USAID's Funding Decisions on Reproductive Health and Family Planning

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Acronyms

CDC	Centers for Disease Control and Prevention
CPR	Contraceptive prevalence rate
CSH	Child survival and health programs fund
EOC	Emergency obstetric care
DFA	Director of Foreign Assistance (State Department)
DHS	Demographic Health Survey
EE	Europe and Eurasia
ESF	Economic Support Fund
F/Bureau	Office of the Director of Foreign Assistance
FP	Family planning
FSA Funds	Freedom Support Act Funds
HIV/AIDS	Human immunodeficiency virus / Acquired immune deficiency syndrome
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunizations
GGR	Global gag rule
GH	Global health
GLP	Global Leadership Priorities
GNI	Gross national income
GHCS Fund	Global health and child survival fund
GPR	Guttmacher Policy Review
HACFO	House Appropriations Committee's Foreign Operations Subcommittee
HSS	Health and Human Services
ICPD	International Conference on Population and Development in 1994
IFFIm	International Financing Facility for Immunization
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
LAC	Latin America and Caribbean
MCA	Millennium Challenge Account
MCC	Millennium Challenge Corporation
MCPR	Modern Contraceptive Prevalence Rate
MDGs	Millennium Development Goals
NGOs	Non-government organizations
NIH	National Institutes of Health
ODA	Oversees Development Assistance
OECD	Organization for Economic Cooperation and Development
OGAC	Office of the Global AIDS Coordinator
OMB	Office of Management and Budget
PAI	Population Action International
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	Presidential malaria initiative
PRSPs	Poverty Reduction Strategy Papers
RH	Reproductive health
RH/FP	Reproductive health and family planning
SACFO	Senate Appropriations Committee's Foreign Operations Subcommittee

SEED Fund	Support Eastern Economic Democracies Fund
STDs	Sexually transmitted diseases
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNAIDs	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USG	United States government

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Summary

For more than 40 years, the U.S. Agency for International Development (USAID) has been a global leader in providing population and family planning assistance to developing countries. Changes in the Agency's organizational structure over the last 15 years have reflected in many ways how the field has changed: Population and family planning now fall within USAID's Bureau for Global Health, and family planning assistance has expanded to include support for broader reproductive health concerns.

USAID operates in more than 100 countries worldwide but only provides health assistance to 40 countries, of which 13 are now identified as priority countries. Such a focus in reproductive health and family planning (RH/FP) is warranted given a relatively flat budget. Since 2001, funding levels for RH/FP have hovered around $430 million. The single largest change in health funding in recent years has been the expansion in funding for HIV/AIDS, most of which is disbursed under the President's Emergency Plan for AIDS Relief, overseen by the State Department in cooperation with USAID.

The overall budget for RH/FP has changed little over the years, as both the nomenclature (population and family planning) and budget accounts have remained relatively constant in the federal budget. USAID remains the principal actor in designing, allocating funds for, and overseeing RH/FP programs. But these programs now operate in the shadow of a much larger program to fight the global AIDS pandemic, making it difficult to propose new initiatives and garner additional funding for longstanding programs such as family planning.

USAID's internal budget process has always been complicated by a plethora of reporting requirements for Congress and a large number of projects requiring tracking, monitoring and evaluation. The budget process is also characterized by a split in funding for the field (programs run by USAID missions overseas) and for centrally funded programs, with field programs predominating in recent years.

The budget process for RH/FP has become even more complicated, however, because of changes ushered in under the G. W. Bush Administration. USAID has undergone a de facto "merger" with the State Department, in which the USAID Administrator is also the Director of Foreign Assistance reporting to the Secretary of State. Such a merger brings foreign assistance more directly in line with the government's foreign policy objectives and fosters greater communication among U.S. embassies and USAID missions. It has also meant that USAID/Washington no longer presents its own budget to the Office of Management and Budget or to its oversight committees in Congress, eroding some of its former influence and interagency relationships.

Operating in this larger bureaucracy, USAID staff working in RH/FP still determine strategic priorities for increasing access to and quality of RH services, meeting unmet need for family planning, and reaching the world's most vulnerable people. USAID staff have had to make strategic decisions on how to use its scarce funds, choosing to allocate more funds to the field. Recently, more funding has been concentrated in programs in Sub-Saharan Africa and South Asia where needs are greatest. As a result of more funds going to the field, maintaining technical leadership in research, contraceptive development, and new program innovations has been challenging.

Much uncertainty remains about how RH/FP programs will evolve under the new U.S. administration. President Obama has expressed interest in increasing foreign assistance and reinvigorating U.S.

leadership in international development; he has also signaled a departure with the Bush Administration on policies related to reproductive health. But whether his leadership on the issues will translate into larger budgets will be largely determined by the U.S. economy and negotiations with Congress over the size of the federal budget.

Those who advocate for RH/FP programs (both within USAID and in the broader NGO community) must determine how to make the most effective use of existing funds and how to make the case for increased funding in an uncertain economic climate. Some advocates have argued for about a doubling of RH/FP assistance ($1 billion or more annually), based on growing needs for contraceptives and related services in the world's poorest and most populous countries. With most of the world focused on keeping economies afloat and making inroads in reducing poverty, advocates must make a convincing case for how RH/FP programs will help governments--around the world and including the United States--achieve their most pressing goals.

1. Purpose of this Report

Funding for population and family planning assistance has enjoyed widespread support in Congress since the program's inception in 1965. Despite this support, funding levels have remained around $450 million in the last five years, down from its peak of $577 million in 1995. These funds have lost ground in terms of purchasing power. When measured in constant 1974 dollars, population assistance has remained stagnant since the 1970s, expect for the peak in 1995. Nevertheless, USAID remains a global leader in population and family planning assistance, which includes support for related reproductive health concerns (see box).

Several developments in recent years, however, have threatened USAID global leadership in RH/FP:

- Stagnant levels of funding have not kept pace with growing needs in developing countries, fueled by growing numbers of women of reproductive age and high levels of unmet need for family planning.
- Dramatic increases in funding to address the HIV/AIDS epidemic have crowded out funding for other RH/FP programs.
- The Bush administration was not supportive of RH/FP programs, placing restrictions on organizations overseas that could receive assistance, denying funds for the UN Population Fund (UNFPA), and refusing to endorse prior agreements such as the Program of Action of the International Conference on Population and Development.

The new U.S. administration has already delivered some successes, such as lifting some funding restrictions and opening the way for renewed funding of UNFPA. Yet it is unclear whether the Obama Administration will obtain increases in its foreign assistance budget that would allow for significant increases in funding for RH/FP programs.

Population and family planning assistance

is the common term to describe U.S. funding for international family planning activities, which have long appeared in U.S. budgets and legislation. This report uses the current USAID term for its programs, reproductive health and family planning (RH/FP) assistance.

To set the stage for discussions on how future population funds can best be spent, this study examines how population assistance funds are allocated to various RH/FP programs. It describes the actors involved in determining funding levels in Congress and the Executive Branch, and the inner workings of the budget process at USAID and the State Department. It also outlines possible scenarios for future funding, trends to watch, and the staff and organizational units that will influence future funding for RH/FP programs.

2. Introduction to USAID

An understanding of the United States Agency for International Development (USAID)and its relationship with the State Department is an important first step before describing how budget decision are made on reproductive health and family planning. This section provides a brief overview of USAID and its technical priorities and organizational structure. The overview is followed by a discussion of the State Department's new role in foreign assistance and other presidential initiatives in health and development.

2.1 Overview of USAID's development goals and technical strategies

USAID's history goes back to the Marshall Plan reconstruction of Europe after World War Two and the Truman Administration's Point Four Program. In 1961, the Foreign Assistance Act was signed into law and created the new federal agency. Since that time, USAID has been the principal U.S. agency to extend assistance to developing countries.

The main purpose of USAID is to advance U.S national security, foreign policy and the War on Terrorism (USAID Primer 2006). USAID's programs foster long-term and equitable economic growth in developing countries by supporting:

- economic growth, agriculture and trade;
- global health;
- democracy, conflict prevention; and
- humanitarian assistance.

Box 1 synthesizes the Agency's core technical areas and objectives based on the joint State Department and USAID 2007 - 2012 Strategic Plan.

Box 1. Overview of USAID's core technical areas

Agriculture USAID works with all participants in agricultural development to increase agricultural productivity. USAID strategies include supporting agricultural trade that link producers to market, harnessing new technology to increase productivity, and developing human capital and institutions in agricultural and natural resource management to increase rural development.

Democracy & Governance USAID promotes sustainable democracy by: strengthening the rule of law and respect for human rights; promoting genuine and competitive elections and political processes; developing a politically active civil society; fostering more transparent and accountable governance; and promoting free and independent media.

Economic Growth & Trade USAID economic growth and trade programs provide support both to government and private sector partners to improve the income levels of people in developing countries. USAID programs focus on strengthening private markets, growing trade and investment, and enhancing energy security.

Box 1., continued

Environment USAID takes an integrated approach to natural resources management and focuses on ensuring fresh water supply, reducing pollution, protecting biodiversity, and conserving forests.

Education & Training USAID helps developing country governments build educational systems that allow their population to compete in a global economy. USAID initiatives emphasize programs focusing on basic education and place special emphasis on improving opportunities for girls, women and other underserved and disadvantaged populations.

Global Health USAID strives to improve global health by improving maternal, child and reproductive health; reducing disease particularly HIV/AIDS, malaria, TB and polio, and increasing access to clean drinking water and sanitation.

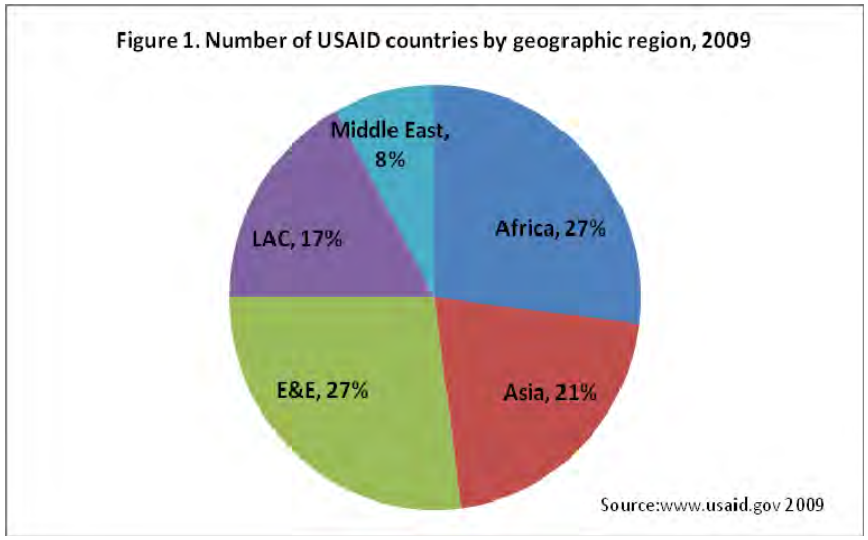
Global Partnerships USAID is committed to an approach that recognizes and incorporates the efforts of partnership and private giving, focusing on grassroots support, local ownership, sustainability, accountability, and commitment.

Humanitarian Assistance USAID strives to save lives, alleviate suffering and minimize economic costs of conflict, disasters and displacement by directing funds to thousands of non-profit partners and international organizations who provide life-saving disaster relief, food aid, and humanitarian assistance.

2.2 Where USAID works in the developing world

USAID provides assistance in approximately 100 countries in five world regions: sub-Saharan Africa, Asia, the Middle East, Latin America and the Caribbean, and Europe and Eurasia (See Appendix A for a list of USAID-supported countries). Figure 1 shows the number of countries by USAID geographic region. Prior to 2008, USAID managed operations in the Middle East under the Asia and Near East (ANE) Bureau, which appears in most of this report (budget detail is available through FY 2008.)

One of the Agency's strengths is its worldwide presence that permits it to work closely with national governments, private voluntary organizations, indigenous groups, local universities, professional associations and other developing country stakeholders. USAID also collaborates with other international donors, international organizations and American businesses.



2.3 How USAID works

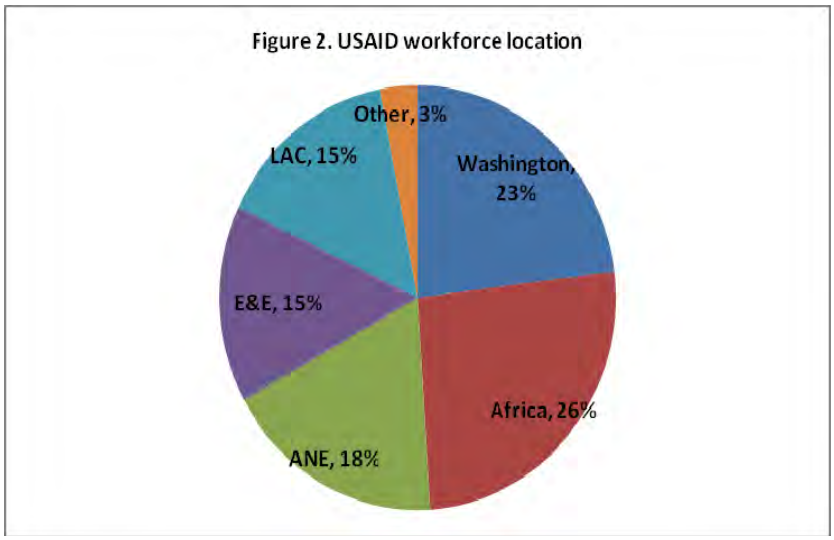
The Agency provides a wide range of assistance to developing countries, including

- technical assistance and capacity building, training and scholarships,
- food aid and commodity purchases, construction and infrastructure (e.g. roads, water systems,
- small-enterprise loans,
- budget support,
- enterprise funds supporting transition to free market societies, and
- credit guarantees.

USAID is not an implementing agency and works through contracts and grant agreements. USAID partners with more than 3,500 companies and over 300 U.S.-based private voluntary organizations. These groups are commonly referred to as cooperating agencies (CAs).

Although USAID's technical work is implemented through cooperating agencies, USAID still has a large number of technical and administrative staff to oversee and monitor the implementing partners' work. USAID staff is comprised of U.S. and foreign nationals. As of 2004, USAID has 2,227 U.S. staff and upwards of 5,000 Foreign Service nationals. Staffing locations reflect the geographic and funding priorities at USAID. The majority of USAID staff are located in sub-Saharan Africa, followed by the Washington-based staff at USAID headquarters.

The staff's technical expertise also reflects the Agency's priorities. In 2004, the Democracy and Governance Bureau had the largest number of staff at 411, followed by General Development at 309 staff persons. The Global Health Bureau had the third largest number of technical staff - both U.S. and Foreign Service nationals - totaling 263, yet Global Health had (and continues to have) the largest budget of the three technical areas. Increasing the number of technical staff at USAID was an important priority for the last USAID Administrator, Henrietta Fore, to address the significant number of USAID professional staff who are about to retire in the next five years. Ms. Fore succeeded in increasing the number of new professional hires before her departure, including several additional hires for the Global Health Bureau (personal communication).



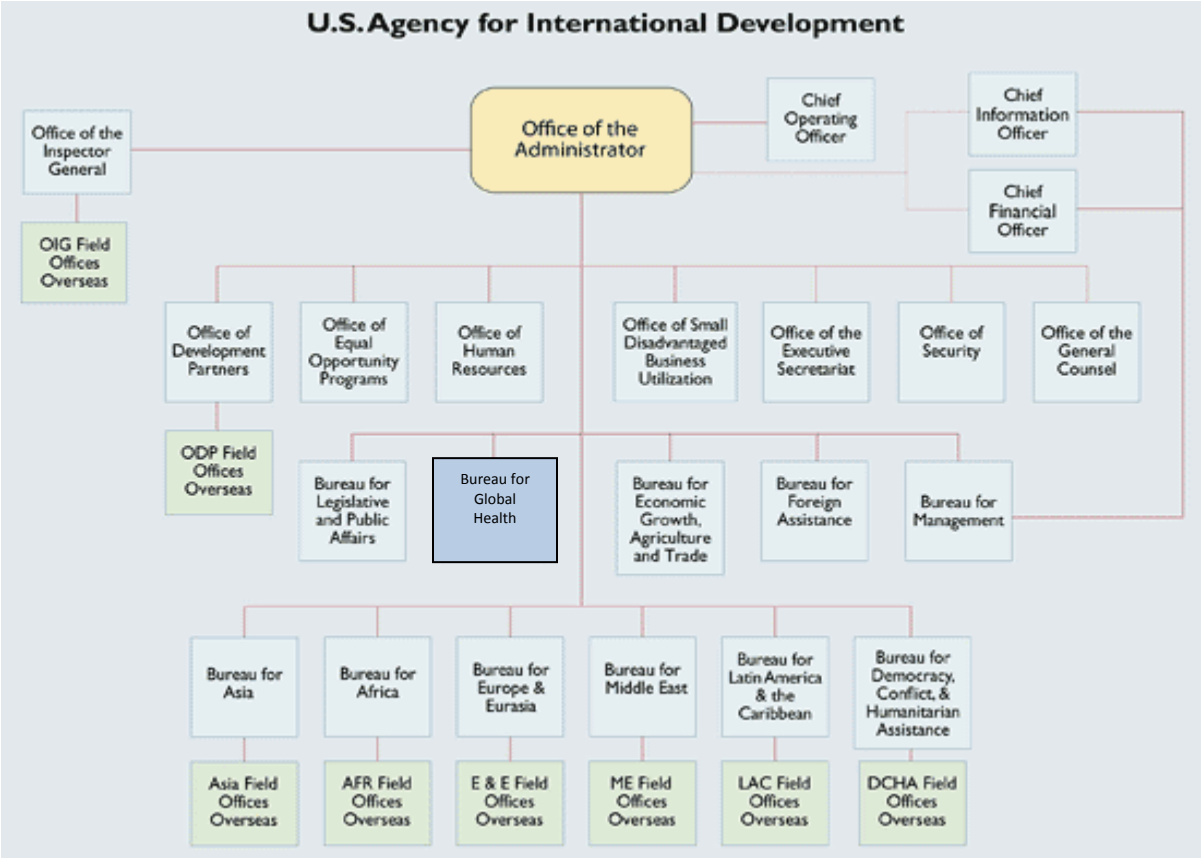
Source: USAID Primer. 2006

2.4 How USAID is organized

The organization is divided between management and technical programs. Management units are called "offices" while technical units are referred to as "bureaus." USAID Management is directed by an Administrator and Deputy Administrator located in the Office of the Administrator. Within the Office of

the Administrator, there are several key management functions such as operations, inspector general, finances, information and others (see Figure 3).

Figure 3. Organization Chart for USAID



In Washington, USAID's major organization units are the technical bureaus. Each bureau houses the staffs responsible for major subdivisions of the agency's activities. There are three categories of bureaus:

- **Geographic bureaus** are responsible for the overall activities in the countries. The five bureaus are: 1) Africa (AFR); 2) Asia(A);3) Middle East (ME) 4) Latin America & the Caribbean (LAC); and 5) Europe and Eurasia (E&E). The Missions are represented in Washington through the regional bureaus.

- **Technical bureaus** conduct the Agency programs worldwide. The technical bureaus reflect the Agency's strategic priorities: 1) Global Health; 2) Economic Growth, Agriculture, and Trade; and 3) Democracy, Conflict, and Humanitarian Assistance.

- **Headquarters functions** are assigned to bureaus such as management (M); Foreign Assistance (FA); and Legislative and Public Affairs (LPA).

The leadership and management staff of USAID are in flux at the moment given the recent presidential election. The Administrator and Assistant Administrator positions are both appointed by the President

and confirmed by the Senate and are currently filled with a staff person serving as the acting Administrator (the Acting Deputy Administrator is vacant). There has been little "industry gossip" on who will fill the USAID Administrator and Assistant Administrator positions (personal communications). Each of the bureaus in Figure 3 is headed by an Assistant Administrator. The Bureau Assistant Administrator positions are also presidential appointees requiring Senate confirmation and are currently filled with acting Assistant Administrators.

2.5 Overview of the Global Health Bureau

The Global Health Bureau is organized by management and technical units also referred to as offices and divisions (see Figure 4, next page). Below is a brief description of the key organization units in the Global Health Bureau that have a role in the budget process allocating RH/FP funds.

