the largest donor at US\$509m or 46% of all donor-funded contraceptives in the period. All other donor funding combined came to US\$605m, or 54% of all donor funding.³⁵

Trends, policies, financing modalities and the channels donors use to get finance and supplies to recipient countries are discussed in detail in the following chapters.

2.4.2 Other stakeholders and participants

UNFPA

UNFPA is a spending channel rather than a donor. Its resources for contraceptive supplies are affected by volatility of donor funding flows and fluctuations in exchange rates.^v Changes in the Euro to US Dollar exchange rate have had a major impact on UNFPA's procurement volumes during the last 15 years.³⁶

UNFPA Supplies is UNFPA's flagship programme to expand access to family planning. Formerly known as the Global Programme for Reproductive Health Commodity Security (GPRHCS), it is focused on improving access to family planning in 46 priority countries, through a mix of contraceptive donations and capacity building.³⁷ It also supplies family planning products in humanitarian crises. The principal funders of UNFPA Supplies are the UK and the Netherlands.

UNFPA Procurement Services Branch (formerly known as AccessRH) does the procurement for UNFPA's own programmes and for third parties such as country governments and NGOs. As a large volume buyer, UNFPA obtains low prices for contraceptives. Volatility of donor funding flows have affected UNFPA orders and hence lead times for delivery of contraceptives to countries, a problem which should diminish with the establishment of the UNFPA Supplies Bridge Funding Mechanism (see section 5.2). UNFPA procurement requires up-front payments from third-party customers, which can have legal obstacles.^{vi}

UNFPA also hosts and maintains the Reproductive Health Interchange (RHInterchange), a database of information on contraceptive orders and shipments for over 140 countries. It includes over 80% of all donor-funded procurement, worth more than US\$2.7bn.³⁸

UNFPA Commodity Security Branch focuses on work at country level, supporting and facilitating processes to strengthen the supply chain and align country efforts with global initiatives. It works with governments at strategic and policy level, supports development of country Costed Implementation Plans (CIPs) for family planning, and helps countries that are graduating from donor support.

v UNFPA budgets are in US\$, while its principal donors use € or £. The US\$ has fluctuated from US\$1.3 per € in 2014 to US\$1.1 in 2016/17, with similar volatility relative to the £.

vi Some countries' laws prohibit up-front payments for supplies by the public sector. The goods have to actually be received in country before payment can be made.

UNFPA also represents WHO in the prequalification of male and female condoms and IUDs and manages the WHO Expert Review Panel (ERP) process for reproductive health medicines.^{vii 39} The ERP is a mechanism to provide temporary approval of contraceptive products that are close to prequalification. ERP approval is used when insufficient prequalified products are available in the market.

Reproductive Health Supplies Coalition (RHSC)

The RHSC was established in 2004 and has been a major player in increasing access to supplies. There are now over 400 coalition partners including governments, civil society organizations, foundations, technical support agencies, commerce and industry. The RHSC has a number of working groups, which are the main fora for cooperation between partners. It has been a key participant in or initiator of major developments and innovations in supplies procurement and financing at global level. It also carries out extensive research and information dissemination.

The Coordinated Supply Planning (CSP) group is one of the RHSC's key working groups. It supports better coordination of procurement between donor agencies and public sector purchasers to smooth procurement volumes, reduce stock-outs at country level, and avoid duplication of supply. UNFPA and USAID (the largest global procurers) are the two major partners. The CSP group seeks to advise participants of potential stock-outs or order duplication in time for them to adjust their procurement.

The RHSC has developed a range of tools and publications to support and strengthen procurement and access to supplies, and to provide up-to-date market information for buyers and sellers. It is currently developing the Global Visibility Analytics Network (see section 4.1.2), and will continue to carry out the CGA annually. The RHSC participates in key initiatives on contraceptive supplies, and works in partnership with other major players in the field including the BMGF, CHAI and the Population Council.

FP2020

FP2020 was launched at the 2012 London Family Planning Summit. It is a global partnership of donor and focus country governments, civil society organizations, multilaterals, foundations and private sector organizations collaborating to achieve the target of 120 million additional family planning users in its 69 focus countries by 2020.

FP2020 fosters partner commitments to advance family planning in focus countries through family planning programme development and resource allocation, including donor funding and domestic finance. It supports countries in the development of CIPs to achieve greater access to family planning. To date, 20 countries have developed CIPs or are in the process of doing so.⁴⁰

She Decides

She Decides is envisioned as a global movement to defend women's and girls' rights to take their own decisions on their sexuality and fertility. It was started in 2017 by the Dutch Minister for Foreign Trade and Development Cooperation, as an immediate response to the reinstatement of the Mexico City Policy ('Global Gag Rule') by the Trump administration. Supporters of She Decides include governments, UN agencies, civil society organizations and foundations. She Decides has a Secretariat hosted by the Children's Investment Fund Foundation (CIFF).

Donors have made funding pledges in support of She Decides, but this funding will not be managed or dedicated by the She Decides Secretariat. She Decides is not a new funding mechanism. The donors themselves decide how they will use these funds and will channel them through their existing funding streams. Funding pledged in support of She Decides has been committed to INGOs and UNFPA, as well as other multilateral and bilateral programmes.⁴¹

vii The Prequalification Schemes were developed by WHO in 2001 with the support of UN and other partner agencies. WHO delegated the management of the prequalification programmes for Male Latex Condoms and Copper IUDs to UNFPA in 2005, and the management of the prequalification programme for Female Condoms in 2006. WHO maintains a normative role in setting the guidelines and requirements for the prequalification programmes. See UNFPA Procurement Services (nd) Prequalification Programmes: <<https://www.unfpaprocurement.org/prequalification-programme>>.

NGOs

The principal INGOs working in family planning are Marie Stopes International (MSI), the International Planned Parenthood Federation (IPPF), Population Services International (PSI), and DKT. John Snow, Inc. (JSI) managed the large USAID-funded DELIVER project until it finished in 2016. The current USAID-funded procurement programme, the Global Health Supply Chain Program – Procurement and Supply Management (GHSC-PSM), which includes family planning procurement, is managed by Chemonics.

In-country, national NGOs which provide family planning services may be eligible for supplies procured through the national supply system. This system has been used by IPPF Member Associations and MSI partner organizations in several countries. In transition countries, they often have to procure direct from the manufacturers' distributors or representatives, at higher prices.

Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)

The GFATM provides countries with funds for supplies purchase including condoms, which have a dual purpose of protection against HIV/STI transmission and prevention of unplanned pregnancies. Principal recipients of GFATM funds do their own procurement for supplies, including condoms. Countries are encouraged to participate in a pooled procurement system developed by the GFATM to reduce prices and increase efficiency. The scheme has a web-based procurement information and supply system, which increases transparency.⁴²

Country governments

Country governments are responsible for allocating domestic resources. Some already spend substantial amounts on contraceptive supplies: for example Bolivia, Burkina Faso, Ethiopia and Honduras budgeted significant amounts in 2016 and spent those budgets on contraceptives.⁴³ Participation by country governments in supplies financing is essential for sustainability. Country commitments to budget allocations for family planning are a basic pillar of FP2020 work. UNFPA and USAID, two of the FP2020 core partners, have carried out advocacy for family planning budgets with governments. Monitoring the commitments to ensure budgeted funds are actually spent on family planning commodities is the following step. National NGOs are important players in monitoring and holding their governments to account.

The FP2020 2016–2017 progress report shows that country commitments are growing.⁴⁴ Of the 69 focus countries, 41 have joined the partnership since 2012, including three new countries at the Family Planning Summit in July 2017.⁴⁵

Private sector

The private sector includes:

Contraceptive manufacturers

European manufacturers with WHO prequalified products supplied over 80% of all contraceptives procured by UNFPA in 2016.^{viii} There are also manufacturers of generic products in Europe and in LMI countries. Not all of these are WHO prequalified, and therefore cannot be used by the international procurement agencies, or by many country governments.

Pharmacies, medical clinics and other retailers

These private sector agents are supplied by the commercial networks within countries. There is usually little control over retail prices. In some countries private sector pharmacies and medical clinics have participated in the national procurement and supply chain, enabling the pharmacies to benefit from lower purchase prices which can be passed on to consumers. Some pharmacies are supplied by social marketing organizations.⁴⁶

Health insurance schemes

These may or may not include family planning. Membership of national insurance schemes may be restricted to specific groups such as salaried workers. Private schemes are likely to be too expensive for participation by low-income groups.

Foundations, think tanks, research and technical assistance organizations

The BMGF, CHAI, CIFF and the Guttmacher Institute are key players. Areas of focus include: research and analysis; development of tools and information dissemination; pilot programmes with potential for scale-up; development and promotion of tools and innovative mechanisms for reducing contraceptive prices and smoothing procurement; improvements in service delivery, advocacy and market shaping.

