

policy

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THE GAP TOOL
A GUIDE TO ASSESSING
THE FUNDING NEEDED
TO ACHIEVE FAMILY
PLANNING GOALS

Version 1.2

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The GAP Tool

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ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
CFA	West African Franc
CPR	contraceptive prevalence rate
CYP	couple years of protection
DHS	Demographic and Health Survey
FP	family planning
GR	growth rate
IEC	information, education, and communication
IUD	intrauterine device
MWRA	married women of reproductive age
NGO	nongovernmental organization
TFR	total fertility rate
USAID	United States Agency for International Development
WRA	women of reproductive age

BACKGROUND

Investment in family planning (FP) improves maternal and child health outcomes, shapes a country's demographic path, and strengthens the impact of other development initiatives surrounding youth employment, education, training, and health (Leahy Madsen, 2012). Despite widespread consensus on the benefits of investing in family planning, gaps persist between the actual resources available for contraceptive supplies and services and the resources required to meet the total need for modern contraceptive care in the developing world.

Access to family planning has improved in many countries, but unmet need remains high, with an estimated 222 million women of reproductive age expressing a desire to delay, space, or limit childbearing but not currently using modern contraception (Singh and Darroch, 2012). While the cost of fulfilling that need is considerable, estimated at \$8.1 billion annually, the benefits are also significant—54 million unintended pregnancies would be prevented, which, in turn, would prevent 21 million unplanned births, 26 million abortions (including 16 million unsafe abortions), 79,000 maternal deaths, and 1.1 million infant deaths (Singh and Darroch, 2012).

PURPOSE

To successfully address unmet need, decisionmakers need to set FP-related goals and estimate the resources required to meet those goals. **The GAP (Gather, Analyze, and Plan) Tool** was developed to help policymakers, ministry officials, and health officials understand and plan for the costs associated with expanding FP approaches to achieve their country's contraceptive prevalence or fertility goals.

Historically, planning has been based on global analyses of FP funding requirements. However, as countries take ownership of the FP agenda and strive to increase and maximize resources to reduce unmet need, basing strategic plans and budgets on country-level data is becoming increasingly important. The GAP Tool allows countries to project the contraceptive, service provision, and program support funding gaps relative to their FP goals.

This manual provides step-by-step instructions on using the GAP Tool, as well as guidance for collecting and using country-specific data on the costs of commodities, labor, overhead, and logistics.

THE GAP TOOL

The GAP Tool is a simple Excel-based tool designed to assist with planning and strengthening national FP programs. Users need not be experts in population studies or demography; only a background in family planning and a basic grasp of Microsoft Excel are required to use the tool.¹ The GAP Tool produces two key results: the funding gap for a country's entire FP program and for commodities alone. Behind these figures lies important information on the distribution of the costs required to fully fund the program to meet national targets. The tool provides decisionmakers with information about the distribution of costs by type (labor, overhead, program support, and commodities), as well by sector (nongovernmental, private, and public).

¹ The GAP Tool will be periodically updated as new cost information and demographic and family planning data at the country level become available. Users should check the Health Policy Project website for updates.

The GAP Tool can address the following questions:

- How much funding is needed to meet national family planning goals?
- What are the government and donor funding commitments for family planning during the period in which goals are to be achieved?
- Are national goals achievable with existing funding?
- What is the funding gap for family planning during the projected period?
- What proportion of costs is incurred in labor, overhead, and commodities?
- How does private sector involvement affect the public sector gap?
- How does method mix—choice of FP products in the market—affect costs and the funding gap?

The cost increases calculated by the GAP Tool are primarily attributed to increases in contraceptive prevalence (a larger proportion of women of reproductive age who use family planning), to population growth (more women of reproductive age to cover given the contraceptive prevalence rate or CPR), and to a lesser extent, shifts in the method mix toward more costly methods. The GAP Tool estimates growth in consumption arising from these changes. The data generated by the GAP Tool can inform discussion and planning on how new initiatives—such as increased community-based distribution of family planning or provision of free commodities in the public sector—may impact future financing gaps for governments at the country level. Low program support costs, in the context of low FP use, should raise questions about whether current investments are adequate to remove barriers to family planning.

The tool provides charts on method mix and source mix—both of which have important implications for issues ranging from male involvement in family planning to method discontinuation rates. Similarly, information on the distribution of clients and costs across private and public sectors can enhance technical discussions on the current and future role of the public sector and on improved market segmentation to reduce inequities in FP access and use. By linking strategic goals to costs, the GAP Tool provides important opportunities for scenario building and planning by stakeholders.

How can countries use results of the GAP Tool?

- For improved understanding of what resources are needed to reach FP targets
- To evaluate gaps in data on costs and resource allocation
- As an instrument for policy dialogue on method mix and private sector involvement in family planning
- To advocate for new domestic and longer term donor commitments for family planning

DATA INPUTS

Data needed to complete the analyses are either pre-loaded into the tool or entered directly by the user. Users may change the pre-loaded data if a better source is available. Definitions and details on some of the major data inputs necessary for the model are covered in this section. Further explanation is also provided in the step-by-step instructions that follow.

Distribution of FP users by method. Base year data for method mix is pre-loaded into the spreadsheet based on the most recent Demographic and Health Survey (DHS).

Method prevalence is the distribution of contraceptive prevalence by method among women of reproductive age and adds up to the overall CPR in the population. *Method mix* is computed from method prevalence and gives the distribution of each method among FP users, adding up to 100 percent. For example, a method mix of 30 percent condoms, 40 percent pills, and 30 percent intrauterine devices (IUDs) indicates that of all women using contraception, 30 percent of them use condoms, 40 percent of them use pills, and 30 percent of them use IUDs. The most desirable method mix is a distribution where each woman is able to use the method most appropriate for her needs and preferences. As such, method mix may vary depending on factors such as culture, national trends, geography, socio-economic status, or age. An older woman who does not desire any more children or who cannot access regular healthcare may opt for female sterilization, whereas a younger woman who wishes to delay childbirth for a few years may opt for a short-term method, like pills or injectables.

In some cases, a method mix that strongly favors one method above all others may indicate a lack of comprehensive choices for adopters of family planning. In countries with low contraceptive prevalence, methods that require fewer skilled providers and less infrastructure, training, and start-up costs tend to be more predominant (e.g., condoms and pills). As contraceptive prevalence increases, method mix generally becomes more robust and representative of methods that may require skilled providers, patient counseling, or a clinical setting to implement (e.g., implants and IUDs). In settings with more developed healthcare services, in urban areas, and where FP users are better educated or have higher incomes, the method mix will generally be more diverse than in rural areas, where less costly methods may dominate the method mix. In the public sector, healthcare service providers are often overburdened, favoring methods that are fast and easy to distribute, such as pills and injectables, over methods that require detailed counseling or a second visit for insertion.

Distribution of FP users by source. This input details the primary source of clients' FP commodities: public sector, nongovernmental organization (NGO), or private sector. Base year data for this component are pre-loaded in the spreadsheet based on the most recent DHS.

