COMPASS INITATIVE SERIES: FINANCE

CONTRACEPTIVE COMMODITY FUNDING DURING THE COVID-19 PANDEMIC

Analysis of funding trends and potential pandemic impacts in low- and middle-income countries

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Reproductive Health
SUPPLIES COALITION

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CONTRACEPTIVE COMMODITY FUNDING DURING THE COVID-19 PANDEMIC

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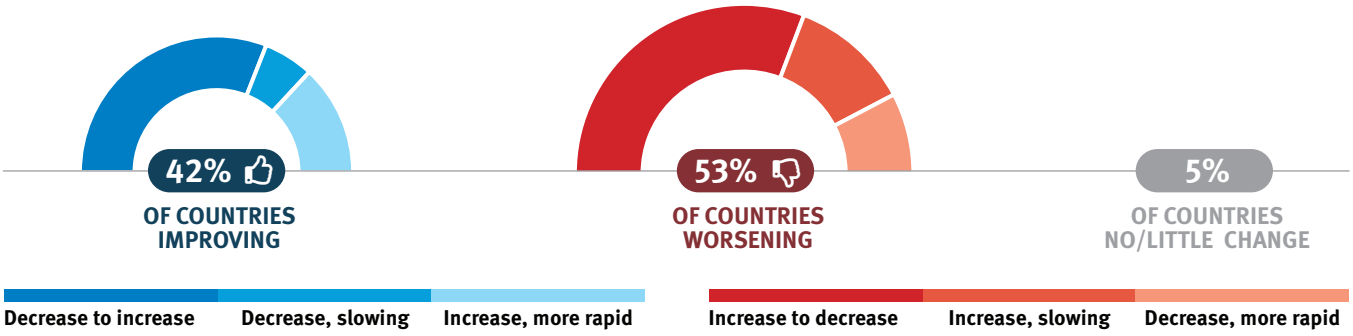

RHViz/VAN data; comparing 2017-2019 trend to 2019-2021 trend. Note: full report includes similar analysis from other data sources and funding sources

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STAKEHOLDERS INTERVIEWED

Including three country case studies focused on risk & resilience factors.

COMMON LESSONS TO STRENGTHEN FINANCING IN THE FUTURE INCLUDE:

- Increase domestic resources
- Learn from other programs
- Develop the private sector
- Improve supply chain management

KEY INSIGHTS INCLUDE:

- Resilience factors protected against funding drops; funding already allocated, leveraging new funding, manufacturer agreements in place
- SRH community reacted with improved coordination and faster decision making; should be maintained in the future
- Global economic and social challenges, some as a result of COVID-19 and some external, may make increased funding difficult

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For a summary of this report's findings, download this slide presentation here.

Acronyms and Glossary

CHAI	Clinton Health Access Initiative, joint publishers with RHSC of the annual Family Planning Market Report used in this analysis
CS Indicators	Contraceptive Security (CS) Indicators Survey, completed every two years by national governments, supported by USAID
DMPA-SC	Subcutaneous depot medroxyprogesterone acetate, a three-month injectable contraceptive
FCDO	The Foreign, Commonwealth and Development Office, the government department in the United Kingdom responsible for overseas development assistance, including funding for contraceptives
FP2020	Family Planning 2020, a global initiative that ran from 2012-2020 that aimed to provide family planning to an additional 120 million women and girls in the world's poorest countries by 2020
FP2030	Family Planning 2030, the successor to FP2020
FP Market Report	Family Planning Market Report, produced annually by CHAI and RHSC (see Box 2 for more details of this report)
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria, a global health partnership that provides funding for contraceptives in some countries
IUD	Intrauterine device, a five or ten year long-acting reversible contraceptive
JSI	John Snow Inc., a global public health consulting organization
KFF	Kaiser Family Foundation, a nonprofit organization, providing policy analysis, journalism and communications programs, related to national health issues and the US role in global health policy
LMIC	Low- and middle-income countries, as defined by the World Bank
RHSC	Reproductive Health Supplies Coalition, a global partnership of public, private, and non-governmental organizations working to improve access to and use of affordable, high-quality supplies
RHViz/VAN	Reproductive Health Supplies Visualizer, public-facing dashboards combining historical procurement data with live procurer shipment data (the public-facing version of the Global FP VAN - see VAN below)
SRH	Sexual and Reproductive Health
UK	United Kingdom
UNFPA	United Nations Population Fund, the United Nations sexual and reproductive health agency, and one of the main procurers of donor-funded contraceptives in the public sector
USAID	United States Agency for International Development, the international development agency of the U.S. federal government, and one of the main providers of global contraceptive funding
USD	United States Dollar
VAN	Global Family Planning Visibility and Analytics Network, an RHSC platform that captures data from multiple sources to improve supply chain visibility

Data Note

In this report we have used '**funding**' to refer to the overall amount of money spent on contraceptives.[1] This funding focuses on the purchase of contraceptive commodities (products) themselves, and not any other associated costs (e.g., service delivery costs). We include funding for hormonal and non-hormonal contraceptives, including condoms.[2]

For the purposes of this analysis, we focused on '**publicly funded**' commodities, which means the analysis includes funding from donors (e.g., UNFPA, USAID) and funding from national governments in low- and middle-income countries (LMICs) within their own country (referred to in this report as '**domestic funding**'). Note that commodities purchased using these public funds may be provided to consumers outside of the public sector (e.g., via non-profit or private providers). This analysis does not include out-of-pocket expenditures by individual consumers or others, or other commercial/private sources of funding.

The data sources used in this analysis measure contraceptive funding in different ways. The main areas of difference across the funding sources include:

- **Source of funding included in the data**: domestic government expenditure, donor expenditure, or both.
- **Timing**: which year funding is assigned to, depending on whether the data is based on when the contraceptives were ordered, shipped, or received in-country. This means the same funding may be counted in different years by different data sources.
- **Monetary value (in USD) of the contraceptives**: this may be the true cost incurred, or an estimate based on actual volumes multiplied by the average market price. Sometimes, the monetary value may include additional costs, like inspection, testing, and freight.

Generally, specific years are used to indicate the time period of analysis; however, for readability, sometimes the term '**pandemic period**' is used to describe trends observed from 2020 onwards (exact years dependent on data availability).

See Box 2 (in Quantitative Data & Analysis) and Annex 2 for more detail on the data sources used, including the type of funding they include.

1 Note that some data sources include allocations of funding, thus the term funding in this report may refer to these allocations (which may or may not be spent). See Annex 2 for more details of which data sources this applies to; when allocations are shown this is clearly noted.
2 Note that different data sources may define the included commodities differently; see Annex 2 for more detail about what is included in each data source used

Introduction

Report Background

In early 2021, John Snow, Inc. (JSI) and the Reproductive Health Supplies Coalition (RHSC) issued a report, Building resilient sexual and reproductive health supply chains during COVID-19 and beyond: community roadmap for action and technical findings (referred to here as the 'Roadmap report') to promote more resilient supply chains and markets for reproductive health products in the face of COVID-19. The Roadmap report contains a series of broad, far-reaching recommendations in the areas of market dynamics, financing, supply chain strategies, policies and stewardship, and data visibility and access.

One primary message in the Roadmap report was the increased competition for scarce resources. Since early 2020, many in the Sexual and Reproductive Health (SRH) community have expressed concern that funding for contraceptives would be deprioritized due to diversion of funds towards COVID-19 response efforts, and to cover higher supply chain expenses (e.g., freight). Concerns have been voiced over the potential for these competing demands to undermine domestic and donor spending in the near- to long-term.

In order to better understand the current status and trends in funding for contraceptives, and underlying drivers, RHSC commissioned Avenir Health in May 2022 to conduct a deep analysis of the status of contraceptive funding across a wide range of LMICs. This analysis seeks to identify changes in budget allocation and spending on contraceptives before and during the pandemic period, as well as the underlying drivers for these changes (COVID-19 and otherwise).

Understanding Contraceptive Funding before COVID-19

The funding environment for contraceptives in LMICs is dynamic, and involves many players at national, regional and global levels. In any given country, funding for contraceptives may come from a range of sources including:

- Domestic government funding, at a national or subnational level; either using their own revenues or allocating funds from a basket fund, or other externally supported mechanism
- Donors to the country, which in turn may be other national governments, international non-governmental organizations, or private sources (e.g., philanthropic organizations)[3]
- Individual users of contraceptives (paying the full or partial cost of their contraceptives)
- Private organizations, such as insurance companies

The proportion of contraceptive funding from each source varies greatly across LMICs. For instance, in 2019, the last full year before the COVID-19 pandemic, in countries such as India, Pakistan and many countries in Latin America, almost all public sector contraceptive commodities were self-financed by domestic governments using internally generated revenues.[4] By comparison, in countries like Bangladesh and Ethiopia, domestic governments contributed large shares of contraceptive funding utilizing basket funding mechanisms. Many other LMICs, especially those in sub-Saharan Africa, relied almost exclusively on donor funded commodities.[5]

Globally, donor funded commodities are mostly procured by either USAID (using bilateral funding from the United States government) or UNFPA (using pooled funding from multiple donors). In some cases, UNFPA also procures commodities on behalf of domestic governments or other partners.[6] Donors also contribute resources to family planning programs beyond commodities, such as funding for training, infrastructure, personnel and program implementation; this funding is primarily provided by bilateral donors, but foundations and nonprofit organizations also contribute. The largest donor governments providing family planning funding in 2019 were the United States, the United Kingdom (UK), the Netherlands, Sweden and Canada.[7] While donor government funding for family planning has fluctuated over the last decade, the overall trend has been an increase.

Even before the COVID-19 pandemic, there were large year-on-year fluctuations in contraceptive funding; Figure 1 displays some of these existing (pre-pandemic) factors that influence contraceptive funding. It is also important to note that the same amount of funding in each year may purchase a different amount of commodities due to changes in prices, and changes in the mix of commodities ordered.

3 Donors may also contribute to domestic government basket funds or provide loans to Governments, but we are distinguishing based on who is ultimately allocating the funding to commodities

4 Data drawn from the USAID Global Health Supply Chain Program 2019 Contraceptive Security Indicators (2019 data available here; report here).

5 Ibid

6 Through 'Third Party Procurement (TPP)' or co-financing mechanisms. For the purposes of this report co-financing is not classified as UNFPA/donor funding.

7 KFF (2019) Donor Government Funding for Family Planning in 2019

Figure 1: Existing (pre-pandemic) factors impacting contraceptive funding

- **Year-on-year funding fluctuations are the norm**
- **Shifting balance in donor funding**
  UNPFA increasing share of funding, USAID decreasing
- **Introduction of National Health Insurance Schemes**
  That may or may not include contraceptives
- **Changes in methods**
  e.g. more products available, rapid growth in demand for implants
- **Manufacturing contraints**
  e.g. production limitations on some methods
- **Inflation and changing exchange rates**
- **Humanitarian crises and regional/internal conflicts that divert contraceptive funding**
- **Countries reducing overseas development assistance**
- **Increasing wealth in LMICs, increasing ability of national governments to fund contraceptives**
- **National economic, social and political changes**

In recent years, there has been an increasing desire and attempts by both donors and national governments to diversify funding sources for contraceptives. This has primarily been driven by the uncertainty of donor funding, which can increase or decrease based on factors such as changes in political leadership, global and national economies, and exchange rate fluctuations.

Additionally, an increasing recognition of the importance and value of family planning, and growing national ability to pay, as countries' wealth increases, may result in increased national budget allocation for family planning services. Since the 2012 London Summit on Family Planning, national governments in LMICs have increased their own commitments; by 2020, 44 of the 48 commitment making FP2020 countries included a domestic financial commitment with their pledge.[8] Note that most, if not all, of the factors included in Figure 1 above continued to impact contraceptive funding during the pandemic, in addition to the pandemic-specific factors which are explored in the next section.

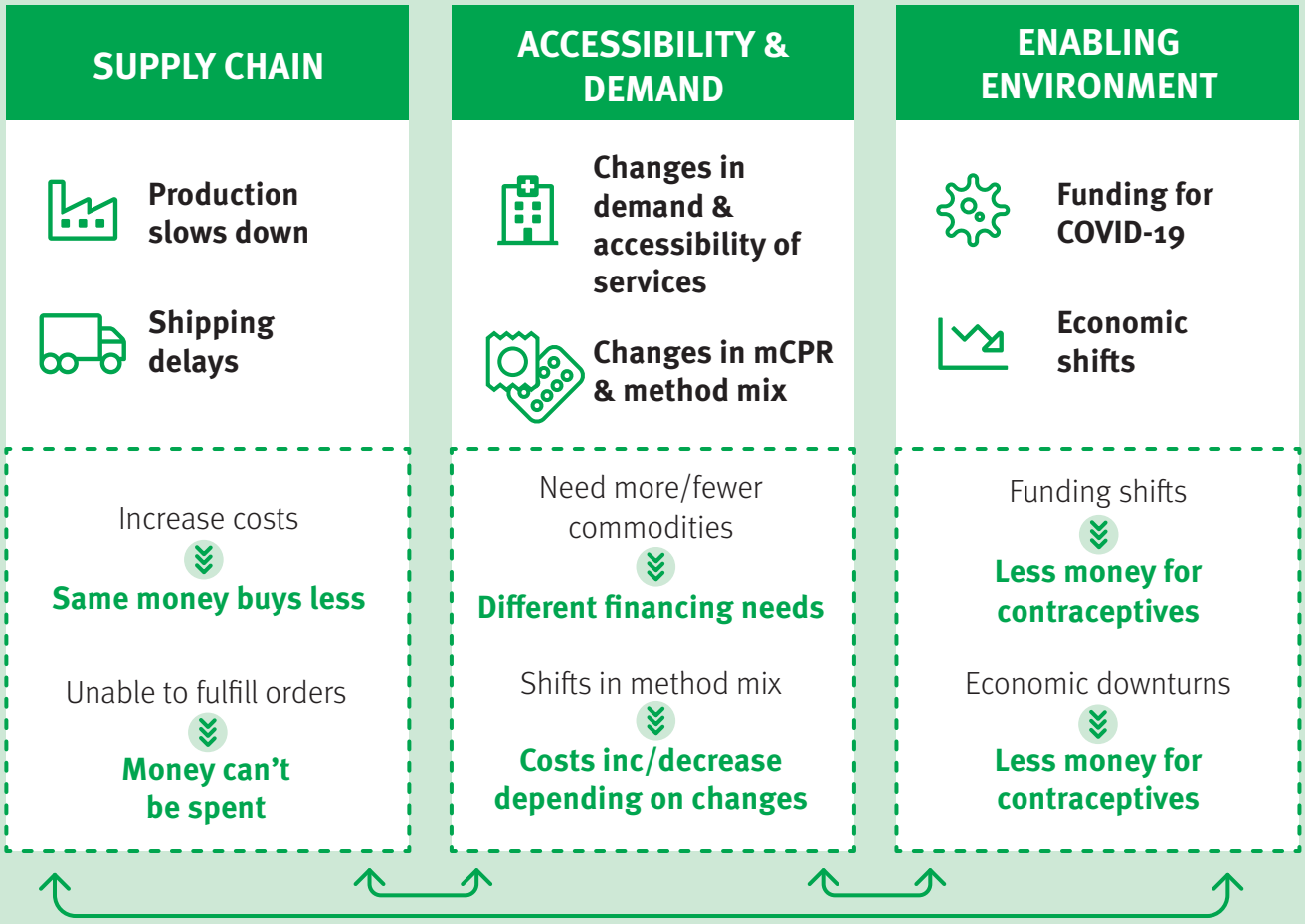
8 FP2030 (2021). Measurement Report 2021.

Potential Impact of COVID-19: Conceptual Framework

This report seeks to understand the various impacts of the COVID-19 pandemic on public funding for contraceptive commodities. We developed a simple theoretical framework of possible impacts of the pandemic under three domains (Figure 2); changes to the supply chain, changes to accessibility and demand, and factors within the wider enabling environment. Changes within each of these domains could impact funding in different ways; illustrative examples are included in Figure 2. In addition, the potential impacts of COVID-19 on these three domains are all interrelated.

Our analysis focused on identifying what changes (if any) occurred to publicly funded contraceptives since the start of the COVID-19 pandemic, and identifying some of the underlying drivers of these changes. However, the analysis was broad in scope and does not look in detail at all aspects of the framework. In particular, the analysis does not focus on changes in accessibility and demand for contraceptives.

Figure 2: Theoretical framework of potential impact of COVID-19 on contraceptive funding



Box 1: Some caveats to keep in mind for this report

- Fluctuations in funding for contraceptives are common, especially at the country level; not all changes seen will be related to COVID-19
- Many other things (outside of the pandemic) are occurring that impact on contraceptive funding
- There is only limited data available so far "during" the COVID-19 pandemic (either one or two years, depending on the data source) so it is not yet possible to establish definitive trends
- There is often a long lead time for contraceptive orders and funding allocations; so, the impacts of the COVID-19 pandemic might not appear in 2020 or even 2021 data
- Our analysis does not consider changes in the cost of commodities, which may have affected how much was bought with available funding
- We do not have a counterfactual against which to compare our results - i.e. we don't know what would have happened to funding over this timeframe if there had been no pandemic

Method Overview

This report is based on quantitative analysis of existing data sources, combined with qualitative data collected specifically for this report. Below is a brief overview of the main data sources; see Annex 3 for further methodological detail.

Quantitative Data & Analysis

We used four data sources for the quantitative analysis, each of which included different countries and somewhat different data on funding for contraceptive commodities (see Box 2). Quantitative data analysis focused on trend analysis for each data source at a country and global level, comparing trends in contraceptive funding 'pre-pandemic' (2017-2019) with trends in contraceptive funding from 2019 onwards.[9] The analysis focused on changes in trends (rather than in specific amounts of funding), as each data source included slightly different types of data and thus differing total funding in each year of analysis (Box 2).

Analysis was conducted at three levels: (1) all public funding combined, (2) donor funding, and (3) domestic funding. This approach was used to maximize data available for the analysis, since not all data sources provide all three data types, and to explore potential changes to different types of funding.

For any given country and data source, the funding situation was categorized as 'improving', 'worsening' or 'no/little change' (see Box 3).

9 Note only one data source had 2021 data available at the time analysis was conducted for this report.

Box 2: Quantitative Data Sources

Four main quantitative data sources were used in this analysis; each reports on somewhat different funding data across different countries. This box summarizes the main data used from each source; Annex 2 includes more details of each data source.

- RHViz/VAN (RHSC): RH Viz combines historical procurement data with live procurer shipment data from the VAN. This data includes public funding for 130 countries - primarily donor funding, with some non-profit organization and government funding. Data used in this analysis is the **reported estimated line value of contraceptives received in-country** in a calendar year.[10] Our analysis included RHViz/VAN data from 2015 to 2021.[11]

- Family Planning (FP) Market Report (CHAI and RHSC) : Includes donor and domestic funding in focus countries - the 2022 report includes the 83 FP2030 countries; previous reports included 68 of the 69 FP2020 countries.[12] Country level analysis in this report is based on the reported **volume of contraceptives shipped with public sector funding** as reported by manufacturers;[13] we converted this to a monetary value based on average public sector unit prices. Our country-level analysis included the FP Market Report data from 2015 to 2020.[14]

- Contraceptive Security (CS) Indicators Survey (USAID): This analysis includes the domestic funding reported by countries responding to this survey - 63 countries responded to the 2021 survey. Data used is the **reported estimate of government expenditure** on contraceptive commodities in the most recent fiscal year. Our analysis included the CS Indicators data from the 2015, 2017, 2019 and 2021 surveys.

- National Budget Allocation and Spending (UNFPA Countries): Includes domestic funding reported by 48 countries supported by UNFPA. Data used is the amount allocated and spent by national governments on contraceptives in each fiscal year.[15] Our analysis included data from 2015 to 2021.

Each country included in the analysis may have data from one, two, three or four of the data sources.

More details of each data source, including which countries are included in each, can be found in Annex 2.

10 RHViz/VAN estimates monetary value by multiplying shipment volumes for specific commodities by a unit reference price.
11 Analysis based on data extracted from RHViz/VAN on August 12, 2022. Subsequent data was extracted on January 2, 2023 for Box 4 analysis of 2022 funding to date.
12 No data available for one FP2030 country (Western Sahara), so Western Sahara not included in analysis
13 With the exception of male condoms where volumes are based on data from RHViz/VAN rather than manufacturer reports.
14 Note that 2021 data is included in our overall funding results, as the 2021 data was released as this report was being drafted. However the country level data for 2021 had not been released, so our detailed country analysis only includes FP Market Report data until 2020, in the smaller set of 69 FP2020 countries.
15 Note that data on funding allocation is treated separately in our analysis to funding spent.

Box 3: Trend Categories

Improving is used to describe a positive change in the national funding situation for contraceptives from 2019 onwards, compared to the trend in 2017-2019. This includes countries where:

- Funding was decreasing pre-COVID-19, but reversed during the pandemic and began to increase
- Funding was decreasing pre-COVID-19, but the trend of decreasing funding slowed during the pandemic
- Funding was already increasing pre-COVID-19, and this increase accelerated

Worsening is used to describe a negative change in the national funding situation for contraceptives from 2019 onwards, compared to the trend in 2017-2019. This includes countries where:

- Funding was increasing pre-COVID-19, but reversed during the pandemic and began to decrease
- Funding was increasing pre-COVID-19, but the trend of increasing funding slowed during the pandemic
- Funding was already decreasing pre COVID-19, and this decrease accelerated

Countries where there was little or no discernible change in funding were categorized as '**no/little change**'.

In 32 countries there was 'agreement' of trends across the two main data sources (RHViz/VAN and FP Market Report) in terms of overall public funding (i.e., the country was categorized as 'improving', 'worsening' or 'no/little change' across both data sources).[16] For these countries, we had more confidence that the trends observed were likely accurate, and thus conducted more detailed analysis at the national level.

See Annex 3 for a fuller description of the quantitative data analysis approach, including limitations.

16 To allow for comparability of trends RHViz/VAN data was analyzed exclusive of 2021 for the 'agreement' analysis. In total, 58 countries had trend analysis available from both data sources. Of these, 34 had 'agreement' in the overall trend; however, Bangladesh and Mongolia were excluded due to data sources only capturing a small share of funding in these countries (e.g. data sources not capturing domestic funding which accounts for a large proportion of funding).

Qualitative Data & Analysis

We conducted interviews and informal discussions with multiple global and national stakeholders (see list of contributors in Annex 1).

Initially we interviewed individuals and organizations involved in collecting quantitative data on contraceptive funding to better understand what the data included, which data sources would be most relevant to include in our analysis, and their analysis approaches.

After conducting the quantitative analysis, we held further interviews with stakeholders in November and December 2022 to explore the drivers behind the trends we had discovered. At the same time, we conducted additional interviews with stakeholders in Kenya, Uganda and Zambia; these countries were selected for deeper analysis to represent a range of settings and trends observed in the quantitative data analysis. Country-level interviews and analysis were led by locally based staff/consultants.[17]

Stakeholder interviews were analyzed thematically, with findings and relevant quotes included in the findings sections.

The main limitation of the qualitative data concerned the number of interviews we were able to conduct within the available time and resourcing; only a select number of stakeholders were able to be approached and were also available for interview during the data collection phase. Attempts were made to ensure a broad representation of perspectives at both a global and national level, including donors, national governments and others.

17 Daniel Mumbia (Kenya), Rogers Kagimu (Uganda) and Kumbutso Dzekedzeke (Zambia); Gabrielle Appleford supported data collection and analysis in Kenya and Uganda, and led on writing these country case studies.

Findings: Overall Public Sector Funding Trends

In this chapter:

- Aggregate Trends
- Country Level Variation
- Donor Funding Trends
- Domestic Funding Trends

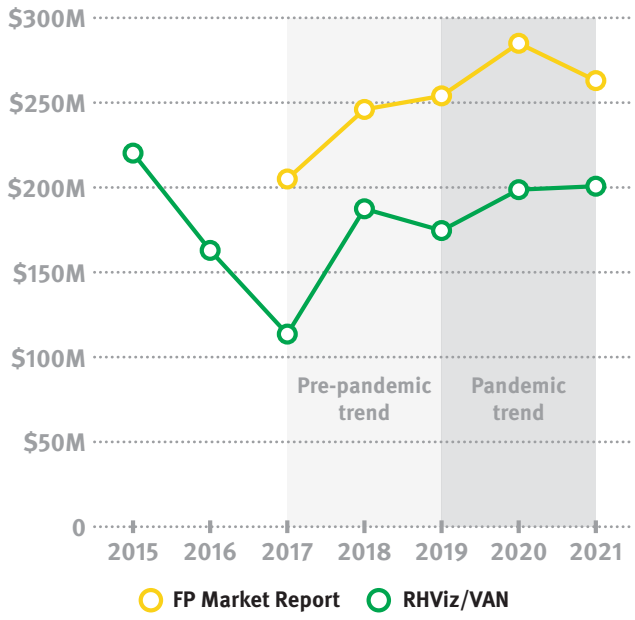
Aggregate Trends

In order to maximize use of available data (see Box 2), we first looked at trends in overall public sector funding for contraceptives.

