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Accelerating Progress in Family Planning: Options for Strengthening Civil Society-led Monitoring and Accountability

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Accelerating Progress in Family Planning: Options for Strengthening CSO-led Monitoring and Accountability

Executive Summary

Ensuring that women around the world have access to high-quality family planning (FP) information, services, and commodities requires commitments such as those made as part of Family Planning 2020 (FP2020). However, a myriad of bottlenecks, including diversion of funds due to competing priorities, delays and leakages of resources, limited contraceptive choice, poor quality service provision, and inadequate protection of women's rights, can prevent these commitments from translating into real progress in family planning access, quality, and rights. Further, limited resources and disincentives often limit government efforts to monitor and address these problems. New solutions are needed.

In recent years, accountability initiatives led by citizens and civil society organizations (CSOs) have proliferated, particularly in the health and education sectors. These initiatives, also referred to as social accountability (SAC) initiatives, are designed to empower citizens and ensure that government policy, spending, and services are high-quality, efficient, and responsive to citizens' needs. There is growing evidence that when appropriately designed and implemented these interventions produce important results including greater citizen agency and engagement, higher quality and more appropriate services, improved provider performance, increased service utilization, more efficient allocation and use of resources, and improved development outcomes. With appropriate support, social accountability initiatives in the FP sector can address bottlenecks and help FP programs achieve their goals.

This study – led by the Results for Development Institute (R4D) with generous support from the William and Flora Hewlett Foundation – was designed to identify options to support stronger monitoring and accountability (M&A), particularly social accountability, around Family Planning 2020 and family planning more broadly.

Options for strengthening social accountability around family planning

To inform the design of these options, R4D participated in numerous FP events and activities, interviewed major stakeholders in the FP community, reviewed the literature on family planning monitoring and accountability, and benchmarked M&A efforts around comparable international initiatives in other fields. In addition, in February and April 2013, R4D teams made visits to India, Indonesia, Senegal, and Uganda to observe family planning activities on the ground, assess the plans and early impact of FP2020 at country level, and consider new ways in which M&A could be strengthened.

Overall, R4D's fact-finding and analysis suggest that significant progress is being made in family planning monitoring and accountability, in great part thanks to FP2020's focus on M&A. Over the past year, FP2020 has established the systems and infrastructure necessary to monitor the impact of family planning programs and to strengthen accountability for the implementation of financial, policy, and programming commitments. Core indicators were selected, corresponding baseline data was collated, tracking of family planning expenditures was improved, and electronic data collection was launched in select countries. Monitoring capacity is being expanded in government agencies in 23 high fertility countries. New survey methods are being designed and tested. A yearly global report on FP2020 could help to stimulate and channel key information on progress and problems to senior decision-makers and donors, and hold them more accountable for committed funding and results. An upcoming DfID program will build civil society capacity to hold their governments to account for their commitments and to ensure that women's and girls' rights are upheld through the provision of resources, expertise, and a robust lesson learning strategy.¹

However, civil society-led (CS-led) accountability remains an underdeveloped mechanism for improving family planning, despite proven success and widespread adoption of these approaches around primary health care, basic education, and water and sanitation services. The energy and momentum created by FP2020 are an opportunity to strengthen civil society M&A; however, civil society needs

¹ DfID support to Family Planning 2020: Monitoring and accountability at global and country level – Extracted sections from the Business Case.

to be equipped to carry out sustainable M&A beyond FP2020 commitments. The report is timely given the upcoming DFID tender for CS-led accountability.

Using a “design framework” that we developed for this project, we have laid out three broad options for possible support by the Hewlett Foundation and others who wish to sponsor CS-led M&A around family planning in a number of high fertility countries in Africa and Asia. These options include: (1) M&A around national plans, funding commitments, and policies affecting family planning efforts; (2) M&A on program performance targeted at selected levels and dimensions of national family planning programs (e.g., flow of funds and contraceptive commodities from the center to the periphery; coverage and quality of service delivery); and (3) citizen voice and engagement as well as monitoring of service quality, user satisfaction, and respect for rights. Under each of these options, we have highlighted a recommended approach to capacity building, experimentation, documenting and sharing best practices, and joint learning among CSOs within and across countries.

Any of these individual options would make a significant contribution to monitoring and accountability in the sector and to improved access and quality of family planning services. If implemented together, there is even greater potential to build a consistent, cohesive, and sustainable model for the improvement of family planning worldwide. We believe that by investing in these options, or a combination of them, high fertility countries, donors, and civil society groups can spur important improvements in the design and implementation of FP programs. These options will help identify and rectify issues in FP programming and service delivery, uphold clients’ rights, and enhance the quality, appropriateness, and uptake of FP information, services, and commodities.

Some components of the options require tailoring at the country level. It is therefore critical that any option should be coordinated and led by a coalition of international organizations with substantial experience in both family planning and CS-led accountability. The design and implementation of the actual interventions will involve identifying and partnering with relevant national, subnational, and local stakeholders. To effectively implement these options, we recommend that they be carried out in a minimum of three high fertility countries, ideally in a larger number (four to six or more). Countries should be selected on the basis of need; a preliminary assessment of the key bottlenecks to faster progress in expanded family planning; commitment from country-based organizations; the current strength of civil society institutions; and donor preferences.

While the costs and efforts needed to implement the options will vary significantly across contexts, we estimate that Option 1 is the least expensive and easiest

to implement. Option 2 is likely to be the most costly but could reinforce other efforts in expenditure tracking and service delivery monitoring with large resulting benefits. Option 3 would be challenging to implement, as it would entail managing a group of CSOs and community-based organizations, but could yield enormously valuable results and lessons on how to promote citizen engagement in family planning.