Units per couple years of protection (CYP). FP methods differ in duration of protection per unit, and method mix varies across populations. The concept of CYP is used as a standard metric of the overall coverage of family planning in a population, independently of method mix. The number of units per CYP describes the number of units required to prevent pregnancy for one year. Longer term methods, such as IUDs or implants, may provide 2–3.5 years of protection per IUD or implant. Shorter term methods, such as pills and condoms and injectables, require many units to provide 1 year of protection: 15 cycles/units for pills and 120 condoms (it is standard to assume, for condoms, an average coital frequency of 120 acts per year). The number of CYP assigned to different FP methods is calculated based on typical usage and accounts for factors such as discontinuation rates, wastage, and method failure. The GAP Tool uses CYP as estimated and published by the U.S. Agency for International Development (USAID) for its calculations. Because methods vary in cost, longevity, and effectiveness, the cost of providing a fixed number of CYP in a population will also vary with the method mix.

Commodity costs. Commodity costs include the cost of the actual FP devices and drugs (e.g., condoms, pills, and IUDs) and the necessary consumable medical supplies (e.g., gloves, gauze, and antiseptic). Commodity unit cost defaults are included in the GAP Tool, based on an average of USAID and United Nations Population Fund prices. To prevent stockouts, a buffer stock of commodities should also be budgeted for, as a percentage of the entire supply.

Other sources for contraceptive commodities data include

1. **RH Interchange website**—provides the price of contraceptive commodities in more than 140 countries. Available at: <http://rhi.rhsupplies.org/rhi/index.do>.

2. **The International Drug Price Indicator Guide**—issued by Management Sciences for Health (MSH) and the World Health Organization (WHO), lists prices of generic drugs on the international market, as well as the procurement prices from various national procurers.

Available at:

http://erc.msh.org/dmpguide/index.cfm?language=english&year=2011&class_code=18.&class_name=Hormones%2C%20other%20endocrine%20medicines%20and%20contraceptives&action=classdetail&display=yes&module=dmp

Additionally, the Ministry of Health purchasing records and drug procurement information from relevant donors or procurers could also be potential sources of commodity costs.

Labor costs for service delivery. Labor cost default values included in the tool are based on Vlassoff et al. (2004), inflated to 2009, and Wiessman (2007). Note that the values exclude commodity and overhead costs.

Labor is often the largest component of FP program costs and includes healthcare workers', providers', and distributors' wages and benefits. Labor costs can vary depending on the methods used. For example, the labor required for administration of an IUD can include the cost of a clinician for IUD insertion, a follow-up visit, and then a final visit for IUD removal. On the other hand, the labor cost associated with contraceptive injectables includes the cost of the first visit for client acceptance and the cost of regular follow-up visits for subsequent doses. To customize labor costs by country, it is helpful to think about *how service delivery is implemented* (e.g., Who delivers care? The public sector? The private sector? Doctors? Nurses? Healthcare workers?) and *how they do it* (e.g., In an integrated maternal and child health program? Seconded with vaccine clinics? Specialized FP clinics? Mobile rural outreach?).

Overhead costs. Overhead is estimated as a percent of total costs. Default values included are based on Vlassoff et al. (2004). Overhead includes components such as the cost of running a facility (e.g., rent, water, electric, and security), transportation, maintenance, and clinical support costs (e.g., administrative or supervisory staff). In general, the overhead in a large facility, such as a hospital, will be more substantial than in smaller, satellite facilities. Overhead costs may account for the largest component of total costs.

Program support costs. There is an option to include program support as a percentage add-on. Alternately, program support costs can also be included as annual costs by program area (policy, management, logistics, monitoring and evaluation, training, etc.). The level of program support costs and the relevant program areas can vary from country to country, depending on national regulatory barriers, healthcare infrastructure, or local capacity. For example, scaling up implant use can incur lower training costs in a country where local policies or task shifting allow mid-level clinicians or community health workers to perform insertions. Similarly, when introducing a new method into the country, the costs associated with overcoming regulatory barriers, training, and monitoring and evaluation can be more substantial.

Current and projected funding for family planning. Total funding, both current and projected, can be calculated by adding up values by source (government, donor, and out-of-pocket). Funding support specifically for commodities should be denoted. This funding data provides decisionmakers with a realistic picture regarding the funding resources for family planning in their country. These figures will help them advocate to donors and the national government about how much funding is realistically needed to address the funding gap and achieve the CPR target. Good data sources are national FP technical working groups, individual donors, donor assistance groups, or the Ministry of Health's resource mobilization unit.

For country-specific cost information, GAP Tool users can consult with the national ministries of health and finance or other government agencies with an interest in family planning or health staffing. Major NGO providers may also have information on local FP service provision costs. It is important to also consider costs in the private and public sectors, as these may vary dramatically. Consulting any association of private sector providers or public sector health system employees may be instrumental. Moreover, a search of recently published reports and papers of cost studies conducted in country, or a comparable country, may also be helpful.

USING THE MODEL

Inputs

Enter data in yellow cells, and review and revise data in blue cells, as necessary.

You may find it helpful to refer back to the “Data Inputs” section for more detail and explanations of concepts and terms used in the step-by-step instructions.

1. Click on the “Inputs” tab to enter the model.
2. Begin to construct your model by entering data into the yellow cells or selecting from the drop down menus. When you enter data or make a selection, pre-loaded data drawn from the “Database” tab will populate the blue cells.
3. On the “Country name” line, click on the yellow box and you will see a dropdown menu with all of the countries listed. Find your country and select it. The example used here is Mali.
4. Choose either the country’s CPR or total fertility rate (TFR) as a goal to gauge progress. You will notice that your country’s current CPR or TFR and the unmet need for family planning have already been populated by the model based on the most recent DHS data. However, the user can also input the country’s current figures by using data from other national surveys.

The **contraceptive prevalence rate** is the percentage of women of reproductive age (WRA) who are using family planning. The CPR used in the GAP Tool includes both modern methods (pills, condoms, IUDs, sterilization, etc.) and traditional family planning (withdrawal, abstinence, lactational amenorrhea).^a Women who express a desire to delay or stop childbearing, but are not using modern family planning, are described as having an “unmet need” for family planning for either spacing births, limiting births, or both. In this model, increases in CPR draw exclusively from the pool of women with unmet need for both spacing and limiting.

The **total fertility rate** of women of reproductive age indicates the average number of children a woman would have if she were to complete her childbearing years (defined as ages 15–49), adhering to current age-specific fertility rates.

The CPR and TFR are inversely related; higher contraceptive prevalence results in a lower TFR, and reducing TFR usually means increasing CPR (although other proximate determinants of fertility also mediate this relationship).^b

^a One can also speak of a modern CPR including only modern FP methods; to use modern CPR, the user can edit the method prevalence in the “Database” tab to reflect zero percent prevalence for traditional methods.

^b Bongaarts, J. (1979) *A Framework for Analyzing the Proximate Determinants of Fertility*. Population and Development Review, Vol. 4, No. 1 (Mar., 1978), pp. 105-132. Accessed at: <http://www.jstor.org/discover/10.2307/1972149?uid=3739584&uid=2&uid=4&uid=3739256&sid=21103607917157>.

