Final report on the FP2020 Resource Flows pilot project in Tanzania and Ethiopia Data for 2012

Main Results and Experiences

Final Report

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Netherlands Interdisciplinary Demographic Institute (NIDI)

Acknowledgements

This reports was produced with the collaboration of the African Population and Health Research Center (APHRC), who developed the field test of the survey in Tanzania and Ethiopia and Futures Institute, Health Policy Project (HPP) (2014) who has provided rich insight, OOPS data and financial means to the study.

Netherlands Interdisciplinary Demographic Institute, NIDI, is a research institute of the Royal Netherlands Academy of Arts and Sciences (KNAW) and is affiliated with the University of Groningen (RUG). NIDI is engaged in the scientific study of population (demography).
http://www.nidi.nl/en?set_language=en

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1. Background

Increasing access to family planning (FP) can reduce poverty and hunger, avert maternal and childhood deaths and increase women's empowerment (John Cleland et al., 2006). Effective FP also promotes an economic boom as it ensures a healthier, better educated, and skilled workforce, as well as low dependency ratios (World Health Organisation, United States Agency for International Development, Population Reference Bureau, & Academy for Educational Development, 2008).

For many years, international donors, multilateral corporations, governments and philanthropies have invested heavily in supporting family planning programs in sub-Saharan Africa. Regardless the resources applied to FP, the gap of the needs met is still huge: if unintended pregnancies would drop by 70%, the number would mean a reduction of undesired pregnancies from 74 million to 22 million per year (UNFPA, Guttmacher Institute, 2014). Recently, however, funding for FP has begun to decline leading to reversals in gains already achieved in some developing countries (Barbara O'Hanlon, 2009).

In response to the need for a revamped family planning agenda, several initiatives have been developed, among them, the Family Planning 2020 (FP2020) Initiative. FP2020 is a global partnership that supports the rights of couples, women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. The initiative works with governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020 (FP2020, 2013).

To reach the above-mentioned goal financial information is required to estimate the additional resources needed as well as to find opportunities of an effective and efficient use of the expenditure. The aim is to get clarity on how much is currently spent on family planning and to which components the expenditure go to. Considering the experience in the Resource Flows Project in NIDI, Futures Institute, HPP invited NIDI to develop this study and to identify the major flows of FP funds through a pilot study, which could lead to an enriched tool and more relevant and comprehensive data.

Given the paucity of information on this expenditure, this pilot study was implemented in Tanzania and Ethiopia. The aim was to ascertain the feasibility of generating quality data on expenditure on family planning from the public and private sectors involved in providing family planning goods and services in the two countries. Additionally, estimates on OOPs and the external funding reaching the country with a FP purpose would be prepared. The study was also expected to provide lessons to guide efforts to bring tracking of FP expenditure to scale (please refer to the planning process in annex 1).

This report presents the various contributions to the study, notably from Futures Institute proposing the content and including the measurement of OOPS; from APHRC performing and reporting the domestic survey in both countries; and from NIDI with the platform for the domestic component, the external resources measurement and the integration of all components. The content includes the following sections: a) Methodology and approach for each area of work: external funding, the domestic survey and OOPS, as well as the quality control and verification process; b) The results on the external funds channeled to FP services in Tanzania and Ethiopia collected by the Resource Flows project; c) Main results of the pilot survey in Tanzania and in Ethiopia, by component: Government, NGO, Corporations, collected and reported by APHRC; d) Family Planning OOPs estimates in both

countries, by Futures Institute; e) Summary overview of the experiences and respondent feedback to the domestic survey with a discussion to briefly reflect on the response of the questionnaire and how it served its purpose; f) General discussion and conclusions.

2. Methods and approach

The study used the Netherlands Interdisciplinary Demographic Institute (NIDI) Resource Flows (RF) project platform, methodology, procedures, database and data collection forms to estimate FP expenditures in 2012 for both countries. The project was collaborative to estimate external and domestic resources through a survey by NIDI and APHRC respectively (refer to definitions used in annex 2). OOPs estimation was performed by Futures Institute through a secondary data procedure.

2.1 Survey implementation

Two set of surveys were used in this study. The RF survey for external funding, with results collected and handled by NIDI and reported by the United Nations Population Fund (UNFPA). The domestic financing survey, with the NIDI input and platform, developed by APHRC.

2.1.1 Donor assistance to family planning

To monitor the progress in achieving the financial aid targets, UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI) started a close collaboration in 1997. The UNFPA/NIDI Resource Flows (RF) project covers financial resource flows based on the "costed population package" as described in paragraph 13.14 of the ICPD Program of Action (UNFPA, 2015) covering the following categories: 1) Family planning (FP) services; 2) Basic reproductive health (RH) services; 3) Sexually transmitted diseases and HIV/AIDS prevention; 4) Basic research, data and population and development policy analysis.

The project involves an annual Resource Flows survey collecting data on international population assistance, which is the source of this report. The data collection instrument involves funding for population activities from donor countries and organizations. The coverage aims at bilateral, multilateral and global donors, e.g. foundations, intermediate organizations (NGOs, universities, UN organizations, and network organizations), development banks and governments, most of which are member of the OECD DAC.

The survey presents project information from donor governments and several UN organizations extracted from the online OECD Creditor Reporting System (CRS) database[1]. The surveyed donor is asked to confirm or refine the CRS data to identify the amounts devoted to ICPD classes and specifically, to family planning. The OECD data report on FP is retained and based on the responses received from donors, other components can be added to this line purpose.

[1] OECD CRS is the international agreed depository of an annual donor survey (http://stats.oecd.org/). The content refers to project information on donor, recipient countries, sectors, commitments /disbursements, flows, channels of delivery and the type of aid. Although this database has progressively improved in quality and coverage, still has limitations on coverage and also, only one purpose by project can be reported at the time, leaving areas partially or over reported. Various initiatives recode the data for specific purposes based on the original surveys. The Resource Flows survey allows the donor to recode the expenditure.

The data management and database generation was developed by NIDI directly.

2.2 Domestic survey

NIDI operates the UNFPA-funded Resource Flows (RF) Project, to collect and publish data on the financial resources seeking to address population and HIV/AIDS issues worldwide. For that project, NIDI has collaborated with the African Population and Health Research Center (APHRC), to track population and HIV/AIDS programs expenditure in over 30 countries in sub-Saharan Africa. This pilot used a similar platform to collect data with special focus on family planning expenditure in two countries; Ethiopia and Tanzania.

The project involved the data collection on income and expenditure from the various family planning actors:

- Public sector: Ministry of Health principally. However, other Ministries (Women's Affairs, Youth, Social Affairs, etc.) as well as other public sector organizations (parastatals) FP providers and / or financiers in the countries also provided data.
- NGOs: both local and international, which provided family planning goods and services, either exclusively or as part of other activities.
- Local philanthropies: which funded family planning goods and services.
- Corporations: which provided family planning goods and services to their employees or the communities or geographic areas in which they work.
- Insurance companies who either:
    - Reimbursed policyholders for family planning goods or services.
    - Subcontracted the provision of family planning goods and services to their policyholders.

The first step in implementing the survey was to prelist all known key players in FP financing and provision. From that list was extracted all government, insurance companies, and large corporations to be included. For parsimony, the top 10 NGOs and a simple random sample of the remaining NGOs were included in the sample. The top 10 NGOs and other major players were identified based on the consultant's knowledge of the specific organization's approximate market share of FP involvement in their respective countries and consultative discussion with national FP service provision experts.

The next step was for the consultant to identify a contact person or respondent from each of the selected organizations or government office. For improved data quantity and quality, a few organizations were selected for further visits with an aim of improving the response rate, as informed by previous experiences in the RF study. The few contact persons were visited and informed beforehand of the planned pilot study. These key contacts were pre-identified as follows; one from the Central MoH, two from any other public sector FP providers or financiers and four key NGOs. The consultants conducted three visits to each of these seven institutions with the following agenda for each visit:

- At the initial visit, the consultant would go over the questionnaires and the manuals, clarifying issues with the contacts person in these institutions. The consultant would also demonstrate some of the areas of estimation.
- On the second visit, the consultant would check the progress, review the estimations, verify already collected data and agree on finalization schedule for the remaining data.
- On the third/final visit, the consultant would finalize the questionnaire and check the consistency of the data provided so far.

The consultants distributed the questionnaires and manuals, (a detailed and a brief manual) to all identified target institutions either physically or via email after identifying and making contact with the respondents. The consultant followed up by booking an appointment with the respondents, during which the consultant went through the questionnaire with the respondents, identifying any areas that the respondent needed support in, especially the estimation process.

Data collection in Tanzania spanned between May and July 2014 while in Ethiopia, data collection was between July and November 2014.

After all data were collected, the questionnaires were forwarded to APHRC for entry into an MS Access database developed to capture the data from paper form to soft format. All data were exported to STATA for further management.

2.3 Quality Control

Additional to the quality of data developed by AHPRC, NIDI performed a data verification a) comparing the original questionnaires and the entries in the database, b) selected entries and estimations were verified and their impact in the data (e.g. rates, time of transactions); c) suggestion of non- data entry error detection e.g. double count search (see annex 3); and d) a report with specific suggestions was given back to help the improvement of the results.

Data cleaning ensured that inconsistent entries were checked against original data to rid all data entry errors. Other non-data entry errors that could not be verified against the paper questionnaires could be corrected after seeking corrections from the consultant or the respondent. The final clean data were used to produce summary measures such as proportions, summations and averages as presented in the results section of this report.

2.4 Family Planning OOPs

The approach used to estimate the OOPS in both countries was proposed by Futures Institute, using information available to generate a plausible amount of FP OOPS. It relies in the principle:

E= PxQ Expenditure = Price x Quantity,

Where the expenditure refers to the OOPS on Family Planning, the price refers to the annual cost/price of each FP method, and the quantity refers to the users that have purchased the method during that year.

It specifically implies to estimate the annual average cost of each method and to apply it to its users in the country, adding the value of all methods. The steps followed ca be briefly described as:

- To estimate the number of user by method. Preferably regardless the marital status, but mainly within the fertile age, knowing that not only married women use contraceptives. Data were taken from DHS for the percentage of users by method. Only FP methods for which a purchase is involved were considered, which in general are the modern ones. The percentage of users was applied to the number of fertile age women for 2012, obtained from UN POP database.
- The amount paid is estimated through the average price of the method in the market, as presented in the commercial pharmacies and applied to purchases needed in the period. To estimate the cost / price by method per year, for this study, the price of contraceptives was collected in Kenya and converted in USD to be used in both country estimates.

- To calculate the cost per year per method. The consumption per method per year should be applied to the unit cost of the method and the complementary service. The consumption proposed is: sterilization is a unique event; 13 cycles of pills or injections, unless they are trimestral; condoms used 3 per 52 weeks; implants and IUD lasting 3.5 years. Not all months the follow up services are needed. The unit cost per method should preferably be locally obtained. For this study the price in Kenya was used.
- The total spending per year per method is applied to the users per method and the source of the method.
- The source of contraceptive method was taken from DHS, considering any medical facility, medical professionals and retailers. When available, the share of non- free FP services should be accounted for. When this information is not available, an assumption proposed is that the users obtaining the method in private providers are likely to pay for the full cost of contraceptives, but also the fees and payments in governmental facilities should be accounted for.

3. Results

In this section results are presented for each of the components: external resources (by NIDI), domestic spending by providers (mostly APHRC report) and OOPS (by Futures).

3.1 Family planning external funding in Tanzania and Ethiopia

NIDI estimates the ICPD and FP donor data for countries, which are reported annually by UNFPA in the "Financial flows for population activities" (UNFPA, 2014). An extract from the related NIDI database was made for both countries which are reported here.

3.1.1 Total ICPD and FP aid

Donor governments and organizations disbursed approximately $394 million to Ethiopia and $337 million to Tanzania for all four ICPD categories (family planning, reproductive health, HIV/AIDS, and basic research). Of this amount, the proportion allocated to family planning was greater in Ethiopia than in Tanzania – 8.65% and 4.79% respectively -. This lower share in Tanzania is far from the estimated average of 9% of FP funds among the ICPD resources, and it falls into the expected range for Ethiopia (UNFPA 2014 pp 4).

In Ethiopia, organizations allocating the largest proportion of their population budget to family planning include DKT International allocated (90%), Pathfinder International (45.5%) and the David and Lucile Packard Foundation (31.4%). In Tanzania the most family planning-oriented budgets for population activities were from Population Action International (100%), Department for International Development (47.4%) and the Canadian International Development Agency (23.1%). In 2012 roughly $44 million in Ethiopia (table 1) and $23.2 million in Tanzania (table 2) was disbursed to family planning projects and programs.

Table 1.

Total FP Disbursements by Donors in 2012 in Ethiopia (Millions of Current US$)		
Amount	%	Donor organization
1.12	3	Packard Foundation
10.82	25	DFID* (UK)
0.04	0.1	NORAD (Norway)
0.00	0.01	Federal Ministry of Foreign Affairs Austria
11.16	25	USAID
7.16	16	Pathfinder International
0.40	1	International Projects Assistance Services
12.18	28	DKT International
0.58	1	UNFPA
0.10	0.2	Direction des Politiques de Développement France
0.40	1	Government of Republic of Korea
43.97	**100%**	

**Note: Per the request of the organization, data was not collected from the OECD but was collected from the Statistics on International Development of the Department for International Development (DFID). Source: RF NIDI database.*

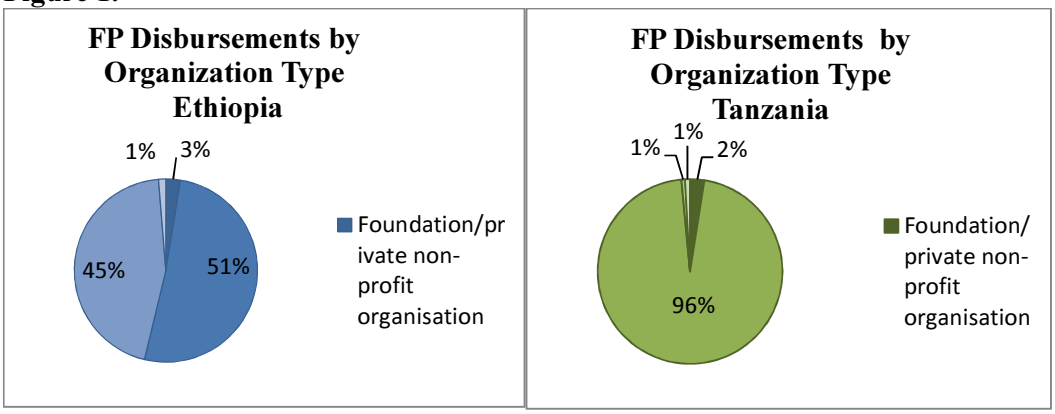
Table 2.

