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REVIEW OF POLICIES FOR FREE FAMILY PLANNING SERVICES FOR CLIENTS IN WEST AFRICA

September 2018

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It was prepared by Anthony Leegwater and Ffiona Patel for the Health Finance and Governance project.

The Health Finance and Governance Project

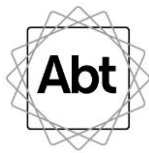
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The six-year, \$209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

CONTENTS

Contents	i
Acronyms.....	iii
Acknowledgements	v
Executive Summary	vii
1. Introduction	1
1.1 Background and Rationale.....	1
1.2 Research Questions.....	1
1.3 Country Selection.....	1
2. Methods	3
2.1 Study Design and Procedures	3
2.2 Secondary Data Collation and Use.....	3
2.3 Literature Review	3
2.4 Policy Document Review	4
2.5 Interview Subjects and Sampling.....	4
2.6 Data Cleaning and Analysis	6
3. Core-Country Profiles.....	9
3.1 Ghana	9
3.2 Mauritania	15
3.3 Niger	21
4. Cross-country Comparisons	27
4.1 Common Themes Across Core Countries.....	27
4.2 Divergences across Core Countries.....	30
4.3 Family Planning Policy Summary for Non-Core Countries	31
4.4 Comparisons across Core and Non-Core Countries	35
5. Discussion and Recommendations	41
5.1 What does “Free FP” Mean?	41
5.2 Implementation Challenges.....	41
5.3 Barriers to Access	42
5.4 Data and Research Needed.....	43
6. Conclusion and Limitations.....	45
6.1 Conclusion.....	45
6.2 Limitations	45
References	47
Annex A: Selection Matrix	53
Annex B: Interview Guide	55
Annex C: Key Informants	63
Annex D: FP Policy Table.....	71



List of Tables

Table 1: Summary of Common Themes	27
Table 2: Summary of Divergences	30
Table 3: Summary of Current Family Planning Policy Documents by Country	36
Table 4: Basic Characteristics of Six Study Countries	38
Table 5: Recent Trends in FP indicators; Funding Totals	39

ACRONYMS

AMPF	Mauritanian Association for Family Promotion (Association Mauritanienne Pour la Promotion de la Famille) (Mauritania)
ANBEF	National Association of Family Well-Being (Association Nationale de Bien-Etre Familiale) (Niger)
CHPS	Community-based planning and services (Ghana)
DBC	Community-based distribution (<i>Distribution à Basé Communautaire</i>) (Niger and Mauritania)
DHS	Demographic and Health Surveys
CFA	West African CFA franc (currency in Niger)
FP	Family planning
FP2020	Family Planning 2020
GDP	Gross domestic product
GHS	Ghana Health Service (Ghana)
HFG	Health Finance and Governance project
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HP+	Health Policy Plus project
IUD	Intrauterine device
mCPR	Modern method contraceptive prevalence rate
MICS	Multiple Indicator Cluster Surveys
MOH	Ministry of Health (Ghana, Mauritania)
MSI	Marie Stopes International
MSP	Ministry of Public Health (<i>Ministère de la Santé Publique</i>) (Niger)
NGO	Non-governmental organization
NHA	National Health Accounts
NHIA	National Health Insurance Agency (Ghana)
NHIS	National Health Insurance Scheme (Ghana)
PANB	National Costed Action Plan (<i>Plan d'Action National Budgétisé</i>) (Niger)
PMA2020	Performance Monitoring and Accountability 2020 Surveys
PNSR	National reproductive health policy (<i>Politique Nationale de la Santé Réproductive</i>) (Mauritania)
RH	Reproductive health



ROASSN	Collective of Health Sector NGOs and Associations (<i>Regroupement des ONGs et Associations du Secteur de la Santé</i>) (Niger)
SWEDD	Sahel Women's Empowerment and Demographic Dividend (<i>L'initiative régionale Autonomisation des Femmes et Dividende Démographique au Sahel</i>) (Niger and Mauritania)
TFR	Total Fertility Rate
UHC	Universal health coverage
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

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EXECUTIVE SUMMARY

Some countries in sub-Saharan Africa have enacted policies declaring family planning (FP) services free of cost for clients, that is “free FP” policies, or are considering doing so in the near future. To inform decisions about future policy for countries considering such policies, and to encourage efficient use of resources toward any such policy, policymakers and donors alike would benefit from understanding the underlying objectives of “free FP” policies as well as results and lessons learned from their implementation. This report presents the findings of a study that examined six countries in West Africa, looking specifically at their policies related to free FP services. This study was conducted by the Health Finance & Governance project (HFG) in collaboration with the United States Agency for International Development (USAID) Africa Bureau and USAID West Africa Regional Health Office. As part of this work, we acknowledge voluntarism and informed choice are essential underpinnings of any family planning service provided to clients,¹ whether free or otherwise.

In addition to USAID, governments of the six countries featured in this report, other countries in West Africa, and other development partners supporting FP in the region, may be interested in this report.

This report contains six chapters, not including this Executive Summary. Chapter 1 introduces the study, and Chapter 2 outlines the study methodology. We follow with Chapter 3 which presents in-depth profiles of three West African countries that have implemented national “free FP” and illustrate the various considerations, policy vehicles, and experiences: **Ghana, Mauritania, and Niger**, henceforth referred to as “**Core countries**.” Chapter 4 provides a cross-country comparison of these Core countries, including relevant common themes and divergences. This comparison may illuminate considerations for countries in the region that are contemplating providing FP services free of charge to clients. Accordingly, Chapter 4 then broadens the regional perspective on free FP by presenting information from three additional West African countries that are on the threshold of providing free FP services: **Burkina Faso, Cote d’Ivoire, and Mali**. With these three additional countries, HFG presents comparative data for six study countries in Chapter 6. We conclude with Chapter 7, a discussion of study findings and key takeaways for policymakers in West Africa.

For this study, HFG collated secondary data, reviewed documents, and conducted in-depth key informant interviews (Core countries only) to explore the study questions. The bulk of the analysis was qualitative.

Profiles of Core Countries

The profiles of the three Core countries include a country snapshot and background, followed by information on the policy objectives for free FP, how these policies have played out so far in practice, and what the outlook remains for free FP.

Ghana has a long history of FP policy and has substantial commitments and plans related to FP. Aside from counseling, no FP services are currently free in the public sector. However, Ghana passed an act in

¹ The Tiahrt Amendment of 1998 reaffirms and expands upon standards for voluntary FP service delivery projects funded by USAID. The standards protect recipients of FP services. Source: <https://www.usaid.gov/what-we-do/global-health/family-planning/voluntarism-and-informed-choice>

2012 adding FP to the benefit package for its National Health Insurance Scheme (NHIS). A pilot is underway to help estimate the cost of this addition. In 2020, the NHIS will review the pilot results to inform future replication and scale-up of free FP.

Despite a low national income and high total fertility rate (TFR) as measured by births per woman, **Niger** decreed in 2005 that FP would be added to the free health services benefit package. Implementation began in 2006. Although donors finance the majority of FP commodities, the Government of Niger covers the cost associated with clinical services as well as human resources and infrastructure costs through a reimbursement system. However, Niger has not been able to effectively compensate all facilities for the free services. The current practice of donors paying for financial shortfalls sustained by facilities is not assured in the future.

Mauritania is also heavily focused on FP, enacting three national policy documents in the last decade. In 2003, the government recognized low demand for FP products and instituted free FP services through a Ministry of Health letter. Since 2011, FP products have been free of charge. While FP is officially free, policy enforcement is weak. Because the government does not pay facilities to provide FP services or products, facilities lack incentives to do so, threatening availability of FP.

Cross-Country Comparisons

Several common themes emerged from the Core country study data. For instance, all Core countries note the importance of donor contributions to fund FP, but they also acknowledge the potential for future reductions in donor financial and technical resources. While Core countries have made commitments to increase their own funding of FP, key informants acknowledged that government-led changes in FP financing have been slow. No Core country has yet **met its financial targets for funding FP, and all lack concrete plans to boost domestic resource mobilization for FP.**

Countries face **multiple barriers to boost FP uptake, with certain barriers more prominent than out-of-pocket cost.** Sociocultural barriers, including along religious and gender norms, and the extent to which FP programs incorporate youth and adolescents are two examples. We also identified barriers to FP access, including distance to health facilities, particularly for clients living in rural areas; gender roles are also a barrier, as married women are reluctant, if not unable, to access services without their partners' agreement or participation.

In addition to common themes, HFG identified some points of divergence between Core countries. First, **Core countries used different health financing mechanisms to provide “free” FP services.** Ghana included FP services in the benefit package of the NHIS, whereas Niger developed a government facility reimbursement mechanism to cover the costs of a free health services benefit package that includes FP; Mauritania used an input-based financing system leaving it to facilities to recoup their costs in providing free FP. Second, the study found **differences across Core countries in what “free” FP actually meant in practice.** With the exception of FP counseling and education, we found that clients accessing FP do bear some, although often nominal, out-of-pocket cost. In each Core country, the study found that key informants presented **unique lessons learned** on addressing barriers to FP access that can support future peer learning across the region. These included connecting FP with the religious beliefs of Mauritania's Muslim-majority population and modeling the success of FP education and promotion programs targeting husbands in Niger.

HFG also **provides a broader view of the policy environment for FP in West Africa by reviewing FP policies in three additional West African countries: Burkina Faso, Cote d'Ivoire, and Mali.** We then present a cross-country comparison of all six study countries, highlighting the most common strategies for increasing access to FP and the most cited plans for financing for FP. We also note several recent trends in FP as well as general and FP health expenditure.

Discussion

Based on the findings from the six study countries, we considered what this **study can tell policymakers and stakeholders interested in advancing FP policy in West Africa, particularly those considering making FP free or nearly free for clients.** This study sought to clarify what countries and donors mean when they talk about “free FP.” It appears that the definition can vary widely in terms of what services are covered and the extent to which facilities provide such services without charging the client, be it for the consumables, commodity and/or procedure. **Further work should be done to develop a systematic and consistent definition of what free FP means,** in practice or in planning, for each country. This study also noted the paucity of literature on the subject of free FP, although articles are available on the related topic of user fee exemptions. Our study should be considered an exploratory analysis, a first step to closing the gap in knowledge about policymaking for free FP and the experiences that may follow after such policies are implemented in West Africa.

The study found that **“free” as expressed in policy documents does not necessarily translate into financial commitment for FP.** Policy changes on paper are slow to materialize into implementation. Nor does a policy of “free FP” necessarily equate to cost-free FP services for clients. In practice, countries routinely fall short of allocating committed financial targets for FP. Although available data are sparse, they suggest that allocated funds are even less likely to be disbursed. None of our study countries has consistently met its financial commitments regarding FP. Countries continue to rely on donors for the purchase of commodities. These challenges, accompanied by concern about donor drawback, continue to diminish the outlook for all FP services, including those that are free. Countries in West Africa seeking to meet ambitious FP commitments through some form of free FP should first conduct costing studies to estimate the funds needed. Those costing estimates must be coupled with a realistic view of the funding available (with realistic time frames) to meet the increased cost. We recommend a sequential approach to such a policy change, especially to mobilize additional funding before the policy change is made; this will increase likelihood of sustainability, especially as donor resources decline. Also critically important is close coordination across relevant actors: donors, governments, nongovernmental organizations (NGOs), and other stakeholders.

From the client perspective, varying applications of “free” FP can translate to persistent user fees. Even when nominal, user fees may deter youth, adolescents and even married women in some cases from obtaining FP. Across the six study countries, irrespective of the implementation of “free” FP, we see that interventions focused on increasing awareness of FP benefits at the household level are widely adopted and seen as effective by policy makers in increasing access. Specific examples such as husband schools and developing husband champions should be considered by countries in West Africa seeking to increase demand for FP.

Governments and researchers should pursue additional research on factors associated with uptake of modern contraception and reducing unmet need for FP to determine the best approaches for addressing FP access barriers and the relative contribution of free FP policies across West Africa. This research should account for other barriers to clients beyond cost and also the financial and implementation barriers for the government. **Further data collection** would help clarify the picture, particularly on the financial side. Budget figures across years were not widely available in our study countries, especially from standardized, internationally comparative data. Further, data on budget effectiveness were limited.

Main Study Findings

The **key takeaways from our study** are:

- How countries implement free FP can differ widely; a more precise definition would allow the global community to better understand countries' experiences.
- Free FP policies require patience and sustainable financing to implement.
- Socio-cultural factors and geography may inhibit FP access more than out-of-pocket costs.
- Stakeholders, including policymakers and researchers, need better data and more robust study to determine whether and how free FP can be an effective and cost-efficient strategy to accomplish goals for FP and other development goals.

I. INTRODUCTION

I.1 Background and Rationale

As countries across sub-Saharan Africa strive to provide more people with more health services at less cost, family planning (FP) is a health service proven to yield high health and socioeconomic development outcomes relative to the money invested (Singh et al., 2009; Starbird et al., 2016). Regional and national efforts to advance toward universal health coverage (UHC), and implement packages of essential health services, universal access to FP, and provision of FP services free of cost to clients all present opportunities to expand equitable access to FP services for all. A number of countries in sub-Saharan Africa have made FP services free for clients or are considering doing so in the near future. These countries include Kenya, Nigeria, Tanzania, Burkina Faso, Benin, Mali, and Niger. To encourage efficient use of country and donor resources, it is important that policymakers and donors understand the objectives of such policies, their results, and lessons learned from implementation. This understanding, in turn, can promote better policymaking and implementation, ultimately leading to better FP, related health and overall socioeconomic development outcomes.

HFG conducted an analysis of six countries in collaboration with USAID Africa Bureau (USAID/AFR) and USAID West Africa Regional Health Office (USAID/WA), to investigate research questions on free FP policies. The analysis included in-depth reviews in three “Core” countries selected from the larger group of countries in West Africa. We also include three additional countries in West Africa—Burkina Faso, Cote d’Ivoire, and Mali—to broaden our perspective on FP policies, understand relevant socioeconomic and demographic factors and trends, and explore the application of lessons drawn from the Core countries in the region.

I.2 Research Questions

We have two primary research questions related to free FP services in West Africa:

1. What are a country’s underlying objectives when it decides to offer free FP services for clients?
2. What has been the experience and results to-date following the introduction of policies to offer free FP services?

I.3 Country Selection

To determine the countries for this study, HFG ranked potential countries across four selection criteria:

1. Relevance to USAID
2. Data availability
3. Enabling policy environment for free FP
4. Evidence found in the literature

Each of the four selection criteria was scored using the guidelines explained below. The score for each criterion was standardized to a [0–1] scale by dividing it by the maximum score possible (e.g., 8 for relevant policy). The total score for each country equals the sum of standardized scores for the four



criteria. This implicitly assumes that each criterion is equally important to country selection. The scores were then rounded to the nearest digit to ease comparison.

- **Criterion 1: Relevance to USAID:** A score of 1 denotes countries that USAID expressed interest in, and 0 denotes those not mentioned.
- **Criterion 2: Data availability:** Using a 6-point scale, countries were scored on the availability of:
 - Demographic and Health Surveys (DHS) (3 points maximum, with 1 point each for: one available, multiple available, and at least one conducted in the last five years)
 - Multiple Indicator Cluster Survey (MICS) (1 point if survey in last 10 years)
 - Performance Monitoring and Accountability 2020 (PMA2020) surveys (1 point)
 - National Health Accounts (NHA) (1 point if conducted in last five years)
- **Criterion 3: Enabling policy environment for free FP:** The scoring for this criterion uses an 8-point scale. HFG considered countries with a favorable policy environment for free FP as evidenced by:
 - A free FP services policy (3 points, because the existence of a free FP services policy is a source for investigating both research questions)
 - A law or legislative framework for FP (1 point)
 - A FP policy or one in development (1 point)
 - A FP (costed) implementation plan or one in development (1 point)
 - Documented interest in reducing unmet need for FP (1 point)
 - "Free" FP for at least for 100 percent of public facilities (1 point)
- **Criterion 4: Existing evidence on free FP services:** This considers availability of research studies investigating the effect of eliminating financial barriers on use of FP services. A score of 1 denotes countries with any relevant studies identified in the literature, including multi-country studies.

Based on the highest total scores, we considered seven countries for inclusion in this study: Burkina Faso, Cote d'Ivoire, Ghana, Guinea, Mauritania, Niger, and Nigeria (see Annex A). In consultation with USAID, we selected a mix of six countries by geographical location (Sahelian/non-Saharan) and religious majority (Muslim/Christian) to ensure transferability of results to non-study countries. From there, we identified half of the study countries as further advanced in terms of enacting policies regarding free FP; these "Core" countries are: Ghana, Mauritania, and Niger. The remaining three, non-Core countries are not as advanced in policy setting for free FP but are currently considering its pursuit. These countries are Burkina Faso, Cote d'Ivoire, and Mali, for a total of six study countries.

2. METHODS

2.1 Study Design and Procedures

For this study, HFG collated secondary data, reviewed documents, and conducted in-depth semi-structured interviews (Core countries only) to explore the research questions. Qualitative methods enabled the study team to extract and organize data systematically from key documents as well as the relevant literature. A common data abstraction form was used to identify relevant data, policy and literature review results, respectively. In addition, semi-structured interviews in Core countries allowed us to capture narrative data that revealed the actors' understanding of how policies regarding free FP services for clients have been considered and/or implemented, key features of the decision making process, some of the barriers and facilitators to policy implementation, as well as results of the policy implementation (when applicable) that were not captured in the document review.

2.2 Secondary Data Collation and Use

HFG reviewed, collated, and analyzed data to understand the socioeconomic and demographic contexts of each study country and how these contexts may have influenced policies to offer free FP services to clients. HFG also examined the results that may be related to these policies for all study countries. The results included health indicators and financial data (including budget information if available). Our data sources included: DHS, MICS, PMA2020, NHA, and the World Bank World Development Indicators. The data were collated from these sources into a master spreadsheet containing all study countries to identify trends within countries and patterns across countries.

2.3 Literature Review

HFG initially conducted a rapid scan of the literature as part of the country selection process for this study. Few relevant articles were found that referenced the possible pool of study countries in sub-Saharan Africa. After the six study countries were selected, HFG researchers conducted a more systematic literature search.

This more systematic search focused on policies for free FP services for clients. We looked at documents from the peer-reviewed literature, as well as grey literature and government sources.

HFG searched two different social science and health databases: Pubmed (Med-line) and Popline. In addition to the database search, we used Google Scholar to identify sources not included in electronic databases and pursued references in literature already reviewed in a snowball manner. The list of terms below comprises the basic search strategy.

("free") OR ("user fee")

AND

[Ghana OR Niger OR ...]

