# Closing the Gap

Increasing funding for family planning
and reproductive health
in Sub-Saharan Africa

THE WILLIAM AND FLORA
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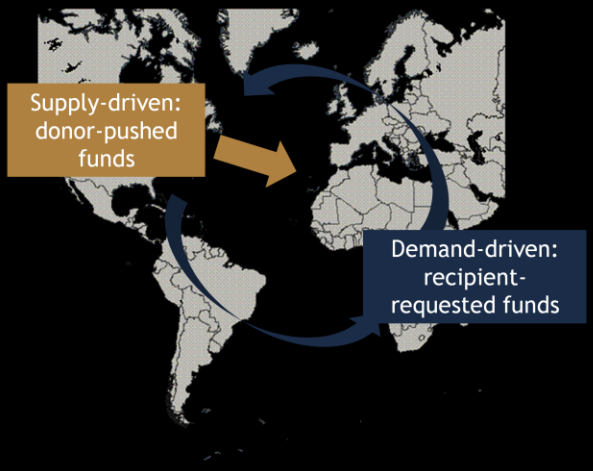
## Conclusions

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA
2. Country and regional analyses lead to customized advocacy strategies aimed at specific funders
3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap

## Advocacy for FPRH funding may be 'demand-driven' or 'supply-driven'




- **Demand-driven advocacy** supports funding appeals by the countries and people who use FPRH services
  - Domestic governments
  - Consumers
  - General budget support funders
  - Demand-driven-project funders
- **Supply-driven advocacy** supports general appeals to donor countries for overall increases in FPRH funding

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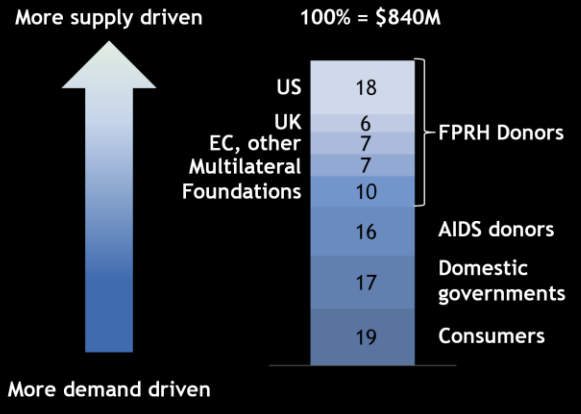
**Conclusions and analysis:** There are two potential approaches to addressing the shortfall in FPRH funding in SSA using advocacy: supply-driven and demand-driven. Historically, FPRH supporters have largely attempted to close the gap through the former approach, advocating directly to donors in rich countries for funding increases by, for instance, calling for increases in dedicated FPRH funding. Demand-driven advocacy, on the other hand, is based on helping recipient countries justify and promote funding requests to domestic and international funding sources that reflect their FPRH needs.

# Today's discussion focuses on demand-driven advocacy (though supply-driven advocacy remains important)

## Demand-driven FPRH funding is significant

$M in SSA, FPRH funding by source




- Demand-driven funding is growing, and may be half of the total for SSA
- Supply-driven funding advocacy remains important
- This presentation is about advocacy to increase demand-driven funding

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**Conclusions and analysis:** Recent estimates suggest that when all sources of FPRH funding are considered, more than half of current funding can be significantly influenced by demand-driven advocacy. Furthermore, additional donors are moving toward a system of development assistance that empowers recipient countries to set their own priorities for funding. This trend makes the need to invest in demand-driven strategies more urgent than ever. However, supply-driven funding advocacy remains important, and new opportunities may arise over time. This presentation provides a framework for developing practical demand-driven advocacy strategies to close part of Africa's FPRH funding gap.

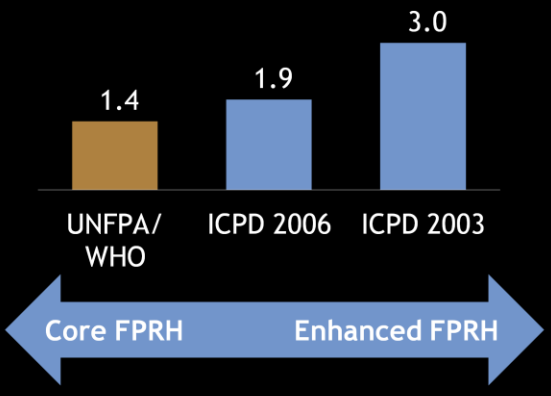
**Technical notes:** FPRH donors contribution is annual average ODA from 2000-2004. Foundations include those with country-specific investments including Buffet, MacArthur, Rockefeller, Ford, Packard, and UN. Government FPRH health spending from NIDI 2005 data. AIDS ODA includes PEPFAR and Global Fund 2007 disbursements, with variable 2-6% applied to FPRH. Private includes out of pocket spending and prepaid insurance, assuming same % FPRH as overall health by country.

**Sources:**


- NIDI 2005a: van Dalen, Hendrik P., and Mieke Reuser. *Assessing size and structure of worldwide funds for population and AIDS activities*. The Hague: Netherlands Interdisciplinary Demographic Institute, 2005.
- PEPFAR 2008: President's Emergency Plan for AIDS Relief. *Table 4: FY 2005-2007 Approved Budget Allocations for Focus Countries. 2007. PEPFAR. 5 Jan. 2008.* <*http://www.pepfar.gov/about/82472.htm*> http://www.pepfar.gov/about/82472.htm
- GFATM 2008: Global Fund to Fight AIDS, Tuberculosis and Malaria. *Current Grant Commitments and Disbursements.* 2008. GFATM. 10 Jan. 2008. <http://www.theglobalfund.org/en/funds_raised/commitments/> http://www.theglobalfund.org/en/funds_raised/commitments/
- OECD 2006: Organisation for Economic Co-operation and Development, Development Assistance Committee. *International Development Statistics Database*. 2006. OECD. 20 Sept. 2007. < http://www.oecd.org/dataoecd/50/17/5037721.htm>
- Foundations 2008: Speidel 2005; Ford 2008; Rockefeller 2008; Gates 2008; Hewlett 2008; Packard 2008; UNF 2008; MacArthur 2008
- WHO 2006: World Health Organization. World Health Report 2006: Working Together for Health. Geneva: WHO, 2006. http://www.who.int/nha/country/en/index.html

## With at least $1.4B/yr of core FPRH funding required, the need for demand-driven funding in SSA is acute

### Core FPRH needs are $1.4 B per year in SSA




### Core FPRH needs are expensive, even without several measures

- Core needs alone are $1.4 B per year
- If maternal and child health, or HIV treatment and prevention are included, the need skyrockets

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**Conclusions and analysis:** Efforts to quantify FPRH needs in Africa have resulted in a range of cost estimates, varying in size and scope. These range from $1.4 billion annually, based on UNFPA 2004 and WHO 2003 estimates, to the $3 billion proposed by the 2003 version of the International Conference on Population Development's estimate.

This paper focuses on the core FPRH needs included in the $1.4 billion UNFPA/WHO estimate: delivery of contraception, counseling on family planning and reproductive health issues, and access to safe abortions and post-abortion care. This definition excludes HIV/AIDS treatment, HIV/AIDS prevention (except condom distribution), maternal health, and child health. It also excludes other less direct FPRH investments like girls' education.

Higher estimates, such as ICPD 2003 at $3.0 billion, are wider in scope, and include broader HIV/AIDS prevention and treatment, maternal health, and research in addition to core FPRH services.