Advocacy organizations and networks

Key players that focus specifically on advocacy for family planning include:

PAI (previously Population Action International), which carries out advocacy with the US Congress and executive branch to protect US funding for family planning, and works to strengthen local partners' advocacy on reproductive rights in the Global South.

Advance Family Planning (AFP), led by the Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health. AFP partner organizations work on advocacy in select countries in Sub-Saharan Africa and Asia to expand access to family planning, in support of FP2020.

Countdown 2030 Europe, which is a European advocacy consortium on family planning and sexual and reproductive health, focused on European donor governments and the EU institutions.

viii The remainder was supplied by the US (3%), India (6%), China (5%), Thailand (2%), and Nigeria, the Democratic Republic of the Congo and 'other' (1%). See UNFPA (2016) *Procurement Statistics 2016*.

3. Current trends in donor finance

3.1 European donors

Countdown 2030 Europe has tracked European policy developments and financial trends on sexual and reproductive health and family planning (SRH/FP) since 2009. The consortium's 2016–2017 tracking report analyses trends in European donor funding for SRH/FP up to 2016, and gives an update on changes to European policy up to 2017.⁴⁷ It looks at policy and funding trends for the 12 European countries that Countdown 2030 Europe partners are based in, and the EU institutions.

The tracking uses a core set of indicators to analyse SRH/FP financing over time. It looks at donor funding of UNFPA (core funding and earmarked funding through UNFPA Supplies); multilateral funding of SRH/FP (a percentage of core funding going to select multilaterals, as well as earmarked SRH/FP multilateral funding); and funding going to international NGOs and initiatives. It does not track bilateral funding for SRH/FP but includes a qualitative indicator on the transparency of SRH/FP bilateral funding.

On policy trends, the 2016–2017 tracking finds that despite increasing influence of conservative voices opposing SRH/FP in European politics, country policies have maintained their support for SRH/FP in principle. On financial trends, it shows that although country policies still support SRH/FP, funding levels have been affected by Official Development Assistance (ODA) cutbacks and by reallocation of funding to meet domestic costs of the 'refugee crisis' in Europe.

Donor funding from the 12 Countdown 2030 Europe focus countries for SRH/FP through all streams that the tracking analyses (i.e. core and earmarked multilateral funding, including UNFPA core funding and funding for UNFPA Supplies, and funding for international NGOs and initiatives) fell from a high in 2014 of €1.228bn, to €1.162bn in 2015 and €1.035bn in 2016. Funding for UNFPA (core resources and UNFPA Supplies) remained fairly steady over the period 2012–2014, followed by a drop of 8% between 2014 and 2015, and a further drop of 11% between 2015 and 2016.

Overall funding for UNFPA (core resources and UNFPA Supplies) from the 12 Countdown 2030 Europe focus countries was €335m in 2016, down from €376m in 2015.⁴⁸ The largest European donors to UNFPA (core resources and UNFPA Supplies) combined in 2016 were the UK (£78m), the Netherlands (€69m), Sweden (€53m), Norway (€43m) and

Denmark (€26m). Looking specifically at donor funding for UNFPA Supplies, the two principal donors in 2016 were the UK (€55m) and the Netherlands (€34m).

EUROMAPPING

Euromapping,⁴⁹ led by Deutsche Stiftung Weltbevölkerung (DSW) and the European Parliamentary Forum on Population and Development (EPF), tracks OECD DAC donor expenditures on reproductive, maternal, newborn and child health (RMNCH) and family planning based on the Muskoka Methodology for RMNCH and a revised version of the Muskoka Methodology for family planning, developed during the Family Planning Summit in 2012. The Methodology applies certain agreed percentages to funding reported to the OECD under certain purpose codes and to selected multilateral organizations. The 2017 Euromapping analyses donor RMNCH and family planning commitments and disbursements in absolute numbers and as a percentage of their total ODA for the years 2012–2015. The latter allows for an assessment of the priority that donors give to RMNCH and family planning in their development cooperation policies.

The 2017 Euromapping shows that in 2015 the US remained by far the leading donor to family planning both in terms of total commitments and share of ODA commitments, followed by the UK and Canada. The EU Institutions, France, Germany and Japan all rank very high in total ODA, RMNCH and family planning commitments and disbursements, but significantly lower when those amounts are assessed as a percentage of their ODA. When looking at the share of ODA commitments allocated to family planning, small European donors stand out: Luxembourg and Ireland allocated more than 1% and 0.77% respectively of their total ODA to family planning.

The Kaiser Family Foundation (KFF) tracks bilateral assistance for family planning as well as core contributions to UNFPA.^{ix 50} It estimates bilateral funding for family planning from the

ix The tracking counts funding as family planning if it meets the OECD Creditor Reporting System purpose code definition, which is "Family planning services including counselling; information, education and communication (IEC) activities; delivery of contraceptives; capacity building and training." It defines bilateral funding as "any earmarked (FP-designated) amount and includes family planning-specific contributions to multilateral organizations [such as UNFPA Supplies]."

major European donors (Denmark, France, Germany, Netherlands, Norway, Sweden and the UK) at US\$593m in 2016, with a reduction in bilateral support for family planning from these donors of 7% between 2015 and 2016. According to the KFF tracking, the largest European bilateral family planning donors were the UK (US\$203m), the Netherlands (US\$183m) and Sweden (US\$93m).

The above figures from the Countdown 2030 Europe and KFF tracking reports analyse donor spending up to 2016. European donor governments made important funding pledges to sexual and reproductive health and rights in 2017, including in support of She Decides as well as on the occasion of the London Family Planning Summit in July. Over €223m was committed in support of the She Decides initiative by six of the Countdown 2030 Europe countries alone.⁵¹ Yet, Countdown 2030 Europe analysis showed that these were not necessarily pledges for additional funds for sexual and reproductive health and rights, and it is too early to say whether these commitments will bring a reversal in longer-term funding trends.

Spending on contraceptives within family planning

Figures for support for family planning quoted above include contraceptive supplies but also other costs, such as capacity building and demand-side work in family planning. It is hard to identify what proportion of the total is spent on supplies, but there are some pointers:

- The proportion of UNFPA Supplies funds spent on contraceptives has varied through the years. It currently stands at 74% of its programme budget.⁵²
- Outside the UNFPA Supplies thematic fund, UNFPA spent 29% of its core funding on family planning.⁵³ This funding may include supplies but is also spent on other elements of family planning programmes including advocacy.
- The RHSC CGA 2018 estimates a total annual spending of US\$2.55bn on contraceptive supplies in the 135 LMI countries (average of spending over the three-year period from 2014–2016), of which 10% (US\$267m) is donor support.⁵⁴
- In bilateral programmes, allocation of funding depends on in-country priorities and may or may not include contraceptive supplies.

UNFPA SPENDING ON FAMILY PLANNING AND CONTRACEPTIVES

At the Family Planning Summit in 2012, UNFPA committed to “double the proportion of its resources focused on family planning from 25% to 40% based on current funding levels, bringing new funding of at least US\$174 million per year from core and non-core funds” which would “include a minimum of US\$54 million per year, from 2013–2019, in increased funding for family planning from UNFPA’s core resources.”⁵⁵

In 2016, UNFPA spent 41.7% (US\$318m) of its resources (core and non-core)^x on family planning. Of this amount, US\$75.6m came from core resources, which represented 29.3% of total expenses from core resources.⁵⁶ The remainder of just over US\$242m came from non-core resources. UNFPA Supplies spending makes up a large portion of UNFPA’s non-core spending on family planning. Family planning spending includes contraceptive supplies, but also other costs such as for training, capacity building, programme implementation etc.

UNFPA Supplies estimates that in 2016, 66% (US\$87.5m) of its total budget went to supplies, including contraceptives and maternal health supplies. As a proportion of UNFPA Supplies’ programme budget (total budget minus the costs of human resources and facility-based Reproductive Health Commodity Security surveys), 74% was spent on commodity procurement.⁵⁷ Actual spending on contraceptives by UNFPA for its own programmes (and Headquarters) in 2016 was US\$78.5m.⁵⁸

It is important to note that fluctuations in exchange rates can have a great impact on the amount of money UNFPA has to spend on commodities, which are procured in US\$.

x Core funding is unrestricted aid and gives UNFPA freedom to define its own spending priorities. Non-core funding is earmarked for specific activities, such as UNFPA Supplies and the Maternal Health Thematic Fund.