Global Health Bureau Front Office: The Global Health Bureau is the Agency's focal point for child and maternal health and nutrition, HIV/AIDS, infectious disease, population, family planning and related reproductive health. The Global Health Bureau is led by an Assistant Administrator who approves projects and programs in health and oversees the allocation of the resources among the three technical offices listed below. The funding for RH/FP programs, managed by the Population and Reproductive Health Office, and malaria initiatives, managed by Health, Infectious Disease and Nutrition, is heavily influenced by the Congressional earmarks and directives. Therefore the Global Health Bureau's Assistant Administrator does not have much discretion with these budgets.

Global Health Technical Offices: There are three technical offices:

- Office of Population and Reproductive Health (PRH);
- Office of HIV/AIDS (OHA); and
- Office of Health, Infectious Disease and Nutrition (HIDN).

These three technical offices are responsible for: setting technical and programmatic direction, providing technical leadership, and supporting field programs in their respective health area. In the budget process, each office defines technical needs and estimates funding requirements. Both the Office of HIV/AIDS and Office of Health, Infectious Disease and Nutrition budgetary processes differ from that of Office of Population and Reproductive Health. The Office of HIV/AIDS has reporting relations with the Office of the Global Aids Coordinator (OGAC) at the State Department, and the Office of Health, Infectious Disease and Nutrition interacts with the Presidential Initiatives on Malaria and Avian Influenza.

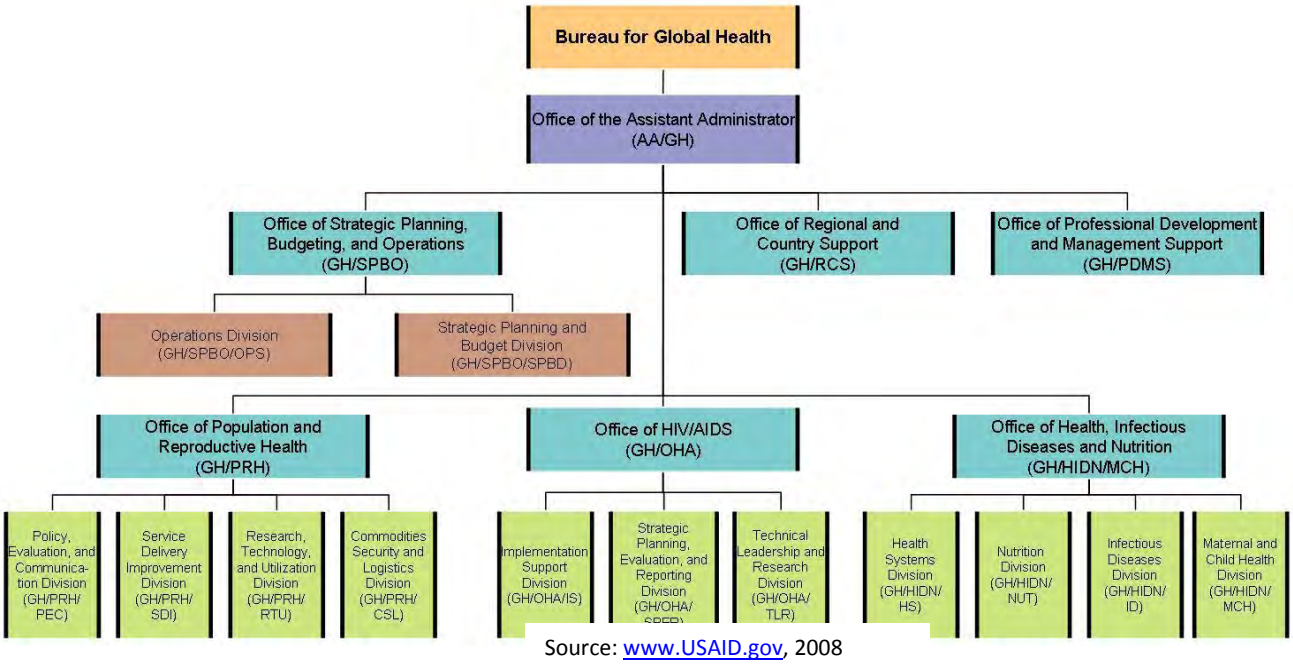
Support Offices of the Global Health Bureau: Each of the three support offices plays a role in the budget process by providing assistance and liaison functions or estimating human resource/staffing needs.

- The *Office of Strategic Planning, Budgeting and Operations* (SPBO) provides advice and support for overall strategic direction, resource allocation and procurement planning for Global Health. In the budget process, SPBO takes the lead in the overall budget planning and preparation of Congressional Budget Justification (CBJ), Bureau Program and Budget Submission (BPBS), Operational Year Budget (OYB), and Congressional Notifications (CN)—described in more detail in Section 3.
- The *Office of Regional and Country Support* (RCS) manages the regional and country support systems and provides technical and logistical support to the regional bureaus and Missions. The RCS is

composed of teams organized by regions parallel to USAID's regional bureaus and teams comprised of field technical advisors. RCS plays an important role in working with the regional bureaus and Missions to identify technical needs, advocating for resources and representing the field perspective during the budget process.

- The *Office of Professional Development and Management Support* is involved in determining staffing needs to implement the GH programs - both in Washington D.C. and in the field.

Figure 4. Organization Chart for USAID's Global Health Bureau



Source: www.USAID.gov, 2008

The Population Reproductive Health **Sector Council** plays an important and strategic leadership role but does not appear on the organization chart. The Sector Council coordinates and liaises with the Global Health Bureau's technical offices, the Agency's regional bureaus (and their technical health staff), and other PRH staff in other units in the Agency. The Sector Council is composed of the directors and other key staff of the technical offices in the Global Health Bureau, and meets at least once a month to address a wide array of issues. The Sector Council is also the forum where priority setting and budget allocation issues are addressed that affects the various bureaus. Described in more detail later, the Sector Council also plays a critical role in the budget process. Although not a "formal" organizational unit within USAID, the Sector Council has become an important decision-making body not only for issues within the Global Health Bureau but also for issues related to other offices in USAID and at the State Department.

2.6 The growing role of the State Department in foreign assistance[1]

After September 11, 2001, the George W. Bush Administration greatly increased foreign assistance from $12.6 billion to $22 billion by 2008 and redirected it to four areas reflecting the administration's new priorities. The four major areas included:

[1] Please refer to Appendix B-Recent Changes in U.S. and International Foreign Assistance for more information on this topic.

(1) Iraq, Afghanistan and other "front-line" states in the war on terror,
(2) the Millennium Challenge Account (MCA),
(3) the President's Emergency Plan for AIDS Relief (PEPFAR), and
(4) Debt relief.

The realignment process continued when, in 2003, the State Department and USAID produced a first-ever joint strategic plan, the Foreign Assistance Strategic Framework. The framework articulated the concept of the "three D's: diplomacy, development and defense," thereby elevating and linking USAID's development mission with that of the State and Defense Departments. Secretary of State Condoleezza Rice named this new approach "transformational diplomacy."

The Strategic Framework identified five programmatic areas - often referred to as ***the five pillars***:

- peace and security,
- investing in people,
- just and democratic governance,
- economic growth, and
- humanitarian assistance.

The Office of Foreign Assistance at the State Department organized its programs into five Pillar Bureaus.

Family planning is part of the programmatic area, ***investing in people pillar*** along with seven other health program elements (HIV/AIDS, TB, malaria, avian influenza, other public health threats, maternal and child health, and water supply and sanitation). The program elements, for the most part, reflect how Congress funds USAID's health programs and therefore, they do not have to compete for resources with each other.

Box 2. F/Bureau Objectives

- Provides leadership, coordination and strategic direction within the U.S. Government and with external stakeholders to enhance foreign assistance effectiveness and integrates foreign assistance planning and resource management across State and USAID;
- Leads strategic, operational, and performance planning of U.S. foreign assistance with a focus on aligning resources with policy priorities;
- Develops and defends foreign assistance budget requests and allocates State and USAID foreign assistance funding to meet urgent needs and new opportunities and to ensure long-term sustainable investments; and
- Promotes good stewardship of foreign assistance funds by strengthening oversight, accountability, and transparency.

Source: www.state.gov.

In addition, the Bush Administration introduced unprecedented restructuring of foreign assistance institutions, resulting in new terms, funding processes and institutions guiding foreign and development assistance. In the past, the U.S. assistance program was led by USAID and complemented with contributions to multilateral institutions, principally the United Nations and the World Bank. The Bush Administration, however, brought USAID under the direction of the State Department through a set of organizational reforms dubbed the "F process."

The centerpiece of the "F process" was the creation of a new bureaucracy called the State Department's Office of the **Foreign Assistance**, made up of approximately 100 people drawn from both USAID and the State Department. This new organization is called the **F/Bureau**. As Box 2 demonstrates, the F/Bureau is responsible for the direction of budgeting, planning, and management across State and USAID.

As a result of to the restructuring, the USAID Administrator is now asked to serve two roles - Director of Foreign Assistance at the State Department and USAID Administrator. The Administrator's dual role was intended to overcome the previous limitations of authority between the two agencies, stove piping, lack of communication, and overlapping priorities. The new position has not fully succeeded in reducing the ongoing tensions that have historically existed between the two agencies, however (direct

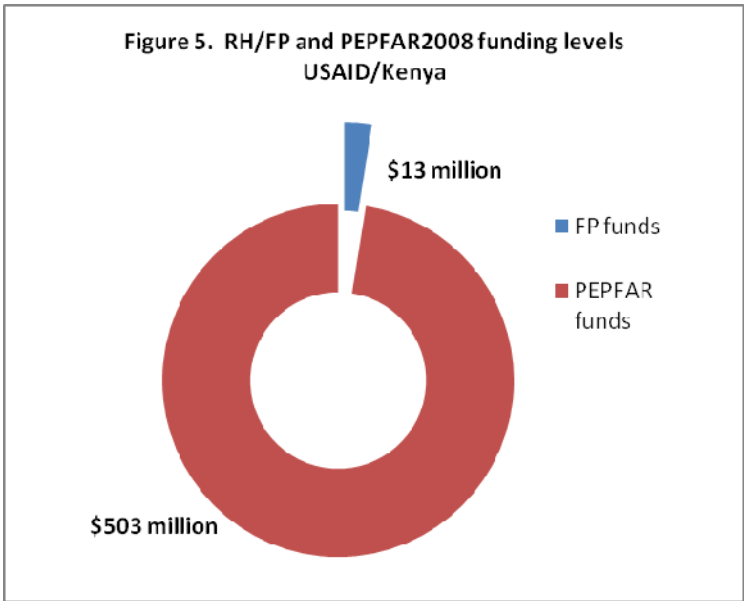
communication). Three former USAID Administrators who served under three Presidential Administrations (J. Brian Atwood-Clinton Administration, M. Peter McPherson-Reagan and Andrew Natsios-Bush) view the organizational changes as a "de-facto" merger of USAID into the State Department. In a recent article in Foreign Affairs, the former USAID Administrators publicly stated this "merger has been a mistake" (Foreign Affairs 2008).

Many long-term observers of foreign assistance argue for the need to insulate the decision-making process for allocation and use of foreign assistance from the short-term diplomatic and political considerations of the State Department. As the former USAID Administrators stated, "The centralization of the U.S. government's aid programs in Washington may satisfy the needs of key players in both executive and legislative branches for command and control, but it increases the risk of program failure and invites attacks from critics, who insist foreign aid is ineffective" (Atwood 2008).

2.7 PEPFAR and other presidential initiatives

New presidential initiatives proliferated under the Bush Administration. To date, 19 initiatives (3 are in the health area) are implemented in part or wholly by USAID. The most notable initiative is PEPFAR, established in 2003 to combat the AIDS pandemic. The other health initiatives are the Global Fund to Fight AIDS, Tuberculosis, and Malaria (referred to as the Global Fund) and Accelerating the Fight against Malaria (usually referred to as the Presidential Malaria Initiative - PMI). When PEPFAR was established in 2003, it was placed under the State Department, with USAID and the Department of Health and Human Services (HHS) given major supporting roles. The recent reauthorization of PEPFAR calls for an increase in funding from its current level of $15 billion over five years to $48 billion over the next five years. Several former USAID Administrators explained the appeal of the presidential initiatives, "The narrower, more focused programs are politically appealing because they appear to have direct, measureable impact on identifiable individuals. But such a concentration on the short-term delivery of goods and services comes at the expense of building sustainable institutions that promote long-term development" (Foreign Affairs 2008). Others view the increased number of presidential initiatives as a strategy by the G. W. Bush Administration to bypass USAID (direct communications).

Many USAID staff interviewed for this paper described the negative impact of PEPFAR on its other health programs. As one USAID staff person interviewed stated, "PEPFAR has had a tsunami effect across the Agency" (direct communication). First, PEPFAR funds have overwhelmed other health programs like RH/FP, child survival and maternal heath. The great sums of PEPFAR funds have further skewed USAID's and Missions' budgets, creating dramatic funding imbalances (see Figure 5). Second, the management and reporting requirements for PEPFAR, for example the annual Country Operating Plans, have become the dominate focus of USAID staff both at headquarters and in the field. Moreover, USAID staff must spend their



Funding Imbalance

Kenya's PEPFAR 2008 budget request is more than the entire USAID reproductive health and family planning budget worldwide.

time on PEPFAR program management to the detriment of their other programs.

The organization and structure of the presidential initiatives have produced dramatically different institutional consequences at USAID. The Presidential Malaria Initiative (PMI) is led by USAID with a PMI coordinator (appointed by the president) in conjunction with Health and Human Services, the Centers for Disease Control and Prevention, the Department of State, the White House, and others within the United States government. PMI has developed an integrated model to manage and implement its activities and is widely regarded as a successful collaboration between different U.S. Government entities. OGAC, on the other hand, is located in the State Department and is perceived to be independent and, at times, in competition with its major implementing partners.

3 "Follow the money": The USAID budget process

Understanding the federal budget process and timeline provides the context in which USAID makes its budget decisions for its RH/FP programs. This section provides an overview of both the federal and USAID budget processes, a description of the key decision makers and actors in USAID's budget process, and a discussion of the challenges USAID confronts in managing its budget under the new F/Bureau budget process.

3.1 Federal budget basics

Each year, the federal government must establish a budget that allocates funds to federal programs and agencies. Both the executive and legislative branches play important roles in formulating this budget.

The Congressional **authorization process** for most federal programs outlines targets for spending and revenues and provides Congress and the Executive Branch with a set of priorities to allocate federal funds. It also sets guidelines and spending limits for the appropriations process. One challenge in foreign assistance is that USAID operates under an authorization dating to the early 1960s, except for some programs like PEPFAR. As a result, there have been many add-ons with no corresponding revisions to clean up and streamline the authorization that created USAID.

Through the **appropriation** process, Congress provides authority to federal agencies to obligate and eventually spend specified federal funds for particular purposes. The last major step in funding the government and its agencies is the actual **allocation** of funds, which takes place within various agencies.

The Congressional budget process outlines federal budget targets for each **Fiscal Year** (FY), which runs from October 1 through September 30. Targets are outlined for two groups of spending: mandatory and discretionary. Mandatory spending such as Social Security and Medicare accounts for two-thirds of all spending and is authorized by permanent law, not by the annual budget and appropriations process. Congress can adjust the spending levels for mandatory programs but is not required to do so. Discretionary spending must be determined annually by Congress and is the major focus of the budget and appropriations process. Funding for foreign assistance in support of international RH/FP programs falls within discretionary spending.

The federal budget process is clearly outlined by law and follows similar procedures - outlined in Table 1 - each year. The **President's budget request** sets the Congressional budget process in motion. Once Congress receives the President's budget request, Congress first creates the **budget resolution**, which must pass both the House of Representatives and the Senate. The Budget Resolution establishes the guidelines and targets for spending and revenue that Congress uses to consider budget and appropriations legislation.

Congress develops the Budget Resolution through a series of public hearings to examine the federal budget and the programs it funds. The House and Senate Budget Committees hold public hearings to receive testimony on the president's budget after its release in February. Additionally, the Congressional Budget Office (CBO) provides these committees with reports analyzing the president's budget request, the existing budget and economic outlook.

Table 1. Congressional budget and appropriation process preferred timeline

Date	ACTION
February	• President submits his budget by the first Monday • Budget committee drafts Budget Resolution • Budget committees hold hearings
March	• Mark-ups • House and Senate each pass a version of the Budget Resolution; • Appropriations subcommittees hold public hearings
April	• Conference Committees releases Conference Report • Deadline for Congress to pass Budget Resolution is April 15, if can't meet deadline, then Congress proceeds with pay-as-you-go measures • Parameters in the Budget Resolution are sent to Appropriations Committee • Appropriations subcommittees public hearing process continues
May	• Appropriations bills may be considered in the House
June through August	• Appropriations subcommittees public hearing process continues until all 13 appropriations bills are passed • President submits mid -session review July 15th • Mark-ups and final appropriations by both the House and Senate finalized by the **end of July**
September	• Reconciliation between the House and Senate appropriations bills in **September** • Appropriations Bills passed with the Managers Report
Source: Quick Guide for Community Forestry Activists, www.communitiescommittee.rog/pdfs/fed_approps.pdf	

In March, the House and Senate budget committees meet to **mark-up** (review and revise) the language and numbers contained in the budget resolutions and legislation. Both the House and the Senate must pass its respective version of the budget resolution. Afterwards, a conference committee is convened to resolve the differences. This committee releases the **Conference Report on the Budget Resolution**. The deadline to vote on the budget resolution is April 15th.

The House and Senate Appropriations Committees follow a similar process from March to September to pass 12 spending bills. USAID falls under the purview of the Appropriations Subcommittee on Foreign Operations in both the House and Senate (HAFCO and SAFCO in Figure 6).

In reality, the budget resolution rarely passes before April 15th. Delays as well as other issues may cause holdups in the appropriations process. If the appropriation bills are not passed by September 30, then Congress must pass a **continuing resolution** to temporarily fund the government. Federal agencies' program decisions are essentially on hold if their respective appropriation bill does not pass. Under continuing resolutions, USAID will make a portion of funds available based on the previous year's allocation, readjusting after the foreign assistance legislation has passed, causing additional work for USAID staff throughout the year.

3.2 USAID budget basics

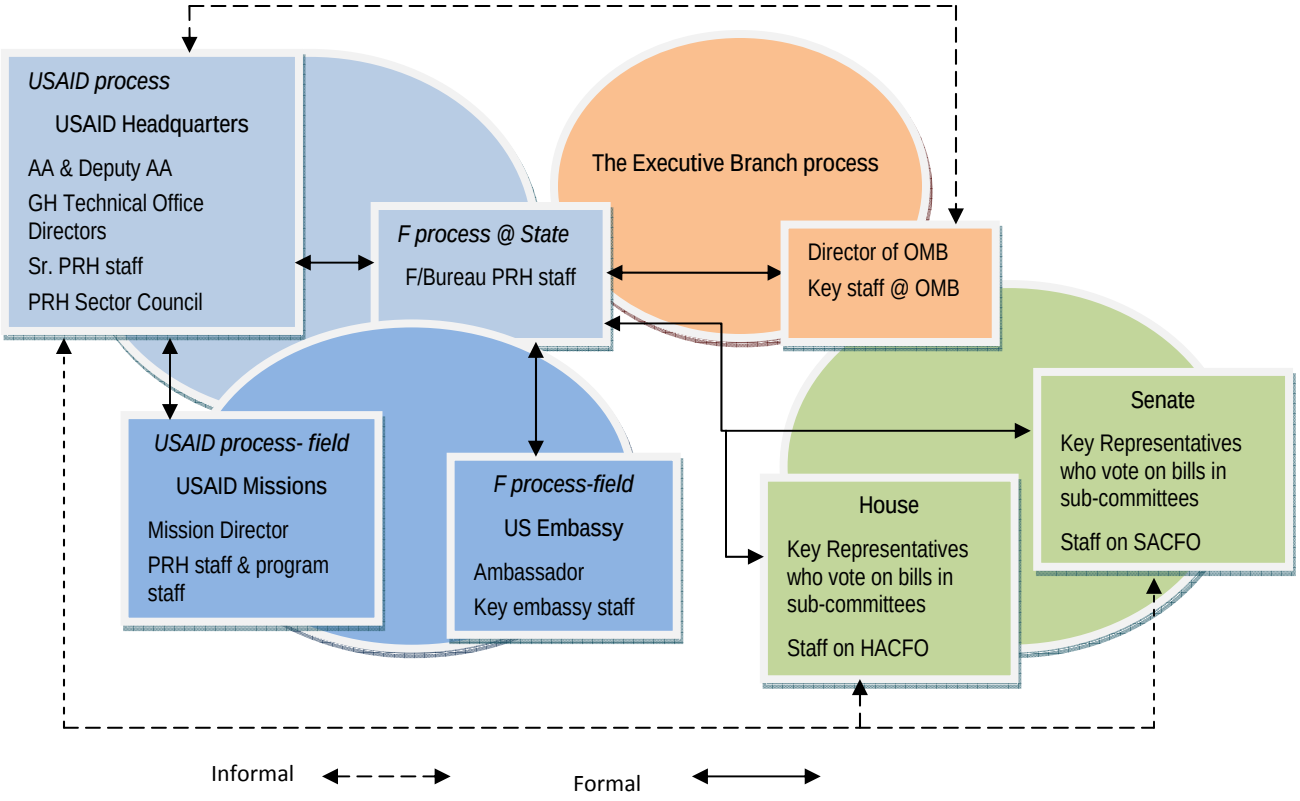
3.2.1 Key Actors in USAID's RH/FP budgeting process

A number of critical actors--agencies, operating units and individuals--affect the budget levels and processes within the Global Health Bureau See Figure 6 on the next page). They are important to

recognize in any attempt to influence the outcomes of USAID budgeting. At USAID's headquarters in Washington D.C., decision-makers include the Agency Administrator and his/her deputy, the Assistant Administrator for the Global Health Bureau, but more important are the senior staff from the Office of Population and Reproductive Health and the Sector Council. The PRH staff located in the geographic bureaus at headquarters also play a critical role, liaising with Global Health and the PRH Office in Washington and the PRH staff in the Missions.