**Technical notes:**

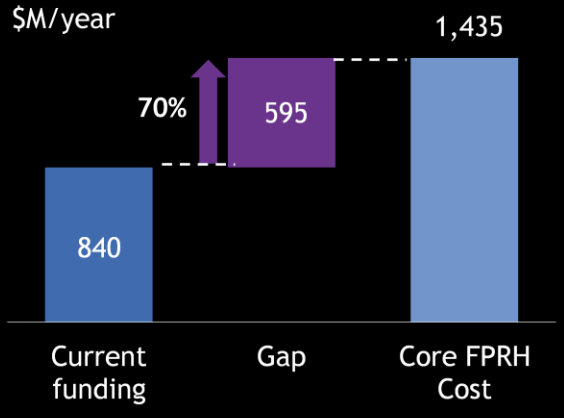
- **UNFPA/WHO** core FPRH estimate is based on cost per current and new contraceptive user to meet current unmet need for contraception, and cost per abortion care case from Johnson 2007 to eliminate unsafe abortion as estimated by the WHO.
- **ICPD 2006** estimate provided by Bernstein et al 2007, using estimate for drug and personnel costs (excluding overhead).
- **ICPD 2003** estimate is reported in UNFPA 2003b and includes HIV prevention and treatment, maternal health, and research in addition to core FPRH services.

**Sources:**


- Bernstein 2007: Vlassoff, Michael, Stan Bernstein, Eva Weissman, Howard Friedman, and Charlotte Juul Hansen. *Resource Requirements for Sexual and Reproductive Health Care in Developing Countries: ICPD Costing Revisited*. United Nations Millennium Project background paper. 2007.
- UNFPA 2003b: United Nations Population Fund. *Country Profiles for Population and Reproductive Health 2003*. New York: UNFPA, 2003. S:\HPOP-Funding\Research\Costs\2003 UNFPA Country Profiles.pdf
- Vlassoff 2004: Vlassoff, Michael, Susheela Singh, Jacqueline Darroch, Erin Carbone, and Stan Bernstein. "Assessing Costs and Benefits of Sexual and Reproductive Health Interventions." *Guttmacher Institute Occassional Report* No. 11 (2004).
- WHO 2007c: World Health Organization. *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003, 5th ed.* Geneva: WHO, 2007. S:\HPOP-Funding\Research\Abortion\2007 WHO Unsafe abortion 5th edition.pdf
- Johnston 2007: Johnston, Heidi, Maria Gallo, and Janie Benson. "Reducing the costs to health systems of unsafe abortion: a comparison of four strategies." *Journal of Family Planning and Reproductive Health Care 33(4) (2007): 250-257.*

## The resulting minimum annual gap of $595M, while significant, is not impossible to close

### A 70% increase in SSA is needed for core FPRH funding




### While significant, narrowing the gap is not impossible

- Five key donors (US, UK, EC, UNICEF, UNFPA) have commit significant resources to ODA
- Demand-driven strategies can tap these donors through requests
- A $600M increase is only 3% of total SSA ODA

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**Conclusions and analysis:** FPRH in Africa currently receives $840 million a year. Covering the $1.4 billion cost of core FPRH services would require a 70 percent increase, amounting to an additional $595 million per year.

An increase of this magnitude is possible – albeit ambitious – given that several large donors already contribute the majority of the current funding. In the league in which these donors play, $595 million is not an impossibly large amount. For example, it represents only a 2.5 percent increase in overall official development assistance (ODA) to Africa – but family planning has not been historically a significant expenditure. Some increases in funding from major donors could be achieved through demand-driven approaches, while others may rely on traditional supply-driven advocacy or a combination of the two strategies. Additionally, funding from other sources, including African governments, HIV/AIDS donors, and private consumers could supplement increases from the major international FPRH donors.

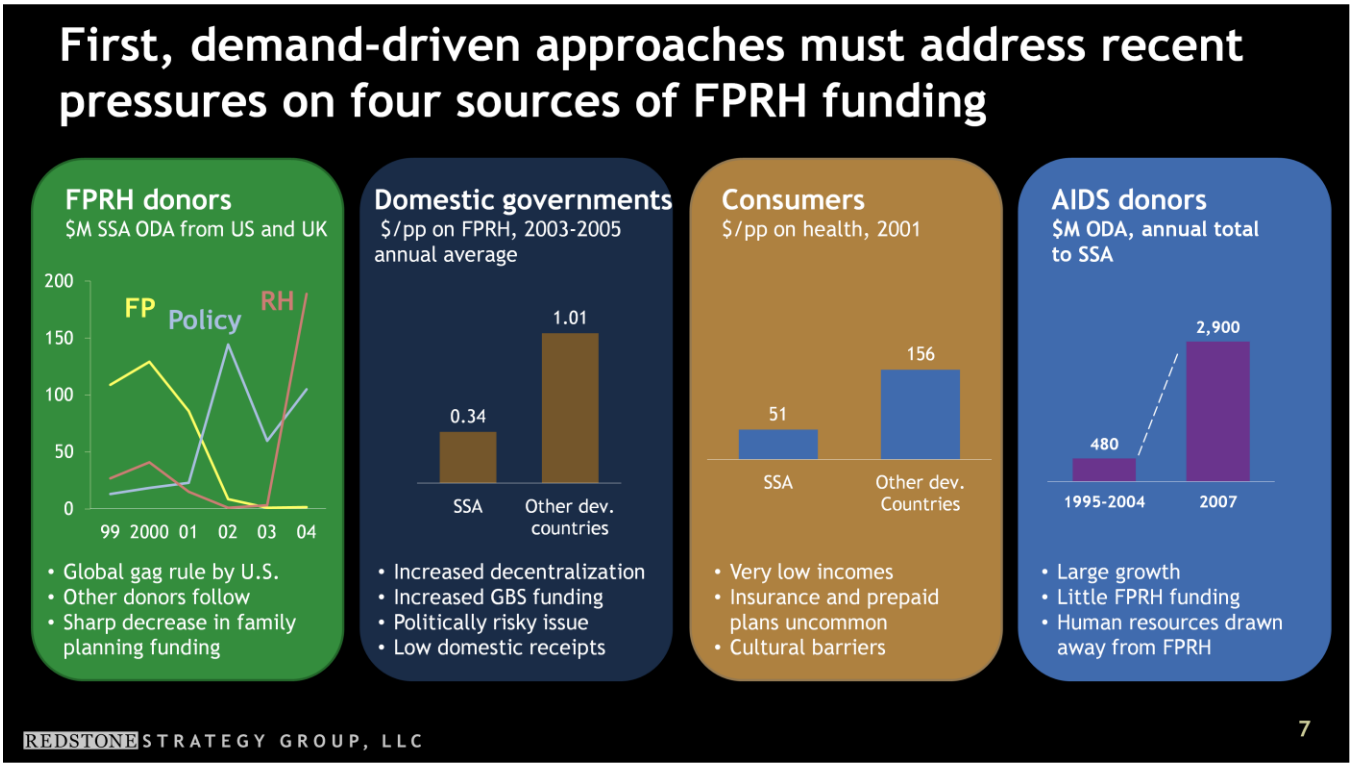
**Technical notes:**

*Current funding:* Includes FPRH ODA, foundation spending, government spending, FPRH-related AIDS ODA, and consumer spending; as described on p.4.

*Core FPRH cost:* Based on core FPRH UNFPA/WHO estimate from previous page. Includes cost of providing contraception to meet current unmet need and provide safe abortions. As described on p.5.