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5. Select “MWRA (married WRA) or WRA” to calculate your country’s unmet need for family planning. Notice that your country’s unmet need for family planning has already been populated, based on data for the number of all WRA (all women ages 15–49). In Africa, it is generally preferable to use WRA, since many women who give birth are not married. Consequently, if you use only MWRA, the unmet need for family planning may be underestimated. In Asia, almost all births are among married women, and the surveys are usually only among married women, so MWRA would be preferable. Note that the database provided is for WRA. If you choose to use the GAP Tool to describe costs of family planning only among MWRA, you must replace WRA2010 and WRA2025 in the Database tab with estimates of MWRA in those years. You should also replace the unmet need method prevalence with estimates of those quantities among MWRA, if available.
6. Enter your country’s CPR or TFR goal, depending on what was selected in Step 4. In the absence of a set goal, there is a default formula already entered, which describes all unmet need being fulfilled.
7. Enter the target year by which you would like to reach your CPR or TFR goal. The database in this tool allows you to project up to 40 years from your base year (i.e., the year of your country’s most recent DHS). Note, however, that the calculations are made for 40 years from the base year regardless of the target year chosen, and so CPR in the figure will continue to increase until either 40 years have elapsed or it reaches the capped maximum value of 80 percent. The target year and target value merely set the rate of CPR increase/TFR decline.

As a result of entering all the information in the first section, you will see a contraceptive prevalence chart that plots your country's CPR goal, projecting past the target year. An example is shown below.

A	B	C	D	E	F	G	H	I	J	K
INPUTS FOR FAMILY PLANNING COST PROJECTIONS										
Version 1.2										
Enter data in yellow cells										
Review data in blue cells and change if necessary										
Country name	Mali									
Year of latest CPR estimate (usually latest DHS)	2006	DHS								
Use TFR or CPR goal?	CPR									
Specify CPR for all women 15-49 (WRA) or married women (MWRA)?	WRA									
Contraceptive prevalence (CPR) (%)	7.7	DHS								
Unmet need for FP 2006	27.6	DHS								
CPR goal (%)	25.0									
Target year	2025									
Number of women in 2006	3,080,995	UN Pop Div								
Annual growth rate in number of women	3.2%	UN Pop Div								
Distribution of FP users by method										
	2006	2025								
Condom	7.7%	7.7%								
Female Sterilization	3.1%	3.1%								
Implants	1.5%	1.5%								
Injectables	33.8%	33.8%								
IUDs	1.5%	1.5%								
Pills	40.0%	40.0%								
Vasectomy	0.0%	0.0%								
Cycle beads	0.0%	0.0%								
Traditional	12.3%	12.3%								
Total	100.0%	100.0%								
Source: DHS										

Contraceptive Prevalence

Distribution of FP users by method

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- In the section “Distribution of FP users by method,” enter the anticipated method mix in your target year in the yellow cells. Since method mix describes all users, the percentages need to add up to 100 percent.

Note that method mix in your base year has been pre-loaded in the blue cells, based on the most current DHS data. If more up-to-date data are available, you may replace the pre-loaded data here or in the Database tab in either method prevalence or method mix. The target year data can be changed based on the country’s CPR goal, and the user can also estimate the target year method mix by using data from government plans, forecasts, Centers for Disease Control and Prevention (CDC) reproductive health surveys, and so on.

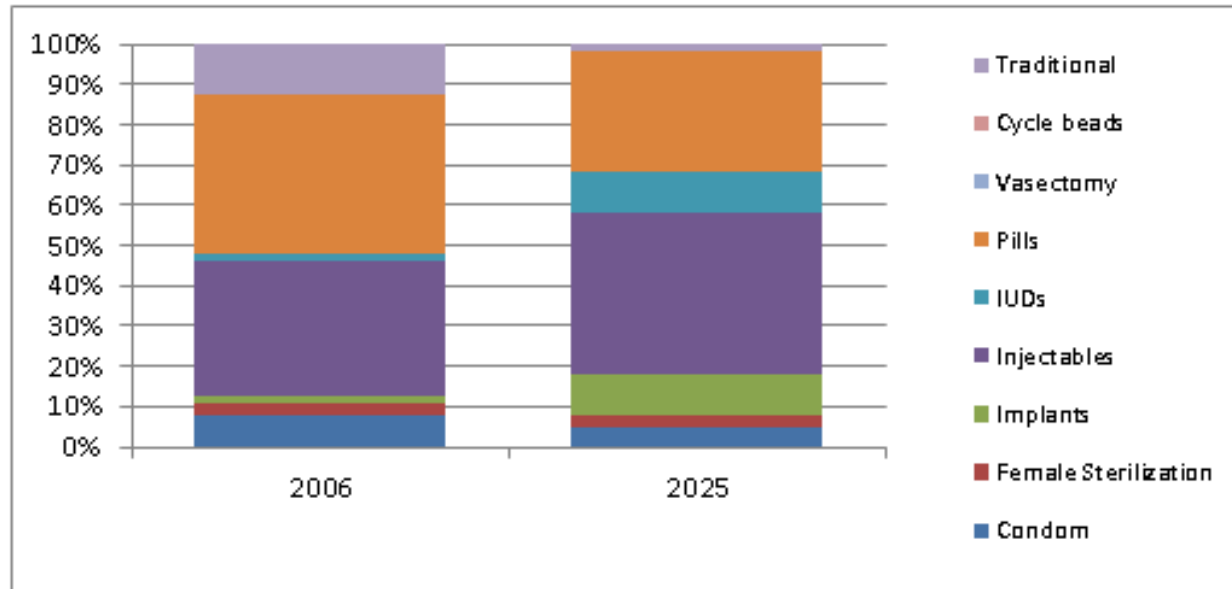
Distribution of FP users by method	2006	2025
Condom	7.7%	5.0%
Female Sterilization	3.1%	3.0%
Implants	1.5%	10.0%
Injectables	33.8%	40.0%
IUDs	1.5%	10.0%
Pills	40.0%	30.0%
Vasectomy	0.0%	0.0%
Cycle beads	0.0%	0.0%
Traditional	12.3%	2.0%
Total	100.0%	100.0%