The creation of the F/Bureau has added steps to and brought new actors into USAID's budget planning processes. One of the F/Bureau's functions is to "develop and defend foreign assistance budget requests and allocate State and USAID foreign assistance funding to meet urgent needs and new opportunities and to ensure long-term sustainable investments" (www.state.gov). As a result, the F/Bureau is an important stakeholder and the PRH staff at the F/Bureau work closely with Global Health at USAID during the budget process.

Figure 6. Map of key actors involved in the RH/FP budget process



There are also a wide array of U.S. government entities and actors outside of USAID who influence the budget. Most important in the Executive Branch is the Office of Management and Budget (OMB), which develops the President's Budget and oversees funding enacted by Congress. In prior years, USAID staff in the Global Health Bureau worked very closely with the OMB staff assigned to work on the Global Health budgets. But this relationship is now managed by the F/Bureau. Furthermore, influential staff in the Senate and House are involved in the budget process. These direct ties and working relations, however, have been weakened because of the management of the budget process by the F/Bureau.

3.2.2 Overview of the USAID budget process[2]

USAID's annual budgets evolve in a cycle spanning many years before budget levels are finalized for an actual fiscal year's operations. During the current FY, USAID must manage functions associated with budgeting and disbursing funds for at least four fiscal years (and often more) as reflected in Figure 7 and Table 2. At any point in time, USAID's PRH staff are preparing for a fiscal year two years out, tracking the Congressional process for the next fiscal year, planning for the allocation and obligation of funds for the present fiscal year, and monitoring performance for the use of the funds from prior fiscal years.

Figure 7. Summary of the USAID budget process

Source: USAID Primer, 2006

Step One - Annual Report: The planning process starts two years before the next FY, usually in April/May (See Table 2 for a calendar of the budget process). All USAID operating units, including USAID Missions, regional bureaus, technical offices and the technical offices at the State Department receive guidance from the F/Bureau regarding the budget parameters within which they can propose their plans and budgets. They then prepare an Annual Report, which includes an operational plan that specifies the procedures for implementing the Mission's strategy, provides a rationale for allocating resources, describes a three-year timeframe for the strategy, defines or revises strategic objectives and program components and discusses special management concerns. The Annual Report also includes a budget

[2] See Appendix C: Glossary of USAID budget terms for additional information and explanation of the budget.

request. Under the F/Bureau approach, the Mission Annual plans (step 1) are submitted in concert with and as part of the Embassy's plan for the country program.

Step Two - Bureau Program and Budget Submission (BPBS): USAID's Washington-based bureaus prepare their own plans - called Bureau Program and Budget Submission - based on the missions' funding requests, their performance results, prevailing political factors, unspent funding and other variables.

Step Three - Agency Budget Submission (ABS): Another series of consultation takes place, this time between USAID and the State Department. These plans then go through a series of reviews, often in the regional bureaus of the respective Missions, within the Pillar Bureaus at State (See section 2.6) for the technical offices. Then, during the summer months, under the auspices of the Secretary of State, the F/Bureau facilitates a country-by-country review process during which all stakeholders are present and attempt to reconcile the budget proposals with the development and foreign assistance priorities for each country. The F/Bureau then rolls up the country level budgets into an integrated USAID and State Department budget request. They also assess levels for each of the program elements, which track closely with the earmarked accounts and directed areas in the health and RH/FP budget. The Secretary of State approves the budget request and submits the FY program plan and budget - called an Agency Budget Submission - to OMB in September/October.

Step Four – Joint USAID-State Budget: The budget submission to OMB is an integrated USAID and State Department budget request with detailed program plans for foreign assistance.

Step Five - President's Budget: By late November, OMB completes its review of the request and informs State and F/Bureau of its determination regarding the request through a "passback." Often the passback levels are sufficiently different from the request, and State and F/Bureau prepare appeals that justify the requested levels and make the case for changes. After a round of meetings with OMB, a final budget level is decided. OMB then combines the State Department's request with others (e.g., parts of the Defense Department) in the "150 account," or International Affairs account, to form the President's budget request, which is usually sent to Congress in early February.

Step Six - Congressional Budget Justification (CBJ): As the Appropriations bills move through the process, USAID notes the proposed funding levels and starts its own planning process for allocating and distributing the funds. After the Appropriations Bill is signed into law by the President, F/Bureau and USAID develop specific plans for the various accounts, including the population and FP earmark. These are combined into a document entitled the Congressional Budget Justification (CBJ), which describes what the Agency is planning to do with the funds. Often there are delays in these steps due to the need to work out disagreements and sort through priorities. For the family planning funds, the Sector Council provides a forum for considering how best to use, in the most strategic way, the limited funding available, particularly for RH/FP programs.

Step Seven - 653(a) report: This report is named after Section 653(a) of the Foreign Assistance Act, which requires USAID to present how funds will be allocated to countries and other operation units. Once the 653A report is approved and the Congressional Budget Justification clears Congress, then the funds can be released by Treasury. Funds move from Treasury to F/Bureau, then to USAID and eventually to the Regional Bureaus (for Mission programs) and Pillar Bureaus (for Technical Office programs).

Table 2. Calendar of the USAID budget process mapped against the F/Bureau and Federal budget processes

		What Should Ideally Be Happening in Each Budget in Real Time (by Year and Quarter)					
		FY08		FY09			
		Q3 (Apr - Jun 2008)	Q4 (Jul - Sept 2008)	Q1 (Oct - Dec 2008)	Q2 (Jan - Mar 2009)	Q3 (Apr - Jun 2009)	Q4 (Jul - Sept 2009)
Budget Year	FY07	Implementation/Use of Funds by Operating Units and Cooperating Agencies		Performance Reports Completed by Operating Units	Performance Reports Reviewed in Washington		
	FY08	Obligation of Funds by Operating Units		Implementation/Use of Funds by Operating Units and Cooperating Agencies			
	FY09	Congress holds Hearings and Mark-Up on 150 Account	Congress passes 150 Account Appropriation Bill	653a report negotiated by Congress and F/Bureau with USAID & State; OYB approved /created	Operational Plans completed by Operating Units and reviewed and approved by Washington	Obligation of Funds by Operating Units	
	FY10	Operating Units formulate FY10 budget requests & send to F/Bureau for review	F/Bureau reviews requests from Operating Units; F/Bureau sends formal request to OMB	OMB reviews F/Bureau's requests. Passback (Nov)	Administration's budget sent to Congress (Feb)	Congress holds Hearings and Mark-Up on 150 Account	Congress passes 150 Account Appropriation Bill (House, Senate, conference report)

Funds are obligated in the Missions through bilateral agreements with governments or direct grants, cooperative agreements or contracts with non-governmental organizations. In Washington, the Regional Bureaus at USAID and "Pillar" Bureaus at State may obligate funds through special agreements with international organizations, or through grants, cooperative agreements or contracts with non-governmental organizations. Once the funds are obligated, the recipient organizations can use the funds in their ongoing activities or start up new activities.

3.3 Budgeting under the new F/Bureau process

The introduction of the centralized budgeting process under the State/F has been challenging for USAID. The first three years of this new budgeting process have been disruptive, with the guidance evolving from year to year on how the new process should work between USAID, State/F and the State Department. As a result, USAID staff have spent an enormous amount of time learning how to comply with the ever changing budget process.

The new budget process has introduced a few positive changes. In some ways, the State/F Bureau budgeting process has achieved one of its goals to centralize and coordinate budgets across development sectors. The "5 by 5 matrix[3]" has brought notable clarity to budget allocations. And, after three years, the country review process is better managed and has created a forum by which to discuss and reconcile the different foreign assistance agendas in each country. But the general feeling is the "kinks" have not been completely worked out of the system and the amount of effort entailed is out of line with the value added.

Putting the budget process aside, many in the development community are concerned about the impact of the merger with the State Department on independence of USAID. Some of the arguments include:

- Through the new restructuring, USAID has lost staff, programmatic flexibility and influence with Congress, OMB and other important stakeholders in the budget process. After the restructuring, the State Department now has the preeminent role in setting foreign aid priorities and allocating funds. USAID now receives its allocations through the State-Department led F/process. USAID's role was further diminished when the State Department took control over USAID's budget accounts and its direct relationships with OMB (Atwood 2008).
- Despite the good intention of a more field-based approach to program planning and budgeting, the process remains primarily a Washington-driven, top-down process. Secretary Rice has set the country allocations with little consultation or transparency. And Mission and Embassy staff have not been effectively brought into the F/ process to help shape funding allocations for their countries. Others claim that the F/process and its ensuing confusion about who is in charge has resulted in "hyper-centralization of decision-making that is paralyzing implementation in the field" (Government Executive.com 2007).
- Another concern is the absence of strategic thinking and direction in program planning and budgeting. State/F has been so focused on launching the new budget process and reporting system that they have lost sight of long-term view and strategy. Due to the transition, combined with the long delays to finalize appropriations, it appears that State/F and USAID are always working on

[3] "5 by 5" matrix is the short-hand term for the Foreign Assistance Framework. This framework is an analytical tool that classifies countries by five broad categories (Rebuilding, Developing, Transforming, Sustaining Partnership, and Restrictive) with similar political, economic, and social characteristics and measures progress against the Five Pillars.

annual operational plans and budgets. This leaves little time for reflection and assessment of progress and strategic directions.

- Finally, when State took over the budgeting process, the Global Health Bureau stopped using its own expenditure tracking system. Previously, the Population Health and Nutrition Center (before it became PRH) had developed a sophisticated system to track the expenditures of funds to organizations, projects, types of activities. Now the tracking function resides with State/F, and the Global Health Bureau's PRH Office cannot generate the same type of budget analyses as before.

4 Analysis of reproductive health/family planning funding trends

This section presents recent information on USAID's global health and RH/FP budgets. First, the section provides key definitions for RH/FP assistance. Second, the section reviews trend data on USAID's global health budget to provide a backdrop and context for the discussion on RH/FP funds. Third, it discusses the factors that have influenced the Agency's decisions on how to allocate the RH/FP funds. Finally, it analyzes the impact of stagnating funding levels for RH/FP programs in different geographic regions.

4.1 Key terms and concepts related to RH/FP funding

USAID's RH/FP funds are used to advance the U.S. foreign policy goal of promoting sustainable development and health in the developing countries, and are primarily intended to help USAID achieve its Agency-wide goal of reducing unintended pregnancies. The activities supported by RH/FP funds are narrower in scope than the ICPD definition of RH, which includes HIV/AIDs, maternal and reproductive health care and research in addition to FP (PAI Fact Sheet #20). (See also Appendix E.)

Box 3 details the type of FP and FP-related activities that can be supported with Congressional funds. These funds are received through a Congressional **"earmark"** where the law is written directing USAID to spend a certain amount of its development assistance funds on population and FP activities.

During much of the history of USAID's population and FP programs, a portion of RH/FP funds have been used to directly fund UNFPA and the International Family Planning Federation (IPPF) (See Appendix E: Historical Overview of U.S. Funding of RH/FP). Several U.S. administrations have denied funding to UNFPA because of interpretations of the **Kamp-Kasten amendment** that prohibits foreign aid funding for any organization that, as determined by the President, "supports or participates in the management of a program of coercive abortion or involuntary sterilization." The Reagan and Bush I administrations interpreted the language very broadly, resulting in presidential determinations that UNFPA was ineligible for funding because of its program of support to China. The

Box 3. Defining "RH/FP assistance"

The term population assistance in this report refers to U.S. funds for population and family planning programs administered through USAID.

FP activities

- Expanding access to and use of FP services
- Supporting the purchase and supply of contraceptives
- Enhancing quality of FP services
- Increasing awareness of FP information and services
- Expanding options for fertility regulation and organizations of FP services
- Integrating FP services into other health activities
- Assisting individuals and couples having difficulties conceiving

RH/FP system strengthening

- Fostering conditions necessary to expand and institutionalize FP services
- Contributing to the sustainability of FP services

Related RH activities

- Integrating FP and antenatal, neonatal and postpartum care
- Post-abortion care
- Integrating and coordinating FP and HIV/AIDS and STI prevention
- Linking to broad-based youth development activities
- Eliminating FGC

Non-RH and Non-health activities

- Adding non-FP products and promotion to a FP marketing campaign
- Mentoring programs
- Using income-generation activities to generate funds for RH/FP activities

Source: http://www.usaid.gov/policy/ads/200/200mab.pdf,

Clinton Administration resumed funding for UNFPA at a level of $14.5 million in 1993. In subsequent years, U.S. funding for UNFPA fluctuated, although a contribution was made in every year except 1999. In July 2002, following the report of a blue-ribbon commission that was asked to study the matter, the Bush Administration invoked Kemp-Kasten, withholding the $34 million appropriated by Congress for UNFPA. There was no change in UNFPA's activities during this time and the administration continued to withhold funding from UNFPA in each subsequent year (See Appendix F:U.S. Population Assistance, 1965-2007).

IPPF, on the other hand, did not accept U.S. funds from 2001 to 2008 because they would not sign the Bush administration's **Mexico City Policy/Global Gag Rule (GGR).** The "global gag rule" was a Reagan-era policy enacted in 1984. Named the "Mexico City" policy after a population conference held there, it prohibited foreign non-governmental organizations that receive U.S. funds for family planning in developing countries from speaking out for or against abortion laws or from providing abortion services, even if they use only their own funds or engage in democratic policy debate in their own countries.

4.2 Overview of USAID Budget Accounts that fund RH/FP

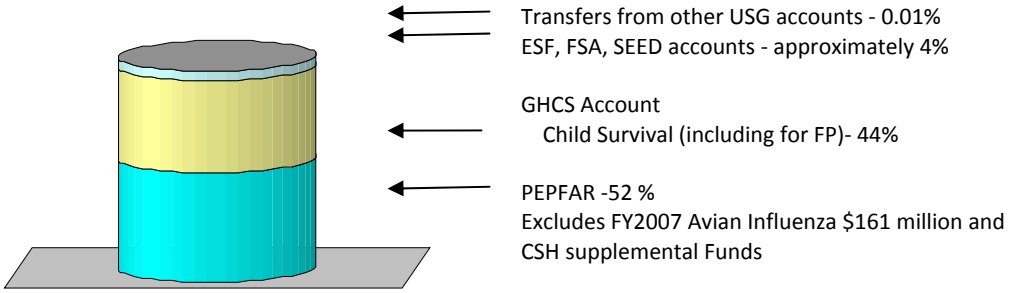
USAID manages a range of budget accounts that are organized largely along functional and regional lines. With the State Department merger, USAID now also co-manages several accounts with the State Department. Funds allocated to RH/FP have not been greatly affected by the new budgeting process. Over the past several decades, Congress has appropriated funds for health, population and family planning through several accounts. Although new directives are periodically identified and funded, there has been sufficient consistency in the accounts and Congressional priorities that both Congress and USAID use the same budget categories in preparing their respective budget requests and appropriations bills. These same budget categories are also reflected in the standard list of program elements now being used to develop operational plans and budgets under the new F/Bureau process.

The most important accounts for health and RH/FP are:

1. **Global Health and Child Survival Fund (GHCS).** Formerly known as the Child Survival and Health Fund (CSH), the name has been adjusted to reflect a broader set of priority health areas. This is the largest account, and in the FY 2008 appropriation, it included funding for the PEPFAR. Other programs that receive funding from this account include (partial list): the Global Fund for AIDS, TB, and Malaria; the Presidential Malaria Initiative; TB; child survival and maternal health; and RH/FP. In addition, a portion of the funding designated for UNFPA is often drawn from this account.
2. **Freedom Support Act Funds (FSA)**. Congress allocates funds to the Independent States of the former Soviet Union to help them advance along the path toward becoming stable, pluralistic and prosperous countries. RH/FP programs have been funded primarily to help these countries reduce reliance on abortion as a method of family planning.
3. **Support Eastern Economic Democracies Fund (SEED).** Funds are designated to Eastern European countries for similar reasons as those for FSA, and population and FP programs have been funded from SEED for similar reasons.
4. **Economic Support Fund (ESF).** ESF promotes U.S. economic and political foreign policy interests by financing economic stabilization programs, supporting peace negotiations and assisting allies and countries that are in transition to democracy. USAID implements most ESF-funded programs with direction from the State Department.

Figure 8 presents the total funding level for global health by accounts for FY2007. PEPFAR funds dominate the Global Health Bureau's budget and are the largest portion (52%) of the Global Health and Child Survival account. The Child Survival Account, where FP funds are embedded, accounted for 44% of the total Global Health budget. As the figure illustrates, the other accounts - ESF, FSA and SEED contribute small amounts (less than 5%) to the Global Health budget.

Figure 8. FY2007 Global health new obligating authority Total $3.98 billion



Source: USAID GH/PRH, 2007

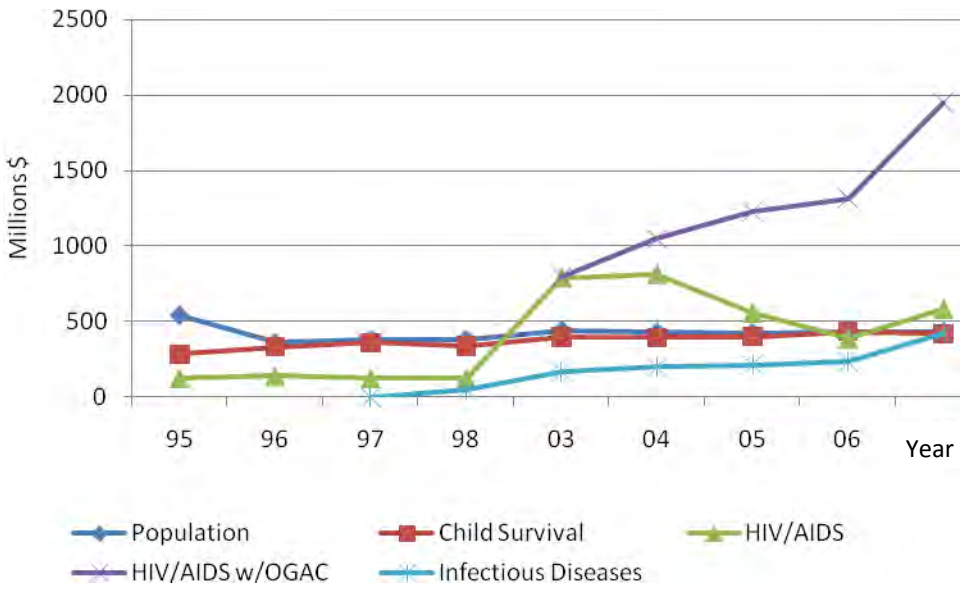
UNFPA recently has received part of its funding from the International Organizations account, which is managed by the Department of State. The larger the portion of funding from the GHCS that goes to UNFPA, the less USAID has available for its RH/FP programs.