For the two data sources we used to explore public sector funding for contraceptives (RHViz/VAN and FP Market Report), no substantial funding decrease during the COVID-19 pandemic (2020 and 2021) is apparent, compared to previous years (Figure 3). Note that public sector funding in these data sources is highly dominated by donor funding (see next section for more details on donor funding).

In both RHViz/VAN and the FP Market Report, the average funding for 2020 and 2021 surpasses 2019 funding levels. This aligns with other recent analyses that have shown impacts of the pandemic on family planning services to be fairly minimal and short lived.[18]

Figure 3: Trends in overall public funding for contraceptives, by data source



18 UNFPA and Avenir Health (2021) Impact of COVID-19 on Family Planning: What we know one year into the pandemic Technical Note, and Polis et al (2022) Impacts of COVID-19 on contraceptive and abortion services in low- and middle-income countries: a scoping review. Sex Reprod Health Matters. 2022 Dec;30(1):2098557.

Even before the COVID-19 pandemic, funding fluctuated (as shown in Figure 1 above showing existing factors impacting contraceptive funding). RHViz/VAN shows a decline in funding for contraceptives from 2015 to 2017 (Figure 3). According to analysis conducted by KFF of wider donor government FP funding (not just commodities), this decline was primarily due to a combination of currency fluctuations and the timing of disbursements, as well as a true decrease in funding amounts.[19] In the few years leading up to COVID-19, both data sources show a general upward trend.

In our qualitative interviews, we were told that we would probably not see an impact of COVID-19 on 2020 funding since much of this funding was allocated (or even spent, if purchases were made in 2019) before COVID-19 began. We heard that most early concerns about major, sustained supply chain disruptions and stock-outs generally did not eventuate.

We also heard that larger potential impacts may occur due to shipping delays, rather than due to actual changes in funding levels. The FP Market Report counts funding based on when orders are shipped, while RHViz/VAN counts funding based on the actual or expected delivery data. Therefore, if orders were placed in 2021, but were not shipped or delivered until 2022 due to logistical delays, they won't yet be captured in the above data (see Box 4). Due to the complexities in supply chain systems and available data, it is challenging to determine which changes are due to changes in ordering and which are due to delays in order fulfillment.

Box 4: Funding for Contraceptives in 2022

Most of the data sources we used in our analysis have long time lags (see Annex 2), so it will be some time before we have a complete picture of 2022 contraceptive funding. RHViz/VAN provides a more current picture of funding, yet it also has a few months time lag. When publishing this analysis, RHViz/VAN showed $169.7 million in funding for 2022 thus far; this value largely reflects funding for the first three quarters of the year, so total funding for 2022 is expected to be higher. For comparison, in 2021, funding for the first three quarters of the year was $170.9 million, rising to $221.5 million (an additional $50.6 million) over the final quarter of the year.

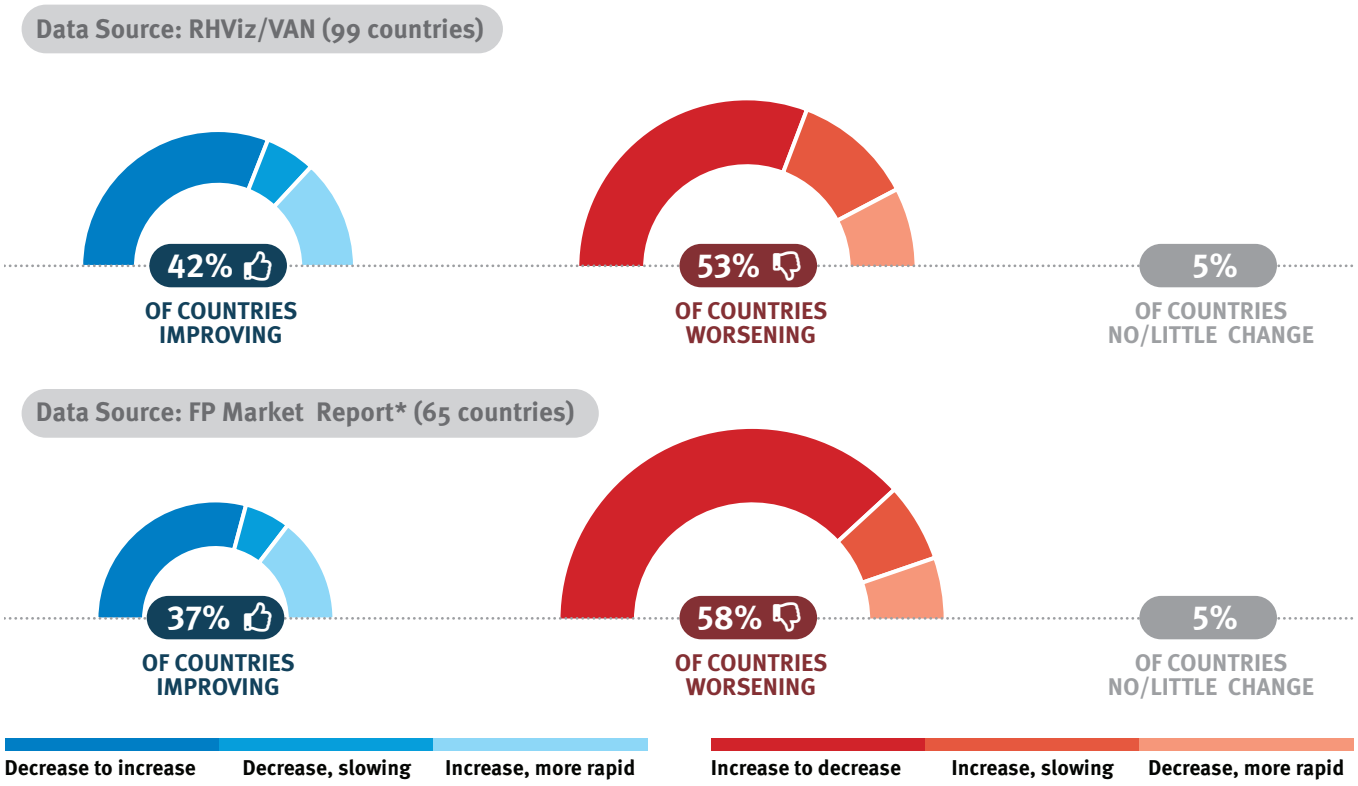
19 KFF (2017) Donor Government Funding for Family Planning in 2016

Country Level Variation

The aggregate trend in contraceptive funding hides a diversity of funding patterns at the country level. For each data source, we compared the trends in contraceptive funding 'pre-pandemic' (2017-2019) with trends in contraceptive funding from 2019 onwards.[20] In this analysis, 'improving' refers to the comparison of these two trends in funding and does not necessarily mean funding increased (see Box 3 - improving also includes the rate of funding decline slowing). Similarly, a 'worsening' trend in funding does not necessarily mean that funding has declined; it also includes the rate of funding increase slowing. See Box 3 in Method Overview for the definition of these terms.

Figure 4 below shows the distribution of countries by type of funding change observed. In both RHViz/VAN and the FP Market Report, worsening trends were the most common pattern seen (58% of countries in the FP Market Report and 53% of countries in RHViz/VAN). Within the 'worsening' group of countries, the most common type of trend in both data sources was an increase of funding pre-COVID-19, which reversed, and funding began to decline during the pandemic.

Figure 4: Distribution of type of change at country level in overall contraceptive funding, by data source



*FP Market Report results do not include 2021 data as it was not published at time of analysis

20 Note only one data source had country-level 2021 data available at the time of publication of this report.

Conversely, among the 'improving' countries (37% of countries in the FP Market Report and 42% of countries in RHViz/VAN), the most common type of trend was a decrease in funding pre-COVID-19, which changed to an increase during the pandemic.

Figure 5 maps the categorization of funding changes in the two main data sources. There is no clear regional variation in funding; within each geographical region, there appears to be a mix of countries where the funding situation is better or worse than before the pandemic. Note that funding is not evenly distributed across countries; for example, nearly 50% of funding in RHViz/VAN for 2021 is for just eight countries.[21] According to one stakeholder interviewed, the biggest impact of COVID-19 may have been due to lockdowns, and different countries had different 'severity' of lockdown - it was not possible to explore this empirically.

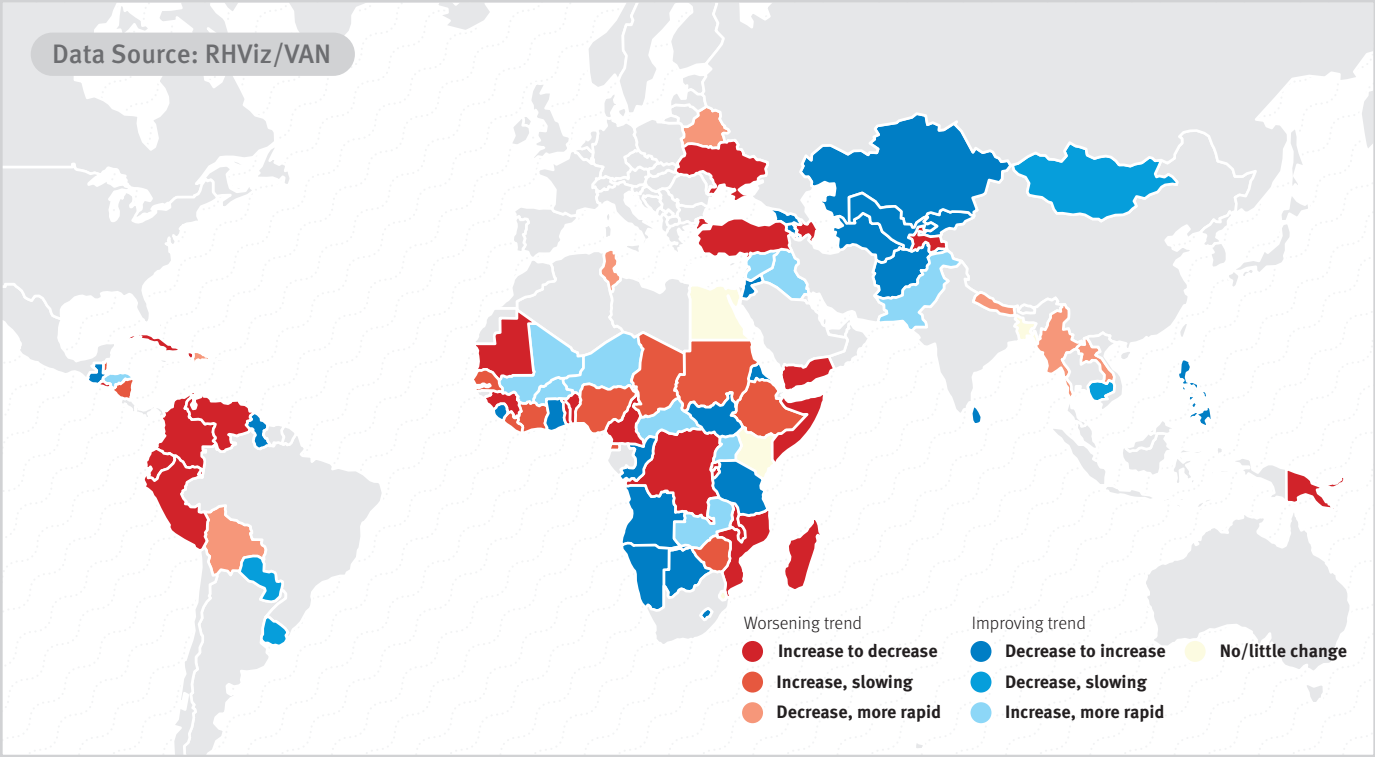
Comparing the two maps, funding in an individual country may appear as 'improving' in one data source and 'worsening' in another. This is due to differences in the data included in each data source and how the data is collected. For example, Democratic Republic of Congo is rated as worsening in RHViz/VAN for data up to 2021 (a trend of increasing funding pre-COVID-19, followed by a decrease), whereas in the FP Market Report it is rated as improving (a trend of increasing funding pre-COVID-19, with a more rapid increase of funding during the pandemic). Another discrepancy between data sources may be the type of trend that is observed within the improving or worsening category. For example, Zambia is categorized as 'improving' in both data sources; however, in the FP Market Report the trend is a decrease in funding pre-pandemic, changing to an increase,[22] while according to RHViz/VAN data, Zambia was already experiencing an increase in funding pre-pandemic, and this increase accelerated during the pandemic. Our Zambia Case Study provides more information about funding changes in Zambia.

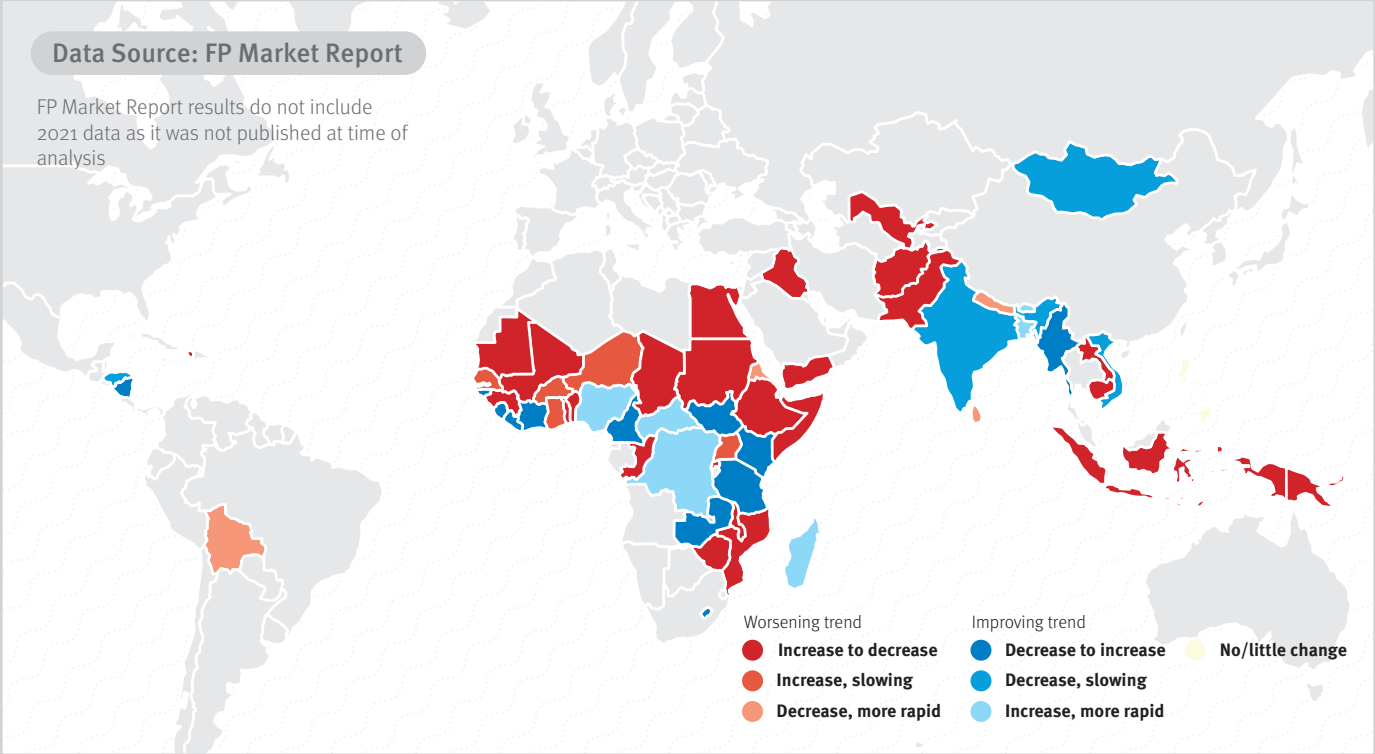
It is beyond the scope of this analysis to resolve or harmonize the differences between data sources. Due to the differences between data sources, we have thus focused examination of country trends on the 32 countries where there is agreement in the broad categorizations (improving or worsening) across available data sources.

21 Uganda, Nigeria, Zambia, Central African Republic, Mozambique, Ethiopia, Tanzania, and Democratic Republic of Congo

22 However, note that the pre-pandemic (2017-2019) trend in funding in Zambia is a slightly negative slope (that may be interpreted as essentially flat). For countries like Zambia, the trend in the years prior to the pandemic is highly influenced by which years are included in the pre-pandemic trend. For instance, in Zambia considering a trend of 2016 to 2019 would show increasing funding, while looking only at 2018 and 2019 would show a rapid decline in funding.

Figure 5: Map of type of change in overall contraceptive funding, by data source





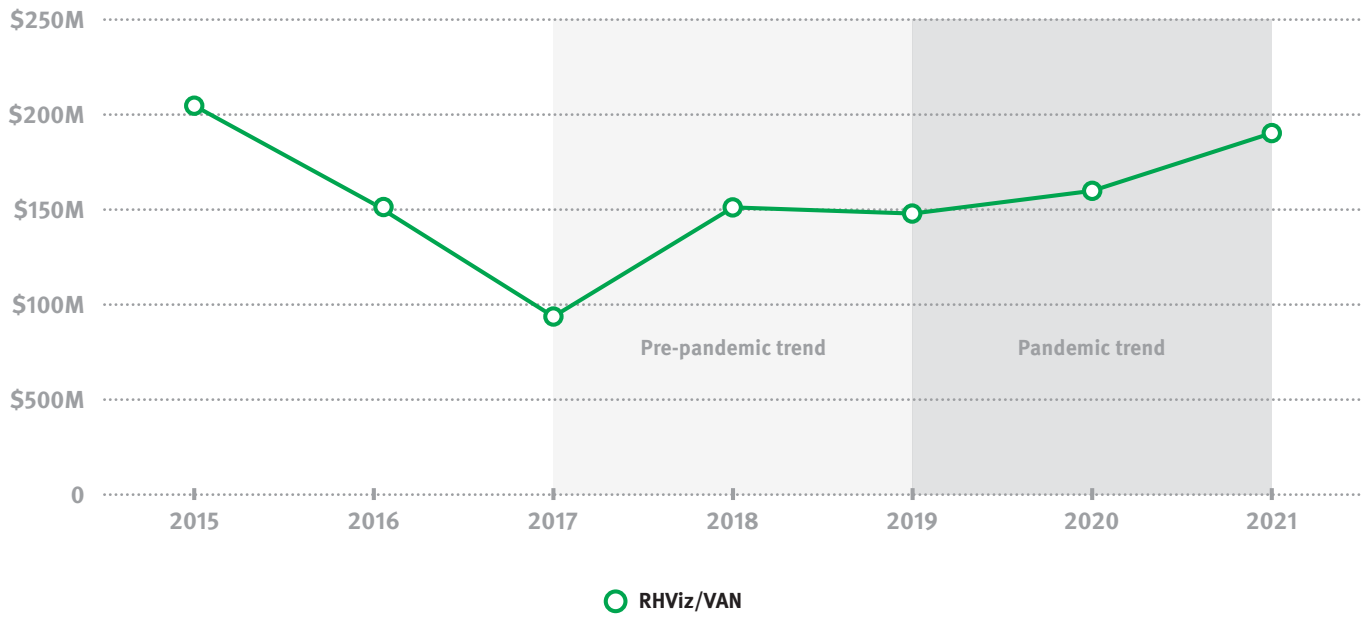
Donor Funding Trends

Aggregate Trends in Donor Funding

Data from RHViz/VAN[23] shows an increase in donor funding for contraceptives in 2020 and 2021 compared to previous years (Figure 6). Before the pandemic there had been a period of decline in funding for contraceptives (2015 to 2017), followed by relative stagnation in funding (2018 to 2019). Thus, it does not appear from the available data that COVID-19 has adversely affected donor funding for contraceptives; in fact if anything, donor funding has increased during the pandemic period compared to the immediate preceding years.

Findings from global stakeholder interviews support this data, with stakeholders reporting that while some donor countries decreased their funding, others increased - resulting in overall funding remaining steady. As most stakeholders mentioned, the biggest impact on donor funding in recent years was FCDO's reduction of their overall overseas aid from 0.7% of gross national income to 0.5% in 2020 - "a "temporary measure" in response to the pandemic's effects on the UK's public finances and economy".[24] The impact of this reduction in terms of actual funding available was exacerbated by the economic slowdown in the UK due to the pandemic. According to several stakeholders, including donors and international organizations,

Figure 6: Trends in total donor funding for contraceptives from RHViz/VAN



23 Only RHViz/VAN data is reported on in this section. CS Indicators includes information on donor funding for contraceptives; however, these estimates are now primarily drawn from RHViz/VAN so would be duplicative of the RHViz/VAN data. Both USAID and UNFPA publish their own data on volume and value of procurement; however, for consistency we only include the USAID and UNFPA data reported within RHViz/VAN in this section.
24 House of Commons Library. Reducing the UK's aid spend in 2021 and 2022. https://commonslibrary.parliament.uk/research-briefings/cbp-9224/

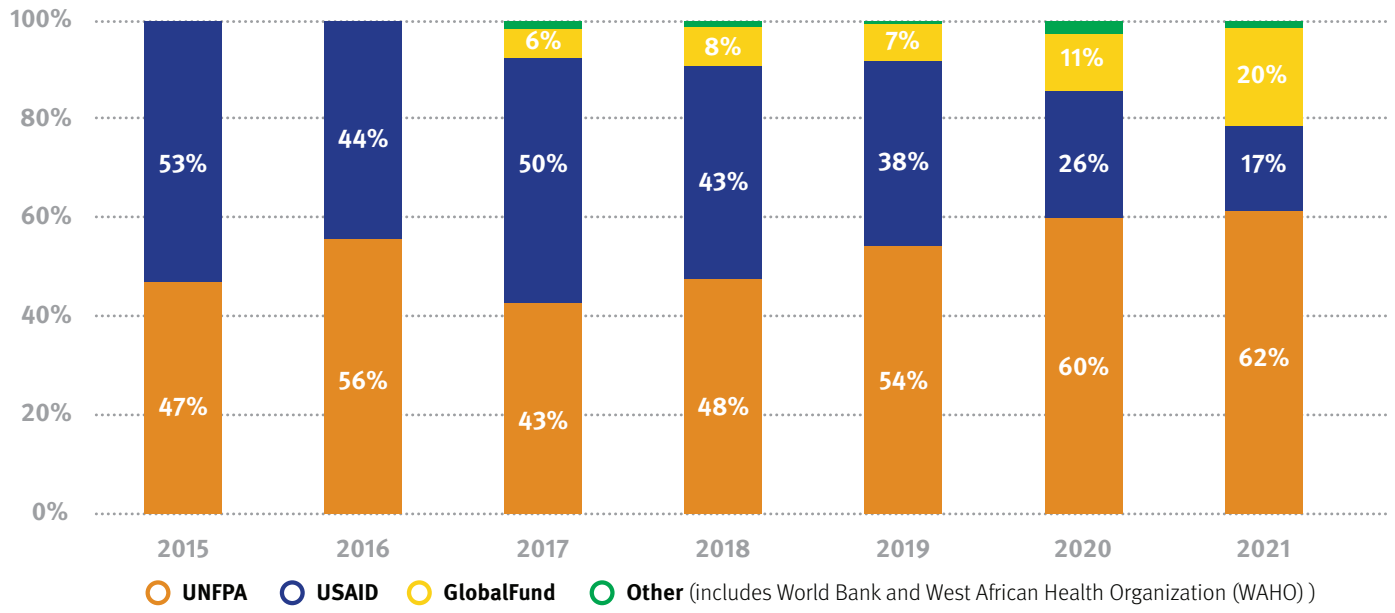
the declines in funding to UNFPA from FCDO were largely offset as a number of donor countries (Sweden, Germany, Australia, France, US, Belgium and Norway) and private foundations increased their funding or made one-off payments to UNFPA, likely to address the FCDO cuts. However, as mentioned above, stakeholders from UNFPA noted that while FCDO's funding was largely replaced, there was a delay in securing this additional funding. This resulted in orders being delayed and further subjected to supply chain slow downs resulting from COVID-19.

