



THE GAP TOOL



OVERVIEW

GAP (Gather, Analyze, and Plan) is a simple Excel-based tool developed to help policymakers, ministry officials, and health officials understand the costs associated with expanding family planning (FP) to achieve their country's contraceptive prevalence or fertility goals.

In 2001, nongovernmental organizations (NGOs), donors, multilateral agencies, private institutions, and other advocates came together in Istanbul, Turkey, to formulate concrete actions to address growing demand and funding shortfalls for family planning supplies in developing countries. The Reproductive Health Supplies Coalition was formed to manage the global response to a looming global contraceptive supply challenge. There is wide recognition that the 2001 Donor Funding Gap¹ prepared for the Istanbul meeting served as a key advocacy tool to bring attention to FP supply issues.

Almost a decade later, countries are taking increasing ownership of the family planning agenda. Funding decisions are coming under country purview with basket arrangements and direct budget support mechanisms. The focus of interest has also shifted from supplying current users to a broader interest in meeting unmet need for family planning. Global analyses of funding requirements for family planning are no longer sufficient in this environment.

Information at the country level is urgently needed to ensure that family planning programs are fully funded as the shift in agenda and ownership takes place. The GAP Tool, developed by the Health Policy Project, allows countries to project the contraceptive, service provision, and program support funding gaps. This brief has been prepared as part of a two-country pilot application of the GAP Tool (Ethiopia and Nigeria) to evaluate the extent of the contraceptive funding gap for a national family

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 products in the market—affect costs and the funding gap?

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planning program. Results of the Ethiopia and Nigeria studies are highlighted in this brief.

Resource Requirements for Family Planning

One major constraint to understanding what is needed to fully fund a national family planning program is the lack of information on the direct and indirect costs of delivering family planning services in-country.² Hence, commodity costs have been commonly used as a proxy for program costs. Commodity costs, based on unit cost data, are more readily available since commodities are procured in the international market—by donors like USAID and United Nations Population Fund. The use of commodity costs, while acceptable as a proxy, has some disadvantages at the country level:

¹ John Ross and Rudolfo Bulatao. (2001). *Contraceptive Projections and the Donor Gap*. Washington, DC: Futures Group for John Snow, Inc.

² For more information on costing family planning programs, see Janowitz, B., and Bratt, J. (1994). *Methods for Costing Family Planning Services*. Accessed at: www.popcouncil.org/pdfs/frontiers/Capacity_Bldg/unpf0050.pdf.

- The “ask” is necessarily underestimated, with an unfortunate result that programs may not budget nor *plan* for important inputs, including routine labor and overhead costs.
- Counting commodity costs alone ignores the additional government share in FP funding.
- Typically, program support costs can be a substantial part of making a program functional, but these costs when not counted, may not be funded, underfunded, or funded sporadically.

The GAP Tool provides decisionmakers in family planning with data from reviews of the costing literature on labor, program support, and overhead costs, along with commodity costs and country-specific data on demographic and programmatic inputs. It provides default values when country information is unavailable. In this way, the tool provides a methodology and process for systematically reviewing the availability and validity of inputs—an important by-product for evidence-based decisionmaking. By making direct and indirect costs explicit and tying strategic goals to budgets, the GAP Tool offers further opportunity to keep countries and donors on track.



COUNTRY APPLICATION: ETHIOPIA

Resource Requirements for Family Planning

In Ethiopia, as in other sub-Saharan African countries, unmet need for family planning serves as an indicator for achieving contraceptive security. Ethiopia has one of the highest levels of unmet need in the region—34 percent of currently married women³—and demographic pressures are viewed as important constraints on future economic growth.⁴ The Health Sector Development Plan 2010–2015 (HSDP IV) guides planning for health investments to reach the Millennium Development Goals (MDGs) by 2015.

HSDP IV calls for reaching a contraceptive prevalence rate (CPR) of 66 percent by 2015 from a

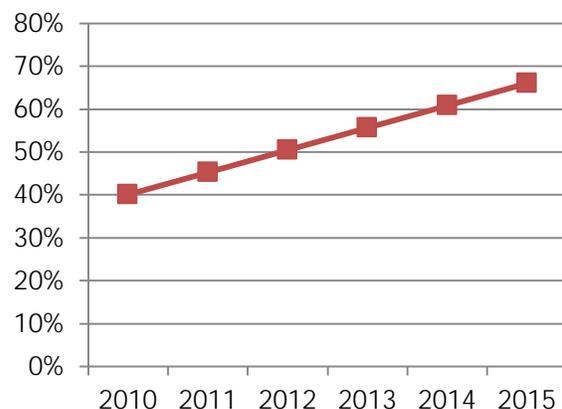
³ Central Statistical Agency [Ethiopia] and ORC Macro. (2006). *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.