In the annual foreign assistance Appropriations bill, Congress has earmarked an overall level for population and FP, always indicating the portion that should come from the GHCS Fund. The earmark requires that the Administration allocate at least that level of funding for RH/FP. However, to date, the RH/FP funds have had no other sub-earmarks and very few Congressional directives--suggestions about desired levels of funding for various programs. This is in contrast with Child Survival funds, which has many directives, e.g., that a specific percentage of funds or dollar amount should be used for immunization, micronutrients, iodine supplementation, and so forth.

4.3 Trends in USAID's overall health budget: the rise and dominance of HIV/AIDS funds

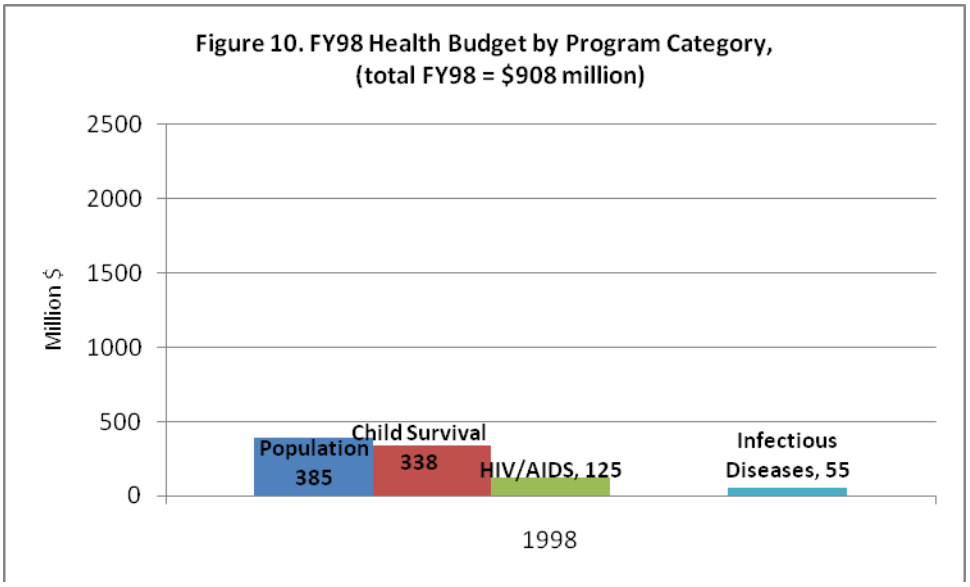
Figure 9 on the next page provides an overview of the global health budgets over time and by program category. With the dramatic increase in HIV/AIDS funds in 2003, HIV/AIDS has overshadowed the other health programs in USAID's health portfolio. In FY 1995, $126 million was allocated to HIV/AIDS programs, compared to $795 million in FY 2003 and $1,948 million in FY 2007. Infectious Disease programs have also grown rapidly, more than doubling from $173 million in FY 2003 to $424million in FY 2007. This increase is attributable to the many presidential initiatives described in Section 2. Child survival, maternal health and RH/FP programs, on the other hand, remained constant over the same time period. Since the 1995 peak in RH/FP funds, budgets have remained "straight-lined" since FY 2003 around the low- to mid- $400 million level.

Figure 9. USAID Global Health budgets by program category, FY95 to FY07

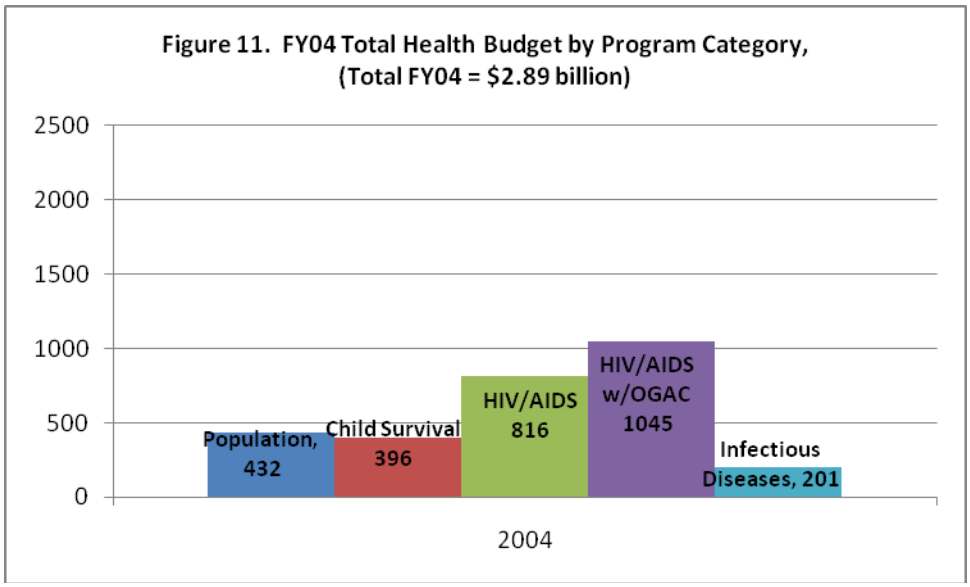


Source: USAID GH/PRH, 2007

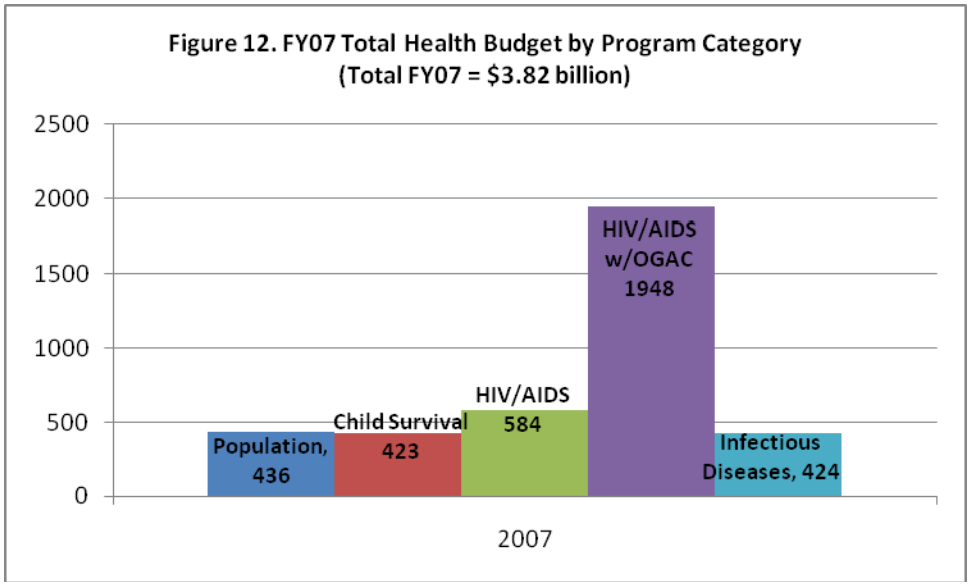
Figures 10, 11 and 12 demonstrate the change in USAID's overall health funding levels since 1998. In FY 1998, USAID's total funding for health was $908 million of which $185 million, (20%) was allocated to RH/FP. In FY 2004, USAID's total budget for global health jumped three fold to $2.89 billion and continued to grow to $3.82 billion in FY 2007. Figure 9 above demonstrates that this rapid growth in funding was fuelled by the introduction of PEPFAR funds through OGAC in 2003. Almost two-thirds of the Agency's health budget is now allocated to HIV/AID (OGAC and HIV/AIDS combined equaling 61%). Other health programs, such as FP and child survival, have been overwhelmed by PEPFAR funding. RH/FP and Child Survival and Infectious diseases tie for "second place" with similar funding levels (14% of total health budget). RH/FP funds as a percentage of the total declined from 20% in FY 1998 to 14% in FY 2007.



Source: USAID GH/PRH



Source: USAID GH/PRH



Source: USAID GH/PRH

4.4 Factors influencing the Agency's budget decisions for RH/FP

4.4.1 Budget allocation model

In response to greater need for FP services in developing countries and competing demands for limited funds, USAID had to make some hard choices on how to allocate its RH/FP funds. In 2003, the Agency (with technical help from GH/PRH) established a modeling exercise to guide how the funds were to be allocated among different countries. At that time, USAID Administrator Natsios was interested in a more rational budgeting process for the Agency as a whole and encouraged the Global Health Bureau and its technical offices to try out a modeling approach. From 2003 to 2005, the Sector Council developed the criteria and agreed upon a set of indicators that would help define country "need" (see Box 4).

Box 4. Criteria to determine country "need" and set funding levels

- Unmet need for contraception
- Number of high risk births
- Contraceptive prevalence rate (CPR)
- Population pressure on arable land and access to clean water resources.

Using data from the Demographic Health Surveys (DHS), the Sector Council developed an allocation model that provides a composite number that is used to rank USAID countries. The Sector Council uses the country ranking to help set the funding levels for each country and adjusts these levels in relation to percentage of women with unmet need and the previous years' expenditures.

In 2008, using the budget allocation model, senior staff at the PRH Office identified 40 priority countries (see Appendix D) known as "focus" countries. Of these, the PRH Office chose a subset of 13 priority countries where the Office would concentrate its resources (see Table 3). With one exception, each country has achieved a modern contraceptive prevalence rate (MCPR) of greater than 10%, which the PRH Office considers a solid foundation to build a FP program. Likewise, each of these 13 countries has a MCPR less than 35%, showing they still have a long way to go to reach program maturity.

As Table 3 also shows, 10 out of 13 priority counties are in Sub-Saharan Africa. Moreover, most of these priority countries, except for Congo, Malawi and Madagascar, are also PEPFAR focus countries. All 13 countries are maternal child health (MCH) focus countries and eight of the 13 are also Presidential Malaria Initiative (PMI) focus countries.

Table 3.USAID Global Health priority countries

Country	PEPFAR focus	MCH focus	PMI Focus
India (Uttar Pradesh State)		❖	
Pakistan		❖	
Nigeria	❖	❖	
Ethiopia	❖	❖	❖
DR Congo		❖	
Rwanda	❖	❖	❖
Tanzania	❖	❖	❖
Uganda	❖	❖	❖
Kenya	❖	❖	❖
Malawi		❖	❖
Madagascar		❖	❖
Zambia	❖	❖	❖
Haiti	❖	❖	

Source: USAID GH/PRH, 2008

4.4.2 Graduation of FP programs

In 2004, to develop a technical approach to "graduation," the GH/PRH and LAC Bureau created a "graduation working group." The working group analyzed the experience of recently-graduated countries, developed criteria (Box 5) and a technical approach, reviewed the graduation process and updated the list of countries scheduled to graduate. The Sector Council endorsed the working group's recommendation for "*a pro-active strategy to identify criteria for graduation and actively plan and manage a country transition process of 2 -6 years to help countries.*"

Box 5. Criteria for country graduation

1. A total fertility rate less than or equal to 3.0.
2. A modern contraceptive prevalence rate of at least 50% or more of married women of reproductive age.
3. At least 70% of the population can access at least 3 FP methods within a reasonable distance.
4. No more than 30% of FP products, services, and programs offered in the public and private sectors are subsidized by USAID.
5. Major service providers (public sector, NGO, commercial sector) generally meet and maintain standards of informed choice and quality of care.

Table 4 lists the countries that have graduated as well as those scheduled to graduate soon and in the near term. To date, USAID has "graduated" 12 countries by withdrawing USAID support for technical assistance and funding for RH/FP programs. Most of these countries were graduated well before 2004. Four countries are scheduled to graduate in the next two to five years and another seven countries are planned to graduate in the next three to six years. Several USAID staff interviewed for this report indicated that due to funding limitations, they were forced to graduate more countries at a faster pace than was optimal.

Table 4. List of USAID Global Health countries by graduation status

Graduate	Imminent (2 -5 years)	Near Term (3-6 years)
Botswana (1995)	Jamaica (Jan 2006)	Bangladesh (TBD)
Brazil (2000)	Paraguay (2005 - 2010)	Dominican Republic (TBD)
Colombia (1997)	Indonesia (2004-2008)	Egypt (2002-2011)
Costa Rica (1996)	Romania (March 2006)	El Salvador (TBD)
Ecuador (2001)		Peru (TBD)
Mexico (1999)		Russia (TBD)
Morocco (2003)		South Africa
Panama (late 1980s)		
South Korea (approx 1976)		
Thailand (approx 1993)		
Tunisia (1990)		
Turkey (2002)		

Source: USAID GH/PRH, 2008

In addition to the twelve graduated countries, USAID has closed Missions in twenty-four countries during the last 25 years -- the vast majority in West Africa. Mission closures included Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Niger, and Togo. As a result of the Mission closures or other political reasons, direct FP assistance was also terminated in these countries.

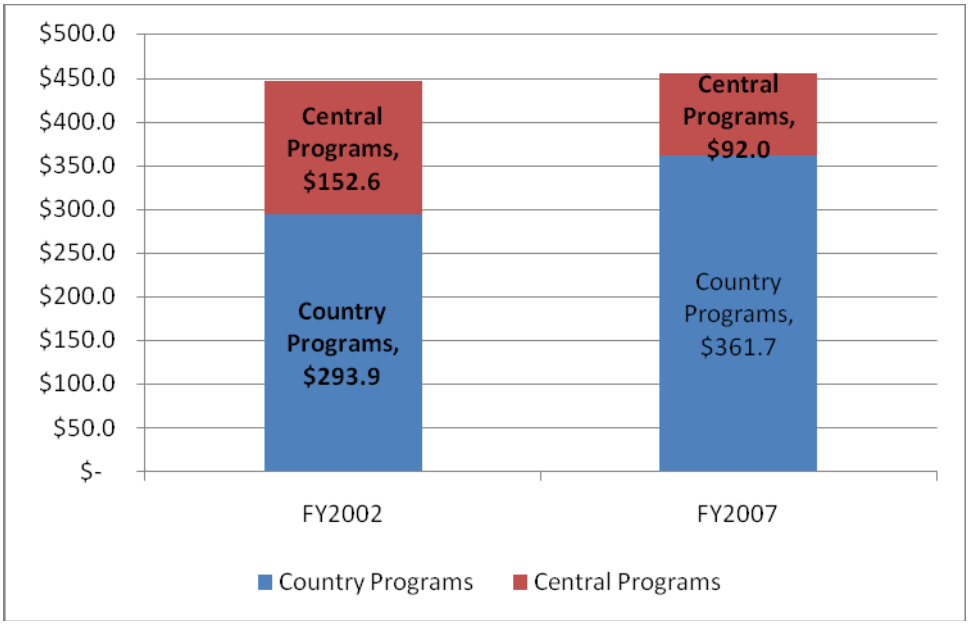
4.5 Recent trends in USAID's reproductive health/family planning funding

4.5.1 More reproductive health/family planning funds going to the field

In the last 10 years, the majority of USAID's health funds have been directed to the field. Under USAID Administrator Atwood, the Agency experienced a policy shift placing greater emphasis on funding Missions to carry out USAID's strategies. This trend has continued under subsequent USAID Administrators including Natsios and, more recently, Tobias and Fore. This "field" emphasis in budgeting has also been supported by the F/Bureau's process in which the State Department brings together all the sectors to program a country's entire portfolio of activities.

Using FY 2002 and FY 2007 data, Figure 13 illustrates this trend. In FY 2002, of a total RH/FH budget of $446.5 million, only 34% ($152 million) went to the field while the remaining 66% ($153 million) was allocated to Washington-based programs. Many of these Washington-based programs, however, supported activities in the field. In 5 years, the funds targeted to the field increased to 80% ($362 million) of the total $454 million in the RH/FP budget.

Figure 13. FY02 and FY07 RH/FP funding levels ($ millions)
Centrally funded vs. Field programs

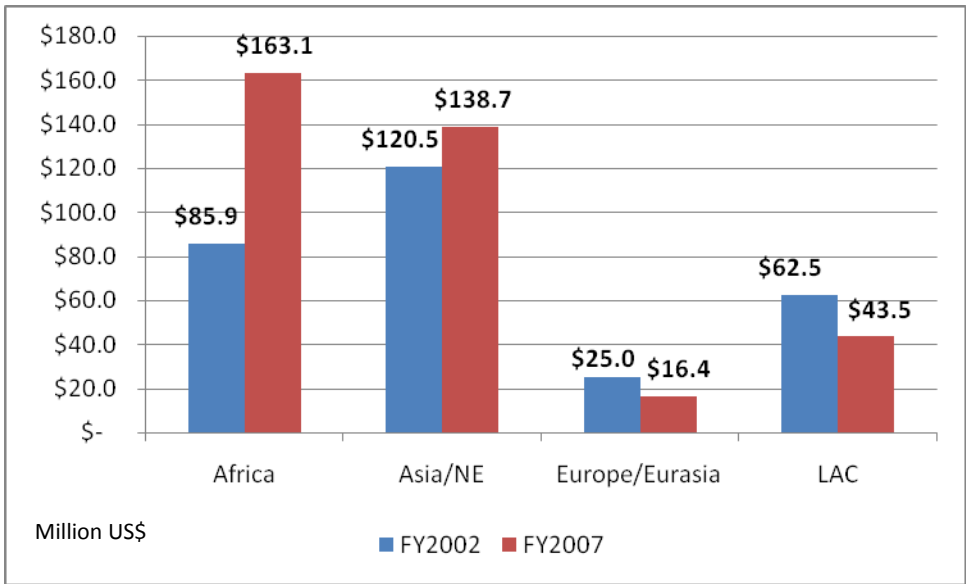


Source: USAID GH/PRH

4.5.2 Concentration of reproductive health/family planning funds in sub-Saharan Africa

With the application of the budget allocation model, there has also been a concentration of the field funds in the Sub-Saharan and South Asia regions. Figure 14 illustrates the geographic shift in funding over the same six-year time period. The most notable change is dramatic rise of RH/FP funds in Sub-Saharan Africa from $86 million in FY 2002 to $163 million in FY 2007. The Asia Near East region experienced a 17% increase from $120 million in FY 2002 to $140 million FY 2007, fueled primarily by the new program in Afghanistan, which received $32 million in FY 2007. These funding increases were at the expense of both E&E and LAC regions that both experienced declines, 35% and 30% respectively, during this same time period.

Figure 14 USAID population and FP funds by geographic region, FY 2002 and FY2007



Source: USAID GH/PRH

4.5.3 Fewer countries with larger RH/FP programs

In recent years the number of countries with RH/FP programs has leveled off and remains between 45 to 50 countries (see Table 5).

Table 5. Number of RH/FP countries, FY02 and FY07*

Region	# of countries FY98	# countries FY02	# of countries FY07
Africa	17	24	22
ANE	10	12	11
E&E	8	13	9
LAC	11	10	9
Total	**46**	**59**	**51**

Source: USAID GH/PRH

*# of countries does not include regional initiatives

Although there are more funds going to **sub-Saharan Africa**, there are also more countries with need, resulting in USAID having to spread the money more thinly. The average country program budget (excluding the two regional initiatives) is approximately $7.5 million in FY 2007. But funds are concentrated in the five largest African programs--Ethiopia, Nigeria, Kenya, Tanzania and Uganda (see Table 6).

Table 6.
Top 5 PRH-funded African countries, FY02 and FY07

Top 5 African countries FY02	Top 5 African countries FY07
1. Nigeria - $11.8 million	1. Ethiopia - $18.2 million
2. Ghana - $ 7.3	2. Nigeria - $15.5
3. Kenya - $ 6.0	3. Kenya - $13.2
4. Mali - $ 5.8	4. Tanzania-$10.9
5. Uganda- $ 5.2	5. Uganda - $10.4

The region with next largest amount of RH/FP funds, **Asia and Near East**, has been taken over by political realities of the war in Afghanistan. In FY 2002, ANE regional budget was dominated by three large country programs: Bangladesh, Egypt, and the Philippines (see Table 7). By FY 2007, the ANE region had made budget adjustments to introduce a RH/FP program in Afghanistan and to beef up support to Pakistan. Bangladesh continues to enjoy budget support, but is short-listed to graduate soon. India experienced a substantial increase in its RH/FP budget while the Philippines realized a modest reduction.