These findings from our stakeholder interviews are supported by a recent report from KFF on bilateral donor funding for family planning (not just commodities),[25] which found that, in 2021, funding from donor governments totaled US$1.39 billion, compared to US$1.41 billion in 2020. While some countries did increase their total family planning funding in 2021 (Australia, Denmark, Germany, Norway and Sweden), others (the Netherlands and, most notably, the UK) decreased theirs - resulting in overall funding remaining steady.

UNFPA and USAID are the largest funders of donor funded contraceptives.[26] Prior to 2018, each accounted for a similar share of overall donor funding for contraceptives (Figure 7). However, this pattern has diverged since 2018. USAID's contribution to donor contraceptive funding has been shrinking, while UNFPA's contribution has been growing - in both relative and absolute terms. The slope of the trends in contraceptive funding (i.e., increase in UNFPA funding and decrease in USAID funding) remained virtually unchanged 2018-2021.

According to our stakeholder interviews, USAID decisions on funding for commodities are made at the country level by Missions; Missions are currently working towards increasing domestic resourcing for

Figure 7: Trends in relative share of donor funding for contraceptives by donor, from RHViz/VAN



25 KFF (2022) Donor Government Funding for Family Planning in 2021
26 UNFPA Supplies procures commodities with donor funding received from a range of donors; UNFPA also procures on behalf of other partners through co-financing or third party procurement mechanisms, but that funding is not included in this donor analysis section.

commodities and are shifting away from reliance on donor funding. Reductions have been seen across numerous countries and some countries, most notably Pakistan and Nigeria, have 'transitioned' and are no longer receiving commodity funding from USAID - a decision made at the country level. A 2019 USAID report on Contraceptive and Condom Shipments mirrors this finding: "This shift, part of a longer term trend, was likely the result of policy changes that emphasized the importance of country-led procurement, countries maintaining FP2020 commitments for funding by budgeting a line item for commodities, and corresponding decreases in procurement funds in line with USAID's push toward the Journey to Self-Reliance."[27]

However, this decrease in USAID funding has largely been accompanied by an increase in funding from UNFPA. This means that, at least in some countries, rather than shifting funding responsibilities to domestic governments or other domestic actors, funding has simply been shifted to another donor. In our stakeholder interviews we heard that UNFPA funding levels are determined by the amount of money they receive centrally each year, with efforts being made to increase available funding year on year. Decisions about how much to allocate to each country are based on a range of factors, including a country's unmet need, population size, and poverty level. In addition, a new four-stage approach aimed at supporting countries to transition away from donor funding also factors into UNFPA's allocation decisions. Details on the current allocation approach are documented in the UNFPA Supplies Partnership (2021-2030) overview.[28]

See Reflections and Looking Ahead for more discussion about the funding challenges facing the family planning sector.

Country Level Variation in Donor Funding

The aggregate trend in donor funding for contraceptives again hides a diversity of funding patterns at the country level (Figure 8). For each data source, we compared the trends in contraceptive funding 'pre-pandemic' (2017-2019) with trends in contraceptive funding from 2019 onwards. In this analysis, 'improving' refers to the comparison of these two trends in funding and does not necessarily mean funding increased (see Box 3 - improving also includes the rate of funding decline slowing). Similarly, a 'worsening' trend in funding does not necessarily mean that funding has declined, it also includes the rate of funding increase slowing. See Box 3 in Method Overview for the definition of these terms).

While at the aggregate, donor funding for contraceptives increased in both 2020 and 2021, just over half of countries (55%) were categorized as having worsening funding at the country level. Most commonly, this was a trend of increase of funding pre-COVID-19, which reversed, with funding declining from 2019 onwards (seen among 35% of countries).

Among countries categorized as having improving funding (27 countries, 39%), the most common trend was a decrease in contraceptive funding, changing to an increase in funding from 2019 onwards (14 countries).

As with the analysis of overall contraceptive funding, there are no clear regional patterns seen in the types of donor funding changes experienced at the country level (Figure 9). Countries experiencing both worsening and improving trends in donor funding for contraceptives are found in all geographical regions.

27 U.S. Agency for International Development (USAID), December 2019. Overview of Contraceptive and Condom Shipments, FY 2019. Washington, DC
28 UNFPA (2021). Welcome to the UNFPA Supplies Partnership 2021-2030: Uniting for Transformative Action in Family Planning & Maternal Health.

Figure 8: Distribution of type of change at country level in donor contraceptive funding

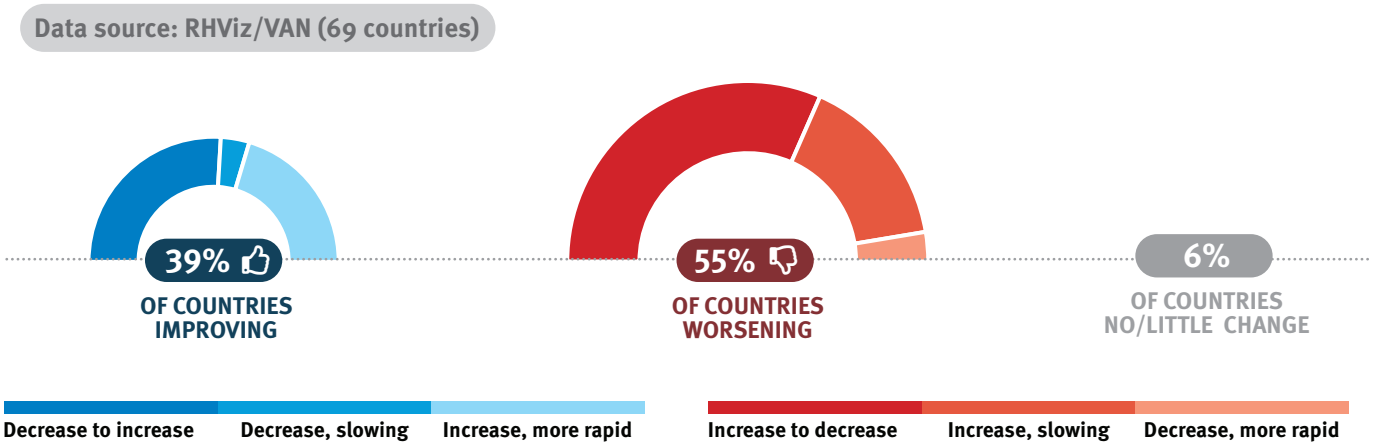
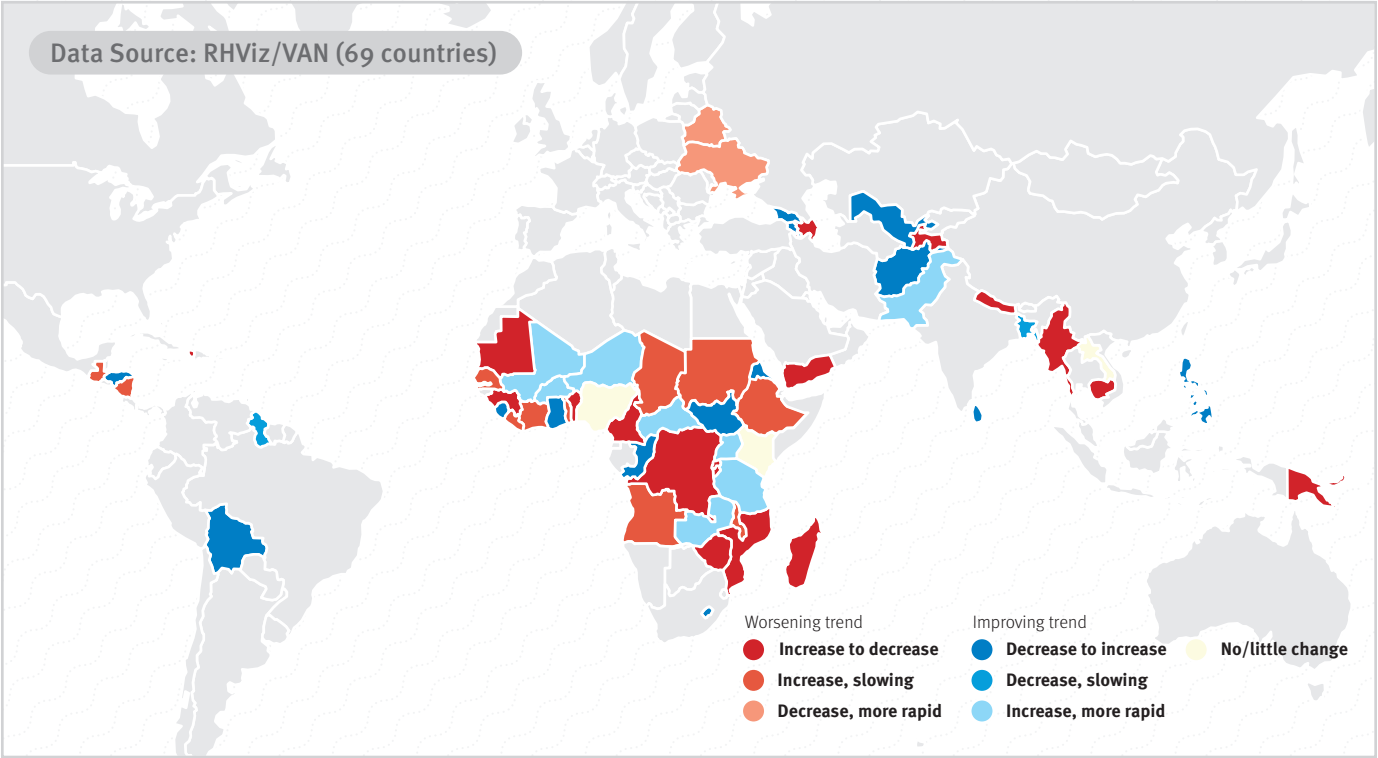


Figure 9: Map of type of change in donor contraceptive funding



According to interviews with stakeholders at UNFPA, it is possible that where reductions were seen in individual countries, they may have been due to delays in UNFPA funding (caused by the FCDO reductions and pandemic-related supply chain and manufacturing challenges) rather than due to actual decreases. Stakeholders suggested that things are returning to pre-pandemic levels, but this return to normal will probably not be seen in the data yet.

Our stakeholders noted that there are many other factors (beyond COVID-19) that affect what is going on in countries in terms of contraceptive commodity funding: *"Non-COVID-19 related shocks are affecting a lot of countries in the region. The food security issues affecting the Horn of Africa countries are a good example. This is creating the need for a humanitarian response in Ethiopia, Somalia, South Sudan, Northeast Uganda, as well as parts of Kenya. You've also had major flooding in Nigeria and Pakistan in the last few months. I think a lot of these other crises can be plausibly linked to climate related risks. There is the conflict in Ethiopia, Burkina Faso has had two coups in six months, Mozambique and Democratic Republic of Congo both have regional insecurity crises." [Multilateral Institution Stakeholder].*

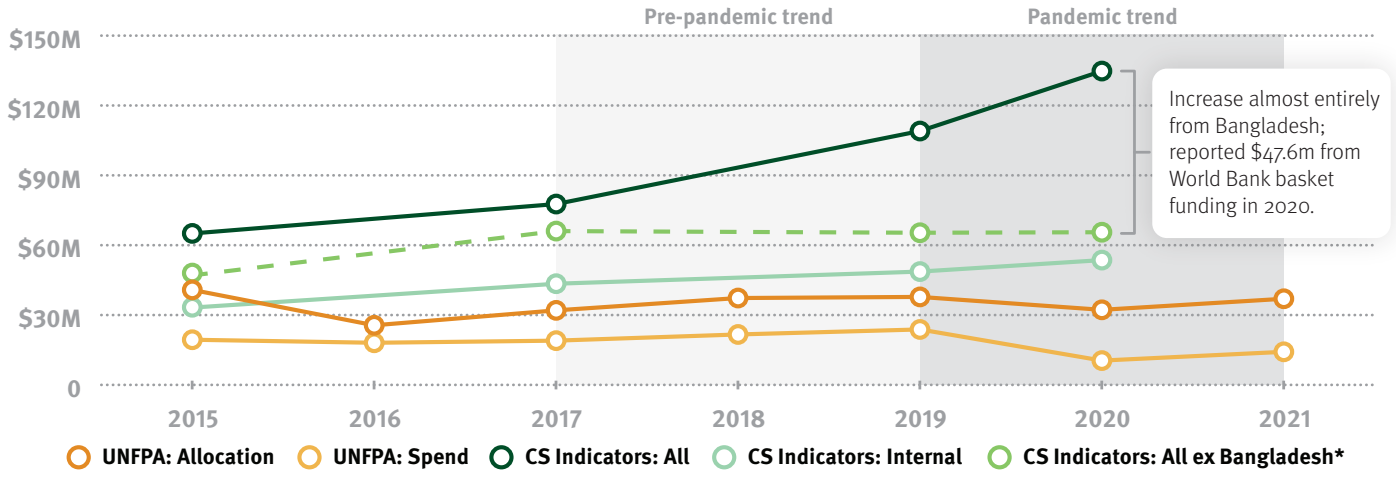
Domestic Funding Trends

Aggregate Trends in Domestic Funding

Since 2015, domestic funding for contraceptives has been low, relative to donor funding, and static over time (Figure 10). Data collected by UNFPA on domestic funding allocation and spending indicates a slight decline in funding from 2019 to 2020, particularly for spend, but this decline does not continue into 2021. CS Indicators data shows a relatively stagnant picture for domestic funding for contraceptives when considering all government funding,[29] or when limiting to nationally generated government funds (e.g., taxes). It does not appear that there has been a large impact of COVID-19 on domestic funding for contraceptives to date.

Stakeholder interviews suggest that domestic government funding was expected to be impacted more than donor funding, as governments with limited resources would be forced to shift money away from family planning (and other areas) to tackle the pandemic. While there are a few examples of that actually happening, several global stakeholders noted that detailed information about government expenditure can be hard to access so it may take time to uncover what actually occurred. UNFPA did have direct experience of this shift in funding: *"For UNFPA Supplies Partnership countries we usually have some visibility into what Governments plan to procure. During COVID we have seen some of these commitments not being fulfilled. When we asked countries why, they would say this is because funding had been redirected to other priorities (COVID response, social welfare, etc.)." [UNFPA stakeholder].*

Figure 10: Trends in domestic funding and allocations for contraceptives, by data source



29 All government funding in CS Indicators includes funding that is sourced from outside the country, which the government controls to some extent (e.g., World Bank loans, donor basket funding). Our conclusions regarding the stagnant funding trend exclude Bangladesh, which shows a large increase in 2019 and 2020 from large purchases of contraceptives from a World Bank basket fund.

Country Level Variation in Domestic Funding

As with the analysis of donor funding, the aggregate analysis finding of no apparent impact of COVID-19 on domestic funding for contraceptives masks large variation between countries. For each data source, we compared the trends in contraceptive funding 'pre-pandemic' (2017-2019) with trends in contraceptive funding from 2019 onwards. In this analysis, 'improving' refers to the comparison of these two trends in funding and does not necessarily mean funding increased (see Box 3 - improving also includes the rate of funding decline slowing). Similarly, a 'worsening' trend in funding does not necessarily mean that funding has declined, it also includes the rate of funding increase slowing. See Box 3 in Method Overview for the definition of these terms.

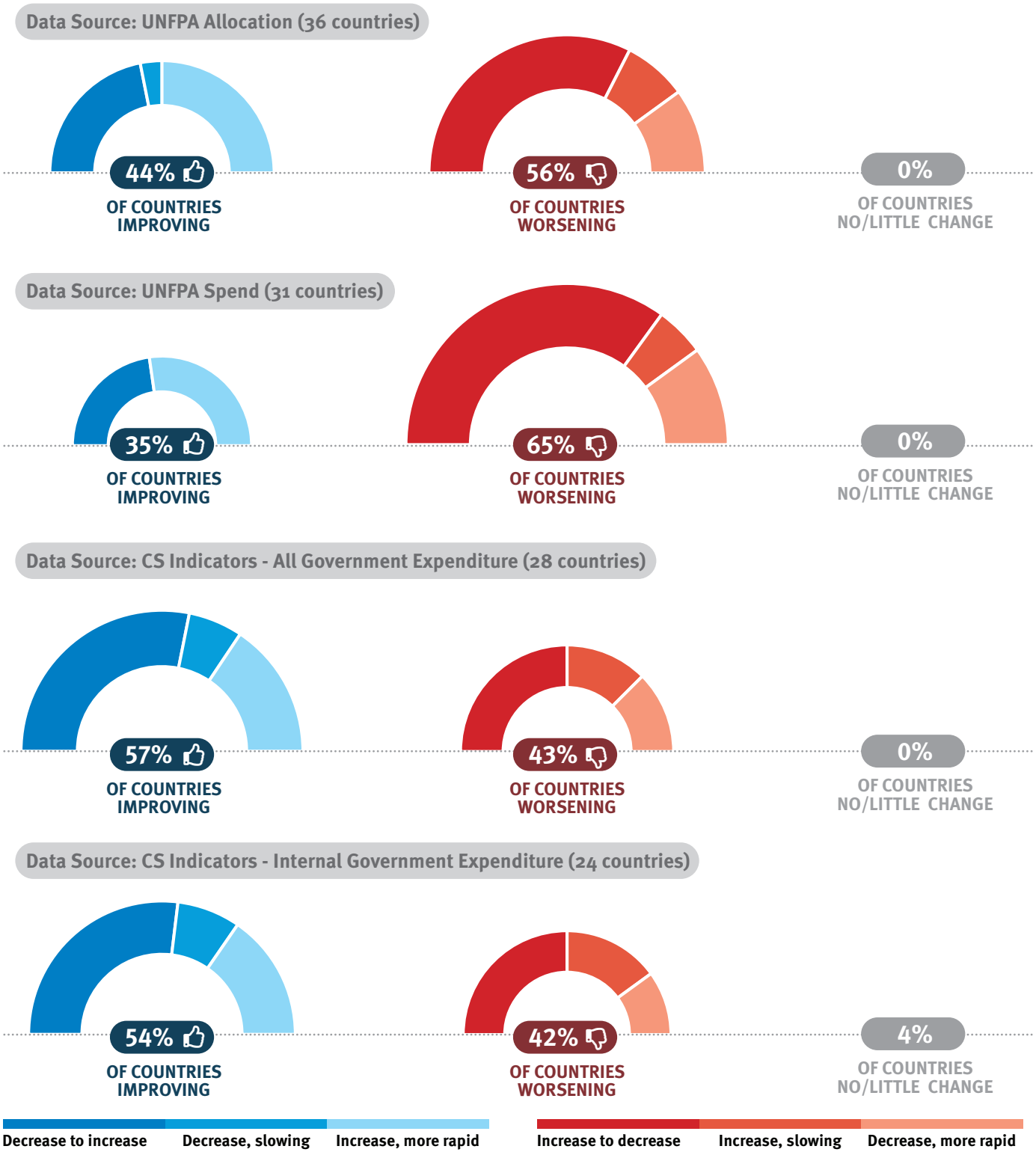
Figure 11 below shows the distribution of types of changes at the country level for four different indicators from two data sources: UNFPA collected data on government budget allocation, UNFPA collected data on government spending, CS Indicator survey data on all Government funding, and CS Indicator survey data on internally generated funding only.

Analysis of data collected by UNFPA on national government allocation and spending found just over half (56%) of included countries were categorized as having worsening trends in funding allocations, and 65% as having worsening trends in actual spending (Figure 11). In contrast, 43% of countries with CS Indicator data available were categorized as having worsening trends in domestic funding, and 42% when only internally generated government funding was included. This apparent discrepancy between the UNFPA and CS Indicator data may be due to the different countries included in each analysis,[30] and differences in data collection processes (e.g., UNFPA data doesn't specify whether to only include internally generated funds, how the information is solicited varies). In our interviews, stakeholders noted the limited availability of data on Government expenditures and potential issues in the quality of the data collected.

Notably, the most common funding trend observed in countries in CS Indicators data was a pre-pandemic decrease in domestic funding, and a shift to increasing funding from 2019 to 2020. This trend was found in nine countries (32%) for all Government funding and seven countries (29%) when only internally generated government funding was included. This same trend of decreasing pre-pandemic domestic funding followed by increasing funding in 2019 and 2020 was also found in five (16%) of the countries included in the UNFPA data. This suggests that, in at least some countries, domestic funding was not negatively impacted by COVID-19 in the timeframe for which data is available.

30 36 countries could be included in analysis of UNFPA allocations (of which 31 could be included in UNFPA spending analysis); 28 countries could be included in CS Indicator total government expenditure analysis; (of which 24 countries could be included in CS Indicator internal government expenditure analysis); 21 countries have both UNFPA allocation data and CS Indicator total government expenditure data.