Total FP Disbursements by Donors in 2012 in Tanzania (Millions of Current US$)		
Amount	%	Donor organization
0.58	2	Gates Foundation
4.76	20	DFID* (UK)
2.02	9	CIDA (Canada)
13.76	59	USAID
1.74	8	Netherlands Ministry of Foreign Affairs
0.10	0.4	Pathfinder International
0.04	0.2	Population Action International
0.20	1	UNFPA
23.21	**100%**	

**Note: Per the request of the organization, data was not collected from the OECD but was collected from the Statistics on International Development of the Department for International Development (DFID). Source: RF NIDI database.*

In both countries the larger amount of aid came through bilateral channels. Figure 1 displays the proportion of FP funding origin by the different organization types in 2012. Donor governments accounted for 51% of family planning disbursements in Ethiopia and 96% in Tanzania.

Figure 1.



Source: Data extracted from NIDI RF database (July 15, 2014)

In Ethiopia, DKT International, DFID, Pathfinder International, John Snow, Inc. and Abt Associates were amongst the largest recipients of family planning funding in Ethiopia (table 3). The first three however reported family planning projects which were implemented and funded by their own organization. Recipients enlisted as unknown can be private consultants, government departments or organizations of which the details were not provided. It also happens that the recipient organization use the funds for their own activities, aligned and/or independent of governmental activities.

Table 3.

Recipients of FP Disbursements in 2012 in Ethiopia (Millions of Current US$)	
Receiving Org	Amount
DKT International*	12.18
Department for International Development (DFID)*	10.78
Pathfinder International*	10.53
John Snow, Inc.	3.48
Abt Associates	1.85
EngenderHealth, Inc.	0.65
United Nations Population Fund*	0.58
ICF Macro International	0.50
University of North Carolina Chapel Hill	0.40
International Projects Assistance Services*	0.40
Unknown - directly from/to University or Research institute	0.37
Save the Children International	0.35
Unknown - directly from/to national NGO	0.28
Family Health International	0.28
Consortium of Christian Relief and Development Association	0.25
Oromia development Association	0.17
Deutsche Stiftung Weltbevölkerung	0.15
Government of Ethiopia	0.13
Ethiopian Public Health Association	0.12
Unknown - directly from/to government	0.10
Relief Society of Tigray	0.10
QED Group, LLC	0.06
United States Agency for International Development*	0.06
Gurage People's Self-help and Development Organization	0.05
Unknown - directly from/to international NGO	0.04
Norwegian Lutheran Mission	0.04
Unknown - directly from/to Public-Private Partnerships (PPP)	0.04
U.S. Government - International Cooperative Administrative Support Services	0.03
Unknown - directly from/to other organizations/individuals	0.01
Federal Ministry of Foreign Affairs Austria*	0.00
Ethiopian Telecommunication	0.00
Green International Logistic Services	0.00

*Funding received from own organization. Source: Data extracted from NIDI RF database (July 15, 2014).

Table 4 indicates that DFID, Marie Stopes International, EngenderHealth, Inc., and Population Services International were the largest recipients of donor aid for family planning projects implemented in Tanzania. Note that DFID, USAID, Pathfinder International and the UNFPA reported family planning funding which went to their own organization.

Table 4.

Recipients of FP Disbursements in 2012 in Tanzania (Millions of Current US$)	
Receiving Org	Amount
Department for International Development (DFID)*	4.76
Marie Stopes International	3.91
EngenderHealth, Inc.	3.40
Population Services International	2.84
John Snow, Incorporated	1.85
Johns Hopkins University	1.67
Primary Health Care Institute	0.78
United Nations Development Programme	0.70
Government of Tanzania (Center for Educational Development in Health)	0.48
African Medical and Research Foundation	0.44
CARE Canada	0.36
Aga Khan Foundation	0.32
Macro International	0.27
KIGOMA ZTC	0.24
Abt Associates	0.24
United Nations Population Fund*	0.20
IntraHealth International	0.20
Plan International Canada	0.15
Pathfinder International*	0.10
Family Health International	0.10
Futures Group International	0.06
International Planned Parenthood Federation	0.05
Broadcasting Board of Governors	0.03
Unknown - directly from/to national NGO	0.03
Marie Stopes Tanzania	0.02
United States Agency for International Development*	0.01
Partnership for Supply Chain Management	0.01

*Funding received from own organization. Source: Data extracted from NIDI RF database (July 15, 2014).

Table 5 summarizes the main destination of the flows generated by the donors. Main recipients are non-for-profit institutions (NPI), NGOs, through a diversity of projects, whereas a relatively low amount is channeled to the government. Governmental funds are mainly provided by bilateral agencies, notably by USAID. The NPI concentrate the larger amount of projects and funds, notably coming from bilateral, NGOs & global agencies (UNFPA). This situation is found both in Ethiopia as well as in Tanzania, with minor variations among them, such as the amount of resources, the number of projects and the diversity of donors. It also reflects that the control of the use of the external resources is largely kept outside the governments.

Table 5. Family planning resources in Tanzania and Ethiopia: origin and destination

Tanzania donor data in Resource Flows database (Feb 2015)			
Recipient	**Amount or FP**	**Number of projects**	**Donor**
Government	0.51	4	Bilateral (USAID)
NPI	22.70	44	Bilateral, NGO & UNFPA
Total	23.21	48	

Ethiopia donor data in Resource Flows database (Feb 2015)			
Recipient	**Amount or FP**	**Number of projects**	**Donor**
Government	0,26	8	Bilateral (USAID & France)
NPI	43,70	72	Bilateral, NGO & UNFPA
Total	43,97	80	

Source: Elaborated from NIDI RF database.

The objective of the projects/programs vary, although many aim to improve integrated reproductive health and family planning services and enhanced accessibility. For example, USAID reported numerous projects they funded in Ethiopia and Tanzania with the same description: "expand access to high-quality voluntary family planning services and information, and reproductive health care. This element contributes to reducing unintended pregnancy and promoting healthy reproductive behaviors of men and women, reducing abortion, and reducing maternal and child mortality and morbidity." The focus of these projects includes social marketing, capacity and communications, service delivery or providing general support to family planning organizations. In both countries, Abt Associates, EngenderHealth, Inc., Family Health International and John Snow, Inc. received funding from USAID to implement these projects. Furthermore, the Government of Tanzania (e.g. Center for Educational Development in Health), IntraHealth International, Macro International, Kigoma Zonal Training Center, Population Services International, Marie Stopes International, amongst others received funding from USAID for implementing these projects in Tanzania, whilst Save the Children International, University of North Carolina Chapel Hill and the government of Ethiopia are examples of organizations receiving USAID funds for family planning in Ethiopia.

A further example includes Population Action International which funded two projects in Tanzania in 2012: 1) Advance family planning which aimed to promote advocacy to advance family planning in Ghana and Tanzania (funds went to Marie Stopes Tanzania) and 2) RH Budget Watch which aimed to build evidence on whether budget lines for contraceptives are actually being spent, and to inform global and national level advocacy to promote access to family planning (funds went to Pathfinder Tanzania). In Ethiopia, the David and Lucile Packard Foundation provided funding to numerous organizations for various projects in that same year. For example, the Ethiopian Public Health Association received funding for "Strengthening the Link between Households and Primary Health Care Units, for Improved Reproductive Health /Family Planning Services" whilst funding to the Gurage People's Self-help and Development Organization intended to "Improve the RH/FP status of young people through economic and social empowerment."

3.1.2 Other references

To provide some perspective on the estimations, we looked at other reports with similar data. These were the national health accounts conducted within the countries which present the amount of reproductive health expenditures financed by donors, amongst other aspects. These reports are the only ones that are published and can be freely quoted. It was also analysed the estimate available for Tanzania through recoding the OECD CRS survey codes in order to identify better the RMNCH data by CountDown. Finally, the report of the SHA 2011 where data on FP has been extracted. These two sources require permission to be cited, thus should be treated as confidential.

National Health Accounts and Reproductive Health Subaccounts for Tanzania

A National Health Account (with sub-accounts for HIV/AIDS, malaria, reproductive and child health) was conducted for the year 2010 in Tanzania[2]. The reproductive health subaccount findings indicate that the Total Health Expenditure on Reproductive Health (THE_{RH}) was roughly $313 million in 2009/2010, of which 30.4% was financed by donors, 48.4% by the private sector and 21.2% was financed by the public sector (including parastatals). This means that according to the NHA donors financed approximately $95 million to reproductive health. The exact amount for family planning contributed by donors cannot be extracted from the NHA. Donors tracked by the RF project financed an amount of $23.2 million to family planning in 2012 (note the different in years) – which is approximately ¼ the amount of the 2010 NHA figure. No conclusion can be drawn here, as the years and ICPD categories are not entirely comparable.

The majority of the THE_{RH} funds in 2009/2010 were used by public hospitals (45.3%) and public health centers and dispensaries (23.6%) to deliver reproductive health care. From the NHA can be extracted that roughly 5% of the amount of the THE_{RH} was used for outpatient family planning services, 0.08% was used for family planning information, education and communication (IEC) (including counseling), and 0.5 % was for maternal and child health, family planning and counseling (including IEC, public awareness campaigns, etc.). Additional expenditures on family planning were probably made, but cannot be explicitly extracted from the NHA. Further details can be found in annex 4.

National Health Account and Reproductive Health Subaccount for Ethiopia

Ethiopia's fifth National Health Account was conducted for the year 2010/2011 and includes a reproductive health subaccount[3]. Fourteen percent of the total health expenditure was used for reproductive health and financed by the rest of the world[4] (47 percent), households (28 percent) and the government (25 percent). This means that approximately $105 million was paid by donors for RH in 2010/2011. The RF project indicated that donors financed an amount of $136 million to RH/FP in 2012 (note the difference in years) of which $43.96 million was for FP only. No conclusion can be drawn here, as the years and ICPD categories are not entirely comparable.

Of the $224 million (Birr 3.6 billion) spent on reproductive health according to the NHA, 42 percent was spent on outpatient maternal health care, 16 percent on prevention and public

[2] Source: National Health Accounts Year 2010. Ministry of Health and Social Welfare. May 2012.
[3] Source: Ethiopia's fifth national health accounts, 2010/2011. Federal Democratic Republic of Ethiopia Ministry of Health. April 2014.
[4] Definition "rest of the world": all international/foreign-based institutions that play a role in the financing and/or transactions of resources in the country's health system, including bilateral and multilateral donors and international NGOs

health programs of reproductive health care, 15 percent on general government administration, 15 percent on capital formation and 10 percent on inpatient care. Of the total amount for reproductive health, roughly Birr 13.44 million was used for the function family planning (pills, depo, Norplant, IUCD) and Birr 176.87 million was used for family planning and counselling. The latter figures are showcased in the table in annex 2.

See annex 4 for background information

Count Down estimates for RMNH for Ethiopia (CONFIDENTIAL DATA)

The aid flows reported by Count Down to Ethiopia[5] for 2010, are also difficult to compare due to boundary uncertain for FP: They are 279.6 Million USD for RMNH and 204.452 Million USD for RH only. Interestingly, both the CD series related to "reproductive health" and that one added to MNH halved the level reported by RF (49.9%). This calls for the identification of the sources of such difference. It seems that one reason apparent could be the boundary too, as "basic research" is included by NIDI but it is not necessarily recognized as health expenditure in all frameworks.

SHA 2011 estimates for FP for Tanzania (CONFIDENTIAL DATA)

Another reference useful to validate the results is the SHA 2011 estimate including data on FP spending for Tanzania. It refers to 2012 and amounts for current spending 18 Million USD, of which 78% is from donors (14 Million USD). This amount is close to that estimated by NIDI of 23.2 million USD but with a difference of 40% lower.

It seems important to clarify from that study the amount of capital spending for FP as shares and amount appear not aligned.

[5] Count Down data was recoded from OECD CRS original reports from donors to capture those resources not reported as RMNCH categories as first and main purpose. These data is not yet released and should be treated as confidential.

	2012
Current expenditure on Contraceptive management (family planning) (million US$)	18
Current expenditure on Contraceptive management (family planning) (million PPP$)	46
Expenditure from government funding (%)	9%
Expenditure from external funding (%)	78%
Expenditure from private funding (%)	11%
% total current expenditure	1%
per capita in US$	368
per Women of 15-44 in US$	
pharmaceuticals % total current expenditure on Contraceptive management (family planning)	11%
Earmarked Contraceptive management (family planning) capital expenditure (million US$)	**373.554.862**
% total capital expenditure	0%

Origins of Funds (million US$)	2012
Government funding	2
External funding	14
Bilateral donors	14
Global Fund	0
other external funding	0
Private funding	2
TOTAL current expenditure on Contraceptive management (family planning)	**17**
Government funding % total expenditure on Contraceptive management (family planning)	9%
Foreign funding % total expenditure on Contraceptive management (family planning)	79%

The use of the foreign resources is described in detail in the next table. The expenditure on pharmaceuticals (including contraceptives) was measured as 1,593.386517 Million USD, though most of the use of the external resources are not able to be identified.