Vision for the Future

The implementation of these options would contribute to a family planning sector that is widely responsive to citizen and civil society voices at the local, subnational, national, and global level. Ultimately, this would lead to a vibrant global network of civil society organizations undertaking effective accountability work around family planning and documenting, sharing, and learning from their collective experience. This network would complement and augment government-led accountability efforts, monitoring and influencing national FP policies and budgets, tracking the implementation of FP programs, service delivery, and the protection of women’s rights. Where policies, programs, and services are found lacking, civil society groups would engage communities and ensure that women’s voices are heard and advocate at the subnational, national, and global level for changes in policy and practice to improve access to and uptake of high-quality FP information, services, and commodities.

While the family planning sector does not yet have the necessary experience and skills to realize the vision described above, it is not outside of reach. The options in this paper provide a pathway for building social accountability skills and activities around family planning and creating the foundations for this vision. If the options presented in this paper are supported and social accountability for family planning developed, citizens will be better informed and more engaged around family planning, FP programs and services will improve, and women will have better access to FP information, services, and commodities that are high-quality, appropriate, and respectful of their rights.

List of acronyms

AFP	Advance Family Planning
CBM	Community-Based Monitoring
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DFID	UK Department for International Development
DHS	Demographic and Health Survey
EWEC	Every Woman Every Child Initiative
FP	Family Planning
FP2020	Family Planning 2020
GARPR	Global Aids Response Progress Reporting
GPE	Global Partnership for Education
KFF	Kaiser Family Foundation
MCPR	Modern Contraceptive Prevalence Rate
M&A	Monitoring and Accountability
NGO	Non-Governmental Organization
NIDI	Netherlands Inter-Disciplinary Demographic Institute
PMA	Performance Monitoring & Accountability
SAc	Social Accountability
UNGASS	United Nations General Assembly Special Session on AIDS
WHO	World Health Organization

I. Introduction

Background and purpose of our study

The London Summit on Family Planning, co-hosted by the UK Department for International Development (DFID) and the Gates Foundation in July 2012, was a watershed moment for the family planning (FP) movement. At the Summit, leaders from 150 countries, international agencies, civil society organizations, foundations, the research and development community, and the private sector endorsed the goal of expanding access to contraceptive information, services, and supplies to an additional 120 million women and girls in the world's poorest countries by 2020. Twenty-four countries made commitments and donors pledged \$2.6 billion in funding. The event attracted high-level media attention and was described as a potentially transformative moment. The Summit filled twin purposes: a symbolic one, as a moment in which family planning was again afforded a prominent place on the development agenda, and a pragmatic one, as a means of drawing out new financial and policy commitments. FP2020 is an outcome of this global momentum and works with partners to help commitment-makers uphold their promise to provide access to high-quality voluntary family planning services, information, and commodities to an additional 120 million women and girls in the world's poorest countries by 2020.

A strong monitoring and accountability system is crucial to fulfilling FP2020's potential. It is critical that parties are held to account not only for commitments made but also for efficient, effective, and equitable use of resources. FP2020 leaders have acknowledged the need for strong M&A and taken steps to support its development. The FP2020 Task Team functions as the hub of global accountability for the initiative while the FP2020 Performance Monitoring & Accountability Working Group (PMA WG) provides technical advice on monitoring and evaluating progress towards the FP2020 goal. Track20 collates and calculates FP2020's core indicator data and works to build monitoring and evaluation (M&E) capacity in FP2020 commitment-making countries. PMA2020 is implementing a rapid data collection scheme that will supplement the Demographic Health Survey (DHS) in 10 countries and the Kaiser Family Foundation provides FP2020 with an annual analysis of donor government disbursements for FP. Finally, DFID is planning to release a tender for a civil society-led (CS-led) accountability program around FP2020 in mid-2014.

In consideration of this ongoing work, we set forth to create a set of complementary options for strengthening

monitoring and accountability around FP2020 commitments and family planning programs and services more broadly. Two principles underpin our work. The first is that both national and subnational monitoring and accountability activities are important and that such monitoring must happen on a consistent basis. The second is that civil society actors have a central role to play in M&A; our analysis placed a particular emphasis on how their contributions can be supported.

Methods

The development of our options was informed by a number of activities. We conducted a series of interviews with FP leaders to bolster our institutional knowledge of key issues in the field. This initial phase also included regular conversations with FP2020 organizers, particularly those involved with monitoring and accountability. Additionally, we attended several key global family planning events, including the London Summit on Family Planning, the post-London FP2020 planning event in New York City, and the Family Planning Conference in Addis. These conversations and events provided insight into the aims and attendant challenges of the Summit and the emerging M&A system.

Additionally, our team conducted a review of monitoring and accountability mechanisms developed around existing international initiatives and commitments. This review, which took the form of targeted interviews with individuals who developed and implemented these initiatives as well as a critical examination of associated reports and documents, served to identify best practices in the design of monitoring and accountability initiatives. The team did an initial scan of global partnerships, electing to focus on three: the Global Partnership for Education (GPE); the Global Aids Response Progress Reporting (GARPR) and the United Nations General Assembly Special Session (UNGASS) on AIDS; and the Every Woman Every Child Initiative (EWEC). The key findings from this benchmarking exercise can be found in Annex 1.

Finally, in February and April of 2013, our team made visits to four FP2020 pledging countries – India, Indonesia, Senegal, and Uganda – where we met with key stakeholders, including: government officials; NGOs involved in service delivery, monitoring, and advocacy; donor agencies; and other leading FP researchers and practitioners. These visits helped us to identify priority FP issues and gaps in monitoring and accountability in each

country. The lessons gathered from these findings can be found in Annex 2.

We drew from the above-described activities as well as our experience supporting and evaluating civil society-led monitoring and accountability to develop a set of draft options for strengthening M&A.

This paper is composed of five main sections. Section II presents potential obstacles to the success of FP2020 and

of FP programs more broadly as well as how monitoring and accountability can help identify and overcome such obstacles. Section III describes existing and emerging initiatives designed to strengthen M&A around FP, highlighting areas for additional support. Section IV lays out a framework for designing and implementing programs to support M&A and recommends three options for strengthening M&A around FP programs and services. Finally, Section V outlines the next steps required to move from these options to implementation.