**Sources:**


- NIDI 2005a: van Dalen, Hendrik P., and Mieke Reuser. *Assessing size and structure of worldwide funds for population and AIDS activities*. The Hague: Netherlands Interdisciplinary Demographic Institute, 2005.
- PEPFAR 2008: President's Emergency Plan for AIDS Relief. *Table 4: FY 2005-2007 Approved Budget Allocations for Focus Countries. 2007. PEPFAR. 5 Jan. 2008.* <*http://www.pepfar.gov/about/82472.htm*> http://www.pepfar.gov/about/82472.htm
- GFATM 2008: Global Fund to Fight AIDS, Tuberculosis and Malaria. *Current Grant Commitments and Disbursements*. 2008. GFATM. 10 Jan. 2008. <http://www.theglobalfund.org/en/funds_raised/commitments/> http://www.theglobalfund.org/en/funds_raised/commitments/
- OECD 2006: Organisation for Economic Co-operation and Development, Development Assistance Committee. *International Development Statistics Database*. 2006. OECD. 20 Sept. 2007. < http://www.oecd.org/dataoecd/50/17/5037721.htm>
- Vlassoff 2004: Vlassoff, Michael, Susheela Singh, Jacqueline Darroch, Erin Carbone, and Stan Bernstein. "Assessing Costs and Benefits of Sexual and Reproductive Health Interventions." *Guttmacher Institute Occassional Report* No. 11 (2004).
- UNFPA 2003b: United Nations Population Fund. *Country Profiles for Population and Reproductive Health 2003*. New York: UNFPA, 2003.
- Foundations 2008: Speidel 2005; Ford 2008; Rockefeller 2008; Gates 2008; Hewlett 2008; Packard 2008; UNF 2008; MacArthur 2008




**Conclusions and analysis:** Over the last decade, funding for family planning in Africa declined precipitously. Meanwhile, more expensive reproductive health activities, like caring for expectant mothers and preventing infant mortality, attracted substantial funding increases. Although the result is an FPRH sector whose total funding appears to be increasing, closer inspection reveals that only certain segments have grown. Meanwhile, the core family planning services crucial to achieving good reproductive health and sustainable population growth have suffered significant losses in funding and support.

The following trends have cut into family planning funding, and slowed growth in the sector overall:

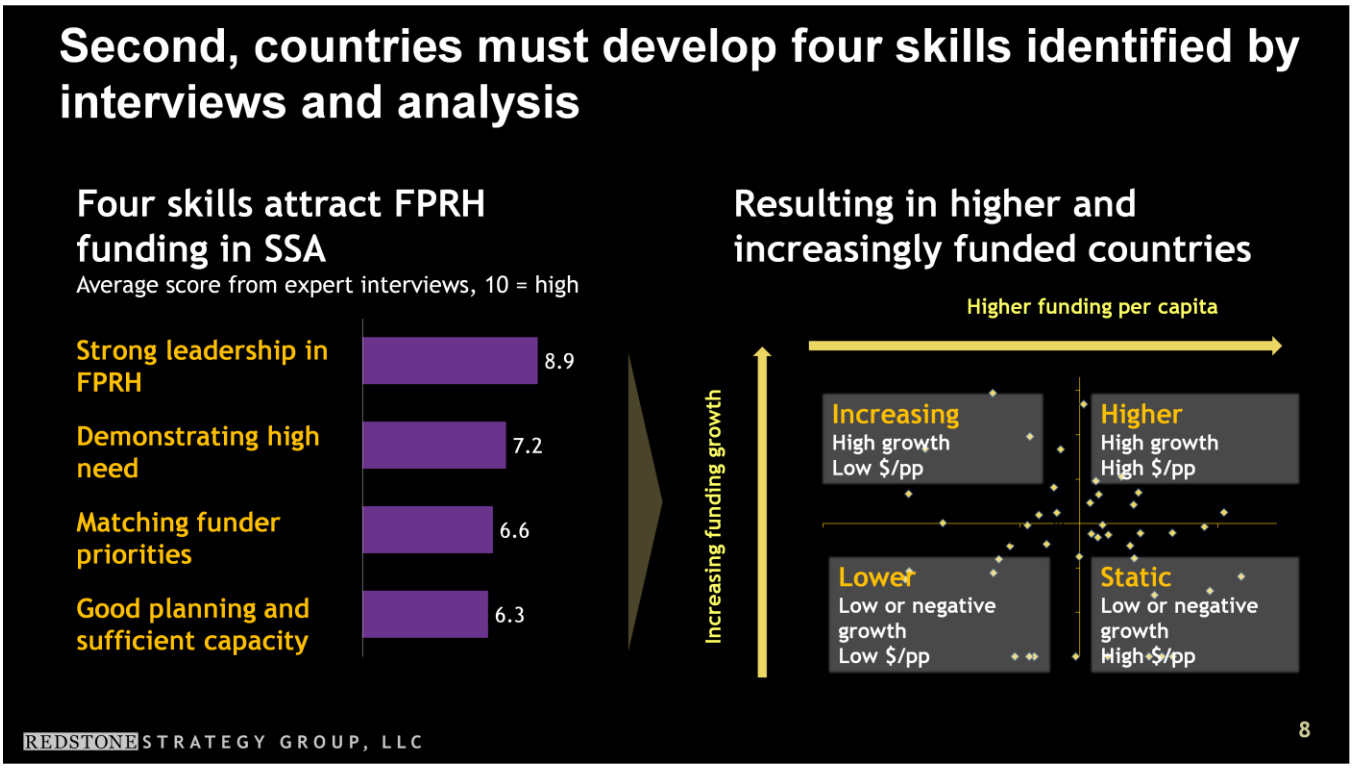
- *Negative FPRH donor policies:* Reinstatement of the Mexico City Policy in 2001 banned US support to any foreign organization that provides abortion services, counseling, or lobbying. As a result, US family planning assistance to Africa fell from $58 million in 2001 to virtually nothing in 2004. The UK's contributions dropped in tandem, from $70 million in 2000 to less than $2 million in 2004. Although these resources may have been shielded into other family planning-related investments like census management, research, and policy making, it is clear that core FP investments faced significant pressure. Because the UK and the US are key donors, these precipitous declines have left a large dent in total funding. To add insult to injury, other major donors appear to have decreased funding levels in response, perhaps in an effort to be politically sensitive to the US. Although funding for population policy and reproductive health have risen as family planning has declined, a large percentage of money in these categories is not applicable to core FPRH service goals.
- *Low domestic government spending:* Few African governments prioritize spending on FPRH. Several factors drive low domestic spending, including low overall government resources, competing development priorities, political sensitivity to family planning issues, and a history of donor-dominated FPRH funding. Increased decentralization and GBS contribute to the problem. Decentralization can negatively affect FPRH funding by disrupting the traditional budget process. Roughly 30 percent of African countries are decentralized, and FPRH receives less attention in many of these countries

because local planners tend to prefer to fund tangible projects like road construction. Furthermore, they are unaccustomed to budgeting for services that have historically been funded by international donors. Increased GBS as a proportion of ODA can divert ODA that was previously dedicated to FPRH, among other topics, and places control over allocation in the hands of the recipient government. In the long run, budget support may be a good tactic: it allows governments to budget according to their own priorities and helps develop local capacity. In the short run, however, FPRH has suffered. This is both because African NGOs were unprepared for the sudden shift of resources to the government, from other recipients, and because the governments themselves may not fully prioritize it for political or historical reasons.

- *Low consumer spending:* Consumers in Africa spend very little on healthcare in general, and even less on FPRH, relative to the rest of the world. In Africa, the average person spends about $51 annually on health care. In contrast, other developing countries spend an average of $156 per person. As a percentage of personal income, consumer spending is quite high, but low absolute incomes in Africa limit the ability of individual consumers to fully finance FPRH services. Exacerbating this problem, access to private insurance and prepaid health plans is uncommon.
- *Increased funding to HIV/AIDS:* Funding for HIV/AIDS skyrocketed in the past decade, increasing 3,200 percent since 1995 as the disease gained public attention. This international rally has been coordinated and highly effective, but has had some negative side effects, including detracting resources from less well-funded FPRH services. For instance, many nurses have moved to AIDS clinics, where they may earn up to $200 per month, compared to FPRH clinic salaries from $50 to $100 per month.