3.2 Impact of changes in US funding

The US is the largest global funder of family planning. Its total spending on family planning and reproductive health (FP/RH), including contraceptive supplies, in financial year (FY) 2017 was US\$608m.^{xi 59} Important changes in US funding under the Trump administration are:

Reinstatement and expansion of the Mexico City Policy

In January 2017, President Trump reinstated and expanded the Mexico City Policy ('Global Gag Rule' – GGR) via presidential memorandum.⁶⁰ The policy curtails US family planning funding for any foreign NGO which "perform[s] or actively promote[s] abortion as a method of family planning," which includes the provision of abortion services, counselling or referral information, and abortion advocacy, using funding from any (non-US) source.^{xii 61} It has been alternately reinstated by Republican administrations and revoked by Democratic governments since 1984. The new expanded policy, renamed as 'Protecting Life in Global Health Assistance', now applies not only to family planning funding, but also to the vast majority of global health funding from the US, including HIV/AIDS funding.⁶² Abortion care in cases of rape, incest and when the woman's life is endangered are excluded from the GGR.⁶³

It is not clear whether the GGR will result in an overall reduction of funds for family planning or a redistribution of funding through different channels. Governments in LMI countries funded by the US are not affected by the GGR and should continue to receive their contraceptive supplies.^{xiii} Multilaterals including UNFPA are also not subject to the GGR.⁶⁴ US NGOs are not directly subject to the GGR, but have to ensure that they do not provide assistance to any foreign NGO sub-recipients that have not agreed to the policy.⁶⁵ However, NGOs that use a rights-based approach to sexual

and reproductive health including abortion, such as IPPF and MSI, will be affected and may have to close some programmes or transfer them to other organizations. The impact at country level will depend on how much of the national family planning work is carried out by NGOs.⁶⁶

Invocation of the Kemp-Kasten Amendment

In March 2017, the Trump administration invoked the Kemp-Kasten Amendment to withhold FY2017 funding for UNFPA, determining UNFPA's activities in China as in violation of the amendment.⁶⁷ The Kemp-Kasten Amendment, first enacted in 1985, states that no US funds may be made available to "any organization or program which, as determined by the president of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization." The Kemp-Kasten Amendment may be invoked against any organization or programme, yet so far it has only been applied to UNFPA. There is no evidence to support the claim that UNFPA supports coercive abortion or involuntary sterilization in China.⁶⁸

The FY2017 determination meant a withholding of US core support to UNFPA expected to amount to US\$32.5m that year as well as of further funding for specific project activities. It has not meant funding cuts for UNFPA Supplies, which is not a recipient of US funding. The US State Department made a further determination that UNFPA was in violation of the Kemp-Kasten Amendment in March 2018 for FY2018.⁶⁹ Including this latest determination, the Kemp-Kasten Amendment has been applied to UNFPA in 17 of the last 34 years.⁷⁰

Under current US law, the funds withheld from UNFPA have to be spent on other family planning, maternal health and reproductive health activities. This requirement was first applied in 2002 when the Kemp-Kasten Amendment was activated by the Bush administration. It was again applied by Congress in 2017 and 2018.⁷¹

xi The US\$608m figure includes the intended US contribution to UNFPA, which was withheld due to the Kemp-Kasten Amendment.

xii Since the 1973 Helms Amendment to the Foreign Assistance Act, US law has prohibited the use of US aid to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practise abortion.

xiii The US does not give funds to countries for supplies, but provides the supplies in kind through its own procurement system.

Pressure on US funding for family planning

The Trump administration proposed to cut all bilateral and multilateral funding for FP/RH for FY2018. Yet, the omnibus spending bill for FY2018 passed by the US House and Senate in March 2018 preserved funding for FP/RH at the FY2017 level of US\$607.5m, including US\$575m for USAID bilateral FP/RH programmes and a US\$32.5m contribution to UNFPA (which will be withheld due to the administration's Kemp-Kasten Amendment determination).⁷² PAI credits family planning supporters within the House and Senate Appropriations Committees for achieving this favourable outcome for FP/RH in the current adverse political environment.⁷³

Pressure on US funding for FP/RH can be expected to continue over the coming years. The Trump administration FY2019 budget request, released in February 2018, proposed a 50% cut in funding for FP/RH.⁷⁴

Other possible implications of the changes in US policy include:

- *'Chilling effect' of the GGR on other donors, country governments and foundations.* In order to avoid any problems with ongoing and potential future US funding, some of these stakeholders may move away from financing organizations or consortia which work in family planning and have a rights-based approach to sexual and reproductive health including abortion, such as IPPF and MSI. Safe abortion programmes may be pushed out by country governments and other stakeholders to avoid problems. At country level, participation of such organizations in national coordination and supplies planning mechanisms may also be affected. US-funded programmes have also been delayed.⁷⁵
- *Compliance with the new US requirements will cost organizations more time and effort.* This will be the case both for organizations that must comply in their programming and for prime recipients, which must ensure that sub-recipients are compliant.
- *Reduction in State Department personnel and the technical capacity of US missions overseas to provide support to in-country family planning programmes.* USAID missions overseas are key elements of technical assistance provided to countries alongside financial contributions. Mission staff have been important, for example in the promotion and establishment of reproductive health commodity security committees and other coordination mechanisms. The skills and experience of these people may be harder to replace than the contraceptive supplies.

Despite these developments, USAID continues as a core convenor of FP2020 and is still a full and active member with family planning focal points at country level. And in countries where NGOs that are no longer eligible for US funding due to the GGR participate in national supply coordination mechanisms, they may still be able to receive US-funded contraceptive supplies through government channels.

4. Processes of supplies procurement and financing

4.1 Global procurement processes, structures and initiatives

4.1.1 Processes and structures

Public sector procurement

Public sector procurement by donors and multilaterals is restricted to products that have WHO prequalification to guarantee their quality. UNFPA manages the prequalification process for male and female condoms and IUDs for WHO.⁷⁶ Public sector procurement may also include products that have been approved by the WHO Expert Review Panel (ERP), which provides temporary approval for products that are close to prequalification. UNFPA manages the ERP process for reproductive health medicines.⁷⁷

In addition to WHO prequalification, each country has its own registration process for contraceptives. Manufacturers are responsible for registration and have to bear the registration costs. Fulfilling country registration requirements can be a slow and expensive process, and for small countries the market size often does not justify the expense for manufacturers.

At global level the largest public sector procurers are USAID, which procures for its own programmes, and UNFPA, which procures for both its own programmes and for third parties, including donor and country governments.

Other multilaterals do their own procurement. For example, the GFATM has developed a pooled procurement system, including for condoms, which can be used by its grant recipients.⁷⁸ Some INGOs and their national member organizations also do their own procurement.

USAID procures through its central procurement programme and disburses contraceptives in kind to country governments. US missions also allocate funds to countries for family planning, but procurement is done through the USAID system.

Given its high volumes, USAID is usually more cost-effective and can get lower prices than most country governments. The current USAID supply programme (Global Health Supply Chain Program – Procurement and Supply Management [GHSC-PSM]), administered by Chemonics, was reported to have management problems leading to long lead times for delivery and risking important stock-outs at country level.⁷⁹

LMI country governments

LMI country governments may procure through UNFPA Procurement Branch or directly from manufacturers. Countries can also spend their own funds on non-WHO prequalified products from local and regional suppliers.

In some decentralized countries, regional, provincial and municipal governments do their own procurement. This often results in higher prices and inefficiencies. Ethiopia and Bolivia are examples of countries where administration is decentralized but procurement remains centralized.⁸⁰

NGOs

The large INGOs have their own central procurement processes. Their country partners may use these systems or may participate in national coordination systems which give them access to national supply chains. Some procure for themselves at national level. Independent procurement often results in higher prices and can be a major problem for NGOs in countries that have graduated from donor aid and are no longer eligible for price discounts.

Private sector

The private sector, such as medical clinics and pharmacies, procures from manufacturers' country distributors or agents. The private sector is sometimes included in government supplies coordination mechanisms and may be eligible to receive supplies through the government procurement

structure. The private sector generally has to pay higher prices for procurement than the public sector.

4.1.2 Initiatives at global level

Better market information

The RHInterchange is a database of information on procurement and shipment of contraceptive supplies for more than 140 countries. It includes more than 80% of contraceptive supplies procured with donor funds over the last few years, worth more than U\$2.7bn.⁸¹ The data is supplied by the large donors and other procurers including USAID, UNFPA, IPPF, MSI and PSI.