Source: DHS

A	B	C	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1	2	3	22	23	Method Prevalence	25	26	27	28	29	30	31	32	33	34	35
Country	Survey Year	Year	CPR		Condom	Injections	Pill	Female sterilization	IUD	Male sterilization	Cycle beads	Implants	Traditional	Other	WRA2010	WRA2025
Albania	2008	2008	48.7%		3.3	0.4	1.2	2.1	0.6	0	0	0	40.1	1	804.555	762.025
Armenia	2010	2010	33.9%		9.1	0	0.9	0.2	5.9	0	0.3	0	16.5	1	764.721	693.151
Azerbaijan	2006	2006	32.0%		1.4	0	0.7	0.3	5.8	0	0	0	22.8	1	2725.962	2630.972
Bangladesh	2011	2011	61.7%		5.5	11.2	27.2	5	0.7	1.2	0	1.1	8.8	1	41634	49986.8
Benin	2006	2006	17.8%		2.6	1.5	1.3	0.3	0.5	0	0	0.5	10.1	1	2240.84	3471.179
Bolivia	2008	2008	41.8%		3.6	7.4	2.4	4.3	5.6	0.1	0	0	17.4	1	2553.769	3300.133
Botswana	1988	1988	30.6%		1.3	3.2	17.7	2.2	4.5	0.1	0	0	0.6	1	521.775	624.713
Brazil	1996	1996	56.1%		4.3	1.1	15.8	27.3	0.8	1.6	0	0	4.2	1	53893.75	56927.57
Burkina Faso	2010	2010	16.2%		3.1	5.1	2.8	0.1	0.2	0	0	2.9	1	1	3579.33	5670.101
Burundi	2010	2010	14.4%		0.8	6.3	1.4	0.4	1.7	0	0	0.4	2.4	1	2220.88	3469.074
Cambodia	2010	2010	32.1%		1.7	6.5	9.5	1.5	1.9	0	0	0.3	9.7	1	3964.832	4675.225
Cameroon	2011	2011	23.9%		10.8	2.3	1.6	0.4	0.2	0	0	0.5	7.1	1	4847.36	7417.907
Cape Verde	1998	1998	38.2%		3.7	5.2	14.7	6.8	2.6	0	0	0	4.2	1	131.318	149.061
Central African Republic	1994	1994	14.6%		1.4	0.5	1.1	0.4	0	0	0	0	10.2	1	1060.48	1520.537
Chad	2004	2004	3.4%		0.4	0.4	0.4	0.2	0	0	0	0	0.9	1.1	2522.03	4256.955
Colombia	2010	2010	61.7%		7.6	7.9	6.5	24.2	5.6	1.9	0	2.9	4.1	1	12644.58	14204.27
Comoros	1996	1996	14.4%		1.6	2.5	1.9	1.6	0.2	0	0	0	5.6	1	162.326	236.812
Congo (Brazzaville)	2005	2005	43.0%		10.4	0.8	2	0.2	0.1	0	0	0	28.4	1.1	977.1	1433.586
Congo Democratic Republic	2007	2007	20.4%		4.8	0.3	0.8	0.6	0.2	0	0	0	12.7	1	14124.84	22287.63
Cote d'Ivoire	2012	2011	19.2%		5	1.9	6.1	0.1	0.1	0	0	0.1	4.8	1.1	4427.146	6438.302
Dominican Republic	2007	2007	54.6%		3	3.2	9.5	33.9	1.6	0	0	0.4	2	1	2626.554	3008.569
Ecuador	2004	2004	48.7%		3.2	3.8	8.5	16.6	6.7	0.2	0	0	8.7	1	3927.091	4746.749
Egypt	2008	2008	61.3%		0.7	7.4	11.9	1	36.1	0	0	0.5	2.7	1	20071.26	25233.91
El Salvador	2008	2008	50.1%		3.4	12.6	3.1	25.5	0.5	0.2	0	0	3.8	1	1720.13	1899.691
Eritrea	2002	2002	5.6%		0.6	1.8	1	0.1	0.3	0	0	0	0.5	1.3	1411.526	2225.935
Ethiopia	2011	2011	20.5%		0.3	14	1.5	0.4	0.2	0	0	2.3	0.8	1	19919.84	32558.22
Gabon	2012	2012	33.4%		18.5	0.2	3.9	0.4	0.1	0	0	0	9.3	1	368.903	536.714
Georgia	2005	2005	28.9%		5.3	0	1.9	1.4	7	0	0	0	12.3	1	1148.624	899.771
Ghana	2008	2008	19.6%		3.6	4.2	3.6	1	0.2	0	0	0.7	5.3	1	6212.328	8491.591
Guatemala	2008	2008	35.7%		2.6	9.3	2.4	12.9	0.8	0.5	0	0	6.2	1	3534.37	5326.422
Guinea	2005	2005	8.3%		2.5	1.1	1.6	0.2	0.1	0	0	0	1.2	1.6	2513.28	3857.455
Guyana	2009	2009	34.8%		14.5	3.3	5.9	3.7	4.8	0	0	0.1	1.5	1	199.739	222.716
Haiti	2012	2012	24.1%		5.8	11.7	1.7	0.9	0	0.1	0	1.1	1.8	1	2576.622	3265.309
Honduras	2011	2011	49.8%		3.6	11.2	7.4	15.9	4.6	0.2	0	0	5.9	1	1969.076	2671.653
India	2006	2005	44.6%		3.9	0.1	2.3	29.6	1.3	0.8	0	0	5.6	1	310528.7	365350.6

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- Once you have input the data, the following chart will depict the changes in the distribution by FP method; be sure that the column of the percentages (C 28) adds up to 100 percent to ensure correct representation in the graph.

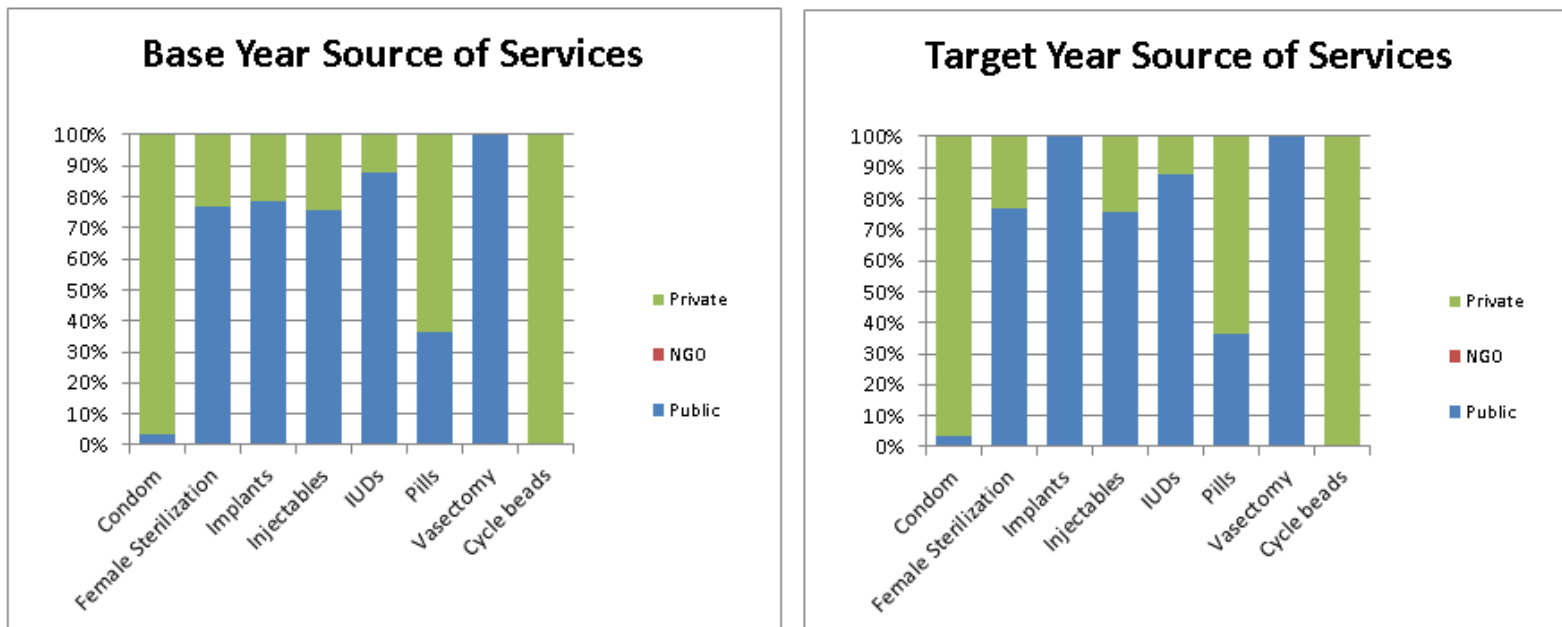


10. The distribution of FP users by source describes what percentage of a certain FP method came from the public sector, the private sector, or an NGO. In this step, you will first enter the distribution percentages for each FP method based on the CPR goal year for the *public sector*. Since each method must have been obtained from one of these three sources, the row of percentages (I34 to I41) must sum to 100 percent for each method in the target year. In the example shown, for the base year 2025, 3.7 percent of condoms come from the public sector, 0.0 percent of condoms come from the NGO sector, and 96.3 percent come from the private sector, adding up to 100 percent in the 2015 total column, and the distribution by source remains the same in the target year. For most countries, the GAP Tool will suggest pre-loaded data for the percent of users obtaining each method from the public sector; it is important to verify these numbers with government experts and commodity suppliers in your country.

