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PRINCIPLES FOR CO-FINANCING OF FAMILY PLANNING COMMODITIES

USAID
FROM THE AMERICAN PEOPLE

HP+
HEALTH POLICY PLUS

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Abbreviations

GDP	gross domestic product
GNI	gross national income
HP+	Health Policy Plus
LMICs	low- and middle-income countries
MOU	memorandum of understanding
RHSC	Reproductive Health Supplies Coalition
SEMA	Shaping Equitable Market Access
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VII	Vaccine Independence Initiative

Executive Summary

Family planning is among the most cost-effective development investments. Yet a significant portion of its funding comes from non-domestic resources, which are expected to decline in coming years. To meet increasing demand for family planning commodities and services—along with national and global commitments to family planning—new sources of domestic financing are needed to improve the sustainability of family planning programs in low- and middle-income countries. **Co-financing**, a resource mobilization approach, is an agreement between a national government and a donor under which government increases its share of financing a health program over a period of time to ultimately assume full financing responsibilities. Co-financing has been an effective tool to assist a country's transition away from its dependence on donors to pay for health interventions. An emerging issue—based on frameworks being developed by major family planning partners, such as the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA)—is how co-financing might be used to help procure family planning commodities.

This document proposes a set of guiding principles for developing a policy on co-financing of family planning commodities by USAID's Office of Population and Reproductive Health. The report comprises these six sections:

1. Introduction: The Need for Co-financing. Sets the context and lays out the rationale for co-financing of family planning commodities and how such a policy may be a logical next step to USAID's 2006 strategy on family planning graduation. The subsequent sections describe a stepwise process used to develop these guiding principles.

2. Assessing Current Co-financing Approaches. Describes the analytical process for reviewing existing co-financing approaches from health and non-health sectors and the reasons for selecting the Gavi model (used for co-financing new and under-used vaccines) for in-depth study and analysis. The proposed approach of the UNFPA Supplies Partnership to domestic financing of reproductive health and family planning commodities was also considered for further analysis but was of limited use in this exercise because it could not be assessed retrospectively.

3. Analyzing the Gavi Co-financing Approach to Inform Family Planning Co-financing Guidelines. Details the analysis conducted using quantitative and qualitative data available from reports to Gavi on co-financing, specific by country. Based on a review of Gavi Annual Progress Reports from 74 co-financed countries, three common issues in co-financing were identified: (1) default, meaning a country fails to pay its full co-financing obligation before the end of the calendar year; (2) late payment, a designation used until a country has successfully paid all its arrears; and (3) possible displacement of domestic financing by external financing within a country's traditional vaccination program, which typically includes vaccines not introduced under the Gavi co-financing agreement.

- The analysis found that a lack of coordination between the ministries of health and finance and a country's lack of ability to pay were the two primary reasons for late payment and default.
- Multiple regression analyses with co-financing data from 64 FP2030 countries that received Gavi support between 2008–2019 revealed that the odds of late payment and of

default *decreased* with increasing government effectiveness (likely reflecting better coordination within the government). Rising inflation and debt service (likely reflecting worsening macroeconomic conditions) *increased* the odds of late payment.

- Country case studies from Angola, Madagascar, and Nigeria highlighted that limited health budgets and sharply escalating co-financing shares often created challenges for national governments to meet Gavi obligations while still funding their traditional vaccination programs. In some cases, these two obligations may have contributed to the country becoming a defaulter or a late payer. In other cases, there was the possibility that some public financing was displaced by donor financing in traditional vaccination programs.

4. Why These Findings Matter: Policy Implications for Co-financing of Family Planning Commodities. Draws the major lessons from the analysis and shapes them into three major policy issues that must be addressed when developing USAID's co-financing policy.

- First, effective engagement of both the ministries of health and finance is critical to the co-financing process. Involving the finance ministry is extremely important since the Ministry of Health cannot commit to multiyear budget appropriations without Ministry of Finance approval. Further, the Ministry of Finance has a better understanding of the budget pressures from other sectors that also have co-financing agreements with donors who are concerned about transition. This lesson also argues for the establishment of a third-party payer system—in line with UNICEF's Vaccine Independence Initiative. A third-party payer can make advance payments to procure commodities on behalf of contracted governments and then governments repay within a defined timeframe. While no similar arrangement currently exists in the family planning space, there may be opportunities to initiate discussions with the Reproductive Health Supplies Coalition or the Shaping Equitable Market Access for Reproductive Health partnership.
- Second, when determining co-financing shares and the rates of increase for governments, it is important to avoid the World Bank's income-based country classification as a sole determinant. Rather, USAID could use the country's average gross national income (GNI) per capita over several years along with programmatic indicators and appropriate flexibility to adjust for evolving macroeconomic changes to judge a country's ability to pay. Alternatively, USAID could also consider using sovereign credit ratings as a more comprehensive measure of a country's capacity to honor the co-financing agreements.
- Third, co-financing of family planning commodities must align with political, ethical, and public health sensitivities that are distinctly different for a family planning program compared to a childhood vaccination program in low- and low-middle-income countries. For example, there might be limited political will of governments to replace donor-funded family planning programs. Additionally, countries' procurement and supply chain management systems for family planning commodities may be inadequate.

5. Insights from the UNFPA Supplies Partnership Approach to Domestic Financing. Briefly draws upon the key principles underpinning UNFPA's new approach to domestic financing and provides an overview of program features, such as the 2022 introduction of a matching fund and a domestic financing requirement from 2023 onward.

6. Guiding Principles for Co-financing of Family Planning Commodities. Presents two sets of guiding principles for developing USAID's co-financing policy: one set to be used for shaping the USAID country co-financing agreements and a second set to guide USAID's comportment as a major donor.

Key Attributes for Shaping a Successful Co-financing Arrangement between USAID and National Governments

1. USAID, through its country missions, should actively engage with both health and finance ministries as well as civil society at an early stage with the intent of jointly drafting the co-financing mechanism. Such approach fosters a potential for real country ownership and puts in place more symmetric power relations. If using a templated agreement (with pre-decided terms and conditions), USAID should remain flexible to address country-specific concerns. USAID should:

- Work jointly to identify potential challenges, like misalignment of fiscal years, and develop mitigation strategies.
- Require both the ministries of finance and health to serve as co-signatories to the co-financing agreement. Involving the finance ministry is critical, as the health ministry has limited authority on multiyear budget appropriations. Further, the finance ministry has a better understanding of the budget pressures from other sectors that also have co-financing agreements with donors who are concerned about transition.
- Require establishment of a dedicated co-financing account/budget line within the Ministry of Finance and a timeline for payments.

2. USAID should carefully consider a country's macroeconomic context while shaping the co-financing agreement. USAID should:

- Judiciously choose the criteria to determine a country's co-financing category—options include using GNI per capita (averaged over several years) along with programmatic indicators; sovereign credit ratings that reflect a country's capacity to honor the co-financing agreements; or the UNFPA Supplies Partnership economic index that includes GNI per capita Atlas method, gross domestic product growth, and World Bank income classification.
- Allow up to 10 years to facilitate a strategic transition to self-financing and flexibility in revisiting the arrangement (including annual co-financing amounts, rate of increase, and time to transition) to address effects of any evolving macroeconomic environment.
- Require country governments to appoint appropriate focal points to monitor and communicate emerging issues and work with counterparts to prevent late payment and default.

3. USAID should ensure that co-financing stimulates additional government spending in the health sector and in family planning programs. For example:

- Include a clause in the agreement to ensure commitment for increased spending to satisfy the co-financing share and a process for monitoring compliance during annual progress reviews or appraisals.

4. USAID should consider a set of strategic incentives for countries that comply with their commitment to transition. For example:

- Provide countries with long-term access to quality-assured and best-valued family planning commodities after transition, along with technical support for a conceivable period to strengthen the national family planning program.

Guiding Principles for USAID, as a Major Donor in Family Planning, to Advance a Stronger Enabling Environment for Co-financing

1. Engage with other donors as possible to synchronize a common co-financing framework and optimally develop coordinated—or multipartite—agreements to provide a common roadmap toward family planning financial self-reliance. Donor coordination will also facilitate better understanding of the combined effect of several competing co-financing policies (like those for vaccination, HIV, and family planning) on the national budget space.

2. Create an independent third-party payer, like UNICEF's Vaccine Independence Initiative, which can make advance payments to procure family planning commodities on behalf of contracted governments. Consider working on this type of initiative through a global platform such as the Reproductive Health Supplies Coalition or the Shaping Equitable Market Access for Reproductive Health partnership.

3. Make co-financing of family planning commodities an integral component of donor-supported efforts in health system strengthening and health financing reforms.