⁴ Federal Ministry of Finance and Economic Development, Ethiopia. *Growth and Transformation Plan, 2010*.

baseline of 40 percent of women in union (Figure 1).⁵ The Ethiopian government has invested in rapidly expanding access to health services through the Health Extension Program. At present, about 37,000 health extension workers deliver a package of high-value interventions at the community level. Family planning has been identified as a high-value intervention, and there is strong commitment to expanding use, increasing use of long-acting methods, and shifting traditional method users to modern methods. The health sector and family planning program in particular has responded to these programming commitments with unprecedented gains in contraceptive prevalence since 2005, when CPR was 14.7 percent. There has also been a reported shift in methods from injectables to greater use of implants, a long-acting method. A particular innovation in Ethiopia was to have health extension workers trained in insertion and linked to health centers for removal of implants so they could successfully deliver this long-acting method in remote, rural areas.

Since March 2011, the Health Policy Project has worked with experts within the Federal Ministry of Health to collect data on targets, demographic patterns, program plans, family planning program costs, and planned funding. Information was also collected from key family planning stakeholders in the NGO and private sectors on planned investments and anticipated results. A draft application of the GAP Tool was completed in April 2011 and presented on May 11, 2011, to the national family planning technical working group for review and consensus.

Figure 1: Contraceptive Prevalence Rate, Women in Union



Source: GAP Tool Analysis Ethiopia, June 2011.

⁵ Federal Ministry of Health, Ethiopia. *Health Sector Development Plan IV (2010–2015)*.

Users, methods, and source

The Ethiopian family planning program is poised for a major expansion in the next five years. This application used HSDP IV targets for contraceptive prevalence for 2015 and Ethiopian census data for demographic inputs. Based on the projected increase in contraceptive prevalence, the total number of users will expand from 5.1 million women to 9.5 million women by 2015. Current plans anticipate expansion of both short- and long-acting methods. The government plans to address unmet need for long-acting methods by scaling up use of intrauterine devices (IUDs), along with implants. As a result, they anticipate the share of IUDs and implants to grow to 10 percent and 25 percent of the method mix by 2015, respectively, from current levels of less than 1 percent for IUDs and 4.1 percent for implants.

While method mix is projected to become more robust by 2015, injectables will remain the dominant method of use. Method mix can be a marker of female empowerment and male involvement. Based on stakeholder plans, the method mix in the next five years continues to show limited male involvement—reflective of limited couple negotiation in fertility planning. Both female and male sterilization and condom use are not expected to be significant in the method mix. The GAP Tool application also showed a continued dominance of the public sector in family planning. Between 2005⁶ and 2010, survey data suggest a shift away from the private and NGO sectors to the public sector for services.⁷

Results

The cost of delivering family planning in Ethiopia was \$39.4 million in 2010. To reach a CPR of 66 percent by 2015, these costs can be expected to more than double to \$88 million in 2015. Commodities are the biggest drivers of costs in Ethiopia, but program support costs continue to represent a substantial proportion of current costs. Unlike most countries in the region, labor costs in Ethiopia are low—a result of Ethiopia's decision to have health services delivered primarily by community health workers.

An important finding of this exercise was that component cost data are not routinely collected and



difficult to disaggregate from bundled health funding. In Ethiopia's case, data on labor costs to deliver family planning were available from a study conducted in 2009.⁸ Data on program support and overhead costs were based on default global values and discussions with the Family Planning Technical Working Group for this exercise. The lack of cost data is and will be a significant hindrance to understanding resource needs for family planning.

The results of this application suggest that commitment from donors for the next two years (2011/2012), if not timely released, will not cover projected demand without even including buffer⁹ contraceptives needed for procurement purposes.