Distribution of FP users by source									
	Public		NGO		Private		Total		
	2006	2025	2006	2025	2006	2025	2006	2025	
Condom	3.7%	3.7%	0.0%	0.0%	96.3%	96.3%	100.0%	100.0%	
Female Sterilization	76.8%	76.8%	0.0%	0.0%	23.2%	23.2%	100.0%	100.0%	
Implants	78.5%	100.0%	0.0%	0.0%	21.7%	0.0%	100.2%	100.0%	
Injectables	75.8%	75.8%	0.0%	0.0%	24.2%	24.2%	100.0%	100.0%	
IUDs	87.8%	87.8%	0.0%	0.0%	12.2%	12.2%	100.0%	100.0%	
Pills	36.1%	36.1%	0.0%	0.0%	63.9%	63.9%	100.0%	100.0%	
Vasectomy	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	
Cycle beads	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	

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11. Enter the distribution percentages for each FP method based on the CPR goal year for the *NGO sector*. See the table above. Again, the sum of the percentages of sources for each FP method should add up to 100 percent for all sectors. The tool will automatically assign remaining source percentages for each method to the private sector. Once you have input the data, the following chart will depict the source of services: public, NGO, and private (the share of private sources is automatically calculated based on public and NGO shares).



12. Most users will not need to modify the average duration of use. However, if you have more accurate data for your country, you can enter the average duration of use of non-coital dependent methods including implants, IUDs, and tubal ligation or sterilization. This input is the method's CYP conversion factor and indicates, with typical use, how many years of protection from pregnancy a method provides. USAID average duration estimates can be found at: http://transition.usaid.gov/our_work/global_health/pop/techareas/cyp.html.

Although female sterilization is permanent, CYP provided by this method will depend on what age the woman received the procedure. For example, a woman who receives the procedure at age 37 is protected for life, but since she only has eight years during which she is at risk of pregnancy, the method only counts as providing protection for eight years. This average duration will vary depending on the average age of female sterilization in a country.

Because there are three types of implants, the duration entered for implants should match your country's guidelines, usually 3–4, 4, or 5 years. If more than one type of implant is offered, and they have different average durations, calculate a weighted average. A weighted average can be calculated with either of these two formulae:

$$\frac{\# \text{Users}_{\text{Implant1}} \times \text{AverageDuration}_{\text{Implant1}} + \# \text{Users}_{\text{Implant2}} \times \text{AverageDuration}_{\text{Implant2}}}{\# \text{Users}_{\text{Implant1}} + \# \text{Users}_{\text{Implant2}}}$$

or

$$\% \text{Users}_{\text{Implant1}} \times \text{AverageDuration}_{\text{Implant1}} + \% \text{Users}_{\text{Implant2}} \times \text{AverageDuration}_{\text{Implant2}}$$

13. Enter the number of units of each method required to provide one year of protection from pregnancy (CYP). This information, as estimated by USAID, can be found at http://transition.usaid.gov/our_work/global_health/pop/techareas/cyp.html. Since these methods are shorter acting, several units are required to provide one CYP. Typical use of these methods, taking into account method failure, wastage, and discontinuation of use, does not vary as much between different countries, so global averages provide a more valid estimate.
14. Choose whether to use your country's local currency (in this example, CFA) or US dollars.
15. If you select local currency, enter the current exchange rate. Conversion rates can be accessed at <https://www.google.com/finance/converter?a=1&from=USD&to=XOF> or other online conversion sites. Keep in mind that the exchange rate might change during the period, which will alter cost estimates in the future.
16. Enter the expected annual inflation rate over your projection period. Enter "0" to complete the analysis in constant currency (no inflation). Inflation will be applied to labor and support costs, but not to commodity costs.
17. Enter the target year commodity costs. Unless you are aware of an upcoming change, such as the loss of a subsidy for a certain method, or a planned price decrease, it is best to assume there will be no changes in commodity costs between the base and target years. Consult a procurement official to get a sense of any upcoming changes.

The decrease seen in the tool for the price of implants takes into account that the Sino-implant II (typically known as Zarin in Africa) will be widely available because it is so inexpensive (Vlassoff et al., 2004).

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18. If you want to include additional commodities as “buffer stock,” enter the percentage extra here. Including buffer stock in your planning can help avoid commodity stockouts and is highly recommended. Consult a procurement expert in your country to find out if there is currently a buffer stock percentage in place.

Units per CYP	
Condom	120
Injectables	4
Cycle beads	1
Pills	13

Currency	
Use US\$ or CFA?	US\$
Annual inflation rate (applied to labor and support costs)	3.0%

Commodity Costs (US\$)	2006	2025
Condom	0.029	0.029
Female Sterilization	20.390	20.390
Implants	24.640	5.000
Injectables	0.850	0.850
IUDs	0.350	0.350
Pills	0.290	0.290
Vasectomy	20.390	20.390
Cycle beads	1.500	1.500

Addition to commodity needs for buffer stock (%)	0%
Include commodity costs for the private sector?	Yes

19. Select “Yes” or “No” from the pull down menu to show whether you would like to include commodity costs for the *private sector*. It is important to consider the role of the private sector in cost calculations because the private sector will satisfy some of the demand for family planning. However, because private providers generally are paying their own commodity costs, as well as NGOs, it is less crucial to incorporate their supply side factors into funding calculations.
20. If you have more current labor cost data for your country, enter it in the public sector and/or NGO sector columns.
21. Select “Yes” or “No” from the pull down menu to show whether you would like to include labor costs for the *public sector*. Since labor costs are usually the largest single component of any FP program, you should generally choose to include them unless special circumstances pertain (e.g., you are limiting your GAP analysis to only one category of costs, such as commodities).
22. The estimates of overhead costs to supply each commodity have already been loaded into the model. This estimate is calculated as a percentage of labor costs per method. For example, it is estimated that the overhead cost associated with condom provision is 332 percent of labor cost or 3.32 times more than the labor cost. However, if you have better figures for your country, enter them here. For example, if IUD insertions can only be performed in a hospital in your country, but may be done by mid-level providers, it is possible that the overhead will represent a higher percentage of labor cost than the suggested default.