Tracking the detail of the use of the resources is a major challenge due to lack of appropriate reporting at country level and lack of monitoring by the donor, which could merit an additional effort when the resources are not earmarked.

Use of current spending on Family Planning in Tanzania by funding agencies, 2012, SHA 2011

	Government	Foreign sources	Global Fund	Other foreign sources	Private sources	TOTAL
Inpatient curative care						
Compensation of employees	**34.775.474**	**113.735.592**	12.418	113.723.174	**24.728.800**	**173.239.866**
Materials and services used	**138.600.894**	**769.819.305**	597.447	769.221.857	**117.793.199**	**1.026.213.398**
Health care goods	**16.199.307**	**337.977.997**		337.977.997	**81.036.116**	**435.213.419**
Pharmaceuticals	**7.977.736**	**220.168.171**		220.168.171	**60.053.938**	**288.199.846**
Diagnostic equipment	**408.784**	**27.565.947**		27.565.947	**3.362.307**	**31.337.038**
Non-health care services	**92.039.179**	**281.720.748**	433.977	281.286.770	**24.947.249**	**398.707.176**
Training	**2.870.243**	**1.861.216**	1.541	1.859.675		**4.731.459**
Technical Assistance	**68.192.324**	**131.117.373**	48.236	131.069.137	**12.055.991**	**211.365.689**
Non-health care goods	**30.362.408**	**150.120.560**	163.470	149.957.090	**11.809.834**	**192.292.802**
Other factors of health care provision (n.e.c.)	**14.331.794**	**530.300.164**	48.917	530.251.247	**802.029.674**	**1.346.661.633**
Outpatient curative care						
Compensation of employees	**140.024.193**	**595.364.762**	28.974	595.335.788	**167.648.613**	**903.037.568**
Materials and services used	**872.931.981**	**3.723.460.803**	1.638.481	3.721.822.322	**643.074.031**	**5.239.466.815**
Health care goods	**93.575.041**	**1.950.911.400**	75.450	1.950.835.951	**450.829.006**	**2.495.315.447**
Pharmaceuticals	**34.297.998**	**1.373.218.346**		1.373.218.346	**319.453.348**	**1.726.969.692**
Diagnostic equipment	**953.829**	**136.402.607**		136.402.607	**37.472.191**	**174.828.627**
Non-health care services	**681.832.446**	**1.178.633.887**	1.166.276	1.177.467.611	**126.288.164**	**1.986.754.497**
Training	**9.758.506**	**4.398.548**	3.595	4.394.953		**14.157.054**
Technical Assistance	**596.735.978**	**514.621.565**	125.823	514.495.742	**46.346.977**	**1.157.704.520**
Non-health care goods	**97.524.494**	**593.915.516**	396.756	593.518.760	**65.956.862**	**757.396.871**
Other factors of health care provision (n.e.c.)	**49.945.177**	**556.126.864**	114.141	556.012.724	**1.350.880.086**	**1.956.952.128**
Medical goods (non-specified by function)						
Other factors of health care provision (n.e.c.)					**51.803.420**	**51.803.420**
Pharmaceuticals and other medical non-durable goods						
Other factors of health care provision (n.e.c.)					**51.803.420**	**51.803.420**
Preventive care						
Materials and services used	**979.935.642**					**979.935.642**
Health care goods	**979.935.642**					**979.935.642**
Pharmaceuticals	**750.000.000**					**750.000.000**
Other factors of health care provision (n.e.c.)	**200.000.000**	**14.427.696.157**		14.427.696.157		**14.627.696.157**
Information, education and counseling programmes						
Materials and services used	**979.935.642**					**979.935.642**
Health care goods	**979.935.642**					**979.935.642**
Pharmaceuticals	**750.000.000**					**750.000.000**
Other factors of health care provision (n.e.c.)	**200.000.000**	**13.495.296.157**		13.495.296.157		**13.695.296.157**
Other preventive care (n.e.c.)						
Other factors of health care provision (n.e.c.)		**932.400.000**		932.400.000		**932.400.000**
Governance, and health system and financing administration						
Compensation of employees	**13.872.704**	**18.077**		18.077	**851.085**	**14.741.867**
Materials and services used	**12.388.402**	**14.333.105**		14.333.105	**743.191**	**27.464.697**
Non-health care services	**5.078.406**	**3.191.789**		3.191.789	**721.346**	**8.991.541**
Non-health care goods	**7.309.996**	**11.141.316**		11.141.316	**21.845**	**18.473.157**
Other factors of health care provision (n.e.c.)	**387.079**	**223.638.066**		223.638.066	**50.848**	**224.075.994**
Governance and Health system administration						
Compensation of employees	**13.872.704**	**18.077**		18.077	**851.085**	**14.741.867**
Materials and services used	**12.388.402**	**14.333.105**		14.333.105	**538.561**	**27.260.067**
Non-health care services	**5.078.406**	**3.191.789**		3.191.789	**516.716**	**8.786.910**
Non-health care goods	**7.309.996**	**11.141.316**		11.141.316	**21.845**	**18.473.157**
Other factors of health care provision (n.e.c.)	**387.079**	**223.638.066**		223.638.066	**50.848**	**224.075.994**
Planning & Management						
Compensation of employees		**18.077**		18.077	**851.085**	**869.162**
Materials and services used		**910.618**		910.618	**381.810**	**1.292.427**
Non-health care services		**761.259**		761.259	**359.965**	**1.121.224**
Non-health care goods		**149.359**		149.359	**21.845**	**171.204**
Other factors of health care provision (n.e.c.)		**223.638.066**		223.638.066		**223.638.066**
Monitoring & Evaluation (M&E)						
Other factors of health care provision (n.e.c.)					**50.848**	**50.848**
Other governance and Health system administration (n.e.c.)						
Materials and services used					**156.751**	**156.751**
Non-health care services					**156.751**	**156.751**
Administration of health financing						
Materials and services used					**204.630**	**204.630**
Non-health care services					**204.630**	**204.630**
Other health care services not elsewhere classified (n.e.c.)						
Other factors of health care provision (n.e.c.)		**699.300.000**		699.300.000		**699.300.000**

Limitations of the survey process

After comparing the various figures available, can be concluded that the expenditure on external resources correspond to the level set by the RF project. However, not a fine accuracy can be expected, due to various factors. In general, reports from country are larger due to the information gaps in the OECD and other records (e.g. linked to Chinese grants, etc).

Several boundaries should be clarified for a more careful comparison on the content, e.g. the basic research component, as well as the spending associated to the donor management, which are both excluded in the national reports. The description of the projects by the donor are the main source of information and they are not fully reported neither in a standardized content to facilitate the resource tracking. It is important to refer that amounts reported by donors use to be larger than those reported by the recipient country for the same donor.

The most common problem experienced by respondents on the difficulty in disaggregating expenditures made to the four ICPD categories as their records may not aim at a single objective. E.g. health of the mother and the child involve both ICPD and non ICPD classes. Besides, there is not in use a standard classification in donor records and not always the aggregates can match the needs. For example, the World Bank tracks commitments for Population and Reproductive Health so although it may seem as if the World Bank does not fund family planning, this is actually just a reflection of their accounting system whereby family planning is included under reproductive health. Due to this, the RF project underestimates the expenditures for family planning as these can be dependent on the donor's definition of reproductive health and family planning, wherein the latter is sometimes included under reproductive health.

For each project/program reported in the RF survey respondents are requested to indicate the location of the project/program. If projects/programs are implemented in multiple countries they are often reported per region or if they are implemented in different regions, even on a global scale. This disallows us to show family planning expenditures at country level. This is the case for data received from the International Planned Parenthood Federation (IPPF) for example. Data received from IPPF indicates that the organization spent nearly $123 million on population in 2012, of which roughly $35.5 million was disbursed to family planning activities. Whether (some of) this funding was allocated to Ethiopia or Tanzania remains unknown, as the recipient countries of the projects are reported on a regional or global level.

Not all major family planning donors have provided data. Marie Stopes International (MSI) was approached for the 2012 survey round but indicated that they could not participate as they are currently working on replacing their grants database and "are taking steps to contribute to DFID's International Aid Transparency Initiative" allowing their activities to be publicly available. The Open Aid Search IATI website[6] presents data on project level, in which three family planning projects (sector code 13030) for Ethiopia were reported by MSI: 1) Preventing maternal deaths from unwanted pregnancy (implemented in numerous countries) (budget GBP £64.07 million); 2) Improving maternal health for poor women in rural Ethiopia (budget: GBP £1.28 million) and 3) Protect and Advance Sexual and Reproductive Health Rights of Poor People (budget: GBP £493,339). It is not clearly indicated in which period these projects were implemented, but it can be assumed that the 2012 figure on donor expenditures for family planning produced by RF is underestimated and should (partly) include MSI's expenditures. No family planning projects were reported by MSI for Tanzania.

[6] Source: http://www.openaidsearch.org

3.2 Family planning spending in Tanzania

This section displays the report as proposed by APHRC with minor editions, and with additional NIDI notes shown in boxes. The results of the domestic survey are displayed for Tanzania: with an outline of all donor financial flows in programs within Tanzania in 2012. This will be followed by a summary of income and expenditure in Tanzania in 2012 as reported by NGOs, government departments and large corporations.

During data collection and identification of organizations, no local philanthropic organization in Tanzania was reported to fund family planning programs. In addition, no insurance company contacted offered reimbursement of any contraceptive methods or family planning services related claims.

3.2.1 Non-Governmental organizations

Table 1 below summarizes the different non-governmental organizations (NGOs) that provided data in Tanzania.

3.2.1.1 Types of NGOs responding to the survey

Out of 25 NGOs sampled, two, one in Arusha and another in Mbeya/Tanga were not reached due to logistical challenges. Twenty-three were served with questionnaires. Of the twenty-three, that received questionnaires, 10 returned completed questionnaires.

Table 3.2.1: Summary of NGOs and types	**No. of NGOs**
Level of NGO operations	
National NGOs	9
Lower level: State / Provincial, Regional, Municipal	1
Type of NGOs	
National NGO	4
Research institute	1
Umbrella organization	1
Other [ξ]	4
Total	**10**

[ξ] *All the four NGOS listed as "Other" were "International NGO"*

Nine of the ten NGOs were national in operations while one operated only in a region in Tanzania. On their legal status, four were international NGOs, one a research institution, while another was an umbrella organization. In this survey, umbrella organizations were defined as coordinating institution/agencies that do not implement their own programs, but only channels funds to other implementing organizations. There were four NGOs, which were nationally registered to operate in Tanzania.

3.2.1.2 Revenue of NGOs in 2012

To estimate the amount of funds flowing into family planning activities in Tanzania through NGOs, we asked respondents to estimate the total income received for FP related activities in 2012 from both domestic and international sources. Table 2 below presents this data by the type of NGO.

Table 3.2.2: Revenue of NGO in 2012

	Income amount in USD.			
	Domestic sources	**International Sources**	**Own sources**	**Total**
Type of NGOs				
National NGO	164,288	334,652	37,590	536,530
Research institute	-	800,000	-	800,000
Umbrella organization	-	-	-	-
Other	-	2,063,987	-	2,063,987
Total	**164,288**	**3,198,639**	**37,590**	**3,400,517**

** Three NGO [Restless Development Tanzania, Christian Social Services Commission (CSSC) and UTU Mwanamke] reported no FP funding in 2012*

Out of the 10 NGOs that provided data, three did not specify any particular income for family planning in 2012. As shown in Table 2 above, out of the seven that provided data, only 5% (USD. **164,288**) of all family planning revenues came from domestic sources. NGOs contributed only about 1% (USD. **37,590**) of revenues from own sources. NGO's own resources considered incomes from contributions, user fees, profits, interest earned on endowments, or forms of cost recovery. Most of NGOs revenues were from international sources.

It seems to be needed a better standardization of the classifications used, in case the research institute is governmental, it should be classified as corporation or governmental, pending in financing status (e.g. autonomous hospitals are corporations).

We also sought to identify the sources of these revenues for family planning. As shown in table 3 below, 70% (USD. **1,804,436**) of all revenues reported were from foreign governments, mostly through the USAID. UN-based organizations provided 10% (USD. **259,551**) of all funds reported by the participating NGOs while International NGOs funded about 19% (USD. **498,940**) of all FP programs reported by all sampled NGOs as shown in table 3 below.

Table 3.2.3: Revenue of NGO by type of source in 2012

	Income Amount in USD.	**%**
Type of donor		
Foreign government	1,804,436	70%
UN organisation/agency	259,551	10%
International NGO	498,940	19%
Total[Æ]	**2,562,927**	**100%**

[Æ] Some of the NGOs were unable to provide this split of funds. This list therefore, only includes NGOs that affirmatively responded to this question.

3.2.1.3 Family Planning Expenditure

In addition to income and its sources, we further sought to identify the general location of activities and programs where the above revenues are spent. As presented in Table 4 below, we identified the proportion of FP funds that were channeled into FP activities within Tanzania or outside Tanzania.

About 19% ($ 633,451) of funds received in 2012 ($3.4 M) were still unspent by the end of 2012, mainly due to pending activities, which split into 2013. A further 8% ($ 233,133) of all funds spent on programs in 2012 was on programs outside the Republic of Tanzania. Therefore, this spending should not be accounted for Tanzania FP, and the amount be adjusted to **2,533,933 USD**.