AND

"family planning"

We applied the following criteria to determine sources to include. Title or abstract of the titles featured three categories of search terms. Articles must also have 1) described any type of Free FP services policy or programs, 2) identified features of the policy or program, and 3) provided clear geographical distinction (including at least one of the study countries)

We excluded sources that were published before 2000, were written in a language other than English or French, focused at a global level, or centered on opinion or advocacy, i.e., editorials, commentaries and reviews.

Despite our expanded efforts, HFG found only a few additional documents, primarily via a snowball method of tracing references.

2.4 Policy Document Review

HFG conducted a desk review of national FP services policies in the study countries. This review enabled us to understand the policy context, including recent history, relevant to considering offering free FP and how it may look if pursued in a country. At the foundation of our policy document review, we sought to address the following questions about the policy context:

- What is the current status of FP engagement by all actors and especially the government?
- Does the country have an FP (Costed) Implementation Plan or is it developing one?
- Are policymakers interested in reducing unmet need for FP? What are major strategic objectives for doing so? What are major documented goals for doing so?
- Are FP services "free" in the country?
- Has the country decided on a free FP services policy?

The policy review identified and elucidated the level of documented, nationally recognized progress toward each study country's goals and strategic objectives around FP. We reviewed what we will generalize as "policies," including national plans, strategies, and formal policy documents. In order to capture FP policies across countries, the review also included policies pertaining to population or reproductive health (RH) that may include FP within them.

2.5 Interview Subjects and Sampling

2.5.1 Study Population

HFG collated data and conducted desktop document review, followed by in-depth interviews with national actors involved in promoting FP services, e.g., ministries of health, international development organizations including bilateral and multilateral agencies, implementing partners, national private sector actors, university researchers, and other FP stakeholders. HFG purposively selected key informants in consultation with USAID based on their areas of interest for this study and upon the advice of national-level government stakeholders and consultants, as well as through snowball sampling (Bernard 2011). The study left open the possibility of including participants who may not have been identified prior to data collection and whose participation was deemed helpful by the researchers as their understanding of the study evolved. After obtaining informed consent from key informants, HFG asked them to participate in an in-depth interview, during which we captured their responses in interview field notes taken by HFG.

HFG selected potential key informants based upon the following eligibility criteria:

- Currently or previously worked in one of the Core countries
- Has knowledge of—or experience in—FP advocacy, policymaking, policy implementation and/or service delivery in one of the Core countries

2.5.2 Study Locations

HFG conducted the key informant interviews in person in Core countries only (Ghana, Mauritania, and Niger). Interviewees typically participated from their place of work. In three instances (two in Ghana, one in Mauritania), we located a key informant who was unavailable to participate in the study in person. This did not exclude the key informant from participation in this study; in these cases, we conducted the key informant interview in the same manner as the others but by phone.

2.5.3 Sample and Sampling Strategy

This study employed a purposive sampling strategy. Key informants were recruited by HFG from study locations based on their knowledge of the thematic areas of interest. HFG consulted an in-country USAID Family Planning and/or Health focal point in a given country to develop a list of relevant key informants that represented a range of backgrounds pertinent to understanding the provision, policy outlook, and financing considerations of FP.

HFG planned to interview approximately eight key informants in each of the Core countries. Our estimated sample size was determined based on funding and time constraints, but also based on identifying the right, key stakeholders who understood the subject matter. While our ability to draw comparative inference would be somewhat limited by the small sample size, the sampling strategy allowed researchers to read across the data to select emerging themes and further explain gaps identified in the literature and policy reviews.

2.5.4 Data Collection Instruments

The researchers used a semi-structured interview guide (see Annex B) to conduct interviews with key informants. The interview guide included 22 open-ended questions and began with a few questions about the key informant's organization and the role of said organization in FP. This section allowed key informants to talk about themselves and settle into the interview.

The following section in the interview guide included a series of questions related to the country's context and objectives regarding FP policy, what policy environment currently exists regarding free FP, and results (if any) from a free FP policy. We concluded the interview by thanking the participant for his or her time and asking if he or she could recommend other key stakeholders whose perspective we may need on the research questions.

HFG wrote the interview guide in English and translated it into French. All interviews were similarly conducted by HFG in English or French. The expected duration of each interview was approximately one hour, but on numerous occasions the interviewee had less time to spare due to other duties intruding on the interview.

2.5.5 Data Collection Field Work

Two HFG researchers, Ffiona Patel, qualitative lead, and Dr. Birahime Diongue, regional consultant, conducted field work from June 18–July 6, 2018, and concluded data collection with the last phone-based interview conducted on July 11, 2018. By country, field work proceeded as follows:

- Ghana: From June 18–June 24, 2018, plus one phone-based interview on July 11, 2018. Eleven key informants were interviewed representing eight unique agencies.
- Niger: From June 25–29, 2018, 16 key informants were interviewed representing nine unique agencies.
- Mauritania: From July 2–9, 2018, 19 key informants were interviewed representing 12 unique agencies.

See Annex C for a compiled list of all key informants and interview status across countries. All key informants were generally happy to contribute their thoughts during the interview; however, several key informants across countries had limited availability to answer all interview questions. As a result, HFG often prioritized interview questions based on the key informant's vantage point of the subject matter. For instance, a key informant who manages FP service provision would be well equipped to answer questions about what services are provided by level of the health system but may be less suited to answer questions about policy.

Also across all countries, due to either not being recommended by USAID and key informants or being unavailable during the data collection period, individuals responsible for government financing of FP (i.e., a Ministry of Finance health focal point or a Ministry of Health financing focal point) were not included in the study.

2.5.6 Field Notes

Field notes were compiled by HFG immediately following the interviews. Researchers recorded all information deemed relevant to the interviews as accurately as possible both during and after the interviews. The researchers reflected on the substance of interview responses and highlighted aspects that are particularly salient for subsequent analysis. They also recorded new questions that arose, persistent gaps in collected data, or problematic lines of questioning in the field notes.

2.6 Data Cleaning and Analysis

HFG analyzed both quantitative and qualitative data as part of this research study. Due to the small sample size of the study and the low expected volume of data from key informant interviews, HFG did not establish a coding framework, employed when handling large amounts of data, prior to data collection. Accordingly, HFG did not anticipate the interviews to generate a significant number of relevant quotes, so HFG also did not use qualitative analytical software for the study. Instead, researchers recorded responses to each interview question, highlighting any notable quotes and themes in the field notes. The researchers reviewed notes following each interview in order to complement, further understand, and try to address gaps in the data through subsequent interviews. Following the data collection, HFG applied a deductive analysis approach, using the research questions to organize the data and then assess data groupings for similarities, differences, and overarching themes. Below, we summarize the process of interpreting and comparing data output.

2.6.1 Data Cleaning and Organization

Following data collection in each country, the study's qualitative lead reviewed field notes from each individual interview. The notes were reviewed for completeness, with any unclear responses or unspecified acronyms flagged for follow-up by the regional consultant. Once finalized, interview notes for each country were organized in a matrix that facilitated cross-interview data comparison. In particular, the matrix laid out interview questions and sub-questions as categories under which researchers identified major themes, commonalities, and areas of divergence across responses.

2.6.2 Interpretation Sessions

HFG conducted internal interpretation sessions led by the study's qualitative lead researcher, who was responsible for conducting interviews, overseeing the qualitative data collection process (with feedback sought separately from the regional consultant who also conducted interviews), writing the field notes (or reviewing their quality if written by the regional consultant), and drawing conclusions. The purpose of these sessions was to collaboratively review and interpret data from the interviews, review any documents collected during in-country interviews, and collate data (Schwartz-Shea and Yanow 2012). The goals of the sessions included:

- Triangulate data regarding FP in the study countries
- Identify trends
- Explore understandings of how countries have pursued or may pursue free FP

HFG engaged in collaborative discussion to understand emerging themes from the document review and interview data. We developed the organization of these themes throughout the process of analysis. Further lines of inquiry and problematic features of the themes that remain unaddressed were identified by HFG for discussion. Similarly, HFG highlighted lessons learned and potential contributions of this study to global knowledge as well as areas for future research.

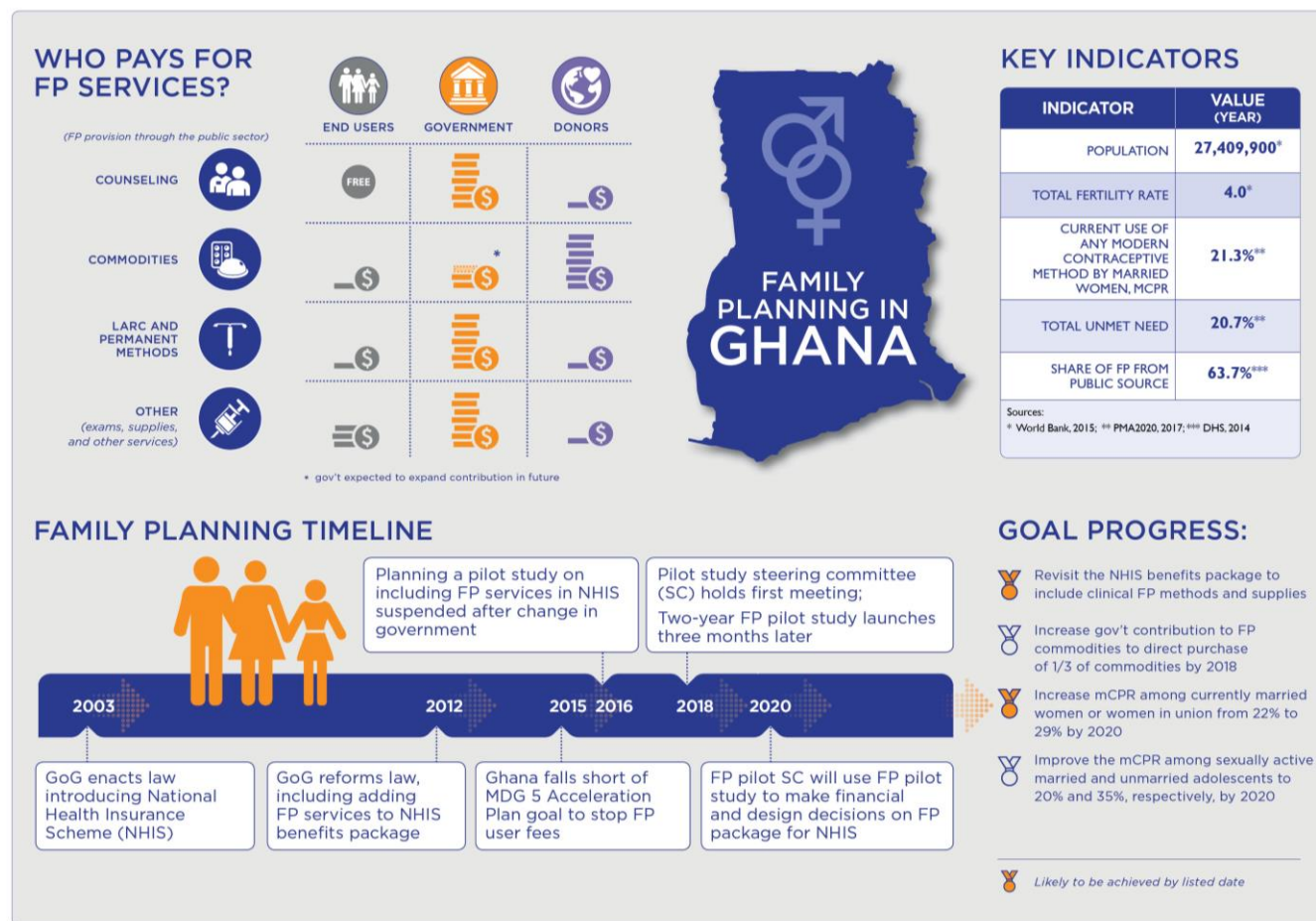
2.6.3 Comparative Analysis

This study was limited in scope to three Core and three non-Core countries [need to standardize language and capitalization] in West Africa, limiting the strength of cross-country comparisons. Nevertheless, HFG made some comparisons in line with our exploratory, lean study design to understand common themes and divergences in the experiences of the Core countries, and then with data from the additional non-Core countries to broaden the perspective on FP policies, socioeconomic and demographic trends, and consider application to the West Africa region. We temper the study results with the caveat that future research will be needed to solidify these cross-country comparisons and lessons applications.

3. CORE-COUNTRY PROFILES

3.1 Ghana

3.1.1 Country Snapshot and Background



Of the six study countries, Ghana has the largest population and the highest income level, as measured by gross domestic product (GDP) per capita. The country's TFR as measured by births per woman of 4.0 is below that of other study countries, although above its planned trajectory (the 1994 Revised Population Policy projected a rate of 3.0 by 2020). Modern method contraceptive prevalence rate (mCPR), a measure of the proportion of women ages 15–49 who are using (or whose partners are using) a modern method of contraception, has been increasing in recent years from 18.2 percent in 2013 to 21.3 percent in 2017 for all women (27.4 for married women). It appears that Ghana's FP2020 commitment of 29 percent mCPR for married women by 2020 is within reach, but remains well below the 1994 Revised Population Policy goal of 50 percent by 2020. In terms of equity, the mCPR for all women does not vary much between wealth quintiles, ranging from 20 to 23 percent in data from 2016 (PMA2020).

Family planning methods are primarily sourced from the public sector, where nearly two-thirds of women using modern FP methods obtain them.

3.1.2 FP Policy Landscape

3.1.2.1 Policy Objectives

Ghana holds an important place in FP discussions in West Africa. The government sees itself, rather than donors or technical and financial partners, as playing a lead role in driving the nation's FP agenda relative to neighboring countries in the region because of its relatively stronger health system and stronger health governance structures. This also stems from history. Ghana passed one of the first national population policies in Africa in 1969 and set national fertility and contraceptive use targets in the 1994 Revised National Population Policy (Asante, 2013). In the past 20 years, Ghana established NHIS in 2003 and then, in 2012, reformed the NHIS in a number of ways, including listing FP as part of the NHIS benefit package.

Alongside these policies, Ghana has made several national and international commitments and plans regarding FP. National goals included those of the 1994 Revised Population Policy, such as reducing the TFR to 3.0 and boosting modern contraceptive prevalence rate (mCPR) to 50 percent by 2020. More recently, the Ghana Family Planning Costed Implementation Plan, 2016–2020 (GFPCIP) named six key strategic priority areas. The Plan also featured updated operational objectives (targets) for mCPR among married women, aiming to increase mCPR among this sub-population to 29.7 percent by 2020 and to 40 percent for unmarried, sexually-active women. FP commitments made by external stakeholders are most exemplified by the Family Planning 2020 (FP2020) engagement commitments from 2017, which were:

- Expand NHIS benefit package to include clinical methods of FP services and supplies
- Increase government financial contribution to procurement of FP commodities from one-quarter of all commodities in 2017 to one-third of all commodities starting in 2018
- Increase mCPR among married women or women in union from 22 percent to 29 percent by 2020 through improved access to FP in peri-urban and rural areas
- Enhance adolescent access to sexual RH information and services, especially improving access and uptake of FP services to improve mCPR among sexually active married and unmarried adolescents from 16.7 percent and 31.5 percent to 20 percent and 35 percent, respectively by 2020.

However, key informants had varying opinions regarding the motivations behind recent pushes for FP policies. One respondent shared that “family planning is about health and safety more than population control.” Key informants see several prominent political players who are seen as champions of FP in

Ghana today, ranging from the current and former presidents to leaders within government agencies such as the Ghana Health Service (GHS) and the National Population Council (NPC) as well as expert advisors from the health sector and academia. That said, a few of the key informants also mentioned that, although there are prominent champions of FP including politicians, FP policy is not a popular topic among politicians.

“Political people do not talk about family planning. They’ll talk about maternal and child health but not family planning. When men talk about family planning, it suggests promiscuity or extramarital activity. The way the story [of family planning] is couched, [it] doesn’t provide political votes.”

Several respondents agreed that the Government of Ghana’s history of supporting FP stems from its strong history of population management. At present, several key informants named reducing fertility rate by birth spacing as a political motivation for promoting FP. On the contrary, despite the opportunity to include FP in the NHIS benefit package as a further hallmark of the nation’s advocacy of FP, respondents suggested that inclusion of FP in the NHIS benefit package could have had political motivations without much thought about implementation: “including family planning wasn’t implementation-focused. It was more about preventing it from being excluded.” In fact, one lesson shared by Ghanaian respondents was the importance of integrating FP into benefit packages at the outset since it is very difficult to add it once a benefit package has been adopted.

Lastly, key informants mentioned the United Nations Population Fund (UNFPA) and USAID as strong influencers in support of FP services. Other influencers mentioned were the Department for International Development (United Kingdom), the Reducing Maternal Morbidity and Mortality (R3M) project, and the Buffett Foundation.

3.1.2.2 Policies in Practice

With the exception of development partner projects that provide FP services at no cost and GHS’ occasional free service promotional weeks that include FP services, no FP services are currently free of charge to clients seeking services in the public or private health sector. There is always some minimal cost for other services even though commodities are supplied free by donors. Clients must pay a user fee, which ranges from about 0.10 United States Dollar (USD) for an injectable to about 10 USD for a permanent method.

Respondents mentioned two development partner projects that are focused on reducing and not eliminating cost to clients. USAID’s Health Policy Plus (HP+) project is exploring the effect of removing high-cost barriers for clients to obtain long-term methods on utilization, hypothesizing that as costs to clients decrease, utilization will increasingly be based on preference, rather than cost.

However, key informants cite other factors beyond cost to client as key barriers to accessing FP services. One such factor is sociocultural challenges. With traditional leadership, men play an outsized role “in influencing whether or not family planning is pursued.” In addition, according to respondents, men are under engaged in education about benefits of FP for the livelihoods of women and children. Among women, a lack of education may likewise dampen FP uptake. As one respondent put it, “[the] greatest reason why clients have problems with family planning is fear of side effects, changes to normal function of the body and misconceptions. It’s not cost, availability, distance or religion.”

In the Core countries, health insurance is not a viable financing mechanism for providing free FP services to clients. Only Ghana has a public insurance option—NHIS—and it does not include FP in practice. Further, respondents had mixed responses on whether private health insurance covers the cost of FP, with responses varying from “perhaps,” to “partial,” to “not sure, but it wouldn’t be surprising if some private health insurance schemes did.” No respondent could name a specific example.

As mentioned, FP services were excluded from the original NHIS benefit package but the 2012 NHIS reform legislation included language concerning a “relevant family planning package” (National Health Insurance Act 852, Section 30). The Ghana delegation at the Family Planning 2020 London Summit in 2012 announced this particular element of the NHIS reform and renewed its commitment to implementing it in 2016. Six years following the reform, it has not been implemented due at least in part to fundamental challenges with the financial sustainability of the NHIS.