II. Strengthening Family Planning: the Role of Monitoring and Accountability

Necessary conditions for the success of FP2020 and national FP programs

The goal of FP2020 is to enable 120 million additional women and girls in developing countries to use contraceptives by 2020, while ensuring the protection of women's rights to quality services, non-coercion, choice, and non-discrimination. Achieving this goal requires that commitments made to FP2020 are fulfilled, that family planning programs are effectively designed and implemented, and that services are high quality and respectful of women's rights and preferences. These conditions, necessary to the success of FP2020 and to FP advancements more broadly, are detailed here:

- **Global enabling environment.** International organizations, including bilateral and multilateral donors, foundations, private companies, and non-governmental organizations that made financial, programmatic and policy pledges, including as part of FP2020, must fulfill these commitments.
 - **Design of national family planning program.** It is essential that country governments develop national FP programs – policies, strategic plans (each country with a single strong one), as well as activities, and financial and other resources to support programs – that meet several criteria. These criteria include: (1) policies and strategies that address priority FP issues, (2) interventions that support these objectives, (3) adequate financial, human, and other resources to achieve the program's objectives, and (4) the presence of safeguards in national programs to uphold FP2020's principles of respect for women's rights to voluntary and quality FP as well as choice.
 - **Implementation of national family planning program.** National FP programs should be implemented faithfully at the national, subnational, and local levels. In practice, effective implementation requires that: (1) the funds, supplies and commodities allocated by the central government be released and reach designated facilities and beneficiaries in a timely manner, (2) quality human resources be available where they are needed, and (3) national policies be effectively communicated and implemented by government officials and service providers, from the national ministry all the way to the outreach worker in the most remote areas.
- **Quality, appropriateness and respect for women's rights.** Finally, it is essential that the provision of FP information, services, and commodities is high quality, respectful of women's rights, and appropriate to their particular needs and preferences. This means that information and education campaigns, facilities, supplies, and commodities are of acceptable quality, and that providers respect clients' needs and preferences.

Each of these conditions is, of course, susceptible to breakdowns and thus has the potential to prevent FP2020 and other FP efforts from reaching their ultimate goal. Our consultations and in-depth study of four FP2020 countries have provided evidence and examples of each of these breakdowns.

FP program breakdowns

- **Global enabling environment.** At this early stage, it is difficult to determine whether those who made pledges as part of FP2020 will realize them. However, prior experience suggests that commitments made as part of international partnerships like FP2020 do not always translate into actual policy and funding changes. In some cases, those who make commitments do not intend to fulfill them; while in others, they fail to deliver due to political pressures or financial constraints. In other instances, pledges made at such events do not represent new policy but rather a re-formulation of existing policy. Even when committed donor funds are actually spent, they may not contribute to commensurate progress if they are not directed to the countries or program areas that need them most. FP2020 is particularly exposed to this risk, given that it is not supported by a central funding mechanism that would coordinate and harmonize funding.
- **Design of the national family planning program.** There are three main types of breakdowns that can occur in the design of national family planning programs. The most basic failure is the absence of a comprehensive, costed program. Second, a program can suffer from fundamental design problems, where it does not adequately address actual obstacles to family planning uptake. Finally, a national FP program that tackles appropriate obstacles can fail if it is under-funded or otherwise under-resourced. FP plans in the countries we visited were criticized for inadequately addressing

some of the most pressing obstacles to increased contraceptive prevalence rates (CPR), for example the lack of appropriate services for youth, and for being under-funded particularly for M&A, human resources, and logistics and other resources needed for demand creation activities and increased provision of FP services.

- **Implementation of the national family planning program.** Implementation issues can take a number of forms. Resources allocated for FP at the national level may not be approved or spent at every step of the funding or procurement chain, and funding, staff, supplies, and commodities may never reach facilities or beneficiaries. In India, our interviews revealed that human resources approved by the national programs do not reach facilities because health workers are unwilling to take posts in certain locations and/or at the salaries offered. In addition, significant funds provided to state governments as part of the National Rural Health Mission are returned to the central government every year due to limited absorption capacity. As a result, increases in FP funds are unlikely to have a commensurate impact on the contraceptive prevalence rate.

National policies and interventions can also fail to “trickle down” through layers of government if officials or service providers have insufficient information about the program, face resource constraints, disagree with the program’s mandate or approach, or face disincentives to implementing the program faithfully. This dilution can lead to a whole range of issues, including inadequate oversight, poor provider performance, absenteeism, unofficial fees, discrimination and other obstacles to access. In Senegal, health workers are reportedly reluctant to provide long-acting methods, even though they are a focus of the national plan. In India, while the FP re-launch emphasizes birth spacing rather than limiting, financial incentives mean that officials and providers continue to promote (and clients to choose) sterilization over reversible methods. In Indonesia, the decentralized nature of the procurement and commodity delivery system leads to leakages and stock-outs. In all of these cases, and many others, key strategy components are not operationalized; as a result, the FP programs are diluted and unlikely to meet their stated objectives.

- **Quality, appropriateness and respect for women’s rights.** A well designed and implemented national FP strategy will not be effective if information, services, and commodities are not high-quality and respectful of women’s rights, specific needs and preferences. This aspect of FP programs is particularly important because it affects the nature and quality of the interaction between health workers and potential users, and thus individuals’ experiences and decisions about whether to seek and continue family planning services. Breakdowns in this condition are of three main types:

- **Inadequate counseling.** In the countries we visited, we heard that service providers often fail to provide comprehensive counseling and accurate information about method choices, correct use, and potential side effects. These failures produce misinformation, fear, contraceptive misuse and discontinuation.
- **Inappropriate service provision.** Quality of care also involves the provision of services that are appropriate to clients’ particular needs and preferences. Providers do not necessarily understand or respect local needs and preferences. This can translate into interactions that are considered disrespectful, facilities open at inconvenient hours, or a lack of confidentiality, among many other issues. In Senegal, youth under-utilize FP services because services are not “youth-friendly” and because providers are known to share information about their patients with community members. Similarly, one in three women reports being mistreated by health workers when they go for family planning services, likely a significant disincentive to utilization.
- **Lack of respect for rights.** Finally, respect for women’s rights to voluntary and non-discriminatory FP services is known to fall short of national and international standards in many places, particularly high-burden countries. Though much progress has been made, India is still infamous for cases of coercive female sterilization and lack of informed consent.