The Coordinated Assistance for Reproductive Health Supplies (CARhs) group of RHSC coordinates efforts to cover urgent shortfalls in contraceptive supplies. It identifies problems and their causes, and develops and applies solutions wherever possible. Core members are UNFPA, USAID, the West African Health Organisation (WAHO), CHAI, and the RHSC Secretariat, with additional participants where necessary.⁸²

In contrast to CARhs' work to address problems that have already occurred or are about to do so, the Coordinated Supply Planning (CSP) group of RHSC aims to help avert stock-outs and duplications (i.e. preventive rather than curative). It was set up in 2012 to improve supplies flows through coordinating forecasts and supply plans of the major donors and the countries they support. It develops joint forecast and supply plans with UNFPA and USAID, coordinates with manufacturers to facilitate production management, and monitors order volumes to ensure they fulfil the conditions for price reduction agreements. It monitors both orders and flows, and makes recommendations to procurers and countries for adjustments when necessary. It also monitors stocks together and advises on potential stock-outs or duplication of supply, and facilitates product transfers between countries if appropriate.⁸³ To date, the group has concentrated on injectables and implants. The system is still manual and time-consuming, but should be automated when the Global Family Planning Visibility Analytics Network (VAN) comes into operation.

The Global VAN will use supply chain data from multiple sources (including manufacturers, procurers and freight forwarders) for better decision-making. Stakeholders and procurers will be able to coordinate forecasts of needs and track progress of orders and shipments in real time. With better information on commodity use and better forecasting, manufacturers will be ready for orders, and the system should help reduce wastage and time lags. The Global VAN is currently at pilot stage. It is hosted by the RHSC and funded by the BMGF, with UNFPA and USAID contributing resources for designing and testing the system. VANs at country level are also being explored to improve national supply chain work.⁸⁴

Pooled procurement

Pooled procurement enables larger orders and gives good leverage for negotiating price reductions with manufacturers, who can reduce prices when they have higher production volumes. It is the basis of price reduction initiatives, such as for Sayana® Press and under the Implant Access Program (see page 25). It can also be applied at country level (a) if the public, private and NGO sectors do joint planning and pool their procurement, and (b) if regional/provincial governments pool their requirements in decentralized countries. At regional level, countries can pool procurement to reduce prices. The countries that are part of the Organisation of Eastern Caribbean States (OECS), for example, set up a joint pooled procurement agency, the Pharmaceutical Procurement Service, which pools product orders from the participating small island economies, including for contraceptives.⁸⁵ The West African Health Organization (WAHO) and KfW set up a Regional Financing Mechanism of Reproductive Health Commodities for countries in the Economic Community of West African States (ECOWAS) region. KfW provided funding for piloting the mechanism and an associated product purchase fund in five countries. Ministries of health in these countries were required to collate commodity requests from actors in the public and private sectors and NGOs and submit a joint annual request to WAHO for approval.⁸⁶

Commodity price negotiations

The Implant Access Program (IAP), launched in 2013, was developed in collaboration between BMGF, CHAI, CIFF, DFID, the Norwegian Agency for Development Cooperation (Norad), the Swedish International Development Cooperation Agency (SIDA), UNFPA and USAID, who worked with the suppliers of two implants (Jadelle®, manufactured by Bayer, and Implanon®/Implanon NXT®, manufactured by Merck).⁸⁷ Prior to the IAP, demand for implants was fragmented, leading to volatility in ordering and making it difficult for the manufacturers to programme efficient production. This resulted in high prices. Under the IAP, four donors (BMGF, CIFF, Norad and SIDA) agreed to guarantee a specified volume of orders; in response, Bayer and Merck agreed to reduce prices for the 69 FP2020 priority countries. The initial agreement has been extended and will now continue to 2023.⁸⁸

Besides the price reductions, the IAP partners have also worked with other organizations to support health worker training in implant insertion and removal and counselling, improve service quality, strengthen supply chains to ensure availability of the implants at health facilities, and raise community awareness of the products.⁸⁹

The Sayana® Press initiative is another price reduction scheme.⁹⁰ Sayana® Press is a new low-dose subcutaneous injectable packaged with a built-in syringe for easy administration. Under the initiative, donors and institutions (including BMGF, CIFF, DFID, USAID and UNFPA) have undertaken to support introduction of the product in-country; in return, the manufacturer – Pfizer – has agreed to lower the price. The reduced price is only available to FP2020 priority countries. PATH has been involved in pilot schemes to introduce Sayana® Press in selected African countries.⁹¹

Critics of the time-bound price reduction initiatives point out that the low prices can distort markets, skew method mix in favour of the products which are included, and cause obstacles to market entry for new manufacturers. With very few manufacturers, supply is very vulnerable to market failures, and there is also a danger that once the markets are established the manufacturers will have less incentive to maintain low prices and renew the agreements in the future.

Smoothing volatility of orders and improved forward planning

Bridge funding mechanisms can reduce dependence on the timing of donor disbursements and enable better forward planning. Unpredictability of funding flows from donors has meant that UNFPA and other large public sector procurers such as country governments cannot provide the forward information manufacturers need to smooth their own supplies ordering and reduce production costs. Reliable information on future orders enables manufacturers to negotiate with their raw materials suppliers, and is a key element in commodity price negotiations between manufacturers and public sector procurers. A bridge funding mechanism has been developed for UNFPA Supplies (see section 5.2). The idea may be extended to national level to allow countries to smooth their own purchase orders over time.

4.2 National procurement processes and supply chain structures

At national level the supply chain to get contraceptives to users at facility or pharmacy level includes the processes of:

- forecasting/planning,
- procurement,
- warehousing and
- distribution.

The public sector contraceptive procurement and supply chain is normally integrated into the national health sector system. Some countries' national supply chains are also used by NGOs and private sector entities that participate in planning and coordination mechanisms. This was a key idea promoted by the USAID DELIVER programme's work in the Americas.⁹² Coordination mechanisms (including the public sector, NGOs, donors and UNFPA) were set up in several countries, and non-public sector participants benefited from the access this gave them to supplies from the public sector supply chain. To work sustainably, this requires excellent coordination between sectors, which can be difficult to achieve.

The supply chain processes should be country led, but capacity building is often needed. As contraceptives are integrated into the overall health systems supply chain, this type of donor support usually has spin-off benefits for the whole health system.⁹³

Forecasting/planning

Forecasts are estimations of the quantities of supplies required to meet expected demand. Supply planning establishes the quantities to be procured taking into account existing stock and orders, funding available etc.

Donors have, for example, supported work to improve monitoring and information systems, and UNFPA Supplies carries out surveys on contraceptive availability and stock-outs at facility level. USAID's DELIVER programme helped countries develop sector-wide coordination mechanisms for forward planning.

Procurement

Governments

Contraceptives procurement with donor funds is carried out by UNFPA or USAID and the contraceptives are shipped to countries in kind. Countries also procure directly through UNFPA Procurement Services with their own and with donor or loan funds.

Countries also procure direct from manufacturers at regional or national level. This may include procurement of products which are not WHO prequalified. Procurement prices for prequalified products are generally lower through UNFPA, however countries can buy generic and non-prequalified products directly at cheaper prices.

Some countries develop their own specific procurement models. In Bolivia, a ring-fenced^{xiv} revolving fund was set up with an initial donation of supplies from UNFPA as 'seed capital'. Decentralized public sector buyers in provincial



xiv 'Ring-fenced' funds cannot be used for other purposes.

governments purchase from the central national warehouse and reimburse the revolving fund. The central stores are replenished by the normal national procurement system.⁹⁴

Contraceptives procurement is usually part of the normal national medical procurement. UNFPA has worked in many countries to get contraceptive supplies into essential medicines lists, which means they are included in national budgets and have higher priority.

NGOs

NGOs at country level may procure through their parent organizations, such as IPPF, MSI and PSI, or buy direct from suppliers, which is an expensive option. In some countries, national NGOs participate in the national coordination mechanisms and receive supplies through the public sector systems.

Private sector

Private sector stakeholders usually procure directly from manufacturers' distributors or agents, or are supplied by social marketing organizations. In some countries, the private sector participates in the public sector supply chain and procurement processes.

As highlighted above, pooling government, NGO and private sector procurement can reduce prices through larger orders.

Warehousing and distribution

This is usually done by the public sector using a central warehousing system and government or government-contracted distribution.



4.3 Procurement problems at global and country levels

At global level, the main procurement problems are:

Long lead times and delays, which can lead to stock-outs at country level:

Long lead times and delays in the global procurement systems affect shipping and availability of supplies in-country. UNFPA Supplies is improving its lead times using the mechanisms described above. USAID has experienced difficulties with its current procurement and supply system. Lead times were reported to be long and deliveries delayed, leading to danger of stock-outs at country level.⁹⁵

Volatility of funding flows and orders, which means manufacturers cannot optimize their production costs:

Order scheduling by UNFPA and at country level is affected by the availability of funds from donors and from national budgets. A bridge funding mechanism for UNFPA is expected to improve this.