In May 2018, Ghana’s National Health Insurance Agency (NHIA)—the government agency that oversees the NHIS, GHS, Marie Stopes International (MSI), USAID, and other partners officially launched a pilot study to operationalize the inclusion of FP services into NHIS. The pilot study is slated to last two years and will take place in six treatment and two control districts. It aims to test the cost, operational needs, and financial viability of including FP clinical methods of services and supplies in the NHIS benefit package. One respondent mentioned that the pilot will also provide insight on maintaining client privacy when obtaining FP because of the “need [for the provider] to validate enrollment [in the NHIS] at the point of service.” Another mentioned that it is “not clear if NHIS integration means totally free [family planning services] for clients or if there’d be point of service user fees.” Most respondents acknowledged the government’s interest in maintaining some level of user fee, even if nominal. One shared that the “NHIS concept was to enable improved and cheaper [but not free] access to health care for all, spreading the health bill across everyone so everyone contributes a little bit to cover everyone who needs services.”

Beyond the integration of FP in the NHIS, a few respondents mentioned the campaign for a “Ghana beyond aid” as a national initiative to reduce donor dependence and improve domestic financing across sectors, presumably including health and FP. At the time of the study, no respondents presented documents regarding this initiative.

3.1.3 The Outlook for Free FP

Among key informants in Ghana, the implementation of the pilot for integrating FP into the NHIS, and key financing decisions that will stem from it, was the most commonly cited next step that will help determine the future of free FP in Ghana. The pilot should provide insights on:

- Commodity costs to be borne by the Government of Ghana through the GHS, assuming donors transition out of financing FP
- Client demand and bias of the provider and government
- The costs of FP based on actual client demand for all methods

Respondents indicated that the results from the pilot will be analyzed in 2020, at which point the NHIS will decide to what extent findings will support replication and scale-up of free FP for clients.

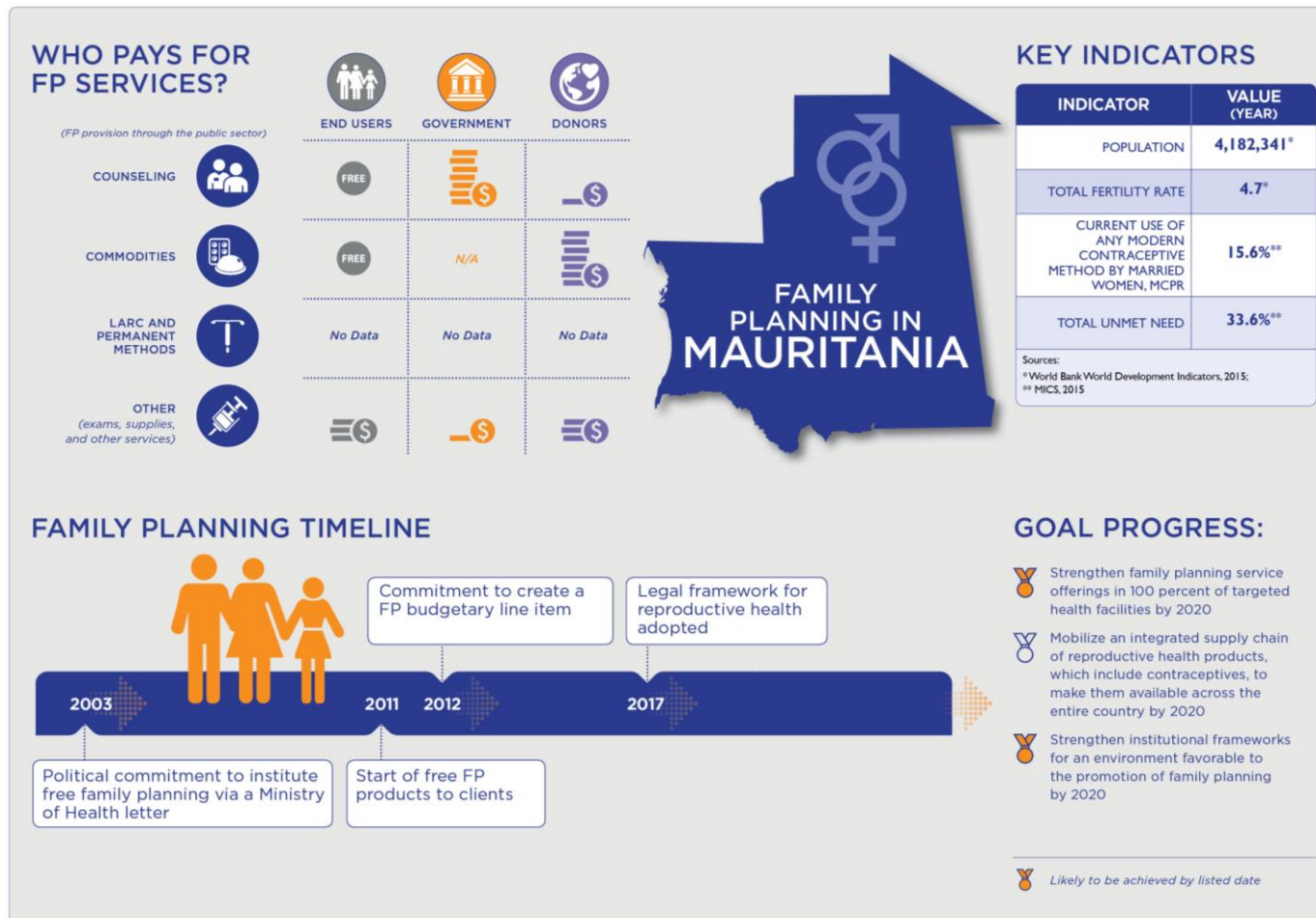
A key factor in the outlook for free FP in Ghana is the ability of the government to assume greater, or all, financing of commodities and services. The government plans to increase the budget line item for FP, especially for commodities procurement. Respondents revealed a dual perception of the financing of FP by donors while increasing government contributions. On one hand, due to limited domestic resources, potential reductions in donor support present a real threat to continued and increased availability of FP services to address unmet need: “The highly donor-dependent nature of funding is extremely worrying. If [donor priorities change], there would be a serious threat to service provision.” On the other hand, a few respondents remarked that there is a “donor-driven prioritization of funding family planning” that may reduce the urgency through which the Government of Ghana prioritizes funding of FP. One respondent shared that if donors transitioned out of FP financing in Ghana, the same issues as seen with the Global Alliance for Vaccines and Immunization and vaccination financing may occur. That is, the

Alliance tried to phase out of vaccination financing but had to extend its phase out plan because the government was unable to meet boosted contribution targets.

Overall, Ghana is on a path to the provision of free FP services and has chosen to do so outside of government-direct financing to health providers. The country enacted a reform of its social health insurance—NHIS—and included FP in NHIS's benefit package as part of that effort. Although the pilot study for integration of FP into NHIS is only a few months into implementation, Ghana has the benefit of several national-level, political FP champions, each of whom makes a case for FP, be it for better health outcomes for mothers and children, better socioeconomic outcomes, or broad health and wealth benefits. As Ghana progresses with its current efforts and toward its FP targets, including its FP2020 targets, regional stakeholders may be interested to see how Ghana balances interest in contributing more financial resources to generate and meet demand as well as pay for commodities while determining how they will sustainably finance the inclusion of FP services in NHIS.

3.2 Mauritania

3.2.1 Country Snapshot and Background



Mauritania is unique among the six study countries. It has the least donor presence in support of FP efforts, and it also has the least amount of data available related to key FP indicators. Recent data from the 2015 MICS indicate that Mauritania had an mCPR of 15.6 percent among married or in-union women, with unmet need (33.6%), the highest of the six study countries. Mauritania has had three national policy documents related to FP since its 2011 participation in the Ouagadougou conference “Population, family planning and development: the urgency to act.” Its most recent policy document is the Action Plan in Favor of Birth Spacing 2014–2018, although the government has drafted a national strategic plan in RH (*Plan National Stratégique en Santé de la Reproduction 2016–2020*). Another interesting point about Mauritania is that despite having a TFR of 4.7 (in 2015), its legal framework for RH has been only recently put forth: It was adopted in late 2017 and the accompanying decree for implementation was published in May 2018.

Key informants reported that FP methods are heavily sourced from the public sector. The last DHS survey (in 2000) reported that nearly 70 percent of women using modern FP methods obtained them there.

3.2.2 FP Policy Landscape

3.2.2.1 Policy Objectives

For over 30 years, Mauritania has put forth policy commitments that include, if not directly address, sexual and RH needs. In 1995, Mauritania declared a national population policy followed by a national policy on sexual and RH (*Politique Nationale de la Santé Reproductive*) developed in 1996 and subsequent national RH policies thereafter. In addition, RH has been integrated by the country into broader-reaching economic development policies, such as 2001’s strategic framework for poverty reduction (*Cadre Stratégique de Lutte contre la Pauvreté*), recognizing that “birth spacing,” as they officially refer to FP there, combats high maternal and infant mortality in the country while addressing rapid population growth and poor health outcomes, both of which impede economic progress. Following its induction into the Ouagadougou Partnership, Mauritania developed a national strategy to advocate for the increased prioritization of FP (*Stratégie Nationale de Repositionnement de la Planification Familiale*); the strategy was developed in recognition of rapidly increasing population growth, high total fertility, and high unmet need for FP across the country. Across Mauritania’s many commitments to improving FP, the common thread has been addressing poor maternal and child health indicators through improvements to “birth spacing,” how FP is officially referred to across religious and nonreligious actors. According to International Planned Parenthood Federation local partner, *Association Mauritanienne Pour la Promotion de la Famille* (AMPF), the maternal, neonatal, and infant mortality rates are 625 per 100,000 live births, 43 per 1,000, and 77 per 1,000, respectively. Despite the introduction of several policies and strategies over the past three decades, Mauritania only in May 2018 officially declared the modes of application of its 2017 RH law.

The public health sector in Mauritania is financed through a cost-recovery system in which clients pay user fees based on the costs of medications and services. This system included FP until 2003, when the government recognized the low demand for FP products and, as part of a political commitment, instituted free FP services through a Ministry of Health letter (*lettre circulaire*). Since 2011, FP products have been free of charge to clients, in parallel to free offerings for Tuberculosis, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), vaccinations, malaria, pregnancy, and under-5 child health services. Mauritania’s challenge in so doing has been securing financing for free FP services. In 2007, Mauritania established a budgetary line item for RH that included FP. In 2012, recognizing that FP received inadequate financial allocations under RH, Mauritania committed to creating a budgetary line item specific to FP.

At present, Mauritania's national FP goals are encapsulated in Mauritania's Action Plan for Birth Spacing for 2014-2018 (*Plan d'Action en faveur de l'Espacement des naissances 2014–2018*), which focused on four strategic areas:

- Improving the demand for FP services
- Strengthening the offering of FP services
- Making an enabling environment for FP services
- Improving the monitoring and coordination of FP actions

External FP commitments are most exemplified by the FP2020 engagement commitments from 2017, which were:

- Strengthen FP service offerings through the introduction of new methods as well as FP of postpartum women, adolescents, and married youth in 100 percent of targeted health facilities by 2020
- By 2020, mobilize an integrated supply chain of RH, maternal, neonatal, infant, and nutritional products, which include contraceptives in order to make them available across the country, "Leave no person behind"
- Strengthen institutional frameworks for an environment favorable to the promotion of FP by 2020

In Mauritania, in addition to the government, there have been a few notable supporters of FP. First, UNFPA has been a stronghold in advocacy for the repositioning FP as well as improvements to the availability of quality FP services. In addition, USAID is recognized as a donor that has contributed invaluable projects like Deliver and AgirPF that have reinforced weak areas of FP service provision. That said, several key informants mentioned that there are not currently any major USAID FP strengthening projects in-country, a gap that is pronounced and of interest to address. One government key informant hoped that the "arrival of [USAID's Global Health Supply Chain project] in 2018 would improve the availability of FP products through better quantification and management of products." The World Bank, and in particular its project Sahel Women's Empowerment and Demographic Dividend (SWEDD), has supported the registration, pharmaceutical regulation, and distribution of FP products nationwide. Last, AMPF, a national NGO that was the precursor to FP service provision in Mauritania and currently operates six FP clinics across the country, was mentioned as a critical local partner in FP.

3.2.2.2 Policies in Practice

In the public sector, all FP services are deemed free of charge for clients, but they pay user fees for complementary exams as well as consumables. That said, there is not yet a legal precedent to harmonize and regulate any fees that may be assessed at point of service for FP services. This means that while FP is officially free, its enforcement is weak in practice. Beyond the public sector, NGOs offer free FP services to youth, adolescents, and the poor. In the private, for-profit sector, all clients must pay fees, which are unregulated, for FP products and services. Health insurance programs, including *mutuelles*, do not currently cover FP services. This means that clients may be subject to out-of-pocket expenditure for accessing FP services unless they are part of one of the target groups for free services through NGOs.

Further, the availability of FP services at point of care is highly influenced by facilities' interest in offering FP services. This is because the government does not reimburse facilities for the provision of FP services or even products, which are mostly provided to the government's central depot (*Centrale d'Achat des Médicaments*) free of cost by donors. This lack of financial incentive at the facility level poses an important constraint to the availability of FP services nationwide and especially in rural areas. One key informant stated, "Certain nurses do not order [family planning] products by their own choice because they are not interested in it and also because there are charges given the services are free to clients."

Another key informant suggested that products distributed to public facilities may be sold privately by providers rather than offered free of charge through the facility, sharing, “Free access [to services] leads to speculation and parallel sales.” As a workaround to this challenge, two communities are contributing their own funds to provide public sector FP services within their respective communities, although contributions from within their territories is weak, threatening sustainability of such local offerings. In contrast, although private facilities charge fees for the provision of FP services, “everyone can buy even youth and adolescents. Although the offerings are limited, there is no discrimination, so the trends are good for private sector provision of family planning services.”

Despite the government’s positive financing commitments to FP noted above, actual financial allocations for FP have yet to meet the nation’s set budgetary goals. In 2014, for example, the government wrote in an allocation of 15 million ouguiyas (USD 41,488) for FP but no money was actually dispersed. This year, an allocation of 50 million ouguiyas (USD 123,294) for FP was written into a finance amendment, although the vote to ratify the amendment had not yet taken place at the time of this study. Indeed, the majority of key informants recognized financing as a top challenge for addressing unmet need for FP. One respondent stated, “The government’s engagements [in family planning] are a challenge and especially the [limited] mobilization [of resources] for the family planning budget... [there was] a written government budget line item but no mobilization.”

In parallel to addressing financing challenges, Mauritania continues to address insufficient access to FP and sociocultural barriers to demand for FP, the two biggest contributors to Mauritania’s current 33.6 percent unmet need for FP. Among the challenges to access described by key informants, limited availability of services ranked highest. Availability is most limited in rural areas. For instance, one key informant shared, “Access to contraception in rural areas is difficult because of weaknesses in health care coverage in general in rural-area health centers and health facilities, including family planning. Also, the presence of Malian camps at the periphery of the city [affects access].”

Sociocultural barriers are also prominent in Mauritania, resulting from the very traditional, faith-based views espoused by a majority of Mauritians. These barriers include pro-abstinence views as well as expectations that only married women would access FP services, and they impact access to FP by youth and adolescents in particular. One key informant stated, “In public facilities, contraceptives are not [offered] to youth. Only married women have the right to them.”

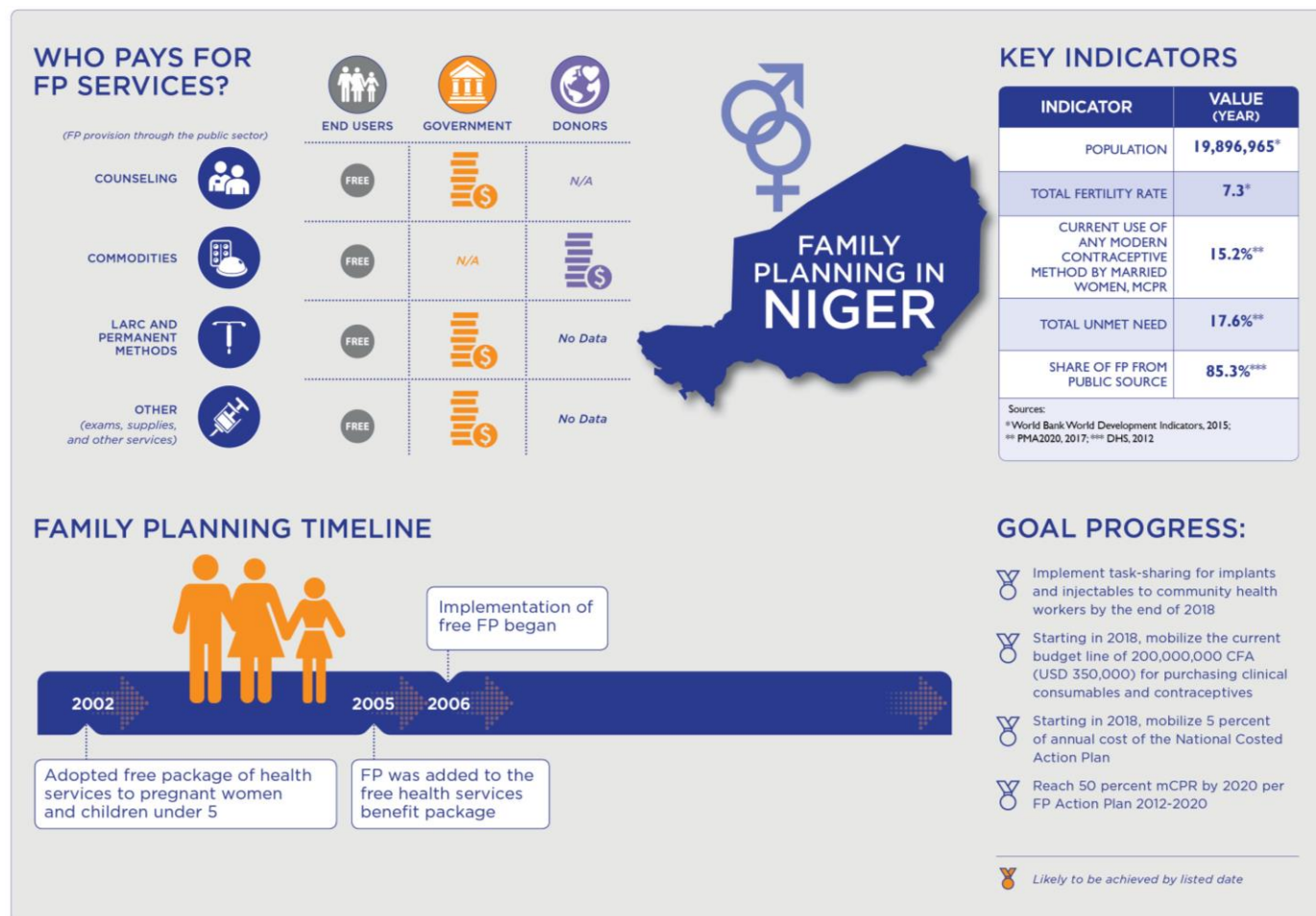
Regarding preferences for FP method, unfortunately, method options in Mauritania are largely limited to short-term methods, especially condoms and oral contraceptives. In contrast, long-term methods are rarely available. Intrauterine devices (IUDs) are becoming more available in Mauritania, but it is uncertain the extent to which the fee associated with their insertion may limit uptake.