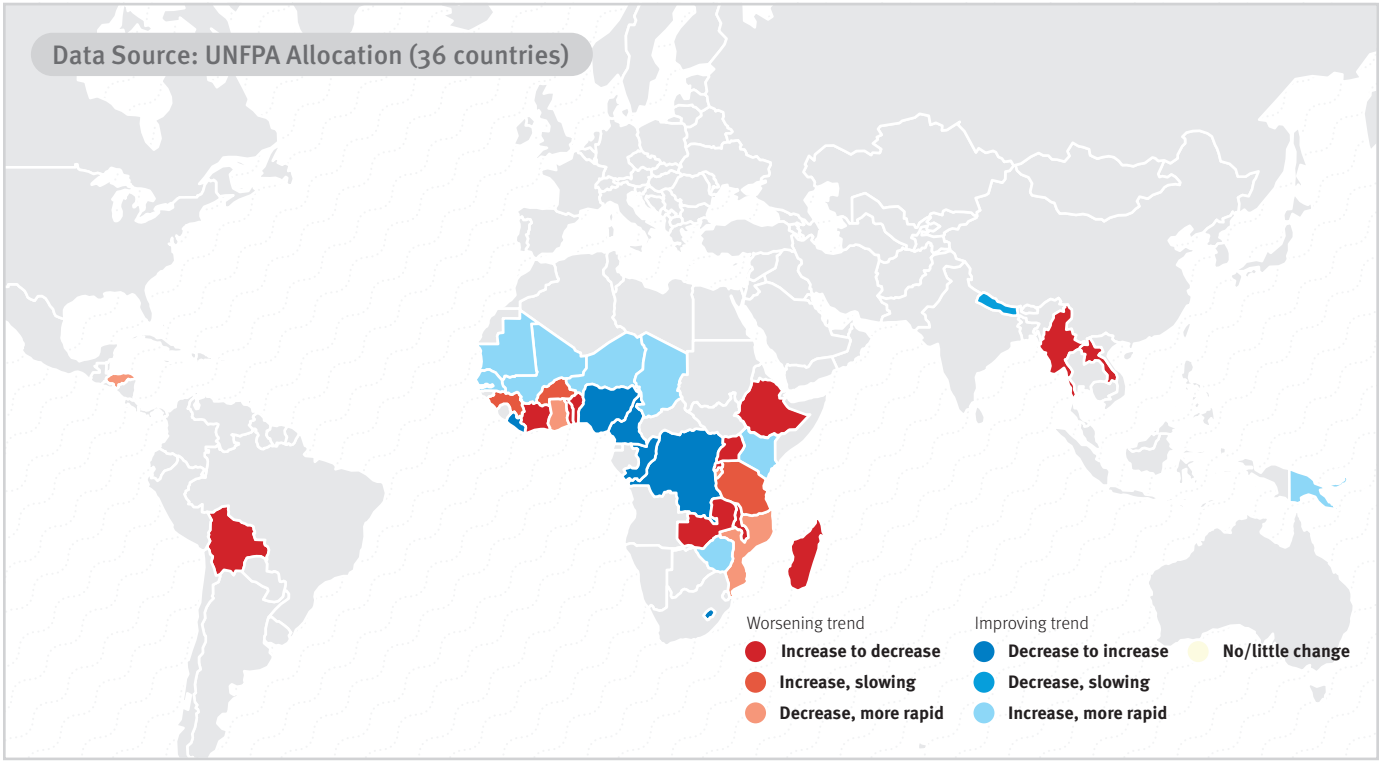
Figure 11: Distribution of type of change at country level in domestic contraceptive funding and allocation, by data source

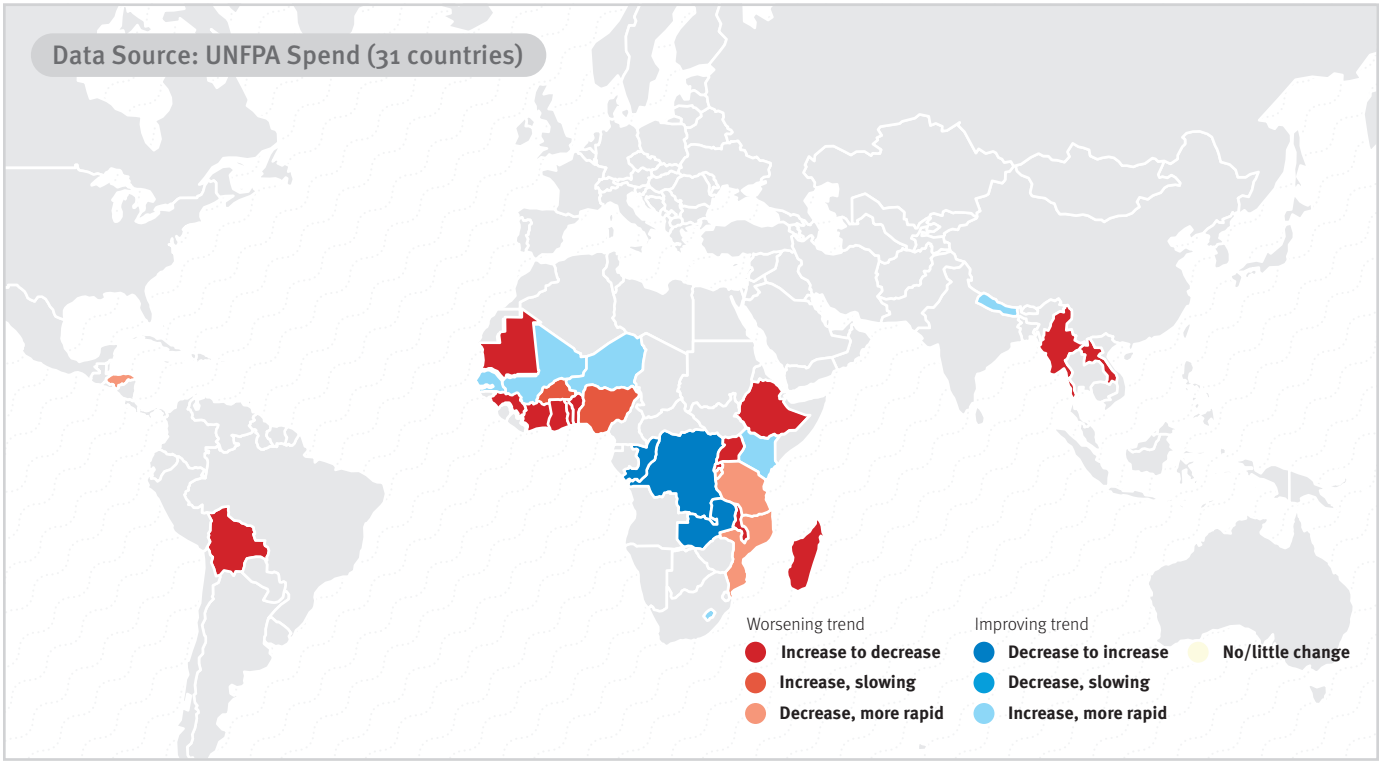


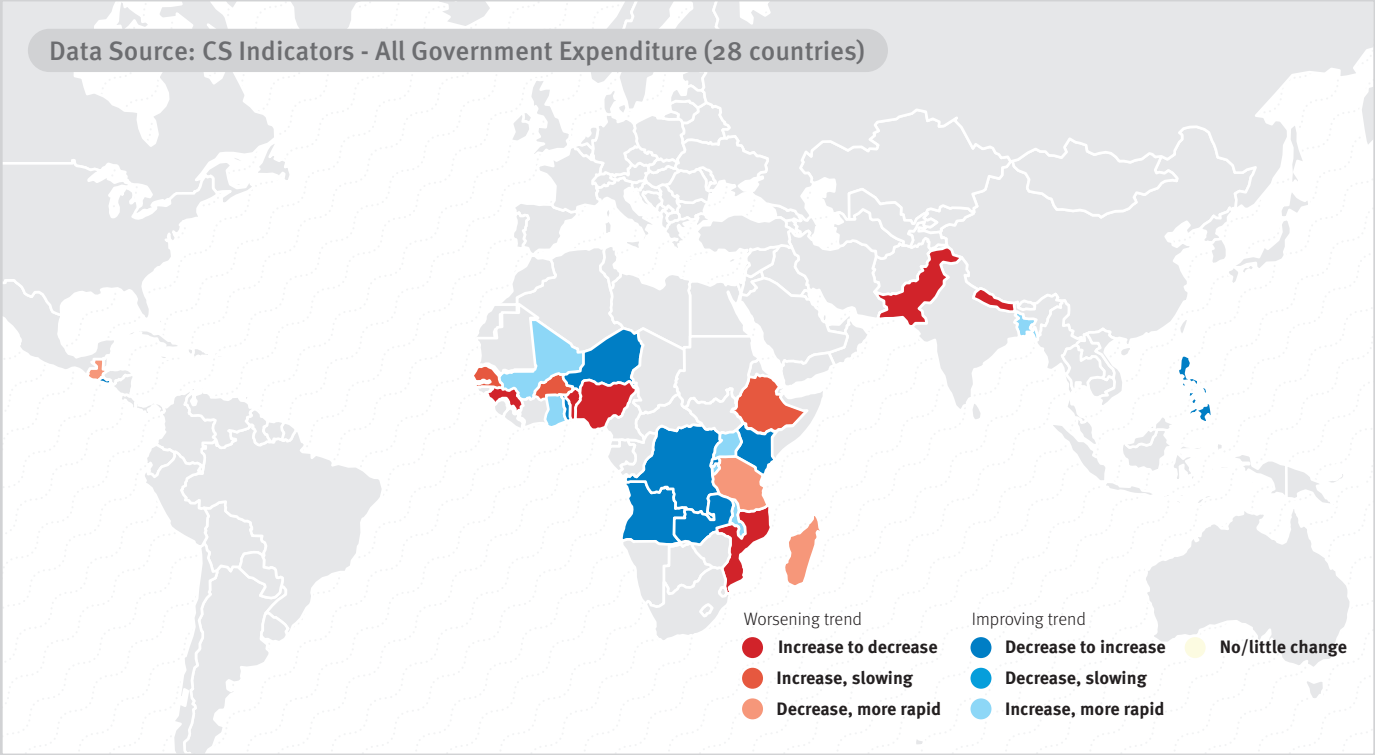
Similar to trends in overall public funding and the subset of donor funding, there are no clear regional patterns seen in the types of domestic funding changes experienced at the country level (Figure 12). Countries experiencing both worsening and improving trends in domestic funding for contraceptives are found in all geographical regions.

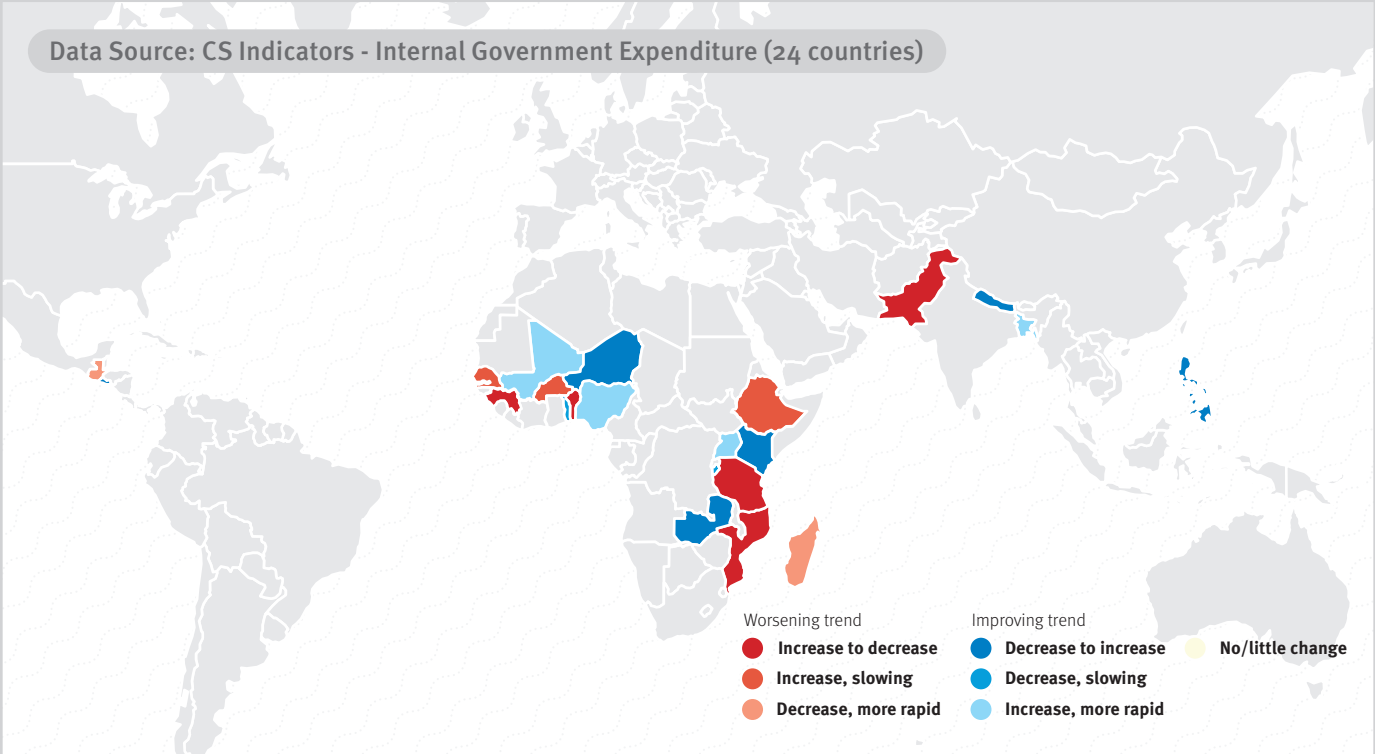
In four countries we find the same type of change across available data for domestic funding: Democratic Republic of Congo, Mali, Benin and Burkina Faso. In Democratic Republic of Congo, data show an improving trend in domestic funding, from funding decreasing 2017-2019, to increasing from 2019 onwards across three of the data sources (CI Indicators shows no internal domestic funding). Similarly, all available data for Mali show an improving trend in domestic funding, from funding increasing 2017-2019, to increasing more rapidly from 2019 onwards. By contrast, in Benin there is a consistent pattern of a worsening trend in domestic funding, from funding increasing 2017-2019, to decreasing from 2019 onwards. Similarly, there is a consistent pattern in Burkina Faso of a worsening trend in domestic funding, from funding increasing 2017-2019, but the increase slowing from 2019 onwards.

Figure 12: Map of type of change in domestic contraceptive funding, by data source






Data Source: CS Indicators - All Government Expenditure (28 countries)
Worsening trend
Increase to decrease
Increase, slowing
Decrease, more rapid
Improving trend
Decrease to increase
Decrease, slowing
Increase, more rapid
No/little change


Data Source: CS Indicators - Internal Government Expenditure (24 countries)
Worsening trend
Increase to decrease
Increase, slowing
Decrease, more rapid
Improving trend
Decrease to increase
Decrease, slowing
Increase, more rapid
No/little change

Findings: Closer Look at Country Trends

In this chapter:

- Country Trends for Overall Public Funding
- Country Trends for Donor Funding
- Country Trends for Domestic Funding

There are 32 countries for which there was agreement between RHViz/VAN and the FP Market Report in terms of the overall public funding trend categorization[31] (i.e., the country was consistently categorized as contraceptive funding improving or worsening from 2019 to 2020 in all available data sources,[32] compared to the pre-pandemic (2017-2019) trend in public funding). In this analysis, 'improving' refers to the comparison of these two trends in funding and does not necessarily mean funding increased (see Box 3 - improving also includes the rate of funding decline slowing). Similarly, a 'worsening' trend in funding does not necessarily mean that funding has declined, it also includes the rate of funding increase slowing. See Box 3 in Method Overview for the definition of these terms.

As the consistency in categorization gives us more confidence that the country funding trends observed are accurate, this section provides a more in-depth analysis of these 32 countries; firstly for overall public funding, then looking specifically at trends in donor and domestic funding. Three qualitative case studies, from Kenya, Uganda and Zambia, are included to illustrate the diversity of country experiences in contraceptive funding during the COVID-19 pandemic.

31 In total, 58 countries had trend analysis available for both data sources. Of these, 34 had 'agreement' in the overall trend; however, Bangladesh and Mongolia were excluded due to data sources only capturing a small share of funding in these countries (e.g. data sources not capturing domestic funding which accounts for a large proportion of funding), leaving the 32 countries included in Table 1. See Annex 3 for more details.

32 At the time of our analysis, 2021 data was only available from one data source (RHViz/VAN). Trend analysis and determination of consistency in categorization were based only on data from 2017-2020, as it was available from both RHViz/VAN and FP Market Report.

Country Trends for Overall Public Funding

Among the 32 countries with consistency of categorization (see below), the majority (22 countries or 69%) saw worsening funding trends from 2019-2020 as compared to the pre-pandemic trend in funding (Table 1). However, 13 of these 22 countries subsequently saw an increase in funding in 2021 compared to 2020. Ten countries had improving trends in funding from 2019-2020 as compared to the pre-pandemic trends, although six of these 10 subsequently saw a decrease in funding in 2021 compared to 2020.

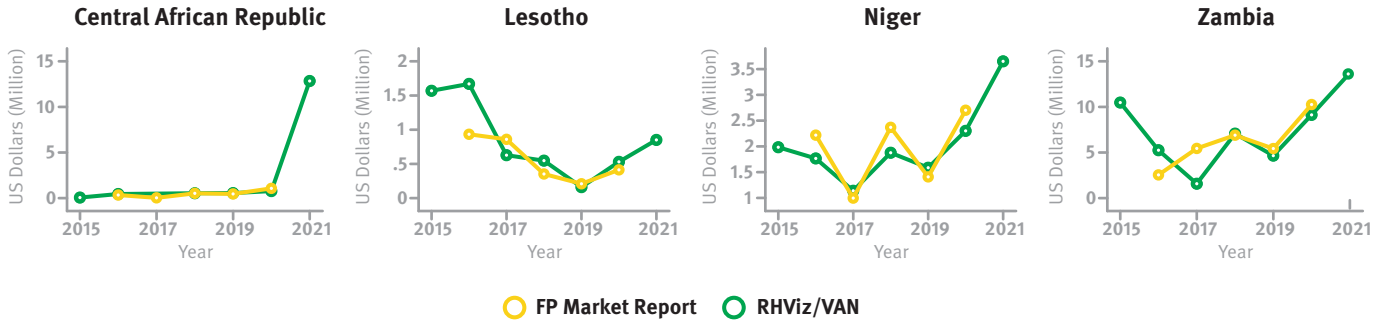
As can be seen in Table 1, there was no clear geographical pattern, with different countries from the same region having different trends in funding. We did also examine whether there were similarities in funding trends based on the level of country dependence on donor funding for contraceptives or on the pre-pandemic level of contraceptive use in the country, but did not find any clear patterns (data not shown).

Table 1: Trends in contraceptive funding from 2019 onwards compared to 2017-2019, for 32 countries with agreement across available data sources

Overall trend of improving contraceptive funding from 2019-2020 compared to 2017-2019: **10 COUNTRIES**		Overall trend of worsening contraceptive funding from 2019-2020 compared to 2017-2019: **22 COUNTRIES**	
Increase in funding 2020-2021: **4 COUNTRIES**	Decrease in funding 2020-2021: **6 COUNTRIES**	Increase in funding 2020-2021: **13 COUNTRIES**	Decrease in funding 2020-2021: **9 COUNTRIES**
Central African Republic	Guinea-Bissau	Bolivia	Benin
Lesotho	Honduras	Chad	Guinea
Niger	Kenya	Djibouti	Haiti
Zambia	Liberia	Ethiopia	Malawi
	South Sudan	Gambia	Mozambique
	West Bank and Gaza	Iraq	Papua New Guinea
		Mali	Rwanda
		Mauritania	Togo
		Nepal	Yemen
		Sao Tome and Principe	
		Tajikistan	
		Timor-Leste	
		Uganda	

For the four countries with improving funding from 2019 to 2020 and an increase in funding from 2020 to 2021, there were large differences in the pre-pandemic funding trends (Figure 13).

Figure 13: Countries with overall contraceptive funding improving 2019-2021, including increasing funding 2020-2021 (four countries)



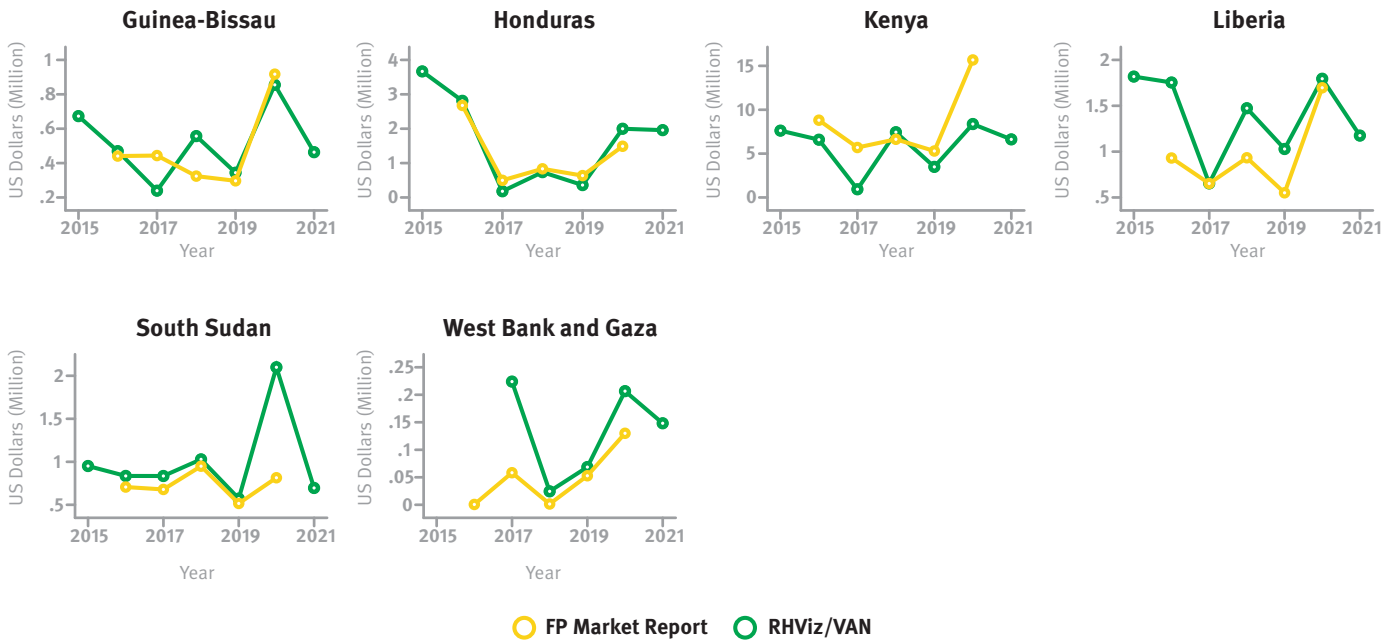
Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

While the Central African Republic had stagnant and low funding in the years leading up to the pandemic, Lesotho had been experiencing a fairly steep decline in funding. Both countries experienced increases in contraceptive funding during the pandemic period. In contrast, Niger and Zambia both had large annual fluctuations in pre-pandemic contraceptive funding, with a consistent and rapid increase in funding from 2019 onwards. In Zambia, this increase in funding was mainly due to large increases in UNFPA funding; the national government had been increasing its commitments to funding commodities, but these were often not met. The pandemic led to diversion of government funding away from contraceptives, and exacerbated issues of stock-outs of contraceptives (see Zambia case study for more details).

Similarly, for the six countries where there was an overall improvement in funding from 2019 to 2021, but a decrease in funding in 2021 compared to 2020, there were large differences in the pre-pandemic funding trends, including large year-on-year fluctuations. (Figure 14). It is possible that the decrease in funding in 2020-2021 is simply a continuation of these large annual fluctuations, rather than driven by pandemic-related factors.

During the past decade in Kenya, there have been several changes to domestic funding for contraceptives; since becoming a middle income country, donor funding has been declining. While the pandemic led to some funding impacts (e.g., diversion and delays in funding, and increased shipping costs and delays), the longer-term (non-pandemic related) trends in domestic and donor funding are having a larger impact on contraceptive funding now and into the future (see Kenya case study for more details).

Figure 14: Countries with overall contraceptive funding improving 2019-2021, but with decreasing funding 2020-2021 (six countries)



Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

Among the 22 countries with overall worsening of funding from 2019 to 2021, 13 did experience an increase in contraceptive funding specifically from 2020 to 2021 (Figure 15). The magnitude of the increase in funding from 2020 to 2021, relative to past funding, varies by country. In Chad, Iraq, Mali, Timor-Leste and Uganda, contraceptive funding in 2021 is greater than any year of funding since 2015. By contrast, in other countries such as Bolivia and Gambia, contraceptive funding seems to have declined and stagnated. For Ethiopia, large differences in trends and funding levels are observed across the two data sources.[33] However, overall both data sources show a decline in funding from 2019 to 2020 (which may have then led to the increase in funding from 2020 to 2021).

In Uganda, stakeholders interviewed reported no clear direct impact of COVID-19 on public funding for contraceptive commodities. As noted above, Uganda's funding for contraceptives in 2021 is higher than any year since 2015, driven mainly by recent increases in donor funding. The main impact of COVID-19 appeared to be on commodity distribution and access, rather than on funding. Funding was preserved primarily due to pre-pandemic funding agreements and (unlike some other countries) limited diversion of domestic commodity funds to the pandemic response. However, the low level of domestic funding for contraceptive commodities remains an ongoing challenge to commodity security (see Uganda case study for more details).

33 This data discrepancy is due to domestic government accounting for a large share of contraceptive funding, which is not included in RHViz/VAN.