The role of monitoring and accountability in addressing these breakdowns

As described below, robust monitoring and accountability can help to identify, mitigate, and redress the breakdowns presented above.

- **Monitoring** – the collection and analysis of data for the identification of breakdowns – can be led both by “implementers” themselves (such as donors, national governments, and implementing organizations) and by local, national, and international independent, non-governmental actors. While implementers have incentives to collect relevant data, good practice calls for independent oversight and input by non-governmental actors and by the ultimate beneficiaries themselves to effectively complement government-led monitoring and ensure that the scope and quality of monitoring is adequate.

- **Accountability** – the use of evidence to ensure that those responsible for the breakdowns are held to account and take action to remedy them – can be realized through a number of channels. In some cases, the implementing organization itself enforces accountability by utilizing evidence to inform its program design, implementation and/or service delivery. In other cases, particularly where there is inadequate information or resistance to change, accountability may require that independent actors translate data, facilitate joint problem resolution, and influence or pressure implementers and decision-makers.

Government-led M&A

As the lead FP program designer and implementer, the government is the main “internal” monitoring and accountability agent. With support from technical and financial partners, government agencies collect a range of data to inform the design, review, and adaptation of the FP program. The quantity and quality of the data collected, as well as how effectively they are used for change, varies widely based on the government’s commitment to evidence-based decisions and its political, financial, technical, and human resources. Demographic and health data are the most widely and regularly collected as part of the Demographic and Health Survey (DHS) and other household surveys. Governments also collect and utilize other data including FP service statistics, budget information, and employment data. Data around rights and the quality and appropriateness of services are typically the least available.

These data are crucial to understanding how the FP program is performing and to improving program design, implementation, and service delivery. However, in practice, data is not always reliable or used for monitoring and accountability. Relevant individuals do not know how to translate the evidence into policy and program changes, or they face resistance and pressure from other stakeholders, including opinion leaders, ministries, parliament, subnational officials, and providers.

Social accountability: civil society-led M&A

Civil society-led M&A, or social accountability (SAC), is an essential complement to formal M&A. Social accountability’s distinctive characteristic is its **focus on promoting citizens’ rights and voice, and ensuring that government is responsive to citizen needs, and that government policy, spending, and services are high-quality, equitable, efficient, and effective.** Experience in

other sectors has demonstrated social accountability’s potential impact on government programs, spending, and services, as well as on citizens’ empowerment and human development. As a result of social accountability initiatives, allocations for priority sub-sectors increase, leakages in funds and resources reduce, and the quality and appropriateness of programs and services improve. At the facility level, stock-outs of key supplies and medicines decrease, and provider performance and the relationship between providers and clients improve. At the individual level, citizens develop a better understanding of their rights and entitlements, their utilization and monitoring of services increases, and they are more likely to provide feedback on services.

In practice, civil society groups can strengthen M&A by:

- Collecting additional data and conducting independent analysis to verify or question government findings where there are doubts about their reliability;
- Bridging evidence gaps in formal M&A by collecting and analyzing complementary data where government data are inadequate to understanding breakdowns;
- Monitoring aspects of programs often neglected by government M&A systems, particularly around equity, quality of care, and respect for women’s rights;
- Obtaining and leveraging citizen input and feedback on the quality and appropriateness of services, as well as on any continued barriers to access and uptake;
- Facilitating citizen participation and empowerment to strengthen knowledge about rights and available services, as well as citizen oversight;
- Addressing government obstacles and disincentives to data use by supporting or pressuring the government and service providers to adopt changes to policies, plans, and services based on the evidence produced by monitoring.

Obstacles and constraints to social accountability

While social accountability has a potential role in enhancing the effectiveness of FP programs and services, the quality and impact of civil society-led M&A and social accountability work is highly dependent on the strength, experience, and connectedness of non-governmental actors, as well as on government transparency and responsiveness to citizen and civil society inputs and demands. Our experience and country visits made clear that, though there are promising opportunities for civil society-led M&A, CSOs, particularly those in high-burden countries, are generally not equipped to leverage the full potential of SAC. These CSOs face four areas of weakness:

- **Information about national commitments, policies, and programs.** In the countries we visited, we found that a set of CSOs working at the national level knew of their government's FP commitments and plans, though most groups operating at the subnational and community-levels were largely unaware of new financial and programmatic commitments made by their governments and donors.
- **Technical skills and connectedness.** The strength of civil society varies extensively across high-burden countries. Widely considered the birthplace of social accountability, India has an experienced and influential civil society; on the other side of the spectrum, Senegal's civil society is young and developing as opportunities for engagement expand. However, gaps in technical skills and intra-civil society collaborations exist across the board. In India, where monitoring of women's FP rights is strong and community monitoring is growing, community monitoring does not yet focus on family planning. Similarly, Indonesia has a robust network of civil society organizations, yet few concentrate on family planning. In Uganda, there is extensive work around national level FP tracking and advocacy, but very limited effort to monitor women's FP rights and needs. Groups working on different dimensions of FP, SAc, and advocacy would benefit greatly from collaborating more closely.

- **Context analysis and evidence.** A major but under-appreciated obstacle is civil society's limited knowledge of evidence around effective SAc and the importance of basing intervention design on a careful analysis of context factors.² R4D's work supporting SAc³ and our country visits made clear that where SAc is taking place, it is too often implemented without consideration for existing evidence and the complex context factors that are key determinants of impact.
- **Relationship with government.** Finally, civil society groups, particularly those new to SAc, do not always know how to engage with service providers and government most effectively. Groups do not know the appropriate individuals to target or what engagement strategy and approach will be most effective in ensuring that their messages are heard and acted upon.