3.2.3 The Outlook for Free FP

Overall, there are many challenges to the provision of free FP in Mauritania, but the most significant are government mobilization of financing and limited availability of services due to sociocultural norms and geographic location. While there have been clear, documented gains in Mauritania’s commitment to fund birth spacing, the mobilization of resources remains weak. Further, the lack of incentives for public health facilities to provide free FP services renders availability of FP services at the point of service susceptible to the beliefs and interests of facility-level providers. At present, there is no task sharing of FP services with community health workers nor precedent for the availability of FP services at the community level. Population trends in Mauritania suggest that rapid increases in population growth will continue. The nonworking, under-18 population will become an increasing majority among population age groups, creating further urgency to promote FP services and make them available, whether free or not.

3.3 Niger

3.3.1 Country Snapshot and Background



Of our six study countries, Niger has the lowest income level (as measured by GDP per capita) and the highest TFR. In fact, Niger has the highest TFR in the world at 7.3 and is among the world's poorest countries (World Development Indicators 2015). This combination has long set a precedent for its FP-friendly policies. mCPR has increased in recent years, from 11 percent (of all women, per DHS) in 2012 to 15.2 percent in 2017 (PMA2020). The mCPR is well below the FP2020 target of 50 percent. In terms of equity, data are available from 2016 on mCPR by wealth tertiles from PMA2020, indicating that women in the highest tertile (18.9%) use modern contraceptives at roughly twice the rate of the lowest (8.3%) and middle (9.2%) tertiles.

Family planning methods are almost entirely sourced from the public sector, with 85.3 percent of women using modern FP methods obtaining them there (DHS 2012).

3.3.2 FP Policy Landscape

3.3.2.1 Policy Objectives

Niger has a history of prioritizing FP that spans 30 years, starting with its creation of a FP directorate within the Ministry of Health in 1988, followed a few years later by the Government of Niger's adoption of a national population policy in 1992. Fifteen years later, in 2007, Niger adopted its national population policy. The importance of FP in Niger stems from the recognition that FP reduces maternal and child mortality and also supports economic development. Given the low-income level of the majority of Nigeriens, in order to improve maternal and child health outcomes, in 2002 Niger adopted a policy centered on providing health services free of charge to pregnant women and children under the age of 5. Later in 2005, by decree, FP was added to the free health services benefit package and implementation began in 2006. The Ministry of Public Health (MSP) houses a coordinating unit to oversee these free services.

Niger has also made substantial commitments and plans regarding FP. National goals included those of the 2012–2020 Family Planning Action Plan, which included reaching 50 percent contraceptive prevalence in 2020 via efforts in three strategic areas:

- Improving the availability of FP services at all levels of the care continuum
- Increasing demand for FP services at all levels
- Promoting a conducive environment for FP

External FP commitments are most exemplified by the FP2020 engagement commitments from 2017, which were:

- Implement task-sharing of the Reproductive Health/Family Planning package of services (implants and injectables) to community health workers by the end of 2018, as proposed by the ministers of health at the West Africa Health Organization on June 16, 2017 in Abuja.
- By 2018, effectively mobilize the current budget line of 200,000,000 CFA (USD 350,000) for purchasing clinical consumables and contraceptives. The budget will be increased by at least 10 percent each year until 2020.
- By 2018, mobilize 5 percent of its annual cost to the National Costed Action Plan (*Plan d'Action National Budgétisé* or PANB) looking to the private sector and regional governments to support financing RH/FP and humanitarian crises.
- By the end of 2017, a focus will be on adolescents and youth, and at least 15 percent of the PANB budget plus revisions are to be allocated to interventions targeting the sexual and RH of adolescents and youth.

There are a number of supporters of FP in Niger. UNFPA and USAID are major donor supporters, particularly UNFPA, which not only supplies commodities but also supports advocacy around the importance of FP. The Collective of Health Sector NGOs and Associations (*Regroupement des ONGs et Associations du Secteur de la Santé*) (ROASSN), a national NGO that operates via grant funding, serves a liaison role between the government, namely the Ministry of Health, facilities, and technical and financial partners. In its capacity, ROASSN supports the development of inclusive policies, dialogue, and educational efforts to improve awareness and uptake of FP across the country.

3.3.2.2 Policies in Practice

All of the services under the free health services benefit package, including FP services, are without user fees to clients. However, financing these services is a challenge; largely, financing mechanisms and systems are incongruent and insufficient. Although donors, primarily UNFPA and USAID, finance the majority of FP commodities in Niger, the Government of Niger covers the cost associated with clinical services as well as human resources and other infrastructure costs through a reimbursement system with public facilities. Unfortunately, Niger has not been able to adequately reimburse facilities for the free services. From 2006 to 2015, Niger was able to reimburse only 61.25 percent of public facilities for claims related to free health services: Facilities submitted 55.9 billion CFA (USD 97.1 million) in claims, but only 34.2 billion CFA (USD 59.4 million) was reimbursed. In addition, in 2017 Niger allocated just 62 million CFA (USD 107,687) out of the 200 million CFA (USD 347,379) written into the provisional budget for the free health services benefit package, which again includes but is not limited to FP services.

The chronic reimbursement challenges have affected facilities' interest in continuing to provide these free health services. Insufficient cost recovery affects facilities' ability to maintain operations if they must provide free services with no reimbursement, or often late, and receive partial reimbursement that is only a small fraction of the cost incurred by the providers. One respondent reflected on the extent of this challenge: "The government doesn't pay. As a consequence, in certain regions, providers submit their claims directly to NGOs who pay. [This is] separate from the government." Further complicating matters, key informants mentioned the varying quality of health-facility claims as a reason for delayed reimbursement. Most notably, claims forms may not just have errors, but also possibly contain fraudulent claims or exaggerations that demand a lot of administrative resources of the MSP and the Ministry of Economy and Finance to review.

Key informants also suggested coordination challenges, one saying "the government should take the lead to obtain the best result possible. In reality, the donors and technical and financial partners work on the same things [and there is] inefficient harmonization of efforts... a representative of each major partner (UNFPA, USAID, etc.) meets to discuss [family planning service provision] with the Ministry of Health but there's no knowledge, even today, of all of the actors in the region."

From the client perspective, although FP services are free in public facilities, sociocultural factors were deemed the most significant barriers to client access. In Niger, FP services tend to be available only to married women, one respondent stating, "Only married women have the right to [family planning] products." Another echoed this reflection but added that their husbands have to approve. Efforts from the government, technical, and financial partners and NGOs continue to increase education, awareness, and engagement of religious and traditional leaders as well as men in general in the importance of FP for Niger. To that point, several respondents pointed to the *école des maris*, an educational training program for married men, as a significant intervention aimed at improving acceptance of FP as a lifesaving health service.

Despite efforts to improve rural area FP services—for instance the National Association of Family Well-Being (ANBEF) (*Association Nationale de Bien-Etre Familiale*) community-based distribution (DBC) program, which provides FP resources like Sayana Press injectables—several key informants mentioned

limited access to services in rural and most remote areas as another client access barrier. This barrier exists for two reasons: limited supply of FP products and trained health professionals in the most remote areas of the country and limited ability and financial resources for individuals to travel to the next closest facility. One respondent shared “for those living in rural areas, there’s no means for finding transport, and it’s not clear why one would walk 5 kilometers for a preventative service.”

Lastly, a few key informants noted that despite Niger’s national and external commitments to increasing access to FP, adolescents and youth have fairly limited access and are stigmatized, especially the not married. One respondent simply said, “Youth and adolescents are excluded.” Another respondent noted that “At large, the youth are on the margin of society. They don’t have access to resources, and their thoughts on life are low. The country is currently working on this problem.”

Of note, the method mix in Niger has evolved over time. Currently, there are five FP methods available in Niger: condoms, injectables, implants, IUDs, and oral contraceptive pills, the last of which is the most available. Where oral contraceptive pills were the most demanded method in 2012, in just five years, the demand became more even across oral contraceptive pills, implants, and injectables, with each now comprising 30 percent of client demand. One respondent mentioned “[This] increase of implants and injectables is probably a function of effective means of [making them] available, [such as] mobile clinics.” Unfortunately, according to the key informants interviewed, long-term methods are not yet available in Niger, though NGOs like ANIMAS-Sutura and private facilities receiving social franchising support from MSI and Population Services International are researching opportunities to introduce them into the market in the future.

At present, no public health insurance option includes FP. Health insurance penetration is low in Niger in general and currently does not cover FP services. In addition, *mutuelles*, that is, community-based health insurance schemes, “have certain difficulties with the free services” because the “facilities abuse them via the claims they submit for providing the free services and products, which are already free.”

3.3.3 The Outlook for Free FP

As mentioned above, financing is the most significant threat to the provision of free FP in Niger. In the past, donors such as the World Bank have covered the cost of claims that the government of Niger has been unable to pay, but it is uncertain if that will continue. In the interim, facilities are facing the strain of providing free services with limited to no payment. Further, though Niger has made commitments to increase government contribution to financing free services including FP, there are limited domestic resources available to do so. Moreover, the domestic resources that are available are not focused on health, let alone free services. As one respondent put it, “Currently, the budget priority is security.”

4. CROSS-COUNTRY COMPARISONS

While the previous section looked at each Core country separately to understand its policy context, implementation, and outlook, we also seek to understand how cross-country observations can shed light on policies and implementation of free FP. We examined common themes (sub-section 5.1) and important divergences (sub-section 5.2) across the three Core countries. To this, we also include findings for **three additional non-Core countries—Burkina Faso, Cote d’Ivoire, and Mali. We do so for four primary reasons:**

1. To provide a broader view of FP policies and the inclination toward free FP among countries in West Africa
2. To identify whether there are socioeconomic and demographic factors or trends associated with a country’s position relative to offering free FP
3. To identify whether broader trends may be driving mCPR that may overwhelm possible effects from the implementation of free FP
4. To consider non-Core countries in West Africa as test cases for applying lessons learned from Core countries, and to extend findings to other countries in West Africa

In sub-section 5.3, we provide a broader view of the policy environment in West Africa by reviewing FP policies in our three non-Core countries. We then compare policies and relevant data on socioeconomic, FP, and financing indicators across all six study countries in the following section. The sum of the findings will assist us later in the Discussion section to apply lessons learned to countries in West Africa.

4.1 Common Themes Across Core Countries

Across the Core countries (Ghana, Mauritania, and Niger), several **common themes emerged from analysis of national-level RH and FP policies and insights from field-based key informant interviews** (See Table I). These common themes include financing for FP as well as barriers to government provision and client access to FP. These themes bear important considerations for the non-Core countries as well as other countries in the region considering whether to pursue free FP.

Table I: Summary of Common Themes

Summary of Common Themes Across Core Countries	
1	Donor financing remains important but is expected to decline.
2	Policies to increase the priority of FP service provision may not be well accepted.
3	No Core country has met financial targets in its FP2020 and/or national commitments to improve financing for FP.
4	Youth and adolescent face considerable barriers to access FP.
5	Geographical location, especially being located in a rural area, is an additional barrier to FP access.
6	Gender norms (e.g., needing husband’s approval to access FP) are a barrier to accessing FP.

All Core countries noted the **importance of donor contributions to FP but also the real potential for reduced donor financial and technical resources in the future**. Countries acknowledged the vast opportunities to improve the cost and availability of FP services to clients thanks to donors, namely USAID and UNFPA, covering the cost of FP commodities. In addition, they mentioned FP donor support in areas such as demand generation activities, improvements to service delivery through programs such as AgirPF, and activities to develop more streamlined health information systems. In order to maintain these gains in FP amidst impending reductions in donor resources, and the threat that such reductions could be implemented with little warning, countries have been motivated to improve the provision of FP services in the next few years. Countries have made 2017 FP2020 commitments, such as increasing demand for FP, increasing awareness of FP in target sub-populations, and increasing their own financial contributions to FP. While these commitments show countries' interest in maintaining, if not increasing, the current level of FP activities in-country, key informants acknowledged that government-led changes in FP financing have not been rapid. Countries are interested in increasing their ownership of financing for FP, for instance, but it has been difficult for stakeholders to determine how to do this sustainably, especially with limited data on the cost and benefits of FP service provision across their respective countries. Beyond contributing more financial resources toward FP, countries are also thinking about how to use existing resources to enhance FP service provision. Key informants in Ghana and Niger named task shifting as a specific example: "Lots of effort is being put into task-sharing to the lower cadre for more effective methods such as implants, driven by policy to increase the availability of family planning services." More training to lower health professional cadres was mentioned by all three countries as another opportunity to make FP services more widely available at a lower cost.

While all three Core countries made 2017 FP2020 commitments to increase the allocation of financial resources to some element(s) of FP service provision—namely in the form of more government funding toward contraceptives—**no Core country has yet to meet its financial targets**. All reported gaps between budgetary commitments to FP and actual allocations, suggesting more to be done to prioritize FP financing. Across all countries, informants cited few concrete efforts for FP-focused domestic resource mobilization, although they mentioned national interest in increasing financing for health, including FP. Moreover, in Sahel countries like Niger where security is a tremendous challenge, this reality is further strained by competing priorities. One key informant remarked, "The budget line item was created to increase the possibility that the government could support the purchase of [family planning] products. Currently, the budget priority is security." Even beyond FP, health and other non-security interventions are competing for resources from the government. As countries grapple with competing priorities within and beyond health, coupled with limited domestic resources, they will need to determine how they see FP benefitting their citizens and where it falls among budget priorities.

Alongside looming changes to financing for FP, all three Core countries have policies to increase the priority of FP service provision. These policies, verified through key informant responses, present interest in improving maternal, neonatal, and infant health outcomes; addressing rising population growth; and/or recognizing the socioeconomic benefits of FP. However, key informant interviews across the three Core countries highlight mixed receptivity to these interests in practice. For example, while key informants recognize that rate of population growth is largest among young, nonworking populations, key informants had mixed views on whether unmarried youth and adolescents, if not all youth and adolescents, should have unlimited access to FP services. One key informant noted, "[There are] cultural/social factors that should go into this in [country's] context to really look at whether/not injectables should be given to young people... [We] will probably end up giving free family planning to a group of people (youth and adolescents) that we don't want to give it to." Another, when asked about any differences in access by age, stated, "Youth and adolescents are excluded. Access depends mainly on age."

Beyond the financing landscape for FP, access to FP, and **especially barriers to this access, was a main topic of key informant interviews.** All Core countries described the prominence of sociocultural norms as barriers to client access to FP. For countries with religious majorities, whether Muslim or Christian, taboos around FP persist. One key informant stated “We must increase efforts toward education and awareness for cultural and local leaders.” Another shared, “[There are] problems of mentality and religion. There are social constraints on youth and adolescents. Married women and youth have problems accessing contraceptives.” A third remarked, “[There are] religious moral constraints and socially, [using family planning] is forbidden.”

All Core countries have at least one 2017 FP2020 commitment identifying **youth and adolescents as a target population for increasing access to FP.** However, as signaled throughout the report, there has been mixed progress in implementing youth and adolescent-focused interventions. Niger, for example, has committed to increasing the fraction of their PANB budget dedicated toward youth- and adolescent-focused interventions to at least 15 percent. However, the nation contends with sociocultural norms and stigma that limit youth and adolescent access to FP to permission of their husband, if married, and access via NGOs for little to no cost or private sector at cost. In addition, although the government had previously invested in youth centers where FP services could be discretely accessed, key informants described them as being currently nonfunctioning. In Mauritania, similar sociocultural barriers limit access for youth and adolescents. One key informant noted, “Adolescents don’t have access to anything but information, education and communication in general and no products in the public sector.” In Ghana, one key informant noted, “Unmet need is about 50 percent, child marriage presents a barrier, youth abstinence is still predominant societal thinking [so there is] stigma against youth use of family planning, youth have limited to no financial means to access family planning.”

Core countries noted **limited access to FP in rural areas** as a particular pain point in FP service provision. A key informant in Niger shared, “There is isolation [of people] and with DBC of products because rural populations are dispersed and clients have access issues. [There are also] security challenges in some areas.” In Mauritania, in particular, FP services seem essentially nonexistent in rural areas. One key informant shared plainly, “There is no effective coverage in rural areas.” In Ghana, access to rural areas has been a particular area of intervention because of the difficulties in ensuring adequate coverage. On top of an explicit 2017 FP2020 commitment to increase mCPR through increased access to FP in peri-urban and rural areas, one Ghanaian key informant noted, “CHPS (community-based planning and services, a community-based health intervention) service expansion, social and behavioral change communication on FP, demand generation activities, and non-health government initiatives to increase literacy and girls’ education” as interventions that targeted rural area coverage and resulted in “the fact that rural area coverage has exceeded that of urban areas for the first time.” For Niger, despite operational challenges, DBC was touted by several key informants as a promising intervention for expanding access to rural areas. One remarked, “DBC is a good experience. Community agents who are chosen to provide [family planning] right next to the people (with UNFPA). Allowing [their] engagement [leads to] access. These agents are organized, motivated, and engaged.”

Gender roles comprise the final prominent barrier to FP access. Across all three Core countries, the role of the husband is prominent in the ability to pursue FP. Married women were reported as having less access by one key informant “independently accessing family planning services without going through a man ‘would be considered a marker of promiscuity.’” Another shared, “In principal, given social norms, [access to family planning] is preferred for married women, with the agreement of their husbands.” While key informants in Ghana and Niger reported changes to FP method mix of choice in

favor of injectables² as a more discrete choice that can be pursued more independently, the implication of husbands in FP remains pervasive across Core countries,

Despite barriers, all countries are motivated to address areas for improvement in the provision of FP services.

4.2 Divergences across Core Countries

While there were several common themes across Core countries, key informant interviews showcased some divergences as well. Differences revolved around the implementation status of free FP and lessons learned from each country (See Table 2).