## Sources:


- OECD 2006: Organisation for Economic Co-operation and Development, Development Assistance Committee. *International Development Statistics Database*. 2006. OECD. 20 Sept. 2007. < http://www.oecd.org/dataoecd/50/17/5037721.htm>
- NIDI 2005a: van Dalen, Hendrik P., and Mieke Reuser. *Assessing size and structure of worldwide funds for population and AIDS activities*. The Hague: Netherlands Interdisciplinary Demographic Institute, 2005.
- PEPFAR 2008: President's Emergency Plan for AIDS Relief. *Table 4: FY 2005-2007 Approved Budget Allocations for Focus Countries. 2007. PEPFAR. 5 Jan. 2008.* <*http://www.pepfar.gov/about/82472.htm*> http://www.pepfar.gov/about/82472.htm
- GFATM 2008: Global Fund to Fight AIDS, Tuberculosis and Malaria. *Current Grant Commitments and Disbursements*. 2008. GFATM. 10 Jan. 2008. <http://www.theglobalfund.org/en/funds_raised/commitments/> http://www.theglobalfund.org/en/funds_raised/commitments/
- WHO 2006: World Health Organization. World Health Report 2006: Working Together for Health. Geneva: WHO, 2006. http://www.who.int/nha/country/en/index.html




**Conclusions and analysis:** Both expert interviews and analysis shows the four skills above help countries attract the highest levels of FPRH funding. Strong leadership signals commitment to FPRH and demonstrates the political will and savvy necessary to make the most out of new funding. Demonstrating need highlights a significant problem to be addressed and shows that funding to the recipient country can have a large impact. The ability to match funder priorities leads to tailored funding requests that illustrate an alignment of interests between funder and recipient country. Finally, proven planning and capacity assures funders that their money can be absorbed and spent on the sector being targeted.

Countries seeking to increase FPRH funding should develop these skills in order to assure funders that their money will be put to good use.

**Technical notes:** Countries are divided into four categories, based on their current annual funding per capita and funding growth over time. We then measured the level of the proposed funding skills in each group.

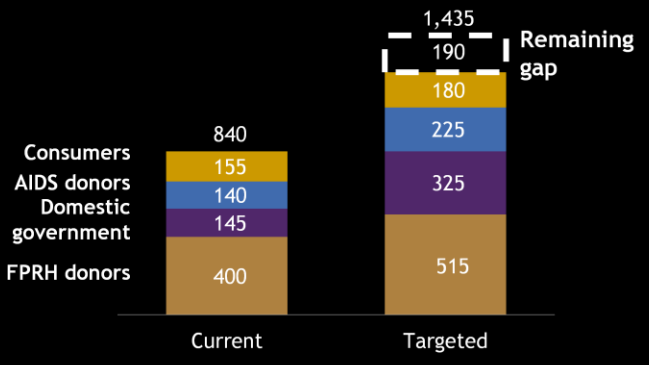
**Sources:**


- **Interviews 2007:** Awiti 2007; Babcheck 2007; Bartlett 2007; Batcha 2007; Belete 2007; Buzingo 2007; Ezeh 2007; Gade 2007; John 2007; Kilonzo 2007; Koemm 2007; Komwihangiro 2007; K'Oyugi 2007; Kundu 2007; Langerstedt 2007; Llewellyn 2007; Lusiola 2007; Maisori 2007; Malengalila 2007; Mbacke 2007; Mbunda 2007; Melesse 2007; Mlay 2007; Mrisho 2007; Munene 2007; Onyango 2007; Osur 2007; Poukouta 2007; Riwa 2007; Vogel 2007; Wamatu 2007; Warratho 2007; Yazbeck 2007
- OECD 2006: Organisation for Economic Co-operation and Development, Development Assistance Committee. *International Development Statistics Database*. 2006. OECD. 20 Sept. 2007. < http://www.oecd.org/dataoecd/50/17/5037721.htm>

# If successful, by setting funding targets these approaches could close 70% of the funding gap

## Increasing funding to regional norms closes 70% of the gap

$M/yr SSA total




## Funding would come from changes at four main sources

- **International FPRH donors**: Donors would match the level of highly-funded countries
- **Government**: Governments would increase spending to regional averages
- **AIDS donors**: AIDS donors would increase integrated funding to regional averages
- **Consumers**: Individuals would increase their spending to 50% of the regional average

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**Conclusions and analysis:** The $595 million FPRH funding gap in Africa can be significantly narrowed through achievable increases from four main sources. To estimate the funding potential of each source, it's necessary to first size up the current contribution from each. Then, one can set a target for each source, based on a regional funding 'norm'. The combined contributions from each source meeting its target would close 70 percent of the funding gap.

The four key sources and their respective targets are:

- **International FPRH donors:** Across Africa, donors currently contribute approximately $400 million per year to FPRH. This estimate includes ODA from bilateral and multilateral donors, spending by INGOs in SSA, and direct support from large private foundations to NGOs in SSA (in order to mitigate double counting between donors and NGOs). However, there is wide variation in the amount received by different countries. Reaching a target that brings countries with lower current ODA funding closer to the level achieved by higher-funded countries would provide an additional $115 million per year.
- **African governments:** African governments currently spend $145 million per year on FPRH. If countries with low spending increased their contribution up to the current average per capita spending by African governments, an additional $180 million would become available. The idea that developing countries can contribute significantly to funding high quality FPRH services has a long history. In 1994, the ICPD Programme of Action estimated that "up to two thirds of the costs [of attaining ICPD goals] will continue to be met by the countries themselves". Matching the regional average for government spending falls well within this expectation.
- **HIV/AIDS Donors:** HIV/AIDS donors currently spend roughly $140 million per year on FPRH-related activities, such as condom distribution. Currently, only 2 to 8 percent of funds from PEPFAR, the biggest donor, support FPRH-related prevention efforts. Raising the FPRH-related portion of funds to 8 percent in all PEPFAR recipient countries could provide an additional $85 million. Both PEPFAR and the Global Fund are increasingly emphasizing FPRH-related prevention, making this target plausible, if ambitious. The recently announced tripling of PEPFAR funding could also provide a major opportunity to increase core FPRH spending.
- **Consumers:** Although FPRH may often be thought of as a strictly publicly-funded sector, consumer spending account for almost 20% of current FPRH funding in Africa, or approximately $155 million per year, including out-of-pocket expenditures and private insurance. Increases in consumer spending are limited by the realities of low personal income in many parts of Africa. However, even reaching 50 percent of the regional average of $0.14 per capita in countries with low consumer spending could amount to another $25 million per year.

**Technical notes:** Current spending is as defined on p.4. Targeted spending is defined as a level of per capita funding from a particular source, adjusted in some cases for country-specific or donor-specific factors.

**Sources: RSG FPRH Funding Model 2008:** Bernstein 2007; DFID 2007; Foundations 2008; GFATM 2008; Johnston 2007; Ndegwa 2002; NIDI 2005a; OECD 2006; PEPFAR 2007a-l; PEPFAR 2008; UNFPA 1997; UNFPA 1998; UNFPA 1999; UNFPA 2003b; UNFPA 2005b; USAID 2007b; Vlassoff 2007; WB 2003; WHO 2006; WHO 2007c