Programs designed to help civil society actors overcome these constraints and carry out effective social accountability interventions around FP can bolster M&A, complement existing efforts, and help ensure that FP goals are reached.

² See, among others: http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1193949504055/Context_and_SAcc_RESOURCE_PAPER.pdf

³ As part of the Transparency and Accountability Program (TAP) and the Building Bridges for Better Spending in Southeast Asia Program (BB), among others.

III. Landscape of Existing Efforts to Strengthen M&A around Family Planning

Recognizing the importance of robust M&A, a number of stakeholders are supporting projects to strengthen M&A around FP2020 and FP more broadly. In what follows, we describe several initiatives, with a focus on two projects that are central to FP2020 monitoring and accountability: Track20 and PMA2020. Our review shows that while these initiatives are advancing monitoring and accountability around family planning, civil society-led M&A remains an area of underinvestment. This is particularly true around program implementation, respect for women's rights, and the quality and appropriateness of services.

Strengthening M&A around donor financial commitments

A number of initiatives have been working to track donor expenditures for family planning. As part of its commitment to FP2020, the Kaiser Family Foundation (KFF) has agreed to monitor the FP disbursements of all donor governments. KFF's findings are published in the annual FP2020 Progress Report. The Netherlands Inter-Disciplinary Demographic Institute (NIDI)'s Resource Flows (RF) project monitors donors' and developing countries' progress in implementing the financial resource targets for population and AIDS programs agreed in 1994 and 2001, respectively.⁴ The World Health Organization's (WHO) National Health Accounts and System of Health Accounts generate data on country-level health spending, including for reproductive health and family planning. The WHO's system looks at spending by the public sector, non-governmental organizations, the private sector, and households. The Futures Institute convened an expert consultation to advance the measurement of country-level family planning expenditures by combining information from, and aligning the methodologies among, groups including KFF, NIDI, the Futures Group, and the WHO.

Several organizations use expenditure data to hold governments accountable and advocate for increased funding for FP, particularly those that focus on European donor governments such as the NGO consortium Countdown 2015 Europe. To encourage greater use of data for accountability, the FP2020 Task Team works closely with Track20 and other partners to make data accessible through the FP2020 website.⁵

Strengthening national and government M&A efforts

- **PMA2020**, a project led by the Bill & Melinda Gates Institute for Population and Reproductive Health in collaboration with national partners in ten countries in Africa and Asia, is designing and supporting the implementation of a rapid data collection scheme that will generate household and facility-level statistics to produce annual Modern Contraceptive Prevalence Rates (MCPR) and other key FP estimates that will be used for monitoring and evaluation purposes. Many national governments see the value in collecting this additional data and are reportedly requesting PMA2020 to expand their sample size (to obtain subnational estimates) as well as the scope of the data collected.
- **Track20**, a project implemented by the Futures Institute and funded by the Bill & Melinda Gates Foundation, supports national governments' capacity to monitor progress by hiring, training and managing M&E officers in Ministries of Health, Offices of Population, or universities in priority countries. This support is designed to improve data collection and reporting and to help ensure that results reporting is organized and implemented according to internationally recognized standards of data quality.

⁴ <http://www.resourceflows.org/>

⁵ USAID's Health Policy Project (HPP) is working with NIDI to set up FP-specific and detailed results using the existing RF system. HPP has entered into a sub-agreement with NIDI and the Nairobi-based African Population and Health Research Center (APHRC) to test the methodology and produce results in two countries: Ethiopia and Tanzania. Data collectors were trained in February and data collection initiated in March 2014; data are expected in July 2014. This pilot is being conducted so that UNFPA can learn from the experience and extend the FP activity into all of the Resource Flow countries in 2015.

Strengthening civil society-led M&A

A number of initiatives related to FP2020 are designed to create opportunities for civil society actors to participate in monitoring and accountability and to develop their capacity to lead effective M&A, or social accountability.

- The largest scale and most promising initiative is the **UK Department for International Development's (DFID) program to strengthen monitoring and accountability for FP2020 through a civil society consortium** that will "support national and local accountability mechanisms and accelerate the full implementation of countries' commitments." This program will focus on independent monitoring of government progress and "ensure that programming respects and promotes the human rights of all women and girls." The details of this program will be made public in mid-2014.⁶

Track20 and PMA2020 both have components designed to create opportunities for civil society engagement.

- **Track20**, as part of its M&E capacity-building at the country level, will conduct "National Consensus Workshops" in each of its focus countries at which data will be shared and discussed with relevant stakeholders, including non-governmental organizations.
- **PMA2020** surveys incorporate a number of questions that measure service access, quality, and choice, with plans for a "community feedback" component. Data collected in each community will be provided back to that community, as well as at higher levels of aggregation, in the hopes of fostering "healthy competition," accountability, and improved FP services.
- While these efforts to create opportunities for social accountability are important, they will need to be complemented by other efforts. PMA2020's community feedback approach is unlikely to succeed without CSO initiatives to inform, engage, and train community members and to highlight the importance of M&A in family planning. Similarly, given non-state actors' uneven experience and skills regarding SAc, training and supporting CSOs will be essential for their contribution to Track20 Consensus Workshops to be effective.