Table 2: Summary of Divergences

	Summary of Divergences Across Core Countries
1	Core countries employed different financing and policy mechanisms to offer free FP services to clients.
2	Core countries differed in how they defined “free” FP.
3	Each Core country provided unique lessons from its experiences that could be shared with other countries in West Africa.

The premise of this study was to explore the motivations, experiences, and results of each country in providing FP services free of charge to clients (that is, eliminating user fees). The three Core countries were all identified as having national policies in place noting FP as free of charge to clients. **The health financing mechanisms through which these “free” services provided differed between countries:** Ghana included FP services in the benefit package for its national health insurance scheme, the NHIS, whereas Niger developed a government-facility reimbursement mechanism to cover the costs of a package of services including FP as well as maternal and under-5 child health and other services, and Mauritania established free FP services but left it up to facilities to determine how they would balance the facility cost of providing free FP with profit opportunities through provision of other services. The policy mechanisms used to initiate the free services also differed. Ghana used an act (National Health Insurance Act, 2012), Niger a decree, and Mauritania a letter from the Ministry of Health within a framework of political commitment.

In addition to differences in financing and policy mechanisms used to fund and institutionalize FP services at no cost to clients, the **study revealed differences in what “free” actually meant.** Across all Core countries, FP services had user fees attached to them, meaning they were not truly free. At minimum, user fees are assessed for the exams and consumables that accompany the FP commodity. In other cases, the provision of clinical methods had its own cost. Overall, with the exception of counseling and education, we found that accessing FP does bear some point-of-service cost, though often nominal, to clients. Further, clients who have to travel incur additional, often substantial, costs. In addition, while Niger and Mauritania have established their current status of “free” FP, Ghana has only just launched its pilot study to understand how providing FP free of charge through the NHIS might work. The two-year study will allow the government to make decisions on which FP services will be included and how it will scale up the effort to cover all regions of Ghana. Since this mechanism of free FP hinges upon

² Note: At the time of study, key informants in Mauritania shared that availability of injectables was extremely limited.

enrollment in the NHIS, if Ghana intends to provide free FP services to all, the government will need to consider how it will scale up NHIS enrollment, which currently stands below 40 percent (HFG 2018).

The HFG study yielded **valuable lessons learned**. Key informants were asked what lessons learned from their country's experience could be interesting to share with other West African countries. Across key informants within a country, there were several common responses; however, across the three Core countries, key informants presented unique lessons learned that could be considered for future peer learning. Key informants in Mauritania provided lessons all around connecting the need for FP with the religious beliefs of its Muslim-majority population, noting its targeted advocacy model to Muslim community leaders, its use of “birth spacing” versus “family planning” as more audience-friendly terminology, and the promotion of birth spacing by the Islamic theological group (*Ligue des Oulémas*) as lessons that could be shared with other countries. Key informants from Niger highlighted the success of “husband schools” (*écoles de maris*), which are locally based FP education and promotion programs geared toward husbands in Niger. Informants from Niger also mentioned DBCs as described previously, education around the health benefits of birth spacing, and educational and access programs focused on youth, including youth in and out of school. In particular, they underscored the ELIMIN program for young girls not in school since it integrated RH into a broader educational curriculum that also included learning how to read and write. Lastly, key informants in Niger mentioned *Projet Jeunes Filles Saisonnières*, a social services and FP educational program geared toward young girls who move away from their families to the capital to work as maids and earn income to send back to their families. “They are the most predisposed to being abused, impregnated and sick.”

In Ghana, lessons learned from key informants ranged from financing, distribution, education, and learning. One key respondent stated, “Family planning should be part of minimum benefit package for any country, especially long-term methods.” Another respondent specifically noted the current dialogue around universal health coverage (UHC) in Burkina Faso and cautioned, “if family planning is not integrated at the outset, [it is] very difficult to include it after.” Another, in reflecting upon successes achieved at the community level, noted that primary health care delivery through the CHPS concept was a valuable lesson to share since “once deployed, [CHPS] centers the household, instead of the health center, for health.” Ghana has achieved some gains in leveraging political champions of FP to support awareness of FP's overarching benefits. A key informant shared, “When mothers know the health and wealth benefits of FP and they take it up, it will affect all health services positively.” Lastly, in order to continue learning about what works and doesn't work for the provision of FP services, a key informant shared the following lesson, “Including the following question in surveys [will help] to better understand demand: ‘What kind of family planning service would be ideal for you?’

4.3 Family Planning Policy Summary for Non-Core Countries

In addition to the three Core countries, HFG conducted desk-based policy, data, and literature analysis on three additional countries in the region—Burkina Faso, Cote d'Ivoire, and Mali. These countries are currently considering whether and how to offer FP services for free to clients. Indeed, through this study, we learned that one of these countries, Burkina Faso, began offering a subsidy for contraceptives within the past year. We present brief summaries of their FP policy histories to broaden the study's perspective in West Africa, permitting us to contextualize and apply the themes identified through the in-depth analysis of the Core countries to these and like countries in the region in the Discussion section.

4.3.1 Burkina Faso

Burkina Faso has had one of the longest histories of political support of FP in West Africa. Since gaining independence in 1960, Burkina Faso has been a mainstay at regional and global conferences on population growth and fundamental rights and has held an understanding of the inverse relationship between population overgrowth and economic development. As early as the 1980s, the Government of Burkina Faso began recognizing organizations like the Burkinabe Association for Family Well-Being (*Association Burkinabè pour le bien-être familiale*) and the National Council on Population (*Conseil National de la Population*), organizations endorsed to support the public provision of FP services and to draft population policy that presented concrete ideas for addressing population growth while recognizing the socioeconomic and cultural norms of the country. In 1985, the Ministry of Family put forth an action plan on FP, which permitted the inclusion of FP service provision at health centers and RH education in schools. It also formally introduced language tying FP to development. Nearly 10 years later, in 1994, the Code of Public Health (*code de santé publique*) was adopted; among its many elements, it established that all FP methods, less abortion, should be available in public and private health facilities.

The government's National Population Policy, National Policy for the Promotion of the Woman, and Strategy for Accelerated Growth and Sustainable Development followed in 2000, 2004, and 2010, respectively, further linking development to FP by promoting FP programs as part of a long-term, transversal strategy for development. As the partnership's name implies, Burkina Faso hosted the 2011 Regional Conference on Population, Development and Family Planning in its capital city of Ouagadougou in 2011. Out of this, the Ouagadougou Partnership launched, establishing Burkina Faso as a pioneering country in FP in the region. In 2012, the government adopted a National Population Policy and related action plan with the main objective of reducing the population growth rate to 2.3 percent by 2030 (it was listed as 3.1 percent as of 2006) and an additional objective of achieving a total contraceptive prevalence rate of 32 percent by 2020. In parallel, Burkina Faso also began implementing its 2009 National Plan to Secure Products (*Plan National de Sécurisation des produits 2009–2015*), including FP products, through a regular surveillance and monitoring system.

In terms of FP financing, Burkina Faso has committed to funding FP since at least 2008. In 2008, the government created a dedicated budget line item for FP in the amount of 500 million CFA (USD 885,000), an amount that fluctuated in the years since—most notably dipping to 150 million CFA (USD 265,000) in 2015—but was re-established at 500 million CFA in 2017. Also in 2017, it introduced a subsidy for contraceptives while it considers whether to make FP services entirely free to clients.

In addition to its national commitments, Burkina Faso is also engaged in international commitments to improved FP, namely through its FP2020 engagement. In 2017, its commitments were:

- Increase the state's budgetary line item for purchasing contraceptives by 10 percent annually from 2017 to 2020
- By 2020, support 50 percent of local authorities to finance FP activities by instituting a FP line item in their community-level budgets
- Scale up the task-sharing policy for health center personnel as well as community health workers by the end of 2018
- Ensure FP is free
- Establish a multisectoral coordinating body to respond to the demographic divide by the end of 2018

Through our desk-based review of policy documents, we were able to pinpoint a number of interventions either planned or currently underway to address challenges in FP access in Burkina Faso.

Similar to efforts in Mauritania and Niger, through the support of MSI the country is conducting FP awareness campaigns targeting men in the cotton production industry. In addition, in the past few years, the government and its partners have scaled up the availability of the injectable Sayana Press in the public sector. Further, the National Family Planning Acceleration Plan 2017–2020 (*Plan National d'Accélération de Planification Familiale du Burkina Faso 2017–2020*) mentions national FP week as well as locally based, NGO-supported organization of special free FP days as initiatives that, although not harmonized, greatly boost the demand for FP. Much like such events in Ghana, these events generate not only demand but also new users. The UNFPA found that in Burkina Faso, 25 percent of women who received free FP during national free FP week were new users. The government sees this as evidence of need for lower cost access to FP; accordingly, since 2017, it has committed to reducing client costs gradually until able to offer FP services for free to clients. In line with its 2017 FP2020 commitment, Burkina Faso is aiming to make FP services free and available across the country much like during special free FP days by 2020.

4.3.2 Cote d'Ivoire

The nation of Cote d'Ivoire is relatively nascent compared to some other study countries in its pursuit of expanded access to FP. Cote d'Ivoire adopted its National Population Policy in 2007 and included FP targets in subsequent policies including its National Health Development Plan 2012–2015. In 2013, the nation put forth two related documents focused on improving access to FP services and related outcomes: the Family Planning Strategic Plan 2013–2016 (*Plan stratégique de la Planification Familiale*) and its accompanying action plan. A few years later in 2015, the government adopted a National Budgeted Action Plan for Family Planning 2015–2020 (*Plan d'action national budgétisé de PF 2015-2020*). Through these policies, Cote d'Ivoire has set ambitious goals, including making FP products available at 100 percent of central and district-level health facilities and at 75 percent of community-level facilities. Starting in 2015, the government also put forth a financial goal around FP, establishing a budget for pursuing the above-listed product availability goal. This budget also covered the provision of FP services free of charge in schools and universities. Most recently, Cote d'Ivoire has adopted a RH law that is pending the decree of application. Of note,

In addition to its national policy commitments, Cote d'Ivoire is engaged in FP2020 and made the following international commitments in 2017:

- Increase the availability of FP in the public and private health institutions to move it to 90.8 percent in 2017 to 100 percent by 2020
- Increase funds allocated to contraceptive commodities by 10 percent per year from 400 million CFA francs in 2017
- Embed the distribution of contraceptives in the minimum package of activities [delivered by] 4,000 community health workers by 2020
- Strengthen supply of FP services in 100 health facilities ... to suit the needs of adolescents and young people by 2020
- Strengthen the drug supply chain “to increase product availability of FP at all levels of the health system”

Through our desk-based review of policy documents, we were able to pinpoint a number of interventions either planned or currently underway to address challenges in FP access in Cote d'Ivoire. For one, policy documents make note of rural access barriers to FP, also a significant barrier across all three Core countries, noting interventions such as a mobile health strategy and efforts to ensure the availability of FP products across levels of the health system as key. Another access barrier is

sociocultural. To this, Cote d'Ivoire has applied the concept of the DBC, seen in Mauritania and Niger, to schools and universities, as a distribution mechanism to provide access to FP. According to policy documents, Cote d'Ivoire is offering these FP services to students free of charge. Alongside this, the government has launched several FP awareness campaigns through the ministries of education and health, boasting slogans such as “Zero pregnancies in school.” Also, sociocultural policy documents note the importance of engaging men in order to make FP more accessible to all. Similar to Niger, to tackle this barrier, the government, NGOs, and civil society stakeholders have developed husband schools (*écoles de maris*) alongside awareness slogans like “Constructive engagement of men” and “male champions.”

4.3.3 Mali

Mali is the first country in Africa to pilot the DBC model, which it started in the 1990s, to distribute contraceptive pills. Relative to some of the other countries in the study, Mali made early advancements in determining FP to be part of the minimum package of health services offered under preventative activities in public health facilities. Also early relative to some other study countries, Mali legally established the importance of RH by adopting its RH law in 2002. The law expanded the distribution of contraceptives to all areas of the country and established FP training across health worker cadres. Nearly in tandem, it established its National Population Policy in 2003, followed by a FP strategic plan in 2004. Ten years later, Mali adopted a new policy, the National Action Plan for Family Planning 2014–2018 (*Plan d'Action National de Planification Familiale du Mali 2014–2018*). The goal of the policy is strengthening access to and interest in FP in high birth rate areas of the country with the ultimate objective of increasing total contraceptive prevalence to 30 percent by 2025, largely emphasizing modern contraceptive methods and uptake by poor and vulnerable populations. For the last several years, stakeholders have been advocating the prioritization, enhancement, and integration of FP into essential health care services in Mali.

Internationally, Mali is engaged in FP2020 and put forth the following commitments in 2017:

- Attain modern contraceptive prevalence of 15 percent by 2018 and 20 percent by 2020
- Increase funds allocated from the national budget by 10 percent annually for the purchase of contraceptives
- Implement specific programs in youth and adolescent sexual and RH so they are operational by 2020
- Strengthen the supply chain in order to reduce stock-outs and guarantee all access to contraceptive products (especially adolescents/youth as well as vulnerable and displaced populations)

Through our desk-based review of policy documents, we were able to pinpoint a number of interventions either planned or currently underway to address challenges in FP access in Mali. Compared to other majority Muslim countries in the study, Mali has established FP as an intervention for all, not just limited to married women. The country also employs husband schools (*écoles des maris*), adopted based on positive results in Niger, to further men's awareness of the benefits of FP. According to policy documents, Mali has made pronounced progress in expanding access to FP through task shifting. In particular, task shifting is said to be effective at the community level, where community health workers are administering injectables. Further, community health-focused interventions are effectively geared toward youth and adolescents, a notable difference compared to core countries Ghana, Mauritania, and Niger where youth and adolescents are named target populations, but the success and sustainability of targeted interventions has varied over time. From a finance perspective, the government of Mali contributes to about 10 percent of the cost of contraceptives, which are then disbursed through the public health system and provided to clients at point of service for a cost.

4.4 Comparisons across Core and Non-Core Countries

With an increased knowledge of the FP policies in three additional countries in West Africa, we are now ready to compare FP “policies” across countries. We add to this a comparison of socioeconomic indicators, FP outcomes, and financing data.

4.4.1 Comparative Policy Observations

Table 3 summarizes each country’s current FP “policies,” **widely defined to also include strategies, action plans, and implementation plans, as well as other national-level plans that strongly emphasize FP.** We broadly grouped each strategy to pursue increased access to FP into one of nine categories as follows:

- FP demand generation (incl information, education and communication)
- Health financing for FP (incl resource mobilization for FP, dedicated budget lines, cost efficiency)
- Enabling political environment (incl FP advocacy, enabling political environment and policy implementation capacity)
- Health workforce (incl education, training, task sharing / shifting of administration)
- FP commodities and technologies (incl FP commodity security, supply chain)
- Information and research (incl FP health information systems, FP data collection)
- FP service delivery (incl availability of services, availability of method of choice, quality of care)
- Community-based interventions (incl community-level distribution)
- Target group-focused interventions (incl youth and adolescent-specific, male-focused, traditional leader-oriented)

For a given country, the table assigns a checkmark to each category of strategies to increase access to FP that are named within current FP policy documents. Looking across Table 3, we see that all six study countries have a current policy, strategy or action/implementation plan specific to FP. One country, Mauritania, has additional plans that present additional strategies to increase access. All countries had additional policies around FP that have become outdated within the past five years.

Though each country presents context-specific strategies for increasing access to FP, there are a few commonalities we note. All country FP policies present strategies to increase demand for FP, with specific strategies varying from information, education, and communication campaigns for the general population to social and behavior change **communication interventions focused on particular sub-populations.** Most countries specify strategies aimed at increasing **demand and accessibility to FP among youth and adolescents.** Most countries also specify strategies to strengthen service provision of FP, be they focused on ensuring supply, improving distribution, expanding method mix availability, or enhancing quality. Lastly, most countries specify at least one strategy to improve the enabling policy and regulatory environment for FP.

With the exception of Niger, all study countries’ current FP policy documents specifically mention **plans to address financing for FP** (See Annex D for full list of main strategies to pursue increased access to FP and plans to address financing for FP, as specified in current FP policies). Plans range based on country context, but **Ghana, Mauritania, Burkina Faso, Cote d’Ivoire and Mali all include advocacy for more government resources for FP,** whether at the national or sub-national level. Also, most countries mention the development of a FP fund.

Lastly, five of the six study countries include strategies to address the enabling environment (all but Mali), strengthen FP commodities and technologies (all but Mali), implement community-based interventions (all but Burkina Faso), and implement target group-focused interventions on special populations, most notably youth and adolescents.

Table 3: Summary of Current Family Planning Policy Documents by Country

Family planning policy, strategy or action/ implementation plan	Main strategies to pursue increased access to FP
Core Countries	
Ghana	
Ghana Family Planning Costed Implementation Plan 2016–2020	<ul style="list-style-type: none">✓ FP demand generation✓ Health financing for FP✓ Enabling political environment✓ FP commodities and technologies✓ FP service delivery✓ Community-based interventions✓ Target group-focused interventions✓ Health workforce• Information and research
Mauritania	
Action Plan in Favor of Birth Spacing 2014–2018	<ul style="list-style-type: none">✓ FP demand generation✓ Health financing for FP✓ Enabling political environment✓ FP commodities and technologies✓ FP service delivery✓ Community-based interventions✓ Target group-focused interventions for FP• Health workforce• Information and research
National Strategic Plan in Reproductive Health 2016–2020	
National Health Development Plan 2017–2020	
Niger	
Family Planning in Niger: Action Plan 2012–2020	<ul style="list-style-type: none">✓ FP demand generation• Health financing for FP✓ Enabling political environment✓ FP commodities and technologies✓ FP service delivery✓ Community-based interventions✓ Target group-focused interventions for FP• Health workforce• Information and research

Family planning policy, strategy or action/ implementation plan	Main strategies to pursue increased access to FP
Non-Core Countries	
Burkina Faso	
National Plan for the Acceleration of Family Planning Costed Implementation Plan 2017–2020	<ul style="list-style-type: none"> ✓ FP demand generation ✓ Health financing for FP ✓ Enabling political environment ✓ FP commodities and technologies • FP service delivery • Community-based interventions ✓ Target group-focused interventions ✓ Health workforce ✓ Information and research
Cote d'Ivoire	
National Budgeted Action Plan for Family Planning 2015–2020	<ul style="list-style-type: none"> ✓ FP demand generation ✓ Health financing for FP ✓ Enabling political environment ✓ FP commodities and technologies ✓ FP service delivery ✓ Community-based interventions ✓ Target group-focused interventions ✓ Health workforce ✓ Information and research
Mali	
National Action Plan for Family Planning 2014–2018	<ul style="list-style-type: none"> ✓ FP demand generation ✓ Health financing for FP • Enabling political environment • FP commodities and technologies • FP service delivery ✓ Community-based interventions • Target group-focused interventions • Health workforce • Information and research

4.4.2 Comparative Data Analyses

Table 4 presents basic characteristics regarding the socioeconomic and FP context in our six study countries. We noted a few items in particular. We saw **substantial variation between countries on most of these measures**. The population of Ghana (the most populous) is more than six times larger than that of Mauritania (the least populous). Niger has the highest TFR in the world at 7.3, nearly double that of Ghana, the study country with the lowest TFR at 4.0. The mCPR rates in the six countries are in general quite low compared to other FP2020 focus countries, with Burkina Faso boasting the highest figure at 26.4 percent. Likewise, unmet need is above 30 percent in three of the study countries, with Mauritania the highest at 33.6 percent. Our six countries are equally split into low- and low-middle income groups per the World Bank groupings. General government expenditure on health varies from 4.5 percent in Mali to 7.2 percent in Burkina Faso.