## Conclusions

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA
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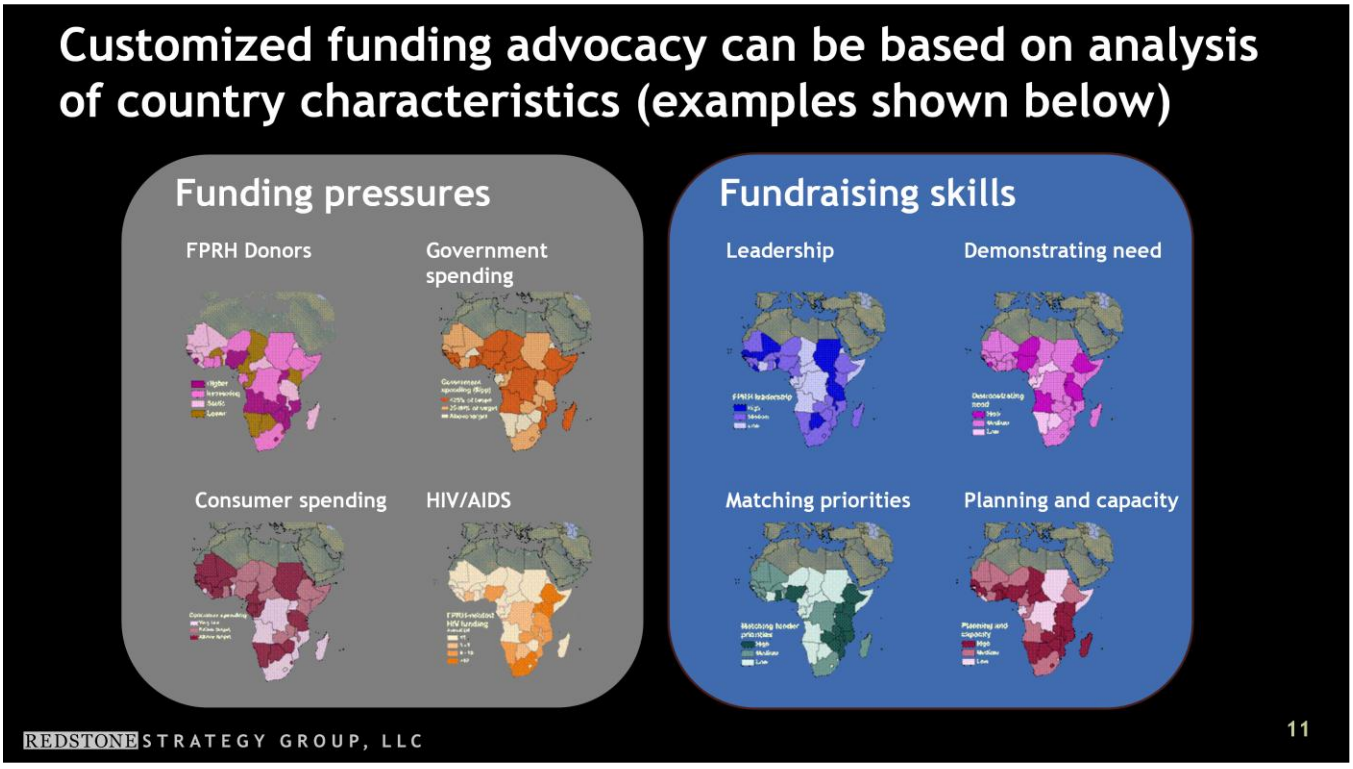


**Conclusions and analysis:** Attracting hundreds of millions of dollars in new funding will require a strategy that takes into account both macro funding trends and the details of the unique relationships between funding source and recipients. The solution proposed is to look for the challenges and solutions that are common across the continent, then target a country, region, or topic and customize a strategy. Country-specific data on common funding pressures and fundraising are critical to building such customized strategies. The data shown above provide examples of the sort of information that is available; further details on each country are provided in the attached excel spreadsheet.

**Technical notes:** Each of the four fundraising skill maps represents a composite index comprised of 2-5 individual factors. An index is created for each factor by representing the score of an individual country as a percent of the maximum score; the overall index for each skill is a weighted average of the factor indices. The data for each factor and skill index can be found in the attached excel worksheet.

**Sources:**


- OECD 2006: Organisation for Economic Co-operation and Development, Development Assistance Committee. *International Development Statistics Database*. 2006. OECD. 20 Sept. 2007. < http://www.oecd.org/dataoecd/50/17/5037721.htm>
- NIDI 2005a: van Dalen, Hendrik P., and Mieke Reuser. *Assessing size and structure of worldwide funds for population and AIDS activities*. The Hague: Netherlands Interdisciplinary Demographic Institute, 2005.
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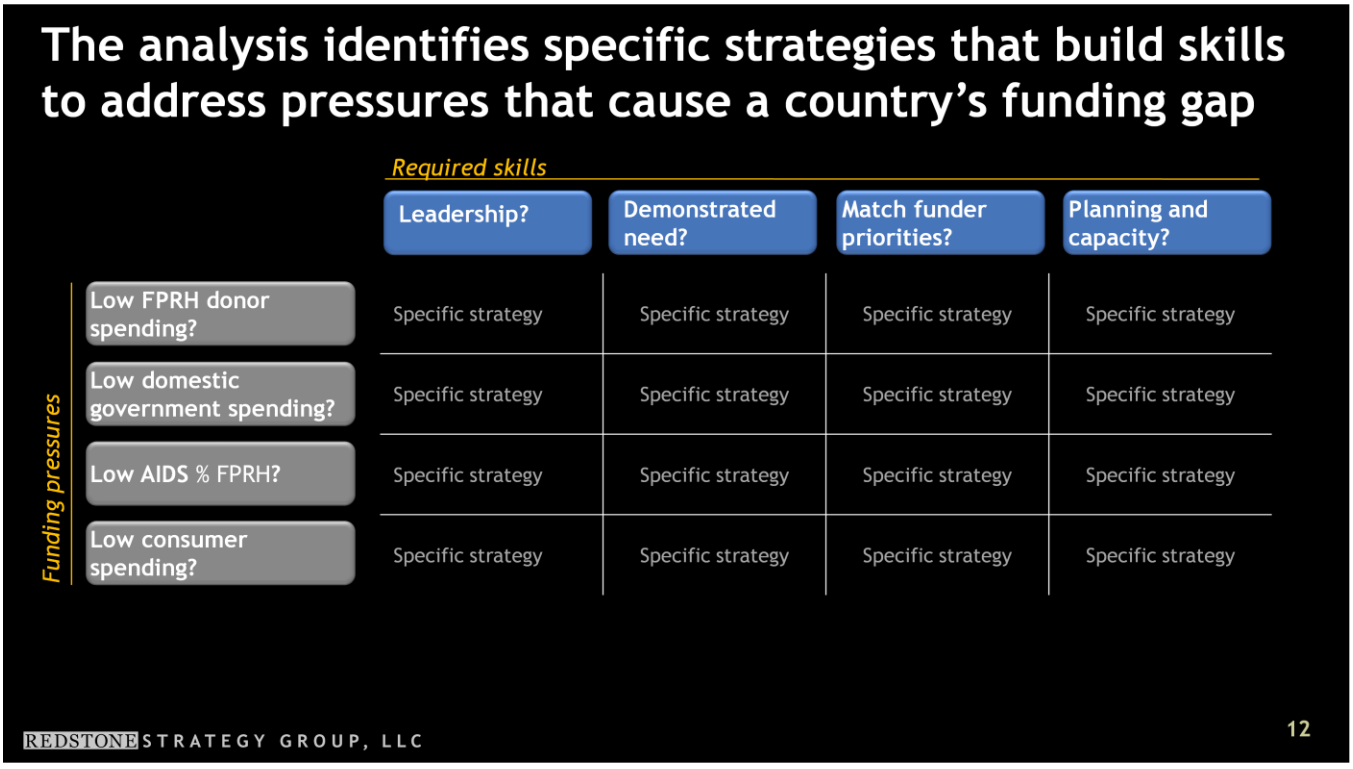
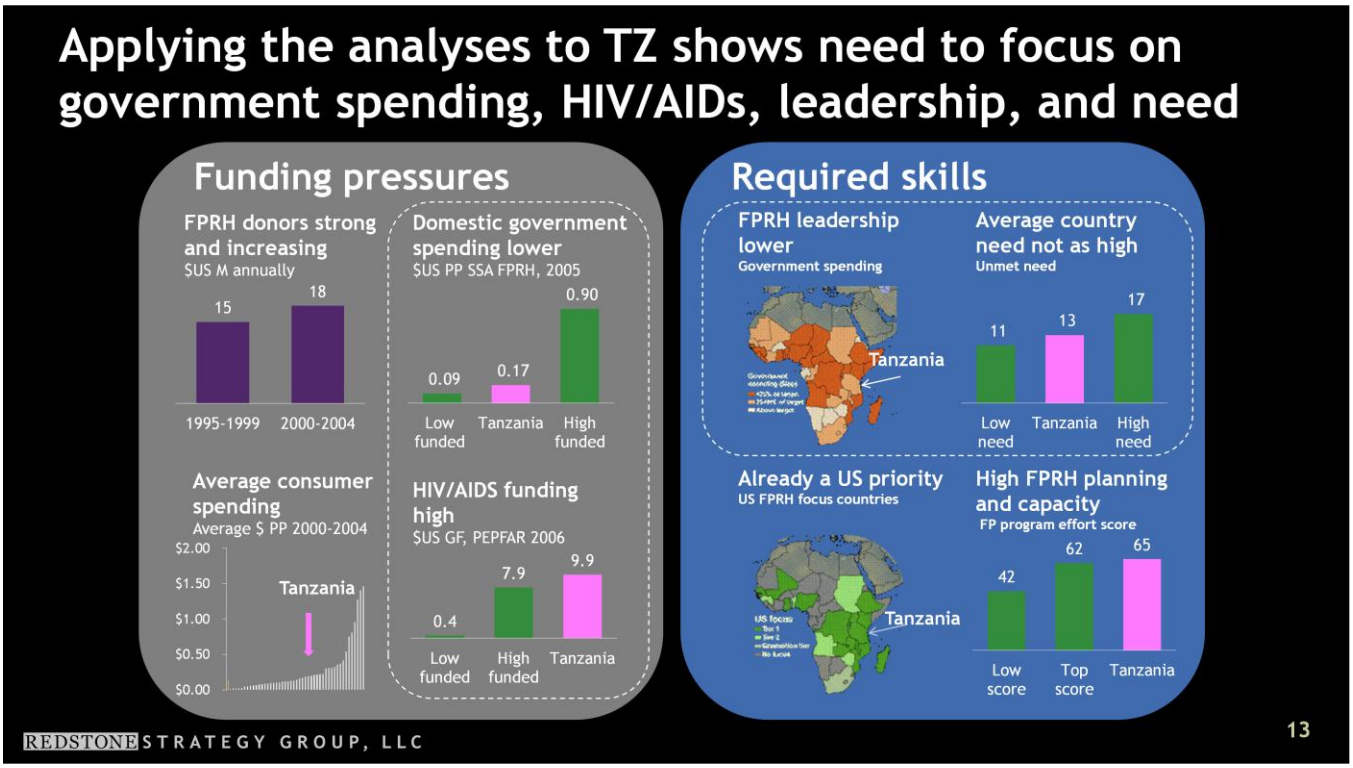
- Ross 2001: Ross, John, and John Stover. "The Family Planning Program Effort Index: 1999 Cycle" *International Family Planning Perspectives* 27(3) (2001): 119-129.