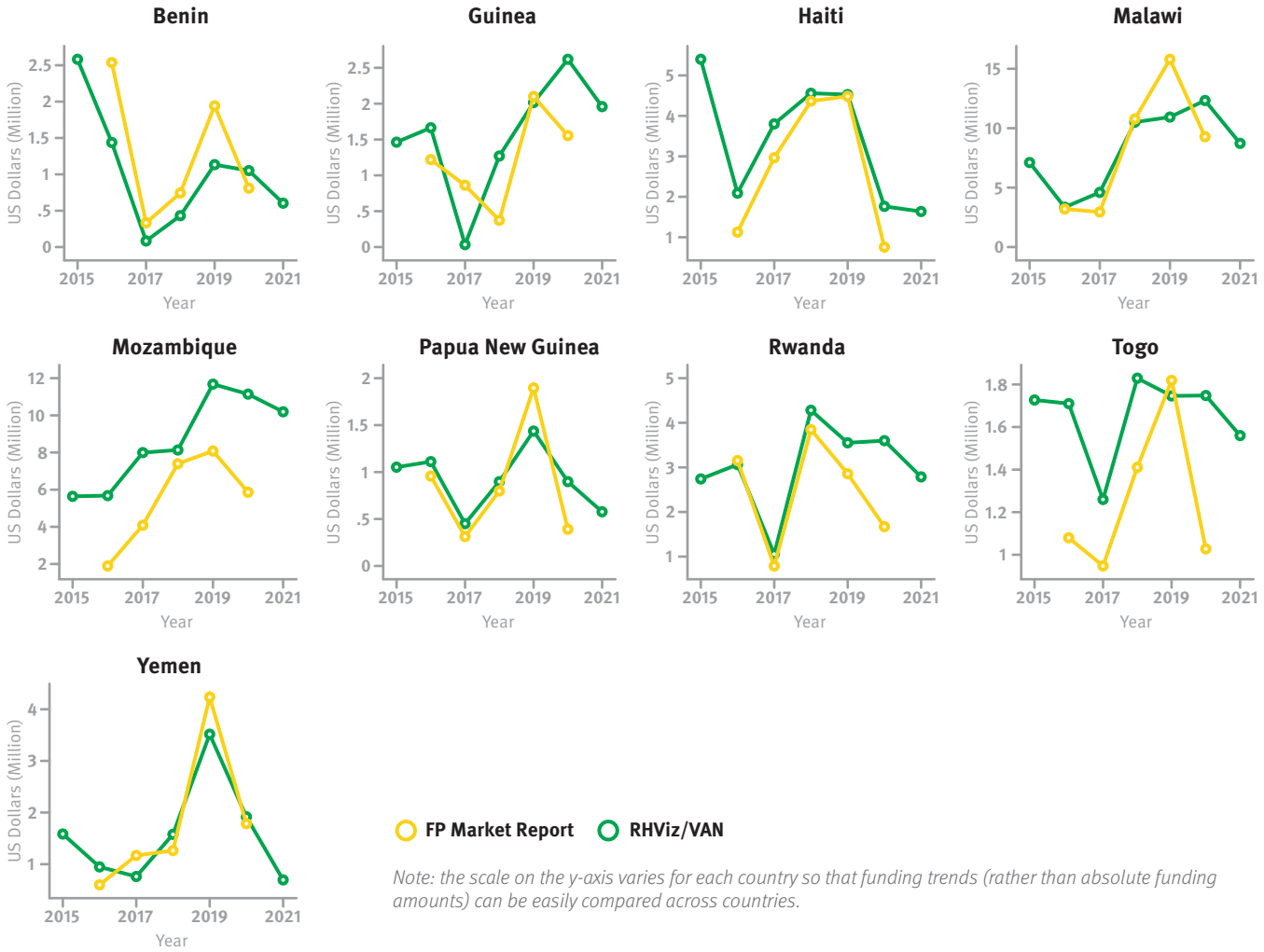
Figure 15: Countries with overall contraceptive funding worsening 2019-2021, but with increasing funding 2020-2021 (13 countries)

Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

The final set of nine countries (Figure 16) saw worsening trends of contraceptive public funding, overall from 2019 to 2021, including a decrease in funding 2020 to 2021. Again, the pre-pandemic contraceptive funding trends vary widely across these countries. Many of these countries experienced large decreases in funding around 2016 or 2017, but then had shown continued increases in funding until the onset of the pandemic. By contrast, Mozambique had experienced slow and steady increase in funding until 2019, when funding began to decline.

As can be seen from Figures 13-16, there was a diversity of funding trajectories prior to the onset of the COVID-19 pandemic. Some countries had been experiencing steady increases in contraceptive funding, others saw steady declines, and many experienced large annual fluctuations in funding levels. While this analysis is able to speak to how these trends changed in recent years, it is not able to provide detailed insights into why these differential changes existed before COVID-19, and why such differential patterns of change have been experienced over the last few years. Interviews conducted for this analysis suggest that the funding trends observed may reflect the culmination of a range of decisions by different funders (including both donors and Governments) based on available resources, levels of stock on hand, and perceived needs both before and during the pandemic.

Figure 16: Countries with overall contraceptive funding worsening 2019-2021, including decreasing funding 2020-2021 (9 countries)



Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

Country Trends for Donor Funding

Among the 32 countries for which there was agreement across available data sources, we conducted specific analysis into trends in donor funding. Due to limited available data on donor funding, two countries were excluded,[34] leaving 30 countries for analysis.

We again examined trends in funding from 2019 onwards, compared to previous years (2017-2019), specifically for donor funding (Table 2). Most of these countries (27 countries, or 90%) fell in the same categorization as overall public funding (see Table 1 in the previous section); three countries (Bolivia, Malawi and Togo) changed categorizations. In two thirds of countries, donor contraceptive funding worsened from 2019 onwards compared to earlier years; note that worsening does not necessarily mean funding declined (see Box 3 in Method Overview). Further, among the 20 countries with worsening trends from 2019 to 2020 more than half (13 countries) saw increases in donor funding from 2020 to 2021.

Table 2: Trends in contraceptive funding from 2019 onwards compared to 2017-2019, for 30 countries with agreement across available data sources, donor funding

Trend of improving donor contraceptive funding from 2019-2020 compared to 2017-2019: 10 COUNTRIES		Trend of worsening donor contraceptive funding from 2019-2020 compared to 2017-2019: 20 COUNTRIES	
Increase in funding 2020-2021: **5 COUNTRIES**	Decrease in funding 2020-2021: **5 COUNTRIES**	Increase in funding 2020-2021: **13 COUNTRIES**	Decrease in funding 2020-2021: **7 COUNTRIES**
Bolivia*	Guinea-Bissau	Chad	Benin
Central African Republic	Honduras	Djibouti	Guinea
Lesotho	Kenya	Ethiopia	Haiti
Niger	Liberia	Gambia	Mozambique
Zambia	South Sudan	Malawi*	Papua New Guinea
		Mali	Rwanda
		Mauritania	Yemen
		Nepal	
		Sao Tome and Principe	
		Tajikistan	
		Timor-Leste	
		Togo*	
		Uganda	

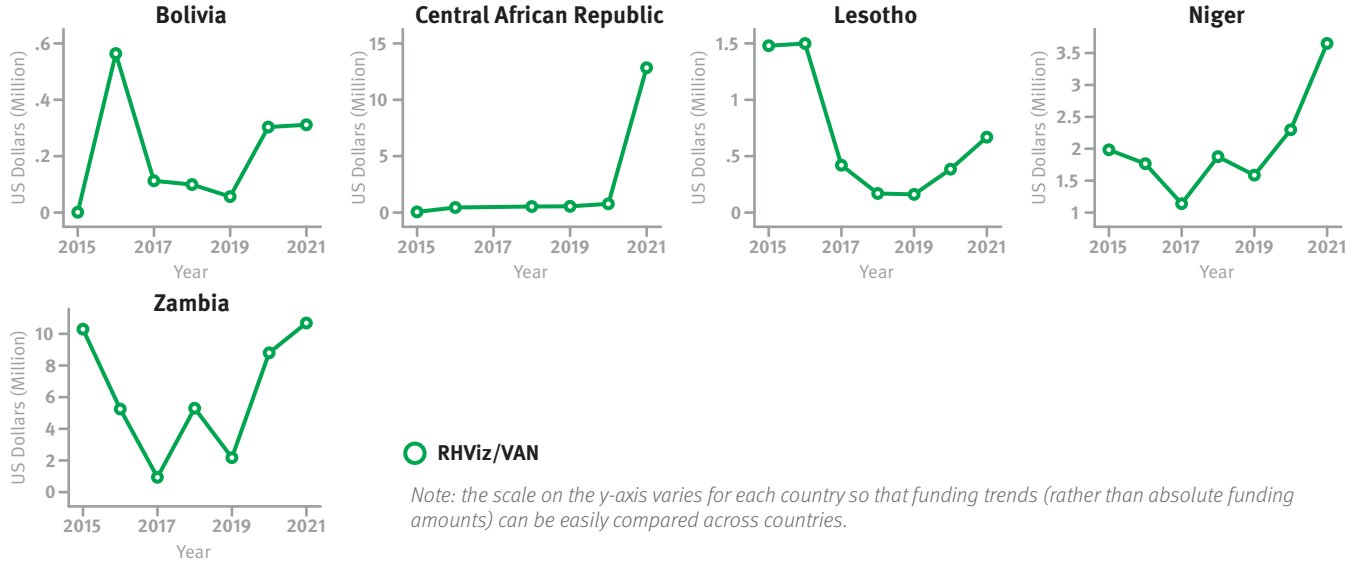
** Country falls in a different categorization than that for overall public funding (i.e., different group for Table 2 vs. Table 1)*

34 Iraq and the West Bank and Gaza

For the five countries with improving donor funding since 2019, including 2020 to 2021, there were large differences in pre-pandemic funding trends (Figure 17). Similar trends in overall public funding were observed for four of the five countries (Figure 13). Bolivia is now also included in this improving category and shows a similar pattern to Lesotho, with donor funding peaking in 2016, then declining steadily before reversing from 2019 onwards.

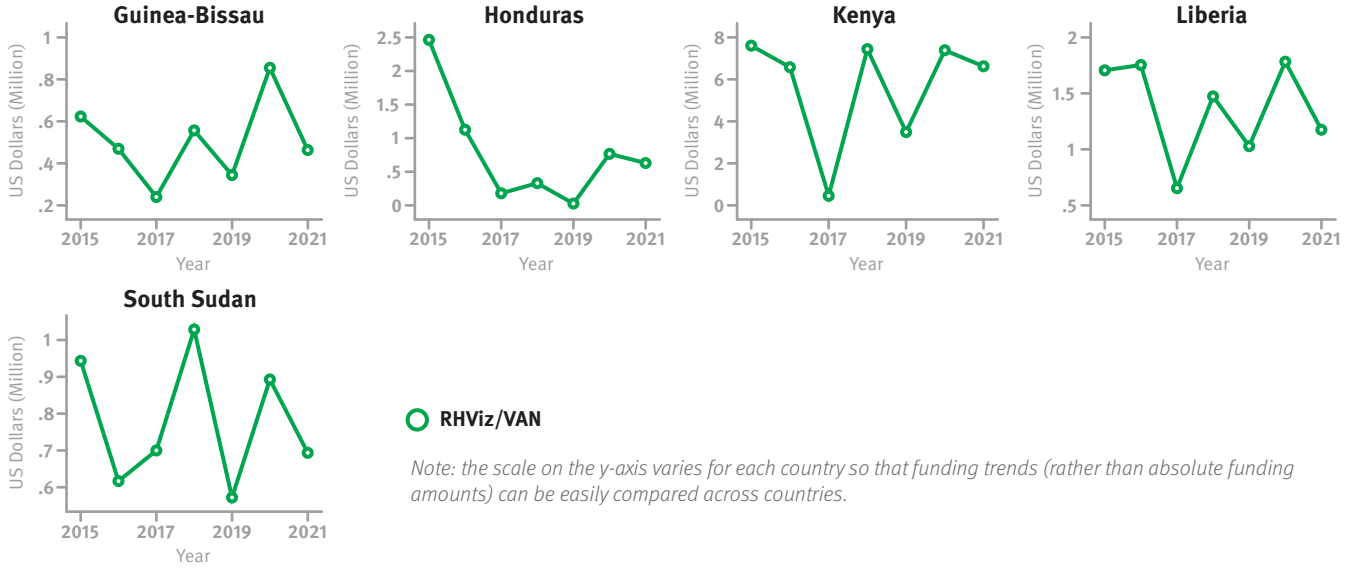
The next group of five countries (Figure 18) also saw overall improvement in donor funding from 2019 to 2021, but a decrease in funding in 2021 compared to 2020. As can be seen in the figure, most of these countries (apart from Honduras), experience large year-on-year fluctuations in donor funding, a pattern which appears to have continued during the COVID-19 pandemic.

Figure 17: Countries with donor contraceptive funding improving 2019 - 2021, including increasing funding from 2020 to 2021 (5 countries)



Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

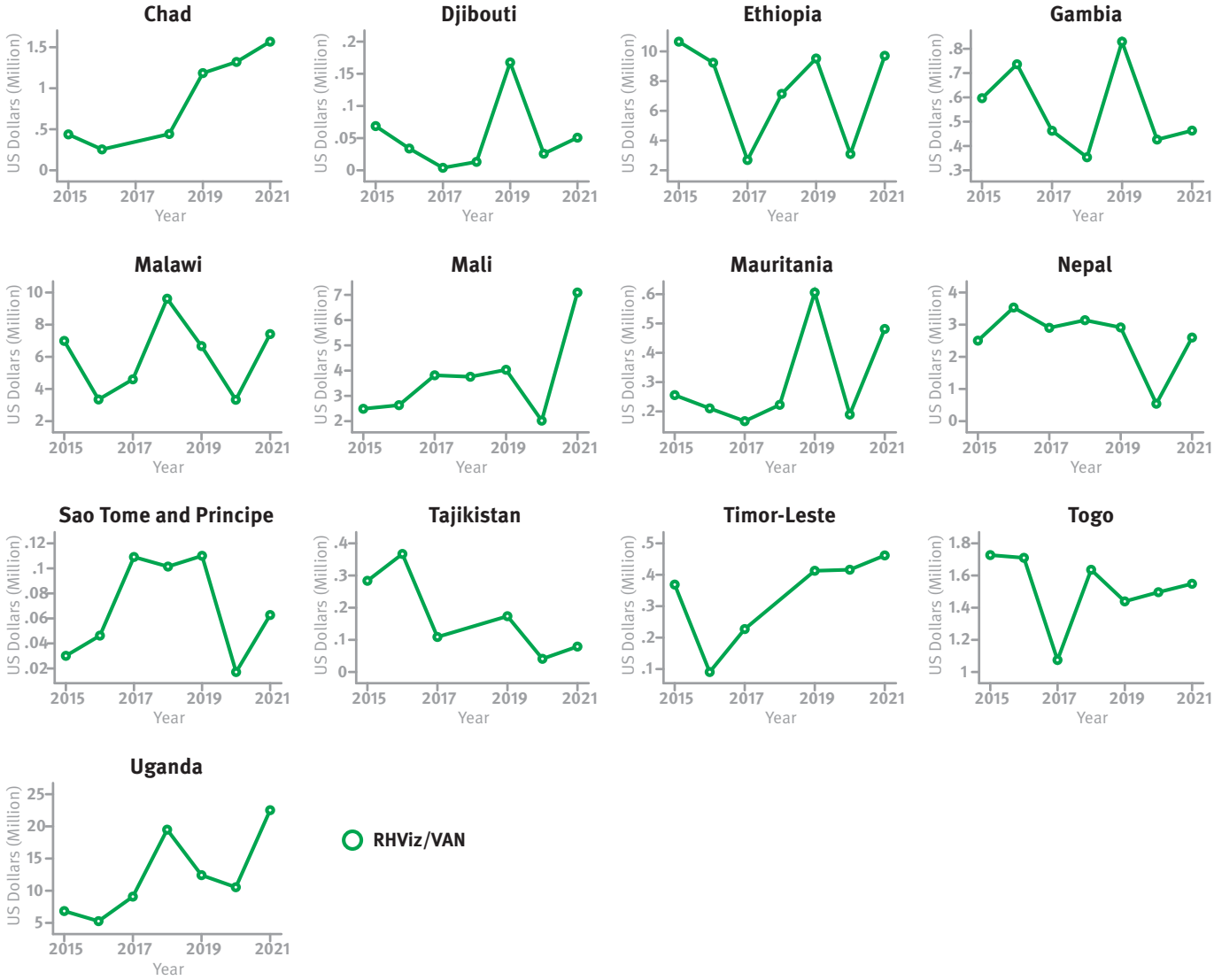
Figure 18: Countries with donor contraceptive funding improving 2019 - 2021, but with decreasing funding from 2020 to 2021 (five countries)



Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

Among the 20 countries with overall worsening of donor funding from 2019 to 2021, 13 did experience an increase in contraceptive funding from 2020 to 2021 (Figure 19), although the pattern of pre-pandemic donor funding varied greatly. For example, Chad and Timor-Leste appear to have been experiencing sustained increases in donor funding from 2016 onwards, with the change in donor funding from 2019 to 2020 representing a slowing down of this increase, which was then reversed from 2020 to 2021 where donor funding reached a historic high. In contrast, in Ethiopia, Malawi and Mauritania, there has been a large degree of fluctuations in pre-pandemic donor funding, which has continued into 2020 and 2021. Tajikistan is the only country in this group that has experienced a sustained overall decline in donor contraceptive funding since 2016, with the increase in funding from 2020 to 2021 being relatively small.

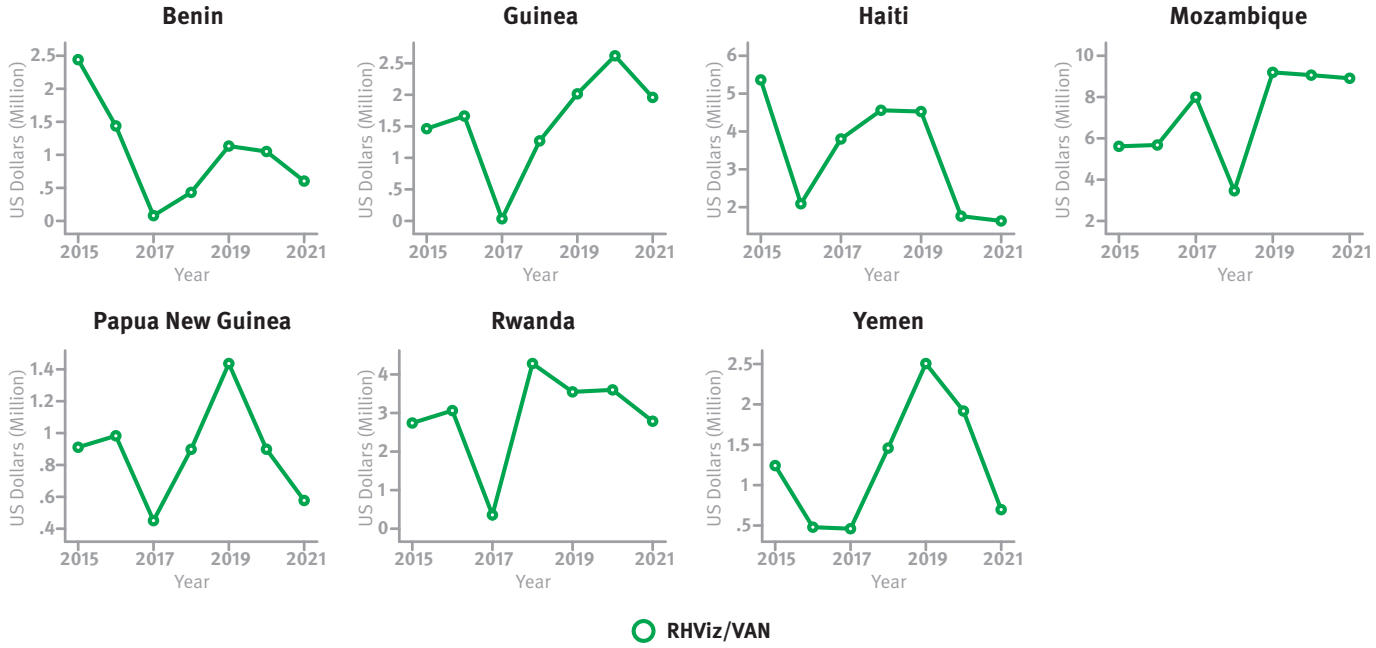
Figure 19: Countries with donor contraceptive funding worsening overall 2019-2021, but with increasing funding 2020-2021 (13 countries)



Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

The final set of seven countries (Figure 20) saw worsening trends of donor contraceptive funding overall from 2019 to 2021, including a decrease in funding 2020 to 2021. Many of these countries reached historic lows of donor funding around 2016 or 2017, with donor funding then increasing until a decline from 2019 onwards. Only Guinea and Mozambique have donor funding in 2022 at or near historic highs; other countries have experienced steep drops in donor funding over time.

Figure 20: Countries with donor contraceptive funding worsening overall 2019-2021, including decreasing funding 2020-2021 (7 countries)



Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

Country Trends for Domestic Funding

For domestic contraceptive funding, we conducted detailed analysis for 21 countries; these 21 countries had consistency in trend categorization across RHViz/VAN and the FP Market Report, and had data available from both the CS Indicators and UNFPA data sources on national budget allocations and spending.

As can be seen in Figure 21, there are often substantive differences in trends in domestic funding across the different data sources, making it difficult to clearly identify patterns of changes. Both Mali and Niger stand out for showing a large increase in domestic funding (based on UNFPA data) in 2021, following years of virtually no funding. Senegal also follows a similar pattern. By contrast, Guinea and Togo appeared to have experienced increases in domestic funding in recent pre-pandemic years, but both have shown declines during the pandemic period. Burkina Faso shows a slight decline in 2021 (based on UNFPA data), but overall appears to have maintained a similar upwards trend in domestic funding.

Ethiopia is an example of a country in which there are quite different trends between data sources. CS Indicators data shows continued increase in overall domestic funding (mostly from the Sustainable Development Goals Fund rather than internally generated funds); UNFPA data for the country showed relative stagnation of domestic funding until 2019 and then a drastic reduction to levels similar to those seen in CS Indicators internal funding data.[35] Stakeholders interviewed for this analysis noted that in 2021 the Government of Ethiopia made resources available from pooled funding mechanisms to offset declines in expected UNFPA procurements (as a result of FCDO reductions) - this may account for the differences seen between the data sources.

35 The UNFPA survey does not explicitly separate internal Government funding from other sources; it is possible that reporting in recent years only captured internally generated funds, while reporting in early years included funds from the SDG fund or other pooled funding mechanisms.

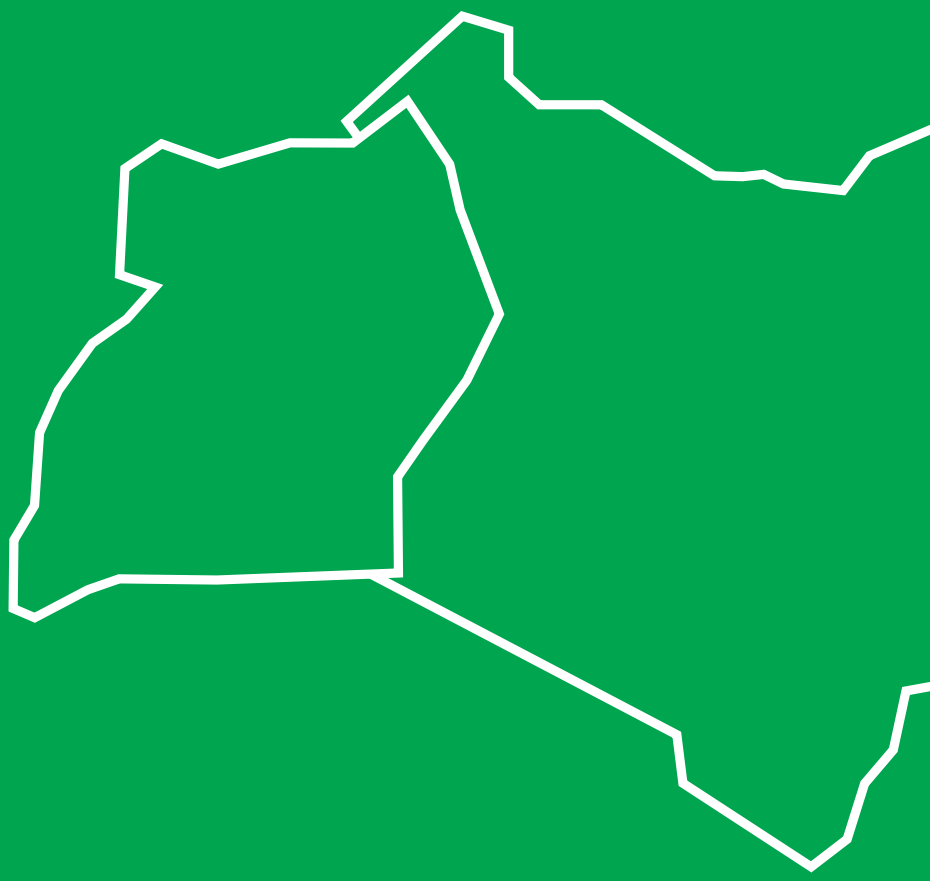
Figure 21: Trends in domestic contraceptive funding (21 countries with available data)

Note: the scale on the y-axis varies for each country so that funding trends (rather than absolute funding amounts) can be easily compared across countries.

Country Case Studies

In this chapter:

- Kenya
- Uganda
- Zambia



Kenya

Country Context

Country Snapshot

- Kenya is a lower-middle income country, with a population of 54 million[36]
- Almost half of all women (46%) use modern contraceptives; 12% of women have an unmet need for family planning[37]
- To date, Kenya has over 5,000 confirmed deaths due to COVID-19, and has an average score of 60 out of a possible 100 on the COVID-19 Stringency Index (higher numbers on the index = more strict)[38]

Contraceptive Funding

Kenya has a pluralist health system in which a mix of public and private sector entities deliver health related goods and services, including family planning. Prior to devolution in 2013, the Government of Kenya financed a substantial proportion of the country's commodity requirements through a ring-fenced budget line for commodities introduced in 2004/5.[39] However, this function was transferred to Kenya's 47 county departments of health, and for several years (roughly 2014-2017), there was very little to no domestic funding of contraceptive commodities.