Table 4: NGO Expenditure in 2012 by type of NGO

	Expenditure amount in USD		
Type of NGOs	**On Domestic programs**	**On international programs**[ξ]	**Total**
National NGO	335,208	177,871	513,079
Research institute	218,750	31,250	250,000
Umbrella organization	-	-	-
Other	1,979,975	24,013	2,003,988
Total [ξ]	**2,533,933**	**233,133**	**2,767,066**

** Three NGO [Restless Development Tanzania, Christian Social Services Commission (CSSC) and UTU Mwanamke] reported no FP funding in 2012*

[ξ] Difference between income (Table 3) and expenditures (Table 4) in 2012

- *Differences were because some activities were still on going and were reported as carried forward to the next financial year 2013/2014*
- *For some NGOs, data was reported inclusive and the respondents were not able to separate these, since the programs reports do not. These are programs implemented by one NGO but would cut across different countries such as Northern Tanzania and southern Kenya.*

Effectively, about 74% ($2,533,933) of all funds received in 2012 were spent on programs within Tanzania in 2012.

As shown in Table 5, almost all funds ($2,529,006) of all domestic expenditure ($2,533,933) were reported as recurrent, while the rest were reported as capital expenditure. These recurrent expenses comprised expenditure on monitoring, evaluation and research (31%- USD. **787,325**), staff costs- for direct service provision (20%- USD. **511,125**), operational expenditure (13%- USD. **332,402**), policy and advocacy (11%-USD. **266,178**) and capacity building and training (9%-USD. **234,085**). Program management staff costs also took up about 8% (USD. **213,848**) of all NGO's recurrent expenditure. Interestingly, only 2% ($53,614) of recurrent expenditure on family planning went directly to funding purchase of contraceptives in 2012.

Table 5: NGO FP Expenditure in 2012 by category of recurrent expenditures	**Recurrent Expenditure in 2012 USD**	**%**
Internal service staff costs (for direct service provision)	511,125	20%
Outsourcing of services	-	0%

Contraceptives, medicine & other consumables (retailed and provided)	53,614	2%
Information, Education and Communication (IEC)	5,673	0%
Policy Development and Advocacy	266,178	11%
Management Information System (MIS) and Health Information System (HIS)	117,199	5%
Monitoring, Evaluation and Research	787,325	31%
Capacity building/training (for all categories mentioned above)	234,085	9%
Program Management Staff costs (non-service delivery)	213,848	8%
Operational expenditure	332,402	13%
Other: please specify:	7,557	0%
Total[§]	**2,529,006**	**100%**
[§] This is the total amount spent on recurrent expenditure.		

Table 6 below shows how the family planning contraceptive expenditure of $ 53,614 was spent on an assortment of methods. These costs included purchase/provision of consumables such as contraceptives (e.g. implants, IUDs, condoms, pills, etc.), medicine (e.g. pain management medication) or other consumables (e.g., cotton wool, medical or surgical gloves, gauze, antiseptic, etc.). In some cases, it also included medications that were dispensed in relation to FP. NGO expenditure on contraceptives in Tanzania is low and goes largely into short-term methods such as injectables (40%- USD. **21,634**), Pills (17%- USD. **9,030**) and condoms (15%-**7,901**). Notably, expenditure on permanent methods or long acting reversible contraceptives (LARCs) in Tanzania is very low as shown in table 6 below.

Table 6: NGO expenditure on FP methods in financial flows 2012 by type of contraceptive method

	Amount	**%**
Condoms	7,901	15%
Pills	9,030	17%
Emergency contraceptives (pills)	2,257	4%
Diaphragm	1,881	4%
Injectable contraceptives	21,634	40%
Implants	3,386	6%
IUDs	1,881	4%
Standard Days Method	1,129	2%
Medicine e.g. painkillers	2,634	5%
Other consumables e.g. gloves,	1,881	4%
Total	**53,614**	**100%**

3.2.1.4 Capital spending

NGOs reported that almost all funds on capital expenditure were used to acquire computers (67% i.e. $ 3,734) and office furniture (33% i.e. 1,872). However, the majority of the NGOs found major challenge separating the total expenditure between recurrent and capital and only reported a total sum.

A key issue is to identify whether some specific equipment is a key investment for FP service provision, so that it is improved the tracking. Besides the equipment it would be important to discuss other components, E.g. stocks on contraceptives.

3.2.1.5 Target populations

The majority of NGO funds were consumed collectively, through media advocacy services, taking up about 26% (USD **645,300**) of total recurrent expenditure. Among the personal services, rural populations follow media at 19% (USD. **474,485**) of all recurrent expenditure. While more family planning programs target women (18%- USD. **450,761**) than men (9%- USD. **237,243**), calls have recently been made for more focus on men as well as youth friendly family planning services (Kabagenyi et al., 2014; Kura, Vince, & Crouch-Chivers, 2013). In addition, there has been growing focus on integration of youth friendly FP services into mainstream care delivery functions such as HIV/AIDS treatment in order to drive FP uptake (Steinfeld et al., 2013). Table 7 below shows the level of concentration of FP-related expenditure on different population segments covered by NGOs in Tanzania.

Table 7: Expenditure on target populations by NGOs in 2012

	Amount	**%** [Æ]
Adolescents (10-19 years)	237,243	9%
Youth (15-24 years)	142,346	6%
Women	450,761	18%
Men	237,243	9%
HIV positive individuals	56,938	2%
Migrants	-	0%
Sex workers	47,449	2%
Health care workers	189,794	8%
Employees	47,449	2%
Rural population	474,485	19%
Researchers	-	0%
Other [¥]	645,300	26%
Total	**2,529,006**	100%

[¥]- *Collective consumption: Media advocacy*

[Æ] *Weighted percentage to account for non-mutually exclusive categories- This was done by summing all reported percentages (always more than 100%) and standardizing them such that all % add up to 100%. This involved expressing each reported proportion as a percentage of the total.*

3.2.2 Family Planning Governmental financing

Similar information to the NGOs was requested to the government.

3.2.2.1 Revenue for FP services in the government

Government spending on Family planning is a key indicator of their commitment to achieving the Millennium Development Goals (MDGs) on maternal health and all other multilateral commitments to achieving universal access to maternal health (Sidze, Pradhan, Beekink, Maina, & Maina, 2013). Table 8 below shows the total FP revenues and expenditure by the government of Tanzania in 2012.

Table 8: Revenues and expenditure of Government in 2012

	Amount (USD)	**%**
Domestic Income	3,125,000	25%
International income	9,600,000	75%

Total	**12,725,000**	**100%**
Domestic expenditure	11,100,000	87%

In Tanzania, government data show that about USD. 13 million was received or budgeted for family planning in 2012. However, 75% (USD. **9.6 million**) of this revenue was from international sources, as either grants or loans to government to implement family planning programs. Only 25% (USD. **3.1 million**) of these revenues were generated domestically as shown in table 8 above.

This information needs to be fully understood, as according to NIDI, the amount transferred directly from foreign origin is 0,51, quite lower to the 9,600,000 reported here. This means that the intermediary organization need to be further requested to indicate the recipient organization. This would allow to really track the flows. If considered RF database information, resources going directly to project are 6.1 million which could be accounted for here. If funds going to project and those given directly to the government are added they represent 6.6 million. That amount looks plausible, notably also admitting that some underreporting exists in RF database due to multiple purpose projects and limited coverage.

Eighty-seven percent (USD. **11.1 Million**) of funds raised by government to support FP activities were spent on domestic FP activities. Delays in the delivery of goods and non-domestic family planning expenditure could have accounted for the 13% difference in expenditure. All the above government expenditure on FP reportedly went into contraceptives.

Here are two remarks, one is that if governmental funds are only accounting for contraceptives, it should be added the value of the complementary services (e.g. delivery to the population, IEC, and procurement). Thus, here is underestimated the governmental expenditure. Also important to note is that whereas NGO s had a lower spending in the direct contraceptive cost, both sectors appear to be highly complementary.

In 2012, 43% (USD. **4.7 Million**) of all government expenditure on FP in Tanzania went into short term solutions: the provision of emergency contraceptive pills while a further 24% (USD. **2.7 Million**), 14% (USD. **1.5 Million**) and 13% (**1.4 Million**) was used to procure injectable contraceptives, condoms and contraceptive pills respectively.

Table 9: Government expenditure on FP methods by type of contraceptive method in 2012

	Amount	**%**
Condoms	1,498,500	14%
Pills	1,387,500	13%
Emergency contraceptives (pills)	4,717,500	43%
Diaphragm	-	0%
Injectables	2,664,000	24%
Implants	555,000	5%
IUDs	277,500	3%
Standard Days Method	-	0%
Medicine e.g. painkillers	-	0%
Other consumables e.g. gloves,	-	0%
Total	11,100,000	**100%**

3.2.2.2 Target populations

The MoH office reported to focus the FP activities focused mainly on women of reproductive age as well as sexually active men. The respondents were however unable to provide specific approximate distribution of how these funds were used across these target groups.

3.2.2.3 Capital spending

Capital expenditure on family planning was estimated from total expenditure as a fraction of the organization's FP component over all programs multiplied by the value of all capital goods used in all programs within the organization. However, no government department that participated in this study gave any specific expenditure lines according to the type of capital goods.

3.2.3 Large corporations and Family Planning

An important point to consider before reading this components, is that there was not a clear understanding on what is a corporation. The definition of corporation is any enterprise working for market production. In that sense, none of those included in the study as corporations belong to that class. They are really NGOs (USAID and John Hopkins). In consequence, a) the questionnaire really cannot be considered as tested in corporations b) the information requested in the NGOs questionnaire was not fully obtained, notably related to recipient organization, c) the information obtained, should be integrated as part of the NGOs results.

We further gathered data from three large corporations and estimated that they received $27.4 million in 2012 for family planning activities. As table 10 below shows, ninety-four (94%- USD. **25.7 Million**) of these funds were spent domestically while 6% (USD. **1.5 Million**) was spent on programs outside Tanzania.

Table 10: Revenue and expenditure of Corporations in 2012

	Amount	**%**

Domestic Income	-	0%
International income	27,400,000	100%
Total	**27,400,000**	100%
Domestic expenditures	25,700,000	94%

Interestingly, none of the corporations reported any domestic funding sources for their FP expenditure. This is understandable since the bulk of the funds raised by these large corporations were actually disbursed to other NGOs. In addition, just like the case for NGOs and government departments, large corporations reported that about 6% (USD. **1.5 Million)** of the total family planning income in 2012 was either unspent by the end of the financial year or spent on international activities outside Tanzania.

3.2.3.1 Type of origin of funds

Table 11: Type of source of funds of large corporations in 2012

	Income amount in USD	
	Total	**%**
Type of donor		
Government department of your own	-	-
Foreign government	4,150,000	15.4 %
UN organization/agency	-	-
International development bank	-	-
National NGO	6,386,000	23.7 %
International NGO	14,912,257	55.4 %
Private for-profit company	1,488,000	5.5%
Other organizations/individuals	-	
Total *	**26,936,257**	**100.0%**

USAID reported income sources as a breakdown of income "spent" and not income "earned" hence the difference in total incomes here and in Table 10.

More than half (55% i.e. USD. **14.9 Million**) of all funds to large corporations were grants from international NGOs, while 24% (USD. **6.4 Million**) were from national NGOs. In addition, 15% (USD. **4.2 Million**) and 6% (USD. **1.5 Million**) of resources for FP to large corporations in Tanzania came from foreign governments and private profit-making companies.

3.2.3.2 Family planning Expenditure

Unlike NGOs, almost half of all revenues generated by large corporation went into supporting programs related to government and community engagements.

Table 12: Corporations' expenditure in 2012 by area of focus	**Recurrent Expenditure in 2012 USD**	**%**
	-	0%
Internal service staff costs (for direct service provision)	-	0%
Outsourcing of services	-	0%
Contraceptives, medicine & other consumables (retailed and provided)		0%

Information, Education and Communication (IEC)	856,000	42%
Policy Development and Advocacy	232,985	12%
Management Information System (MIS) and Health Information System (HIS)	32,000	2%
Monitoring, Evaluation and Research	-	0%
Capacity building/training (for all categories mentioned above)	96,000	5%
Program Management Staff costs (non-service delivery)	316,000	16%
Operational expenditure	139,015	7%
Other: please specify:	-	0%
Total [β]	**1,672,000**	**83%**

[β] *Based on two corporations. The third corporation did not give breakdown of expenditures. These two corporations could not delineate staff costs from other program costs*

The largest portion of Family Planning budget went into information, education and communication activities (42%- USD. **856,000**). Program management comprised about 16% (USD. **316,000**) of funds while a further 12% (USD. **232,985**) of corporations' expenditure supported family planning policy development and advocacy in Tanzania.

Here is important to note that the reported income of the so called corporations involves 26.9 million USD, of which, they report only 1.7 as operational spending. That leaves that the amount received were largely channeled to the government and to NGOs.

3.2.4 Total FP Financing

For this section of the report, the so called here "corporations" should be considered as NGOs.

3.2.4.1 Total income

Table 13 below presents the total funding to government and NGOs in Tanzania in 2012. Over 43 million dollars were reported family planning income to all organizations considered in this survey for the year 2012.

Table 13: The family planning Revenue and expenditure in 2012

	Amount	**%**
Domestic Income	3,289,288	8%
International income	40,198,639	92%
Own Sources	37,590	0%
Total	**43,525,517**	**100%**
Domestic expenditure	39,333,933	90%

In total, similar to what was reported by the different organization-types, 92% (USD. **40.2 Million**) of all FP income was from international sources while only about 8% (USD. **3.3 Million**) was from domestic sources. Organizations' own sources for FP were below 1% (USD. **37,590**). Of the 43.5 million dollars, about 10% (USD. **4.2 Million**) was unspent in 2012 and this was mainly due to delayed project activities.

The total amount reported here appears to be larger than the one estimated by NIDI. However, if considered that the corporations are really intermediary NGOs, their external resources received were

27,4 million, or 26.94, -pending on the table used-, which should be deducted of the total, assuming they were channeled to the government and NGOs and then are reported by them. If fully deducted, the total becomes 12,8 million, which represent about 55% of the total external funds entering Tanzania according to NIDI, which is quite good as sample if considered that this is only a test. This, however, should be verified. If assumed that the test involves 55% of the total external funding received, the shares could be used to expand the total reported by NIDI to integrate the total flows.