Beginning in 2013, there is a substantial gap for family planning funding, largely because some donors have not indicated their planned commitments beyond 2012. In 2013, the family planning gap is \$34 million, and by 2015, this gap is expected to increase to \$54.6 million (Figure 2). Government commitments are expected to rise from \$12.9 million to \$14.8 million in 2012.

How can Ethiopia use results of the GAP Tool?

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

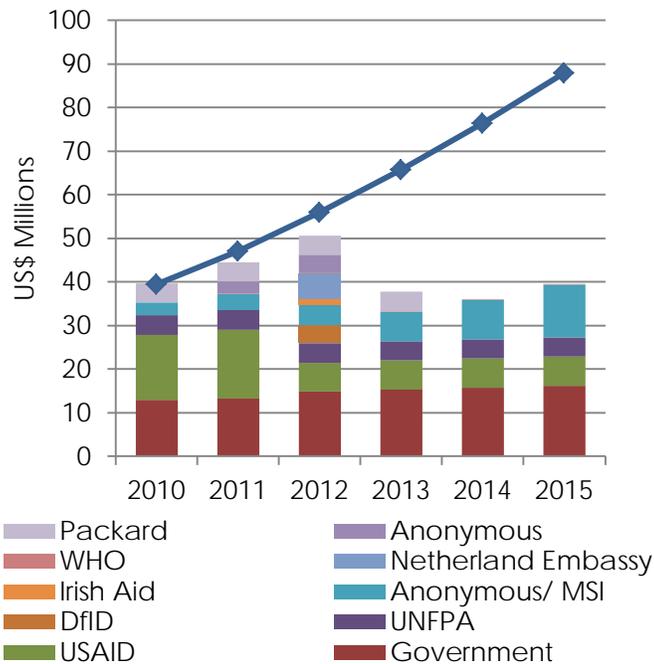
⁸ Weisman, E. (2010). *The Cost of Family Planning in Ethiopia*. Washington, DC: USAID | Health Policy Initiative, Task Order 1, Futures Group.

⁹ Buffer stock is the amount of stock procured and over consumption requirements that is kept in reserve to manage fluctuations in demand and supply. See Binzen, Suzanne. (1998). *Pocket Guide to Managing Contraceptives*. Atlanta, GA: CDC/JSI Family Planning Logistics Management, Department of Health and Human Services, Centres for Disease Control and Prevention.

⁶ Central Statistical Agency [Ethiopia] and ORC Macro. (2006). *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.

⁷ The Last Ten Kilometers Project. (2009). *Baseline Household Health Survey: Amhara, Oromiya, SNNP and Tigray*. Addis Ababa, Ethiopia: JSI Research & Training, Inc.

Figure 2: FP Resource Requirements and Funding (2011 US\$)



UNFPA = United Nations Population Fund; MSI = Marie Stopes International; WHO = World Health Organization; DFID = United Kingdom Department for International Development



COUNTRY APPLICATION: NIGERIA

Resource Requirements for Family Planning

In Nigeria, as in other sub-Saharan countries, unmet need for family planning serves as an indicator for achieving contraceptive security. Nigeria has a high level of unmet need—20 percent of currently married women¹⁰ and demographic pressures are viewed as important constraints on future economic growth. Nigeria's National Policy on Population for Sustainable Development (NPPSD) and National Strategic Health Development Plan (NSHDP) present Government of Nigeria (GON) goals regarding fertility and increases in contraceptive use.

NPPSD's 2015 targets include the following:

- Lower infant mortality to 35 per 1,000 live births
- Lower child mortality rate to 45 per 1,000 live births
- Lower maternal mortality to 75 per 100,000 live births

¹⁰ ORC Macro. (2008). *Nigeria Demographic and Health Survey 2008*. ORC Macro.

- Achieve sustained growth, eradicate poverty, improve living standards

NSHDP's 2015 targets include the following:

- Lower infant mortality to 30 per 1,000 live births
- Lower maternal mortality to 136 per 100,000 live births
- Adolescent births (teenage mothers): 90/1000

Increasing contraceptive prevalence by two percentage points each year would meet all unmet need in Nigeria by 2018 if applied to currently married women beginning in 2008 (Figure 3).¹¹

In 2010, the United Nations Population Fund (UNFPA), United Kingdom's Department for International Development (DFID), and USAID, working with the Federal Ministry of Health (FMOH), Family Health Division, produced a forecast indicating that the complete stocking of the public sector would require about \$10 million in commodities supplies in 2010. With concerted efforts by the Civil Society Organization and led by the Family Planning Action Group (FPAG), the Nigerian government has begun to invest in FP commodities for the first time in 2011. Using MDG funds initiated by the Office of the Presidency, the GON, through the Office of the Senior Special Assistant to the President on Millennium Development Goals, has taken a first step—a commitment of roughly \$3 million for 2011.