**Conclusions and analysis:** These data can be laid into a framework for building demand-driven advocacy strategies, through which African countries can develop and demonstrate the four skills essential to increasing funding. The framework attempts to strike a balance between two opposing considerations in building demand-driven advocacy strategies. On one hand, the definition of a demand-driven strategy precludes a one-size-fits-all solution; funding advocacy that comes from within the recipient country must be specific to that country. On the other hand, the complexity of reinventing the wheel for each of dozens of countries trying to raise money from four different sources would be overwhelming.

This page shows the matrix of four skills that we have asserted can best address the six main causes of Africa's core FPRH funding gap. The relative importance of each cause and skill will differ between countries, as will the nitty-gritty details of strategies.

However, this framework proposes baseline strategies for each combination in the matrix by drawing on the proven ideas of the many experts interviewed for this project. For example, to improve leadership in countries with high GBS, a general strategy could be to support a watchdog NGO to hold the government accountable for allocating funds to FPRH. Or, to increase the ability of a centralized government to demonstrate need, one advocacy strategy might be to work with the ministry of planning to document the health and economic impacts of poor FPRH services. These baseline strategies then need to be customized for a country, region, or topic.




**Conclusions and analysis:** Tanzania provides an example of how to develop country-specific strategies. Because funding from the domestic government and the FPRH-related portion of HIV/AIDS ODA are currently low, demand-driven strategies to raise funding from these sources should be a priority. To a lesser extent, Tanzania may also be able to increase funding from FPRH donors. Consumer spending already exceeds SSA norms, and is unlikely to provide much room for growth.

Tanzania scores comparatively well on all of the four skills that contribute to successful fundraising. However, it scores lowest on leadership and demonstrated need, so focusing on improving these two skills could help increase funding. In developing demand driven strategies, it may also be useful to know that Tanzania's government is relatively decentralized, and that a high percentage of ODA is channeled through GBS.

**Sources:**


- OECD 2006: Organisation for Economic Co-operation and Development, Development Assistance Committee. *International Development Statistics Database*. 2006. OECD. 20 Sept. 2007. < http://www.oecd.org/dataoecd/50/17/5037721.htm>
- NIDI 2005a: van Dalen, Hendrik P., and Mieke Reuser. *Assessing size and structure of worldwide funds for population and AIDS activities*. The Hague: Netherlands Interdisciplinary Demographic Institute, 2005.
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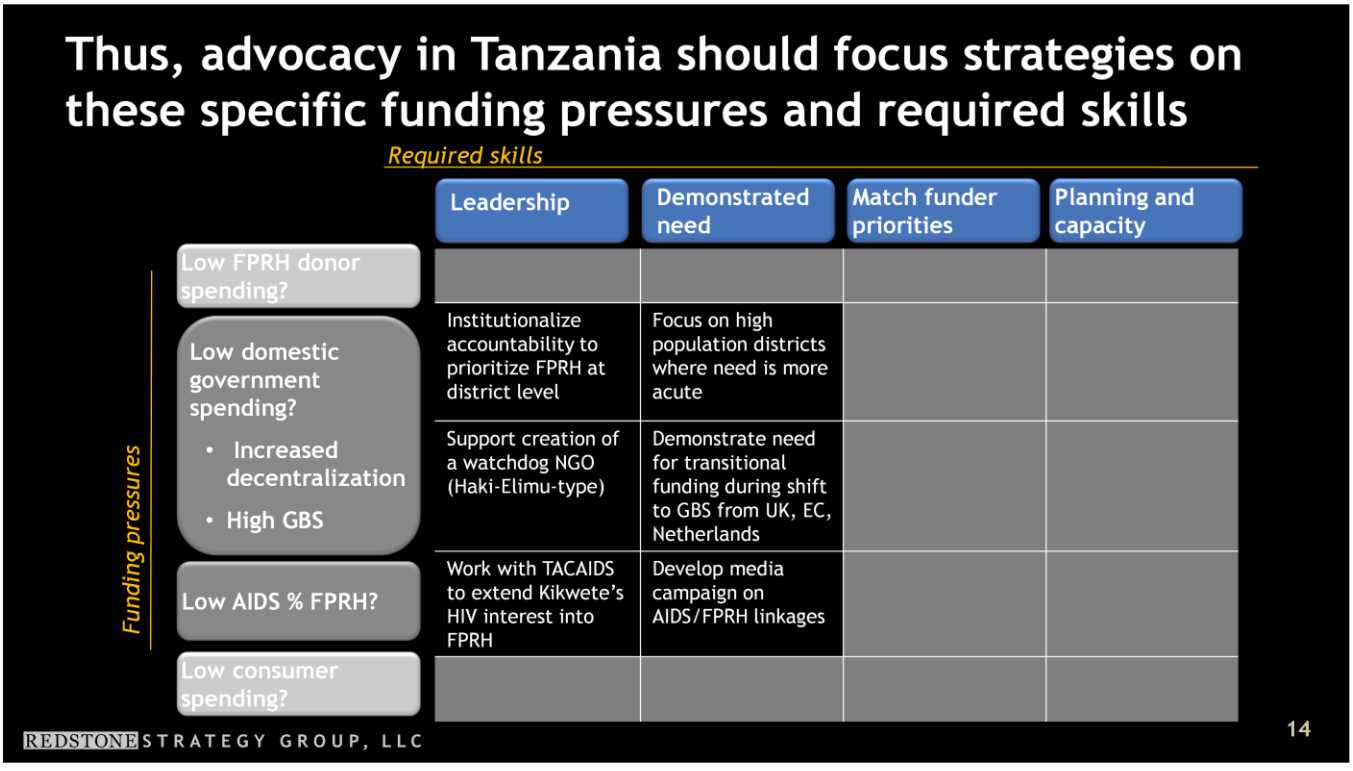
- Ross 2001: Ross, John, and John Stover. "The Family Planning Program Effort Index: 1999 Cycle" *International Family Planning Perspectives* 27(3) (2001): 119-129.