1. Introduction: The Need for Co-financing

Family planning is among the most cost-effective development investments, with cascading benefits across sectors of health, social welfare, and the economy. For every dollar invested in reducing the unmet need for contraception, countries may potentially save US$2.50 expended on maternal and newborn care and realize a long-term gain of US$120 in "accrued annual benefits," most of it because of consequent economic growth (Sundaram et al., 2019; Copenhagen Consensus, n.d.; FP2020, n.d.). However, 48 percent of family planning funding in the 69 priority countries of the FP2020 initiative—mostly in sub-Saharan Africa—came from development partners during 2018 (FP2020, 2021). Total non-domestic funding for family planning has plateaued over recent years and is expected to decline in the near term (ibid).

To meet the increasing demand for family planning commodities and to meet FP2030 commitments, countries need more domestic financing to improve program sustainability. This is particularly important to avoid increased private out-of-pocket expenditure for families to access family planning services and to buy family planning commodities. In 2019, private out-of-pocket expenditure on family planning commodities was estimated to be US$2.73 billion across 132 low- and middle-income countries (LMICs). In both low-income and in lower-middle-income countries, 90 percent of the private out-of-pocket expenditure on family planning commodities was spent on contraceptive pills, condoms, and injectables (Weinberger et al., 2021).

Co-financing is a resource mobilization approach to structure and plan for a country's gradual transition to domestic financing. It is an agreement between a national government and a donor to jointly fund aspects of a program, often with a transition structure for the national government to take on increasing responsibility for the total cost. Even modest co-financing can help build national ownership and program visibility (Saxenian et al., 2011). Development partners, such as the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA), are developing co-financing frameworks to increase domestic buy-in for family planning commodities.

1.1 USAID Family Planning Graduation Policy (2006)

After financing family planning programs across the world for over 40 years, USAID recognized the need to be strategic in focusing its financing on countries with the greatest unmet need for family planning. This decision contributed to the adoption of its family planning graduation policy in 2006, which is currently being updated. To date, USAID has supported 24 countries in successfully transitioning to fully self-finance their reproductive health and family planning programs and at least 10 of those countries have graduated, according to the 2006 policy (Bertrand, 2011; USAID, 2020). USAID's strategy has employed a systematic phase-out approach over a timeframe of two to six years, but allows for up to 10 years (Carr and Rosen, unpublished). Triggers for graduation are based on pre-determined criteria and program indicators (see **Box 1**).

Box 1. USAID Triggers for Family Planning Graduation

1. Total fertility rate is 3.4 children or less per woman of reproductive age.
2. Modern contraceptive prevalence rate (mCPR) is 48 percent or above among married women of reproductive age.
3. At least 70 percent of the population can access at least three family planning methods within a reasonable distance (may be farther than 5 kilometers for long-term and permanent methods).
4. No more than 30 percent of family planning products, services, and programs offered in the public and private sectors are subsidized by USAID.
5. Major service providers (public sector, nongovernmental organizations, and the private commercial sector) generally meet standards on quality of care and informed choice.

Note: Achievement of the first two indicators is necessary to trigger an assessment of other indicators for graduation. When a family planning program meets at least four of the five criteria, it is considered for transition to self-financing within two to six years.

Sources: Bertrand, 2011; Carr and Rosen, unpublished; Chaudhry et al., 2012

Table 1. Best Practices and Success Factors for Family Planning Commodity Transitions

Designing the transition	• Transition planning should start early with care taken on when and how to introduce co-financing requirements. • Sufficient time to plan and prepare for programmatic and financial transition is critical. • The timing and pacing of transition should be predictable for governments. • Co-designing a transition plan with the country enhances the likelihood of success. • Donors need to consider the "convergence" of transitions across health areas. • A successful scheme should be mandatory and set clear and measurable requirements. • Conditions should be realistic. • A transition scheme should favor all commodities equally, consider equity issues, address the realities of decentralization, and allow tailoring to country conditions.
Addressing the interests of governments and other stakeholders	• Advocacy and policy dialogue are critical. • Coordination with key stakeholders can enhance transitions and post-transition success. • The transition scheme needs to be feasible, given organizational structures and priorities.
Managing the transition	• Clear, consistent communication with stakeholders increases the likelihood of success. • Costs relative to potential gains need to be balanced. • Country commitments need to be monitored and enforced. • Donors must commit the requisite resources to "accompany" countries through the transition.
Providing technical support after transition	• Continued post-transition support may be especially helpful in procurement.

Source: Carr and Rosen, unpublished

A comparative review of the USAID strategy identified several best practices: the existence of "pre-determined financial and technical benchmarks" that facilitated successful graduation; contraceptive security ensured by gradually phasing out contraceptive donations prior to graduation; and political support to ensure sustainability of the family planning program after graduation (Shen et al., 2015). A 2018 Health Policy Plus (HP+) project report on family planning commodity transitions noted four key success factors: (1) transition design, (2) addressing the interests of governments and other stakeholders, (3) managing the transition, and (4) providing support following the transition (Carr and Rosen, unpublished). A summary of the best practices for each of these success factors for family planning commodity transition is presented in **Table 1**.

A USAID co-financing framework could support this strategic transition by explicitly laying out the blueprint to replace donor financing with domestic government financing of the family planning program.

1.2 Purpose of the Report

This report is designed to provide analytic support to USAID's Office of Population and Reproductive Health on how it might move forward with developing a co-financing approach that supports a strategic transition to domestic government financing of the family planning program.

The following sections provide a step-by-step description on how this report was developed. Section 2 focuses on the basis for selecting the Gavi immunization co-financing model and UNFPA Supplies Partnership's proposed approach to domestic financing of reproductive health and family planning commodities. Section 3 details the quantitative findings and country case studies based on Gavi data. Section 4 translates these findings into three major policy issues that USAID should address when shaping its co-financing policy. Section 5 presents the most recent updates from the UNFPA Supplies Partnership's new approach to domestic financing. Section 6 builds on this evidence and proposes guiding principles for developing the policy.

2. Assessing Current Co-financing Approaches

A number of current co-financing approaches from health and other sectors were reviewed. These included the Gavi co-financing approach for new and under-used vaccines; the Global Fund's model for HIV, tuberculosis, and malaria; the Nigeria state memoranda of understanding for primary healthcare and routine immunization (Bill & Melinda Gates Foundation and Dangote Foundation); the Ouagadougou Partnership for family planning commodities; the Challenge Initiative for Urban Reproductive Health (Bill & Melinda Gates Foundation and Johns Hopkins University); Medicaid (U.S. Government); and the Global Partnership for Education multiplier model. The UNFPA Supplies Partnership's approach to domestic financing was also reviewed. These co-financing approaches were assessed against the following criteria:

1. **Term to ownership**: The length of time accorded to participating countries from initial signing of the agreement to fully transitioning to self-financing. The sub-criteria for assessment included spelled-out conditions by which the recipient annually increased its co-financing share and the length of the transition pathway.

2. **Ability to pay**: The extent to which the funder considered a country's economic and fiscal situation when determining co-financing amounts. The sub-criteria for assessment included evaluating if previous health expenditures (only for co-financing health programs) and/or gross national income (GNI) per capita was used in this determination, or if a system of fixed annual increase of co-financing share was applied.
3. **Motivation to pay**: The degree to which the contractual agreement motivated the recipient to make timely and full payment of its co-financing share through established compliance measures. The sub-criteria for assessment included reviewing if the agreement required the recipient to spend funds before the donor co-financing share was released and reviewing compliance measures that would incentivize prompt and full payment.
4. **Administrative burden**: The amount of administrative burden (human, financial, and material resources) imposed on the country to provide necessary management and oversight. The sub-criteria for assessment included understanding the process through which the co-financing share was determined, existence of an oversight body to monitor receipt of payments made by the country, and the extent of coordination required with stakeholders regarding compliance measures.

Table 2 summarizes the results from this assessment, which were validated through a key stakeholder meeting that involved the USAID Commodity Supply & Logistics Division and UNFPA. It was decided not to select an approach where the "term to ownership" was not clearly defined (i.e., a score of "none" in the table) and to give priority to approaches that scored higher in the ability to pay and motivation to pay criteria.

Based on this assessment and stakeholder validation, **the Gavi model was selected** for in-depth study and analyses. The **proposed UNFPA model (under development) was also selected,** but because it could not be assessed retrospectively, it did not directly serve the purpose of the analysis. Both the Gavi and UNFPA (proposed) approaches allowed for a "long" time to ownership because the annual increase in recipient's co-financing share was graded and linked to fiscal and economic factors, allowing for a gradual transition.

The Gavi approach scored "moderate" on the ability to pay criteria as it used only GNI per capita to determine the co-financing shares and lacked a systematic process for allowing concessions based on the fiscal space for health, though exceptions were made for some recipients. In contrast, the proposed UNFPA model scored "high" on the ability to pay criterion because it intends to determine a recipient's co-financing shares based on GNI per capita and previous government health expenditure.