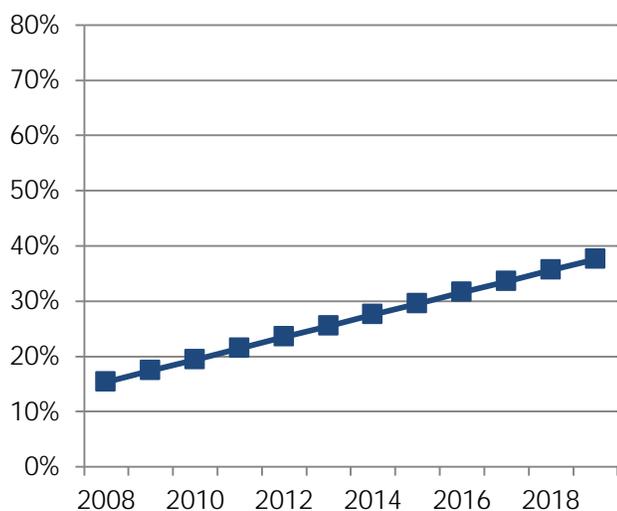
Current annual commitments to fill the gap for commodities come from the UNFPA (\$1–2 million), Canadian International Development Agency (about \$1 million), DFID (\$4.5 million for six years starting in 2010), Global Fund (about \$1.5 million), Oxfam/Novib (about \$0.1 Million), and others. DFID required the Nigerian government to match their donation. Family planning has been identified as a high-value intervention, and it will need more GON and donor support to expand.

Since March 2011, the Health Policy Project has worked with experts within the FMOH to collect data on targets, demographic patterns, program plans, family planning program costs, and planned funding. The project collected information from key family planning stakeholders in the NGO sector (Advocacy Nigeria/FPAG and Society for Family Health) and from the development community (USAID | DELIVER Project) on planned investments. These

¹¹ National Population Commission. 2004. *National Policy on Population for Sustainable Development*.

stakeholders completed draft applications of the tool in April and May 2011 and reached consensus on which data to use by holding a series of meetings in Abuja.

Figure 3: Contraceptive Prevalence Rates, Percent of Married Women of Reproductive Age



Source: GAP Tool Analysis Nigeria, October 2011.

This application used NPPSD targets for annual increases in contraceptive prevalence through 2018 in order to meet 2008 levels of unmet need. This application used the default UN demographic data for demographic inputs. Based on the projected increase in contraceptive prevalence, the total number of users will expand from 5.8 million women in 2008 to more than 17 million women in 2018. Consensus estimates anticipate expansion of both short- and long-acting methods, with an emphasis on short-acting methods.

The experts we consulted forecast increases in the use of implants, injectables, IUDs, and condoms between 2008 and 2018. These increased shares will come primarily at the expense of traditional methods, pills, and female sterilization. Condoms will continue to represent the largest share of the method mix rising to 36.5 percent by 2018. This GAP Tool application also showed that the public and private sectors each play significant roles in the provision of family planning. Between 2008 and 2018, the consensus forecasts suggest a shift away from the private sector to the public (and NGO) sectors for services.