Initially, donors, mainly UNFPA and USAID, stepped in to fill Kenya's commodity needs. In more recent years, these donors still play a key role, but financing through the World Bank[40] has also been leveraged to fund commodities.[41] Due to Kenya's status as a middle-income country (albeit a lower middle income country), current donors are reducing their funding support over time. More recently, a match fund with a sliding scale has been developed between the main donors of contraceptive commodities and the Ministry of Health. This arrangement will see the Government of Kenya assume full responsibility for contraceptive commodity security by 2026.[42] The main procurer of contraceptives is the Kenya Medical Supplies Authority (KEMSA), although some donors, such as USAID and UNFPA, also procure through their procurement mechanisms.

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36 Population size in 2022 from UNPD World Population Prospects (2022), Income Group based on World Bank FY2023 classifications
37 mCP and unmet need in 2022 from UNPD Estimates and Projections of Family Planning Indicators (2022)
38 COVID deaths from Johns Hopkins University CSSE COVID-19 Data accessed via Our World in Data, data as of December 11, 2022; Stringency Index is average of monthly averages from June 2020 to December 2021 from the Oxford Coronavirus Government Resource Tracker (OxCGRT) accessed via Our World in Data.
39 Kenya Country Case Study in: Transitions in Family Planning: Challenges, Risks, and Opportunities Associated with Upcoming Declines in Donor Health Aid to Middle-Income Countries. Pharos Global Health Advisors. 2019.
40 World Bank funding was through the Transforming Health Systems for Universal Care Project for Kenya, which included both grant funding through the World Bank's Global Financing Facility as well as a loan.
41 ibid
42 ibid

COVID-19 in Kenya

The first COVID-19 case was confirmed in Kenya in mid-March 2020. Response measures were introduced in April 2020 and included curfews, international border and school closures, and restrictions to movements between counties, particularly those with high caseloads such as Nairobi and coastal counties. The public was discouraged from visiting health facilities, unless for services deemed essential. Family planning services were restricted to short term methods based on national guidance. Response measures were in place for approximately one year.

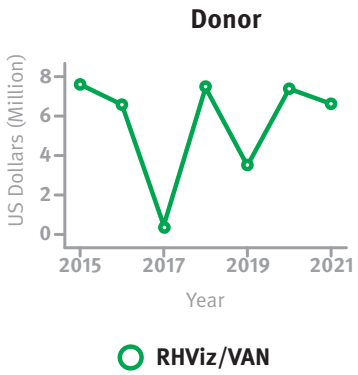
Case Study Preparation

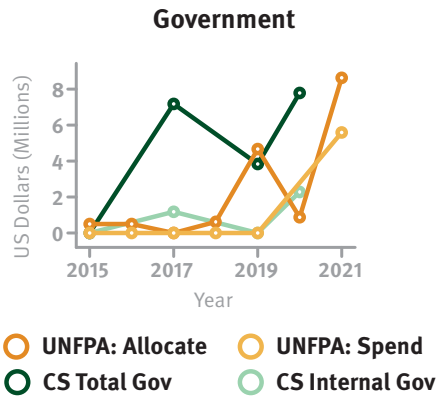
This case study is based on interviews with six stakeholders in Kenya and includes the perspectives of one donor, one UN agency, one government and three NGO respondents. For more details on case study methods, see qualitative data methods overview; for the stakeholders contributing to this case study, see Annex 1.

Pandemic Impact

Our analysis of available data suggested that contraceptive public funding in Kenya improved from 2019 to 2020 (as compared to pre-COVID trends), but then funding decreased in 2021 compared to the 2020 levels (see figures below). However, funding levels fluctuate widely over time. UNFPA has been the largest single donor to Kenya for contraceptives in recent years; its funding showed a large increase from 2019 to 2020, followed by a slight decline from 2020 to 2021, though with funding levels still well above those in 2019. In contrast, domestic funding for contraceptives has been increasing in recent years, including during the pandemic period, albeit from a very low base and with differences in funding amounts across data sources.

During the COVID-19 pandemic, stakeholders reported an overall reduction in funding for contraceptives in





Kenya. This reduction in funding was partly attributed by stakeholders to COVID-19 but also to processes that preceded and coincided with the pandemic, such as donor transitions. Stakeholders reported a reduction in funding for contraceptives as a long-term change, rather than as a temporary change due to the pandemic.

"[Commodity funding] was on shaky grounds. Before COVID as demand was growing, that demand was also not being fully met, either from the donor or the government side." (KE05, NGO)."

Other impacts of the pandemic (outside direct impacts on contraceptive funding) reported by stakeholders included decreased access to family planning services due to the closure of some public health facilities or their designation as COVID-19 treatment facilities. Fear of visiting health facilities and regulations restricting movement also played a factor in suppressing access.

Government guidance restricting the provision of permanent and long-acting methods limited access, but "as soon as the guidelines were relaxed a bit, we saw user behavior normalizing." (NGO). There were also delays in contraceptives arriving in Kenya; partly due to pandemic-related delays in global supply chains and partly due to challenges with the procurement systems operated by KEMSA and USAID. Inside Kenya, contraceptive commodity distribution was deprioritized compared to various other medicines and items required to respond to COVID-19 (e.g., personal protective equipment, oxygen, vaccines, etc.).

Stakeholders also reported that the private sector provided an alternate means for services and commodity access during the pandemic. Although trends are not well understood, this was reported by stakeholders to include greater use of self-care and access through pharmacies.

Risk Factors

Risk factors reported by stakeholders to be contributing to the decreased public funding for contraceptives during the pandemic included:

- **Diversion of funding** – Donors, such as FCDO, reprioritized funding for humanitarian crises and lower-income countries. Globally, stakeholders reported that the funding pool for UNFPA commodity supplies decreased, and the allocation for Kenya relative to other countries reduced. Domestic funding was also reprioritized for the COVID-19 response, with the Government of Kenya reported to have released approximately half of allocated funds for contraceptives in 2020 ($10 million allocated, but only $5 million released).
- **Delay in funding** – There were delays in the release of 'authority to incur' expenditure for domestic funding; this was partly attributed to COVID-19 but also a result of bureaucratic processes. Some donors, such as the Bill and Melinda Gates Foundation, would not release their funds until the 'authority to incur' expenditure was released, with knock-on effects for overall availability and allocation of funds.

Resilience Factors

Resilience factors reported by stakeholders to have limited the impact of COVID-19 on contraceptive funding included:

- **Pre-existing funding agreement** – The match fund and sliding scale initiative that was mapped out prior to COVID-19 largely held (although with some aforementioned funding reductions) and was formalized during the pandemic in a Memorandum of Understanding between the Government of Kenya and donors. The Memorandum of Understanding set out obligations of both parties and created momentum for more resilient, long-term funding of contraceptives. Alongside the MoU, there was strong focus by actors on system strengthening for commodity distribution and reporting.

"…in this current financial year, the contribution as per the MOU [Memorandum of Understanding] should be one to one, we need to see both parties stepping up." (KE02, government)

- **Commodity reserves** – Commodity supply risk factors were mediated to some extent by the inventory holding capacity of KEMSA, which usually keeps 16 to 22 months of contraceptives in stock.

"So even if global production or manufacturing is disrupted for let's say, two months, by the time we feel that impact, we already have a very huge safety net." (KE05, NGO)

- **Diverse funding for the COVID-19 response** – During the pandemic there was increased funding from diverse donors to support the COVID-19 response. This donor support allowed the Government of Kenya to maintain funding for essential health services, including family planning and other reproductive health services.

- **Volume guarantees** – Kenya had volume guarantees in place with UNFPA for some contraceptive commodities, e.g., injectables (DMPA-SC). This arrangement also protected the unit price, which remained constant "before, during, and after" the COVID-19 response.

Insights and Learning

Stakeholders interviewed reported several insights that emerged from the experience of contraceptive funding during the COVID-19 pandemic. These included:

- **Learning from other programs** – There is opportunity to learn from other priority health programs going through donor to domestic funding transitions. The HIV program was cited as a good example of its programmatic efforts to address weaknesses in commodity forecasting, quantification and reporting and partner coordination. Experiences and learnings from the HIV program could be used to strengthen the family planning program in these areas.

- **Viewing family planning as a strategic program** – Kenya has a number of strategic health programs (e.g., HIV, TB, immunization and malaria). There is a need to position family planning within this priority group to ensure that commodity funding is ring-fenced at national level and family planning *"entrenched, as a development agenda for the country." (KE02, government) "Because emergencies always happen. We'll have disasters even now we're talking about drought. Should we say that the money for family planning should be diverted to drought? Just getting our priorities right." (KE02, government)*

- **Improving county accounting** – Availability of contraceptives is a shared responsibility between the national level and county departments of health. For this to function effectively, there is a need to institutionalize forecasting, quantification and data review meetings at national and county level as a *"standard item in the work plans." (KE01, donor).*

- **Regular funding review meetings** – To ensure that momentum is maintained on the match fund and sliding scale initiative, there is a need for regular review meetings of funding commitments, funding execution ('authority to incur' expenditure), funding allocation for forecasted needs and timely procurement through KEMSA.

- **Immediate to longer-term planning** - There is aspiration in the long run for local manufacturing of contraceptives and for regional pooled procurement arrangements. In the immediate term, there was recognition of the need for more responsive and efficient procurement systems, *"when you get a pandemic that upends the whole system, when it's already an inefficient system, then you know, the problems are just made worse." (KE05, NGO)*

- **Developing the private market sector** - The private sector already plays a role in importation and distribution of short-term family planning methods; however, long-acting methods are predominantly supported by donors or government. There is the potential to develop this part of the market.

While it appears that the COVID-19 pandemic has had some impact on funding for contraceptives in Kenya, many factors that complicated the pre-pandemic contraceptive funding landscape are likely to continue. The pandemic experience highlights some strategic directions that could be taken to ensure future security of contraceptive commodities, which are expected to largely shift to domestic funding in the coming years.

Uganda

Country Context

Country Snapshot

- Uganda is a low-income country, with a population of 47.2 million[43]
- Almost one-third of all women (32%) use modern contraceptives; 16% of women have an unmet need for family planning[44]
- To date, Uganda has had nearly 4,000 confirmed deaths due to COVID-19, and has an average score of 66 out of a possible 100 on the COVID-19 Stringency Index (higher numbers on the index = more strict)[45]

Contraceptive Funding

Uganda has a pluralist health system in which a mix of public and private entities deliver health related goods and services, including family planning. The majority of funding for contraceptives is from donors; USAID and UNFPA are the largest donors, with the UK (FCDO) and the World Bank (via the Global Financing Facility) also providing some funding. Under FP2020, and now FP2030, the Government of Uganda has committed to increase domestic funding for contraceptives,[46] which are included under a dedicated budget line item for reproductive health. However, while the amount committed to this budget line item has increased over time, it is largely used to fund maternal health commodities such as mama safe delivery kits rather than contraceptives.

Procurement of contraceptives is done by both the national medical stores and donors; shortages of contraceptives at health facilities are reported to be common.

COVID-19 in Uganda

The first COVID-19 case was confirmed in Uganda in mid-March 2020. The national government reacted decisively: international borders were immediately closed, public and private transport were halted, and a total lockdown was declared, with strict law enforcement measures put in place. The public was discouraged from visiting health facilities, unless deemed essential. These measures were strictly enforced during successive waves of transmission, and school closures lasted two years, the longest in the world. While family planning services were considered an essential health service, in practice they were not easy to access.

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43 Population size in 2022 from UNPD World Population Prospects (2022), Income Group based on World Bank FY2023 classifications
44 mCP and unmet need in 2022 from UNPD Estimates and Projections of Family Planning Indicators (2022)
45 COVID deaths from Johns Hopkins University CSSE COVID-19 Data accessed via Our World in Data, data as of December 11, 2022; Stringency Index is average of monthly averages from June 2020 to December 2021 from the Oxford Coronavirus Government Resource Tracker (OxCGRT) accessed via Our World in Data.
46 Including the partnership with UNFPA, which now includes mandatory and matched funds as part of contraceptive commodity funding arrangements.

Case Study Preparation

This case study is based on interviews with eight stakeholders in Uganda and includes the perspectives of two donors, two UN agencies, one government and three NGO respondents. For more details on case study methods see qualitative data methods overview; for the stakeholders contributing to this case study, see Annex 1.

Pandemic Impact

Our analysis of available data suggested that contraceptive funding in Uganda worsened overall from 2019 to 2020 (as compared to pre-COVID trends), but then funding increased from 2020 to 2021. The increased funding was largely due to increases in donor funding, particularly the Global Fund. Increases from USAID and UNFPA were also observed. As can be seen from the figures below, the increased funding from donors in 2021 took overall contraceptive funding to an all-time high in 2021, above the previous highest level of funding achieved in 2018. Domestic funding for contraceptives has remained fairly low, with fluctuations over time and differences between different data sources.

Stakeholders interviewed for this analysis reported no clear impact of COVID-19 on funding for contraceptive commodities.

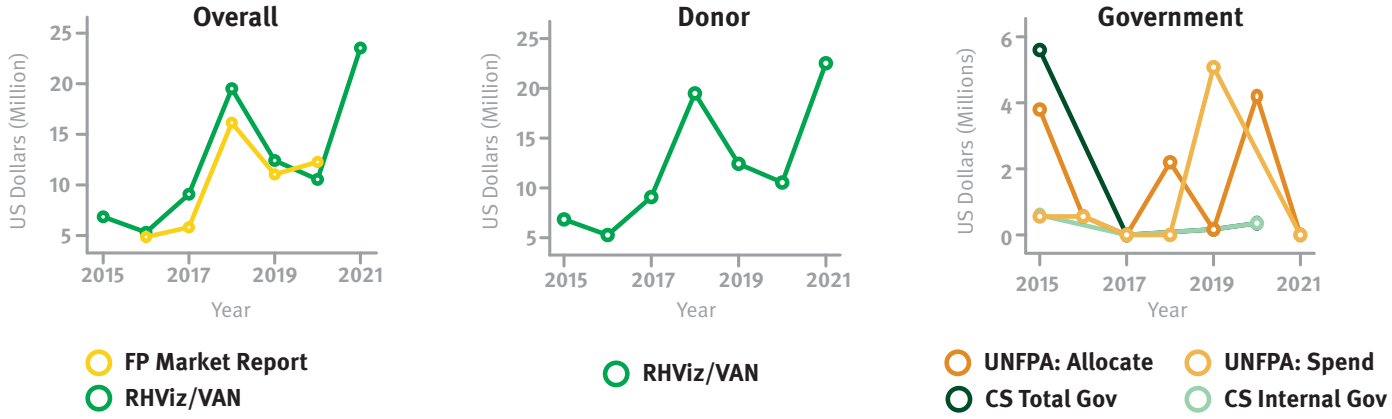
"I don't see a direct hit that we took as a result of COVID-19 from a funding perspective." (UG07, NGO)

"We need to just be grateful that our funding remained stable, despite the demands covid brought to us globally." (UG08, donor)

Domestic funding for contraceptives has remained fairly low over time, and thus there was reported to be limited impact of the pandemic on these funds.

"..there wasn't much for government to reduce" (UG02, donor)

The maintenance of sufficient funding for contraceptives during the pandemic was largely attributed to donors "stepping in", with several respondents reporting that the availability of donor funding has displaced the perceived need for domestic funding,



"…we have primarily been donor dependent; [this] support should be complimentary; it should not be the foundation." (UG02, donor)

The main impact of COVID-19 reported by stakeholders related to the availability and accessibility of contraceptives, rather than direct impacts on funding. COVID-19 was reported by two stakeholders to have caused delays in shipping, and sometimes inability to source the desired commodities, *"…even when you have the resources, you couldn't get some of the commodities that you wanted" (UG02, donor).*

The domestic supply chain for contraceptives was substantially impacted in Uganda, as COVID-19 and other lifesaving commodities were prioritized.

"The priority was to distribute COVID commodities…and family planning was affected so much because you find that districts or facilities would spend about three months without receiving their supplies." (UG06, UN agency)

Furthermore, due to the strict lockdown measures that were introduced in Uganda, clients *"were not moving freely" (UG06, UN agency)*. Thus even when commodities were available at health facilities, individuals were not necessarily able to access them, with two stakeholders commenting that this has led to an increase in unplanned pregnancies among teenagers and others during the pandemic.

Resilience Factors

Stakeholders described several factors that limited the impact of COVID-19 on funding for contraceptive funding.

- **Pre-existing funding agreements** – The two main donors for contraceptives (UNFPA and USAID) had multi-year commitments in place for Uganda, with 2020 commitments already underway before the start of the COVID-19 pandemic. In 2022, UNFPA funding for Uganda increased, and anticipated decreases in USAID funding did not occur,

"…quite often they [USAID] don't necessarily cut the funding as they have indicated but they have always indicated that it's important to plan for sustainability." (UG07, NGO).

- **Limited diversion of funding for the COVID-19 response** – The national government received substantial donor support to respond to the pandemic; this allowed the government to protect its limited public sector resources for the delivery of essential health services (which included operational and human resource costs to deliver family planning services).

In addition, non-public providers of family planning services in Uganda also 'stepped up' their support during the pandemic, including provision of services through outreach, 'in-reach' services provided a public facilities, digital technology and self-care. This may have mitigated the impacts of COVID-19 on the delivery of some public family planning services.

Insights and Learning

Stakeholders interviewed reported several insights that emerged from the experience of contraceptive funding during the COVID-19 pandemic. These included:

- **Domestic funding** – COVID-19 revealed the vulnerability of Uganda's family planning program, given high reliance on donor funding for contraceptive commodities. Following advocacy efforts, one stakeholder reported that it appears that the government is now going to allocate funding for contraceptives under the existing budget line item for reproductive health, *"this is a great win " (UG02, donor)*. This has been spurred by donor action to instill match and conditional funding arrangements, as well as by the increasing nationwide recognition of the need for more domestic funding for health. Heavy reliance on donor funding was recognised as a resilience factor during the pandemic but with longer-term risks for family planning program sustainability *"...maybe we have survived this one [pandemic], but the next one, we may actually see that family planning is adversely affected." (UG01, UN agency)*

- **Learning from other programs** – Some stakeholders referenced the need to learn from other health programs, such as HIV and nutrition, which have successfully advocated for ring-fenced domestic funding as part of program sustainability. There is recognition of the long-term need to position family planning and other vertical health programs within the health benefit package for universal health coverage. In Uganda, this would be done through the anticipated national health insurance scheme.

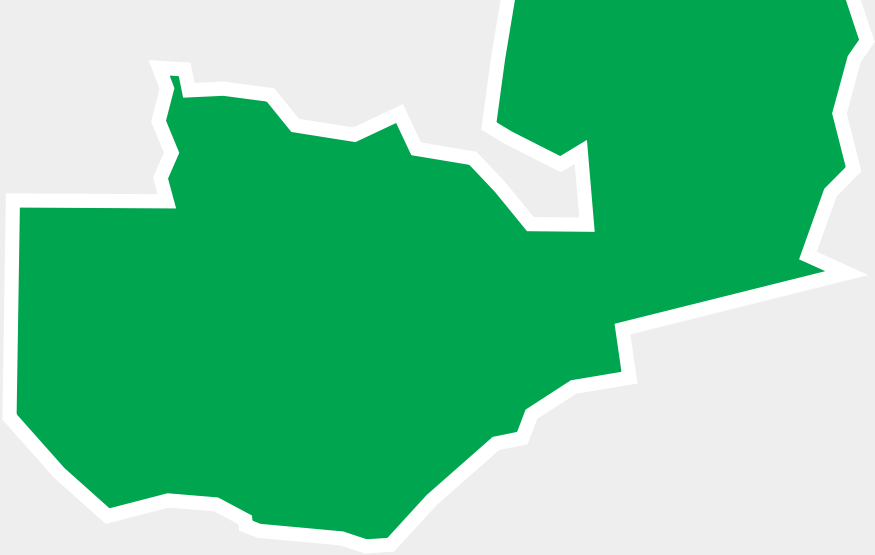
- **Adolescent access** – COVID-19 highlighted the unmet need for adolescent access to family planning services, given reported high rates of teenage pregnancies and school dropouts, with the two inextricably entwined, *"the main reason girls drop out of school, may be poverty, but also pregnancy" (UG01, UN agency)*. The pandemic potentially provides a policy window to operationalize the adolescent and SRH policies.

- **Develop the private sector market** – The private sector played a role in family planning service delivery during the pandemic. This was reported to include greater use of self-care and access through pharmacies, although trends are not well understood. There is increased recognition of the benefits of a total market approach to family planning commodity availability, *"harnessing the private sector as a way of increasing resources towards family planning... that's what COVID taught us" (UG01, UN agency)*.

- **Supply chain managemen**t – Management of the contraceptive supply chain also emerged as a key learning and area for strengthening. System inefficiencies are recognized to have resulted in commodity stock outs, loss/wastage and uneven distribution of commodities. Suggested areas to strengthen include: bulk procurement, buffer stock reserves at central level, monitoring of facility-level stock availability, and last mile delivery. *"Even up to now, we are not yet back to our delivery schedule." (UG01, UN agency)*. Stakeholders also suggested that more work to protect the provision of essential health services is needed as part of emergency preparedness and response, which the recent Ebola outbreak has further tested.

"There is need for agility in our supply chain for family planning that we need to do planning in such a way that we are able to respond amidst any life-threatening situations." (UG08, donor)

Thus, while COVID-19 did not appear to negatively impact funding for contraceptives in Uganda, the experience of the pandemic highlighted several areas for improvement related to contraceptive funding, to ensure future commodity security. This includes increased domestic funding for contraceptives (and overall healthcare) to reduce reliance on donor funding. Improvements to supply chains and service delivery are also needed.



Zambia

Country Context

Country Snapshot

- Zambia, with a population of 20 million, was a lower-middle income country; but in the most recent fiscal year was reclassified as a low-income country[47]
- Over one-third of all women (36%) use modern contraceptives; 15% of women have an unmet need for family planning[48]
- To date, Zambia has had 4,000 confirmed deaths due to COVID-19, and has an average score of 34 out of a possible 100 on the COVID-19 Stringency Index (higher numbers on the index = more strict)[49]

Contraceptive Funding

In Zambia, most health services, including family planning, are delivered by the public sector. The private sector is predominantly located in urban areas and also delivers some health services, including family planning.

For the past decade, the Government of the Republic of Zambia has been increasing its funding for contraceptives. In 2012, under FP2020, the government pledged to double its budgetary allocation for contraceptive commodities, and committed in 2017 to increase its allocation to contraceptives to at least $1.5 million each year by 2020 (which was then met in the 2020 fiscal year).[50]

However the majority of funding for contraceptives in Zambia continues to be provided by donors; UNFPA is the largest donor, with other large donors including the UK (FCDO) and the Global Fund. In the fiscal year 2020, domestic funding accounted for only 14% of all contraceptive funding in Zambia.[51] UNFPA is the main procurer of contraceptives for Zambia, although the government also procures some contraceptives directly.

COVID-19 in Zambia

The first confirmed two cases of COVID-19 were in mid-March, 2020. Lockdown of communities occurred in a few places at the beginning of the pandemic, with isolation and quarantine mainly being applied by place of business

47 Population size in 2022 from UNPD World Population Prospects (2022), Income Group based on World Bank FY2023 classifications
48 mCP and unmet need in 2022 from UNPD Estimates and Projections of Family Planning Indicators (2022)
49 COVID deaths from Johns Hopkins University CSSE COVID-19 Data accessed via Our World in Data, data as of December 11, 2022; Stringency Index is average of monthly averages from June 2020 to December 2021 from the Oxford Coronavirus Government Resource Tracker (OxCGRT) accessed via Our World in Data.
50 PAI Zambia Family Planning Budget Scorecard 2022
51 Ibid

or work premises. At the peaks of the three main waves of the epidemic, schools and colleges were temporarily closed, and access to public premises like pubs and nightclubs was restricted. The country's borders remained open throughout, with some screening measures in place. Many aspects of the healthcare system resources were diverted to the COVID-19 response, and COVID control measures restricted delivery of out-patient services, including family planning.