Comparing Core to non-Core countries, we see that on average, the **two groups are pretty similar across the indicators, using recent data**. TFR averages 5.3 for the Core countries, versus 5.5 for the non-Core. mCPR is about a percentage point lower on average in the Core countries, and unmet need is also somewhat lower (by 2 percentage points) than the non-Core countries. At present, general government expenditures on health are virtually equal between the two groups of countries.

Can our data on socioeconomic and FP context tell us why some countries – the Core countries in our study – have already decided to pursue free FP while others have not yet taken that step? To explore this question, we look at a key indicator at the time that the Core countries announced their intention to pursue free FP (here, we use 2012 for Ghana, 2003 for Mauritania, and 2005 for Niger). At that point, mCPR at the closest measurement date to these announcements were much lower in Mauritania and Niger (both with a mCPR around 5%) and lower in Ghana (around 15%) than at present. This would suggest that these countries, particularly Niger and Mauritania, were motivated **at least in part by low rates of modern contraceptive use**. However, we can point only to **an indicative relationship, and the case of Burkina Faso -- as one of our non-Core countries -- confounds**, given its recent move toward subsidizing FP despite an mCPR rate of 26.4 percent.

Table 4: Basic Characteristics of Six Study Countries

	Income level	Population (thousands)	TFR	mCPR	Unmet need for family planning (%)	General government health expenditure (%)
Core Countries						
Ghana	Lower-middle	27,410	4.0	21.3	20.7	7.1
Mauritania	Lower-middle	4,182	4.7	15.6	33.6	5.5
Niger	Low	19,897	7.3	15.2	17.6	4.6
Non-Core Countries						
Burkina Faso	Low	18,106	5.4	26.4	16.8	7.2
Cote d'Ivoire	Lower-middle	23,108	5.0	14.3	30.5	5.0
Mali	Low	17,600	6.1	15.1	30.7	4.5

Note: Cote d'Ivoire, Mauritania, Mali mCPR and unmet need figures are for married, 15–49 women, while the figures for other countries are for all women 15–49.

Sources: Income level, population, and fertility rate (World Bank World Development Indicators, 2015); mCPR and unmet need: Ghana (PMA2020, 2017), Mauritania (MICS, 2015), Niger (PMA2020, 2017), Burkina Faso (PMA2020, 2017), Cote d'Ivoire (MICS, 2016), Mali (MICS, 2015); government health expenditure as percentage of general government expenditure (WHO, 2015).

Taking a closer look at recent FP trends across the six study countries (see Table 5), we identify a number of additional trends within and across study countries. Generally, we would expect to see that increases in FP laws, policies, and programming that expand accessibility—as we have seen to varying degrees across the six study countries over time—yield increases in mCPR. Further, while our study is exploratory in nature and therefore unable to draw correlations, we may expect that if financing is a significant barrier to FP access, countries that have enacted some form of free FP would generally follow such trends, perhaps to an even more pronounced extent. With that said, we noted several trends. Of our Core countries, Ghana has just begun to explore adding certain FP services to the NHIS on a pilot basis. Even for Niger and Mauritania—both of whom have had free FP officially in place for at least seven years—implementation constraints have likely blunted the impact of the policy shift to free FP. Niger has had a free FP policy the longest (with implementation starting in 2006) and results indicate an approximately 11 percentage point increase in mCPR from 2006 to 2017. In addition, Mauritania’s provision of FP products to clients free of charge began in 2011, with limited relevant data available since then. The 2015 MICS indicates a promising boost in the mCPR between 2011 and 2015, but updated data are needed to determine if this trend has been sustained.

Table 5: Recent Trends in FP indicators; Funding Totals

	Latest mCPR (%)	Previous mCPR (%)	Difference in mCPR (% points)	Latest unmet need (%)	Previous unmet need (%)	Difference in unmet need (% points)	National gov't expenditure on FP (million current US)	National donor expenditure on FP (million current US)
Core Countries								
Ghana	21.3 (2017)	15.4 (2013)	+5.9	20.7 (2017)	21.3 (2014)	-0.6	No data	No data
Mauritania	15.6 (2015)	10.0 (2011)	+5.6	33.6 (2015)	31.1 (2011)	+2.5	0.01	0.36
Niger	15.2 (2017)	4.5 (2006)	+10.7	17.6 (2017)	14.0 (2006)	+3.6	9.00	1.10
Non-Core Countries								
Burkina Faso	26.4 (2017)	15.7 (2014)	+10.7	16.8 (2017)	20.4 (2010)	-3.6	2.0	10.1
Cote d'Ivoire	14.3 (2016)	12.5 (2012)	+1.8	30.5 (2016)	27.1 (2012)	+3.4	2.4	9.1
Mali	15.1 (2015)	6.9 (2006)	+8.2	30.7 (2015)	27.6 (2006)	+3.1	No data	No data

That said, all six countries have seen an increase in mCPR since the previous measurement, with difference in mCPR varying from an increase of 10.7 percentage points in both Niger and Burkina Faso to a 1.8 percentage point increase in Cote d'Ivoire. This suggests that irrespective of types of and frequency of RH and/or FP laws and policies adopted since the previous mCPR, all countries have **experienced some level of enhanced FP access**. It is interesting to note that Niger and Burkina Faso both have large increases in mCPR, given that Niger has had free FP in place for more than 10 years and Burkina Faso is only currently considering free FP for clients as an intervention to expand access to FP. Also, the two countries with the highest latest mCPR irrespective of level of increase between measurements—Burkina Faso (26.4%) and Ghana (21.3%)—are also countries that have not yet

implemented free FP (although Burkina Faso is taking steps in that direction). The only two countries among our study countries to—Niger and Mauritania—to implement free FP vary in level of increase, with Mauritania achieving a 5.6 percentage point increase and Niger a 10.7 percentage point increase (over a much longer interval).

While our research found **relatively sparse available data on FP expenditures**, we do note that of the study countries with data, all but Niger had greater donor versus government national expenditure on FP. We also note that combined government and donor expenditure on FP is extremely low in Mauritania relative to other study countries with available data.

Trends in FP can be linked to many factors, beyond the implementation of a free FP policy. Indeed, looking beyond Mauritania and Niger (including Ghana), we see a generally increasing trend in mCPR over time, absent a free FP policy. For example, Burkina Faso's mCPR has increased by 11 percentage points among all women since 2014 alone. This seems to indicate that **other factors may be overwhelming the “effects” of free FP policies**. However, we would caveat this finding by repeating that our study is exploratory in nature, based on a limited set of countries, and therefore makes no **claim of attribution between free FP services and mCPR** (or other FP and fertility indicators).

5. DISCUSSION AND RECOMMENDATIONS

5.1 What does “Free FP” Mean?

A critical element in this study is articulating what countries and donors may mean when they talk about “free FP” alongside what we observed. It appears the **definition of “free” FP can vary widely**. Some of the variation is linked to the scope of what is free. Counseling is free in Ghana, but facilities charge small user fees for commodities, LARC and permanent methods, and for other related services, exams, and supplies. Some of the costs for these FP services may be reduced to zero as part of a pilot just underway, but which services those will be are currently unclear. In Mauritania, despite a fairly robust “free family planning” policy, users pay fees for consumables and related exams. There is also the extent to which facilities are offering free services in practice, that is, does “free” mean free in every public facility? In Mauritania and Niger, many providers have not been compensated for the FP services that they provided according to the free FP policies. This has reduced their willingness to provide FP services. Evidence from our interviews indicates that some countries are now restricting or denying such services to clients, constraining effective access under a free policy. The study countries offering some element of free FP also differ in how they finance and implement these policies, including via national health insurance and government reimbursement. Two of the non-Core countries have made some initial steps toward free FP, with Burkina Faso deciding in 2017 to subsidize FP services and Cote d’Ivoire making FP services free for those in school and university.

As the number of countries implementing some form of free FP increases, the breadth of definitions used for free FP may widen. We suggest a **systematic effort to define what free FP means by country** utilizing a matrix similar to what is in the Core country snapshots in Section 4: Who is paying, by type of FP service? Further detail on specific user fees, government and donor contributions, and so forth can be added.

5.2 Implementation Challenges

We have mentioned above the limited literature pertaining to country objectives for free FP and the results arising from such policies in West Africa or in Africa more generally. One study specifically addressed the policy discussions in recent years around free FP in Ghana (Koduah et al. 2018), prior to the pilot study on including FP in the NHIS. The authors concluded that the **policy change was on a “static pathway”** because those seeking to influence the policy agenda for free FP “were not able to sustain the much needed institutional and political interest and financial support.” They cited a number of contributing factors. The supportive Minister of Health was replaced in 2013. Despite a detailed cost estimate to provide FP as part of the benefits package, there was no clear government disbursement and there was no precedent for donor funds for FP to route through the NHIS. In addition, the government and donors had broader concerns about the overall financial footing of the NHIS.

We heard a similar story from key informants in Ghana, whose points resonate with the other countries as well. **Policy changes on paper are slow to trickle down to actual implementation on the ground**. In Mauritania, about eight years elapsed between the first policy document on making FP services free and the effective implementation of the policy. It appears that strong and consistent champions of the policies enable transforming policy changes into effective practice. Even then, implementation of free FP policies has been beset by financial challenges. None of our study countries

has consistently met its financial commitment regarding FP. Countries continue to rely on donors and other partners for the purchase of commodities. These challenges, accompanied by concern about donor drawback, continue to affect the outlook for free FP services in those countries. Even though Niger's implementation of free FP services began more than 10 years ago in 2006, the country continues to make slow progress toward meeting its FP financing goals, in large part due to the present priority given to funding for security, a challenge also seen in non-Core country Mali.

The above findings are relevant for the other West Africa region countries not detailed in this study. Countries in West Africa have made ambitious commitments related to FP, both on the national and international stage (e.g., FP2020). These goals are proving difficult to meet, particularly by 2020, due to implementation and funding barriers. Countries considering some type of free FP services should **develop realistic estimates via costing studies** of the funds needed, such as Ghana conducted regarding adding free FP to the NHIS (Asante 2013). Those costing estimates must be coupled with a **realistic view of the funding streams in place (with realistic time frames)** or that might be tapped to meet the increased cost. Accompanying this, relevant actors—donors, governments, NGOs, and other stakeholders—must be in close coordination in the funding and implementations spheres to avoid the inefficient arrangements and funding shortfalls outlined by the key informants in the study countries. We would also suggest that stakeholders pursue a sequential approach to free FP policy change akin to that in McPake et al. (2011), which suggests a six-step process to implementing a policy change (in that case, a user fee exemption). One critical step from that article is the mobilization of additional funding before the policy is enacted.

5.3 Barriers to Access

Another article on Ghana examined the experience of the Talensi district in Ghana where free FP services were being offered in most public facilities (Apanga and Adam 2015). Despite free services, only 18 percent of the women in that district had used FP services. The women cited the opposition of spouses as the most common reason for not accessing services, along with misconceptions about FP. One such misconception was that family services were intended for married couples only. These findings from one district in Ghana track with what we found. According to our interviews, **cost was generally not the strongest barrier to accessing FP**. Instead, potential clients and key informants most frequently cited sociocultural challenges such as religious taboos, gender norms, and treatment of youth and adolescents. They also cited limited education or misinformation about FP methods. Even looking at cost factors, it is likely that the opportunity cost of accessing FP services, especially in remote or rural areas, exceeds the monetary cost of the FP service. Simply eliminating user fees would not address these other barriers.

Our Core countries offered some potential lessons on addressing sociocultural barriers to FP access to other countries in West Africa. In Mauritania, key informants cited the success of an advocacy model targeting Muslim community leaders. In Niger, key informants highlighted education and promotion programs focused on husbands (known as “husband schools”). They also cited the use of educational and access programs to youth and adolescents, in and out of school, as keys to reaching this underserved segment of the population. In total, our findings suggest the need for FP policies and their implementation to reflect **sociocultural and other non-cost barriers and to address these barriers in a holistic way**.

Broadening our lens to look at user fees and maternal and child health revealed a relative abundance of literature. A recent review of literature on user fees and maternal health found that although the grade of evidence was relatively weak, user fee exemptions appear to have boosted the quantity of malaria care-seeking during pregnancy, facility-based deliveries, and caesarean sections in certain settings (Hatt et al. 2013). However, the authors also found that reducing or eliminating user fees is associated with

unintended, negative consequences such as reduced provider motivation and service quality. The review mentioned Ghana specifically in regard to challenges in disbursing funds to health facilities, leading to shortfalls in drugs and supplies that led many of the facilities to cease fee exemptions. These findings seem to mirror what we found in Mauritania and Niger. In both countries, the introduction of free FP services led to provision of uncompensated care and budgeted funds that were not fully disbursed, according to our key informants. This should serve as an instructive warning to other countries in West Africa. As Hatt et al. concluded, **user-fee exemption policies must be designed carefully to ensure that lost revenue is replaced.**

5.4 Data and Research Needed

The quantitative socioeconomic and FP data that we gathered and analyzed for the six study countries yielded some tentative findings regarding what may motivate countries taking steps to free FP and what we can conclude about the results of such policies. Niger and Mauritania are two study countries that have implemented free FP to the greatest extent. At the time they announced their intention to pursue free FP, their modern contraceptive rates were around 5 percent, the lowest of our six study countries. However, we do not consider this a necessary condition for free FP, as Burkina Faso appears to be moving in that direction despite a mCPR above 26 percent. Across our study countries, we see a generally increasing trend in mCPR over time, even absent a free FP policy, which seems to indicate that **other factors may be overwhelming the effects of free FP policies**, at least given the limited amount of data available.

Given the exploratory nature of this study and the relative gap in the literature on free FP policy, governments and researchers should conduct additional research to shed more light on the study questions in West Africa. For example, they could conduct more comprehensive research of factors associated with uptake of modern contraception and reducing unmet need for FP, while accounting for other barriers to clients beyond cost and also budget and financing barriers for the government. One such effort is currently underway in Ghana with the pilot to test the effect of including certain FP methods in the NHIS in certain districts. We encourage those involved in that study to make the design rigorous enough to enable **drawing stronger conclusions about the link between FP policy, FP outcomes, and budget realities**. This pilot study also offers potential lessons for francophone West African countries, which generally have no-to-limited preventative services as part of their health benefit packages. Further data collection is also needed to clarify the picture, particularly on the financial side. Budget figures across years were not widely available in our study countries, especially from standardized, internationally-comparable sources such as NHAs. Further, data on budget effectiveness were limited. One notable area this study was unable to explore is budget execution, that is, how much is actually spent on FP relative to how much funding was dispersed. Often, this dictates how much is allocated in subsequent years and would present a more complete picture of how and how much domestic financing for FP is used to implement given strategies aimed at improving access. Given the limitations on government and donor resources, much study remains to be done to determine the best approach for addressing barriers in FP access and **for gauging the relative contribution of free FP policies**. Especially as countries pursue UHC and expanded access to FP, more and better quality data on FP financing, especially by wealth quintile and other socioeconomic indicators, would support efforts to improve equitable coverage.

6. CONCLUSION AND LIMITATIONS

6.1 Conclusion

This exploratory HFG study examined the motivations of six countries already pursuing or interested in pursuing free FP in West Africa – Ghana, Mauritania, Niger, Burkina Faso, Cote d'Ivoire and Mali – and the results and experiences in these countries to-date. Among these six countries, our initial understanding was that Ghana, Mauritania and Niger had implemented free FP. However, we found that only two countries—Mauritania and Niger—had done so in practice. Yet, both of these countries have experienced challenges in implementing and financing free FP. Along with the other four countries studied, they offer lessons for countries in West Africa considering free FP policies.

The main takeaways from this study are:

- How countries implement free FP can differ widely; a more precise definition would allow the global community to better understand countries' experiences.
- Free FP policies require patience and sustainable financing to implement.
- Socio-cultural factors and geography may inhibit FP access more than out-of-pocket costs.
- Stakeholders, including policymakers and researchers, need better data and more robust study to determine whether and how free FP can be an effective and cost-efficient strategy to accomplish goals for FP and other development goals.

Until further research is completed, countries in West Africa considering free FP policies should proceed cautiously, employing realistic cost estimates and reliable funding streams. If pursued, free FP should be designed as a suite of interventions aimed at addressing countries' main barriers to FP access.

6.2 Limitations

There were some limitations with the qualitative and quantitative methods used for this study.

Qualitative research limitations. Effectiveness of the qualitative research component hinged upon the availability of a diverse set of key informants in each country as well as the responses they provided. As mentioned earlier, we were unable to meet with finance point persons at ministries of health nor health point persons at ministries of finance, a viewpoint that would have illuminated progress as well as shortcomings in financing for FP. In addition, given the small sample size of this exploratory study, HFG did not employ a rigorous qualitative analysis approach. Should further research on this topic be explored, we recommend sufficient time and resources to ensure a sample representative of all major stakeholder groups as well as more rigorous qualitative analyses.

In addition to limitations on who was interviewed, study participants may have responded to questions in ways that may not accurately reflect actual arrangements in practice. While the desk-based research was used to triangulate the qualitative data whenever possible, given the unique institutional arrangements and diverse actors through which FP is discussed, provided, financed, and accessed, the findings of the qualitative data are inherently grounded in the perspectives of those interviewed. This also means that findings do not include the unique perspectives of those not interviewed, for instance, finance point persons in ministries of health, health point persons in ministries of finance, regional-level

actors, and clients themselves. Further, as both point persons and citizens, key informants may have had official and personal stances on FP that either coincided or conflicted. The semi-structured interview design, being interpretive in nature, permitted key informants to portray their views as factually or strategically as they chose, which could have presented the state of affairs in a favorable (or even unfavorable) light. That said, the researchers were aware of this and were therefore hesitant to equate key informant portrayals of various ideas as fact. Further, the field notes offered a venue to identify and discuss any of these shortcomings or insights among researchers.