Table 7.
Top 5 PRH-funded ANE countries, FY02 and FY07

Top ANE countries FY02	Top 5 ANE countries FY07
1. Bangladesh -$24.5 million	1. Afghanistan- $32.0 million
2. Egypt - $23.4	2. Pakistan - $18.0
3. Philippines - $17.0	3. Bangladesh - $17.5
4. Jordan - $12.8	4. India- $15.7
5. India - $10.0	5. Philippines- $14.8

Egypt and Jordan have always received substantial RH/FP support because of their role in the Middle East peace process. However, Egypt's RH/FP budget was slashed by almost 50% from its FY 2002 level of $23.4 million to $12 million in FY 2007. Jordan, on the other hand, realized a modest increase from $12 million in FY 2002 to $14 million in FY 2007. There will be further changes in how funds are distributed in Asia and the Middle East given that three important countries are scheduled to graduate: Indonesia followed by Bangladesh and Egypt.

Table 8.
Top 3 PRH-funded LAC countries, FY02 and FY07

Top 3 LAC countries FY02	Top 3 LAC countries FY07
1. Peru - $14.0 million	1. Haiti - $9.2 million
2. Bolivia - $13.0	2. Bolivia - $9.1
3. Guatemala- $ 9.5	3. Guatemala - $6.6

Funding for the **Latin America and Caribbean** region declined from $62.5 million in FY 2002 to $43.5 million in FY 2007. The top 3 countries also shifted during this time period (see Table 8). In FY 2002, Peru, Bolivia and Guatemala received the most RH/FP funds. In FY 2008, Haiti's budget doubled from $4.5 million in FY02 to $9.2 million. Haiti's gain was Peru's loss; Peru went from the 1st place in RH/FP allocations in the 4th place with a reduction from $14 million to $5.2 million. Peru is scheduled to graduate in the near term, possibly reducing even further the amount of funding allocated to this region.

Table 9.
Top 3 PRH-funded E&E countries, FY02 and FY07

Top 3 E&E countries FY02	Top 3 E&E countries FY07
1. Russia - $4.04 million	1. Russia - $4.7 million
2. Albania - $3.30	2. Armenia - $2.2
3. Armenia - $ 2.9	3. Albania - $1.9

Similarly, the **Europe and Eurasia** region has also experienced a dramatic decline in RH/FP programs (see Table 9). In the last six years, population and FP funds dropped from $25 million in FY02 to $16.4 million in FY07. Table 9 demonstrates that the same three countries in the E&E region have enjoyed the majority of funding; Russia tops the list followed by Albania or Armenia. But Russia is scheduled to graduate soon. It is unclear what will happen to funding levels in this region when Russia graduates in the next 3 - 5 years.

4.6 Decline in centrally-funded RH/FP programs

Confronted with straight-lined funding levels, USAID has shifted more of its RH/FP funds to the field, resulting in a sharp decrease in funds available for USAID's centrally funded programs. These Washington-based funds are often referred to as "core funds." In FY2002, the $152 million available in core funds represented 34% of the total RH/FP budget. Five years later, the amount of core funds decreased to 20% ($92 million).

4.6.1 Type and scope of USAID's centrally funded programs in RH/FP

USAID field Missions and the Global Health Bureau contribute in different ways toward achieving the Agency's goal *"to expand access to high-quality, voluntary FP services and information and RH care on a sustainable basis."* USAID Missions, through their bilateral programs, provide direct support to country governments and local counterpart organizations to improve the availability and quality of their RH/FP services. The Global Health Bureau, on the other hand, offers global and technical leadership by "*articulating the importance of FP ,defining strategies, building constituencies, identifying and sharing models for programming and best practices, and moving successful interventions to the field"* (USAID PHR 2007 Strategic Plan).

The PRH Office's strategies include global leadership, knowledge generation, and strategic support to the field. It works through its implementing partners on centrally funded programs to carry out these strategies, which are organized into four areas (see Table 10; for more detail please refer to Appendix H).

Table 10.Current USAID Population and FP Centrally Funded Programs

Research, Technology and Utilizations (6)	Policy, Evaluation and Communication (11)	Commodities Security and Logistics (2) ($amount)	Service Delivery Improvement (8)
Contraceptive Research and Development **(CONRAD III)**	**MEASURE**:BUCEN Survey and Census Information, Leadership, and Self-Sufficiency	**DELIVER**	Private Sector Partnerships **(PSP)** IQC (11 active task orders, 2 closed)
Contraceptive and Reproductive Health Technology Research and Utilization **(CRTU)**	MEASURE CDC/DRH MEASURE PHASE II MEASURE Evaluation Phase II	Central Contraceptive Procurement	Addressing Unmet Need for Family Planning in Maternal, Neonatal, and Child Health Programs **(ACCESS-FP)**
Natural Family Planning and Reproductive Health Awareness (The **AWARENESS** Project)/ Fertility Awareness-Based Methods **(FAM)**	Healthy Families, Healthy Forests: Population-Environment Award of the Global Conservation Program		Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services **(RESPOND)**
Reproductive Health Operations Research What is name of new project with FHI	Health Policy Initiative **(HPI)** IQC (4 task orders)		The **Capacity** Project

Reproductive Health and Research: World Health Organization Umbrella Grant	Health Communication Partnership		CARE RH Trust Fund
The Population Council: Product Development Agreement	Information and Knowledge for Optimal Health **(INFO)**		Leadership, Management and Sustainability **(LMS)**
	Bringing Information to Decision-makers for Global Effectiveness **(BRIDGE)**		Grant Solicitation Management (GSM)
	Successful Communities from Ridge to Reef: Population-Environment Associate Award of the Global Conservation Program		Extending Service Delivery **(ESD)** for Reproductive Health and Family Planning
Source: USAID, 2008 Global Health User Guide, accessed at http://www.usaid.gov/our_work/global_health/home/Resources/users_guide.html			

1) **Research, Technology, and Utilization:** These projects primarily focus on research to identify and bring to market new contraceptive technologies and as well as creating better understanding, through operations research on the use and preference of existing contraceptive methods.

2) **Policy, Evaluation, and Communications**: USAID has a long tradition in supporting core research necessary to measure the impact of RH/FP programs. The foundation of this research centers on helping developing countries improve their census data and to carry out periodic Demographic Health Surveys (DHS). A hallmark of USAID's population portfolio is its policy and communication projects. Both the policy and communication programs rely heavily on the data generated by DHS and census, along with other data sources, to communicate the benefits of RH/FP to change individual's behavior and to reform policies so as to create more supportive policy environment for RH/FP programs and services.

3) **Commodities Security and Logistics:** Historically, USAID has been the largest donor of FP commodities in the developing world. Although they remain the largest donor of commodities most developing countries, USAID has had to change its role from providing contraceptive supplies to the supplier of last resort. USAID policy now urges countries through technical assistance to become more contraceptive self-reliant. The Commodities Division's only centrally funded project is DELIVER, which provides technical assistance to developing countries to improve their capacity in all areas of FP supply. DELIVER has also pioneered the new approach of contraceptive security.

4) **Service Delivery Improvement:** This division manages all of PRH's service delivery support programs. Each one has a different focus: ESD and RESPOND are USAID's "flagship" service delivery programs spanning all regions in the developing world; PSP-*One* and Banking on Health work with the private sector to increase FP services and products through private sector channels; LMS focuses on strengthening the leadership and management capacity of FP policymakers and decision makers; and the CAPACITY project addresses human resource issues in health. Finally, in the 1990s the RH Trust Fund provided Care International funds to create an endowment that has enabled them to integrate RH/FP programs in their health and development activities.

4.6.2 Global leadership priorities

Embedded in the centrally funded programs are selected technical priorities referred to as global leadership priorities (GLPs). The Global Leadership Priorities are systematically addressed and are considered "cutting edge" topics that require investments of core funds. In FY07, the Global Bureau funded these initiatives with addition resources from its own centrally funded RH/FP funds. In FY08, however, Global Health asked the centrally funded programs to allocate funds from their own operating budget to pay for the Global Leadership Priorities because the Global Health Bureau no longer had sufficient RH/FP central funds.

Box 6. Global Leadership Priorities

1. Contraceptive security
2. Community based services
3. FP-HIV integration
4. FP-MH-newborn/child health integration
5. Health timing and spacing of pregnancies
6. Long-acting and permanent methods

4.6.3 Programmatic impact of declining core funds

The reduction in USAID's total RH/FP budget has resulted in three consequences for the Agency's RH/FP programs:

- **Reduction in biomedical research and other forms of research such as operations research and monitoring and evaluation.** Of the four programmatic areas, Research Technology and Utilization has experienced the most cuts. The research area hardest hit has been USAID's support to uncover and pioneer new contraceptives technologies. The second area experiencing budget cuts has been operations (OR) research, focusing OR only on existing contraceptive methods.

- **Reduction in core funds available to maintain global leadership.** Core- funded projects have historically supported many activities that Missions' will not pay for that greatly contribute to USAID's global technical leadership, such as monitoring and evaluation, operations and other forms of research and dissemination of knowledge about best practices. With fewer core funds available, the centrally funded projects have had to cut back on the number of activities and restrict them to the 13 focus countries, limiting the geographic scope and regional comparisons that have provided the international health community many key lessons learned in the RH/FP field.

- **Limits to USAID's ability to undertake new initiatives.** The technical strategies embedded in the Agency's central funded projects are pretty consistent over time, but every five to seven years, the Agency is able to fund a major new technical area. For example, the CAPACITY project moved USAID into the technical area of human resource issues, in addition to continuing its training and capacity building activities. CAPACITY, awarded in 2002, was the last major RH/FP initiative launched by the Agency and there is no new one on the horizon.

5 Reproductive health/family planning funding under different scenarios and implications for programs

Below is a discussion of three possible scenarios for RH/FP funding at USAID. These scenarios take into account the changing nature of foreign assistance community, the evolving dynamics of PEPFAR and other presidential initiatives, and the recent change in presidential administrations. These scenarios are based on interviews with USAID staff - current and retired - and representatives from the RH/FP advocacy community.

5.1 Funding scenarios

Worst case scenario: decrease in population funding levels. This scenario is unlikely with the recent election of President Obama, along with the solid majority of Democrats in both the Senate and House. In fact , many of the policy predictions described below happened shortly after President Obama assumed office. The real threat to population funding is the ever growing economic crisis.

Conservative scenario: no change in funding levels but significant legislative reform. As the interviews revealed prior to the new administration taking office, President Obama did take action in the following areas:

1) Overturning Mexico City Policy/GGR: On the anniversary of Roe v. Wade, the Obama Administration overturned the Mexico City/Global Gag Rule. Additionally, there is discussion that there is sufficient support in both the Senate and House to draft legislation that will prohibit any new president from re-instating the policy.
2) Resuming funding of UNFPA: Several individuals interviewed indicated there is no legal reason why funding of UNFPA should not start as soon as FY 2009, as the new president will have the authority to quickly release funds to UNFPA (direct communications).

These actions will remove some of the constraints associated with donation of contraceptives. Without the GGR, USAID could provide contraceptives to IPPF affiliates. With revised interpretations of the Kemp-Kasten amendment, the Agency will also be able to fund and provide contraceptives to Marie Stopes International.

Optimistic scenario: steady increase in funding over time. There is cautious optimism in the RH/FP advocacy community that the funding request for FY 2009 may actually create a higher baseline for population funding. Funding for FY09 is still unresolved and USAID is operating under a continuing resolution until March 7, 2009. The RH/FP advocacy community is pushing to get as much funding as possible to serve as a baseline for discussions on future funding levels. Currently, the House has proposed $600 million and the Senate's proposal is $540 million for FY09. Realistically, the advocacy community believes that that funding for FY 2009 will be closer to the Senate proposal. Nonetheless, this would represent a 20% increase in population funds and create a new baseline for future budget requests.

Several factors will influence future funding levels for USAID's RH/FP programs. Last year, many in the advocacy community did not think that proposing a $1 billion annual budget for RH/FP was unrealistic compared with funding levels for PEPFAR. Given the **emerging economic crisis** and dramatic downturn

in the US economy, however, many now realize that $1 billion is inspirational but highly unlikely to be passed in Congress.

Despite the downturn in the economy, funding for population and family planning assistance continues to enjoy **widespread support** in both the House and Senate. Long-time Congressional supporters will not let FP and population issues fall by the wayside and will continue to find ways, now made more possible with a supportive White House, to provide the much needed funding.

One possible strategy is to explore how PEPFAR funds can be used to strengthen both HIV/AIDS and FP programs. Many members and staff on the Appropriations Committee are increasingly concerned about **PEPFAR's impact on USAID's overall health budget and programs**. They have expressed a keen desire to continue funding HIV/AIDS programs but not at the expense of all other health programs. There may be an opening to discuss how PEPFAR funds can be used to not only fund HIV/AIDS program but also strengthen related health interventions like RH/FP. Future appointments by Obama to key positions such as USAID Administrator and U.S. Global AIDS Coordinator will indicate how realistic this opportunity will be.

5.2 USAID investments of reproductive health/family planning under two scenarios

This section focuses on how USAID will use its funds under the conservative – or status quo – and optimistic scenarios.

Conservative scenario: no change in funding levels. Under a conservative scenario, USAID would continue to analyze how its scarce funding can best be spent, look for further cost-cutting measures and streamline systems to become more efficient.

- GH/PRH will first conduct a comprehensive situation analysis of the 13 priority countries to identify gaps and opportunities to influence and strengthen programming. The assessment will also provide guidance on the type of core-funded technical assistance that would yield the greatest impact.
- Second, to reduce costs, PRH staff will provide more technical assistance directly to Missions instead of relying on implementing partners. In addition, senior PRH staff will provide technical expertise and help backstop programs in the 13 priority countries to help address the management overload and staffing shortages in the Missions.
- Third, PRH will propose an optimal set-up and staffing to support country programs.
- Finally, PRH will explore mechanisms to translate lessons learned and research into proactive and useful information the Mission staff can apply in managing FP programs (GH/PRH Strategic Plan).

Optimistic scenario: steady increase in funding level over time. Under a more optimistic scenario, G/PRH would undertake the above mentioned strategies but will also re-invest the funds in the field. Below is a list of activities, in order of priority that USAID would resume if they have more funds (PAI 2008).

- *Expand programs in highest need countries in Africa.* Even though USAID has already doubled funds to this region from $86 million to $140 million, the African priority countries could easily absorb even higher funding levels given need. GH/PRH considers increased funding levels to this region even more imperative given the fact that other bilateral donors are using sector-wide approaches to

channel their funds (see Appendix B), often resulting in less direct funding to RH/FP programs in African countries.

GH/PRH staff also believe they had to close down many RH/FP programs too soon in several African countries. Seventeen countries are either served by a regional program or receive no financial or technical support. USAID would ramp up its West Africa regional program to provide the much needed support in this region.

- *Expand programs in select number of Asia, Middle East and E&E countries.* Many countries such as Bangladesh, Cambodia, Northern India, Nepal, Pakistan, Philippines and Yemen continue to experience high levels of unmet need but have a FP program base on which to build. Additional funding could help consolidate these countries' FP programs. The E&E region has a different FP profile but requires continued funding because of high levels of abortion. *Slow the pace of graduating countries in LAC.* Many countries are nearing "graduation" in the LAC region and would benefit from a few more years funding to assure sustainability and successful transition as USAID withdraws its support. Those countries in the region who are far from graduating, Bolivia, Guatemala and Haiti, will also require continued financial support after most of the LAC programs have been closed.
- *Restore funding for central programs and special initiatives.* USAID/Washington has been forced to scale-back its work as a result of shifting more funds to the field, thereby weakening its capacity to provide global leadership in RH/FP. The areas hardest hit by the reduction in core funds have been contraceptive research, operations research and program innovation. GH/PRH would bring back funding levels so that it can achieve, through its implementing partners, its strategic objectives of global leadership, knowledge generation and technical support. Also, GH/PRH would resume funding its special initiatives that it had cut to keep its ongoing program afloat.

5.3 Implications: Areas for change in a new administration

There is a great deal of speculation about which processes described above are likely to change under the new administration and how. Given the uncertainty during this transition, it is impossible to predict how some of the trends described in this report will unfold. We can, however, present the issues to track in coming months that will have direct impact on the future levels of RH/FP funds.

- *New appointments:* While nothing is clear at the moment, it appears likely that a new USAID administrator and deputy will be named very soon and that s/he will be confirmed fairly quickly. Another position critical to RH/FP funding will be the US Global AIDS Coordinator of PEPFAR. Depending on the new appointee, s/he could provide new guidance on how PEPFAR funds can be spent in relation to RH/FP programs and try to address some of the consequences of the funding imbalance created by PEPFAR in the Agency's health budget.

- *New hires to increase the career staff working in development.* President Obama's budget blueprint opens the way for new hiring at the State Department and USAID, especially the recruitment of new foreign services officers. Some of the new hiring began last year to support more staff going to Iraq and Afghanistan. And not all of the new hires will represent a net increase; some is intended to replace the large group of Foreign Service officers approaching retirement. Still, new recruitment has the potential to bring in new blood and fresh ideas at both USAID and State.

- *USAID, State/F:* Although the three former USAID Administrators are calling for USAID to return to its former autonomy, it is highly unlikely, at least in the short-term, that there will be any changes in

the current structure. What may change, however, are the internal processes and structuring between USAID, State and F. One of the most important changes to track will be whether PEPFAR will continue to reside in the State Department or come under the management of USAID like the PMI. Other areas to monitor will be the evolving working relationships between USAID Global Health and the State/F Bureau in the budget and programming process.

- *Foreign assistance:* There is a lot of interest among NGOs, Washington DC "think tanks" and representatives on Capitol Hill in restructuring foreign assistance. Proposals range from streamlining the foreign assistance apparatus and reinvigorating USAID to creating a Cabinet level post on foreign assistance. These proposals will depend on President Obama, who has not committed to a new Cabinet post, and on Obama's new National Security Advisor, who will oversee foreign assistance and development issues for the US government.

- *Foreign assistance funding:* Overall funding for foreign assistance has been increasing during the Bush Administration. During his campaign, President Obama committed to doubling funding foreign assistance to $50 billion. He has not backed off from this position but instead, due to the economic crisis, proposed a slower pace to increase funding. Funding levels are still up in the air and will not be resolved until President Obama's first budget makes it way through Congress, thereby signaling the pace and level of funding for foreign assistance.

6 Conclusions

There is a lot of room to increase RH/FP funding, but it is too early to predict the levels given the current state of the U.S. economy and contentious budget environment in Congress. Nevertheless, there are important trends, organizations, and people to watch as the new administration develops and reforms policies related to foreign assistance and RH/FP programs.

6.1 Trends to watch

Under the Bush Administration, several **trends in U.S. foreign assistance** have dramatically changed the operating environment in which RH/FP funding decisions are made. Most notable among these changes has been the growing role of the Department of State and the realignment of USAID with between State and USAID. Furthermore, the centralization of budget decisions under the F/Bureau has implications for how USAID must now develop their RH/FP budgets. Despite these organizational changes, F/ Bureau process does not greatly impact the RH/FP funding levels because of the Congressional earmarks.

Although earmarks have protected the RH/FP budget, it is important to monitor any further developments in the de-facto merger of USAID with the State Department and develop relations with the new decision makers at the F/Bureau to ensure that RH/FP remains a development goal. These new stakeholders need to understand the importance of RH/FP funding and its allocation to countries with high unmet need.

One of the most important trends in foreign assistance has been the **emergence of new U.S. agencies working in health**. Although there are an increased number of USG agencies in international health, to date USAID is the only agency receiving RH/FP planning funds. Nonetheless, continued monitoring of all the new USG actors in international health will be needed to see whether they will be given scope and funds to enter into the RH/FP arena.

PEPFAR has had a profound impact not only on RH/FP but on all other USAID health programs**.** In five short years, HIV/AIDS and PEPFAR funds now dominate USAID's health budget, overwhelming the Agency's portfolio, management and staff focus. Until GH and OGAC can resolve how to balance these two activities, RH/FP will always be the "step child" and continue to suffer the consequences of decreased health priority in developing countries: fewer USAID central- and field-based staff with RH/FP experience and a migration of developing country staff to HIV/AIDS.