Both approaches ensured that spending by the recipient country was required before activation of the funder's contribution, with different ramifications for defaulters and late payers—therefore giving both a "high" score on the motivation to pay criteria. Further, both approaches allowed for a "high" administrative burden, requiring annual assessments to determine co-financing shares, creation of an oversight body to monitor receipt of recipient payments, mandatory coordination with stakeholders on repayment plans, considerations of waivers, etc.

Table 2. Assessment of Select Co-financing Approaches

Co-financing Approaches	Criteria for Assessment			
	Term to Ownership*	Ability to Pay**	Motivation to Pay**	Administrative Burden
UNFPA (under development)	Long	High	High	High
Gavi, the Vaccine Alliance	Long	Moderate	High	High
Global Fund	Long	Low	Low	Moderate
The Challenge Initiative	Short	Low	Low	Low
Nigeria State Memoranda of Understanding	Short	Low	Moderate	Moderate
Ouagadougou Partnership	None	High	High	Moderate
Global Partnership for Education Multiplier	None	High	Low	Low
U.S. Government, Medicaid	None	High	High	Moderate

* Those with "none" would not be selected for analysis.

** Most important selection criteria overall.

Explanation of selection criteria:

1. Term to ownership:
   a) Long = Recipient countries required to annually increase their share as a function of economic factors so that it would take a long time for countries to become fully self-financing.
   b) Short = Recipient countries must become fully self-financing within a standard, fixed timeframe.
2. Ability to pay:
   a) High = Donor considered both GNI per capita and fiscal space in determining share.
   b) Moderate = Donor considered only GNI per capita in determining share.
   c) Low = Country's income category influenced the specific interventions it must prioritize, but not the size of its co-financing share.
3. Motivation to pay:
   a) High = Donor requires spending to occur before co-financing share is released; there are ramifications for defaulters and late payers.
   b) Moderate = Limited compliance measures from donor.
   c) Low = No compliance measures.
4. Administrative burden:
   a) High = Maximum administrative burden to estimate co-financing shares annually based on data, an oversight body to monitor and verify receipt of recipient payments, and coordination with stakeholders to ensure adherence to compliance measures.
   b) Moderate = Limited oversight and no standard enforcement measures.
   c) Low = Minimal administrative burden with no oversight or compliance measures.

While co-financing arrangements under the Ouagadougou Partnership, Global Partnership for Education Multiplier, and Medicaid (U.S.) did not meet the selection criteria due to the absence of a clearly defined "term to ownership," they presented some important lessons on ensuring that the recipient has a high ability and a high motivation to pay. Their matching fund arrangements accorded a recipient full autonomy to allocate within its macro constraints (thereby ensuring a high ability to pay), while Medicaid additionally calculated matching rates based on the individual state's per capita income. The Ouagadougou Partnership ensured a recipient's high motivation to pay by designing the matching fund based on retrospective increases in domestic spending and verifying that at the end of each fiscal year. Medicaid achieved the same objective by using quarterly state-level projections to activate the federal match, reconciling these projections with actual spending at the end of the quarter.

3. Analyzing the Gavi Approach to Inform Family Planning Co-financing Guidelines

3.1 An Overview of the Gavi Co-financing Approach

Since 2008, Gavi has required that countries cover a share of the cost of new and under-used vaccines introduced with Gavi support—the policy having evolved since it was launched. The current version (2.0), adopted in 2016, bases country eligibility on GNI per capita being less than US$1,500 in 2011 and assigns recipient countries into three categories:

- Initial (typically low-income countries)
- Phase 1 ("preparatory transition" countries)
- Phase 2 ("accelerated transition" countries)

Initial countries are eligible to apply for new vaccine and health system support and are required to pay US$0.20 per dose for vaccines, with no annual increase. Once GNI per capita has increased above the threshold for more than two years, a country moves into the phase 1 category and participates in the co-financing mechanism. For countries in phase 1 and phase 2, the domestic co-financing share typically increases by 15 percent per year and Gavi actively reduces its financing support, usually over five years (Carr and Rosen, unpublished; Gavi, 2016). At the end of the transition period, countries are expected to be funding their own new and under-used vaccines.

If a country fails to meet its co-financing requirement, it is classified as either a defaulter or a late payer, as explained in **Box 2**. Defaulting and late-paying countries may experience additional budgetary stress as they try to repay the previous years' arrears and the current-year obligation, which can more than double what they had owed in the previous year (Gavi, 2016). It is notable that while Gavi has the authority to suspend funding to countries that become defaulters and late payers, in practice it sends strongly worded letters to the Ministry of Health for years, threatening to suspend funding, without actually doing it (Gavi, 2019).

Box 2. Gavi's Definition of Defaulters and Late Payers

Default: Country failed to pay its full co-financing obligation before the end of the calendar year.

- If in default for more than a year, the country faces suspension of the relevant vaccine until all arrears are paid, barring an exception from the Gavi board of directors.
- Countries in default must agree to a repayment plan to pay the previous year's arrears in tranches over a set period of time alongside the current year obligation.
- To come out of default, countries must pay the current year co-financing dues along with the first tranche of arrears payments.

Late payer: A country is designated as a late payer until it has successfully paid all its arrears.

3.2 Methodology

Gavi annual progress reports from 74 co-financing countries were reviewed, and three common issues in co-financing were identified: **(1) late payment, (2) default, and (3) possible displacement of domestic financing by external financing for the traditional vaccination program** (i.e., for the vaccines that were not introduced under the Gavi co-financing agreement) (Dieleman and Hanlon, 2013). To better understand each of these three issues, two simultaneous analytical approaches were adopted.

A quantitative analysis was conducted using co-financing data from 64 FP2030 countries that received Gavi support between 2008 and 2019 (Gavi, 2019).[1] Separate panel regression models were developed to identify the effects of a range of 35 potential predictors (such as indicators related to governance, financing, macroeconomic conditions, health, and population) on late payment, default, and displacement.[2] Late payers and defaulters were identified by country, year, and reason described in the Gavi annual progress report. Four measures of displacement were tested: (1) government expenditure on immunization, (2) government health expenditure, (3) percent change in government health expenditure, and (4) government priority on health (ratio of government health expenditure to general government expenditure) (Kutzin et al., 2016).

In addition, Angola, Madagascar, and Nigeria were selected for case studies because these countries were under co-financing arrangements with Gavi and were recipients of USAID family planning commodity support in fiscal year 2020 (USAID, 2020). For each country, the case study: (1) assessed possible displacement of government financing with donor financing in the traditional vaccination program (*which was typically financed by the government and various donors, including Gavi, but there was no link between this financing and the Gavi co-financing*), (2) identified if the country became a late-payer and or defaulter in its co-financing payments, and (3) contextualized this with respect to the level of government health expenditure. Displacement was measured by computing the overall and line-item costs associated with procurement of traditional vaccines and cold chain equipment, paying

[1] Originally 69 FP2030 countries were considered, however, Iraq, Palestine, the Philippines, and Western Sahara were excluded as they did not receive Gavi support between 2008 and 2019; Gavi co-financing data was not available for North Korea.
[2] Exclusive of squared, logged, and interaction terms.

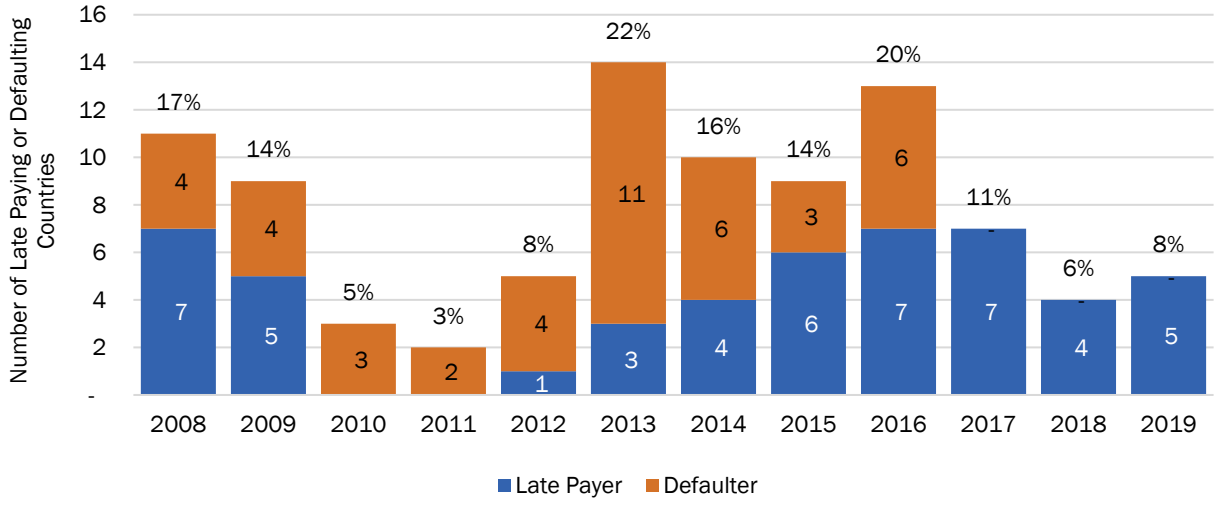
personnel, and other operational costs (e.g., injection supplies, routine recurrent costs such as for transportation and monitoring, capital costs, and campaign costs), and one-time costs such as outreach for measles or polio vaccination campaigns.[3] For the three countries, Gavi annual progress reports were only available from 2010–2014 (Gavi, n.d., a–c).