3.2.4.2 Total expenditure

If added the totals reported as spending: NGOs 2.53, government 11.1 and corporations 25.7, the total spending on FP vary from 39.2 million USD, to 27,4 pending on the assumption used to integrate the spending of the intermediary NGOs. A reliable overview of the uses of the funds is not possible here. However, shares can be applied to NIDI totals to re-build the flow.

The NGOs reported highest expenditure on Information, Education and Communication (21%- USD. **861,673**) and Monitoring, Evaluation and Research (19%-**787,325**).

Table 14: Total FP expenditure by type of activity in 2012

	Recurrent Expenditure in 2012 (USD)	**%**
Internal service staff costs (for direct service provision)	511,125	12%
Outsourcing of services	-	0%
Contraceptives, medicine & other consumables (retailed and provided)	53,614	1%
Information, Education and Communication (IEC)	861,673	21%
Policy Development and Advocacy	499,163	12%
Management Information System (MIS) and Health Information System (HIS)	149,199	4%
Monitoring, Evaluation and Research	787,325	19%
Capacity building/training (for all categories mentioned above)	330,085	8%
Program Management Staff costs (non-service delivery)	529,848	13%
Operational expenditure	471,417	11%
Others	7,557	0%
Total	**4,201,006**	100%

Data available only for NGOs and large corporation. In addition, one large corporation which was a major spender in FP could not give breakdown of data in this section

According to table 14, another areas of FP expenditure focus was on program management staff costs (non-service delivery) (13%- USD. **529,848**). Policy development and advocacy as well as internal service staff costs (for direct service provision) each at 12% (USD. **499,163**) while 11% of expenditure was on operational costs (USD. **471,417**).

Table 14 does not appear clear on how the values are reported: before, the total spending of government (11.100 million) was devoted to contraceptives, which are consistent with the table below, but not evident in table 14.

Table 15 below shows the breakdown of 11 million dollars reported by NGOs and Government that was spent on contraceptive methods according to type of method. Emergency contraceptives consumed the largest chunk of these resources (42%- USD. **4.7 Million**) while injectable contraceptives followed closely taking up 24% (USD. **2.7 Million**) of all FP commodity resources.

Table 15: Total FP expenditure on family planning methods 2012 by type of contraceptive method		
	Amount	**%**
Condoms	1,506,401	14%
Pills	1,396,530	13%
Emergency contraceptives (pills)	4,719,757	42%
Diaphragm	1,881	0%
Injectables	2,685,634	24%
Implants	558,386	5%
IUDs	279,381	3%
Standard Days Method	1,129	0%
Medicine e.g. painkillers	2,634	0%
Other consumables e.g. gloves,	1,881	0%
Total	**11,153,614**	**100%**

Notably, the high expenditure on emergency contraception was mainly driven by government's expenditure of 43% of its 11 million dollars on emergency contraceptives. In total, only about 8% of all revenues spent on FP goods was on long-acting methods i.e. IUDs (3%) and implants (5%).

3.2.4.3 Comments provided in the survey by respondents

There were 9 comments received out of the 17 surveys responded. Mainly as requested in the questionnaire, they referred to comments to clarify their scope of work (6). In 2 questionnaires it was mentioned the survey as useful, though in one case it was also mentioned that specific accounting knowledge was needed to fill it. The same questionnaire was very positive of the study.

3.3 Family planning spending in Ethiopia

This section presents data collected from a sample of Non-governmental organizations in Ethiopia who are actively implementing family planning programs either nationally or sub-nationally, in different regions of the country. No data was obtained in the other FP actors.

3.3.1 Non-Governmental organizations

Table 13 below summarizes the different non-governmental organizations (NGOs) that provided data in Ethiopia.

3.3.1.1 Types of NGOs responding to survey

Table 16: Summary of NGOs and types	**No. of NGOs**
Level of NGO operations	
National NGOs	4
Lower level: State / Provincial, Regional, Municipal	4
Type of NGOs	
National NGO	5
Other[ξ]	3
Total	**8**

[ξ] *2 of the 3 NGOS listed as "Other" were "International NGO" and FBOs. The third was unspecified*

Eight NGOs out of 21 sampled NGOs responded and returned completed questionnaires. Of these, one NGO began family planning programming in 2013, and so did not return any data for the 2012 financial year. Of the seven NGOs with complete data, four were large NGOs with national operations while four were regional with operations limited to specific regions in Ethiopia. In terms of registration, five of these NGOs were nationally registered, two were international NGOs and one was a faith-based organization.

3.3.1.2 Revenue of NGOs in 2012

Table 17 below presents the estimated total and percentages revenues reported by the responding NGOs for the financial years 2012.

Table 17: Revenue by source in 2012

	Income Amount in USD. and % share						
Type of NGOs	**From Domestic Sources**	%	**From International sources**	%	**From Own sources**	%	**Total**
National NGO	3,263	0%	5,707,907	93%	424,232	7%	6,135,403
Other	-	0%	2,095,001	100%	-	0%	2,095,001
Total	**3,263**	0%	**7,802,908**	95%	**424,232**	5%	8,230,404

A total of USD. 8.2 million was received by these seven NGOs in 2012 in Ethiopia for FP related activities. Of these, 95% was from international sources while a further 5% was from own sources from NGOs mainly through cost-shared programs and revenues from facilities. Notably, only less than 0.5% of these revenue were from domestic funding sources.

On the types of revenue sources to NGOs in Ethiopia, table 18 below shows the distribution of revenue to NGOs in Ethiopia according to the type of source. These sources range from foreign governments to international NGOs or revenues from for-profit organizations.

Table 18: Type of source of funds of NGO in 2012

	%	**Income Amount in USD**
Type of donor		
Government department of your own	0%	-
Foreign government	57%	4,258,915
UN organisation/agency	12%	892,824
International development bank	0%	-
National NGO	6%	452,566
International NGO	23%	1,728,349
Private for-profit company	2%	176,713
Other organisations/individuals	0%	-
Total[ξ]	100%	**7,509,367**

[ξ] *A few NGOs did not provide information on the breakdown of sources of revenue. This*

explains the difference in total revenue between table 17 and 18

Almost six out of every ten dollars of funds going into family planning in Ethiopia through NGOs originated from foreign government, mainly the USAID and DFID. Interestingly, no NGO reported any income from Domestic government. Another significant source of FP funds in Ethiopia is international NGOs (23%- USD. **1.7 Million**) and UN agency such as the UNFPA.

3.3.1.3 Family Planning Expenditure

In order to estimate the amount of family planning revenues actually spent within Ethiopia, we identified the general location of activities and programs where these revenues were spent. The details are presented in Table 19 below.

Of the USD. 8.2 million received by NGOs to implement FP programs in Ethiopia, 91% (USD. **7.5 Million**) was used in financing family planning activities in 2012. The 9% (USD. 729,143) difference was attributed to differences between project financial cycles where money received for 2012 was not used in 2012 since it was scheduled to finance activities in subsequent years.

Table 19: Expenditure in 2012

Type of NGOs	**Expenditure on domestic programmes (USD)**	%	**Expenditure on international programmes (USD)**	%	**Total expenditure (USD)**
National NGO	5,127,042	93%	404,759	7%	5,531,801
Other	1,969,460	100%	-	0%	1,969,460
Total*	**7,096,502**	95%	**404,759**	5%	7,501,261

**Difference between income and expenditure in 2012/2013*

**One NGO (Wabe Children's Aid and Training (WCAT)) reported that their FP programs begun in 2013 and were hence not implementing any FP programs in 2012*

The main explanations for differences were because some of the program activities were still on-going

The differences were reported as carried forward to the next financial year 2013/2014

Of the USD 7.5 million spent in 2012, a further 5% (USD. **404,759**) was spent on programmes and activities outside Ethiopia, with the remaining 95% (USD. **7.1 Million**) used to finance family planning programs within Ethiopia. Effectively, about 86% of all funds received in 2012 were spent on programs within Ethiopia in 2012.

Further, we present (in table 20 below) the distribution of spending according to how these are utilized within programs involved in family planning services.

Table 20: Type of NGO expenditure in 2012

	Amount in USD	**%**
Internal service staff costs (for direct service provision)	2,037,577	30%
Outsourcing of services	51,931	1%
Contraceptives, medicine & other consumables	802,197	12%
Information, Education and Communication	421,740	6%

Policy Development and Advocacy	23,976	0%
MIS and HIS	119,023	2%
Monitoring, Evaluation and Research	217,873	3%
Capacity building/training	933,647	14%
Program Management Staff costs (non-service delivery)	329,721	5%
Operational expenditure	1,296,243	19%
Other	504,005	7%
Total	**6,737,933**	**100%**

As shown on table 20 above, about 95% (USD. **6.7 Million**) of all expenditures on FP in Ethiopia were recurrent. These were mainly composed of expenditure on staff costs (30% - USD. **2.0 Million**), Operational expenditures (19%- USD. **1.3 Million**), capacity building and training (14%- USD. **933,647**) and contraceptives and related consumables (12%- USD. **802,197**).

In Ethiopia, the USD. 802,197 contraceptives spending by NGOs comprise a substantive proportion of all recurrent expenditure as shown in table 21 below.

Table 21: NGO Expenditure in contraceptives in 2012 by type of method

	Amount	**%**
Condoms	93,938	12%
Pills	122,268	15%
Emergency contraceptives (pills)	4,473	1%
Injectables	219,188	27%
Implants	158,799	20%
IUDs	84,991	11%
Standard Days Method	8,946	1%
Medicine e.g. painkillers	22,366	3%
Other consumables	87,228	11%
Total	**802,197**	**100%**

While this contraceptive expenditure was dominated by injectable contraceptives, (27%- USD. **219,188**) there was a significant expenditure on LARC such as Implants (20%- USD. **158,799**) while about 1% (USD. **8,946**) percent of contraceptive commodity expenditure was on IUDs.

3.3.1.4 Capital spending

NGOs further reported the amounts of money spent on capital expenditures in support of family planning programs in Ethiopia. Of about $170,000 spent on capital goods such as buildings, furniture and ICT equipment, a great portion of these funds (84%- USD. **142,746**) financed either renovation, rent or rates of upgrading existing structures. As further shown in table 22 below, an additional 10% (USD. **17,153**) of capital expenditure financed motor vehicle purchases while ICT and office furniture took up less than 1% (USD. **1,218**) of these capital expenditures.

Table 22: Capital expenditure in provision of FP services in Tanzania in 2012 by expenditure type.		
	Amount in USD	**%**
Infrastructure and Upgrading of Facilities	142,746	84%
Car purchase	17,153	10%
Computer and ICT purchase	609	0%
Office Furniture	609	0%
Medical equipment	-	0%
Other equipment	-	0%
Other capital expenditure items	9,345	5%
Total	**170,463**	**100%**

3.3.1.5 Target populations

Table 23 below shows the level of concentration of FP-related expenditures on different segments of the populations covered by NGOs in Ethiopia.

Table 23: Expenditure on target populations by NGOs in 2012		
	Amount in USD	**%** [Æ]
Adolescents (10-19 years)	1,671,483	25%
Youth (15-24 years)	1,634,339	24%
Women	1,723,484	26%
Men	482,873	7%
HIV positive individuals	-	0%
Migrants	-	0%
Sex workers	-	0%
Health care workers	1,225,754	18%
Employees	-	0%
Rural population	-	0%
Researchers	-	0%
Other	-	0%
Total	**6,737,933**	**100%**
[Æ] *Weighted percentage to account for non-mutually exclusive categories- This was done by summing all reported percentages (always more than 100%) and standardizing them such that all % add up to 100%. This involved expressing each reported proportion as a percentage of the total.*		

Most NGOs reported activities targeted at Women, spending USD. **1.7 million** (26%), Adolescents (25%- USD. **1.7 Million**) and youths (24%-**1.6 Million**). As shown in table 23 above, a further 18% (USD. **1.2 Million**) of NGO expenditure was reportedly targeting healthcare workers, with the remaining 7% (USD. **482,873**) of effort being on men.

3.3.1.6 Comments provided in the survey by respondents

There were 8 questionnaires received and 3 included comments. Mainly as requested in the questionnaire, they referred to comments to clarify how they generated some estimate (2), and other one to state the year where they initiated the work on FP.

4. OOPS in Ethiopia and Tanzania

To be added by Futures Institute

5. Challenges reported by APHRC about implementing the domestic survey

The study experiences can be summarized into the following broad categories; those concerning **the planning the field work**, **implementation** and **oversight the survey**. These were all at multiple levels and some are highlighted in detail within the consultants' reports.

5.1 Planning the field work

5.1.1 Experiences

- During the field work stage, there was need for greater communication between the survey partners, the consultant and a key contact person in the Ministry of Health in both countries. For instance, NGOs in Ethiopia expected letters from the government authorizing them to participate in this survey.
- There was need for a more robust analysis and understanding of the organizations providing family planning, but also, the relevance of data to be collated as well as potential data sources and their handling.
- It became evident the need of a better knowledge of the universe of FP actors. This would have produced a more relevant sampling frame, and minimize cases of non-participation.
- When this process set off, it was evident that an economist would better act as a consultant. However, as implementation continued, there was evidence that all consultants needed a strong background in family planning.

5.1.2 Challenges

- To ensure better involvement and communication of support of key organizations, such as UNFPA and MoH in the country.
- Due to budgetary inadequacies, a number of key family planning organizations were not reached since they were based outside Dar es Salaam and Addis Ababa.
- Identification of consultants was based on experience in the resource flows project. However, this study required more involvement and the level of consultant availability is critical.