Case Study Preparation

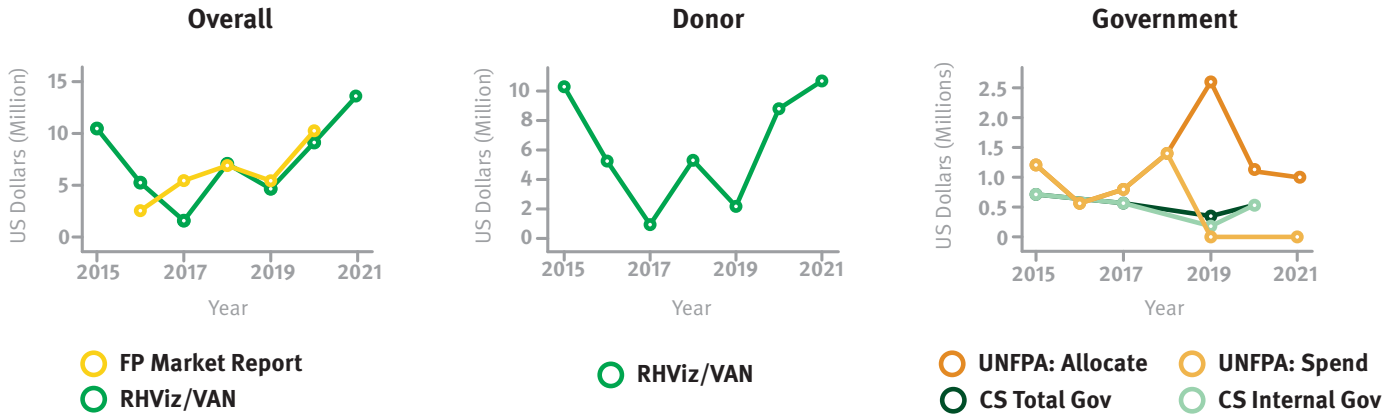
This case study is based on interviews with six stakeholders in Zambia and includes the perspectives of one UN agency, two government and three NGO respondents. For more details on case study methods see qualitative data methods; for the stakeholders contributing to this case study, see Annex 1.

Pandemic Impact

Our analysis of available data suggested that contraceptive funding in Zambia improved overall from 2019 to 2020 (as compared to pre-COVID trends), and continued to increase in 2021. The increase in funding from 2020 to 2021 is mostly attributed to a large increase in funding from UNFPA. Trends in government funding vary across time and data sources; some of this variation may reflect changes in the domestic budgeting process.

Stakeholders interviewed for this analysis reported that while there have been long-standing frameworks between the government and donors to provide funding for contraceptive commodities, the commitments have typically not been sufficient to meet demand, and the government often has not met its commitments. The inability of the government to meet its funding commitments continued during the pandemic.

"...[the] government also commits resources in the yellow book [budget approved by Parliament] towards reproductive health commodities. But what we observed over the years, particularly for 2020, 2019 and 2020, was that the resources that were committed by government were not disbursed" (ZM02, UN agency)



While donor funding for contraceptives had been increasing in recent years, stakeholders interviewed for the analysis expected that donor funding would reduce in the future, due to pressures on their own national budgets, including those due to COVID-19.

"Yes, we've had indications from a couple of donors that put money in the (UNFPA) Global Supplies Partnership that they have reduced their funding to the partnership. And the reasons being given are basically COVID." (ZM02, UN agency)

Other impacts of the pandemic reported by stakeholders included reduced delivery of family planning services due to reduced staff availability (staff getting sick and/or being re-deployed to the COVID-19 response) and clients' fear to visit health facilities. *"At our clinics the fear to visit was noticeable." (ZM03, NGO)*. Stakeholders reported that this had led to an increase in unplanned pregnancies and unsafe abortions.

Stakeholders interviewed also reported that global manufacturing and shipping delays due to COVID resulted in changes in contraceptive procurement and use. This included sourcing of alternative brands, increased use of private facilities to access contraceptives, and the introduction of the self-injectable DMPA-SC

"... we had to start looking for alternative equivalent products. So instead of having Jadelle and Implanon, we started now looking for Levoplant which we managed to access so that we replace or co-position, with the Jadelle and Implanon which was not available." (ZM05, government)

" we saw a huge move for the clients that were accessing commodities from the public sector into the private sector,.... there was quite a widespread stock out level within the public sector facilities. " (ZM06, NGO)

"The introduction of Sayana Press [DMPA-SC] in place of cheaper monthly oral disbursements reduced the number of clients coming through to be served over any given time. " (ZM03, NGO)

Risk Factors

Stakeholders reported two main COVID-19 related risk factors affecting funding for contraceptives during the pandemic:

- **Diversion of domestic funding** - The Government was unable to meet its commitments to fund contraceptives due to diversion of funds to the COVID-19 response

".....there was a refocus on activities and a good portion of money was allocated for the unplanned COVID-19 programs. So, I think 2020, that's how we saw that a number of programs financing was affected ...COVID supplies, medicines were prioritized." (ZM05, government)

"It was not just the family planning budget but other budgets were cut." (ZM01, government)

Risk Factors

(continuation from previous page)

- **Shipping cost increases and delays** - The disruption to global supply chains led to delays in shipping contraceptives to Zambia. At one point, contraceptives had to be delivered via air freight (with higher associated costs) due to the stock-outs being experienced. Higher costs mean that for the same amount of money, fewer contraceptives are purchased.

"... the costs of doing business increased. Some of the commodities were transported at a high cost using the flight mode instead of the road or sea. So, the cost increased." (ZM05, government)

The increase in costs also affected supplies other than contraceptives needed for delivery of family planning services.

Resilience Factors

Resilience factors reported by stakeholders to have limited the impact of COVID-19 on funding for contraceptives included:

- **Volume guarantees** – UNFPA procures the majority of contraceptives used in Zambia, and their pre-existing agreements with manufacturers ensured price and volume stability.

"... there were those [prices] that were agreed with the manufacturers. And I don't think after the lock down they were able to increase the costs because they had to meet the purchase agreements that were made before. So, despite the increase in the cost to transport the commodities that the importers faced, they could not pass much of it to the retailers." (ZM01, government)

- **Rapid resumption of global supply chains** – The delays and disruption to global supply chains were relatively short-lived.

"I think it was temporary [effect] because afterwards, we were able to ship what we had already procured. And, and because of that, the stock-out was actually – it was managed and we got the supplies that we needed after the restrictions were lifted." (ZM01, government)

Insights and Learning

Stakeholders interviewed reported several insights for contraceptive funding that emerged during the COVID-19 pandemic. These included:

- **Improve forecasting and monitoring of family planning commodities utilization** - Appropriate forecasting and supply management have been ongoing challenges in Zambia; they were exacerbated during the pandemic. Two stakeholders commented on the potential of digital tools to support SRH services, including to improve contraceptive forecasting and supply. *"The digital landscape that emerged in the COVID should be used to improve the perennial mis-alignment of demands, supply and needs at various levels of the family planning sector. These digitals should be used to develop a bottom-up quantification process unlike the top down being practiced now which mis-aligns demands to supplies because estimates are somewhat made from nowhere but the expectation is that the people need these types of methods of family planning. Hence pills are sent to rural areas where maybe long-acting methods would fit the intrusions of the cultural norms" (ZM04, NGO)*

- **Regional manufacturing of contraceptives** - Several stakeholders commented on the need to manufacture contraceptives within Africa, so that the impact of future global supply chain disruptions on availability of contraceptives is lessened. *"...this is one thing that Africa and Zambia specifically should be looking at investing in, is to ensure that our local production is increased so that it doesn't disrupt services." (ZM02, UN agency)*

- **Increased domestic funding for contraceptives** - Stakeholders reflected on the need for the Government to continue to increase its commitments and allocations of funds for contraceptives. One stakeholder also suggested that corporate entities in Zambia should support the delivery of family planning services.

- **Improvement in family planning services** - Several stakeholders commented on how family planning services could be improved to mitigate the impact of future pandemics or other disruptions. This included better integration of family planning within routine health services and increasing the role of the private sector in service delivery. *"Integration of family planning into medical care still lags behind. And the pandemic exposed this because care for COVID and prevention could be done by the staff who could also have taken care of the family planning needs." (ZM03, NGO)*

While COVID-19 did not appear to negatively impact funding for contraceptives in Zambia, the experience of the pandemic has highlighted the ongoing reliance of Zambia on donor funding. During the pandemic, this was somewhat protective due to the pre-existing funding agreements with manufacturers. Going forward, contraceptive security in Zambia will rely on the Government meeting its commitment to fund contraceptives (especially if/when donor funding decreases, as predicted by some). Improvements to supply chain management and service delivery are also required.

Reflections and Looking Ahead

Our analysis sought to understand the impact of the COVID-19 pandemic on funding for contraceptive commodities. We developed a simple theoretical framework to help contextualize possible impacts in three domains: changes to the **supply chain**, changes to **accessibility and demand**, and factors within the **wider enabling environment** (see Figure 2). Our quantitative analysis sought to look at changes in funding trends, while our qualitative analysis sought to understand the story behind the trends, and how they may have related to the three domains. Overall, our quantitative analysis found limited impacts of COVID-19 on contraceptive funding to date, at least at the aggregate. However, our analysis highlighted fluctuating trends of contraceptive funding pre- and during the pandemic at the national level. Below, we summarize what we learned from our qualitative work about changes across the three domains of our framework.

Early in the pandemic, concerns surfaced about large disruptions related to the first two domains of our framework: supply chain and accessibility and demand. The stakeholders interviewed who are most closely involved in supply and manufacturing (UNFPA, Viatris and DKT WomanCare) explained the pandemic did cause **supply chain** issues at all levels, leading to large increases in costs (particularly freight costs), significant delays in ordering and delivery of commodities, and some canceled purchase orders. DKT WomanCare reported that severe lockdowns in China caused difficulties with manufacturing and supply chains; for example, conducting inspections was extremely difficult, but they were able to surmount the challenges. The increases in production costs were mostly absorbed by the manufacturers, according to Viatris, UNFPA, and DKT WomanCare. This was partly due to multi-year price agreements established before the pandemic with donors. However, UNFPA noted that, in some instances, they took on the increases in commodity prices. While the freight costs now seem to be reverting to roughly pre-pandemic levels, the stakeholders interviewed cautioned that future or long-term cost increases would result in fewer commodities being purchased, unless funding for commodities increases, because manufacturers would need to adjust their prices to ensure they are able to generate a reasonable profit from contraceptive sales. Overall, it seems that while the supply chain challenges certainly occurred, they were mainly addressed without severe, prolonged disruptions, as had been feared.

In terms of how changes to **accessibility and demand** may have affected commodity funding, the limited data that is available does not show any major declines in terms of contraceptive use and thus no identified knock on effects on commodity procurement and funding. Indeed an analysis of PMA data in four countries found that "over this period [comparing the turn of the year 2020/21 to a pre-pandemic baseline], rates of modern contraceptive usage rose significantly among the surveyed female populations in several sample countries."[52] While changes in this domain are

52 Andreas Backhaus, 2022. "Pregnancies and contraceptive use in four African countries during the COVID-19 pandemic," Vienna Yearbook of Population Research, Vienna Institute of Demography (VID) of the Austrian Academy of Sciences in Vienna, vol. 20(1), pages 459-476.

likely not to have impacted contraceptive commodity funding, access could have been impacted for some women, particularly groups who are more difficult (and more expensive) to reach.

Notably, it is factors within the third domain of our framework - **wider enabling environment** - that may be most salient for contraceptive commodity funding going forward; this includes factors related directly and indirectly to COVID-19 and factors unrelated to COVID-19, which are currently shaping the landscape for funding. Beyond the typical funding fluctuations, global stakeholders interviewed commented that the war in Ukraine (and shifting funding to support Ukrainian refugees), the FCDO spending cuts, and the global economic downturn and inflation, were likely to have long-term and potentially serious consequences for contraceptive funding. In addition, as noted in the section on donor funding and in Figure 1, there are ongoing factors that existed prior to the pandemic and that affect contraceptive funding, such as humanitarian crises, changes in government, and internal and regional conflicts.

Key Resilience Factors & Lessons Learned from COVID-19

Despite the pandemic having a large impact on contraceptive supply chains and cost of commodities, the overall impact on contraceptive funding apparently remained small. Stakeholders had several thoughts on why this was, and what lessons could be taken from the family planning sector's response to the pandemic.

The primary reasons described by stakeholders for the limited impact on commodity funding were because 1) funding was already committed (at least for 2020), and 2) other donors stepped in to fill funding gaps caused by the FCDO cuts. This highlights the importance of UNFPA being funded by multiple donors - this diversification protects the contraceptive funding from shocks. In fact, thanks to other donors stepping in, UNFPA was able to retain some reserve funding to make dealing with future shocks more manageable. However, the increased reliance on UNFPA as the main procurer of donor funded commodities, and, increasingly, more domestic government funded commodities through co-financing and third-party procurement, may present future risks.

Despite supply chain delays, stakeholders reported that there were few reports of stock outs, which was attributed to the fact that most countries had high levels of stock (more than may be considered best practice) and there was inventory in regional distribution centers. *"So even if global production or manufacturing is disrupted for let's say, two months, by the time we feel that impact, we already have a very huge safety net." [NGO stakeholder in Kenya]*. Furthermore, most of the cost increases were absorbed by manufacturers, according to multiple global stakeholders. While this allowed donors to continue to buy the same quantities with their available funds, it may not be sustainable in the long term.

Stakeholders agreed that the SRH community reacted quickly and collaboratively to address the issues caused by the pandemic, and other factors. Governments and service delivery organizations introduced or expanded new service delivery approaches to respond to the challenges of the pandemic, such as self-care, telemedicine, and mobile outreach. *"On the positive side- a lot is happening in countries in terms of expanding choices: new products being introduced, embracing human rights and gender-transformative approaches to programming, community dialogues and sensitization, and other demand creation strategies. During COVID, different initiatives like self-care became commonplace and accepted as service delivery options. We think some of these practices will continue beyond COVID and will help us reach more women and girls." [UNFPA stakeholder]*

Decisions were made quickly at a global and national level to reprogram money, expedite processes, and release new guidance, showing that a sector where *"decision making by donors, governments and others can be slow and laborious" [DKT WomanCare stakeholder]* can be more nimble than it currently is, without necessarily sacrificing quality.

The pandemic also put a spotlight on historical challenges in the family planning sector that were exacerbated by the pandemic. Primarily, stakeholders were concerned about inaccurate and last-minute projections of commodity needs from many (not all) countries, which make it hard for donors and manufacturers to accurately plan and allocate resources. This is in part due to limited data, at all levels, on which to make forecasting decisions; it is also caused when decisions are made based on the funding available, rather than on the true need of countries.

The pandemic also highlighted how dependent the sector is on donor funding for contraceptives, at a time when the push by some is to move towards domestic resource mobilization, greater national ownership of supply chains, and national and health insurance schemes. Dependence on donors leaves countries and manufacturers at the mercy of last-minute and short-term funding decisions by donors; delays are common, and countries may be forced to place just a few, extremely large purchase orders each year.

"When things change significantly it impacts on everyone who is part of the global supply plan community. We can't have long-term planning and can't be very certain of how we can address country needs and at the same time ensure we are well coordinated with manufacturers." [UNFPA stakeholder].

Stakeholders also noted both challenges and opportunities in engagement of the private sector. Opportunities largely focused on the potential role for the private sector as a service provider, with multiple examples of how this had occurred during the pandemic. However, the financing of this role needs further consideration to ensure funding does not simply shift to women paying out-of-pocket for contraceptives. This could include models of public sector financing (e.g. through insurance schemes, contracting out, or provision of free or subsidized products), or greater contributions from private actors (e.g. through employers covering the cost of health services for their employees).

The pandemic also made it clear that, despite the push for domestic resource mobilization, many countries are unprepared to take on the full burden of financing of contraceptive commodities, and remain vulnerable to challenges such as the pandemic.

Box 5: Risks, resilience and lessons learned: insights from global and country stakeholders

Several common themes arose from our stakeholder interviews regarding risk and resilience factors highlighted by the pandemic, and general lessons learned. Note that not all of the risk factors included came to fruition, in some cases because of actions taken to counteract them.

RISKS	RESILIENCE	LESSONS LEARNED
Diversion of funding to tackle the COVID-19 pandemic.	Pre-existing funding agreements and large amounts of donor funding allocated prior to 2020.	■ Need to increase domestic funding, including National Health Insurance Schemes (including family planning), to reduce reliance on donor funding. ■ Apply learnings from other programs e.g. HIV to improve the funding and accessibility of contraceptives.
Reduction of funding due to impact of pandemic on global economy.	Donors showed their recognition of the importance of family planning by increasing funding, or making one-off funding, to fill funding gaps.	■ Importance of diverse funding sources for family planning commodities, and risk of over-reliance on one procurer. ■ Need for UNFPA (as the largest procurer) to maintain 'cushion funding' to prevent disruptions to procurement due to delays or changes in funding from individual donors.
Increasing costs (mainly freight/ shipping costs).	Volume and price guarantees ensured that countries were not unduly impacted by increasing costs. Manufacturers and donors absorbed cost increases.	■ Need to adapt the current procurement system so that domestic governments can order directly from the manufacturer, and with the same beneficial terms as donors. ■ Need for funding to increase if prices go up again, or price increases are sustained. Otherwise fewer commodities bought, and/or production of contraceptives becomes less financially sustainable for manufacturers and they exit the market.

Box 5: Risks, resilience and lessons learned: insights from global and country stakeholders (continues from previous page)

RISKS	RESILIENCE	LESSONS LEARNED
Shipping and delivery delays.	Many countries had large stocks of commodities already in-country. Rapid resumption of the global supply chain.	■ Need for quality, accurate, transparent supply chain management (including forecasting and procurement). ■ Need for quality procurement and expenditure data. ■ Fast-tracking ordering and spending decisions without sacrificing quality is possible.
Changes in accessibility and demand impacting the amount and type of contraceptives needed.	SRH community, including the private sector, adopted or scaled-up innovative approaches (e.g. task-sharing, use of CHWs, self-care, telemedicine) to ensure access was maintained.	■ SRH community must advocate for the innovative approaches adopted during the pandemic to be maintained and scaled-up as appropriate.

Recommendations for the Future

Prepare the SRH sector and governments to transition away from reliance on donors

We heard through our stakeholder interviews that there is a clear push, primarily from donors, to transition to domestic resource mobilization for contraceptive commodities. However, our analysis shows that domestic funding has remained relatively low and stagnant both before and during the pandemic. Stakeholders also commented that countries with already limited resources are especially vulnerable to fiscal pressure and other major events (such as regional and internal conflict, humanitarian crises, and economic downturns) and as such may not be ready in the near-term to fully take on commodity funding domestically.

This echoes a recent call from FP2030: "The focus for the next decade must be on achieving sustainability, with a combination of country-led domestic resource mobilization, broadly supported universal health schemes, greater private sector involvement, co-financing development opportunities, cross-sectoral partnerships, and donor funding for the neediest countries and programs."[53]

We also heard that even if resources were available, current contraceptive markets are largely set up for institutional purchasers who make large multi-year purchases, which may not be appropriate for all national governments.

At the same time, there is limited visibility into domestic funding contributions, and what limited data we do have may not always be accurate and has a year plus time lag. This limits governments' ability to forecast contraceptive needs and funding gaps. Greater national ownership of supply chains might address at least some of these challenges. However, a larger-scale adjustment of the current procurement system will also be needed to allow governments, some of whom will only purchase relatively small quantities, to be able to work directly with manufacturers (for example, mechanisms that allow for pooled procurement across countries).

We also heard about the importance of the private sector, both as a provider of services as well as playing roles throughout the supply chain (e.g. warehousing and distribution of commodities). Alongside women and couples paying out-of-pocket for contraceptives from private sector actors, where appropriate, Governments and donors should also consider how public sector financing can be channeled into the private sector to ensure equitable access and leverage private sector efficiencies.

Finally, donor funding will continue to play an important role, at least in the short term. Stakeholders noted that a more strategic approach may be needed to determine how donor funds will be utilized alongside increasing domestic resources.

53 FP2030 2022 Measurement Report Brief (fp2030.org)

Improve forecasting and procurement processes through better understanding and use of data

At national, regional and global levels, more accurate, transparent and timely forecasting and procurement processes are critical to better identify and respond to any emerging funding gaps. Clear and timely reporting of funding data by both donors and national governments is a critical step in ensuring future funding decisions at a national and global level are more strategic. Acknowledging this need, the VAN is currently working towards producing consistent quality data for all countries to enable more accurate forecasting. For our analysis we drew on the available data sources to identify trends in contraceptive funding before and during the pandemic. However, each data source differed in important aspects, such as how and when commodities are valued, which countries and type of funding are included, and when data is available. This made analysis and understanding of the data challenging, and it somewhat limits the utility of existing datasets to support proactive and timely interventions when funding gaps may be emerging. Furthermore, while our analysis focused primarily on what was spent, understanding what needs to be spent and to what degree funding is sufficient is also critical to making informed and strategic decisions.

To improve resilience, and to allow the shift to domestic financing, investment is needed in human resources, systems and infrastructure at the national level. This investment is essential for stronger supply chain management, including strengthened forecasting and procurement, which can then better manage future shocks.

Annexes

Annex 1: List of Contributors

Where consent was provided, contributors to the analysis are acknowledged by individual name as well as organization

Global Stakeholders

- Advance Family Planning: Sabrina Karklins, Beth Fredrick
- CHAI: Mindy Scibilia, Eleni Han, Anne Kuster
- DKT WomanCare: Tracey Brett
- FP2030: Jason Bremner
- John Snow, Inc.: Alexis Heaton
- Kaiser Family Foundation: Adam Wexler
- PAI: Jennifer Sleboda
- RHSC: Trisha Long
- SEMA Reproductive Health: James Droop
- UNFPA: Ayman Abdelmohsen, Desmond Koroma, Stephen Mawa
- USAID Global Health Supply Chain Program: Suzanne Gold
- USAID: Sharmila Raj
- Viatris: Ashish Das
- World Bank Global Financing Facility: Brendan Hayes

National Stakeholders

Kenya

- FCDO: Akaco Erikipa
- inSupply Health: Johnson Anyona
- National Council for Population and Development (part of Government of Kenya): Beatrice Okundi
- Options: Timon Ayieko
- UNFPA: Dan Okoro
- Note: One additional organization was interviewed in Kenya, but opted to remain anonymous in this report.

Uganda

- CHAI
- FCDO: Kabbale Arnold
- National Medical Stores: Nsubuga Benard
- Population Services International (PSI)
- Samasha Medical Foundation: Jemera Nabuguzi Eric
- UNFPA: Moses Walakira and one other respondent
- USAID Global Health Supply

Zambia

- Copper Rose Zambia: Muchinga Mutambo
- John Snow Health Zambia: Mika Bwembya Mwambazi
- Ministry of Health: Dr Caren Chizuni, Maxwell Kasonde
- Planned Parenthood Association of Zambia
- UNFPA: Dr Wezi Kaonga

Annex 2: Data Sources

Summary of Data used in Country Analysis

DATA SOURCE	USED IN ANALYSIS		DATA SCOPE			DATA COLLECTION	
	Data	Years included in analysis	Countries	Donor funding included	Domestic funding included	Frequency of collection	Method of collection
RHViz/VAN Produced by RHSC	Estimated line value of contraceptives received in-country in calendar year,[1] converted to monetary value in RHViz/VAN by multiplying shipment volumes of commodities by reference list prices	2015, 2016, 2017, 2018, 2019, 2020, 2021[2]	Varies; 130 unique countries captured in analysis	Yes	Partially; only when purchased through UNFPA[3]	Ongoing; updated weekly	Uploads of shipments of contraceptives to the VAN [4]
Family Planning (FP) Market Report Produced by CHAI and RHSC	Volume of contraceptives shipped to public sector in calendar year; converted (in our analysis) to monetary value by multiplying volumes of commodities by average unit prices (see Annex 3)	2015, 2016, 2017, 2018, 2019, 2020[5]	69 FP2020 countries[6]	Yes, but can't disaggregate funding source	Yes, but can't disaggregate funding source	Annually[7]	Reports from manufacturers
Contraceptive Security (CS) Indicators Produced by USAID Global Health Supply Chain Program	Estimate of government expenditure in most recent fiscal year[8]	2015, 2017, 2019, 2021	Varies;[9] 63 unique countries captured in analysis	Yes (but not included in analysis)[10]	Yes; internally generated and externally sourced[11]	Every two years[12]	Survey of national governments
National Budget Allocation and Spending (UNFPA Countries)[13] Produced by UNFPA	Amount allocated and spent by national governments on contraceptives in each year	2015, 2016, 2017, 2018, 2019, 2020, 2021	48 countries supported by UNFPA	No	Yes	Annual	Survey of national governments (via UNFPA country offices)

Note that CS Indicators and the UNFPA National Budget Allocation and Spending do not define the specific contraceptives included; they ask about funding of commodities overall, without specification.