3.3 Key Findings

3.3.1 Late Payment and Default

The quantitative analysis of co-financing data from 64 priority countries for FP2020 showed a wide variation in the number of defaulters and late payers over the period of assessment (2008–2019). The proportion of late payers ranged between 2 percent and 11 percent, while defaulters ranged between 3 percent and 17 percent. As shown in **Figure 1**, there were no late payers in 2010 and 2011 and no defaulters in 2017, 2018, or 2019.

Figure. 1 Frequency of Late Payment and Default among 64 FP2020 Priority Countries, 2008–2019



Note: The percentages at the top of the bars represent the proportion of countries defaulting and paying late that year among the 64 FP2020 priority countries.

Lack of coordination between the Ministry of Health and the Ministry of Finance was the primary reason cited in annual progress reports for late payment (nearly half of the cases) and default (40 percent of instances). Lack of coordination can result in challenges with disbursement of funds for procurement, payment schedules misaligned with the financial year, etc. They are referred to here as "Ministry of Finance-related issues." A lack of ability to pay was documented as the reason for one-fifth of the countries paying late, and for nearly one-tenth of those in default. Both these issues are discussed in further detail in Section 4. For almost a third of the late payments and over half of the default instances, there were no reasons documented.

[3] Traditional vaccines included BCG, DPT, OPV (or IPV), measles first dose (or the combined measles and rubella [MR], measles, mumps, and rubella [MMR]), and tetanus toxoid (TT) vaccines. Hepatitis B and Haemophilus influenzae type B (Hib) vaccines were also included only if these had been introduced without Gavi support.

The multiple regression analysis identified statistically significant predictors for late payment and default, after controlling for other variables in the model (like GNI per capita). The adjusted odds ratios are presented in **Table 3**. The odds of both late payment and default decreased with increasing government effectiveness, likely suggesting that better coordination between the ministries of health and finance may be key to ensuring payment compliance.[4] Increasing inflation and debt service—two factors that negatively affected the macroeconomic condition—increased the odds of late payment.[5] No other significant factors related to policy were identified as associated with default or late payment status.

Table 3. Predictors of Late Payment and Default

Significant Predictors*	Adjusted Odds Ratio (90% Confidence Interval)	
	Late Payment	Default
Government Effectiveness	0.1 (0.01–0.92)	0.03 (0.001–0.78)
Inflation	1.06 (1.0003–1.13)	Not significant
Debt Service	2.61 (1.27–5.36)	Not significant

* Only predictors that were statistically significant ($p<0.10$) are retained in the model.

Interpretation: For every 1 point increase in the government effectiveness index score, the odds of late co-financing payment decreased by 90 percent (90 percent confidence interval: 8–99 percent), and default decreased by 97 percent (22–99.9 percent). For every 1 point of increased inflation, there was a 6 percent (0.03–13 percent) increase in the odds of late co-financing payment. For every 1 point increase in debt service, the odds of late co-financing payment increased by 161 percent (27–436 percent). It is urged to exercise judgement while interpreting these results.

3.3.2 Displacement of Government Financing in Traditional Vaccination Programs

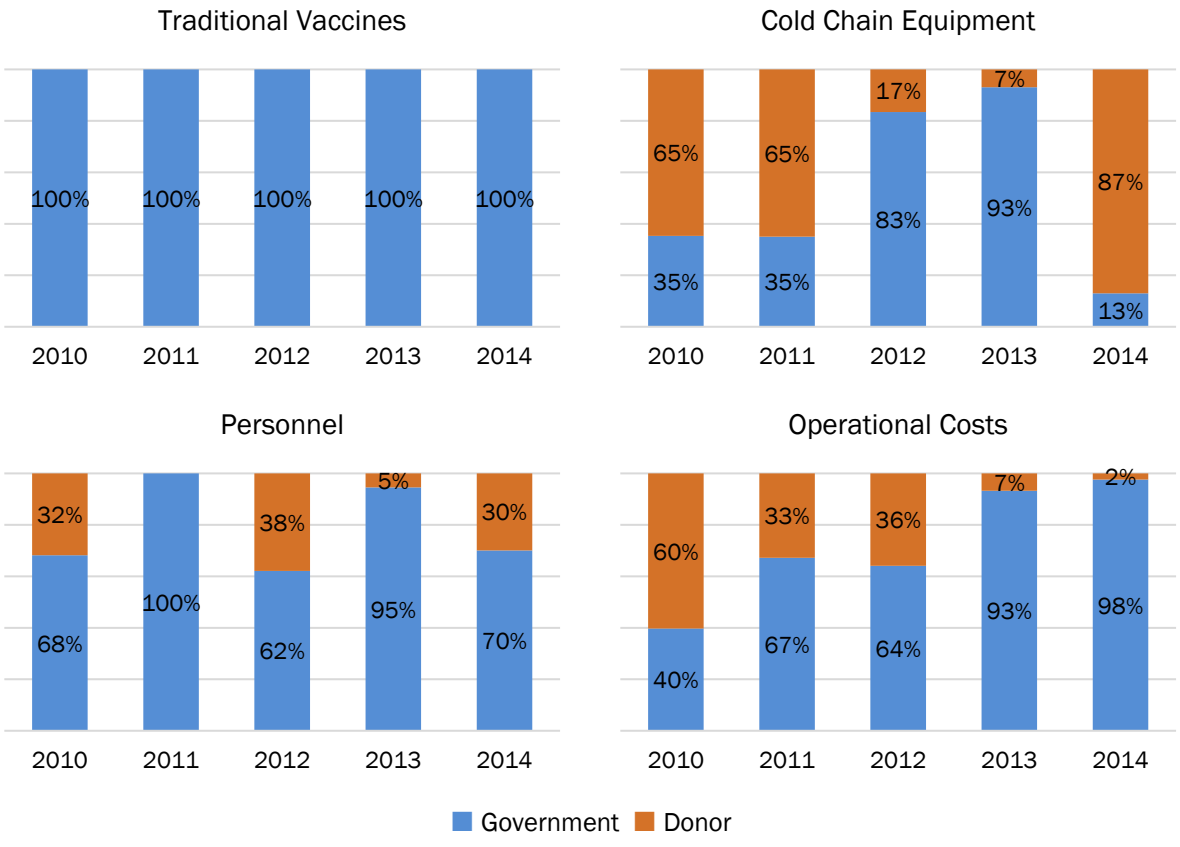
Gavi only co-finances new and under-utilized vaccines, which excludes cheaper, traditional vaccines. Gavi does not impose financial conditions related to traditional vaccine procurement and operational costs,[6] meaning that countries are on their own to obtain these vaccines outside of Gavi co-financing support. The regression analysis did not provide meaningful insight into the nuanced association between co-financing and displacement. This was likely due to the three outcome variables that were considered to understand displacement, namely: (1) government health expenditure (the absolute amount of spending and its annual percentage change), (2) the ratio of government health expenditure to general government expenditure (a marker for the government's priority on health), and (3) government expenditure on vaccination. In relation to government health expenditure, the data did not show any evidence of either displacement or of increased vaccine financing due to co-financing. A possible reason for this is that co-financing

[4] Government effectiveness is a composite World Bank governance indicator that captures the perception of the quality of public services, the quality of civil service and the degree of its independence from political pressure, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies (Kaufmann et al., 2010).
[5] Debt is the sum of principal repayments and interest paid in currency, goods, or services on long-term debt, interest paid on short-term debt, and repayments to the International Monetary Fund (World Bank, 2019). Debt service is a measure of debt as a proportion of GNI.
[6] Procurement and operational costs include the cost of injection supplies, routine recurrent costs such as for transportation and monitoring, capital costs, and campaigns costs.

amounts are extremely small relative to government health expenditure and, hence, statistically significant results were unlikely. The country case studies from Angola, Madagascar, and Nigeria (Gavi, n.d., a–c) provided an in-depth understanding of how countries managed to finance their traditional vaccination programs while also complying (or failing to comply) with their co-financing dues.