New donor funding mechanisms and foreign assistance frameworks have emerged in the last two decades that also influence how donors finance their development programs (see Appendix B). As these new funding mechanisms shift the locus of decision-making to the field, recipient governments are increasingly making decisions regarding funding priorities for their own countries instead of donor institutions. A key focus in these country strategies is poverty reduction: For RH/FP advocates to have a seat at the table in these country deliberations, they need to be able to articulate how RH/FP helps lift families out of poverty. Otherwise, RH/FP runs the risk of becoming further marginalized as governments place greater emphasis on other development and health issues. Future advocacy strategies need to persuade developing country governments that it is in their interest to raise and/or maintain RH/FP as national priorities.

Administration support for the Millennium Development Goals (MDGs). The Bush administration, which was not supportive of UN initiatives in general, paid little attention to the MDGs and the process for developing targets and indicators. Yet several of the Millennium Goals are related to RH/FP—notably the empowerment of women, improvements in maternal and child health, and combating HIV/AIDS. In 2006, Goal 5 (improve maternal health) was revised to include a target calling for universal access to RH, as well as a key indicator to measure progress, reducing unmet need for family planning (PATH and UNFPA, 2008). RH/FP advocates should educate new appointees at the State Department and USAID about the importance of promoting the MDGs for reducing poverty and achieving sustainable development.

6.2 Less money better spent

In response to resource constraints, the PRH Office has made decisions to strategically allocate funds to the countries in most need. With growing demand for FP services and products competing for the same level of funding, the PRH Office established criteria using the budget allocation model to shift funding to countries with the greatest need. Also, the PRH Office had to graduate countries more quickly than they would have preferred, risking that countries may not be on track for an orderly transition and sustainable FP program.

The funding shifts have been dramatic: there are **more RH/FP funds going to the field than before**. In the last five years, most of the RH/FP funds are concentrated in countries with the greatest need; those in Sub-Sahara Africa and South Asia. PRH has also concentrated the funds in fewer countries in these priority regions, thereby creating larger programs. These same countries also receive core funds through the centrally funded projects. USAID instructs these projects to direct their core funds and activities to the 13 priority countries. PRH has made some difficult programmatic decisions but, in light of the straight-line budgets in the last five years, has made the best and most effective use of their resources.

PRH Office leadership are concerned that ”straight-lined” - or worse yet, reduced - RH/FP funds may have on a **negative impact on program management and staffing**. Currently, the PRH Office remains intact and leadership has been able to maintain the necessary number of staff at headquarters and in the field to manage its portfolio of activities worldwide. But any future cuts in RH/FP funding may compromise the PRH Office’s ability to retain the staff needed to manage its global presence and technical leadership.

6.3 Way forward to influence the budget process

This report highlights the “pressure” points for continued advocacy efforts.

- **Focus on Congress.** There is strong support for RH/FP among key staff and the budget processes are well known and are unlikely to change much under the Obama Administration. The Congressional staff are always interested in information that can help them make the case for more RH/FP funds.

- **Consider the role of OMB.** OMB provides guidance on overall U.S. budget parameters and its staff plays a key role in reviewing programs and allocations from the agency submissions. There are usually several key staff members in OMB who work with USAID and on Global Health issues. The

F/process has minimized USAID's relations with OMB, possibly requiring additional advocacy efforts with this key group.

- **Target new stakeholders at the State Department**. To date, most of the advocacy efforts have focused on key staff on the Hill. The advocacy efforts need to be widened due to the emergence of new foreign assistance players and the involvement of F/Bureau in the RH/FP budget process. These new stakeholders need to understand the importance of RH/FP, the lack of funding needed to respond to unmet need for FP, and the strategic allocation of existing RH/FP funds to countries with high unmet need.

- **Work with key staff in the Global Health Bureau's technical offices**. They help make many decisions about the allocation of RH/FP funds to countries and programs, and help identify and set technical priorities and funding for innovation.

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Appendix A: USAID-Assisted Countries and Regional Programs

Sub-Saharan Africa				
Angola Benin Dem. Rep. of the Congo Dijbouti Eritrea Ethiopia Ghana Guinea Kenya Liberia Madagascar Malawi	Mali Mozambique Namibia Nigeria Rwanda Senegal Sierra Leone South Africa Sudan Tanzania Uganda Zambia Zimbabwe	**Graduated** Botswana **Regional Center for Southern Africa (RCSA), Gaborone, Botswana.** Serves Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe	**Regional Economic Development Support Office (REDSO), Nairobi, Kenya.** Serves Angola, Burundi, Central African Republic, Comoros, Dem. Rep. of the Congo, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rep. of the Congo, Rwanda, Seychelles, Somalia, South Africa, Sudan, Tanzania, Uganda, Zambia and Zimbabwe	**West Africa Regional Program (WARP), Accra Ghana.** Serves Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal Sierra Leone, Sao Tome and Principe and Togo
Asia and Near East				
Afghanistan Bangladesh Cambodia East Timor Egypt India Indonesia	Iraq Jordan Lebanon Mongolia Morocco Nepal	Pakistan Philippines Sri Lanka Vietnam West Bank-Gaza Yemen	**Graduated** Oman South Korea Thailand Tunisia Taiwan	**Office of Middle East Program, Cairo, Egypt.** Serves Lebanon, Morocco and Yemen. **Regional Development Mission for Asia (RDMA), Bangkok, Thailand.** Serves Burma, China, Laos, Thailand and Vietnam
Europe and Eurasia				
Albania Armenia Azerbaijan Belarus Bosnia-Herzegovina Bulgaria Croatia Cyprus Georgia Kazakhstan Kosovo	The Kyrgyz Republic Macedonia Moldova Montenegro Romania Russia Serbia Tajikistan Turkmenistan Uzbekistan Ukraine	**Graduated** Czech Republic Estonia Hungary Latvia Lithuania Poland Slovenia Slovakia	**Regional Program for the Central Asian Republics, Almaty, Kazakhstan.** Serves Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan	**Regional Service Center (RSC), Budapest, Hungary.** Serves Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Hungary, Kosovo, Macedonia, Romania and Serbia and Montenegro

Latin American and Caribbean				
Bolivia Brazil Colombia Dominican Republic Ecuador El Salvador Guatemala Guyana	Haiti Honduras Jamaica Mexico Nicaragua Panama Paraguay Peru	**Graduated** Argentina Belize Chile Costa Rica Uruguay	**Caribbean Regional Program (J-CAR), Kingston, Jamaica. Serves** Antigua, Dominica, Grenada, St. Kitts-Nevis, St. Lucia and St. Vincent and the Grenadines	**Central American and Mexico Regional Program (E-CAM), San Salvador, El Salvador.** Serves Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua and Panama **South American Regional Program (P-SAR), Lima, Peru.** A trade program serving Bolivia, Colombia, Ecuador, Peru and Venezuela.

Appendix B: Recent Changes in U.S. and International Foreign Assistance

This appendix gives an overview of changes in the development field, including new players in the U.S foreign aid community and new donor funding mechanisms. The latter have emerged in the last six to ten years and have influenced how many bilateral and multilateral donor organizations fund their programs. Both U.S. and international trends have implications for USAID's programs in general and for RH/FP in particular.

New players in the U.S. foreign assistance community

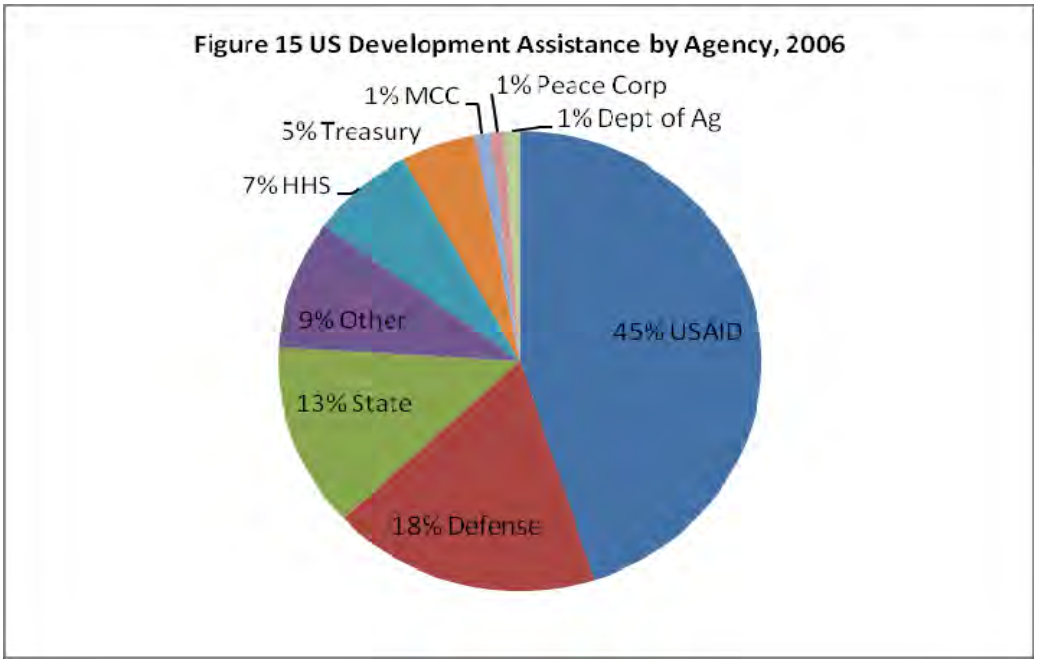
During the Bush Administration, many new players entered the foreign assistance arena. One of the newest actors in development assistance is the Millennium Challenge Corporation (MCC). Using a business-model approach to development assistance, MCC's goal is to reward a small number of well-performing countries committed to good governance, economic freedom and investing in people. MCC requires countries to meet eligibility criteria in these areas and, in return, it provides large five-year grants ("compacts") toward development projects that the country proposes.

MCC has further "crowded" the foreign assistance arena, although it works in fewer sectors than USAID and has yet to develop a health program. The MCC is an independent government corporation with a Chief Executive Officer and a board of directors. The Secretary of State - *not* the USAID Administrator - chairs the Board. Other board members including the Treasury Secretary, the USAID Administrator/Director of Foreign Assistance and private sector representatives appointed by the President and the congressional leadership. The MCC operates autonomously and can choose to design a health initiative independent of USAID's health goals and objectives—although it has not done so to date.

Many have regarded the creation of the MCC as a "vote of no confidence" of USAID by the Bush Administration to effectively implement foreign assistance funds. In fact, many MCC staff were discouraged from even working with USAID when it was created (Atwood 2008). According to some observers, the results have been disappointing: MCC has been slow in moving the funds to developing countries and many of the countries that have qualified for funding are not necessarily development priority countries (direct communication).

Other federal agencies have also become more visible and involved in U.S. development assistance policy and programs. The most notable example is the growing prominence of the HHS' increased participation in HIV/AIDS policy and programs overseas through the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). The Defense Department, through its new Africa Command, is the newest addition to the foreign assistance community.

As a result, there is no longer a single approach and vision in development assistance, with many agencies with competing agenda. Figure x shows how the development assistance funds are allocated among all the different actors. USAID receives 45% of development assistance budget. The Department of Defense is taking a growing role, accounting for almost 1/5 (18%) of the budget. State receives the 3rd largest portion (13%) of the overall development assistance budget, followed by the HHS with 7%.



Source: Foreign aid 101: A quick and easy guide to understanding US foreign aid. OXFAM

An Oxfam policy brief states, "foreign assistance is more complicated than ever" (Oxfam 2008). By some accounts, there are at least 12 departments, 25 different agencies and almost 60 government offices involved in development assistance although not all are involved in health programming. All of these organizations have independent organizational structures, set their own policies and implement their own programs, often with little or no coordination. One of the former USAID Administrators describes the consequences of the proliferation of development actors, "Not surprisingly, this has led to policy incoherence, a lack of integration across program and issue areas, inefficient and overlapping bureaucracies and endless conflicts over roles and responsibilities - not to mention confusion among the donor recipient." (Atwood 2008). He further notes that many of the new development players use the same contractors as USAID, including the commonly known RH/FP contractors, which creates further confusion among USAID developing country counterparts. It should be noted, however, that for RH/FP programming, USAID plays the predominate role or is often the only U.S. Government actor.

Box 7
Different Foreign Assistance budget mechanisms

Direct budget support: Finances channelled into the general treasury account of a recipient country that co-funds the national budgets.

Poverty Reduction Strategy: (PRS) Through a participatory process, government defines its overall strategy to promote growth and reduce poverty that defines external financing needs. A PRS is a precondition for receiving debt relief under the HIPC **(debt-relief)** initiative and grants from the World Bank and IMF.

SWAps: A partnership between government and donor agencies. Donor funds contribute to a sector-specific umbrella and are tied to a defined sector policy under a government authority.

Basket funding: Basket funding is the joint funding by a number of donors of a set of activities through a common account. Basking funding is often arranged as part of a SWAp through direct budget support.

New foreign assistance policies and frameworks

The last 15 years have witnessed a change in the environment for international development assistance. In the 1990s, in an effort to improve the coordination and effectiveness of donor funds, international donors introduced several approaches

that changed how aid was delivered. These approaches include basket funding, direct budget support, sector-wide approaches (SWAps) and poverty-reduction strategies (see Box 7).

The fact that USAID cannot participate in these funding mechanisms represents an opportunity. By definition, all funding mechanisms that provide direct budget support require donors to work exclusively with the public sector. USAID, on the other hand, has the flexibility to fund other actors in the health sector, such as non-government organizations and for-profit health providers. USAID, as a result, has many large and important programs with these non-state players that have successfully increased access to and the quality of RH/FP services and products.

Since the early 2000s, the International Monetary Fund and the World Bank initiated the Poverty Reduction Country Strategy Papers (PRSPs) to increase country ownership of development assistance plans and increase focus on poverty reduction. The PRSPs aim to provide the crucial link between national public policies and programs, donor support, and development outcomes, for example, those needed to meet the United Nations' Millennium Development Goals (MDGs). The World Bank and other multi- and bilateral donors fund the priorities outlined in the PRSP. Although the PRSP may encourage investment in strengthening the overall health system, which may benefit RH/FP indirectly, there is no guarantee, unless the PRSP specifically mentions RH/FP, that these investments will directly support these programs.

Donor agencies have also established new partnerships and funding structures for selected initiatives. The partnerships include not only bilateral donors, but also foundations and other private sector partners. The Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines and Immunization (GAVI), Global Alliance for Improved Nutrition (GAVI), and Stop Tuberculosis are a few examples.

The European donors have also pioneered several new innovative financing options to change how funds are allocated to developing country governments and to increase overall development assistance. These mechanisms include airline taxes to finance the Global Funds to Fight AIDS, debt buy-downs and the International Financing Facility for Immunization (IFFIm). The Airline Tax Initiative -amounting to just a few dollars for most travelers - applies to all airline flights in participating countries and raises revenues for HIV/AIDS. The other mechanisms, in particular the financing facility, are designed to accelerate the availability of funds to be used for health programs by investing the majority of resources up front - “frontloading”.

While these innovative financing mechanisms may increase overall resources for development assistance, they are often dedicated to specific health interventions such as childhood immunizations and HIV/AIDS, making it more difficult to ensure that RH/FP remains a priority and is adequately funded. Only the Reproductive Health Supplies Coalition has taken on a role like GAVI to promote RH/FP and address supply problems globally.

Box 8
Five Principles of the Paris Declaration

1. Ownership
2. Alignment
3. Harmonization
4. Managing for results
5. Mutual accountability

The advent of the new century also introduced further changes in foreign assistance approaches, culminating in the Paris and Accra Declaration. The international donor community, driven by the Europeans and the World Bank, are promoting greater ownership by recipient countries while at the same time reducing poverty. The new aid architecture emerged from a high-level forum held in France

in 2005 where 93 countries (including all key donor and major aid recipient countries) signed a declaration outlining five key principles in the new development paradigm (see Box 8). Called the Paris Declaration, it strives to give countries more control on how donor assistance is allocated and to increase efficiencies by ensuring donors collaborating with one another. As a result, European governments and the World Bank have been moving away from vertical support to specific sectors or specific programs such as RH/FP, and giving donor assistance directly to a country's ministry of finance through direct or general budget support.

Appendix C: Glossary of USAID budget terms

The glossary defines legislative, administrative, programming and budget terms referred to in this report. Underscored terms in the definitions are defined elsewhere in the glossary. Frequently used abbreviations are included (source: http://www.usaid.gov/pubs/bj2001/glossary.html).

Actual Year: Last completed fiscal year; in this case, FY 1998.

Agency Strategic Plan: The Agency's overall plan for providing development assistance. The strategic plan articulates the Agency's mission, goals, objective, and program approaches. The Agency strategic plan is coordinated with and reflects the priorities of U.S. Government international affairs agencies.

Annual Performance Plan: The Agency's annual performance plan (APP) summarizes the agency's performance plans for the same year as the budget request year (e.g., FY 2001). It is organized by the Agency goals outlined in the Agency strategic plan. The annual performance plan is a required document under the Government Performance and Results Act. In contrast, the annual budget justification, formerly titled the Congressional presentation, is organized by specific countries, regions, or global programs. The budget justification contains the plans for each Agency operating unit.

Annual Performance Report: The Agency's annual performance report (APR) synthesizes the agency's program performance for the year ending the past September (e.g., FY 1999). It reports by Agency goal against the Agency's FY 1999 annual performance plan that was prepared and submitted to Congress in 1997. The annual performance plan is a required document under the Government Performance and Results Act. In contrast, the annual budget justification, formerly titled the Congressional presentation, is organized by the operating, or management, units in countries, regions, or Washington. The budget justification reports on the performance of each program managed by each Agency operating unit.

Appropriation: An act of Congress permitting Federal agencies to incur obligations for specified purposes, e.g., Foreign Assistance and Related Programs Appropriation Act, 1998.

Appropriation Accounts: The separate accounts for which specific dollar amounts are authorized and appropriated.

Authorization: Substantive legislation which establishes legal operation of a Federal program, either indefinitely or for a specific period, and sanctions particular program funding levels, e.g., the Foreign Assistance Act of 1961, as amended (FAA).

Budget Authority: Authority provided to the U.S. Government by law to enter into obligations which result in outlays or government funds.

Budget Justification: The presentation to the Congress that justifies USAID's budget request and provides information on the programs, objectives, and results. Formerly referred to as the Congressional Presentation (CP).

Budget Year: Year of budget consideration; in this case, FY 2000.

Continuing Resolution: A joint resolution passed to provide stop-gap funding for agencies or departments whose regular appropriations bills have not been passed by the Congress by the beginning of the fiscal year.

Development Assistance: Assistance under Chapters I and 10 of the Foreign Assistance Act primarily designed to promote economic growth and equitable distribution of its benefits.

Disbursement: Actual payment made for a product, service, or other performance, pursuant to the terms of an agreement.

Expenditure: As reported in this document, represents the total value of goods and services received, disbursement for which may not have been made. A disbursement, also referred to as an actual expenditure or outlay, represents funds paid from the U.S. Treasury.

Fiscal Year: Yearly accounting period, without regard to its relationship to a calendar year. (The fiscal year for the U.S. Government begins October 1 and ends September 30.)

Foreign Assistance Act (FAA): The Foreign Assistance Act of 1961, as amended (USAID's present authorizing legislation).

Global Program or Activity: A global program or activity refers to a USAID program or activity that takes place across various regions (i.e., trans-regional in nature). This type of program is most often managed by a central operating bureau such as Global Bureau or Bureau for Humanitarian Response.

Joint Planning: A process by which an operating unit actively engages and consults with other relevant and interested USAID offices in an open and transparent manner. This may occur through participation on teams or through other forms of consultation.

Mission: The ultimate purpose of the Agency's programs. It is the unique contribution of USAID to our national interests. There is one Agency mission.

Non-Presence Country: A country where USAID-funded activities take place but where U.S. direct-hire staff are not present to manage or monitor these activities. Note that some non-presence countries may have other USAID employees, such as foreign service nationals or U.S. personal service contractors, present.

Non-Project Assistance: Program or commodity loans or grants which provide budget or balance-of payments support to another country. Such assistance is usually funded under the Economic Support Fund or Development Fund for Africa.

Obligation: Legal commitment of funds through such mechanisms as signed agreements between the U.S. Government and host governments, contracts and grants to organizations and purchase orders.

Operating Expenses: Those appropriated funds used to pay salaries, benefits, travel, and all support costs of direct-hire personnel. The "cost of doing business."