5.1.3 Lessons learnt

- Future studies need to consider more inclusive participation of key person in the ministry of health at the planning phase. This would assure a buy-in from the ministry, who are key in ensuring success in data collection.
- It might be necessary have a better idea of the universe and based on that to rethink the sampling procedure in order to include as many real actors as possible.
- Need to allocate sufficient funds to reach out all relevant organizations, and maybe those outside the capital cities as well as regional governments.
- Consultants need to be available 100% since the project required enough time to meet with ministry officials and heads of NGOs to ensure completion of questionnaires.
- Consultants should be knowledgeable in family planning.

5.2 Implementation of the Pilot Survey

While implementing the survey in both Tanzania and Ethiopia, a number of lessons, experiences and challenges were notable.

5.2.1 Experiences

- Both consultants felt like the funds available for this work was not commensurate with the time they spent on this activity.
- There was evidence of respondent fatigue and a feeling of duplication of work, since most organizations and offices targeted were also in the resource flows study.
- Most of the respondents did not read the manuals developed to guide respondents when filling questionnaires and the consultant had to explain the estimation procedures one by one, even though these had been well captured in the manual.
- There were numerous complaints from respondents concerning the tools. While some thought the questionnaires were too detailed, others believed that it was difficult to estimate some of the expenditures or income, especially those that receive co-funding for as many project as there are in there organizations. Nonetheless there were also responses of interest and enthusiasm about the survey content.

5.2.2 Challenges

- It was extremely difficult to identify some of the organizations relocated. In Ethiopia, majority of NGOs in affected areas of road construction have migrated to other areas without updating their contact information on their websites.

5.2.3 Lessons learnt

- There is need to consider training survey respondents as well as to training consultants to train the respondents. This might need bringing these respondents to a central point and spending more time with them as mentioned above under project development.
- Further development of clear and precise estimation methods/procedures for costs based on different scenarios will improve the quality of data collected in future.
- Using "peer" organizations for identification of new locations can improve response rates. In addition, the above suggestion of purposive sampling would make it easier to not only identify organizations through their peers, but also make targeting of these organizations more specific.
- Prior listing of organizations is important. This is costly, though it can lead to improved response rate. This could be done together with mobilization activities to make organizations ready and more willing to participate. This procedure will also be helpful in identifying key players in family planning.
- Need to incentivize respondents when collecting data. In most of the cases, respondents had to go out their way to complete questionnaires outside working hours since this work was not allocated any staff time. The less motivated respondents opted out of the survey while others continued to give the excuse of workload.

5.3 Oversight of this study

In supervising this survey, we had a number of experiences, challenges, and built some lessons from this pilot survey.

5.3.1 Experiences

- The time allocated to staff in this study was extremely inadequate and staff had to borrow time of other projects to manage this activity well, with the aim of ensuring high quality data.

5.3.2 Challenges

- Communication breakdowns was rampant more so in Ethiopia even though it was also evident in Tanzania. Frequent power failures in Addis Ababa could keep the consultant off communication for up to two weeks, a situation that can highly affect the data quality.
- Scarcity of funds, which could facilitate better supervision of work that happens in other countries.

5.3.3 Lessons learnt

- There is need to ensure increased funding to these activities for improved staff time allocation as well as time by consultants.
- The need to have well documented roles of consultants, including a very well outlined reporting structure and timelines, where consultants commit to these.

6. General discussion and conclusions

As expected, the study to test the questionnaire has offered several key learning/refreshing points. On the design of the study and the appropriateness of the instrument, on the field work and on the data gathering and integration of the results.

6.1 On the approach and methods

a) A first relevant point is to better plan the field work, including the support and communication of relevant partners, notably UNFPA and MoH to facilitate the interaction with institutions and organizations providing data, but also, to consider the transport and mobility required in the countries, as demonstrated the case of Ethiopia, and to assess the convenience and modalities to link the questionnaire to be filled at the same time to other initiative;

b) Regarding the questionnaire itself, it may be good to discuss how to improve it, e.g. to reduce unnecessary detail, to use more standardized categories on the classifications (e.g. beneficiaries and services not to need weights) and to be complemented: -with questions to better extrapolate the results to a national level (e.g. denominators), -to avoid double count (e.g. external funds cannot be added to domestic funds without considering the flow from donors to government and NGOs) and to complement data needed, (e.g. market price of contraceptives). Another point to consider is the potential convenience to develop the questionnaire to approach the financing flows involved in a more comprehensive way for which two questions are key: what is the expected use of the results (program managers, in search of efficiency gains? or global monitoring to oversight compliance?) and how to interact with the full HA initiatives (complementing, substituting or corroborating?). The instrument needs to be revised considering specific data needs. Some analysis and proposals are already made in annex 5;

c) The full understanding of the questionnaire by consultants and project managers is needed, on the categories contained, their relevance and meaning as well as how to obtain and handle the data and estimate or adjust when needed. (e.g. to apply the right questionnaire to the right organization and understand their role in the financing flow);

d) It is important to better guide the respondents. The idea mentioned by APHRC of training the respondents in group and work with their own records to guide them on how

to use them to fill the questionnaire has been used in various projects successfully. It has been proposed as a mean to institutionalize the data collection;

e) The knowledge of the universe to be studied is required to develop an appropriate sampling of the establishments to be covered. This is relevant as the entities handling FP are not the same involved in other ICPD and the mix of full to partial involvement of FP needs to be understood.

6.1. The results of Tanzania and Ethiopia are not fully compatible on the areas filled due to major gaps on the case of Ethiopia. Also relevant, the questionnaire for corporations and for insurance companies need to be considered as not tested. However, the various areas filled by some respondents and the questionnaires seem able to be responded. The coverage of the sample in Tanzania appears to be good, whereas for Ethiopia is not enough to reach any conclusion besides NGO.

6.2 On the results

1. The results obtained appear to be consistent: Non-governmental organizations, multinational donor organizations as well as government are the major players in provision of family planning services in Tanzania and Ethiopia. However, in both countries, most of these governmental and non-governmental organizations over rely on international sources to fund family planning activities, which may affect the sustainability of their work. The need for increased government participation in provision of family planning services has been noted elsewhere (Sidze et al., 2013). We also established the prevalence (though low) of unspent funds both in government and non-governmental organizations in both countries due to delayed supplies and protocols such as partner delays in collaborative programs. These delays affect a country's contraceptive security and hence can heighten levels of unmet need for family planning and risks of unplanned pregnancies. There is therefore need for improved channels of supply delivery and restocking to minimize these chances of contraceptive running out-of-stock.
2. In Tanzania, we found high levels of spending on short acting contraceptive method such as condoms and pills, especially emergency contraceptives for both NGOs and government. In Tanzania, almost half of government's recurrent expenditure on family planning went into emergency contraception rather than the preferable long-acting or permanent methods. In Ethiopia, a slightly improved scenario is evident, with higher spending on LARC methods compared to NGOs in Tanzania. There is therefore need for concerted effort in increasing the prevalence and adoption of longer-term reversible methods as well as permanent methods of family planning, especially in Tanzania, where the focus seems very high on short-acting methods.

6.3 Rethinking the questionnaire

Section A of the questionnaire requested information about the organization (such as contact details and administrative level), the currency used in the survey, the currency rate used (when applicable), whether they used financial or calendar year and what type of organization they are. All NGOs, government departments and corporations which filled in the questionnaire fully completed this section. As the questions were very straightforward they were filled in correctly and the responses made sense. For future tracking initiatives, it is suggested to keep this section in the questionnaire although close attention needs to be

paid to the currency and currency rate (and ensure it is consistent throughout the questionnaire), and to make sure the period indicated falls in line with the survey year.

In *section B* an overview of the organization's income (to be enlisted in the subsequent section) and expenditures (to be enlisted in the project section) was requested. All organizations answered these questions, though some put '0' for questions such as 'Income received from domestic sources' or 'International expenditures'. For the NGOs, all organizations mentioned they received funding from international sources for their FP projects or programs. Roughly 70% of the NGOs also reported to have generated no income from own sources such as members' contributions, user fees, interest earned on endowments or other forms of cost recovery. The government departments which provided data on FP received funding from domestic sources and the Ministry of Health and Social Welfare also indicated international income (DFID, UNFPA). Information provided in this section gives a good overview of an organization's financial activities. As these NGOs received most of their funding from external sources you would expect them to spend (most of) their budgets – which was usually the case. As a check, NGOs were asked to compare their total income and total expenditures and provide a reason why the amounts are significantly different. Most organizations reported no significant difference between their figures on income and expenditures. For two NGOs there was a large difference between income and expenditures and they attributed this to the expenditures being dispersed over several years (and not only the 2012 survey year).

The NGO and Corporation questionnaires requested a specification of the organization's income in section C. Specifically, the donor's name, location, type of organization, administrative level (if a domestic source) and the amount they received was requested. For both the NGOs and corporations, most funding originated from organizations based in the United States with donors including the CDC, USAID, the Gates Foundation and Engender Health. Obtaining this information is important if you want to make corrections for double counts and if you want to try and gain insight on the funding flows. Respondents did not seem to have trouble with this section and it would therefore be useful to request this information in future tracking exercises.

The final section requesting project information provided the most difficulties, perhaps due to the level of detail. Respondents were asked to report each family planning project they implemented in 2012 separately. In case this information was not available, they could aggregate the projects and report all information as one project – although this should be highly discouraged as it compromises the level of detail. All organizations reported one project. Some respondents indicated that it takes a lot of time to fill in the survey and that other departments' involvement is sometimes required – making it more time consuming. It is therefore not surprising that they choose the "easy" way and report only one project. Considering the response to the project section it seems as if what was asked was well

understood by the respondents. Information such as the project name or reference number of the project was sometimes not provided, but the most important information such as a breakdown of the recurrent expenses was always given. Overall, the question on capital spending was poorly answered. Although the purchases made in 2012 on durable goods should be readily available, the fact that respondents need to estimate how much of this was for the benefit of FP could be too much work. This section definitely requires some reviewing in which a more concise section should be developed and discussed with future respondents and the consultant. To do so, an important point is to discuss and identify if there is a key equipment important to monitor in FP.
It would be important to standardize more the question of the objectives of the project.

Lessons learned

To summarize the lessons learned from the field and to reflected on them:

- The consultant selected insurance companies to visit within Dar es Salaam and its satellite towns but established than none of these companies offer FP services. The National Social Health Insurance provider did not provide such services either. As a result, there are no Tanzanian insurance companies included within the pilot. *Early results from the RF 2013 survey also indicate that not many countries are including insurance companies as they are a) not present or b) not providing FP services. One UNFPA country office mentioned the important role private hospitals and pharmacies play in the FP sector within the country and suggested to target those instead. This is definitely something to consider for the future.*
- In addition, the consultant could not establish any credible organization that would qualify as a local philanthropy. As a result no philanthropies were included in the pilot. *This is an aspect we discussed in the February 2014 Nairobi meeting. Several years ago NIDI conducted a study together with UNAIDS on 'HIV/AIDS contributions made by philanthropies based outside of the United States and West and Central Europe.' Results indicated the limited amount of such organizations. However, for this study they were included as we were all curious to find out whether any philanthropies in Tanzania and Ethiopia were present and involved in FP – but not much was expected from this.*
- Initially, it was challenging to obtain contact with the suitable person within government offices and parastatals as they were attending important meetings elsewhere, such as the National Assembly meetings. *This remains a continuous struggle as is the case with the RF project. Establishing a contact person and making an appointment to meet as early as possible in the process remains key.*
- Within research institutes such as the Ifakara Research Institute and the National Institute of Medical Research, the survey was first sent to the research department. After going through the tools this department then forwarded the survey to the

finance department. *This costs precious time. In addition, the level of detail of the survey might require the help of several individuals (from several departments) which could also cause delays. The consultant personally going through the survey tools with someone knowledgeable within the organization could have avoided this, although this was done. Discussing which department and individual is going to fill in the survey (or which part of the survey) beforehand and making a concrete plan could have decreased delays. However, research institutes are not NGOs. The survey should have been the one of corporations.*

- There was a complaint that the questionnaire was too long and detailed. *Asking organizations with a lack of records, time and staff to fill in the survey could indeed be facilitated. In this case, besides an improvement of the tool, the consultants should be better trained, and the organization of meetings to collectively train the focal points of the organizations can be easier. The consultant should be closely involved in the whole process, assists the organizations as much as possible and emphasize the importance of participating in the study.*
- *It would be important to send the right questionnaire to intermediate NGOs and certainly to include the appropriate corporations and insurance organizations. For corporations, could be private medical facilities and pharmacies or wholesalers for contraceptives. For insurance, it should be based on the rules and [practice in the country, as not always are included.*
- The Demographic Training Unit of the university of Dar es Salaam was in the midst of a staff reorganization, which makes it difficult to firstly identify the right person and secondly, to find the time to fill in the survey. *This is another challenge we face with the RF project and is something you have little control over. In most cases the best thing to do is to try again the following year.*
- In order for the Ethiopian NGOs and government offices to participate in the survey, some of these required an official letter from the Minister of Health. Obtaining such a letter required many follow-ups and time. *Early in the process it was apparent that an official letter should be issued in Ethiopia in order for organizations and government departments to participate. What delayed the process was from which organization or department we could receive such a letter. Firstly, NIDI tried to engage UNFPA in order to receive a letter from them – but this request was left unanswered. Subsequently, after many efforts APHRC obtained a letter from the Ministry and the data collection was started soon after. Having this official letter in the beginning of the project is key to staying on track with the schedule.*
- Estimating the total expenditure for NGOs. *Results of the pilot were limited and the issue arose that we could not create a complete picture of family planning expenditures made by NGOs in Tanzania. It was important to triangulate the information to assess the levels obtained, and to come up with an estimated figure. Firstly, the sample of the pilot was compared to the donor sample of the Resource Flows project. Specifically, the organizations which received family planning funding from donor organizations were identified and compared with the sample of the pilot. The idea was to compare the amounts of both projects and identify what information*

in the pilot is missing and can be filled with the RF data and other reference values. It seems the totals from NIDI could be used to upgrade the level considering the share going to NGOs. Then to use the level of the survey and assume this can be extrapolated to the totals to get the detail.