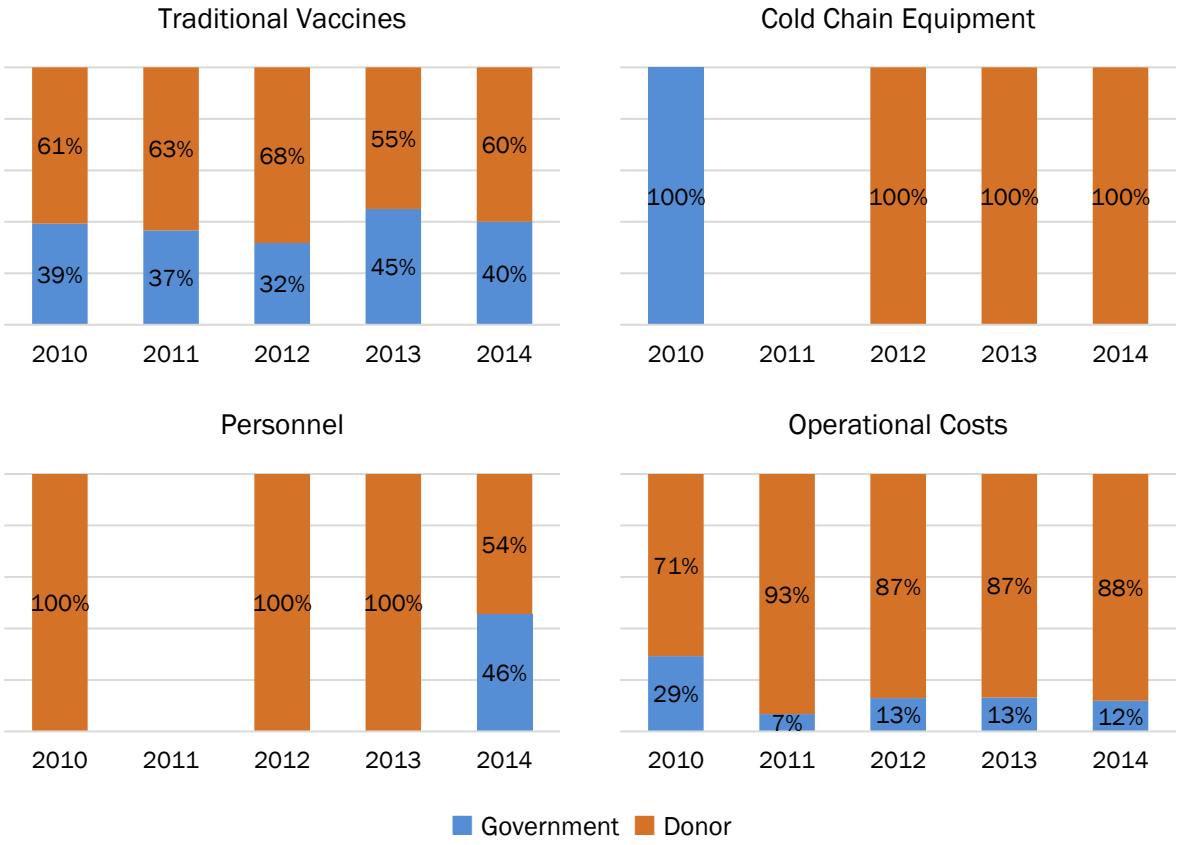
Angola: The overall share of government financing for Angola's traditional vaccination program increased consistently, from 45 percent of total expenditure in 2010 to 97 percent in 2014 (no displacement). **Figure 2** (line-item breakdown) shows that the government covered 100 percent of vaccine costs over these five years, while steadily increasing its contribution for cold chain equipment (2010–2013) and operational costs (2010–2014). Angola's co-financing share increased more than four-fold from 2012 to 2015, leading the country to default in 2013, and to be a late payer in 2014, 2015, and 2017. Gavi reports often cited Ministry of Finance-related issues and the possibility of reduced ability to pay due to a financial crisis resulting from a drop in oil prices in 2015–2016. The oil price reduction seemed quite likely a reason for the country's inability to pay as government health expenditure declined from 1.7 percent of gross domestic product (GDP) in 2013 to 1.2–1.3 percent over the next four years (2014–2017)—indicating a narrowing fiscal space for health. **Thus, while the government increasingly funded its traditional vaccination program, constraints on the public health budget and rising co-financing shares might have contributed to the country becoming a defaulter and late payer to Gavi.**

Figure 2. Trends in Line-Item Financing—Traditional Vaccination Program, Angola (2010–2014)



Madagascar: The overall share of government financing for the traditional vaccination program steadily declined, from 33 percent of the total expenditure in 2010 to 20 percent or less during 2012–2014**. Figure 3** shows displacement in at least two line-items—cold chain equipment and operational costs, as government funding was replaced by donor funding. This displacement mirrored a decline in government health expenditure from 1.9 percent of GDP in 2010 to 1.3 percent of GDP in 2013. At the same time, Madagascar's GDP also declined due to its political crisis, which contributed to a worsening of health financing (World Bank, 2013). The country's co-financing share increased by at least 30 percent year-on-year in 2013, 2014, 2016, and 2018. The country was reported to be a consistent late payer over the six-year period from 2013–2018 (no clear reasons cited in the Gavi reports). **The Madagascar experience demonstrated the need to account for an evolving macroeconomic situation while determining a country's co-financing payments in order to prevent adverse outcomes.**

Figure 3. Trends in Line-Item Financing—Traditional Vaccination Program, Madagascar (2010–2014)



Nigeria: The country presents a complex picture, as the overall amount of government funding for the traditional vaccination program steadily increased between 2010 and 2014 (funding in 2013 and 2014 was three times that of 2012), but the share of government funding for the traditional vaccination program remained between 20 percent and 40 percent of the total expenditure in 2011, 2012, and 2014. **Figure 4** shows displacement in at least two line-items—cold chain equipment and personnel costs, evidenced by government funding being replaced by donor funding. Nigeria's co-financing dues increased steeply year-on-year after 2011, as shown in **Figure 5** and the country was reported to be a defaulter in 2016 (no clear reasons cited in

Gavi reports). In light of the fact that Nigeria's level of government health expenditure remained stable but very low (0.46–0.65 percent of GDP) from 2008 to 2018, **the case study highlighted the challenges countries face to simultaneously manage financing their traditional vaccination programs while meeting the incremental increase in Gavi co-financing dues.**

Figure 4. Trends in Line-Item Financing—Traditional Vaccination Program, Nigeria (2010–2014)