23. Click on the yellow box and select from the pull down menu to indicate whether to include overhead costs for the *public sector*. Since overhead costs are usually a large component of FP program costs, you should generally choose to include them unless special circumstances pertain (e.g., you are limiting your GAP analysis to only one category of costs, such as commodities).
24. Click on the yellow box and select from the drop down menu to indicate whether program support costs will be input directly by component, or calculated as a percentage add-on of all other costs. Entering program support costs by component will yield a more accurate overall GAP analysis, but requires accurate estimates by component. Entering support costs as a percentage add-on to other costs is cruder and more approximate, but less onerous. If you are not confident in your ability to obtain accurate support cost estimates by component, you may wish to consult a range of FP system experts and obtain a best-guess percentage add-on estimate.

Program support costs typically represent substantial investments in areas such as logistics; influencing the policy environment; information, education, and communication (IEC) campaigns; and training, which once in place, are expected to diminish over time. Support costs are not routine costs, but costs incurred to reduce supply- or demand-side barriers to FP use or investments to improve the quality or efficiency of service delivery.

25. If you selected “Add-on to other costs,” enter the percentage of program costs that you would like to account for as a part of the total cost.
26. If you selected “Enter costs by component,” enter the estimated program support costs by component.

Default values for annual program support costs and suggested percentages are based on technical discussions with experts at the global level who work on USAID-supported projects. However, collecting country-level data on program costs is recommended. To obtain estimates of the annual costs of developing and implementing programs in your country, you may collect data from financial managers and heads of FP programs working specifically in health policy, logistics, IEC, provider training, among others.

27. Enter the amount of current and projected funding for the FP program within your country. This can be obtained from the ministries of health or finance, national FP technical working groups, or large NGOs working in family planning or from direction discussions with donors.

The “Current and projected funding for family planning” screen provides decisionmakers with a realistic picture regarding the funding resources for family planning in their country. These figures will help them advocate to donors and the national government about how much funding is realistically needed to address the funding gap and achieve the CPR target.

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Current and projected funding for family planning (US\$)						
Source	2010	2011	2012	2013	2014	2015
National government	14,077,920	14,077,920	14,077,920	14,077,920	14,077,920	14,077,920
USAID	0	0	0	0	0	0
UNFPA	0	0	0	0	0	0
KfW	0	0	0	0	0	0
DfID	0	0	0	0	0	0
EU	0	0	0	0	0	0
CIDA	0	0	0	0	0	0
PSI	0	0	0	0	0	0
DKT	0	0	0	0	0	0
MSI	0	0	0	0	0	0
Gates	0	0	0	0	0	0
Packard	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total	14,077,920	14,077,920	14,077,920	14,077,920	14,077,920	14,077,920

28. Enter the amount of current and projected funding for FP commodities within your country. This can be obtained from the ministries of health or finance or from direct discussions with donors. Large NGOs working in family planning may also have funding information for your country.

Note that this tool provides the user with specific outputs regarding the FP gap and the contraceptive commodity gap. The FP funding gap measures the total amount of resources available for a country’s national family planning program as compared with the program’s total cost. This estimate is different from the amount of donor resources committed for FP commodities. For example, USAID has specific resources and commitments set aside specifically for commodities.

Outputs

The Database Tab

To change the data in the tool, you can just type over the data provided, but once data are changed, you cannot change the model to a different country in the same file. To begin a new country analysis, open and use a new master copy of the tool.

Click on the “Database” tab to see the screen below, which displays prevalence for selected methods, number of WRA, population growth rate (GR), unmet need, and TFR for 76 countries. The data are presented as follows:

Column(s)	Data Presented
D–M	Method mix among all FP users
N–U	Percentage of each method obtained from public sources
V	National CPR, including traditional methods
X–AF	CPR broken down by method (the sum of columns X–AF should equal column V)
AH, AI	Number of women (in thousands) of reproductive age in 2010 and 2025, respectively
AJ	Projected GR of the population of WRA
AK	Proportion of WRA who have an unmet need for FP
AL	TFR

Country	Survey Year	Year	Condom	Injections	Pill	Female sterilization	IUD	Male sterilization	Cycle beads	Implants	Traditional	Other	Condom	Injections	Pill	Fer
Albania	2008	2008	6.9%	0.8%	2.5%	4.4%	1.3%	0.0%	0.0%	84.1%	0.0%	6.9	83.5	32.9		
Armenia	2010	2010	27.7%	0.0%	2.7%	0.6%	17.9%	0.0%	0.9%	0.0%	50.2%	0.0%	4.7	0.0	9.3	
Azerbaijan	2006	2006	4.5%	0.0%	2.3%	1.0%	18.7%	0.0%	0.0%	0.0%	73.5%	0.0%	5.6	0.0	22.4	
Bangladesh	2011	2011	9.1%	18.5%	44.8%	8.2%	1.2%	2.0%	0.0%	1.8%	14.5%	0.0%	16.2	68.0	41.2	
Benin	2006	2006	15.5%	8.9%	7.7%	1.8%	3.0%	0.0%	0.0%	3.0%	60.1%	0.0%	8.7	75.4	32.9	
Bolivia	2008	2008	8.8%	18.1%	5.9%	10.5%	13.7%	0.2%	0.0%	0.0%	42.6%	0.0%	7.5	74.4	31.2	
Botswana	1988	1988	4.4%	10.8%	59.8%	7.4%	15.2%	0.3%	0.0%	0.0%	2.0%	0.0%	69.9	95.6	96.5	
Brazil	1996	1996	7.8%	2.0%	28.7%	49.5%	1.5%	2.9%	0.0%	0.0%	7.6%	0.0%	9.3	3.9	7.8	
Burkina Faso	2010	2010	20.4%	33.6%	18.4%	0.7%	1.3%	0.0%	0.0%	19.1%	6.6%	0.0%	6.1	96.6	80.1	
Burundi	2010	2010	6.0%	47.0%	10.4%	3.0%	12.7%	0.0%	0.0%	3.0%	17.9%	0.0%	0.0	97.4	85.1	
Cambodia	2010	2010	5.5%	20.9%	30.5%	4.8%	6.1%	0.0%	0.0%	1.0%	31.2%	0.0%	20.6	57.9	32.4	
Cameroon	2011	2011	47.2%	10.0%	7.0%	1.7%	0.9%	0.0%	0.0%	2.2%	31.0%	0.0%	6.2	74.1	48.9	
Cape Verde	1998	1998	9.9%	14.0%	39.5%	18.3%	7.0%	0.0%	0.0%	0.0%	11.3%	0.0%	0.0	0.0	0.0	
Central African Republic	1994	1994	10.3%	3.7%	8.1%	2.9%	0.0%	0.0%	0.0%	0.0%	75.0%	0.0%	26.4	78.5	59.6	
Chad	2004	2004	17.4%	17.4%	17.4%	8.7%	0.0%	0.0%	0.0%	0.0%	39.1%	0.0%	21.3	79.0	66.2	
Colombia	2010	2010	12.5%	13.0%	10.7%	39.9%	9.2%	3.1%	0.0%	4.8%	6.8%	0.0%	1.2	11.2	15.2	
Comoros	1996	1996	11.9%	18.7%	14.2%	11.9%	1.5%	0.0%	0.0%	0.0%	41.8%	0.0%	33.3	92.1	84.2	
Congo (Brazzaville)	2005	2005	24.8%	1.9%	4.8%	0.5%	0.2%	0.0%	0.0%	0.0%	67.8%	0.0%	10.3	78.6	53.4	
Congo Democratic Republic	2007	2007	24.7%	1.5%	4.1%	3.1%	1.0%	0.0%	0.0%	0.0%	65.5%	0.0%	1.0	75.3	45.4	
Cote d'Ivoire	2012	2011	27.6%	10.5%	33.7%	0.6%	0.6%	0.0%	0.0%	0.6%	26.5%	0.0%	8.6	49.3	34.3	
Dominican Republic	2007	2007	5.6%	6.0%	17.7%	63.2%	3.0%	0.0%	0.0%	0.7%	3.7%	0.0%	9.2	79.6	30.6	
Ecuador	2004	2004	6.7%	8.0%	17.8%	34.8%	14.0%	0.4%	0.0%	0.0%	18.2%	0.0%	5.8	17.1	27.9	
Egypt	2008	2008	1.2%	12.3%	19.7%	1.7%	59.9%	0.0%	0.0%	0.8%	4.5%	0.0%	16.6	85.2	19.3	
El Salvador	2008	2008	6.9%	25.7%	6.3%	51.9%	1.0%	0.4%	0.0%	0.0%	7.7%	0.0%	25.3	78.9	58.8	
Eritrea	2002	2002	14.0%	41.9%	23.3%	2.3%	7.0%	0.0%	0.0%	0.0%	11.6%	0.0%	11.3	91.0	73.5	
Ethiopia	2011	2011	1.5%	71.8%	7.7%	2.1%	1.0%	0.0%	0.0%	11.8%	4.1%	0.0%	17.3	85.2	70.5	
Gabon	2012	2012	57.1%	0.6%	12.0%	1.2%	0.3%	0.0%	0.0%	0.0%	28.7%	0.0%	18.6	64.8	30.4	
Georgia	2005	2005	19.0%	0.0%	6.8%	5.0%	25.1%	0.0%	0.0%	0.0%	44.1%	0.0%	0.0	0.0	0.1	