Operational Year: Fiscal year in progress (current year), presently FY 1999.

President's Budget: Budget for a particular fiscal year transmitted to Congress by the President in accordance with the Budget and Accounting Act of 1921, as amended.

Program: A coordinated set of USAID-financed activities directed toward specific goals. For example, maternal and child health, nutrition, education and family planning activities designed to promote the spacing of children may comprise a program to reduce infant deaths.

Project: A single activity designed to generate specific results. For example, a maternal and child health project may be designed to extend basic health services to 60% of children under five years of age in a poor, rural district of the recipient country. A project is USAID's basic unit of management.

Reobligation: Obligation of an amount which had been obligated and deobligated in prior transactions.

Strategic Framework: A graphical or narrative representation of the Agency's strategic plan. The framework is a tool for communicating the Agency's development strategy. The framework also establishes an organizing basis for measuring, analyzing, and reporting results of Agency programs.

Appendix D: USAID's Focus Countries in Global Health

Tier	Country	Aggregate goal Country will receive at least $2 million of FY08 funding	MCPR Goal Country with MCPR of 10 - 50 % and at least $4 million in FY08	Equity Goal Country with MCPR of 30 - 50 % and at least $X million in FY08
Tier One Focus	1. Bangladesh	✓	✓	✓
	2. Bolivia	✓	✓	✓
	3. Guatemala	✓	✓	✓
	4. Jordan	✓	✓	✓
	5. Kenya	✓	✓	✓
	6. Liberia	✓	✓	✓
	7. Nepal	✓	✓	✓
	8. Peru	✓	✓	✓
	9. Philippines	✓	✓	✓
	10. Russia	✓	✓	✓
	11. Ukraine	✓	✓	✓
Other Tier One	12. Cambodia	✓	✓	
	13. Ethiopia	✓	✓	
	14. Ghana	✓	✓	
	15. Haiti	✓	✓	
	16. India (UP)	✓	✓	
	17. Madagascar	✓	✓	
	18. Malawi	✓	✓	
	19. Mozambique	✓	✓	
	20. Pakistan	✓	✓	
	21. Rwanda	✓	✓	
	22. Senegal	✓	✓	
	23. Tanzania	✓	✓	
	24. Uganda	✓	✓	
	25. Yemen	✓	✓	
	26. Zambia	✓	✓	
Tier Two	27. Afghanistan	✓		
	28. Albania	✓		
	29. Angola	✓		
	30. Armenia	✓		
	31. Azerbaijan	✓		
	32. Benin	✓		
	33. DR Congo	✓		
	34. El Salvador	✓		
	35. Georgia	✓		
	36. Guinea	✓		
	37. Honduras	✓		
	38. Mail	✓		
	39. Nicaragua	✓		
	40. Nigeria	✓		
	41. Tajikistan	✓		

Notes:

1. Other Tier One countries include: Bangladesh, Afghanistan, Yemen, Mali, Philippines, Senegal, Mozambique, Ghana, Guatemala, Bolivia, Liberia, Russia, Ukraine, Armenia, Azerbaijan, Georgia, Albania

2. Tier Two countries include: Sudan, Indonesia, Angola, Guinea, Benin, Egypt, Nepal, South Africa, Zimbabwe, Cambodia, Jordan, Peru, El Salvador, Dominican Republic, Honduras, Jamaica, Paraguay, Nicaragua, Kazakhstan, Tajikistan, Turkmenistan, Kyrgyzstan, Uzbekistan

3. Some countries that would qualify to be listed as Tier One have been placed in Tier Two because (a) limited absorptive capacity (e.g. Sudan, Angola, Guinea, Benin) and (b) scheduled to be graduated (e.g. Egypt, Indonesia). In addition, some Tier Two countries have been elevated to Tier One status for several reasons: (a) regional representation and balance (therefore inclusion of Bolivia and Guatemala where there still is high need for FP), (b) recognition of high performance (such as Zambia).

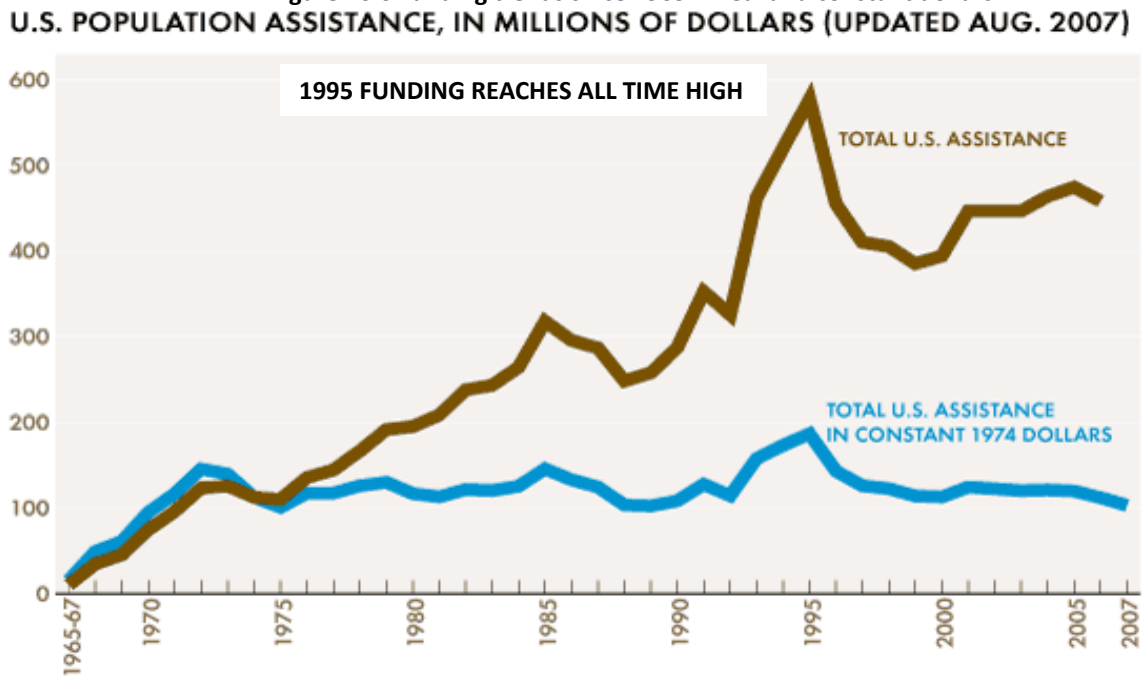
Appendix E: Historical Overview of U.S. Funding of RH/FP

Funding trends in RH/FP assistance since 1965

For the much of its history, RH/FP assistance enjoyed strong bipartisan support in Congress. As Figure 16.0 illustrates, funding levels have steadily increased over the years. Despite the changes in political climate during the Reagan and Bush (senior) Administrations, Congressional support remained strong and RH/FP funding increased during this time period. Under the Clinton Administration, RH/FP assistance benefited from strong political support from the White House, as evidenced by some of the Administration's first acts in power: rescinding the GGR and restoring funds to UNFPA. Moreover, the U.S. played a leadership role at ICPD in 1994 and U.S. funding reached its all time high in 1995 at a funding level of $543.6 million.

Although the Clinton Administration strongly supported family planning and reproductive health during his two administrations funding levels for RH/FP assistance experienced major set-backs. After two years into the Clinton Administration, the mid-term elections in 1994 ushered in dramatic change in the political landscape with the Republican majority in Congress and, "Contract with America", and the triumph of the American Conservative Movement. Since 1995, a small but powerful group of social conservatives, led by Rep. Chris Smith (R-NJ), successfully undermined funding for U.S. RH/FP assistance. Rep. Chris Smith relentlessly sought to write into federal law a version of the "Mexico City/GCR." For his part, President Bill Clinton was adamant in his opposition to the effort. This time was marked by intricate battles between the White House and Congress over the RH/FP budgets, resulting in funding cuts and spending restrictions, but without a provision that would impose "Mexico City/GCR". In 1996, Congress appropriated $356 million to population assistance, down from $541 million in the previous year.

Figure 16.0 Funding trends since 1965 in real and constant dollars



YET FUNDING IN CONSTANT $ HAS REMAINED STAGNANT SINCE THE MID-1970's

Source: Craig Lasher, PAI (see appendix A for data and notes on how funding levels were calculated)

Funding levels have slowly regained ground from the precipitous drop in 1996. When President Bush reinstated Mexico City Policy/GGR, there was an understanding that population funds should be at or around $425 million. This "understanding" was upheld and enforced by Secretary Powell and Deputy Secretary Armitage. Congress, on the other hand, generally increased this amount. As a result, RH/FP on funding hovered around $450million during President Bush's first administration. In more recent years, Congressional funding has remained in the ranges from $429.8 in FY2006, to $435.6 in FY07, and $456.8 in FY08.

However, when accounting for inflation, U.S. funding for international family planning has stagnated. In Graph 1.0, the blue line measures RH/FP assistance in constant 1974 dollars. Notwithstanding the funding peak in 1995, RH/FP funding has remained constant at around $100 million level in 1974 dollars since the mid-1970s.

How U.S. contributions to RH/FP compares domestically and abroad

US Federal Budget

Should the U.S. government increase its contribution to population assistance? One can make the case that U.S. government should increase its overall funding for foreign assistance. U.S. foreign assistance is a meager amount compared to other domestic expenditures. The international affairs budget (or 150 account), which includes both the State Department and USAID budgets, is only about 1.3 percent of the federal budget. About one half of the 1.3 percent is spent on development aid (Oxfam 2008).

There is a lot of room to improve and increase RH/FP budget levels with the U.S. domestic budget. Funding for RH/FP assistance remains less than one-fiftieth of one percent (0.02%) of the total federal budget and less than ten percent of USAID's overall budget (PAI Factsheet #20). With increased overall funding going to foreign assistance, Congress can, and has demonstrated in the past a desire to increase funding for RH/FP assistance as well.

OECD Population Assistance

The United State's contribution to foreign assistance in relation to gross national product (GNP) is small compared to other developed countries. In 2008, the U.S. government allocated $22 billion dollars to foreign assistance. The United States, in absolute terms, is the largest bilateral donor in the world. However, when compared to the nation's income, U.S. aid level ranks in 11th place among OECD member and behind most industrialized countries.

Figure 17 illustrates how the United States compares with other OECD countries using the most recent Development Assistance Country data (2002) on the following page. The U.S. falls behind large countries such as Canada and the United Kingdom, and smaller ones like Denmark and, the Netherlands and Luxembourg.

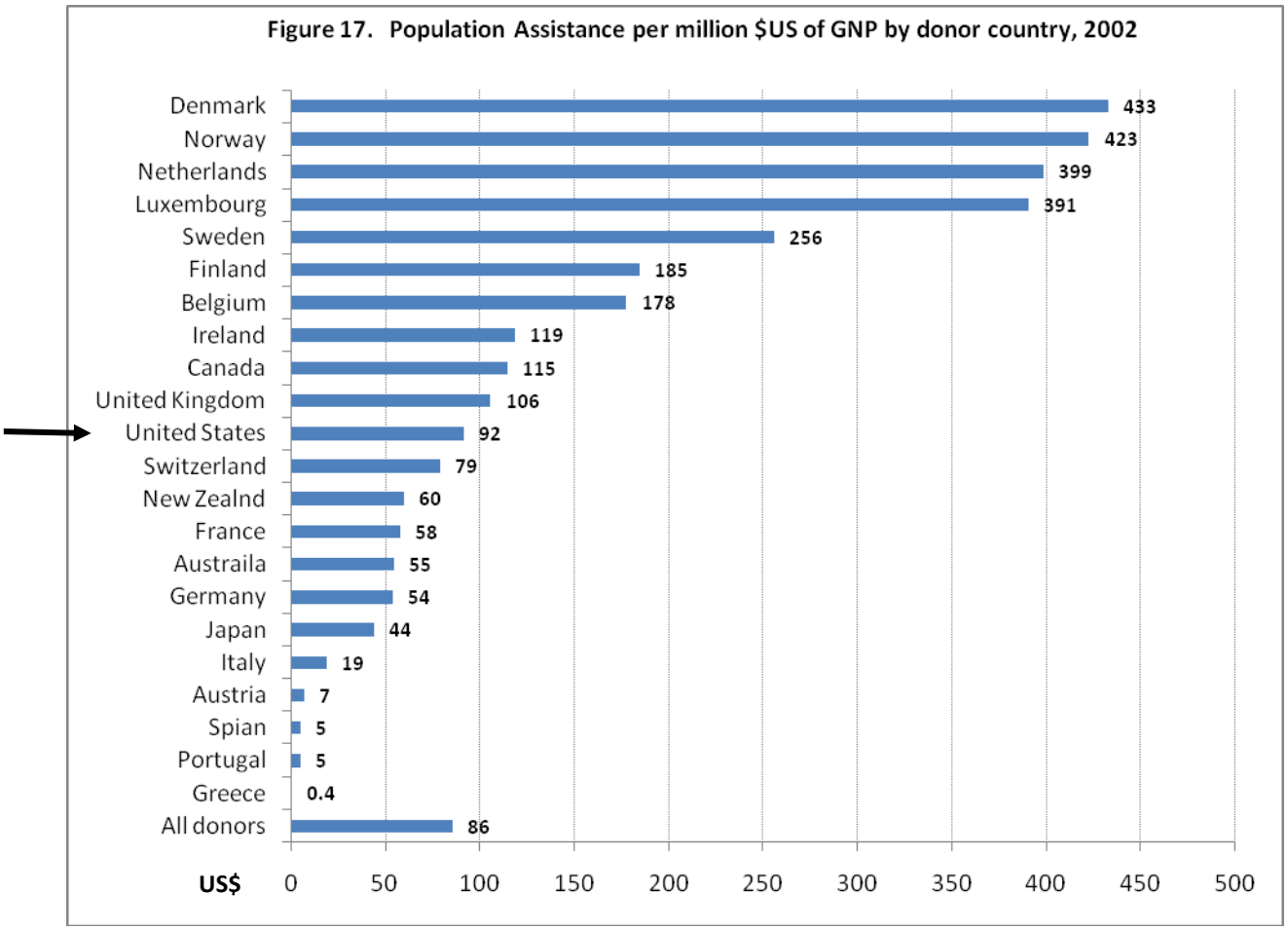


Figure 17. Population Assistance per million $US of GNP by donor country, 2002
Denmark 433
Norway 423
Netherlands 399
Luxembourg 391
Sweden 256
Finland 185
Belgium 178
Ireland 119
Canada 115
United Kingdom 106
United States 92
Switzerland 79
New Zealnd 60
France 58
Austraila 55
Germany 54
Japan 44
Italy 19
Austria 7
Spian 5
Portugal 5
Greece 0.4
All donors 86
US$ 0 50 100 150 200 250 300 350 400 450 500

Appendix F: U.S. Population Assistance, 1965-2007

U.S. Population Assistance, 1965-2007 (in millions of dollars)

Fiscal year	Bilateral Programs (USAID)	U.S. Contribution to UNFPA	Total U.S. Assistance	Constant 1974 Dollars
1965-67	10.5		10.5	15.5
1968	34.8	(0.5)	34.8	49.3
1969	45.4	(2.5)	45.4	61
1970	74.6	(4)	74.6	94.8
1971	95.9	(14)	95.9	116.7
1972	123.3	(29)	123.3	145.4
1973	125.6	(9)	125.6	139.5
1974	112.4	(18)	112.4	112.4
1975	110	(20)	110	100.8
1976	135.5	(20)	135.5	117.4
1977	144.3	(29.4)	144.3	117.4
1978	166.5	(28)	166.5	125.9
1979	191.4	(30)	191.4	130
1980	195	(32)	195	116.7
1981	208.4	(35)	208.4	113
1982	237.8	(33.8)	237.8	121.5
1983	243.1	(33.8)	243.1	120.3
1984	264.2	(38)	264.2	125.4
1985	317.7	(36)	317.7	145.6
1986	295.5	(0)	295.5	132.9
1987	286.6	(0)	286.6	124.4
1988	248.1	(0)	248.1	103.4
1989	257.6	(0)	257.6	102.4
1990	287.1	(0)	287.1	108.3
1991	352.3	(0)	352.3	127.5
1992	325.6	(0)	325.6	114.4
1993	447.8	14.5	462.3	157.7
1994	480.2	40	520.2	173.1
1995	541.6	35	576.6	186.5

1996	432	22.8	454.8	142.9
1997	385	25	410	125.9
1998	385	20	405	122.5
1999	385	0	385	113.9
2000	372.5	21.5	394	112.8
2001	425	21.5	446.5	124.3
2002	446.5	0	446.5	122.4
2003	446.5	0	446.5	120.2
2004	429.5 #	0	463.5*	121.0
2005	437.3 #	0	474.3*	119.7
2006	435.6 #	0	458.1*	112.0
2007 (est.)	435.6	34	TBD	103.0

Source: Craig Lasher, Senior Policy Advisor, PAI.

Notes

2. Figures reflect actual expenditures for family planning and reproductive health programs and are separated into funding for bilateral programs managed by the U.S. Agency for International Development (USAID) and the U.S. voluntary contributions to the United Nations Population Fund (UNFPA). Between 1968 and 1992, however, the U.S. contribution to UNFPA was channeled through and administered by USAID and is reflected in the bilateral assistance column. Amounts in parentheses indicate the contribution made to UNFPA in each of those fiscal years.

3. Figures on U.S. funding are for population assistance programs as defined by the U.S. government. Numbers do not reflect additional U.S. funds appropriated for other programs falling under the broader definition of population assistance adopted at the 1994 International Conference on Population and Development in Cairo, which incorporates expenditures for family planning, basic reproductive health care (such as safe motherhood), research, and services for HIV/AIDS and other sexually-transmitted diseases. In 1999, the latter category was expanded to include treatment, care and support activities, as well as prevention efforts.

4. Constant 1974 dollars calculated using the U.S. Bureau of Labor Statistics inflation calculator, which can be accessed http://data.bls.gov/cgi-bin/cpicalc.pl.

5. ***Total expenditures for FY 2004** – $463.5 million including $429.5 million earmarked for bilateral family planning/reproductive health (RH/FP) programs and $34 million allocated to UNFPA in FY 2002 but withheld from UNFPA by the Bush Administration when it invoked the Kemp-Kasten amendment in July 2002. The reprogramming of the FY 2002 UNFPA contribution remained blocked by a congressional "hold" until January 2004 when the funds were reprogrammed to USAID RH/FP programs in a specified list of countries under the terms of the FY 2004 omnibus spending bill.

6. **Total expenditures for FY 2005** – $474.3 million including $437.3 million earmarked for bilateral RH/FP programs; $25 million withheld from the FY 2005 UNFPA contribution within the international organizations and programs account (IO&P) and reprogrammed to USAID for "family planning, maternal, and reproductive health activities;" and $12.5 million of the withheld FY 2004 UNFPA contribution reprogrammed to USAID RH/FP programs in a specified list of countries under the terms of the FY 2005 omnibus spending bill.

7. **Total expenditures for FY 2006** – $458.1 million including $435.6 million earmarked for bilateral RH/FP programs and $22.5 million earmarked for UNFPA within the IO&P account but withheld as a result of the Kemp-Kasten amendment and transferred to USAID's Child Survival and Health Programs Fund for "family planning, maternal, and reproductive health activities" under the terms of the FY 2006 foreign operations appropriations bill.
8. With regard to withheld **UNFPA contributions**, it is also important to note that $25 million of the FY 2003 contribution and $12.5 million of the FY 2004 contribution were diverted to programs to combat sex trafficking at the insistence of the Bush Administration, contrary to congressional intent.
9. **Bilateral figures** in FY 2004 and FY 2005 reflect government-wide across-the-board cuts imposed on all non-defense, non-homeland security discretionary spending totals 0.59 percent and 0.83 percent respectively. The FY 2007 bilateral level is identical to the FY 2006 level under the terms of the FY 2007 continuing resolution.

Appendix G: Estimating the resources required to fund the ICPD Program of Action

Much has been written about the cost to meet ICPD commitments and who is contributing their "fair share" to the financial requirements needed to fund the ICPD program of Action. This appendix offers a review of the ICPD funding targets, advancements made in achieving these targets, and the debate on reassessing these targets and concludes with a presentation of the FP advocacy community's new estimate of the U.S. government's fair share to address unmet need and the growing demand for FP.