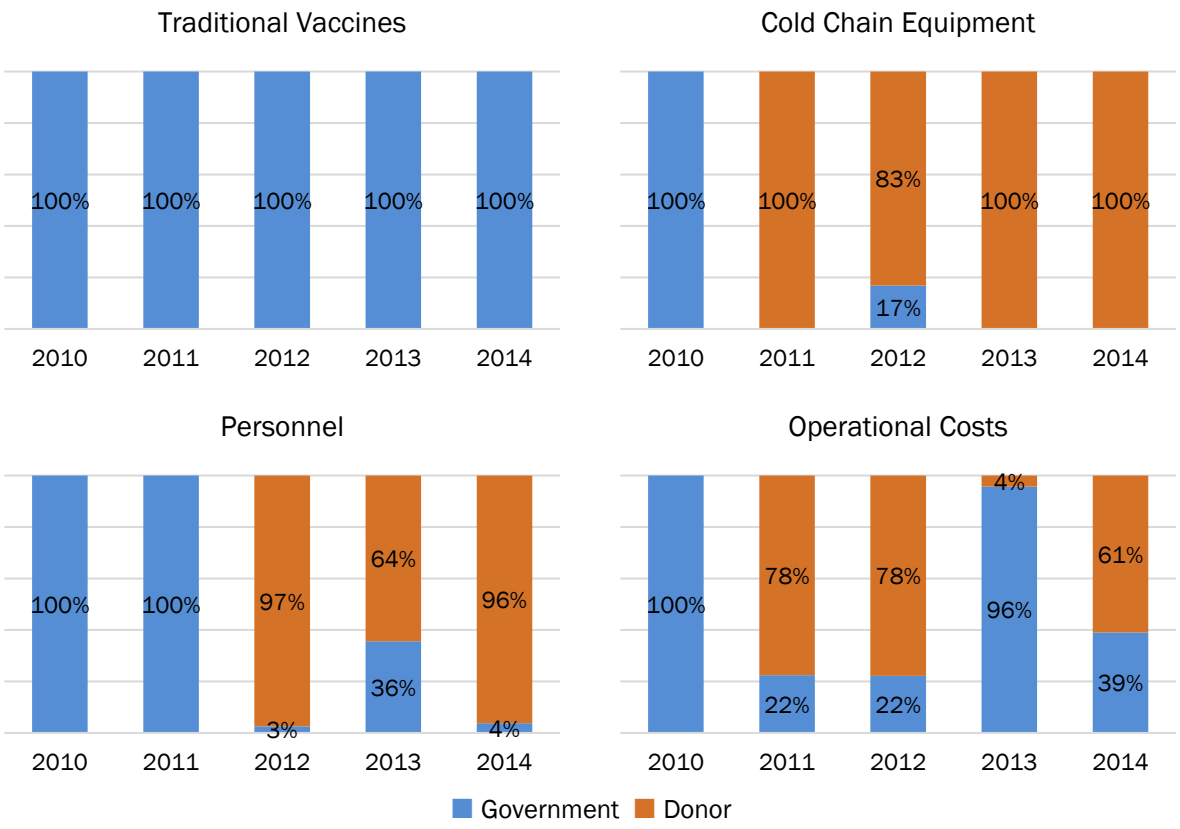
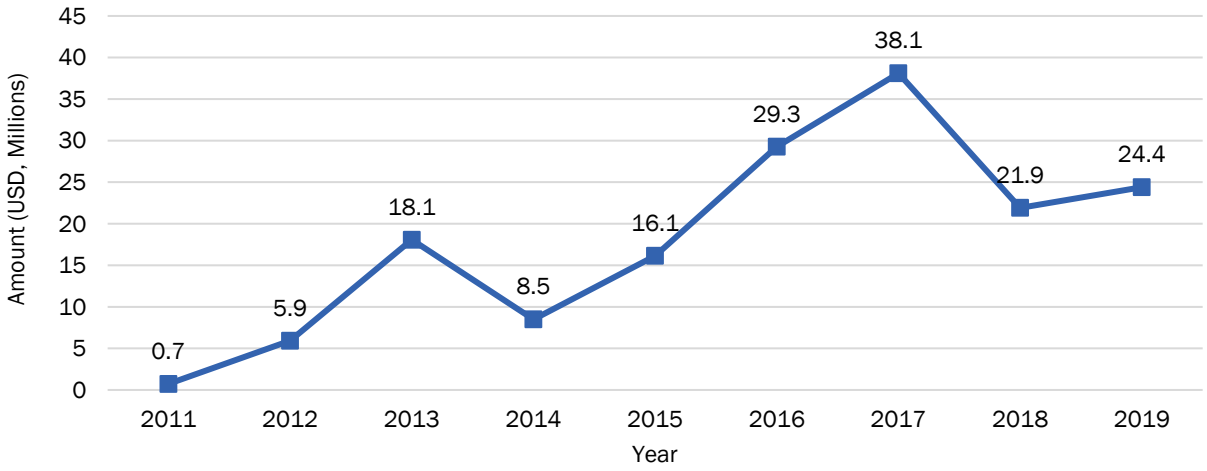


Figure 5. Country Co-financing Shares for Nigeria (2011–2019)



4. Why These Findings Matter: Policy Implications for Co-financing of Family Planning Commodities

This section explores three major policy lessons that can be derived based on findings from the quantitative analyses and the country case studies.

4.1 Policy Lesson: Addressing Ministry of Finance-Related Issues

Ministry of Finance-related issues remain a concerning cause for late payments and defaults. The Ministry of Finance typically prefers transferring large sums of funds for commodity procurement after delivery, not in advance of delivery. In certain cases, finance ministries allow advance payments up to certain amounts before requiring payment-upon-delivery. However, UNICEF's Supply Division, from which Gavi-eligible countries procure vaccines, requires that payment be delivered before vaccines can be delivered. This fact contributes to significant challenges for countries to meet the timeline for co-financing dues. An additional challenge is that there is weak engagement of finance ministries in the Gavi co-financing mechanism. The Ministry of Health is responsible for signing these agreements on behalf of the government but it does not have direct control over the national purse. As a result, the Ministry of Finance often does not understand Gavi's co-financing rules and procedures and may not prioritize co-financing payments. In addition, Gavi joint appraisal reports demonstrate that health and finance ministries may have misaligned forecasting and administrative procedures that contribute to delays in payments to the UNICEF Supply Division.

For these reasons, the Vaccine Independence Initiative (VII) was established under UNICEF to provide short-term bridge financing, requiring repayment of funds within 30 days. This allows countries to reduce programmatic disruptions and potentially avoid becoming defaulters or late payers. The VII requires that the Ministry of Finance sign a letter of guarantee that strategically engages it into the co-financing arrangement. More than 20 countries have used the fund to pre-finance vaccines, injection supplies, and cold chain equipment. The VII fund is most helpful for countries with cash-flow timing challenges. VII funds are expected to increase substantially, from US$35 million in 2019 to more than US$200 million per year in the future (UNICEF Supply Division, 2020; Arias et al., 2017).

Thus, USAID's co-financing policy for family planning commodities should incorporate measures to counter similar challenges. Potential solutions may include:

a. Early engagement with health and finance ministries to jointly plan and identify challenges, such as the possible misalignment of fiscal years between the donor and the recipient, and to develop mitigation strategies.

b. Making both ministries co-signatories to the family planning co-financing agreement and requiring the establishment of a dedicated co-financing account within the Ministry of Finance. Involving the Ministry of Finance is extremely important since the Ministry of Health cannot commit to multiyear budget appropriations without finance approval. Further, the Ministry of Finance has a better understanding of the budget pressures from other sectors that also have co-financing agreements with donors who are concerned about transition.

c. Establishing an independent, third-party payer (like VII) that can make advance payments to procure commodities on behalf of contracted governments. Governments relying on the third-party payer would then have to repay the fund within a defined timeframe, such as 30 days. While no similar arrangement currently exists in the family planning space, there may be opportunities to initiate discussions with the Reproductive Health Supplies Coalition (RHSC) or the Shaping Equitable Market Access for Reproductive Health (SEMA Reproductive Health) partnership.

   Since 2010, RHSC has pioneered innovative procurement and funding mechanisms for contraceptives and other reproductive health supplies (RHSC, 2022). The RHSC's "Pledge Guarantee" had previously used donor commitments as collateral to provide short-term loans to countries to enable immediate procurement. While this arrangement benefitted UNFPA, which typically requires upfront payment (as does the UNICEF Supply Division), most countries were reluctant to incur this debt (RHSC, 2007).

   The SEMA Reproductive Health partnership, which was established in July 2021, is mandated to support countries to identify market weaknesses for specific commodities at a national level to ensure an equitable, affordable, and predictable supply of high-quality products and to advance gender equality (SEMA Reproductive Health, n.d.).

   Thus, creating a third-party payer to support the co-financing of family planning commodities could be a new and useful initiative, perhaps best facilitated by a convergence of major donors like USAID and UNFPA, along with partnerships like the RHSC and SEMA Reproductive Health.

4.2 Policy Lesson: Addressing the Lack of Ability to Pay

The lack of ability to pay not only contributes to late payments and defaults but may be associated with displacement of government financing from related health sectors. This is an undesirable consequence for any co-financing arrangement whose primary goal is to enable countries to sustainably increase domestic resources for financing its health needs.

The country case studies show evidence that nations with extremely limited health budgets faced difficulties in meeting the two-pronged challenge—scaling up domestic financing of their traditional vaccination programs while also being able to meet the sharply escalating Gavi co-financing requirements. This difficulty seemed to become worse when external factors caused economic crises and led to reductions in government health expenditure.

A key reason behind this challenge is likely Gavi's calculation of co-financing shares using the World Bank's country income groups based on GNI per capita, adjusted for annual inflation. A study focused on the initial Gavi co-financing policy found that as countries' economic growth followed different trajectories, the World Bank groupings were no longer a meaningful category reflecting a country's ability to pay. In addition, the initial Gavi policy did not do enough to help prepare countries to take on the responsibility for financing a larger share of their vaccine purchases as they approached graduation, leaving countries unprepared for this transition (Saxenian et al., 2011). An evaluation of Gavi's co-financing policy concluded that it was important to support the GNI-based approach with programmatic indicators when determining a recipient country's transition to the next phase toward graduation (CEPA, 2019). The evaluation also noted that such an approach should incentivize increased domestic investments

in the health system and the vaccination program, while not rewarding governments that do not invest to improve their readiness to graduate.