**Conclusions and analysis:** Based on the scores, generalized strategies can help direct country-specific interviews to determine specific strategies needed to address the funding pressures and required skills. Above are just a few examples of customized versions of baseline strategies based on interviews that could lead to increases in spending in a country like Tanzania.

**Sources:**

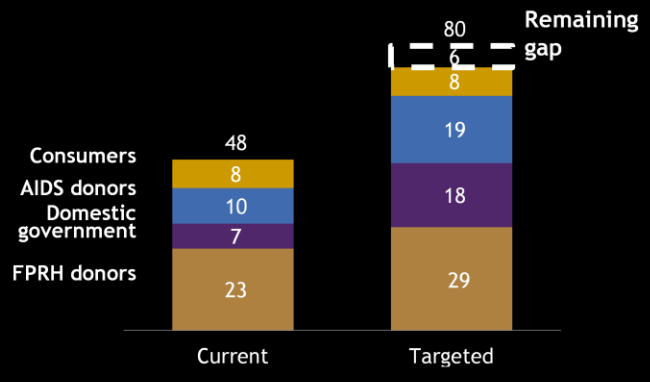
**RSG FPRH Funding Model 2008:** Bernstein 2007; DFID 2007; Foundations 2008; GFATM 2008; Johnston 2007; Ndegwa 2002; NIDI 2005a; OECD 2006; PEPFAR 2007a-l; PEPFAR 2008; UNFPA 1997; UNFPA 1998; UNFPA 1999; UNFPA 2003b; UNFPA 2005b; USAID 2007b; Vlassoff 2007; WB 2003; WHO 2006; WHO 2007c; PEPFAR 2008; UNFPA 1997; UNFPA 1998; UNFPA 1999; UNFPA 2003b; UNFPA 2005b; USAID 2007b; Vlassoff 2007; WB 2003; WHO 2006; WHO 2007c

**Interviews 2007:** Awiti 2007; Babcheck 2007; Bartlett 2007; Batcha 2007; Belete 2007; Buzingo 2007; Ezeh 2007; Gade 2007; John 2007; Kilonzo 2007; Koemm 2007; Komwihangiro 2007; K'Oyugi 2007; Kundu 2007; Langerstedt 2007; Llewellyn 2007; Lusiola 2007; Maisori 2007; Malengalila 2007; Mbacke 2007; Mbunda 2007; Melesse 2007; Mlay 2007; Mrisho 2007; Munene 2007; Onyango 2007; Osur 2007; Poukouta 2007; Riwa 2007; Vogel 2007; Wamatu 2007; Warratho 2007; Yazbeck 2007

# These strategies could fill 80% of Tanzania's funding gap

## Tanzania could fill 80% of its gap

$M/yr SSA total




## Funding would come from changes at four main sources

- **FPRH donors**: US and UNFPA have strong potential for funding increases, but high GBS lowers potential for UK and EC
- **Government**: TZ currently has low spending and should more than double
- **AIDS donors**: Integrating additional prevention into AIDS activities could direct more of AIDS funds to FPRH
- **Consumers**: Relatively high current consumer spending means opportunity is low

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**Conclusions and analysis:** Targeting the funding sources as described earlier could fill up to 80% of Tanzania's funding gap going from $48M per year to $74M per year. Fundraising efforts could focus primarily on increasing government spending and directing more funding from HIV/AIDS donors toward FPRH-related activities. Secondarily, more funds can be raised from FPRH donors, especially the UNFPA and US. Because consumer spending is already above the norm for SSA, the funding model assumes no potential for increases from that source.

**Technical notes:** Current and targeted funding are Tanzania-specific versions of the analysis shown on p.9.

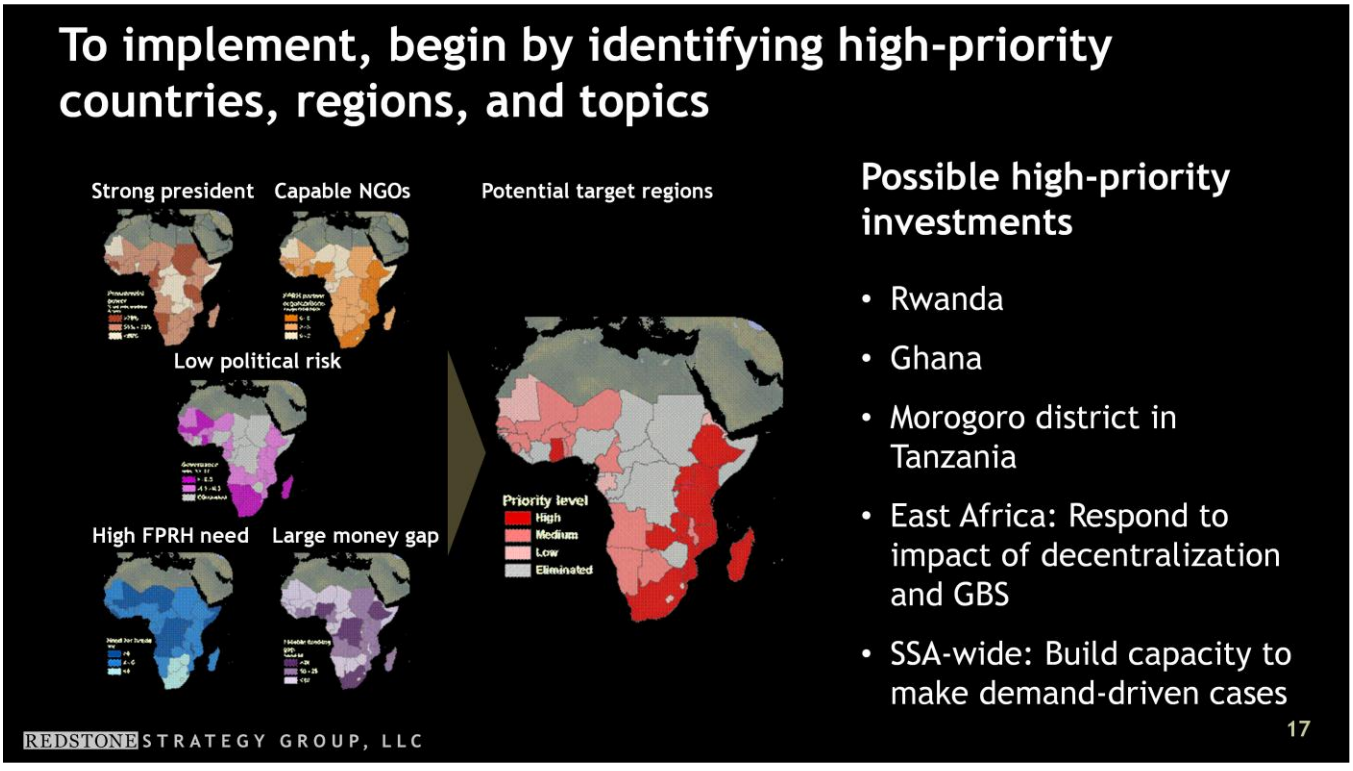
**Sources:**

**RSG FPRH Funding Model 2008:** Bernstein 2007; DFID 2007; Foundations 2008; GFATM 2008; Johnston 2007; Ndegwa 2002; NIDI 2005a; OECD 2006; PEPFAR 2007a-l; PEPFAR 2008; UNFPA 1997; UNFPA 1998; UNFPA 1999; UNFPA 2003b; UNFPA 2005b; USAID 2007b; Vlassoff 2007; WB 2003; WHO 2006; WHO 2007c

**Interviews 2007:** Awiti 2007; Babcheck 2007; Bartlett 2007; Batcha 2007; Belete 2007; Buzingo 2007; Ezeh 2007; Gade 2007; John 2007; Kilonzo 2007; Koemm 2007; Komwihangiro 2007; K'Oyugi 2007; Kundu 2007; Langerstedt 2007; Llewellyn 2007; Lusiola 2007; Maisori 2007; Malengalila 2007; Mbacke 2007; Mbunda 2007; Melesse 2007; Mlay 2007; Mrisho 2007; Munene 2007; Onyango 2007; Osur 2007; Poukouta 2007; Riwa 2007; Vogel 2007; Wamatu 2007; Warratho 2007; Yazbeck 2007

## Conclusions

1. Demand-driven funding advocacy can help close a $575M gap in core FPRH funding for SSA
2. Country and regional analyses lead to customized advocacy strategies aimed at specific funders
3. Coordinated actions by governments, NGOs, and funders are needed to close the funding gap




**Conclusions and analysis:** The first step of implementation is to identify high-priority countries, regions, and topics. The example analysis can help narrow the range of potential priorities by showing a rough country-level expected value calculation. Potential benefit is based on the size of the surmountable funding gap and level of FPRH need in each country. Likelihood of success includes factors such as having a strong president and capable NGOs to help drive a funding package, and low political risk based on governance indicators. The results of these analyses show that countries in East Africa, or the whole region, could be priorities for demand-driven funding efforts. However, an initiative could also focus on topics like decentralization and GBS which are important factors in funding in East Africa, or on helping all countries in SSA improve their ability to demonstrate need and make demand-driven cases.