Both RHViz/VAN and the FP Market Report include the following contraceptives: male and female condoms, injectables, oral contraceptive pills (combined, progestin-only and emergency), IUDs (hormonal and non-hormonal) and implants. RHViz/VAN also includes data on additional products.[14]

Other data sources considered for inclusion in the analysis, but ultimately excluded:

- Family Planning Spending Assessment (FPSA) by Track 20: This tracks annual national government expenditure on contraceptives, applying a methodology that tracks flow of resources and expenditures, informed by surveys and review of data and documents.
- Contraceptive & Condom Shipment Reports from USAID: These include the quantities and value of contraceptives procured and delivered with USAID family planning assistance funds.
- Procurement Statistics from UNFPA: These report on the value (in US dollars) of purchase orders created for contraceptives by UNFPA, including through UNFPA Co-Financing Agreements (see footnote 3) for more information on these agreements)

These data sources were excluded as they duplicated or overlapped substantially with the included data sources, provided limited visibility into country details, or had insufficient coverage of countries (FPSA only).

1 Calendar year based on actual or estimated date of delivery
2 Partial 2022 data is included in Box 4; country level analysis only captures data through 2021 as 2022 data was not available at the time of analysis
3 In some cases, Governments or other partners purchase commodities through UNFPA using their own funding, through Third Party Procurement (TPP) or co-financing mechanisms. These purchases are included within RHViz/VAN (as 'co-financing'); in recent years RHViz/VAN has recorded between $20M and $40M of commodity funding through these mechanisms.
4 VAN = Global Family Planning Visibility and Analytics Network. See VAN website for more details
5 2021 data included in aggregate funding trend analysis but not country level analysis as country data was not available at the time analysis was being conducted
6 2022 FP Market Report expanded its scope to 83 FP2030 countries; but country results do not include this data as it was not available at time of analysis
7 Often a one year lag time in reporting e.g. the report containing data for 2020 was published in late 2021.
8 Fiscal year not specified in survey (countries report based on their own fiscal years), so may be some variation in the time period reported by countries; respondents can report different spending types e.g. some report based on purchase order date and others on shipment date
9 USAID Family Planning Priority Countries, USAID Family Planning transitioned countries, and Ouagadougou Partnership countries are prioritized to receive the CS Indicators Survey. The corresponding report of survey data is released up to 12 months later e.g. the 2021 report is based on survey data collected in August - November 2021 reporting on expenditure in the most recently completed fiscal year
10 See note above; donor estimates from CS Indicators not included in this analysis
11 Externally sourced domestic funds is funding that is sourced from outside the country, but that the government has some control over (e.g. World Bank loans, donor basket funding),
12 From 2010-2015 the survey was annual but has shifted to every two years; often a long time lag to publication (e.g. the 2021 report was published in mid 2022, and expenditure values largely reflected spend in 2020).
13 Data is not available online but was shared by request for this analysis
14 RHViz/VAN also includes personal lubricants, syringes and accessories and standard days method. However these account for a very small proportion of overall volumes.

Data Sources by Country

Note: table based on availability of data in any year (among the years included in analysis, see table above)

	RHVIZ/VAN	FP MARKET	CS INDICATORS	UNFPA GOV
Afghanistan	•	•	•	•
Albania	•		•	
Algeria	•			
Angola	•		•	
Anguilla*	•			
Antigua and Barbuda*	•			
Argentina			•	
Armenia	•		•	
Azerbaijan	•		•	
Bahamas*	•			
Bangladesh	•	•	•	
Barbados*	•			
Belarus	•			
Belize	•			
Benin	•	•	•	•
Bermuda*	•			
Bhutan	•	•		
Bolivia	•	•	•	•
Botswana	•		•	
Brazil	•			
Burkina Faso	•	•	•	•
Burundi	•	•	•	•
Cambodia	•	•		
Cameroon	•	•	•	•
Cape Verde	•		•	
Central African Republic	•	•		•
Chad	•	•		•
Chile*	•		•	
China	•			
Colombia	•			
Comoros	•	•		
Congo Rep	•	•		•

	RHVIZ/VAN	FP MARKET	CS INDICATORS	UNFPA GOV
Costa Rica	•			
Côte d'Ivoire	•	•	•	•
Cuba	•			
Denmark*	•			
Djibouti	•	•		•
Dominican Republic	•		•	
Dem. Rep of Congo (DRC)	•	•	•	•
Ecuador	•		•	
Egypt Arab Rep	•	•		
El Salvador	•		•	
Equatorial Guinea	•			
Eritrea	•	•		•
Eswatini	•			
Ethiopia	•	•	•	•
Fiji	•			
Gabon	•			
Gambia	•	•	•	•
Georgia	•		•	
Ghana	•	•	•	•
Grenada	•			
Guatemala	•		•	
Guinea	•	•	•	•
Guinea-Bissau	•	•		•
Guyana	•			
Haiti	•	•	•	•
Honduras	•	•	•	•
India	•	•	•	
Indonesia		•	•	
Iraq	•	•		
Jamaica	•			
Jordan	•			
Kazakhstan	•			

	RHVIZ/VAN	FP MARKET	CS INDICATORS	UNFPA GOV
Kenya	•	•	•	•
Korea Dem Rep	•	•		
Kosovo	•			
Kyrgyz Republic	•	•	•	
Lao PDR	•	•	•	•
Lebanon	•			
Lesotho	•	•		•
Liberia	•	•	•	•
Madagascar	•	•	•	•
Malawi	•	•	•	•
Maldives	•			
Mali	•	•	•	•
Mauritania	•	•	•	•
Mauritius	•			
Mexico	•		•	
Mongolia	•	•		
Morocco	•			
Mozambique	•	•	•	•
Myanmar	•	•		•
Namibia	•			
Nepal	•	•	•	•
Nicaragua	•	•	•	
Niger	•	•	•	•
Nigeria	•	•	•	•
Pakistan	•	•	•	
Panama*	•			
Papua New Guinea	•	•		•
Paraguay	•		•	
Peru	•		•	
Philippines	•	•	•	
Republic of Moldova	•			
Russia			•	
Rwanda	•	•	•	•
St. Kitts & Nevis*	•			
St. Lucia	•			

	RHVIZ/VAN	FP MARKET	CS INDICATORS	UNFPA GOV
St. Vin. & the Gren	•			
Sao Tome and Principe	•	•		•
Senegal	•	•	•	•
Seychelles*	•			
Sierra Leone	•	•	•	•
Solomon Islands		•		
Somalia	•	•		•
South Africa	•		•	
South Sudan	•	•	•	•
Sri Lanka	•	•	•	
Sudan	•	•		•
Suriname	•			
Switzerland*	•			
Syrian Arab Republic	•			
Tajikistan	•	•		
Tanzania	•	•	•	•
Thailand	•			
Timor-Leste	•	•		•
Togo	•	•	•	•
Trinidad and Tobago*	•			
Tunisia	•			
Turkey	•			
Turkmenistan	•			
Turks and Caicos Islands*	•			
Uganda	•	•	•	•
Ukraine	•		•	
United Kingdom*	•			
Uruguay*	•			
Uzbekistan	•	•		
Venezuela	•			
Vietnam	•	•	•	
West Bank and Gaza	•	•		
Yemen	•	•	•	•
Zambia	•	•	•	•
Zimbabwe	•	•	•	•

**Non-LMIC; some non-LMICs are captured in RHViz/VAN as recipient countries; in 2019 these countries accounted for less than 0.3% of funding in RHViz/VAN.*

Annex 3: Detailed Methodology for Quantitative Analysis

This annex provides additional details on the methodology used for the quantitative analysis.

A summary of the approach can be found in the Method Overview section of the full report, along with the methods for the qualitative portion of this work.

Country Level Commodity Funding Estimates

The quantitative analysis in this report drew on four main data sources. In some cases, estimates of funding were taken directly from these data sources, while for others funding estimates were derived from available data, as detailed below. More details on each data source can be found in Annex 2.

- RHViz/VAN: country level funding estimates were extracted directly from RHViz/VAN, using the indicator "Estimated Line Value USD". The total estimates across all methods and funders were extracted.
- FP Market Report: The FP Market Report provides country level estimates of the volume of commodities by method and year. This data was extracted, and a single global average unit price was applied to each method to estimate value of these volumes. This estimation of value is imperfect as it is unable to account for differences in the mix of specific brands or differences in prices across countries or over time but is the best that could be done with available data. For 2020 the 'constructed' estimate of funding from this approach was $263.6 million. Our calculated total differs from the published total in the report ($285 million); the aggregate analysis (see below) utilized the published totals.
- Contraceptive Security Indicators: country level estimates were the reported totals from the survey.
- National Budget Allocation and Spending from UNFPA: country level estimates were the reported totals from the survey.

Developing Aggregate Trends

The aggregated trends presented (Figures 3, 6, and 10 in the main report) are constructed differently depending on the data sources. For trends from RHViz/VAN and the FP Market Report, aggregate trends show the funding totals across all countries included, as these data sources capture funding across a wide set of countries and on which countries report data in any given year.

For Government funding the data sources used (National Budget Allocation and Spending from UNFPA and the Contraceptive Security Indicators) are based on country surveys, to which different countries respond in different

years. Therefore, for these data sources the aggregate totals are limited to a subset of countries that consistently reported across all years, so that changes in the aggregate total do not simply reflect more or fewer countries reporting. Because of these exclusions, the aggregate total presented is an underestimate of total Government funding but allows for a reliable trend over time to be examined. In addition, if all countries who responded in a given year were included, overall Government funding would still be underestimated as these sources do not capture expenditures from all countries, particularly upper-middle-income countries.

For Contraceptive Security Indicators, of the 63 countries with any data from 2015 to 2020, only 30 countries consistently reported in all years (thus are the only countries included in the aggregate total). For 2020 included countries represent more than 80% of total funding. Of the countries that were excluded from our analysis due to not responding every year, the most notable exclusion is India who did not complete the CS Indicator Survey in 2021.

For the National Budget Allocation and Spending from UNFPA, of the 28 countries with any data reported from 2015 to 2021, 22 countries consistently reported in all years (thus are the only countries included in the aggregate total for our analysis). Despite the exclusions the majority of funding is still captured in our aggregate totals, because excluded countries reported no or minimal funding. For funding allocation, between 80% to 100% of the total is captured each year by the included countries. For spending, between 67% and 100% of the total is captured each year by the included countries.

Determining COVID-19 Impact

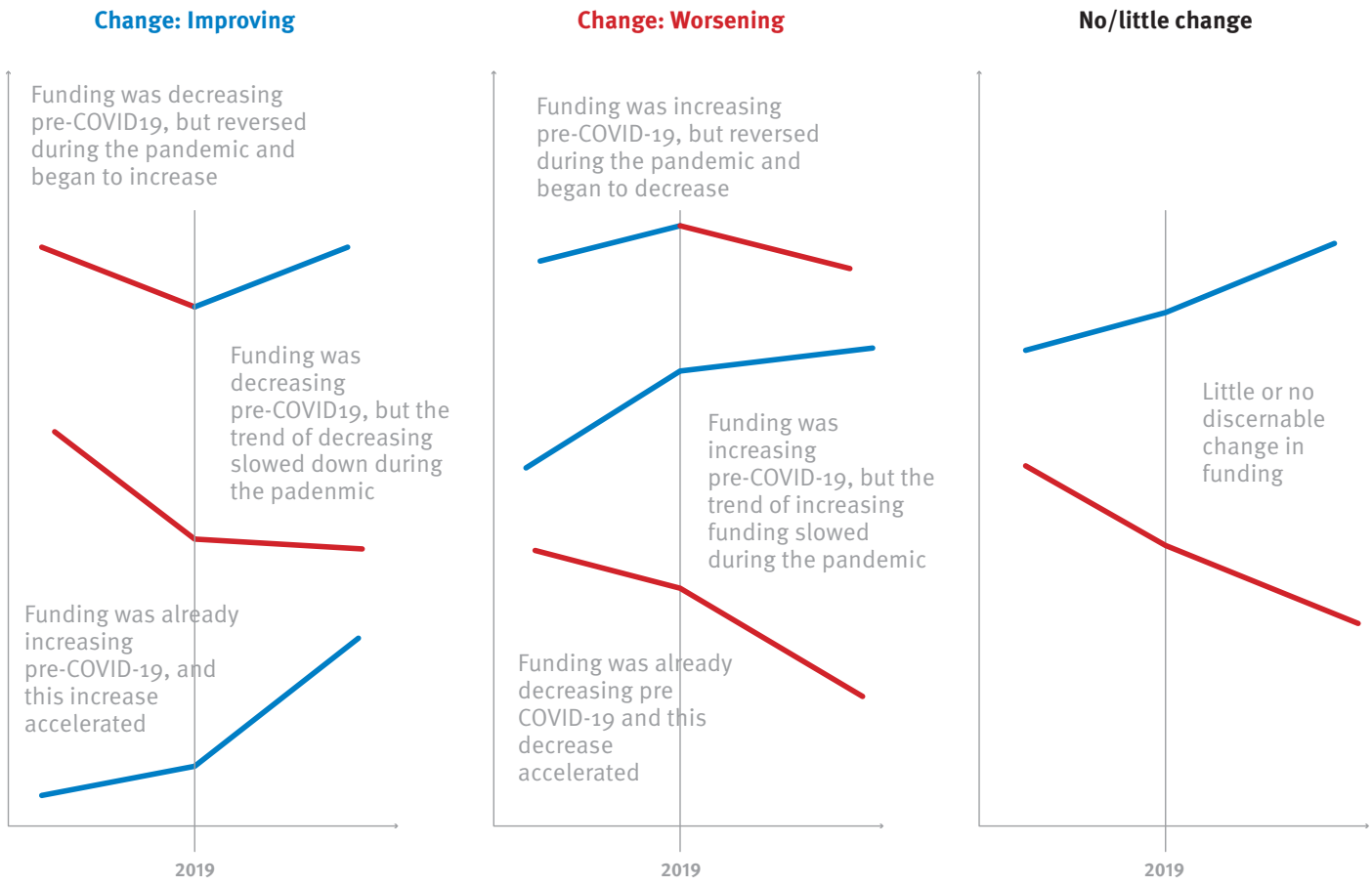
Funding for contraceptives continually fluctuates (see Figure 1 in the main report), and we do not expect funding to always increase from the previous year in all countries. Therefore, we needed a methodology that did not simply look to see if funding declined during the years affected by COVID-19.

To address this, for this analysis we compared the slope of funding in the years leading up to COVID-19 ('pre-pandemic' trend) to the slope from 2019 onwards ('pandemic' trend). A 25% threshold was used for comparing slopes; a change under this threshold was considered to be "no/little change" and a change that exceeded this threshold was categorized based on pre-pandemic and pandemic slopes shown in figure A2.1 below.

This approach has limitations. First, this methodology is unable to distinguish between 'normal' fluctuations in funding versus changes due to the pandemic. However, given limited data and discrepancies between data sources, this approach was selected as the best option for this analysis.

Second, for most data sources only one year of data was available post-2019, therefore the 'slope' is based only on two data points. For RHViz/VAN the 'pandemic' slope was calculated both including and excluding 2021, with the overall findings presenting results including 2021. For determining country agreement in categorization across data sources, the assessment excluding RHViz/VAN 2021 data was used to have comparability (see next page).

Figure A2.1: Categorization of Funding Changes



For the slope of the 'pre-pandemic' trend we sought to use three data points for each source, though some adjustments were needed as noted below:

- **RHViz/VAN and FP Market Report**: Used the three most recent data points (2017, 2018, 2019)
- **Contraceptive Security Indicators**: Only used two data points (2017, 2019). Adding a third data point would have required using 2015 data (as the survey is only published bi-annually). It was decided that only two data points was preferable to inclusion of this older data.
- **National Budget Allocation and Spending from UNFPA**: Used four data points (2016, 2017, 2018, 2019). Notably, the 2017 round had a lot of zeroes for countries that had positive funding values in both 2016 and 2018. It was not possible to determine if in some instances these zeroes were true zeroes versus missing data. Starting the trend in 2017 led to large positive slopes in many countries that may not in fact have been actual trends as they were based on an increase from zero funding in 2017; therefore, for this data source an additional year (2016) was added to the 'pre-pandemic' trend to smooth out these potential discrepancies.

It is important to note that at least in some countries the choice of years included in the "pre-COVID-19" trend may impact on the interpretation of the trend (see box A2.1).

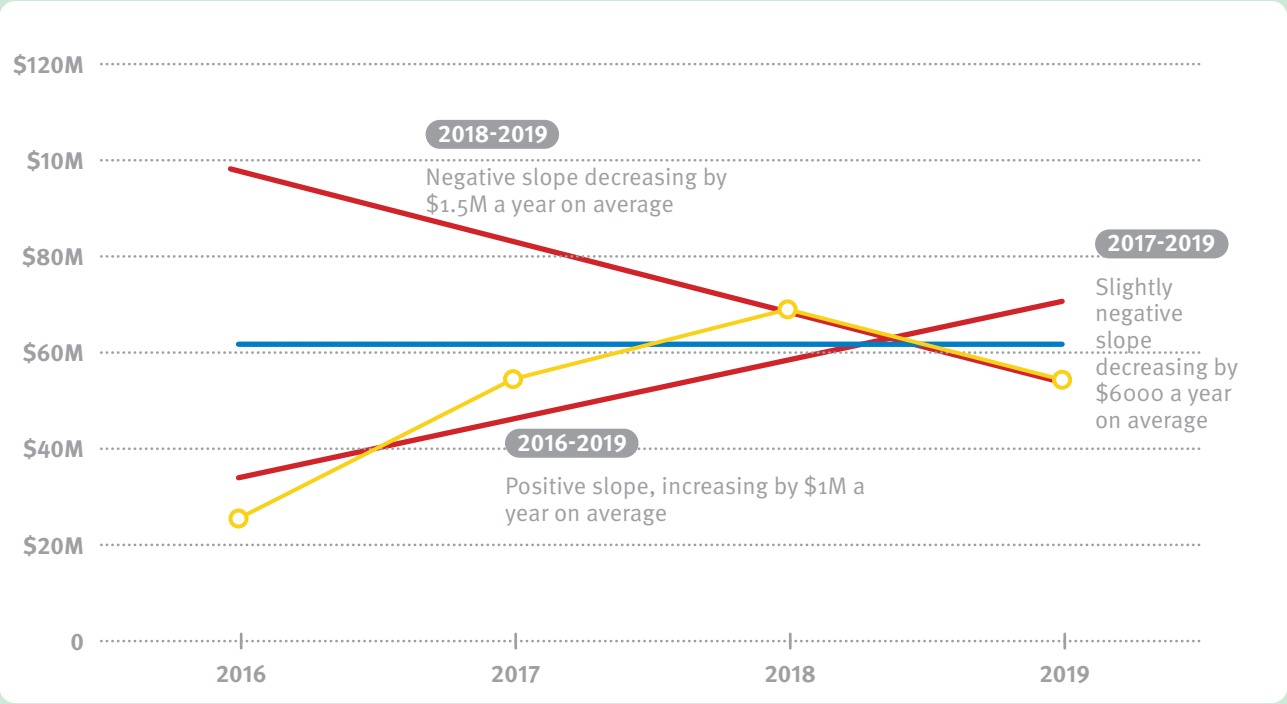
Box A2.1: Illustrative Example of Establishing Country Trends: Zambia Overall Funding Trends based on FP Market Report

As noted above, the choice of which years to include when establishing the 'pre-pandemic' trend has the potential to influence the categorization of a country, especially in countries that experienced large fluctuations in funding in the years leading up to the pandemic.

Based on the FP Market Report, funding for the years leading up to 2019 has been fluctuating in Zambia, first increasing and then decreasing. Defining the 'pre-pandemic' trends required making a determination about how many years to include when establishing this trend.

For all countries, we decided to use a three year time period (2017, 2018, 2019) to establish the 'pre-pandemic' trend for this data source. In the case of Zambia, had we added an additional year, the trend would have changed to increasing. If we removed a year, the trend would still have been negative but gone from a very slight decline to a much larger decline.

For many countries, there was not this level of fluctuation in the 'pre-pandemic' trend, and so the choice of year had less influence on the country's categorization. The country specific trend graphs shown in the Closer Look at Country Trends section of the report give visibility to the level of fluctuation in countries.



Determining Country Agreement

In instances where more than one data source was available for a particular set of funding (overall public, government), there was often disagreement between the data sources in how a country was categorized (improving, worsening, no change). In some cases, this could be due to differences in the nuances of how the source is capturing the data, or potentially due to issues with data quality among some sources. We therefore established the notion of determining if countries had 'agreement' across data sources, with the idea that in countries where data sources agree, we have more confidence in the accuracy of the observed trends and in the subsequent analysis of country trends.

Agreement was established by having the same overall category of change (i.e, improving, worsening or no change) in overall public funding between RHViz/VAN and the FP Market Report. In some cases, countries agreed at the overall category but were classified based on different trends (e.g., in one data source a country was classified as worsening with a decline in funding 'pre-pandemic' that accelerated during the pandemic, while in the other data source the same country was also classified as worsening but with an increase in funding 'pre-pandemic' reversing to a decline during COVID).

RHViz/VAN included an additional year of 'pandemic' funding (2021) which was not available from FP Market Report at the time this analysis was conducted. Therefore, in order to ensure comparability in the agreement assessment, the category of change for RHViz/VAN was based on the trend from 2019 to 2020 only (e.g., excluding 2021).

In total, 58 countries had trend analysis from both of these data sources. Of these, 34 had 'agreement' in the overall trend. Two countries (Bangladesh and Mongolia) were excluded from analysis due to data sources only capturing a small share of funding in these countries (e.g., data sources not capturing domestic funding which accounts for a large proportion of funding). This left 32 countries as having aggregate 'agreement' between the two data sources for analysis.

For the analysis of trends in donor funding, since RHViz/VAN was the only data source it was not possible to do an agreement analysis. Therefore, it was decided to focus the more detailed analysis of donor trends on the same 32 countries that had agreement in the overall public funding trend. However, an additional two countries (Iraq and West Bank and Gaza) were also excluded due to limited data on donor funding not allowing for sufficient trend analysis.

Initially a similar 'agreement' analysis was conducted looking at agreement across data sources on Government funding. However, due to more limited data on Government funding, and more inconsistencies between data sources, it was decided not to pursue this analysis. Rather, detailed Government funding trends are presented for the set of 32 countries that had agreement in overall funding.

For the assessment of overall public funding and donor funding, the agreement analysis further classified countries taking into account their classification (improving vs worsening), as well as the change in funding seen in RHViz/VAN from 2020 to 2021 (since the 2021 data was excluded from the agreement analysis). This left the following four categories:

Trend of improving donor contraceptive funding from 2019-2020 compared to 2017-2019		Trend of worsening donor contraceptive funding from 2019-2020 compared to 2017-2019	
Increase in funding 2020-2021	Decrease in funding 2020-2021	Increase in funding 2020-2021	Decrease in funding 2020-2021
1	**2**	**3**	**4**

For Government funding this further categorization was not done given inconsistencies within the data. Rather trends for all countries are presented together.

Limitations

There are important limitations, both in the data sources used for this analysis, and in the approaches used to determine the impact of COVID-19 on commodity financing.

In terms of the data sources, the main limitation is that differences in how funding is captured in each data source may limit comparability. See more details in Annex 2.

In terms of the analysis, two main limitations are that the approach used is unable to fully account for expected fluctuations of funding (even in the absence of COVID-19), and for most data sources only one year of data 'during' the pandemic is available.

Further, given discrepancies between data sources, only a subset of countries with data agreement could be included in the more detailed country analysis as to provide more confidence in the results.

As more data becomes available a more complete picture of COVID-19 impact on funding can be established.