These findings and observations emphasize the need to carefully select economic and programmatic parameters that can guide a co-financing policy and that incentivize improving the fiscal space for health, while being cognizant of the country's macroeconomic challenges. Considering government health expenditure per capita has been discussed as a possible benchmark for co-financing policies because it may better reflect a country's capacity to finance various health programs. However, given USAID's co-financing policy has historically been targeted toward LMICs (USAID, 2020), which typically have low levels of public health expenditure, considering only government health expenditure per capita may risk seeming to endorse these current low levels of spending.

USAID's 2006 family planning graduation policy clearly outlines specific programmatic indicators that should trigger assessment for a country's transition from donor dependence. These benchmarks provide a good foundation for USAID's proposed co-financing policy to adopt a pragmatic approach which entails:

a. Using an economic parameter like the actual GNI per capita on a scale (i.e., considering an average of several years of GNI), along with programmatic indicators to determine the starting share and the rate of increase. Alternatively, sovereign credit ratings (by four major global credit rating agencies: Standard & Poor's, Moody's, Fitch, and Scope) can be used as a more comprehensive measure of a country's capacity to honor the co-financing agreements based on their history of defaulting (TheGlobalEconomy.com, 2022)—something not captured through the World Bank or GNI-only classifications.
b. Accounting for a country's current macroeconomic situation while determining its co-financing category and allowing flexibility to adjust the co-financing amounts and rates of increase so that they are based on evolving macroeconomic conditions that may limit the fiscal space for health (inflation, GDP, etc.).

4.3 Policy Lesson: Understanding the Sensitivities of Co-financing Family Planning Commodities

While co-financing mechanisms for family planning commodities should incorporate measures to counter challenges, it remains equally important to recognize the vastly different political, ethical, and public health concerns of a family planning program relative to a childhood vaccination program in LMICs (Carr and Rosen, unpublished). There might be limited political will for governments to replace donor-funded programs while transitioning support (Gotsadze et al., 2019). Also, a country's procurement and supply chain management system may be inadequate, which would undermine securing an uninterrupted supply of quality-assured drugs and commodities (ibid).

A potential way to address contextual issues is to include family planning in the essential package of services under a national universal health coverage scheme (or equivalent subnational schemes). While economic growth increases the fiscal space for health and enables a transition from donor dependence, it is important to think about ways to achieve the economies of scope and scale, improve access, and advance universal health coverage at the same time. Including priority health programs like family planning in the universal health coverage benefits

package would allow countries to leverage available funding to address system-wide shortcomings, such as deficiencies in the supply chain for essential drugs and commodities that impede implementation of many health programs (Kutzin et al., 2018). Alternatively, in the absence of any national essential package of services, consideration should be given to integrate family planning under a comprehensive program for primary healthcare provision, as such inclusion can have cascading benefits that improve reproductive, maternal, and child health outcomes (Bill & Melinda Gates Foundation, n.d.; OECD, 2020).

Donors like USAID can play a pioneering role in promoting the inclusion of family planning in universal health coverage benefits packages. Donors should consider a coordinated approach for developing co-financing frameworks that leverage their collective negotiating power and consider their respective institutional regulations and limitations. This arrangement, while difficult to coordinate, could also mitigate competition among donors and reduce fragmented financing with host country governments. The approach could increase opportunities to gradually integrate co-financing arrangements for family planning and other health commodities within a broader range of health development programs and financing mechanisms, such as through national health insurance agencies. For example, co-financing of family planning commodities could be considered an integral component of donor-supported efforts in health system strengthening and health financing reforms.

5. Insights from the UNFPA Supplies Partnership Approach to Domestic Financing

Under the UNFPA Supplies Partnership's phase III (2021–2030), it will sharpen its focus on financial sustainability. Over the coming years, the UNFPA Supplies Partnership will introduce new program features to support countries to increase the mobilization of national resources as donor support decreases. This will include the introduction of a matching fund in 2022 and a domestic financing requirement from 2023 onward.

5.1 Minimum Domestic Financing Contribution

Starting in 2023, the UNFPA Supplies Partnership will move away from a model of product donation to one of product subsidization. This means that partnership countries will be required to make an annual minimum domestic financing contribution toward the cost of commodities provided by the UNFPA Supplies Partnership. The overall goal of this new requirement is to support governments to gradually increase domestic financing for contraceptives and maternal health medicines. This means they should have a budget line for family planning/reproductive health commodities and be accountable for budget execution as part of broader efforts to strengthen sustainable financing for essential health services. The minimum domestic financing requirements for participating countries will be based on the UNFPA Supplies Partnership economic index, which includes GNI per capita, Atlas method; GDP growth; and World Bank income classification. While this index is yet to be evaluated, it arguably provides a more comprehensive assessment of the "ability to pay," compared to GNI alone. Countries will be categorized into four groups based on this economic index, with poorer countries having a more graded and slower increase in contribution amounts. Domestic financing contribution requirements for recipient countries will begin at a low level: 1 percent of the UNFPA annual

commodity contributions in 2023 for countries in groups 1 and 2, a 5 percent contribution for countries in group 3, and 10 percent for countries in group 4. The minimum annual rate of increase will also vary accordingly so that countries with a higher GNI will be required to increase their domestic financing contributions at a faster rate than poorer countries: from 0 to 1 percent for group 1, 1 percent for groups 2 and 3, and 5 percent for group 4. This contribution can be made using public funds or concessional financing, such as zero- and low-interest loans (called "credits") provided by the International Development Association (IDA, 2022).

5.2 Matching Fund Pilot

From 2022–2023, the UNFPA Supplies Partnership will pilot a matching fund—an innovative financing mechanism that will enable UNFPA to match domestically raised contributions for quality-assured family planning/reproductive health commodities. Above all, the matching fund aims to support governments to increase and diversify funding for these commodities at the country level, and to lessen the impact of UNFPA funding cuts. Governments will be allocated a two-year matching fund budget ceiling and will be able to access this funding on a rolling basis. Funding will be available to 48 partnership countries but will be targeted to countries facing the most severe budget cuts. To access the funds, governments must first meet their minimum domestic financing requirement. For example, when a government makes a direct payment to the UNFPA Supplies Partnership for commodities, UNFPA may deduct the minimum domestic financing contribution and then match the remainder. Matching ratios have been determined based on country context, with countries able to leverage US$1, $2, or $4 worth of commodities from the UNFPA fund for every $1 that they contribute.

5.3 Key Principles

The key principles and lessons learned that have underpinned the UNFPA Supplies Partnership new approach to domestic financing may be helpful in shaping USAID's co-financing approach, in several ways:

- Given the challenging context and constrained fiscal space in many countries, domestic financing requirements need to be proportionate, manageable, and tailored to the country context.
- Ensuring alignment among donors is critical. The memorandum of understanding (MOU) for sustainable financing of family planning commodities signed between Kenya's Ministry of Health, the Bill & Melinda Gates Foundation, the UK's Foreign, Commonwealth and Development Office, and USAID is a good example of how strong donor alignment can support sustainable domestic resource mobilization and transition planning. Under this agreement, in effect from July 2019–June 2026, the three donors collaborate with the Ministry of Health to develop a joint "forecast, budget, and quantification" plan for the next five years for all family planning commodities required in Kenya. Subsequently, the donors match the ministry contribution through an agreed-upon budget that strategically transitions the full financing responsibility to the ministry by 2025. The agreement covers procurement of a defined list of family planning commodities to be provided free of cost to all Kenyan women and holds the ministry responsible for allocation and distribution of these commodities across Kenya (DESIP et al., n.d.).

- In many partnership countries, budget execution rather than budget allocation remains the biggest challenge. Finding ways to unlock domestic expenditure, including early engagement with the Ministry of Finance, should be prioritized.
- The transition to domestic financing should not come at the expense of quality. The global donor community must work together to ensure that family planning/reproductive health commodities procured by governments meet the highest quality assurance standards, meaning they meet stringent regulatory authority or World Health Organization-prequalified status.
- Stronger alignment is needed among partners on budget monitoring and accountability, including expenditure verification. Misalignment between external data sources on family planning commodity expenditure (such as USAID's commodity security indicators, Track20's Family Planning Spending Assessment, and UNFPA internal data) makes it difficult to track progress and ensure accountability.

6. Guiding Principles for Co-financing of Family Planning Commodities

As a result of economic shocks related to COVID-19, many FP2030 countries are expected to experience near-term reductions in general government expenditure per capita (Kurowski et al., 2021). Most of the 46 least-developed countries will require several years to regain their 2019 levels of GDP per capita growth, with the median recovery period being about three years (UNCTAD, 2021). This situation will likely translate to challenges with current or future co-financing arrangements. The International Monetary Fund recently noted that the increases in the U.S. Federal Reserve System interest rates could have a severe impact on vulnerable countries. In anticipation of these challenges, some LMICs have already started to adjust monetary policies and are preparing to scale back fiscal support in national budgets to address rising debt and inflation (Danninger et al., 2022).