**Technical notes:** Potential target regions are determined using the five factors shown on the left.

**Sources:**


- Kaldor 2005: Kaldor, Mary, Helmut Anheier and Marlies Glasius. *Global Civil Society Yearbook 2004/5*. Center for the Study of Global Governance. 2005.
- WB Governance Matters 2007: World Bank. *Governance Matters, Worldwide Governance Indicators 1996-2007*. 2007. World Bank. 20 Oct. 2007. <http://info.worldbank.org/governance/wgi2007/sc_country.asp>
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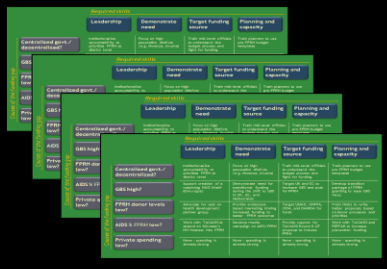
- **RSG FPRH Funding Model 2008:** Bernstein 2007; DFID 2007; Foundations 2008; GFATM 2008; Johnston 2007; Ndegwa 2002; NIDI 2005a; OECD 2006; PEPFAR 2007a-l; PEPFAR 2008; UNFPA 1997; UNFPA 1998; UNFPA 1999; UNFPA 2003b; UNFPA 2005b; USAID 2007b; Vlassoff 2007; WB 2003; WHO 2006; WHO 2007c

## With priorities set, put the team together and implement

### Generate baseline strategies at the country, region, or topic level



### Implementation steps

1. **Select priority countries, areas, topics**
2. **Bring the team together** and fund it**:** coordinator or lead NGO, strong government commitment, donors
3. **Refine the baseline strategies:** in country interviews and research
4. **Develop fundraising goals** and measures of success
5. **Implement!**

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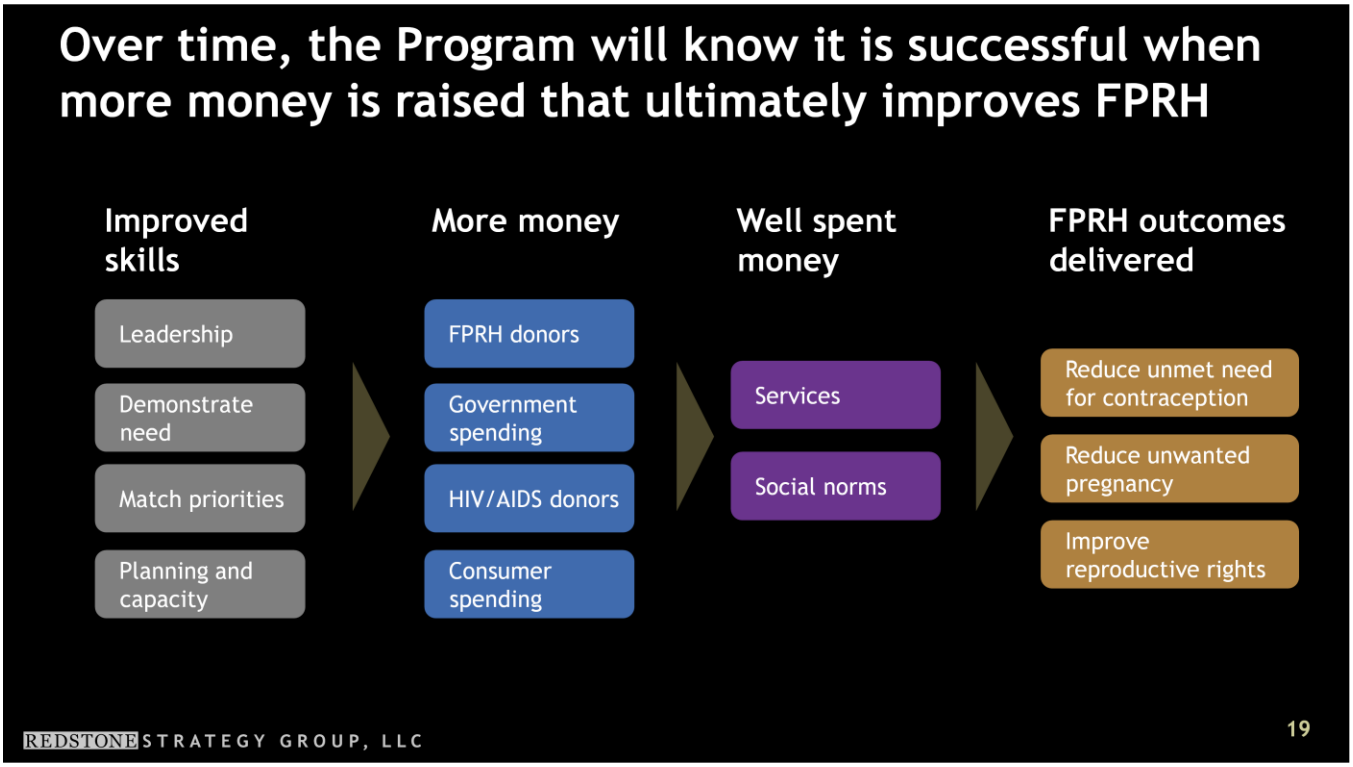
**Conclusions and analysis:** Armed with a realistic fundraising plan and measurable goals, FPRH supporters can move into the implementation phase of demand-driven advocacy. Coordinating action and ensuring commitment from key players is crucial to implementation success.

Recommendations for implementation follow two initial steps:

1. *Assemble a project team:* Implementing demand-driven advocacy through a project team can ensure coordination between – and commitment from – key players. Typically, such a team might include the government(s) of the target country or region, lead funders, and a lead in-country NGO. Other stakeholders whose input is valuable, but who are less directly or critically involved, can be included through a larger working group.
2. *Use the project team to drive coordinated action:* Each member of the project team will have an important role to play in making demand-driven advocacy successful. Government involvement signals credible commitment to potential funders. It also provides a channel through which to implement skill-building projects to improve leadership, demonstration of need, and so on. A lead in-country NGO should be skilled in advocacy and familiar with country or regional conditions. It can implement and coordinate advocacy efforts, and assist the government in skill-building. The involvement of supportive funders encourages buy-in from potential funding sources, and builds a link with donor countries. Other stakeholders to involve in the working group might include secondary in-country NGOs, donor-country NGOs, researchers, and representatives of parallel efforts in other countries.

The team can then refine the baseline strategies identified by the model through in-country interviews and more country-specific research. Finally, a team should set fundraising goals, likely based on the targets set in this document, establish measures of success, and start implementing.




**Conclusions and analysis:** Over time, the success of demand-driven funding advocacy efforts can be tracked through intermediate and ultimate outcomes in a logic model. Initially, positive outcomes will include improvements in fundraising skills, which result in more money being raised for core FPRH services from a variety of sources. Ultimately, efforts should result in money being well spent on FPRH services and noticeable improvements in FPRH outcomes in target regions.