- *Data from Ethiopia cannot be accounted for given the poor coverage or the study.*
- *This study shows that it is important to create a denominator and gather important information via the questionnaire. For example, if we would have requested information on the NGO's total expenditure on health as well, we would have an idea of the proportion they spend on FP which could be useful for making estimates.*

Conclusion

Non-governmental organizations, multinational donor organizations as well as government are major players in provision of family planning services in Tanzania and Ethiopia. However, in both countries, most of these governmental and non-governmental organizations over rely on international sources to fund family planning activities, which may affect the sustainability of their work. The need for increased government involvement in provision of family planning services has been noted elsewhere (Sidze et al., 2013). We also established the prevalence (though low) of unspent funds both in government and non-governmental organizations in both countries due to delayed supplies and protocols such as partner delays in collaborative programs. These delays affect a country's commodity security and hence heighten levels of unmet need for family planning and risks of unplanned pregnancies. There is therefore need for improved channels of supply delivery and restocking to minimize these chances of out-of-stock commodities.

In Tanzania, we found high levels of spending on short acting contraceptive method such as condoms and pills, especially emergency contraceptives for both NGOs and government. In Tanzania, almost half of government's recurrent expenditure on family planning went into emergency contraception rather than long-acting methods. In Ethiopia, a slightly improved scenario is evident, with higher spending on LARC methods compared to NGOs in Tanzania. There is therefore need for concerted effort in increasing the prevalence and adoption of longer-term reversible methods as well as permanent methods of family planning, especially in Tanzania where the focus seems to be highly directed towards short-acting methods, especially emergency contraception.

We identified a couple of challenges in implementation, management and planning of similar survey in the future. There is need to further develop the resource flow methodology with an aim of improving the quality of data, its representativeness and ability to draw conclusive recommendations based on data collected using the methodology. Funding, personnel/staff, remunerations of consultants, increased supervision and better engagement with government offices as well as incentivizing respondents are some of the areas worth improving in developing and scaling up this pilot.

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Annex 1

Summary of the planning process of the study

The principal goal of this activity was to track both public and private FP expenditure in two selected countries: Ethiopia and Tanzania. The most efficient way to produce the tools for the family planning pilot was to base them on the existing tools of the domestic survey of the RF project. A meeting was held in Dar es Salaam, Tanzania in September 2013 where the technical issues related to the study were discussed and the timeline was agreed upon. A discussion on the private sector led to include the largest employers (corporations) providing services to employees and/or communities; philanthropies (to see what information can be obtained from them); as well as insurance companies so that we can gain insight on their FP-related payments to service providers or reimbursements to FP providers and NGOs, with emphasis on the most significant players. For the public sector, all governmental agencies involved in the field as well as universities which should also be included as they could be linked to FP research and monitoring and evaluation.

A second meeting in February 2014 was held in Nairobi, Kenya to discuss and finalize the questionnaires and manuals. It was emphasized that for this pilot study, all expenditure that benefited family planning projects or programs within the country are of interest. Therefore, imported goods and services provided to resident population should be included. For example, if the government of Tanzania purchased contraceptives abroad but distributed them within Tanzania this should be included. Further aspects discussed include the overlap between HIV and FP and the difficulty in separating the two; that only direct spending would be included, thus not costs related to transportation to a FP clinic or organization; and that the coverage would be taken as per convenience as the idea was to test the questionnaires and set the process: for countries which are a federal state or regional governments we would use a sample of the most important regions; Regarding the sample, it was mentioned that most of the organizations' headquarters would be located in the capital city and therefore the focus should be there. This also makes it easier for the consultant to visit each organization.

Subsequently, APHRC met with the consultants they hired, already familiar with the RF project, to discussed the tools and the execution plan of the survey. Important concerns mentioned included the delay in survey submission by respondents, monetary expectations from the respondents, transport issues experienced by the consultant and the need for a brief manual. Some of these concerns were addressed by making sure the consultant had enough resources to be closely involved in the data collection process and was able to personally visit the potential respondents on a regular basis. Additionally, both summarized and extensive manuals were distributed so that respondents could choose which one to use. Data collection in Tanzania took place between May and July 2014 whilst in Ethiopia data was collected from July to September 2014.

Upon receiving the questionnaires and manuals documentation the UNFPA country office either hires a consultant or institution or conducts the research themselves. A questionnaire for the consultant in charge of the data in the country is also sent, to requests information on the national budget (income and expenditure for population activities), the country's private

sector expenditure on population activities and the future expected national budget for population activities in the following two years.

The person in charge of conducting the survey is requested to return also a "upon receipt" format to NIDI as soon as possible, indicating which organizations they are going to approach and when they are expecting to submit the data. NIDI and its partners conduct continuous follow-ups with comments and suggestions and send reminders where necessary, to ensure a comprehensive overview of the survey.

The existing RF government, national NGO and related consultant questionnaires were adjusted so that they would fit into the requirements of the FP pilot. All definitions were changed from population activities to family planning; and the project sections were transformed to include family planning recurrent and capital expenses. New questionnaires were developed for local philanthropies, corporations and insurance companies whilst minor adjustments were made to the related consultant questionnaire. All questionnaires were accompanied by a (summarized and comprehensive) manual providing detailed information on the project and instructions on how to fill in the questionnaires. A manual with thorough guidelines was also developed for the consultant.

The first step in implementing the survey was to prelist all known key players in FP financing in each of the above organization types. From the list generated through expert knowledge of the country specific roles of organizations by APHRC consultants, all government, insurance companies, and large corporations were included. For parsimony, the top 10 NGOs and a simple random sample of the remaining NGOs was included in the sample. The next step was for the consultant to identify a contact person or respondent from each of the selected organizations or government office. For improved data quantity and quality, a few organizations were selected for further visits with an aim of improving the response rate. The few contact persons were visited and informed beforehand of the planned pilot study. These key contacts were pre-identified as follows; one from the Central Ministry of Health, two from any other public sector FP providers or financiers and four key NGOs.

The consultant report mentioned that data collection in Tanzania occurred between May and June 2014 to sampled institutions, which were presumed to be involved in family planning in Tanzania. Figure 1 below shows the initial chart of activities as planned in Nairobi in February 2014, which was expected to span about 2 months.

Figure 1. Activity Schedule May – June 2014

Activity/day	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**
Distribution of questionnaire								
Identification of key respondents								
Follow-ups, clarification								
Follow-ups and collection of questionnaires								
Follow-ups and Cross validation of collected questionnaires								
Cross validation and Analysis and report writing								
Submission of the questionnaire and evaluation report								

Annex 2

Definitions of terms used in the survey

Capital Investment:
The acquisition of a capital good, also referred to as durable goods, which are used in the production of FP methods and services and last longer than 1 year. E.g. a car, furniture, computers, medical equipment, etc. Only capital investments acquired in 2012 is included.

Domestic sources:
Funding from national sources (central, subnational, local and municipal). Examples: Ministry of Finance, regional health offices, national foundations.

Expenditures:
The amount of money that has *actually been spent/disbursed* by an organisation for the project/programme in the given year. Expenditures made both locally and abroad which benefited local family planning projects/programs or activities are included. For example, condoms purchased abroad but distributed within the country are included.

General development projects/programmes with a family planning component:
Development projects/programmes sometimes contain a family planning component. A general rural development programme may, for example, contain a family planning component. The amount requested in the survey is only the amount of money spent on family planning activities in this general development project/programme.

International sources:
International donors encompassing foreign governments, UN organisations/agencies, international development banks, international NGOs, foreign foundations, foreign private for-profit companies or other international organisations/individuals.

Own income:
Any income generated from own sources e.g. contributions, profits, user fees, interest earned on endowments, or forms of cost recovery.

National NGO (Non-Governmental Organisation):
Private not-for-profit organisation which operates *exclusively in one* country.

Recurrent expenses:
Recurrent expenses are those which occur periodically to produce FP services and which are fully consumed during the provision of the service. It includes salaries, FP methods and services and all operational spending, condoms, paper, electricity and contracted services such as security, or the production of quarterly dissemination of family planning-related information to the communities, patients, children, etc. Only recurrent expenses which were made in 2012 are included.

Annex 3

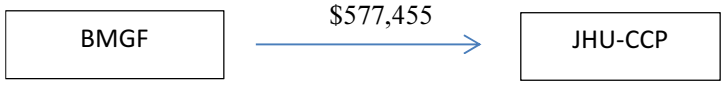
Reconciliation: linking donor data and domestic data

Ideally, to create a complete picture of the financial flows for FP you would need to follow the money from its source to its final destination – from donor to domestic organizations. In order to do so you need to obtain data from all actors involved along this financing chain. Along the way however, project names and budget amounts (amongst other things) change which makes it harder and harder to keep track of the same project increasing the risk for double counting. Analyses within the RF project therefore never combine the donor and domestic data, as it remains very difficult to correct for double counts. Moreover, increasingly donors provide budget support which makes still more difficult to identify the use of the resources provided, while the implicit understanding is that contribution to a country's resources should allow the local authorities to use them to cope with their priorities.

Nonetheless, several projects within the pilot in Tanzania could be linked with a donor organization. The following is an example which was suggested to be applied to all components, when feasible:

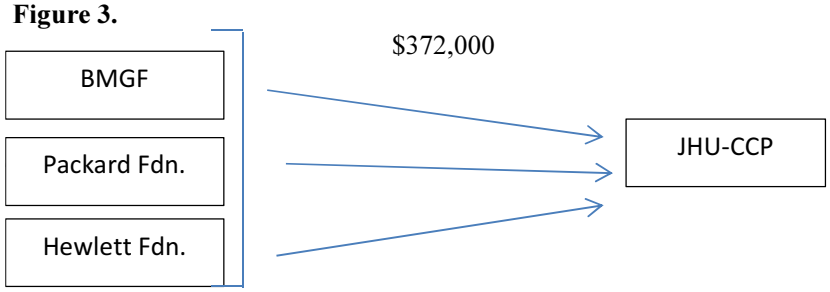
The donor data received from the Bill and Melinda Gates Foundation (BMGF) (and also reported to the OECD) indicated that they disbursed an amount of $577,455 for the period of 11 January 2012 to 30 September 2017 to Johns Hopkins University in Tanzania with the intention to "sustain resources of quality family planning programs, contribute to universal access to reproductive health services, Millennium Development Goal 5b, and the vision of the London Summit on Family Planning" (figure 2). There is no mention of the AFP project or Health Promotion Tanzania.

Figure 2.



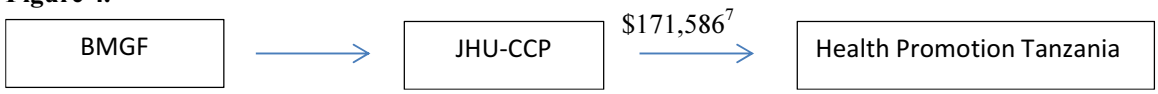
JHU-CCP filled in a domestic FP questionnaire and mentioned they received funding for the AFP project in a form of basket funding from BMGF, amongst two other donors (figure 3). How much was specifically received from BMGF remains unknown due to the aggregation of the funding, but what is known is that JHU-CCP received a total of $372,000 from BMGF, Hewlett foundation and the Packard Foundation altogether.

Figure 3.



Health Promotion Tanzania reported the Advance Family Planning (AFP) project and mentioned that it was funded by the Bill and Melinda Gates Foundation (BMGF) through the Johns Hopkins University Center for Communication Programs (JHU-CCP), receiving a total 271.6 million Tanzanian Shillings (figure 4). The NGO reported that the project is "purely an advocacy intervention for influencing central and local government to improve policy and increase domestic resources for family planning" to be implemented in the districts of Kinondoni and Kisarawe between the period of 1 January 2012 and 30 September 2012.

Figure 4.



From this we can conclude that the actors involved in funding and implementing the AFP project are clear (based on the information we have received), although the exact amounts that were transferred for the AFP project remain somewhat unclear. The funding BMGF provided to JHU-CCP (figure 1) was not specifically for the AFP project, whilst the funding mentioned by the JHU-CCP (figure 2) and received from BMGF, Packard Foundation and Hewlett Foundation *was* specifically for this project. Of the amount JHU-CCP received from BMGF, roughly half was received by the Health Promotion Tanzania (figure 4).