Delays and uncoordinated planning can lead to stock-outs in some places and duplication in others. The RHSC CSP group is working to reduce these problems.

Exchange rate fluctuations, which affect the amount of US\$ available for procurement:

Exchange rate fluctuations exacerbate the volatility of donor funding and affect the buying power of domestic procurement funds. Most international procurement is denominated in US\$.

At country level, important problems are:

Insufficient or unreliable information on stocks, consumption and real levels of need:

Poor information on consumption and stocks, and poor quality projections of future needs can result in inappropriate volume and mix of contraceptive orders, and incorrect scheduling.

Legal restrictions on up-front payment by governments, which mean that these countries cannot use UNFPA as a procurer and benefit from UNFPA's low prices:

Some countries' laws only allow the public sector to pay for supplies once they have been received in-country. This means they cannot pay for orders up front, as required by UNFPA. As a result, they have to procure through more expensive channels. The Pledge Guarantee for Health (see section 5.2) was designed to overcome this problem and had some success in raising loans for contraceptives procurement, but the scheme has now folded. Prices on procurement by governments direct from manufacturers can be high, and there may be quality problems in products without WHO prequalification.

Poor quality planning and lack of coordination between sectors for pooled procurement:

Lack of coordination between the public, NGO and private sectors in-country may make it impossible to pool procurement and obtain better prices from manufacturers for larger volumes.

Promotion of specific contraceptive methods, leading to market distortion:

Promotion of specific contraceptive methods by governments and donors may distort the market and lead to procurement of a more expensive method mix.

Further challenges include poorly designed supply chain systems which lead to unnecessary stock-outs, and lack of resource allocation and infrastructure to ensure commodity delivery and availability at all service delivery points.

The role of donors in country-level procurement:

Donors of contraceptive supplies have allocated resources to supply chain strengthening at global and at country level, to complement their donations of contraceptives and improve the systems' capacity to get the products to the women and girls who need them. The systems are complex and a failure to focus on the supply and service delivery mechanisms reduces the efficacy of the contraceptives donations. USAID and UNFPA have both worked in supply chain strengthening for many years.^{xv} The RHSC, BMGF and CHAI are also very active participants.

xv For extensive information on their support for supply chain strengthening, see the UNFPA Supplies and GPRHCS annual reports, as well as the annual reports of the USAID DELIVER programme.

5. The role of donors, focusing on European donors

The main donors, their policies, level of funding, and the financing modalities they use for family planning were summarised in earlier sections. This chapter looks in more detail at how the financing modalities work.

5.1 Donor activities

Activities supported by donors are:

- Filling the gap in contraceptives supply at country level – this is done through UNFPA Supplies, USAID, and direct donor contributions in the form of grants or loans.
- Improving international information flows and transparency of procurement processes, to help avoid stock-outs and/or duplication of orders (such as through the RHSC CSP group and the RHInterchange).
- Providing technical support and negotiating deals at global level, for example pooled procurement, volume guarantees to manufacturers, negotiation of contraceptive price reductions and bridging finance to smooth procurement.
- Supporting development of sustainable reproductive health commodity security processes and structures at country level through supply chain strengthening, capacity building and technical support to improve efficiency and efficacy. UNFPA Supplies and USAID are both major players. Both aim to support countries in transitioning from dependence on donors to sustainable national systems.
- Advocacy to increase country ownership and commitment. This is a focus of FP2020. UNFPA Country Offices are major advocacy players, and have been successful in getting country commitments to family planning.
- Providing contraceptive supplies in humanitarian and emergency situations. The UNFPA-managed reproductive health kits for use in crisis situations include a range of contraceptive options.

- Market shaping – “activities that seek to proactively influence the dynamics of a given market.”⁹⁶ This includes interventions concerned with choice, equity and sustainability and may include interventions to lower prices, and also to ensure competition between manufacturers.

European donors finance all these activities. Some donors focus specifically on commodity supply, which gives more tangible and visible results than more integrated approaches. Other organizations also propose a specific focus on contraceptive supplies on the grounds that donors can only have an impact on some elements of sexual and reproductive health and rights and that focusing on contraceptive supplies will at least help solve one important problem area.

Other donors are more interested in the integration of family planning within support for sexual and reproductive health and rights or broader health projects rather than ‘silo-ing’ it as a separate area for support, and in increasing country ownership for family planning through bilateral funding. In bilateral support, the donor country agrees an overall programme with the recipient country, which should be based on the latter’s priority development areas. This means the recipient countries themselves decide whether and how much funding should go to family planning.

5.2 How donors channel their financial support to countries

The principal financing modalities used by European donors for contraceptive supplies are:^{xvi}

- bilateral
- multilateral
- multi-bilateral
- loans (including World Bank and bilateral loans; the GFF is an example of a mixed grant/loan scheme)
- volume guarantees
- partnerships with the private sector
- pledge guarantee funds
- bridging finance mechanisms
- direct support for NGOs

Other modalities that may be applicable to contraceptive supplies financing include:

- results-based financing
- development impact bonds
- co-financing

This chapter describes each of these mechanisms, with a critical analysis of its advantages and disadvantages based on information from the document review and discussions in the key informant interviews. Table 6 at the end of this section summarizes the identified positive and negative aspects of each modality.

Bilateral

In bilateral funding, donors identify the priority countries they will support and disburse their funds directly to the recipient country's public sector or NGOs. In government-to-government bilateral flows, donors and recipients agree on the priority areas, and the recipient government is responsible for implementation.

The percentages of aid flows from European countries provided in the form of bilateral aid vary widely between individual donors, ranging from 14% to 64% in 2013.⁹⁷ Whether contraceptives are included depends on the recipient's priorities. Figures of the bilateral spend on family planning by European donors were given in section 3.1 but it is difficult to identify or track financing for contraceptive supplies within this total.

Multilateral

In multilateral funding, donor countries channel their support through multilateral organizations (such as UN agencies and funds, the World Bank's International Development Association and the GFATM). This aid is core support for the multilateral agencies, which determine their own programmes and priorities, often in consultation with the donors who may sit on their governing bodies.

Percentages of European donors' ODA provided in the form of multilateral aid vary widely, accounting for between 16% and 83% in 2013.⁹⁸ Amounts spent on family planning can usually be identified, but specific spending on contraceptives is difficult to estimate.

Funding flows from donors to UNFPA are the most important multilateral flows for family planning. Core funding from European donors for UNFPA was US\$275m (of a total of US\$353m in core funding contributions) in 2016, with Sweden, Norway and the Netherlands as the largest donors.⁹⁹ In 2016, UNFPA spent 29.3% of its core funding on family planning.¹⁰⁰

xvi These categories are not necessarily mutually exclusive. For example, loans are often an element of bilateral funding and support for NGOs may be included in multilateral donor funding.

Multi-bilateral

Multi-bilateral funding (between 0% and 29% of spending of European donors in 2013),¹⁰¹ is earmarked, non-core contributions by donors to multilateral organizations. This enables donors to specify more precisely how their funds are to be spent. Spending on contraceptives can be identified in multi-bilateral financing of thematic funds such as UNFPA Supplies.

European donors provide the vast majority of UNFPA Supplies' funding. In 2016, European donor contributions to UNFPA Supplies comprised US\$67m from the UK and US\$36m from the Netherlands, as well as smaller contributions from the European Union (US\$3m); and Luxembourg, Spain, Portugal and Liechtenstein (combined contribution of US\$700,000).¹⁰² Combined European donor contributions amounted to US\$107m, out of a total of US\$113m in donor contributions to the programme.

Comparisons between bilateral and multilateral channels have shown that bilateral funding can be more politicised whereas multilateral funding tends to be more responsive to recipient country needs.¹⁰³ There is a trend towards including family planning in bilateral aid, which gives more country 'ownership', however there is no guarantee that funds will actually be spent on contraceptives, which may fall through the gaps. Evidence on relative efficiency of the different channels is inconclusive.¹⁰⁴ Earmarked funding for any organization can lead to distortions in organizational priorities.

Global Financing Facility

The Global Financing Facility (GFF) is a financing mechanism in support of reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH+N). It was launched at the Third International Conference on Financing for Development in 2015. The GFF's Secretariat is based at the World Bank.

The GFF has a multi-donor Trust Fund, which, as of July 2017, had received contributions of approximately US\$575m from Canada, Norway, the UK, the BMGF and MSD for Mothers.¹⁰⁵ In September 2017, the GFF launched the first replenishment of its Trust Fund with a US\$2bn funding target. Further contributions have since been announced by the BMGF (US\$200m), Japan (US\$50m) and Denmark (US\$4m).¹⁰⁶

The GFF Trust Fund provides grants that are blended with loan finance from the World Bank's International Development Association (IDA) or International Bank for Reconstruction and Development (IBRD).^{xvii} The GFF further aims to mobilise additional resources for RMNCAH+N from domestic government and private sector resources and external donor resources. GFF countries are expected to identify priorities for GFF funding in Investment Cases developed in inclusive, country-led processes bringing together all RMNCAH+N stakeholders.