Results

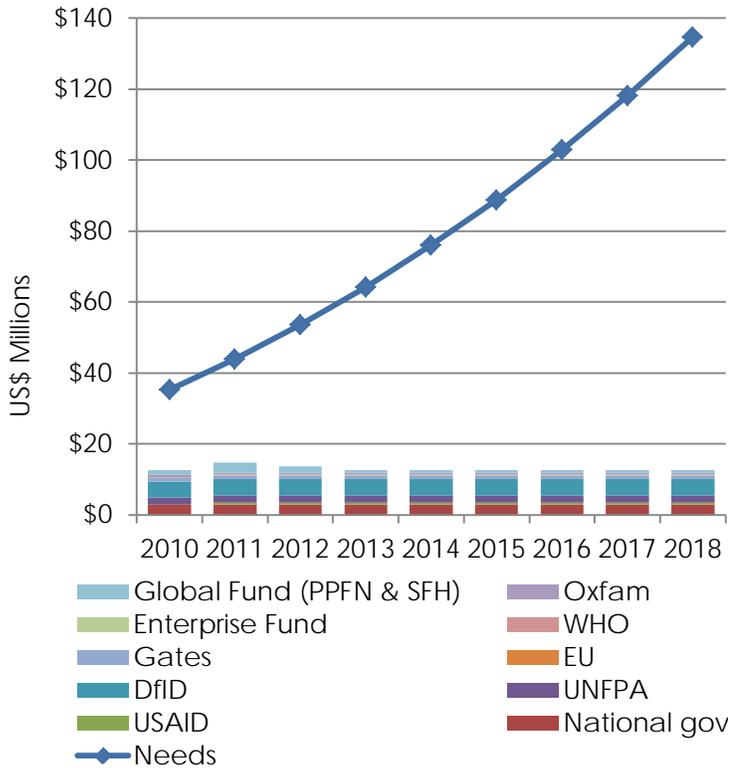
The total cost of delivering family planning in Nigeria surpassed \$260 million in 2010. To reach a CPR of 36 percent by 2018, these costs can be expected to more than double to \$632 million in 2018. Today, support costs for family planning are significant drivers of overall FP programs, but support costs will fall once Nigeria has an established, well-run FP program. We revised data on program support and overhead costs upward from the default global values for this exercise because Nigeria is a larger than average country and has a great need for these resources. The lack of Nigeria-specific cost data is and will be a significant hindrance to understanding resource needs for family planning, but these rough estimates will sufficiently illustrate the general trajectory of cost increases for FP.

The results of this application suggest that Nigeria has not obtained sufficient resources to meet projected demand through 2018. Furthermore, the total need is not inclusive of buffer requirements, as these estimates are not intended for procurement purposes. A substantial gap for family planning commodities funding continues to exist. In 2010, the FP gap was roughly \$23 million, and by 2015, this gap could increase to \$76 million if current commitments remain constant over time (Figure 4). The GON commitments must continue to rise to close this funding gap. Donor commitments represent the bulk of funding for FP commodities, representing all of funding in earlier years and most of funding in 2011.

How can Nigeria use results of the GAP Tool?

- For improved understanding of what resources are needed to reach targets in family planning.
- To advocate for new GON and donor commitments for family planning.
- To advocate for the passage of the National Health Bill, which will provide more funding for maternal and child health services.
- As an instrument for policy dialogue on method mix and private sector involvement in FP.

Figure 4: Commodity Resource Requirements and Funding (2011 US\$)



DFID = United Kingdom Department for International Development; WHO = World Health Organization; EU = European Union; UNFPA = United Nations Population Fund



CONCLUSION

The right “ask” begins with countries seeking and using information on all the costs that go into making a family planning program fully operational.

GAP is a strategic planning tool to help frame the right “ask” at the country level, by linking a country’s FP goals with what it will cost to reach those goals. The pilot application in Ethiopia shows that information on costs may be difficult to obtain but is essential to estimating resource requirements for FP. It required stakeholders to come to consensus on target, demographic, and cost inputs to arrive at the “one agreed-on number” for family planning. Through a process of gathering, analyzing, and planning, the GAP Tool presents a methodology for stakeholders in-country to take leadership and ownership of their family planning program.¹²

¹² 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. Data from the EDHS 2010 will be used to update Ethiopia’s GAP analysis.

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 global values provide global averages for family planning program costs. There is a large variation in family planning costs at the country level, which means that complete reliance on global defaults may be misleading in a particular country context.

A secondary issue is that family planning is increasingly delivered as a package of services and integrated in health service delivery. Disaggregated country-level data is difficult to obtain but must be sought in order for stakeholders of family planning to understand the extent and nature of their gap to advocate successfully for country ownership of the family planning agenda.

This tool does not capture the capital investments necessary to make programs functional, such as health infrastructure for service. In addition, the tool does not explicitly include costs of pre-service training needed to produce 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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The information provided in this brief is not official U.S. government information and does not necessarily represent the views or positions of the U.S. Agency for International Development.

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