Quantitative research limitations. There is a limited amount of secondary data available for the six study countries. This was particularly true for information related to FP expenditures, but also for mCPR. We had no data on FP spending for Ghana and Mali from international sources, and the data for the other countries were generally from 2014 or before. We also had very limited data disaggregating FP expenditures by source (e.g., government, donors, out-of-pocket). In addition to limited expenditure information, for certain countries, MICS data were the most recent available. Unfortunately, the MICS do not ask about FP source. Wherever possible, HFG supplemented international sources with information collected in the field from government officials. HFG notes that given the limited time frame and the limited set of data available, the study was exploratory in nature and in no way assessed causal linkages between policies to offer free FP services and FP-related results to-date.

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ANNEX A: SELECTION MATRIX

Potential Countries	Selection Criteria				Total Score	Proposed for selection	Other relevant information	
	1. Relevance to USAID	2. Data availability	3. Enabling policy environment	4. Existing evidence (Lit review)			Mission and/or regional sign off	Other Notes
Benin	0	1	0	0	1	No		
Burkina Faso	1	1	0	1	3	Yes		
Cote d'Ivoire	1	1	0	0	2	Yes		
Ghana	1	1	0	1	3	Yes		
Guinea	1	1	0	0	2	Yes		
Mali	0	1	0	0	1	No		
Mauritania	1	1	1	0	3	Yes		
Niger	1	1	1	0	3	Yes		
Nigeria	0	1	0	1	2	Yes		
Selected =								
Other Potential Countries							Scoring Legend	
Senegal (in OP)	0	1	0	0	1	No		Max possible score
Togo (in OP)	0	0	0	0	1	No	2. Data	6
							3. Policy	8



ANNEX B: INTERVIEW GUIDE

Key Informant Interview Guide: HFG Review of policies for free family planning services for clients in sub-Saharan Africa V 20 June 2018

Study Introduction Script

Instruction to Interviewer: Share introduction letter signed by Anthony with participant

Hello, my name is [HFG interviewer]. I am studying policies to provide family planning (FP) services in sub-Saharan Africa, with a focus on West Africa. I am one of the researchers conducting this exploratory review on behalf of the Health Finance and Governance (HFG) project. HFG is a global project of the United States Agency for International Development (USAID), and it is led by Abt Associates. This is a descriptive review that aims to help USAID West Africa Regional Health Office and USAID Africa Bureau to answer two primary questions:

1. What are a country's underlying objectives when it decides to offer FP services at no cost, or for "free," to clients?
2. What has been the experience and results to-date following the introduction of policies to offer free FP services to clients?

Better understanding these two questions will help USAID to support countries to address their priority FP needs with the limited resources available. Again, by "free" FP services, we mean services that are provided to clients at no cost to them. As a key stakeholder in [country], your perspective will help us better understand the context for FP services in [country] and any policy decisions about cost borne by clients to receive FP services.

During this semi-structured interview, I will ask some basic questions about you, [country]'s recent history and priorities related to FP, and experiences to-date related to FP policies and results in [country]. The questions are intended to guide our discussion, and I will be taking some notes to accurately capture your responses. Your responses along with those of everyone we interview will only be accessible by the HFG team. The HFG team will compile all responses and analyze them for common themes, but we will not use any names or identifying information in any written results. We will only list your contact information among all participants we interviewed. Accordingly, the Abt Associates Institutional Review Board (IRB) believes this review involves very minimal to no risk to participants. If you have any questions or concerns about how this exploratory review is conducted, you may contact Technical Lead Anthony Leegwater at Anthony_Leegwater@abtassoc.com.

Once more, we thank you for sharing your perspective on FP services in [country]. You may choose not to answer a question or to stop the interview at any time. Do you have any questions before we begin? May we begin?

Background on Interviewee

To start, I'd like to learn a bit more about you, your organization and its role in FP services.

1. Could you briefly describe your current role at [organization and division] as well as your professional expertise and training?
2. What role does your organization play in family planning services?
 - a. *Probe:* Does it influence policies or government actions related to FP services?
 - b. *Probe:* Or perhaps it is affected by such policies or government actions?
 - c. *Probe:* Is there anything else you'd like to share about your organization's role and/or your specific role when it comes to family planning services?

Country context and motivation around free FP

Next, I'd like to learn a bit about [country]'s priorities and recent history related to FP.

1. How would you say FP services are currently organized in [Country]?
 - a. *Probe:* In public sector? In private sector?
 - b. *Probe:* For public, how does this differ across primary, secondary and tertiary levels of care? What role, if any, do community health workers play?
1. Across the different levels of the health system, how does client access to FP services differ by:
 - a. *Income level (poor vs. wealthy)?*
 - b. *Geographical location (urban vs. rural)?*
 - c. *Marital status (married/unmarried)?*
 - d. *Age (youth, adolescents, adults)?*
 - e. *Vulnerable groups (sex workers, PLHIV)?*
 - f. *Other sub-populations?*
2. Across these different levels, how does client access to FP services differ by method (i.e., short-term vs long-term)?
 - a. *Probe:* Has demand for certain types of FP methods influenced availability and access at all?
3. Is any of what you've shared about client access different when it comes to the private sector's provision of FP services?
4. What challenges do clients currently experience when trying to access FP services? For example:
 - a. *High out of pocket spending for services?*
 - b. *Availability of services?*
 - c. *Cultural/social/gender norms?*
 - d. *Geographic or other physical constraints?*
 - e. *Other?*

- f. *Probe: Which of these, in your opinion, is most important to address?*
 - i. *Probe: In what ways is this currently being addressed?*
- 5. What challenges does the government currently experience with trying to provide FP services? For example:
 - a. *Financing FP services?*
 - b. *Availability of commodities (including stock management, logistics, etc.)?*
 - c. *Availability of human resources for health?*
 - d. *Quality of services?*
 - e. *Cultural/social/gender norms?*
 - f. *Geographic or other physical constraints?*
 - g. *Other?*
 - h. *Probe: Which of these, in your opinion, is most important to address?*
 - i. *Probe: In what ways is this currently being addressed?*
- 6. We understand from [country's] FP2020 engagement that the priorities are [refer to country table to list these priorities]. What do you see as the top priorities regarding the provision of FP services?
 - a. *Probe: Why these?*
 - b. *Probe: Do you think other stakeholders would agree? Why or why not?*
 - c. *Probe: What underlying cultural, socioeconomic, religious, or other considerations may impact the success of addressing priorities?*
 - d. *Probe: What would you say have been the top 3 milestones of progress for achieving these priorities?*
- 7. We understand that the following are major contributors to financing FP services in [country]: [refer to table to list major financing sources]. Are there any other types of financing available to fund FP services (e.g., government, client out of pocket, donor, other)?
 - a. *Probe: How would you rank these sources from greatest to smallest source of financing toward the cost of FP services in [country]?*
 - b. *Probe: How does this ranking of financial contribution differ between public and private facilities (e.g., Does government contribute more to the cost of FP services at one or the other? Clients? Donors? Other?)*
 - c. *Probe: How does this ranking of financial contribution differ by FP method (e.g., short-term vs long-term)?*
 - d. *Probe: Has there been any legal precedent for the current state of financing of FP services (e.g., specific policies/strategies/action plans)?*
 - e. *Probe: What challenges exist with the way FP services are currently financed?*

8. Does health insurance currently include (or partially include) the cost of any FP services?
 - a. Which services are covered?
 - b. How much coverage is provided, i.e., is the cost fully covered for any of these services?
 - c. Does this differ between government-sponsored vs private insurance?
 - d. Are there plans to change this from the current status? How?
- I. Are any FP services “free,” that is provided at no charge, irrespective of health insurance status?
 - a. Which services?
 - b. Are there any conditions on this “free” status, for instance, only:
 - i. For certain clients (e.g., adolescent women, married individuals)?
 - ii. At certain facility types (e.g., CHIPS compounds)?
 - iii. In certain geographical settings (e.g., rural facilities)?
 - iv. Other?

Country policy and political experience and results

We’re interested in better understanding what considerations policymakers in [country] have had or may be thinking about when it comes to making FP services “free” and the vision for doing so.

- I. Has [country] changed any policies/laws/budgets regarding the financing of FP services (or is it planning to change) in recent years?

IF YES, continue below. IF NO, continue to question #18.

- a. Probe: What did the policies/laws/budgets change (or what would they change)?
- b. Probe: In particular, has the government enacted policy to make FP services “free,” that is, have they eliminated user fees (or is the government planning to put forth policy to make FP services “free”)?
- c. Probe: How has [country] implemented “free” FP (or how do you imagine they would implement “free” FP)?
 - i. What are key milestones (or would be key milestones)?
 - ii. Target populations (or would be target populations)?
 - iii. Target regions (or would be target regions)?
 - iv. What were other areas of priority for free FP in [country] (or what might be other areas of priority)?
- d. Probe: What do you think has motivated the government to make these changes (or to consider making these changes)? For example:
 - i. To reduce out-of-pocket spending?
 - ii. To increase equity in access to FP services?
 - iii. To reduce unmet need for FP services?
 - iv. To reduce maternal mortality?

- v. *Other?*
- e. *Probe: What are the next steps envisioned?*

IF COUNTRY HAS DEVELOPED POLICY TO MAKE FP SERVICES “FREE,” continue below. IF NOT, continue to question #18.

1. What have been the key strategies used to implement policy for “free” FP in [country]?
2. What has been the experience in [country] with implementing the free FP policy?
 - a. *Probe: What factors have facilitated implementation?*
 - i. *Political will?*
 - ii. *Policy formulation?*
 - iii. *Implementation?*
 - iv. *Monitoring and evaluating results?*
 - v. *Funding?*
 - vi. *Others?*
 - b. *Probe: What barriers have been encountered?*
 - i. *Political will?*
 - ii. *Policy formulation?*
 - iii. *Implementation?*
 - iv. *Monitoring and evaluating results?*
 - v. *Funding?*
 - vi. *Others?*
 - c. *Probe: What have been political motivations for considering whether or not to develop policy for “free” FP services and eventually deciding to develop the policy?*
 - i. *Would an upcoming election or other happenings that may have played a role?*
 - ii. *How might policymakers have wanted to please their constituencies?*
 - iii. *Did any changes to information, education, and communication about FP (or the problems associated with inadequate FP) occur?*
 - iv. *What other political elements may have motivated this change?*
 - d. *Probe: What political processes have been important for implementing “free” FP? For example:*
 - i. *Electoral positioning?*
 - ii. *Coalition-building?*
 - iii. *Were there individuals who championed these efforts, for instance, key government officials, motivators, people who uniquely communicated the message?*
 - iv. *Framing the policy issue?*
 - e. *Probe: What are some lessons learned that could be shared with other countries?*

3. How has client access to FP services changed since they were made “free”?
 - a. Probe: *How has client access changed?*
 - i. *Has it improved?*
 - ii. *Has it differed by wealth status (i.e., poor vs. wealthy)?*
 - b. Probe: *How has availability of FP services changed?*
4. How has financing of FP services changed since they were made “free”?
 - a. Probe: *Did government investment change in:*
 - i. *FP commodities?*
 - ii. *Health facilities?*
 - iii. *Health workers?*
 - iv. *Other?*
 - b. Probe: *What has been the budget impact of making FP services “free”?*
 - c. Probe: *How has the ranking from highest to lowest in terms of their financial contribution to the cost of FP services in [country] changed: government, client, donor, other?*

IF COUNTRY HAS NOT DEVELOPED POLICY TO MAKE FP SERVICES “FREE,”
continue below. IF THEY HAVE, continue to question #20.

5. What reasons drove [country]’s choice against putting forth policy to make FP services “free”?
 - a. Probe: *Could you tell me more about the factors that drove this decision?*
 - b. Probe: *What would you say were (or are) barriers to enacting policy that eliminates user fees for FP services?*
 - i. *Political will?*
 - ii. *Policy formulation?*
 - iii. *Implementation?*
 - iv. *Monitoring and evaluating results?*
 - v. *Funding?*
 - vi. *Others?*
 - c. *How has [country] decided to address its top priorities for provision of FP?*
6. What have been political motivations for considering whether or not to develop policy for “free” FP services and eventually deciding not to develop the policy?
 - a. Probe: *Would an upcoming election or other happenings have played a role?*
 - b. Probe: *How might policymakers have wanted to please their constituencies?*
 - c. Probe: *Did any changes to information, education, and communication about FP (or the problems associated with inadequate FP) occur?*
 - d. Probe: *What other political elements may have motivated this change?*

TO ALL RESPONDENTS:

7. What are the government's plans for continuing to contribute to the cost of providing FP services?
 - a. *Probe: Is there a dedicated budget line for FP?*
 - i. *If yes, where is it in the budget? How was this budget line determined?*
 - b. *Probe: Are there plans to progressively increase the funds allocated to this?*
8. Through our desk based research, we were able to find the following data sources on FP and health expenditures [refer to table with data information from DHS, MICS, PMA2020, NHA]
 - a. *Could you share any additional, more recent and/or more relevant data? For example, annual statistical reports, data that supports budget advocacy?*
9. As [country] continues pursuit of its FP priorities what would be of interest for [country] to learn from other West African countries?
 - a. *What lessons learned from the [country] experience would be of interest to share with other West African countries?*

Thank you for your contribution to better understanding the provision and financing of FP services in [country]. As mentioned earlier, HFG is collecting data on several countries in West Africa as part of the study. We will document major themes in a report for USAID which we expect to be publically available on our website www.hfgproject.org in August 2018.

Before we conclude, as we interview other key Government focal points, family planning provider associations, and family planning programs, is there anyone you would strongly recommend we interview? If yes, please provide the following:

Full name

Title

Organization

Contact information (telephone/ email)

ANNEX C: KEY INFORMANTS

Country	Interviewed	Organization	Title	Office address	Office number	Mobile number	Email address(es)	Recommended by	Interview Details	
	Name (First, Last)								Day	Time
Ghana	Joseph Addo-Yobo	Abt Associates	Chief of Party, SHOPS AA				Joseph_Addo-Yobo@shopsproject.com	SHOPS Plus	6/19/2018	9:00
Ghana	Prof. Easmon Otupiri	Kwame Nkrumah University of Science and Technology (KNUST)	Dean	KNUST		+233 0208111980	easmono@yahoo.com	Nora Maresh, USAID Ghana	6/19/2018	10:00
Ghana	Ms. Anne Coolen	Marie Stopes International	Point Person for MSI-NHIA Cost Analysis Pilot Study for select FP services free of cost	Marie Stopes Ghana, H/No. 36, Akwei Street, Tesano, Accra, Ghana (TBD)	+233 (0) 302 241517	+233 (0) 244320745	anne.coolen@mariestopes.org	Nora Maresh, USAID Ghana	6/19/2018	16:00
Ghana	Dr. Placide Tapsoba	Pop. Council	Country Director	14B Ridge Road at Roman Ridge Accra	0302 780711/2	0244 660 990	ptapsoba@popcouncil.org	Dr. Dela Kusi-Appouh	6/20/2018	9:00
Ghana	Mr. Emmanuel Kuffour	Pop. Council	Associate	14B Ridge Road at Roman Ridge Accra	0302 780711/2		ekuffour@popcouncil.org	Dr. Dela Kusi-Appouh	With Dr. Placide Tapsoba	
Ghana	Dr. Lydia Dsane-Selby	National Health Insurance Authority	Ag. Deputy Chief Executive, Operations	NHIA		+233 (0)242 689232	baaba.selby@nhia.gov.gh	Nora Maresh, USAID Ghana	6/20/2018	15:00
Ghana	Francis Asenso-Boadi, PhD	National Health Insurance Authority	Ag. Director, Provider Payment	NHIA				Lydia Selby	With Dr. Lydia Dsane-Selby	
Ghana	Dr. Patrick Aboagye	Ghana Health Service	Director, Family Health Division			+233 207369326	yaboagye2003@yahoo.com	Nora Maresh, USAID Ghana	6/22/2018	14:00
Ghana	Dr. Leticia Adelaide Appiah	National Pop. Council	Executive Director	NPC, Ministries	+233 0302 665944		lappiah@npc.gov.gh	Nora Maresh, USAID Ghana	6/23/2018	9:00
Ghana	Dr. Emmanuel Odame	MOH	Director, Policy Planning Monitoring and	N/A				Pop Council, NHIA	7/11/2018	17:00 (part I) 19:15

Country	Interviewed	Organization	Title	Office address	Office number	Mobile number	Email address(es)	Recommended by	Interview Details	
	Name (First, Last)								Day	Time
			<i>Evaluation Department</i>							(part 2) 20:30 (part 3)
Ghana	Ms. Claudette Diogo	Ghana Health Service	<i>Head of Logistics, Family Health Division</i>			+233 020 815 1826		Emmanuel Kuffour	N/A	N/A
Ghana	Dr. Dela Kusi-Appouh	Pop. Council	<i>Point Person for Sayana Press affordability/feasibility study</i>	TBD	TBD	507405225	dkusiappouh@popcouncil.org	Nora Maresh, USAID Ghana	N/A	Referred us to Dr. Placide Tapsoba and Mr. Emmanuel Kuffour

Pays	Nom (Prénom, Nom)	Organisation	Titre	Adresse Bureau	Télé Bureau	Mobile	Adresse(s) Email	Recommandé par	Calendrier d'Entrevue	
									Jour	Heure
Niger	Elhadj Ide DJERMAKOYE	ROASSN (Regroupement des ONGs et Associations du Secteur de la Santé) + RCPFAS (Reseau des Champions en Plaidoyer pour le Financement Adequat de la Sante)	Coordonnateur National	Colle à l'Ambassade d'Espagne, 151, Avenue de la Rádio,Yantala Commune I B.P. 11888 Niamey, Niger	(227) 20 72 38 62	(227) 96 99 59 30	roassen@yahoo.fr	Safiatou Wahi, USAID	6/27/2018	9:00
Niger	Sameile MAMADOU	ROASSN + RCPFAS	Chargé de projets	Voir Elhadj Ide DJERMAKOYE			ordphid@yahoo.fr	Elhadj Ide DJERMAKOYE, ROASSN/RCPFAS	avec Elhadj Ide DJERMAKOYE	
Niger	Mme Traore ZEINABOU	ROASSN + RCPFAS	Membre	Voir Elhadj Ide DJERMAKOYE			hadjia.zeinabou@yahoo.fr	Elhadj Ide DJERMAKOYE, ROASSN/RCPFAS	avec Elhadj Ide DJERMAKOYE	
Niger	Dr Amadou HOUSSEINI	DSME (Direction de la Sante Mere et Enfant)	Directeur Intermédiaire , DSME et Responsable Programme Transmission Mere-Enfant (PTME)	BP 623 Niamey	227 96889564	227 96261520	amadoouhousseini@yahoo.fr	Dr Marcel Lucien Omar, DSME	27/06/2018	10:30
Niger	Mme Ekhizi AISSATA	DSME (Direction de la Sante Mere et Enfant)	Alternate contact de M. Hassan Atamo et Membre, Division Planification Familiale	Voir Dr Amadou HOUSSEINI		227 9939898	ekhiziaissata@yahoo.fr	M. Hassan Atamo, DSME	avec Dr Amadou HOUSSEINI	
Niger	M Mohamed DICKO	UNFPA	RHCS Technical Specialist	28 Avenue du Fleuve Niger	22720722980	22798638503	mdicko@unfpa.org	Safiatou Wahi, USAID	27/06/2018	17:00
Niger	M Ismaila MBENGUE	Voir M DICKO	Representant du NIGER	Voir M DICKO	227 20722956	227 80068666	mbengue@unfpa.org	M Dicko	avec M DICKO	