An inclusion of family planning in Investment Cases depends on whether it gets prioritised in country processes. Family planning has been included in Investment Cases developed so far, but this is not a guarantee that it will receive funding through the GFF Trust Fund and IDA/IBRD or through other funding sources. Several of the World Bank Project Appraisal Documents (PADs), which determine activities funded by GFF Trust Fund and IDA/IBRD resources, were approved ahead of the finalisation of the respective Investment Cases; and a review of some of the early Investment Cases and PADs showed that a prioritisation of family planning in Investment Cases did not necessarily translate into funding allocated to this area through the respective PADs.¹⁰⁷ Information on resources mobilised in support of Investment Cases from funding sources other than the GFF Trust Fund and IDA/IBRD is not made available systematically.

The GFF currently works in 26 focus countries. It hopes to expand to a further 24 of the 67 eligible countries over the 2018–23 period. It expects to contribute significantly to closing the funding gap for RMNCAH through efficient financing, mobilising more domestic government as well as private sector resources, and attracting more ODA.^{xviii 108}

xvii IDA provides long-term loan finance to low-income countries at reduced interest rates; IBRD loans are aimed at middle-income countries, and are provided at market rates.

xviii The GFF suggests that "the 'savings' from the GFF approach (the difference in the resource gaps between a scenario with the GFF and one without) would amount to US\$83.5 billion over the period 2015–30."

It is too early to make a judgment on the success of the scheme. Some concerns have been raised, including:

- Unsustainability of financing consumables such as contraceptives through loans rather than real mobilisation of domestic resources. Contraceptive supplies are consumed and have to be purchased every year. Purchase of consumables with loan funds can lead to an increasing debt burden for recipient countries.
- Danger that linking grant (GFF Trust Fund) and loan (IDA/IBRD) resources may inadvertently lead to higher out-of-pocket spending, as countries struggle to repay the loans.
- It is not clear whether the loans are providing additional funding for family planning, or substitute other government resources.
- It has been difficult to track funding mobilised by the GFF, and to understand how much of the funding actually goes to contraceptives.
- Although the GFF has potential to raise more family planning funding through World Bank loans and funding from other sources, there is a downside risk. If donors reallocate from direct support for family planning to the GFF, their family planning funds will be diluted and overall family planning funding may go down.¹⁰⁹
- There has been insufficient civil society participation, essential to ensure inclusion of core rights-based principles and accountability. This may be remedied through an implementation of the GFF Civil Society Engagement Strategy, which was adopted in 2017.

The GFF is a new financing modality supported through the World Bank. Loan requirements are complex, as is the process for in-country participation and the process for raising complementary funding. However, the GFF does have potential to mobilise funds and contribute to filling the contraceptives financing gap.

Volume guarantees

Volume guarantees are agreements between a guarantor and a supplier to maintain agreed procurement volumes in exchange for price reductions. If the procurers do not reach the agreed volume, the guarantors undertake to finance complementary orders.

The Implant Access Program (IAP), started in 2013, is based on a volume guarantee backed up by four donors.¹¹⁰ At the time of the launch of the IAP, implants had only a small market share due to high prices in comparison with other contraceptives, and insufficient availability in-country. Small quantities and fragmented procurement led to unfulfilled demand, and there were insufficient trained service providers to scale up service provision. Small and volatile procurement volumes meant that manufacturers could not plan ahead and optimise production, leading to higher prices.

The IAP guarantors were the BMGF, CIFF, Norad and SIDA, working in partnership with CHAI, DFID, UNFPA and USAID, who supported implementation to increase accessibility. The manufacturers were Bayer (Jadelle®) and Merck (Implanon®/Implanon NXT®). The partners negotiated a volume-guaranteed price reduction of around half the previous cost of the products for the 69 FP2020 priority countries. As UNFPA and USAID cannot participate in multi-year guarantees due to legal constraints, a grant from BMGF enabled development of better market information to improve UNFPA and USAID forecasting and coordination of their supply planning to make sure volumes were met. The scheme is supported through the RHSC CSP group.

The IAP is suggested to have had positive results for all participants: donors, manufacturers, countries and implant users.¹¹¹ Guaranteed volumes have enabled the manufacturers to optimise their production, reduce costs and lower prices. The manufacturers have agreed to extend the scheme to 2023. To date, the guarantors have not had to step in, so although donor money is available if necessary there has been no need to use it.

In common with other 'market shaping' initiatives, there is a danger that the lower prices of volume guarantee schemes will stifle competition from other manufacturers. The IAP and other price reduction schemes for specific methods can also skew method mix.

Partnerships with the private sector to reduce contraceptive prices

Donors have collaborated with contraceptive manufacturers to introduce new products and reduce prices. A group of donors and institutions, including the BMGF, CIFF, DFID, PATH, UNFPA and USAID, and country governments have worked together with the manufacturer Pfizer to introduce the new product Sayana® Press (a lower-dose injectable with a built-in syringe) at a reduced price in selected FP2020 priority countries.¹¹² The donors have undertaken to support country governments' introduction of the new product (including through supporting awareness raising, service provider training etc.). This will help establish a market for the manufacturer, who has responded by offering lower prices.

Stakeholders suggest that the partnership brings positive results for all participants. The manufacturer benefits from collaboration in introduction and demand creation, and the donors, country governments and ultimately the users benefit from lower prices.

The Contraceptives Security Initiative, launched in 2010, was a partnership between USAID and Bayer to position Microgynon® Fe, a contraceptive pill, in the commercial market in 11 African countries.¹¹³ USAID funded Bayer's marketing and promotion costs and in return, Bayer lowered the price, placing the product in retail pharmacies and the private sector supply chain. Bayer still markets the product at a reduced price in the pilot countries, suggesting that the initiative has had positive results and that the market is sustainable.

As these types of initiatives are seen as beneficial for all the collaborating parties, they are likely to continue. However, there are risks in using public funding in the commercial sector, and safeguards have to be in place to make sure the funds are used for the public good rather than simply for commercial gain.¹¹⁴

Pledge guarantee funds

The Pledge Guarantee for Health (PGH) was a bridging finance mechanism to enable recipients to use donor funds before they were disbursed.¹¹⁵ It made donor pledges 'bankable' i.e. they could be used to raise credit to purchase supplies. The aim was to avoid procurement delays and stock-outs due to slow funds disbursement.

The PGH was set up under the auspices of the RHSC in 2009. It was hosted at the UN Foundation for a pilot funded by the BMGF, before it became an independent entity. In 2013, SIDA and USAID provided a five-year US\$50m guarantee, which was to allow the PGH to leverage up to US\$100m in credit from commercial lenders. Once a donor issued a pledge for future funding, the PGH gave a guarantee to a private sector lender for 50% of the funding. The lender then gave credit for the full amount to the recipient of donor funds, who could start procurement immediately instead of having to wait until the donor funds arrived. When the donor funds were disbursed the lender was repaid. As the commercial lender put in 50% of the funding, it was sharing the risk that the donor would not fulfil its pledge.¹¹⁶ The PGH negotiated up front discounts with suppliers, which effectively covered the financing costs of the credit.

The scheme was used to facilitate the purchase of contraceptives for Ethiopia and the Philippines. It was also used for a range of purchases in the wider health sector. Experience suggests that there were advantages and disadvantages.

Advantages:

- Rapid use of funding pledges, avoiding delays waiting for donor disbursements. This stabilises aid flows and increases predictability.
- Consequently, better planning of procurement and smoothing of commodity flows, as the recipient has control over the timing of the orders.
- Low cost, as financing costs are offset by manufacturer discounts.
- Leverages bridging finance from the private sector.

Disadvantages:

- A fairly complex instrument that may be difficult for recipient countries and organizations to fully exploit.
- Difficulty in motivating recipients to raise loans. This may be due to the perceived risk, and the overall complexity of the scheme.

UNFPA Supplies Bridge Funding Mechanism

The UNFPA Supplies Bridge Funding Mechanism (BFM) was set up by UNFPA with support from DFID and the BMGF as an alternative to the pledge guarantee scheme. As a UN agency, UNFPA is not permitted to use donor pledges as collateral for commercial loans and therefore could not participate in the PGH. Without bridging finance, UNFPA has to wait for donor funds to actually be disbursed before it can procure, so it cannot always provide the supplies to countries when they are needed. Like the PGH, the BFM scheme is aimed at smoothing availability of donor funding for procurement, and hence reducing supply delays and stock-outs.