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The Results Tab

Click on the “Results” tab to view the screen below. Data are presented as follows:

Columns	Data Presented
B–F	Costs by component (commodities, personnel, overhead, support)
G–K	Costs by sector (public, NGO, private) needed to achieve success in reducing the FP gap
L–O	FP and commodity resources available and resource gaps

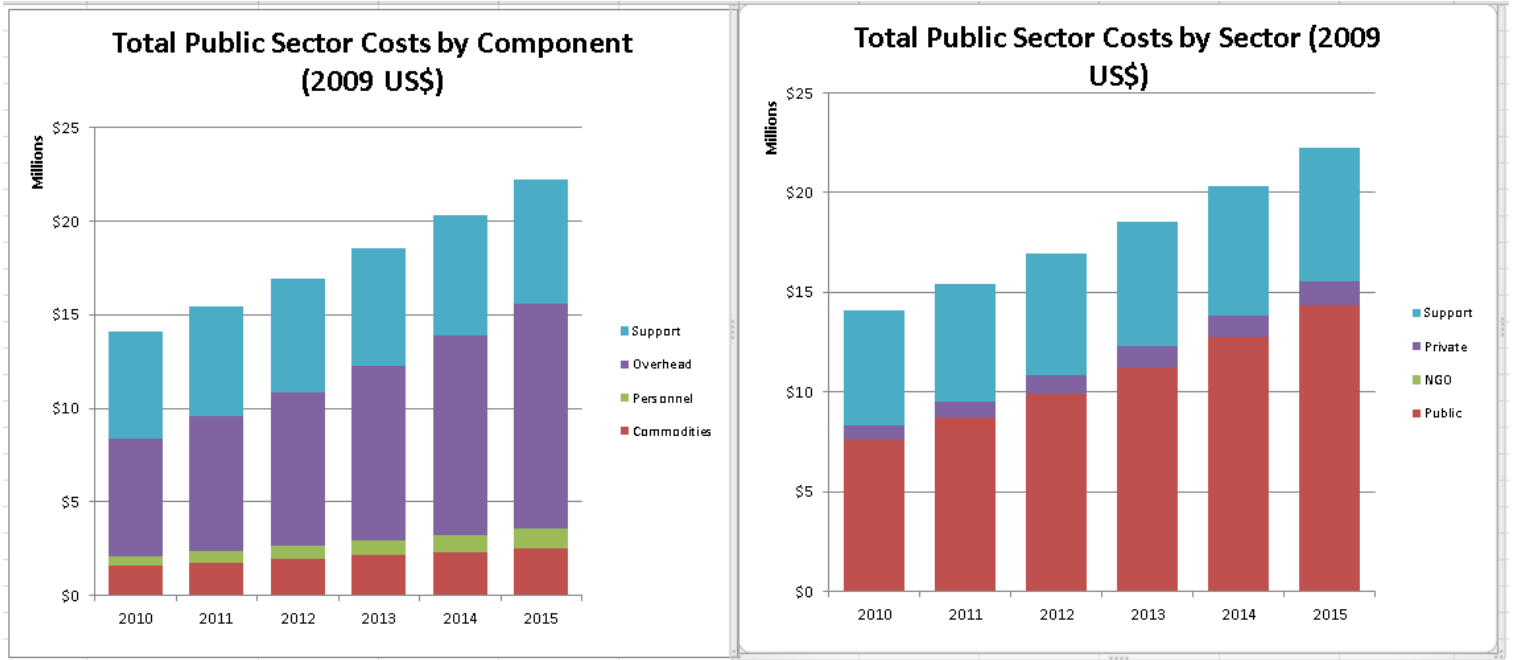
Year	Costs by Component (US\$)					Costs by Sector (US\$)					FP Resources Available
	Commodities	Personnel	Overhead	Support	Total	Public	NGO	Private	Support	Total	
2006	934,340	271,151	3,337,788	5,089,392	9,632,671	4,075,907	0	467,372	5,089,392	9,632,671	
2007	1,081,901	322,089	3,953,743	5,242,074	10,599,807	4,818,898	0	538,835	5,242,074	10,599,807	
2008	1,239,368	379,695	4,644,106	5,399,336	11,662,506	5,650,240	0	612,930	5,399,336	11,662,506	
2009	1,404,564	443,883	5,409,569	5,561,316	12,819,332	6,568,585	0	689,432	5,561,316	12,819,332	
2010	1,577,298	515,300	6,257,166	5,728,155	14,077,920	7,581,636	0	768,129	5,728,155	14,077,920	14,077,920
2011	1,757,358	594,657	7,194,543	5,900,000	15,446,558	8,697,736	0	848,822	5,900,000	15,446,558	14,077,920
2012	1,944,514	682,727	8,230,006	6,077,000	16,934,248	9,925,916	0	931,332	6,077,000	16,934,248	14,077,920
2013	2,138,520	780,353	9,372,582	6,259,310	18,550,765	11,275,954	0	1,015,501	6,259,310	18,550,765	14,077,920
2014	2,339,108	888,457	10,632,072	6,447,089	20,306,726	12,758,431	0	1,101,206	6,447,089	20,306,726	14,077,920
2015	2,546,000	1,008,040	12,019,118	6,640,502	22,213,660	14,384,800	0	1,188,358	6,640,502	22,213,660	14,077,920
2016	2,758,899	1,140,197	13,545,272	6,839,717	24,284,085	16,167,458	0	1,276,911	6,839,717	24,284,085	
2017	2,977,498	1,286,120	15,223,070	7,044,909	26,531,596	18,119,816	0	1,366,872	7,044,909	26,531,596	
2018	3,201,477	1,447,104	17,066,116	7,256,256	28,970,953	20,256,389	0	1,458,308	7,256,256	28,970,953	
2019	3,430,509	1,624,565	19,089,163	7,473,943	31,618,181	22,592,880	0	1,551,357	7,473,943	31,618,181	
2020	3,664,261	1,820,041	21,308,213	7,698,162	34,490,677	25,146,279	0	1,646,236	7,698,162	34,490,677	
2021	3,902,396	2,035,205	23,740,616	7,929,107	37,607,324	27,934,964	0	1,743,254	7,929,107	37,607,324	
2022	4,144,578	2,271,881	26,405,179	8,166,980	40,988,619	30,978,816	0	1,842,823	8,166,980	40,988,619	
2023	4,390,476	2,532,052	29,322,286	8,411,989	44,656,804	34,299,341	0	1,945,473	8,411,989	44,656,804	
2024	4,639,766	2,817,873	32,514,026	8,664,349	48,636,015	37,919,798	0	2,051,868	8,664,349	48,636,015	
2025	4,892,140	3,131,690	36,004,328	8,924,279	52,952,438	41,865,342	0	2,162,816	8,924,279	52,952,438	
2026	5,218,266	3,471,911	39,788,897	9,192,008	57,671,082	46,191,842	0	2,287,232	9,192,008	57,671,082	
2027	5,559,279	3,844,285	43,917,656	9,467,768	62,788,988	50,905,690	0	2,415,530	9,467,768	62,788,988	
2028	5,915,769	4,251,618	48,419,553	9,751,801	68,338,741	56,039,167	0	2,547,773	9,751,801	68,338,741	
2029	6,288,346	4,696,949	53,325,855	10,044,355	74,355,505	61,627,126	0	2,684,024	10,044,355	74,355,505	
2030	6,677,644	5,183,566	58,670,323	10,345,686	80,877,219	67,707,191	0	2,824,343	10,345,686	80,877,219	
	7,084,318	5,715,030	64,489,411	10,656,056	87,944,815	74,319,971	0	2,968,788	10,656,056	87,944,815	
	7,509,047	6,295,194	70,822,467	10,975,738	95,602,446	81,509,292	0	3,117,417	10,975,738	95,602,446	