Pays	Nom (Prénom, Nom)	Organisation	Titre	Adresse Bureau	Télé Bureau	Mobile	Adresse(s) Email	Recommandé par	Calendrier d'Entrevue	
									Jour	Heure
Niger	Dr Arziki SOULEY	Direction des organisations des soins	<i>Chef de Division Formations Sanitaires Privées</i>	MSP, Quartier poudrière, à côté de l'hôpital régional	227 96210006 OU 227 91585515		souleyarziki@yahoo.fr	Safiatou Wahi, USAID	28/06/2018	9:00
Niger	M Galadima Abdoul Karim SOULEY	Direction de Ressources Financières et des Matériaux, Direction Générale des Ressources, MSP	<i>Directeur</i>	BP 623 Niamey	227 20 72 47 26	227 96 97 81 52/227 90 40 87 64	souleygala@yahoo.fr	HFG, un intervenant clé in 2016 HFG landscape study	28/06/2018	10:30
Niger	Dr Barira Dan NOUHO	Directeur des pharmacies labo et médecine traditionnelle, Ministère de la Santé	<i>Directrice</i>	MSP, Quartier poudrière, à côté de l'hôpital régional	20 20 33 63	<u>90 66 50 45 /96 98 10 56</u>	bariradany@gmail.com	HFG, un intervenant clé in 2016 HFG landscape study	29/06/2018	8:00
Niger	Denis ANGEVIN changé par Mme Badou HEDWIGE	MSI	<i>Directeur des Opérations et des Programmes</i>	Quartier Plateau , Boulevard Mali Béro, Rue Issa Béri Niamey Niger		227 92 18 84 15	denis.angevin@mariestopes.org.uk	Safiatou Wahi, USAID	29/06/2018	10 H
Niger	Mme Moustafa BALCEM	Association Nationale de Bien-Etre Familiale (ANBEF)	<i>Responsable clinique</i>			227 96592316	balkissa.moustapha@yahoo.com	M. Sama MOSSI	29/06/2018	12:00
Niger	M. Mahazou MAHAMAN	ANIMAS-SUTURA (L'Association Nigérienne de Marketing social)	<i>Responsable Département Recherche & développement</i>		227 20739050	227 90517662/ 96997126	mmahazou@yahoo.fr ou m.mahazou@animas_sutura.org	Safiatou Wahi, USAID	29/06/2018	16 H
Niger	Mohamed ABDOULAYE	ANIMAS-SUTURA	<i>Directeur Exécutif</i>			90 517 629	Mohamed05@yahoo.fr	M. Mahazou Mahaman	avec M. Mahazou MAHAMAN	
Niger	Franzke MONIKA	ANIMAS-SUTURA	<i>Conseillère technique</i>			82 24 57 92	Monika.franck@gfa-group.de	M. Mahazou Mahaman	avec M. Mahazou MAHAMAN	

Pays	Nom (Prénom, Nom)	Organisation	Titre	Adresse Bureau	Télé Bureau	Mobile	Adresse(s) Email	Recommandé par	Calendrier d'Entrevue	
									Jour	Heure
Niger	Kazella IDRISSA	ANIMAS-SUTURA	Chargé des activités du Département Santé			96 295 840	Kazella75@gmail.com	M. Mahazou Mahaman	avec M. Mahazou MAHAMAN	
Niger	Dr Marcel Lucien OMAR	DSME	Directeur			227 96261520	lucmarcelantara@yahoo.fr	Safiatou Wahi, USAID	N/A	N/A
Niger	Dr Sanda SARATOU	DSME	Alternate contact to M. Hassan Atamo			227 96992151	saharatouchaibou@yahoo.com	M. Hassan Atamo, DSME	N/A	N/A
Niger	Dr. Sani ALIOU	PATHFINDER INTERNATIONAL	Directeur du Pays		227 20351168	227 92553611		Safiatou Wahi, USAID	N/A	N/A
Niger	M. Ibrahim BOUBACAR	Association Nationale de Bien-Etre Familiale (ANBEF)	Directeur Executif			227 96965882/ 90779443	hima-issa@yahoo.fr	Safiatou Wahi, USAID	N/A	N/A
Niger	M. Sama MOSSI	Association Nationale de Bien-Etre Familiale (ANBEF)	Directeur Executif Intermediaire		227 97221414			M. Ibrahim BOUBACAR	N/A	N/A
Niger	M. Hassan ATAMO	DSME	FP CHIEF DIVISION	MSP, Quartier poudriere, a cote de l'hopital regional	227 20724726	227 90331266	atamoh41@gmail.com	Safiatou Wahi, USAID	N/A	N/A
Niger	Mme Sourghia MARIAMA	Direction des organisations des soins	Directrice	MSP, Quartier poudriere, a cote de l'hopital regional	227 96278066 OU 227 90089410		mariama662001@yahoo.fr	Safiatou Wahi, USAID	N/A	N/A
Niger	Dr. Ibrahim SOULEY	Direction générale de la SR, Ministère de la Sante	Directeur General	MSP, Quartier poudriere, a cote de l'hopital regional		227 96884198/ 90579050	ibrahimsouley34@gmail.com	Safiatou Wahi, USAID	N/A	N/A
Niger	Dr Nassirou OUSMANE	Ministere de la Sante	Directeur Nutrition	MSP, Quartier poudriere, a cote de l'hopital regional		96879816	naous001@gmail.com	Dr. Ibrahim Souley	N/A	N/A
Niger	Dr ZARATOU (Intermediaire de Dr Nouhou)	Direction des pharmacies labo et médecine traditionnelle, Ministère de la Sante	Intermediaire de Dr Nouhou	MSP, Quartier poudriere, a cote de l'hopital regional		227906650 45	zankourao@yahoo.fr zaratou.kalla@gmail.com	Dr. Nouhou	N/A	N/A

Pays	Nom (Prénom, Nom)	Organisation	Titre	Adresse Bureau	Télé Bureau	Mobile	Adresse(s) Email	Recommandé par	Calendrier d'Entrevue	
									Jour	Heure
Mauritania	Dr Ahmed Mohamed NAGI	PNSR (Programme National de la Sante de la Reproduction)	<i>Chef de Service la chaine d'approvisionnement</i>	CENTRE SANTE KAYERET	37 11 11 40 46 51 44 45		ahmedounagi69@gmail.com	USAID/Mauritanie	3-Jul-2018	9 H
Mauritania	Khadijetou Ahmed EL HEDI	PNSR	<i>Chef de Service PF</i>	CENTRE SANTE KAYERET	22 27 93 74		bintouainina@yahoo.fr	USAID/Mauritanie	avec Dr Ahmed Mohamed NAGI	9 H
Mauritania	Brahim AHMEDOU	AMPF (Association Mauritanienne for the Promotion pour la Promotion de la Famille)	<i>Directeur Executif</i>		36 39 47 73		ampfrim@yahoo.fr	USAID/Mauritanie	3-Jul-2018	10 H
Mauritania	Dr Moussa MBOW	SWEDD (L'initiative régionale Autonomisation des Femmes et Dividende Démographique au Sahel)	<i>Coordinator</i>	Nouakchott	47 42 94 55		moussambow@outlook.com	USAID/Mauritanie	4-Jul-2018	11 H
Mauritania	Yousseuf LIMAME	Direction de la Sante de Base et de la Nutrition, Ministere de la Sante	<i>Chef Service</i>	Nouakchott	22 24 37 98		yousseouflimame@gmail.com	USAID/Mauritanie	4-Jul-2018	12 H 30
Mauritania	Fatimetou MAHAM	Point focal HP+	<i>Point focal</i>		46 42 01 42		fatisenls@yahoo.fr	USAID/Mauritanie	4-Jul-2018	15 H
Mauritania	Bocar M'BAYE	UNFPA	<i>responsible supply chain point focal FP2020</i>		22 24 37 95		mbaye@unfpa.org	USAID/Mauritanie	4-Jul-2018	16 H
Mauritania	Dr. Mohammed Lemin KHOUNA	Independent mais il a travaillé pour plusieurs projets PF en pays comme AGIR/PF	<i>Consultant</i>	Nouakchott	22 26 03 93		mlmedkhouna@yahoo.fr	USAID/Mauritanie	4-Jul-2018	17 H 30
Mauritania	Mohamed Cheikh MOHAMED	FHP/OMS (Family Health Program/OMS)	<i>CT</i>	Nations Unies/PNUD	48 48 21 60		mohamedcheihkm@who.int	USAID/Mauritanie	5-Jul-2018	8 H 30

Pays	Nom (Prénom, Nom)	Organisation	Titre	Adresse Bureau	Télé Bureau	Mobile	Adresse(s) Email	Recommandé par	Calendrier d'Entrevue	
									Jour	Heure
Mauritania	Mohamedbouye Ahmed ABDALLAHI	CAMEC	Responsable Informatique et Statistique	Nouakchott	222 37 07 37 00		medbouye.ahmed@gmail.com	USAID/Mauritanie	5-Jul-2018	9 H 30
Mauritania	Dieynaba Ta TANDIAN	CAMEC (Centrale d'Achat des Médicaments)	Directeur Communication	Nouakchott	46196591		dieynabatandiang@gmail.com	LE DIRECTEUR DE LA CAMEC	avec Mohamed bouye Ahmed ABDALLAHI	
Mauritania	Brahim Ould SALEH	CAMEC	Responsable des Programmes	Nouakchott	22298749		brahimsaleh63@yahoo.fr 05/07	LE DIRECTEUR DE LA CAMEC	avec Mohamed bouye Ahmed ABDALLAHI	
Mauritania	Dr Sira BA	ENEM (Ensemble Espacons les Naissances en Mauritanie)	Coordinatrice	Nouakchott	41 54 37 11		illahba@gmail.com	USAID/Mauritanie	5-Jul-2018	11 H 30
Mauritania	Dr Soumaré BAKAR	Direction de la Pharmacie et des Laboratoires	Directeur Adjoint	Nouakchott	36303825 OU 46025730		soumare.bakar@yahoo.fr	Dr Ahmed Mohamed NAGI	5-Jul-2018	10 H 30
Mauritania	Alioune DIOP	ENEM	President	Nouakchott	46 41 25 41		alioudiop01@yahoo.fr	USAID/Mauritanie	5-Jul-2018	12 H 40
Mauritania	Thierno Ousmane COULIBALY	Former EngenderHealth / AGIR PF	Ancien Coordonnateur de Projet	Nouakchott	36674755 OU 22674755 OU 44969594		touscoulibaly@gmail.com	USAID/Mauritanie	5-Jul-2018	13 H 45
Mauritania	Komura Yohei	IOM	gestionnaire de projet en gestion des Frontières	Nouakchott	222 45 24 40 81	222 49 38 37 90	ykomura@iom.int	USAID MAURITANIE	9-Jul-2018	10 H
Mauritania	Dr. Sidi Mohamed Abdel AZIZ	PNSR	Coordinateur	MAE	22 37 22 72	22 37 22 72	smaz01@yahoo.fr	USAID/Mauritanie	3-Jul-2018	
Mauritania	Aminetou MBOUROU	PNSR	Chef Service Communication	Nouakchott		22 20 99 71	aminetoumbourou@gmail.com	USAID/Mauritanie	3-Jul-2018	
Mauritania	Djigo Djibril Yéro	IOM		Nouakchott	222 45 24 40 81		ddjigo@iom.int	USAID MAURITANIE	9-Jul-2018	
Mauritania	Mohamed VADEL	SWEEP	Coordinator	Nouakchott	26 18 16 81		vadel222@hotmail.fr	USAID/Mauritanie	3-Jul-2018	

ANNEX D: FP POLICY TABLE

	Family planning policy, strategy or action/ implementation plan	Main strategies to pursue increased access to FP	Government plans to address financing for FP
Core Countries			
Ghana	Ghana Family Planning Costed Implementation Plan 2016–2020	<ul style="list-style-type: none"> Promote and nurture change in social and individual behavior Increase age-appropriate and rights-based information, access, and use of contraception among young people ages 10–24 Improve availability and access to a full method mix; quality of client-provider interactions with a particular focus on improving counseling on delaying, spacing, and limiting for all client age and population groups Improve distribution and ensure full financing for commodity security in public and private sectors Strengthen advocacy to build political will for rights-based FP among community leaders, religious and cultural institutions, and policymakers at all levels Strengthen provision of FP services and information through community-based health planning and services 	<ul style="list-style-type: none"> Promote advocacy and monitoring to increase government allocations within national budgets, including official budget line items (separate from RH) for FP commodities as well as FP programs Improve financing from development partners Improve domestic resource allocations Improve funding from the private sector Design and implement a resource mobilization plan
Mauritania	<p>Action Plan in Favor of Birth Spacing 2014–2018</p> <p>National Strategic Plan in Reproductive Health 2016–2020</p> <p>National Health Development Plan 2017–2020</p>	<ul style="list-style-type: none"> Create information and awareness campaigns directed at the general population and among women in particular Promote constructive engagement of men with RH and FP Launch innovative communication strategies for young people in school and out of school Create access points for FP Improve access outside the health coverage Improve FP services offered to adolescents and young people Ensure the security of contraceptive products Increase the supply of FP services by 	<ul style="list-style-type: none"> Stabilize and diversify funding for FP Advocate for state involvement in FP funding

	Family planning policy, strategy or action/ implementation plan	Main strategies to pursue increased access to FP	Government plans to address financing for FP
		<p>civil society organizations and the private sector</p> <ul style="list-style-type: none"> • Provide FP services to people living with HIV and other key populations • Continued advocacy efforts with influential decision makers • Adopt and implement legislative and regulatory texts on RH and FP • Improve offering of priority RH services • Increase demand and promotion of RH, FP, and birth spacing using information education and communication and behavior change communication–advocacy • Strengthen institutions' implementation of the RH policy • Develop resources for maternal, newborn, and infant health • Ensure availability of modern methods in all hospitals and health centers • Ensure an offering of injectables and oral contraceptives in all health posts • Strengthen the supply and distribution of RH products • Revise national directives on the supply of RH products • Develop and implement National Reproductive Health Policy communication strategy • Strengthen the community-based distribution of certain FP/birth-spacing products 	
Niger	Family Planning in Niger: Action Plan 2012–2020	<ul style="list-style-type: none"> • Increase the availability of contraceptives, materials, and other FP inputs and services at all levels • Increase the demand for FP services at all levels, including involving men in FP actions • Promote the large-scale and community-based distribution of contraceptives through public and private health facilities, including social marketing 	<ul style="list-style-type: none"> • Not mentioned

	Family planning policy, strategy or action/ implementation plan	Main strategies to pursue increased access to FP	Government plans to address financing for FP
		<ul style="list-style-type: none"> • Integrate FP into the basic health care package • Promote an enabling environment for FP • Create information, education, and communication campaigns for FP, RH, and population issues • Employ mobile and other advanced strategies for the provision of FP and RH services 	

Non-Core Countries

Burkina Faso	National Plan for the Acceleration of Family Planning Costed Implementation Plan 2017–2020	<ul style="list-style-type: none"> • Increase the demand for FP information and services by women and especially youth • Make the environment more favorable to FP through strong engagement with social actors of Burkina Faso • Strengthen the capacity of public, private, and community providers in targeting youth in rural and closed-off areas through the expansion of the range of methods and the improvement of services to youth • Strengthen capacity in quantification, planning, management of the supply chain, and of logistics at all levels of the health system to ensure the security of contraceptive products at all times • Strengthen advocacy activities toward decision makers at all levels of government and also including traditional, religious, and elected leaders • Strengthen the framework for coordination of FP actors at all levels • Improve the monitoring and evaluation to improve FP data 	<ul style="list-style-type: none"> • Strengthen and sustain FP financing
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Cote d'Ivoire	National Budgeted Action Plan for Family Planning 2015–2020	<ul style="list-style-type: none"> • Promote information and awareness campaigns favorable to FP • Training and involvement of community leaders, opinion leaders, and local elected officials in FP awareness • Promote the constructive engagement of men in RH and FP • Launch novel communication strategies targeting adolescents and youth in and out of school • Strengthen and extend FP/HIV/AIDS service offerings to 100 percent of health facilities and also integrate them into police, military, customs, and large businesses' health structures • Implement advanced mobile strategies across all regions • Strengthen the inclusion of FP/HIV activities in advanced intervention strategies across all health districts • Organize special FP days once a year by integrating screening tests for breast and cervical cancers • Organize a national forum on community health and the role of community health workers in FP once every two years • Strengthen the technology platform of the health training in order to improve the quality of FP services through training and equipment • Promote operational research to develop novel approaches in the FP domains of interest • Strengthen adolescent and youth FP services • Implement a results-based financing program that will include FP • Strengthen FP service offerings by the private sector • Improve the security of contraceptive products • Improve the enabling environment for FP services through advocacy and RH legal, regulatory, and institutional improvements • Regular, systematic monitoring of FP activities and the National Health Development Plan at all levels of the 	<ul style="list-style-type: none"> • Organize an advocacy day for resource mobilization • Introduce a fund specific to financing maternal and child health • Advocate to members of the government and parliament to add a budgetary line item for contraceptive supply • Advocate to husbands and decentralized authorities to encourage additional local resources for FP
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	Family planning policy, strategy or action/ implementation plan	Main strategies to pursue increased access to FP	Government plans to address financing for FP
		health system	
Mali	National Action Plan for Family Planning 2014–2018	<ul style="list-style-type: none"> • Integrate FP messages in <i>mutuelles</i> • Develop a policy for introducing a third-party payer for FP services on behalf of adolescents and poor women • Develop performance-based financing strategy that will include FP • Mali government has committed to financing 10 percent of costs of contraceptives. 	<ul style="list-style-type: none"> • Advocate for the increase and diversification of financing for FP, including the government's contribution and the harmonization of costs • Launch a fund specific to financing of maternal and child health



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