The BFM will have a revolving fund of cash or cash-equivalent guarantees of up to US\$80m, which can be used for procurement in the period between donor pledges and the actual arrival of their funds.¹¹⁷ It will be used in procurement for the UNFPA Supplies priority countries. Once the donor funds arrive, the revolving fund will be reimbursed.

More predictability and smoothing of procurement in time should lead to lower prices from manufacturers, and should reduce the high cost of stock-outs currently incurred by UNFPA. The scheme may also enable UNFPA Supplies to make multi-year commitments to countries, which would be valuable for forward planning.

The BFM was operationalized in early 2018, and stakeholders have high expectations that it will reduce delays and lead times. It is hoped to extend the scheme to countries, which have the same problems of time gaps between the availability of donor funding and the need to purchase contraceptives.

Support for NGOs

Donor support for family planning is also channelled through large INGOs and their national member organizations. As mentioned, INGOs and their member organizations use a range of procurement processes. Some member organizations procure from the INGO central procurement system, others are included in national procurement systems and get their contraceptives from the national supply chain, and others, especially in transition countries, do their own procurement in the private sector, which is generally the most expensive option.

Donors have also, for example, supported a parallel procurement system for contraceptive supplies in Uganda.¹¹⁸ Donors have withdrawn their support from the public sector supply chain, instead channelling their donations through the 'Alternative Distribution Mechanism' administered by the Uganda Health Marketing Group, a Ugandan non-profit organization. The system distributes free contraceptive supplies to non-profit, for-profit and faith-based organizations throughout the country. Organizations that use the system are reported to be satisfied.¹¹⁹ On the downside, withdrawal of donor support from the public sector means that women who rely on public sector facilities for their contraceptive supplies will be affected.¹²⁰

Other modalities

Other modalities that may be applicable to contraceptive supplies financing include:

Results-based financing mechanisms

Results-based financing mechanisms focus on achievement of agreed results rather than the traditional ODA focus on input or short-term outputs. The donor undertakes to pay the recipient on achievement of the results. Results-based programmes need clear and measurable results and outcomes, as well as good monitoring systems.

The World Bank has used results-based financing for health programmes, which often include family planning as part of a primary health care package in the public sector. Programmes have been designed at national level and at facility level, using a mix of loan and grant money together with domestic government funds. Results-based financing based on results at facility level is to help ensure that the funds get to facilities and that service quality is good.

UNFPA Supplies is currently investigating the potential of results-based financing. One problem in results-based schemes for family planning is the risk of coercion if specific family planning targets form part of the agreed results. Many stakeholders avoid the use of targets in family planning, as they may encourage health providers to over-promote family planning and not respect potential users' right to free choice on whether to use family planning, and which method to choose.

Development impact bonds

Development impact bonds (DIBs) are a results-based mechanism which uses private loan capital to invest in social programmes. The investor provides up-front funds that the implementers (often NGOs) use to establish and run the programme. When the agreed results are achieved, the private investor is reimbursed with interest by the 'outcome funder', who may be a donor, a foundation or a country government.

DIBs are a means of obtaining private sector capital for development. As the initial capital is provided by the private sector investor who is only reimbursed if the programmes achieve the expected results, DIBs transfer risk from governments to the private sector. The instruments are complex and difficult to set up. A maternal-newborn health DIB has just been launched in Rajasthan, India, with participation by USAID, UBS Optimus Foundation, Palladium, PSI, Hindustan Latex Family Planning Promotion Trust and MSD for Mothers.¹²¹ This is the first DIB in health, and it is not yet clear whether DIBs are suitable for family planning work. However, some major donors, such as DFID and USAID, are interested in their potential.¹²²

Co-financing

Co-financing is a method of stimulating national government contributions to supplies and easing countries' transition to self-sufficiency. GAVI uses a co-financing model for vaccines, only releasing its own donations of vaccines when the recipient country has contributed its own agreed share. The share paid by country governments increases as they approach transition. As GAVI is the sole global supplier of donated vaccines, it can negotiate co-financing shares directly with country governments.

The model may have potential for contraceptive supplies financing. Although there is no single global body such as GAVI providing contraceptive supplies, the two big actors (UNFPA and USAID) would be large enough to take on the counterpart role with countries.

Adaptations suggested for family planning include setting country contributions as a fixed price per CYP, and increasing this amount over time until it reaches the real procurement cost;¹²³ and agreeing a cost division between donors and country governments for family planning programmes with both supplies and other components. Formalising the co-financing contributions of donors and governments may lead to better accountability.



TABLE 4: COMPARISON OF THE FUNDING MODALITIES

FUNDING MODALITY	POSITIVES	NEGATIVES
Bilateral	More country 'ownership'	Can be more politicised No guarantee that funds will be spent on contraceptives
Multilateral	May be more responsive to recipient countries' needs	
Multi-bilateral	Guaranteed spend on supplies	Can distort institutional budgets and priorities
GFF	Potential to mobilise additional funding from different sources	Unsustainability of financing consumables through loans Linking grant (GFF Trust Fund) to loan (IDA/IBRD) resources may lead to higher out-of-pocket spending for the poor May not be additional funding for family planning Difficult to track spending on supplies Donors may reallocate funding to the GFF from direct support for family planning Insufficient civil society participation Not nimble financing – long and complex processing systems
Volume guarantees	For donors: more products for their money For manufacturers: optimise their production, reduce costs, and lower prices For countries and implant users: cheaper supplies	May stifle competition May skew method mix
Pledge guarantee funds	Avoids waiting for donor disbursements Better procurement planning and smoother commodity flows Low cost, as financing costs are offset by manufacturer discounts Leverages bridging finance from the private sector	Complex instrument Difficulty in motivating recipients to raise loans
UNFPA Supplies Bridge Funding Mechanism	Smoothing procurement should lead to lower prices from manufacturers Multi-year commitments possible Will reduce delays and lead times	
Results-based financing		Risk of coercion if targets are set for contraceptive use
Development impact bonds	DIBs transfer risk from governments to the private investor	Complex and difficult to set up Not yet clear whether suitable for family planning work
Co-financing	Stimulates national government contributions to supplies Eases transition to self-sufficiency	

5.3 Interface between donors and countries

Country 'ownership'

Country ownership of family planning programmes is essential for sustainability. Donors therefore actively seek country commitments, but national commitment can be difficult to achieve. Many countries have long experience of financial support from donors, and rely on donors to fill the contraceptives gap. USAID and UNFPA Supplies have 'graduation' schemes for gradually withdrawing support for supplies as countries move towards higher income levels and higher national capacity to support their own programmes, but the transition itself can be traumatic when support is withdrawn.

Strategies to stimulate country ownership through bilateral aid and other modalities which pass decision-making on spending to national governments may lead to difficulty in tracking contraceptive supplies spending, which may 'fall through the cracks'. Donors and international stakeholders like UNFPA Supplies can and do advocate for government budget lines for family planning, but existence of a budget does not guarantee that money will actually be used for contraceptive supplies. In 2016, 30 of the UNFPA Supplies priority countries had contraceptives budgets. Of these, 16 countries spent the amount allocated in the budget, and four spent less. The other 10 with contraceptives budgets did not report any spending at all on supplies.¹²⁴ There are other urgent needs in low-income countries, and governments often give priority to the productive sectors, which have a more direct impact on raising national income.

SWAps and basket funds

Donors have participated in sector-wide approaches (SWAps) and basket funds that include family planning. In these approaches donors usually participate in coordination mechanisms at policy level with the ministries of health, where general guidelines for spending priorities are set and

the level of donor funding is agreed.^{xix} Actual implementation and resource allocation is the responsibility of the ministry of health and the donors have little influence downstream: these approaches give the donors influence on policy, but no control over spending. It can also be difficult to monitor actual spending. Earmarking of funds for family planning has been tried, but earmarking tends to distort national budgeting and allocation processes and may thus better be avoided.¹²⁵

Market shaping

Donors have also used their contraceptive supplies finance for in-country 'market shaping'. This has included introduction and promotion of new contraceptive methods (e.g. implants), and influence on the method mix (e.g. through support for service delivery of long-acting methods). Dalberg and the RHSC's *Market Shaping for Family Planning* report¹²⁶ has a broader view of market shaping as a means of reducing market inefficiencies such as:

- information and data gaps
- challenges for companies in gaining regulatory approval
- sub-optimal global procurement practices
- lack of demand predictability
- lack of coordination among actors

Donors can make important contributions to these areas at country level, with consequent positive impacts on equity. However, there are dangers of market distortion, including a skewed method mix. Pitfalls which have to be avoided include reducing country ownership, prioritising short-term over long-term market development, emphasising price reductions which can eliminate competition and lead to over-reliance on one supplier, and losing a more holistic view of the needs for programmatic solutions for long-term sustainability.¹²⁷

xix A basket fund pools resources from various actors, such as governments and donors. A SWAp has been defined as "a method of working that brings together governments, donors, and other stakeholders within any sector. It is characterized by a set of operating principles rather than a specific package of policies or activities. The approach involves movement over time under government leadership towards: broadening policy dialogue; developing a single sector policy (that addresses private and public sector issues) and a common, realistic expenditure programme; common monitoring arrangements; and more coordinated procedures for funding and procurement." See World Health Organization (2000) *World health report 2000. Health systems: improving performance*. p.123. Available at: <<http://www.who.int/whr/2000/en/>>.