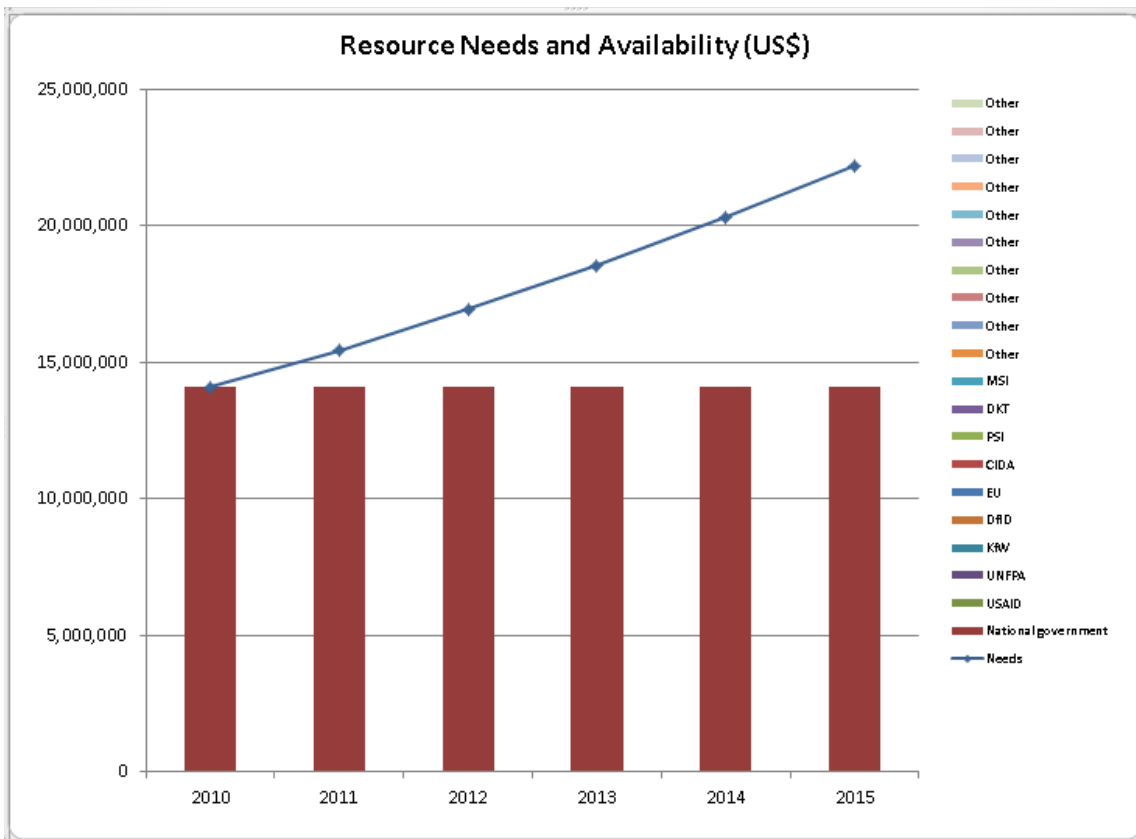
Note that there is an entry for buffer stock. This can adjust the commodity needs projections for the amount of buffer stock maintained. This is done by adding an amount to the commodity needs that is equal to the growth in needs from the previous year multiplied by the percentage of buffer stock maintained. The formula is: $NeedsWithBuffer[t] = Needs[t] + (Needs[t] - Needs[t-1]) * Buffer\ percent$. We assume that there were adequate buffer stocks in the first year, so we only need to increase the buffer stock for the growth in needs.²

² Even with the buffer stock in the calculations, this model does not indicate the amount of commodities that need to be purchased, since that depends on current stock levels and procurement delays. The model primarily estimates consumption. The amount that needs to be procured may be more or less than this figure.

The Charts Tab

Click on the “Charts” tab to view the following screen. Here, you will see two charts depicting resource needs over time by component and sector. The final two tabs display the GAP Chart and the Commodities GAP Chart, which depict resource needs with a blue line against projected resources by funder—for all FP costs and commodities only, respectively. These are the most salient charts for most users, but you can use the data and calculations in the GAP Tool to create your own charts, as needed.





LIMITATIONS

The GAP Tool represents a compromise between ease of use and comprehensiveness of data. When countries opt for greater ease of use, specificity in data quality is diminished. The default values included in the tool provide global averages for FP program costs; however, users should keep in mind that true country-level costs can vary significantly from the global averages. The more country-specific data the user can input into the tool, the more true to the country context the outcomes will be.

A secondary issue is that family planning is increasingly delivered as part of an integrated health services package. While disaggregated country-level data on FP services may be difficult to obtain, FP-specific data can better demonstrate the extent and nature of funding gaps and support advocacy for country ownership of the FP agenda.

This tool does not capture the capital investments necessary to make programs functional, such as health infrastructure for service delivery. In addition, the tool does not explicitly include costs of pre-service training needed for skilled health personnel. These costs are typically borne by governments, and in this way, the tool may underestimate government contributions to family planning.

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