Given the global economic outlook, it becomes clear that the political and financial contexts of recipient countries should be accorded priority while shaping USAID's co-financing policy for family planning commodities. HP+'s 2022 *Sustainability Planning Resource Guide for Family Planning* can be leveraged for assessing a national family planning program and developing a plan for transition readiness. An HP+ document on family planning commodity transitions (Carr and Rosen, unpublished) recommends that USAID should adopt the "Graduation Plus" approach for family planning commodity transition, which should be triggered when a country reaches a modern contraceptive prevalence rate of 40 percent. The Graduation Plus approach builds upon USAID's 2006 family planning graduation strategy but strongly emphasizes the need for specifying financial and non-financial conditions in agreements with countries. That need is provided for in the following guiding principles for shaping USAID's co-financing agreements and facilitating successful transition of countries to self-reliance in financing family planning commodities.

6.1 Considerations in USAID/Country Co-financing Agreements

1. **USAID, through its country missions, should actively engage governments and civil society while designing country-specific co-financing arrangements.** A participatory process will increase understanding among key government decisionmakers of the importance of family planning for development and will foster greater ownership of their family planning programs. While the Kenya family planning commodities MOU described previously exemplifies involvement of the Ministry of Health in the co-financing process, it did not directly involve the Ministry of Finance. However, UNFPA's new approach to minimum domestic financing contribution has recognized the additional need to engage the Ministry of Finance because budget execution, rather than allocation, often becomes the main challenge. The same was seen in the analysis of Gavi's experience (Section 4.1). The Ministry of Finance has authority over multiyear budget appropriations and a better understanding of the budget pressures from other co-financing agreements. Hence, the following is likely to be a more prudent approach:

    - USAID should engage with both health and finance ministries at an early stage with the intent of jointly drafting the co-financing mechanism.

    - USAID should encourage both the ministries of health and finance to identify potential challenges such as the misalignment of fiscal years, as well as misaligned forecasting, financing, and procurement cycle lead times, between USAID and the recipient government and should develop mitigation strategies.

    - After mitigation strategies are developed, USAID should require both ministries to serve as co-signatories to the family planning co-financing agreement and require a dedicated co-financing account/budget line within the Ministry of Finance and a timeline for payments. (UNFPA's minimum domestic financing contribution approach is also supportive of establishing a budget line for reproductive health/family planning commodities.)

    - Additionally, USAID should encourage participation of civil society to conduct advocacy and generate demand for family planning services so that enough political will is created, and leadership remains committed to the co-financing arrangement.

2. **USAID should carefully consider a country's macroeconomic context (exchange rate, overall government budget deficit as a proportion of GDP, projected economic growth rate, etc.) while shaping the co-financing agreement.**

    - USAID should avoid using only the World Bank country income categories when determining a country's co-financing category. Instead, there can be several options as outlined in **Box 3**.

    - USAID should aim to gradually increase country co-financing shares to guide the strategic transition away from donor dependence in family planning financing. Allowing up to 10 years for strategic transition, as is provided in the 2006 USAID family planning graduation policy, may be beneficial to achieve co-financing goals. See **Box 4** for examples.

- USAID should allow flexibility in negotiating the initial co-financing amount and the rate of increase for different countries. The agreement should include terms for revisiting these conditions based on the evolution of the macroeconomic situation. These adjustments can be achieved through regular reviews of the agreement and its payment structure by USAID and the national government.

- USAID should require country governments to appoint appropriate focal points to monitor and communicate emerging issues and work with counterparts to prevent late payment and default. Ensuring accountability of countries through a structured monitoring system is an important element for the successful implementation of the co-financing agreement. **See Box 5** for examples.

Box 3. Options for Determining a Countries Co-financing Category

Option 1: Use the actual GNI per capita on a scale that considers an average of several years of GNI along with programmatic indicators. The programmatic indicators are outlined under the "Graduation Plus" approach in a 2018 HP+ report on family planning commodity transitions (Carr and Rosen, unpublished).

Option 2: Use sovereign credit ratings published by the four major global credit rating agencies (Standard & Poor's, Moody's, Fitch, and Scope) to assess a country's capacity to honor the co-financing agreements based on their history of defaulting.

Option 3: Use the UNFPA Supplies Partnership economic index that includes GNI per capita, Atlas method; GDP growth; and World Bank income classification, or an equivalent parameter.

Box 4. Examples of Gradual Increase in Country Share of Co-financing

The **Kenya** family planning commodities MOU proposes that donors share co-financing responsibilities by matching the health ministry contributions in a 1:1.5 ratio for the first year, a 1:1 ratio for years two through four, a 1:0.5 ratio for year five, and a 1:0.25 ratio for year six. From year seven onward, the Kenyan Ministry of Health is expected to assume full financial responsibility.

Alternatively, **UNFPA's** minimum domestic financing contribution program advocates the following co-financing scheme based on the category of the country:

Requirements	Country Category (based on economic index)			
	Group 1	Group 2	Group 3	Group 4
Minimum contribution by the country, as a proportion of total UNFPA annual commodity contributions	1%	1%	5%	10%
Minimum annual rate of increase of the country contribution amount	0–1%	1%	1%	5%

Box 5. Examples of Monitoring for Accountability

Under the **Kenya family planning commodities MOU**, the donors provide their financing share directly to the Kenya Medical Supplies Authority (which procures medical commodities in Kenya) upon documented confirmation of the Ministry of Health's payment on its share of the procurement. There are further specific documentation requirements to ensure that: (1) the health ministry makes the budget estimates available to the Kenya Medical Supplies Authority within 30 days, (2) the Kenya Medical Supplies Authority initiates procurement within the next 30 days, and (3) monthly reports on procurement, storage, distribution, consumption, and utilization of these commodities are made available.

The **UNFPA** minimum domestic financing contribution program requires documentation of direct payment of the country's share to the agency, or documentation of procurement and distribution to the last mile when a country places an order for its share of commodity procurement through a third-party procurement agency. The program also proposes incremental annual penalties for countries failing to meet their domestic financing share, ultimately leading to ineligibility for co-financing.

3. **USAID should ensure that co-financing stimulates additional government spending in the health sector and in family planning programs.**

   - USAID should avoid seeming to endorse a country's existing low levels of public health financing when determining co-financing categories and shares and should push government to increase health allocations.
   - USAID should include a clause in the agreement that ensures commitment for increased spending to satisfy the co-financing share and a process for monitoring compliance with this clause during annual progress reviews or appraisals.
   - USAID should advocate that the health and finance ministries use available guidance to understand and secure sustainable funding sources for family planning programming and commodities. These efforts toward resource mobilization may require that countries address issues to improve allocative and technical efficiency within the existing family planning program, consider catalytic investment options to raise domestic resources, and mobilize private capital through blended finance.

4. **USAID should be flexible and seek to tailor any use of a templated agreement** (one that has pre-decided terms and conditions regarding the initial co-financing country category and starting amount, the annual rate of increase in co-financing payments, the length of time accorded for strategic transition, etc.). An approach that considers country-specific issues fosters a potential for real country ownership and puts in place more symmetric power relations.

5. **USAID should consider a set of strategic incentives for countries to commit to the co-financing agreement and transition over a mutually agreed-upon time period.** Such incentives should include long-term access to quality-assured and best-valued family planning commodities after transition, along with technical support for a conceivable period to strengthen the national family planning program.

6.2 Considerations for USAID as a Major Donor

1. To the extent possible, **USAID should coordinate with other donors, such as UNFPA, to synchronize their co-financing frameworks and optimally develop coordinated—or multipartite—agreements** to provide a common roadmap toward family planning financial self-reliance. While it is understood that such coordination may be difficult to achieve given the mandates and institutional regulations of individual organizations, the Kenya family planning commodities MOU shows that this approach is possible. UNFPA has also emphasized this issue as it formulated its minimum domestic financing contribution program.

   Further, it is also important for donors to develop a better understanding of the combined effect of several competing co-financing policies—like those for vaccination, HIV, and family planning—on the national budget space. Developing this understanding will help set pragmatic goals for the recipient countries to achieve self-reliance.

2. **USAID should collaborate with other donors to consider establishing an independent, third-party payer that can make short-term advance payments** to procure commodities on behalf of contracted governments, who then reimburse the payer within a defined timeframe. While no similar arrangement currently exists in the family planning space, USAID might consider working with the Reproductive Health Supplies Coalition or the SEMA Reproductive Health partnership. Over a period of time, donors should also look to expand this arrangement, much in line with the Vaccine Independence Initiative expansion.

3. **USAID should leverage current and future development assistance for health system strengthening and health financing reforms,** especially programs that contain reproductive health components, to incorporate co-financing of family planning commodities as a standard procedure.

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