Technical assistance and capacity building

Funding for family planning has often included technical assistance and capacity building as well as supplies. This is an area where donors and institutions have provided a lot of support and have skills and experience to offer, as well as finance. It is a key area for sustainability.

Family planning in universal health coverage

Donors can also promote family planning in the context of universal health coverage and support work to include family planning in national health insurance schemes. Inclusion of family planning in insurance schemes can remove cost barriers for low-income groups if they are covered by the schemes.

Donors have financed voucher schemes for family planning and maternal and child health services. The schemes can be difficult to sustain, but they need similar organizational arrangements for selection of health providers, monitoring and quality control as health insurance schemes. Voucher schemes have been set up with donor finance as a first step towards development of social insurance schemes.



6. Recommendations for advocacy

Recommendation 1: Use the 'funding gap' concept for advocacy.

The RHSC Global Contraceptive Commodity Gap Analysis and other funding gap estimates can serve as useful tools for advocacy on contraceptive supplies financing. Advocates can use the estimates at global and country levels with donors. Bilateral donors can use the estimates with their recipient countries to promote family planning.

Recommendation 2: Select the main focus of family planning advocacy work.

Decide whether to focus only on supplies advocacy, or to place supplies within the broader context of family planning or wider health programmes. A clear focus on supplies alone can give more tangible and measurable results. A broader focus recognizes that products themselves are not enough without capacity building and health systems strengthening, gives more sustainable results, reduces risks of dependence on donors for supplies, and can integrate family planning better with other development sectors.

Ways of filling the funding gap or making it less inequitable are:

- Purchase more supplies with donor funding – through increased funding, or through using the funds better.
- Increase domestic funding from country governments.
- Improve the distribution of out-of-pocket spending between income quintiles to minimise costs for lower income groups.

Advocacy recommendations for each of these three areas are:

Recommendation 3: Continue advocacy for more donor funding and more efficient use of funds.

Many of the initiatives to date have focused on getting more contraceptives with the available funding – through more efficient procurement, negotiation of price reductions, better information flows, coordination of procurement, volume guarantees, bridging finance etc. These should all be promoted, with some caveats:

- They may lead to market distortions and sub-optimal method mix, and may eliminate competition.

- Use of loan funds, such as in the context of the GFF, for buying consumables may lead to greater country indebtedness in future.
- They will not solve the major problem, which is the increasing share of out-of-pocket spending and its inequities.

Recommendation 4: Promote options that are good value for money for donors and can provide long-term solutions.

Bridging finance, for example, involves an initial injection of donor funding which can then be used on a revolving basis in the medium and long term. The same donor money can smooth the timing of procurement orders many times over with a single injection of funds (plus any necessary top-ups). Volume guarantees are one-off donor commitments, using donor credibility to enable manufacturers to forward plan, optimise production and reduce prices. In the case of the IAP, as the global procurers have coordinated their buying to ensure appropriate order volumes of implants, the donors' volume guarantee finance has to date not actually had to be used.

Recommendation 5: To increase sustainability, advocate for financing modalities that encourage government commitment and country ownership.

Country ownership and commitment is essential for sustainable family planning programmes. Bilateral funding is a modality that leaves decision-making on resource allocation with the recipient country government, which increases country ownership. However, there is no guarantee the country will give priority to contraceptive supplies. UNFPA and its UNFPA Supplies thematic fund specifically seek to increase country commitments to family planning.

Recommendation 6: For sustainability, advocate for options that promote a rational method mix within the country's capacity to pay, coupled with a rights-based approach to ensure choice.

Price reductions linked with government commitments to strengthen delivery of specific methods can lead to a more cost-effective method mix. However, there is a danger that

market shaping can push out even more cost-effective methods such as the IUD, and that choice is reduced. And out-of-pocket expenditure is inevitably skewed towards the costlier short-term hormonal methods. Countries need to have a clear understanding of the overall cost-effectiveness of all methods and maintain a wide method mix.

Recommendation 7: Explore modalities and initiatives that involve the private sector.

As out-of-pocket spending can be expected to increase in future, it is important to explore modalities and initiatives that involve the private sector and may reduce inequity. Private sector participation could include:

- funding for social marketing, which reduces prices
- inclusion of private sector stakeholders in country coordination mechanisms for pooled procurement, with reciprocal commitment to retail price controls

Recommendation 8: To increase equity and sustainability, advocate for financing which promotes universal health coverage and inclusion of family planning in national health insurance schemes.

Direct payments for health services are often borne by those who can least afford them. A move away from out-of-pocket spending for health services and towards prepayment and risk pooling benefiting all, including low-income groups and those in the informal sector, is essential to decreasing inequities and improving coverage. Inclusion of family planning in national health insurance schemes removes cost barriers for those covered by the schemes.

Recommendations for transition countries:

Recommendation 9: To help ease transition and maintain equity, advocate to include transition countries in price reduction and volume guarantee schemes.

This could be done through pooled procurement at national level and bilateral negotiation of price reductions, or price reductions for transition countries which procure through UNFPA. Donors could assist with volume guarantees and negotiations with manufacturers.

Recommendation 10: Advocate for financial support for new procurement and domestic financing initiatives in transition countries.

One option is support for pooled procurement of all sectors to get price reductions. Private sector access to the public sector supply chain at reduced cost can be tied to commitment to control retail prices. Co-financing schemes can also be piloted as a means to smooth transition.

Recommendations 7 and 8 also apply to transition countries.

Key abbreviations

BFM	Bridge Funding Mechanism	KfW	Kreditanstalt für Wiederaufbau
BMGF	Bill and Melinda Gates Foundation	LMI	Low- and middle-income
CARhs	Coordinated Assistance for Reproductive Health Supplies	mCPR	Modern contraceptive prevalence rate
CGA	Global Contraceptive Commodity Gap Analysis	MISP	Minimum Initial Service Package
CHAI	Clinton Health Access Initiative	MSI	Marie Stopes International
CIFF	Children's Investment Fund Foundation	NGO	Non-governmental organization
CIP	Costed Implementation Plan	Norad	Norwegian Agency for Development Cooperation
CSP	Coordinated Supply Planning	ODA	Official Development Assistance
CYP	Couple Years of Protection	OECD	Organisation for Economic Co-operation and Development
DAC	Development Assistance Committee	PGH	Pledge Guarantee for Health
DFID	Department for International Development	PSI	Population Services International
DIB	Development impact bond	RH	Reproductive health
ERP	Expert Review Panel	RHSC	Reproductive Health Supplies Coalition
EU	European Union	RMNCH	Reproductive, maternal, newborn and child health
FP	Family planning	RMNCAH	Reproductive, maternal, newborn, child and adolescent health
FY	Financial year	RMNCAH+N	Reproductive, maternal, newborn, child and adolescent health and nutrition
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	SDGs	Sustainable Development Goals
GFF	Global Financing Facility	SIDA	Swedish International Development Cooperation Agency
GGR	Global Gag Rule	SRH	Sexual and reproductive health
GHSC-PSM	Global Health Supply Chain Program Procurement and Supply Management	SRHR	Sexual and reproductive health and rights
IAP	Implant Access Program	SWAps	Sector-wide approaches
IAWG	Inter-Agency Working Group on Reproductive Health in Crises	TMA	Total market approach
IBRD	International Bank for Reconstruction and Development	UNFPA	United Nations Population Fund
ICPD	International Conference on Population and Development	UK	United Kingdom
IDA	International Development Association	US	United States of America
INGO	International non-governmental organization	USAID	United States Agency for International Development
IPPF	International Planned Parenthood Federation	VAN	Visibility Analytics Network
IUD	Intrauterine device	WHO	World Health Organization
JSI	John Snow, Inc.		

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web: www.countdown2030europe.org
twitter: [@C2030Europe](https://twitter.com/C2030Europe)
email: countdown2030europe@ippfen.org