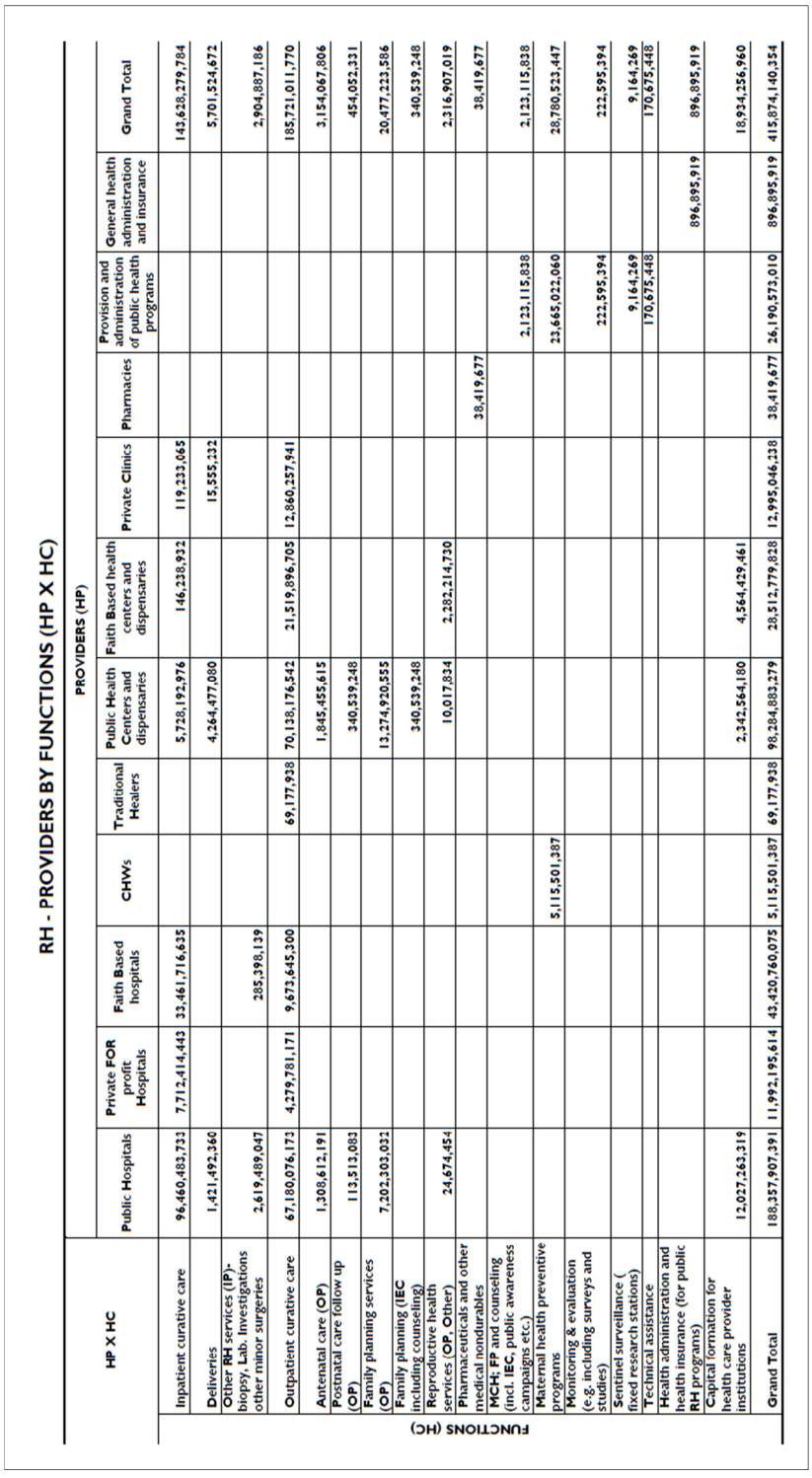
From this example, it can be concluded that following the money is a very complex task as information keeps changing as it passes through the chain of financing. It is therefore ever as important to collect this kind of information on a detailed and accurate level, so that the information can be connected with certainty.

In the more comprehensive approaches such as the health accounts, with the explicit objective of monitoring the financial flows, the double count is controlled also in a similar way: a) by identifying the original donor and the recipients and the amounts involved and looking for the similarities and same actors and flows reported (see the WHO HAPT), b) by analyzing the full flow and identifying well the place in the flow of each transaction.

[7] Amount converted to USD using the IMF annual average exchange rate (similar methodology as the RF project).

Annex 4

NHA Tanzania



RH - PROVIDERS BY FUNCTIONS (HP X HC)

HP X HC		PROVIDERS (HP)											
		Public Hospitals	Private FOR profit Hospitals	Faith Based hospitals	CHWs	Traditional Healers	Public Health Centers and dispensaries	Faith Based health centers and dispensaries	Private Clinics	Pharmacies	Provision and administration of public health programs	General health administration and insurance	Grand Total
FUNCTIONS (HC)	Inpatient curative care	96,460,483,733	7,712,414,443	33,461,716,635			5,728,192,976	146,238,932	119,233,065				143,628,279,784
	Deliveries	1,421,492,360					4,264,477,080		15,555,332				5,701,524,672
	Other RH services (IP)- biopsy, Lab. Investigations other minor surgeries	2,619,489,047		285,398,139									2,904,887,186
	Outpatient curative care	67,180,076,173	4,279,781,171	9,673,645,300		69,177,938	70,138,176,542	21,519,896,705	12,860,257,841				185,721,011,770
	Antenatal care (OP)	1,308,612,191					1,845,455,615						3,154,067,806
	Postnatal care follow up (OP)	113,513,083					340,539,248						454,052,331
	Family planning services (OP)	7,202,303,032					13,274,920,555						20,477,223,586
	Family planning (IEC including counseling)						340,539,248						340,539,248
	Reproductive health services (OP, Other)	24,674,454					10,017,834	2,282,214,730					2,316,907,019
	Pharmaceuticals and other medical nondurables									38,419,677			38,419,677
	MCH; FP and counseling (incl. IEC, public awareness campaigns etc.)										2,123,115,838		2,123,115,838
	Maternal health preventive programs				5,115,501,387						23,665,022,060		28,780,523,447
	Monitoring & evaluation (e.g. including surveys and studies)										222,595,394		222,595,394
	Sentinel surveillance (fixed research stations)										9,164,269		9,164,269
	Technical assistance										170,675,448		170,675,448
	Health administration and health insurance (for public RH programs)											896,895,919	896,895,919
	Capital formation for health care provider institutions	12,027,263,319					2,342,564,180	4,564,429,461					18,934,256,960
	Grand Total	188,357,907,391	11,992,195,614	43,420,760,075	5,115,501,387	69,177,938	98,284,883,279	28,512,779,828	12,995,046,238	38,419,677	26,190,573,010	896,895,919	415,874,140,354

RH Health Service Provider by Function (Services and Commodities)| (HP x HC)

HPxHC	HP:1.1.1.1 Federal Hospitals	HP:1.1.1.2 Regional/Zonal Hospitals	HP:1.1.1.99 Other Government/General Hospitals	HP:1.1.2.1 Private for Profit Hospitals	HP:1.1.2.2 Private not-for-profit Hospitals	HP:2.1 Offices of physicians (Private Clinics)	HP:3.4.1 Family planning centers	HP:3.4.5.1 Public PHCU (Health Center and Health Posts)	HP:3.4.5.2 Not for profit (NGO) PHCU-Health Centers, clinics and posts	HP:3.4.3.99 OTHER PUBLIC other outpatient multi-specialty and co-operative services centers	HP:3.9.3 Alternative or traditional practitioners	HP:4.1.1 Private Pharmacies	HP:5 Provision and administration of public health programs	HP:8.1. Government administration of health	HP:8.9 All other providers of health administration	HP:7.1 Establishments as providers of occupational health care services	HP:9 Rest of the world	HP:xxk Provider not specified by kind	Row Total (THE)	HP:8.1 Research Institutions	HP:8.2 Education and training institutions	HP:8.3 Other Institutions providing health-related services	Row Total (NHE)
HC.1.1.1.1 Maternal Health (delivery, management of abortion complication-ip)		1,415,917		4,076,431	20,000			2,080,296	7,413,860	19,409									15,025,913				
HC.1.1.1.99 Other RH related Inpatient Curative Care (fistula,fiberoids, cancer)	16,285,332	37,232,013	110,740,402	132,389,038	4,736,936	15,361,459		6,451,421								3,947,227	506,201	36,333,207	363,983,237				
HC.1.3.1.1.1 Maternal Health (Ante and Post Natal Care, op post abortion care)								6,754,644	7,833,681									30,360,820	44,949,144				
HC.1.3.1.1.2 Family Planning (Pills, Depo, Norplant, IUCD)					214,139	235,112		12,888,470	100,000										13,437,721				
HC.1.3.1.1.99 Other RH-Basic medical and diagnostic services (e.g. STI)	22,392,332	54,344,532	315,538,735	35,347,890	163,216	201,529,511		230,485,949	5,429,239		2,098,143					40,082,847		545,828,896	1,453,241,291				
HC.5.1.4.2 RH Pharmaceticals dispensed to out-patients												445,977							445,977				
HC.6.1.1.1 Family planning and Counciling							1,353,917						175,519,335						176,873,251				
HC.6.1.1.2 Maternal Health (eg. campaigns related to fistula, breast cancer early detection...)									53,080				185,176,680						185,229,760				
HC.6.1.1.99 Other Reproductive Health Related Prevention and Public Health Services (eg. STI prevention campaigns such as condom promotion)								1,266,255					211,050,339						212,316,595				
HC.7.1.1.1 RH-General Government Administration of Health								105,211						415,542,555	118,296,662				533,944,428				
HC.R.1.1 RH-Capital formation of health care provider institutions	23,819,835	252,366,807				147,650	157,689	249,394,455	1,537,622									113,282	527,537,340				
Column total (THE)	**62,497,500**	**345,359,268**	**426,279,137**	**171,813,360**	**5,134,291**	**217,273,732**	**1,511,606**	**509,426,702**	**22,367,481**	**19,409**	**2,098,143**	**445,977**	**571,746,354**	**415,542,555**	**118,296,662**	**44,030,074**	**506,201**	**612,636,205**	**3,526,984,656**				
HC.R.2.1 RH-Education and Training																					63,372,626	14,746,495	78,119,120
HC.R.3.1 RH-Reasearch and Development																				6,728,185			6,728,185
Column Total (NHE)																				**6,728,185**	**63,372,626**	**14,746,495**	**3,611,831,961**

Annex 6

SHA 2011 aggregates for FP in Tanzania for 2012

				2012
		Total current health expenditure, NCU		3.189.479.567.401
		Total capital health expenditure, NCU		200.734.951.745
FS.RI.1.1	DIS.2.3	Government	Contraceptive management (family planning)	2.457.193.341
FS.RI.1.2	DIS.2.3	Corporations	Contraceptive management (family planning)	717.728.574
FS.RI.1.3	DIS.2.3	Households	Contraceptive management (family planning)	2.441.874.374
FS.RI.1.5	DIS.2.3	Rest of the world	Contraceptive management (family planning)	21.653.792.895
FS.RI.1.5.1	DIS.2.3	Bilateral donors	Contraceptive management (family planning)	21.651.352.517
FS.RI.1.5.2.8	DIS.2.3	Global Fund	Contraceptive management (family planning)	2.440.378
FS.RI.1.nec	DIS.2.3	Other institutional units providing revenues to financing schemes (n.e.c.)	Contraceptive management (family planning)	537.698.554
HP.1	DIS.2.3	Hospitals	Contraceptive management (family planning)	4.124.226.669
HP.3	DIS.2.3	Providers of ambulatory health care	Contraceptive management (family planning)	5.781.816.490
HP.6	DIS.2.3	Providers of preventive care	Contraceptive management (family planning)	15.608.173.849
HP.7	DIS.2.3	Providers of health care system administration and financing	Contraceptive management (family planning)	1.542.967.310
HP.nec	DIS.2.3	Other health care providers (n.e.c.)	Contraceptive management (family planning)	751.103.420
HC.1	DIS.2.3	Curative care	Contraceptive management (family planning)	11.183.269.962
HC.5	DIS.2.3	Medical goods (non-specified by function)	Contraceptive management (family planning)	51.803.420
HC.5.1	DIS.2.3	Pharmaceuticals and other medical non-durable goods	Contraceptive management (family planning)	51.803.420

HC.6	DIS.2.3	Preventive care	Contraceptive management (family planning)	15.607.631.799
HC.6.1	DIS.2.3	Information, education and counseling programmes	Contraceptive management (family planning)	14.675.231.799
HC.6.nec	DIS.2.3	Other preventive care (n.e.c.)	Contraceptive management (family planning)	932.400.000
HC.7	DIS.2.3	Governance, and health system and financing administration	Contraceptive management (family planning)	266.282.557
HC.7.1	DIS.2.3	Governance and Health system administration	Contraceptive management (family planning)	266.077.927
HC.7.1.1	DIS.2.3	Planning & Management	Contraceptive management (family planning)	225.799.656
HC.7.1.2	DIS.2.3	Monitoring & Evaluation (M&E)	Contraceptive management (family planning)	50.848
HC.7.1.nec	DIS.2.3	Other governance and Health system administration (n.e.c.)	Contraceptive management (family planning)	156.751
HC.7.2	DIS.2.3	Administration of health financing	Contraceptive management (family planning)	204.630
HC.9	DIS.2.3	Other health care services not elsewhere classified (n.e.c.)	Contraceptive management (family planning)	699.300.000
FP.1	DIS.2.3	Compensation of employees	Contraceptive management (family planning)	1.169.673.544
FP.3	DIS.2.3	Materials and services used	Contraceptive management (family planning)	7.717.256.141
FP.3.2	DIS.2.3	Health care goods	Contraceptive management (family planning)	4.240.209.486
FP.3.2.1	DIS.2.3	Pharmaceuticals	Contraceptive management (family planning)	3.070.948.945
FP.3.2.2	DIS.2.3	Other health care goods	Contraceptive management (family planning)	1.169.260.541
FP.3.2.2.4	DIS.2.3	Diagnostic equipment	Contraceptive management (family planning)	210.602.982
FP.3.3	DIS.2.3	Non-health care services	Contraceptive management (family planning)	2.490.555.078
FP.3.3.1	DIS.2.3	Training	Contraceptive management (family planning)	19.143.108
FP.3.3.2	DIS.2.3	Technical Assistance	Contraceptive management (family planning)	1.444.973.043
FP.3.3.nec	DIS.2.3	Other non-health care services (n.e.c.)	Contraceptive management (family planning)	963.354.707

FP.3.4	DIS.2.3	Non-health care goods	Contraceptive management (family planning)	986.491.577
FP.nec	DIS.2.3	Other factors of health care provision (n.e.c.)	Contraceptive management (family planning)	18.921.358.053
HK.1	DIS.2.3	Gross capital formation	Contraceptive management (family planning)	372.797.168
HK.nec	DIS.2.3	Other gross fixed capital formation (n.e.c.)	Contraceptive management (family planning)	757.694

Non health accounts series

	2012
Population - GHED data	47.783
Exchange Rate (NCU per US$) - GHED data	1.583
WHO International $ - GHED data	602