Additionally, there are two multi-stakeholder initiatives that are aimed at building the advocacy capacity of CSOs to ensure that country policies, FP plans, and funding are adequate:

- **Advance Family Planning (AFP)** advocates for stronger FP funding, policy, and programs and builds CSO and policymaker accountability capacity. One of AFP's main objectives is to mobilize and sustain effective family planning advocacy at the regional, national, and subnational level; the program does not focus explicitly on the implementation of FP programs. To date, they have successfully advocated for increased funding for family planning (including increasing government allocation for FP in Indonesia, Nigeria, Tanzania, and Uganda) and eliminated policy barriers (for example by achieving policy changes that allow community health workers to provide injectables in Kenya and Uganda).⁷ They have developed several tools to tie advocacy efforts and achievements to longer-term goals, including FP2020's.
- The **Partners in Population and Development Africa Regional Office (PPD-ARO)** and other regional intergovernmental organizations work with parliamentarians and civil society organizations to monitor government action and ensure that FP2020 pledges are delivered. In Uganda, PPD-ARO is coordinating a parliamentary effort to hold President Museveni's government accountable for its FP2020 commitments.

As the preceding section makes clear, much work is being undertaken to strengthen monitoring and accountability around FP2020. Track20 and PMA2020 will significantly enhance data availability, frequency, quality, and use by government. In addition, both initiatives will create opportunities for citizens and civil society groups to engage at the community and national levels, and DFID's CSO-led accountability program is expected to support civil society capability to lead M&A interventions.

Strengthening social accountability around FP2020: untapped opportunities

Comprehensive support for civil society-led monitoring and accountability efforts is needed, especially around (1) service quality and respect for women's rights, needs, and preferences, and (2) implementation of national FP programs. Experience in other sectors and sub-sectors demonstrates that independent actors

⁶ <https://supplierportal.dfid.gov.uk/selfservice/pages/secure/supplier/myTenders/viewMyFullTender.cmd?dGVuZGVySWQ9NTkyMjQzNTA4>

⁷ http://advancefamilyplanning.org/sites/default/files/resources/brochure_final.pdf

can play a significant M&A role: informing citizens and amplifying their voices; monitoring policy and program implementation, client rights, and service quality and appropriateness; and advocating for improvements when and where issues are found. Below are examples of social accountability initiatives that have successfully supported and augmented official M&A.

Resource Tracking. Civil society organizations track financial and other resources (including commodities) from the national level to points of service to identify delays or leakages and to ensure that resources – including funds, supplies, commodities, and personnel – are available when and where they are needed. Experience from the administration of public expenditure tracking surveys and advocacy campaign have demonstrated their ability to significantly reduce delays and leakages of financial and other resources. The public expenditure tracking survey conducted in Uganda in 1996, for example, famously reduced leakages in education capitation grants from 87% to 20% between 1991-95 and 1999-2000.⁸ A number of organizations have begun tracking FP spending, particularly for contraceptives.⁹

However, these exercises remain limited, largely focused on contraceptive budget lines at the national level. More comprehensive tracking of financial and other resources for FP would significantly enhance the FP commodities, funds, and other resources available in health centers.

Monitoring service delivery. CSOs monitor the quality of services through direct observation and through exit and household interviews. This monitoring can assess infrastructure, supplies and commodities, as well as human resources, particularly staff attendance and behavior. Similarly, CSOs monitor the extent to which government policies are implemented and client rights respected. For family planning, this includes determining and documenting whether women's rights are respected, adequate counseling provided, and non-discrimination practices upheld. Organizations in India, including the Centre for Health and Social Justice, monitor FP services and document and report instances of rights violation. These advocacy efforts have pressured the government to issue a series of guidelines for the provision of female sterilization that is high-quality and respectful of women's

rights. Similar monitoring and accountability efforts in other countries would help governments understand and rectify rights violations and other quality issues in the provision of FP services.

Empowering citizens and communities, improving communication, facilitating problem resolution.

Organizations working at the community level mobilize citizens and service providers to identify and share information about entitlements, priority needs, and constraints. These organizations then facilitate the adoption of practical solutions by spurring dialogue between stakeholders. One example is Rahuma, a Pakistani NGO that aims to ensure that youth are made aware of reproductive health policies and programs, and given a voice to express their views. This involves many channels, including bringing young Pakistanis to reproductive health stakeholder meetings and cultivating relationships with parliamentarians in order to redress reproductive health problems.¹⁰

CSOs also measure the appropriateness of service provision and user satisfaction through facility and household surveys as well as focus group discussions and help to spur service improvements, at the local level or above, through advocacy campaigns.

These efforts have improved service, satisfaction, and service uptake in India, where they were piloted by the Public Affairs Center,¹¹ as well as in other countries, including as part of the Transparency and Accountability Program. Apart from a pilot led by India's National Rural Health Mission, these community engagement approaches have not been widely adopted around family planning. Supporting such interventions around FP would enhance citizen understanding of FP entitlements and help overcome obstacles to uptake that can be addressed at the community level.

Operationalizing these and other social accountability initiatives around FP would significantly improve program implementation, service provision, and uptake. The section that follows presents options for building the capacity of civil society organizations to undertake this type of work.

⁸ http://siteresources.worldbank.org/INTEMPowerment/Resources/15109_PETS_Case_Study.pdf

⁹ These include the Health Rights Advocacy Group (HERAF) in Kenya and Pathfinder Tanzania as part of Population Action International's (PAI) RH Budget Watch, Health Promotion Tanzania (HDT), Reproductive Health Uganda (RHU) and other International Planned Parenthood Federation (IPPF) affiliates, Deutsche Stiftung Weltbevölkerung (DSW) in Kenya, Uganda and Tanzania as part of the Healthy Action budget studies.

¹⁰ <http://www.fpapak.org>

¹¹ <http://internationalbudget.org/wp-content/uploads/Public-Affairs-Centre-Develops-Citizen-Report-Cards-in-India.pdf>.

IV. Options for Strengthening M&A around Family Planning

Our review of existing monitoring and accountability initiatives in family planning in the previous sections reveals clear gaps and urgent needs. How should M&A capacity building programs (including DFID's) be designed and implemented to ensure that these gaps are filled?

We have used our analyses of both the bottlenecks in family planning and the evidence regarding effective civil society-led accountability efforts to develop a framework for identifying and designing results-oriented M&A efforts for family planning.