Box 8. Defining "ICPD contributions"

To differentiate US funds for population assistance from the wider ICPD definition, this report will use the term "ICPD contributions". This term encompasses a broader reproductive health agenda with activities groups into 4 categories:

1. Family planning services
2. Basic reproductive health services
3. HIV/AIDS includes all prevention activities plus treatment, care and support
4. Population-related research

Progress towards achieving ICPD financial targets

Fifteen years ago, 179 nations endorsed the ICPD agenda based on an approach that focuses on meeting individual needs and respecting human rights to improve reproductive health care. The ICDP Program of Action included cost estimates to achieve this goal of universal access to basic reproductive health services by 2015. The costs were divided between developing and donor countries; two-thirds and one-third respectively. Together, the countries pledged to raise $18.5 billion annually.

Many articles were written at the 10th year anniversary of ICPD, taking stock of the progress in meeting the programmatic goals of the ICPD Plan of Action and progress made in raising the financial resources needed to make it a reality. UNFPA reports that the donor community mobilized only $2.6 billion - approximately 46% of the Cairo target - in 2002. By 2004, however, donor assistance to ICPD reached its goal and even surpassed the 2005 target. Estimates for 2006 show that donors contributed $8.1 billion and in 2007, $9.8 billion.

Table 11 provides an accounting of the 2006 level of ICPD contribution and estimates for 2006/2007 by donors and other funding sources and estimates. Donations from developed countries continue to provide the largest share of funds for the ICPD Program of Action.

Table 11. ICPD Contributions by Donor Category 2005 - 2007

Donor Category	2005	2006 estimates	2007 estimates
Developed Countries	6,346	7,031	8,764
United Nations System	96	101	106
Foundations/NGOs	364	382	402
Development Bank grants	186	195	205
Subtotal	**6,992**	**7,709**	**9,477**
Development Bank loans	367	367*	367*
Grand Total	**7,359**	**8,076**	**9,844**

Source: UNFPA, Financial Resources Flows for Population Activities in 2005

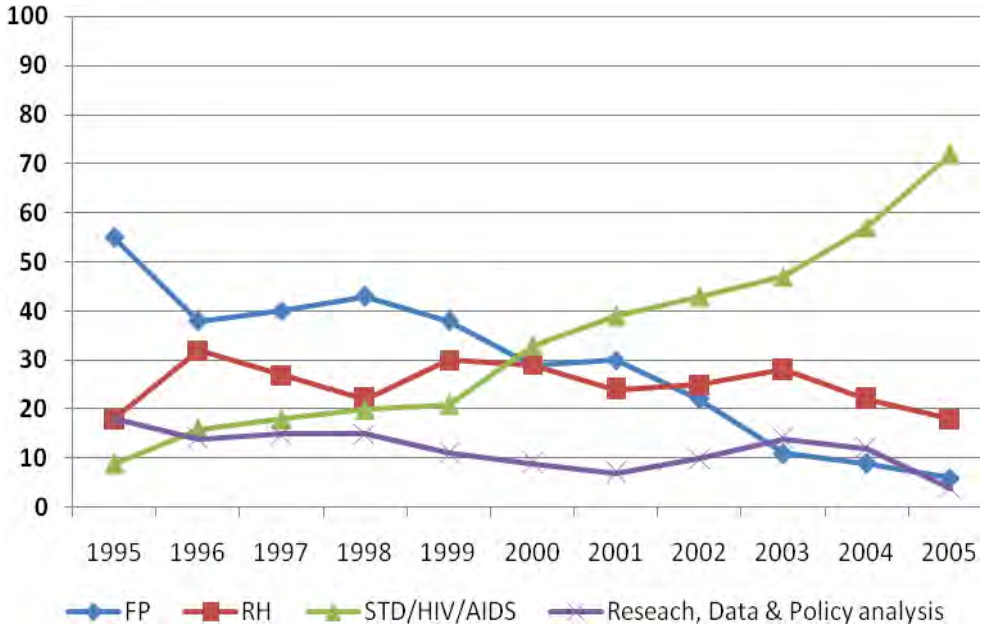
*The 2006 and 2007 figures for development bank loans are estimated at the 2005 level

Private foundations are another significant source of funding, increasing from the $100 million level in 1995 to an estimated $402 million in 2007. Development Banks are also another source of funds either

in the form of grants or loans. Development Banks' commitments averaged at least $450 million annually over the period of 1996 - 2002, but have dropped over $30 million to approximately $367 million in more recent years. Although the data indicate that countries and other sources have reached the financial targets set out in by ICPD, there have been some important problems with the data. First has been the definition problem: there is no consistent definition of reproductive health; as a result each donor and agency uses their own definition. Another problem has been the difficulty in getting donors to report the data consistently and every year, resulting in sporadic responses.

Although the data (with the aforementioned problems) indicate that donors have surpassed their financial targets, there is concern whether these funds are sufficient to meet family planning and reproductive health needs. The increase in funding levels of the ICPD agenda is driven primarily by the dramatic increase in HIV/AIDS funding. As Figure18 demonstrates, funding for family planning has declined dramatically. In 1995, approximately 55% of total population assistance was dedicated to family planning compared to less than 10% by 2005. In sharp contrast, STDs and HIV/AIDS prevention and treatment has been increasing steadily. In 1995, only 8% was directed to STDs and HIV/AIDS activities whereas in 2005, approximately 70% of total population assistance came from HIV/AIDS funding sources. Funding support for reproductive health programs has varied from year-to-year, experiencing peaks in funding levels that surpassed 30%. By 2005, reproductive health expenditures as a percentage of total population assistance returned to the 1995 levels of less than 20%.

Figure 18 Expenditures by ICPD Category as a % of Total Population Assistance, 1995, 2000 and 2005



Source: Financing the ICPD Program of Action: Data for 2005, Estimates for 2006/2007

The debate to recalculate the ICPD funding projections

Although the international community has reached its financial commitments, even surpassing them, the original ICPD funding goals are now outdated. The costs need to be revised, in large part, due to the greater financial resources needed to combat HIV/AIDS. Also, it is acknowledged that additional

resources are needed for related activities such as emergency obstetric care (EOC), health systems strengthening and RH services for unmarried youth.

Revising the cost estimates to meet the ICPD agenda faces several challenges:

- Cost estimates have not been officially revised due to **increased political opposition**, particularly in the Unites States, to reproductive health and rights since ICPD. The Bush Administration brought in a set of players who were not supportive of the ICPD agenda and therefore many in the population and FP community were hesitant to re-open discussion on ICPD.

- Determining **what to include in the cost estimates** of the ICPD Program of Action is very complicated. The definition of reproductive health is very broad, leaving broad scope for interpretation. Although ICPD defined family planning, safe motherhood, reproductive health care as the "constellation of methods, techniques and services that contribute to RH and well-being", there are more ways to define them. One asks if related health services, such as infertility, breast cancer and other cancers of the reproductive health system should be included.

- Challenges in **how to account for the costs of programs that promote reproductive rights and address gender inequality**. Donor spending on these activities is credited against the more limited financial targets agreed at the ICPD.

There have been several efforts to revise the global estimates to meet the ICPD agenda. In 2003, the Guttmacher Institute and UNFPA estimated the cost of providing services to women in developing countries who use modern contraceptive methods. In 2005, the Joint United Nations Programme on HIV/AIDS (UNAIDs) further refined the estimates on the annual cost to address HIV/AIDS in low- and middle-income countries. Finally, the UN Millennium Project produced a third set of estimates in 2006 that covers the costs of family planning; a package of health interventions for maternal and newborn care, including EOC; treatment of selected STDs; and HIV/AIDS research and prevention.

As even the authors of these three studies will acknowledge, these figures, although comprehensive, have limitations. What all these studies underscore, however, is that the resource requirements for the basic reproductive health package will be significantly higher than the estimates over a decade ago. The revised estimates made by the UN Millennium Project (see Table 12) show that the costs to meet the ICPD Program of Action in 2015 will be more than $35 billion, $14 billion more than originally estimated.

Table 12. UN Millennium Project Estimates of Resource Needs for ICPD Package (US Billions)

Component	2005	2010	2015
Basic reproductive health services including FP	$13.9	$19.4	$24.4
STD and HIV/AIDS activities	$ 4.1	$ 9.7	$11.1
Research, policy analysis and development	$ 0.3	$ 0.8	$ 0.4
Total	$18.2	$29.8	$35.8

Source: Public Choices, Private Decisions

The rationale for $1 billion for budget request for U.S. P/FP assistance

In light of the revised estimates to fund the ICPD program, RH/FP advocates have proposed that Congress appropriate almost double current funding levels - $1 billion in fiscal year 2009 - to be allocated between USAID and multi-lateral agencies. The FP experts have estimated that $1 billion is

the United State's fair share of the $4.42 billion in donor resources are required to provide services and products to address unmet need[4] for modern contraception for an estimated 201 million women in the developing world.

In order to calculate the appropriate U.S. share of financial resources required to meet the current unmet need for contraceptive services in 2007, standard practices for international burden sharing are applied[5].

• Additional global expenditures required in 2007, adjusted for inflation[6]	=	$4.42 billion
• Donor country share of additional global expenditures under funding goals in the 1994 International Conference on Population & Development's Programme of Action—donor nations provide one-third of total funding	=	$1.47 billion
• Appropriate U.S. share of additional global expenditures to meet unmet need—based on percentage of total donor country Gross National Income[7]	=	$562 million
• FY 2008 appropriated level for bilateral & multilateral RH/FP assistance	= +	$464 million
Appropriate U.S. contribution to total global expenditures required to meet unmet need for contraceptives in FY 2009—current plus additional funds	**=**	**$1.03 billion**

The $1 billion request, according to FP advocates, is still below the United State's "fair share" of global expenditures necessary to achieve universal access to reproductive health care by the year 2015.

• ICPD target for total global expenditures on population assistance in 2005, adjusted for inflation, 2007[8]	=	$25.2 billion
• Donor country share of inflation-adjusted target—one-third of total funding	=	$8.4 billion
Appropriate U.S. share of ICPD funding target to achieve universal access to reproductive health care by 2015 in FY 2010—based on percentage of total donor country Gross National Income	**=**	**$3.2 billion**

The FP advocacy community is optimistic about the $1 billion budget request. They were successful in FY09 budget negotiations because, according to one interviewee, "the reason why we were successful this year is we did not devote our efforts on policy issues like the Mexico City policy….we concentrated our efforts on funding and did not beat our head on the wall trying to get Mexico City policy overturned. This was a good lesson for us". The interviewee continued, "We feel less constrained on asking for what we need given the outrageous amounts PEPFAR requests" (direct communications).

[4] Unmet need for modern contraception who desire to delay childbearing, space births or desire no more children and not presently using FP.
[5] Calculations are taken from PAI Fact Sheet for $1 billion budget request for international R\H/FP assistance
[6] U.S. Bureau of Labor Statistics inflation calculator—see http://data.bls.gov/cgi-bin/cpicalc.pl
[7] Organization for Economic Co-operation and Development, *Statistical Annex for the 2006 Development Co-operation Report*, table 38, updated January 2007 (see www.oecd.org/dac/stats/dac/dcrannex). U.S. GNI represented 38 percent of total donor country GNI in 2005, the latest available year.
[8] Vlassoff, M. and Bernstein, S., *Resource Requirements for a Basic Package of Sexual and Reproductive Health Care and Population Data in Developing Countries: ICPD Costing Revisited—Summary* (New York: UN Millennium Project, 2006), pp. 1-4. (see http://www.unmillenniumproject.org/documents/Resource_requirements-for-RH-1.pdf)

Appendix H: USAID-Funded Projects in Reproductive Health and Family Planning

Project name	Contract number	Project start date	Anticipated project end date	Project director	Goals and objectives of project
I. Research, Technology, and Utilization Supports biomedical research to increase understanding of contraceptive methods and to develop new fertility regulation technologies and conducts operations research to improve the delivery of family planning and reproductive health services.					
Contraceptive Research and Development (CONRAD III)	HRN-A-00-98-00020-00	1998	2009	Henry Gabelnick, CONRAD	Develop safe, effective, and acceptable methods of FP, HIV prevention, and other RH technologies for use in developing countries
Contraceptive and Reproductive Health Technology Research and Utilization (CRTU)	GPO-A-00-05-00022	2005	2010	Dr. Ward Cates, FHI	• Develop, evaluate, and introduce a range of safe, effective, and acceptable contraceptive and HIV/AIDS prevention technologies • Enhance the capacity of RH/FP programs in developing countries to provide these technologies
Fertility Awareness-Based Methods (FAM) Project	GPO-A-00-07-00003-00	2007	2012	Victoria Jennings, Georgetown IRH	Improve contraceptive choices by expanding access to fertility awareness-based methods
Program Research for Strengthening Services (PROGRESS) Project		2008	2013	Maggwa Baker Ndugga, FHI	• Identify the need for new or improved family planning methods for individuals and communities • Provide increased access to contraceptive services • Strengthen the capabilities of health researchers
Reproductive Health and Research: World Health Organization Umbrella Grant	AAG-G-00-99-00005	2003	2009	Paul Van Look, WHO	Provide support to the World Health Organization's Department of Reproductive Health and Research (RHR) to carry out collaborative activities in RH/FP and safe motherhood
The Population Council: Product Development Agreement	GPO-A-00-04-00019-00	2004	2009	John Townsend/ Naomi Rutenberg, Pop Council	Develop, evaluate, bring to market, and make available to public sector programs new and better products for FP and for the prevention of HIV/AIDS and other STIs

Project name	Contract number	Project start date	Anticipated project end date	Project director	Goals and objectives of project
II. Policy, Evaluation, and Communications Collects and analyzes family planning and other reproductive health information; improves the policy environment for family planning and reproductive health services; and strengthens methodologies for evaluation of family planning and reproductive health programs. Increases the awareness, acceptability, and use of family planning methods and expands and strengthens the managerial and technical skills of family planning and health personnel.					
MEASURE:BUCEN Survey and Census Information, Leadership, and Self-Sufficiency	HRN-P-00-97-00016-00	1997	2008	Kevin Deardorff, US Census Bureau	Strengthen the capability of statistical offices in developing countries to collect, analyze, disseminate, and use data to better understand population structure, demographic trends, and implications for development planning and policy making
MEASURE CDC/DRH	HRN-P-00-97-00014-00	1997	2008	Howie Goldberg, CDC	• Increase understanding of the key RH/FP issues and improve the quality and availability of RH data • Enhance the ability of local organizations to collect, analyze, and disseminate this data
Healthy Families, Healthy Forests: Population-Environment Award of the Global Conservation Program	GPO-A-00-05-00030-00	2005	2008	Janet Edmond, Conservation Int'l	• Facilitate delivery of RH/FP services in areas where high population growth threatens biodiversity or natural resources • Build networks of community health workers to promote links between family health and natural resources
Health Policy Initiative (HPI) IQC (PDI) IQC Task Orders: HPI Task Order 1, USAID Regional Development Mission /Asia, Peru, South Africa	Multiple	2005	2010	IQC holders: Abt Assoc., Chemonics, Futures Group, and RTI	• Exercise global leadership and provide field-level programming in health policy development and implementation • Improve the enabling environment for health, especially HIV/AIDS and maternal health
Communication for Change (C-Change)	GPO-A-00-07-0004-00	2007	2012	Susan Zimicki, AED	Improve the effectiveness and sustainability of behavior change and social change communication as an integral part of development efforts in health, environment, and civil society
Information and Knowledge for Optimal Health (INFO)	GPH-A-00-02-00003	2002	2008	Earle Lawrence, JHUCCP	Provide RH/FP information, IT services, and best practices for health
Bringing Information to Decisionmakers for Global Effectiveness (BRIDGE)	GPO-A-00-03-00004	2003	2010	Jay Gribble, PRB	Support policy reform efforts by providing influential audiences up-to-date information on key population and health topics
Successful Communities from Ridge to Reef: Population-Environment Associate Award of the Global Conservation Program	GPO-A-00-03-00008	2003	2008	July Oglethorpe, World Wildlife Fund	• Facilitate delivery of RH/FP services in areas where high population growth threatens biodiversity or natural resources • Address population-based threats to biodiversity while capitalizing on synergies achieved by combining RH/FP activities with conservation/natural resource management activities

Project name	Contract number	Project start date	Anticipated project end date	Project director	Goals and objectives of project
III. Commodities Security and Logistics Supports a program to strengthen public health supply chains for pharmaceuticals, diagnostics, and other essential health supplies; coordinates with international partners, collaborators, and stakeholders to improve long-term availability of essential public health supplies; and operates a centralized system to process, manage, and deliver contraceptives, condoms, and other essential supplies to Mission-supported programs. Learn more about best practices in achieving RH/FP goals for the Europe and Eurasia region and the role of the private sector in meeting these goals.					
DELIVER	GPO-I-01-06-00007	2006	2011	Edward Wilson, JSI	• Design, develop, and strengthen supply systems that provide essential health commodities • Improve availability of essential health supplies
Central Contraceptive Procurement	Multiple	2010	2012	Varies by year	• Provide an efficient mechanism for consolidated USAID purchases of contraceptives • Provide a mechanism for independent testing of USAID-purchased contraceptives
IV. Service Delivery Improvement Increases availability and quality of family planning and related reproductive health services through strengthening government programs, local private voluntary organizations, for-profit organizations, and commercial channels.					
Private Sector Partnerships-One (PSP-One)	GPO-I-01-04-00007	2004	2009	Ruth Berg, Abt Associates	Support, expand, and improve private sector service delivery in RH/FP and other priority health areas
Private Sector Program (PSP) IQC Task Orders: PSP-One (global), Banking on Health (global), PSP Jordan, PSP Zimbabwe, PSP Ethiopia/PC4, PSP Tanzania/T-MARC, Point-of-use Water Disinfection and Zinc Treatment (POUZN) (global), ITAP/India, COMPRI-A/Afghanistan, N-MARC/Nepal, MBP (India)	Multiple	2004	2009	IQC holders: Abt Associates Inc., AED, Chemonics, Constella Futures, John Snow, Inc., URC	Promote private and commercial sector strategies to expand access to quality RH/FP products and services in developing countries
CARE RH Trust Fund	HRN-A-00-99-00009-00	1999	2007	Mona Byrkit, CARE	• Promote technical excellence in key areas of RH • Promote a scale-up of best practices towards sustainability of quality interventions • Build CARE's capacity to address the underlying causes of poor RH

Project name	Contract number	Project start date	Anticipated project end date	Project director	Goals and objectives of project
Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND)	GPO-A-00-08-00007-00	2008	2013	TBD, Engender-Health	• Advocate for supportive policies and increased resources for FP services, specifically long-acting and permanent methods • Improve the quality and availability of RH/FP services • Strengthen the supply of FP and the demand for services
The Capacity Project	GPO-A-00-04-00026-00	2004	2009	Anne Wilson, IntraHealth	Strengthen the human resources needed to implement quality health programs in reproductive health, HIV/AIDS, child survival, maternal health, and infectious disease (ID) programs
Addressing Unmet Need for Family Planning in Maternal, Neonatal, and Child Health Programs (ACCESS-FP)	GPO-A-00-05-00025-00	2005	2010	Catharine McKaig, JHPIEGO	Reduce unmet need for FP among postpartum women by strengthening maternal, neonatal, and child health service delivery programs
Leadership, Management and Sustainability (LMS)	GPO-A-00-05-00024-00	2005	2010	Joseph Dwyer, MSH	Improve sustainable service delivery results in the areas of RH, HIV/AIDS, infectious disease, and maternal and child health programs in leadership, management, and organizational capacity development
Grant Solicitation Management (GSM)	GPO-A-00-04-00021-00	2004	2009	Randy Willard, World Learning for Int'l Dev.	Channel USAID funds to an individual grant or grants program targeting PVOs/NGOs and their partners
Extending Service Delivery (ESD) for Reproductive Health and Family Planning	GPO-A-00-05-00027-00	2005	2010	Milka Dinev	Increase utilization of community-level RH/FP services by poor, at-risk, and other underserved groups
Banking On Health	GPO-I-02-04-00007 Order No. 2	2004	2009	Meaghan Smith, Banyan Global	Improve the ability of private sector health care providers to access commercial loans, thereby improving their sustainability and capacity to delivery high-quality RH/FP services

For more information, please see http://www.usaid.gov/our_work/global_health/pdf/phnug-prh.pdf.