The process involves answering three sequential sets of questions:

1. What are the core family planning problems to be addressed? (What needs improving?)
2. What is the appropriate civil society-led accountability approach to these problems? (What actions are needed for M&A?)

3. What is the best way to provide support for civil society organizations seeking to design and implement these approaches? (What are the modalities of support for CS-led M&A?)

For each of these questions, we have identified several choices (see the matrix below). By combining these choices in logical chains, we have put together what we believe are three of the fundamental options for high fertility countries and external donors who might seek to support social accountability activities for family planning.

Regarding the first question, social accountability can be targeted by the main type of bottleneck that needs to be remedied. The central problems may revolve around: policy and program design and financing; program execution including flow of resources and service delivery; and the rights and satisfaction of family planning clients. These issues occur at the national, subnational, and/or facility and community level(s).

A Framework for Designing Family Planning M&A Options					
What needs improving?	FP issue or bottleneck				
	Policies, regulations, and budgets	Implementation of policy and regulations	Resource flows	Quality & respect for rights	User experience – appropriateness and satisfaction
	Focus level				
	National	Subnational	Facility	Community or household	
What actions are needed?	Social Accountability approach				
	Evidence-based advocacy	Resource tracking	Monitoring service provision	Empowerment	Community/provider engagement
What modalities of support?	Capacity building area				
	Policy and budget analysis	Data collection	Data analysis	Advocacy	Community engagement
	Capacity building model				
	Technical training and mentoring	Intra-country joint learning	Inter-country learning and mentoring		Joint implementation
	Documentation and learning component				
Support to experimentation, learning, and evaluation		Documentation and dissemination (Social Accountability Atlas)		Cross-country case studies and analyses	

The main approaches for FP social accountability range across expenditure and resource tracking, monitoring service provision (quantity, quality, and appropriateness), citizen and community empowerment, and advocacy.

Finally, in the third set of questions for option development, the appropriate focus and models for CSO capacity building may entail improving CSO's ability to conduct policy analysis, data collection and assessment, and advocacy and communications. This can be done within or across several countries where multiple CSOs are working to strengthen their family planning M&A by using a joint learning approach as well as through mentoring of nascent CSO efforts by more experienced organizations. Documenting innovations and sharing best practices are potentially key activities in generating new and relevant knowledge about social accountability for family planning, coupled with rigorous evaluations of country experiences.

Three Options. We sketch out three broad options below, using this three-tiered framework. These options are meant to be illustrative, not exhaustive. They highlight distinct areas of focus for CSO-led monitoring and accountability in family planning. Option 1 is oriented toward monitoring national FP plans, strategies, and budgets. Option 2 concentrates on monitoring program performance, looking at resource flows and service provision. Option 3 is centered at the facility and community level and involves equipping citizen organizations to conduct independent monitoring of service delivery and community engagement, with a special focus on quality and client rights and customer satisfaction.

Option 1 – Strengthening civil society's capacity to conduct analysis and advocacy on national FP policies and plans

In many high-burden countries, national governments do not have the resources or capacity to lead effective program design, M&A, and program adaptation at the national level and civil society could play a vibrant role in supporting and complementing public sector-led M&A by analyzing existing FP data and leveraging them for evidence-based advocacy.

Option 1 thus focuses on building CS's capacity to monitor countries' FP program design and underlying policies and to engage with the government and donors in constructive criticism and the search for solutions.

Such an option would be built upon independent CSO assessments of national FP plans, laws and regulations, as well as of existing demographic and health data collected by the government and its partners. The mix of linked choices within our design framework at the different tiers is highlighted in the shaded squares in the chart on the next page.

Description of Activities

While most countries would benefit from this option, the best candidates would be countries where the most important FP breakdowns are issues around the design of the FP plan that can be rectified at the national level, and where civil society's social accountability experience and capacity to engage are most limited. Carrying out this option in multiple countries could create efficiencies, given that the option focuses on building a narrow set of similar skills among a particular type of CSO.

Under this option, expert organizations would assist in building CSOs' capacity to lead independent analyses of existing family planning data and programs, develop recommendations to improve program design, and advocate for their adoption. The CSOs would analyze relevant data from the national health information systems, national health and demographic surveys, FP budgets, and other policy documents. The focus would be on using existing data, rather than generating new data. Based on their analysis, the CSOs would identify bottlenecks (for example, insufficient funding, regulations impeding uptake of diverse FP methods, lack of national coordination of implementing partners), propose solutions, and advocate for these.

Under Option 1, CSO capacity building would focus on developing data and policy analysis skills to identify discrepancies between FP needs and planned programs, and other policy design and implementation issues, as well as national-level advocacy leveraging analysis and evidence-based recommendations. Such capacity building could be provided by a consortium of organizations with strong knowledge of policy analysis techniques, demographic and health data, and accountability techniques through direct technical support and mentoring, as well as inter-country joint learning. Given this option's narrow focus on analysis and advocacy at the national level, peer sharing and learning between national CSOs in different participant countries would be particularly valuable. Support could also be provided to CSOs to undertake cross-country peer learning, enabling groups to share their experiences and lessons learned. Case studies of country experiences and successes could be developed to expand the existing documentation of CSOs' role in national-level monitoring and accountability around FP.

What needs improving?	FP issue or bottleneck				
	Policies, regulations, and budgets	Implementation of policy and regulations	Resource flows	Quality & respect for rights	User experience – appropriateness and satisfaction
	Focus level				
	National	Subnational	Facility	Community or household	
What actions are needed?	Social Accountability approach				
	Evidence-based advocacy	Resource tracking	Monitoring service provision	Empowerment	Community/provider engagement
What modalities of support?	Capacity building area				
	Policy and budget analysis	Data collection	Data analysis	Advocacy	Community engagement
	Capacity building model				
	Technical training and mentoring	Intra-country joint learning	Inter-country learning and mentoring		Joint implementation
	Documentation and learning component				
	Support to experimentation, learning, and evaluation		Documentation and dissemination (Social Accountability Atlas)		Cross-country case studies and analyses

Case Study: Senegal

A review of countries studied for this paper suggests that Senegal would be a good candidate for Option 1. With support from the Ouagadougou Partnership donors, the country developed a strong FP country plan through a participatory process. However, there are issues around both the level of resources allocated to the plan and its operationalization at the regional level. The country's relatively young civil society does not have extensive experience leading SAc, but has shown interest in engaging with the government on good governance and FP issues. In addition, recognizing its limited human and financial resources, members of the government, including the head of the Directorate for Reproductive Health and the Minister of Health, are open to independent organizations supplementing the government's M&A efforts.

The first step in Senegal would be to identify CSOs that are well-positioned to engage with those designing, implementing, and assessing the FP program at the national level. These organizations might include FP research organizations and good governance, accountability, and advocacy organizations working on issues such as equity, youth, quality or rights. Once these organizations are selected and their needs assessed, a technical support and engagement plan would be developed. In Senegal, much of the TA around accessing and analyzing data and effective advocacy would be provided by an external organization. Organizations would also benefit from more tailored support and mentoring around their particular advocacy issue.

We have also learned that there is a disconnect between national policies and plans and subnational levels of government in Senegal. Individuals within the government and civil society groups suggested that "observatoires" (observatories) that bring together state and non-state actors be established in each region to ensure that all actors are aware of and fulfilling their FP responsibilities.

Supporting this option in multiple Francophone West African countries could produce efficiencies, given Senegal's close ties to other Francophone countries, both historically and as part of the Ouagadougou Partnership. Supporting this option in 5-10 countries in West Africa and beyond would promote joint learning and sharing of lessons, and allow for regional collaborations and advocacy around FP.

Potential Impact

Experience from other sectors demonstrates the impact of CSOs leading independent data analysis of plans and policies and related advocacy at the national level. In Mexico, for example, an NGO coalition’s analysis of official data on agricultural subsidies revealed the very inequitable distribution of the subsidies. The subsequent advocacy campaign compelled the government to reform their subsidy system to ensure that it was benefitting those that need it most.¹² In Uganda, the Coalition for Health Promotion and Social Development (HEPS) utilized data about stock-outs of essential medicines to advocate for a new national procurement system for medicines, leading to reforms of the system and major improvements in the availability of medicines at health facilities across the country.

Similar initiatives, for example led by Senegalese and other Francophone West African countries, and leveraging existing FP plans and policies and government and PMA2020 data, could help call attention to likely funding shortfalls, questionable target setting, legal barriers, and other weaknesses in current FP strategies. A focus on equity of service provision and availability of commodities in national policies and plans could also significantly improve government performance on youth uptake of FP

and women’s access to expanded choice of commodities. More details on how this option could be applied in Francophone West Africa are given in the box on the previous page.

Option 2 – Strengthening civil society data collection and advocacy for accountability on FP program implementation

This second option would focus on strengthening civil society actors’ capacity to identify and remedy issues in the implementation of FP programs – insufficient disbursements, interruption in funding flows to providers, breakdowns in the FP commodity supply chain, failure to train and supervise frontline FP workers, etc. With appropriate technical support, CSOs can monitor such implementation breakdowns, develop creative solutions, and work to have these adopted by government and service providers. This option would entail a distinct mix of choices at the different tiers of our design framework (see below).

What needs improving?	FP issue or bottleneck				
	Policies, regulations, and budgets	Implementation of policy and regulations	Resource flows	Quality & respect for rights	User experience – appropriateness and satisfaction
	Focus level				
	National	Subnational	Facility	Community or household	
What actions are needed?	Social Accountability approach				
	Evidence-based advocacy	Resource tracking	Monitoring service provision	Empowerment	Community/provider engagement
What modalities of support?	Capacity building area				
	Policy and budget analysis	Data collection	Data analysis	Advocacy	Community engagement
	Capacity building model				
	Technical training and mentoring	Intra-country joint learning	Inter-country learning and mentoring		Joint implementation
	Documentation and learning component				
	Support to experimentation, learning, and evaluation		Documentation and dissemination (Social Accountability Atlas)		Cross-country case studies and analyses

¹² <http://internationalbudget.org/publications/evidence-for-change-the-case-of-subsidios-al-campo-in-mexico/>

Description of Activities

In this option, the key monitoring activities would concentrate on the level of the system where the most important breakdowns are occurring in the implementation of the FP program. Data that can be used to monitor program implementation are typically less available than information about program design and may have to be collected at subnational and facility levels. Evidence suggests that advocacy efforts are most successful when they begin at the level at which the breakdown occurs. If contraceptives are not reaching clinics because they are being held up at the district health offices, for example, monitoring and related advocacy will be most effective if initiated at the district level. However, in some cases, advocacy needs to go up to higher levels, for example to pressure regional or national officials to find a solution.

In Option 2, the social accountability approaches utilized to identify breakdowns in the implementation would focus on resource tracking and monitoring of service provision. Whereas Option 1 involves reviewing national resource allocation and disbursement data, in the second option such tracking would entail collecting data about allocations, spending, and the flow of resources at every point in the chain, in order to uncover and rectify delays and leakages. Monitoring services at the point of provision would help to pinpoint quality of care issues, rights violations, levying of unofficial fees, etc. This could be done through a combination of facility and household surveys, client exit interviews, and direct observation.

While in a number of countries civil society has experience tracking resources and monitoring services in some sectors, such work is still nascent in the area of family planning. In addition, ongoing resource tracking tends to focus on the national level, rather than tracking resources through levels of government and down to facilities. Furthermore, such monitoring is not always utilized effectively for advocacy.

To address these shortfalls under Option 2, capacity building would focus on developing CSO skills for data collection, analysis and interpretation at subnational and facility levels, and evidence-based advocacy.

Such capacity building would utilize several approaches including direct technical support and intra-country learning. In some countries civil society organizations outside of FP (say, in education or agriculture) may be leading efforts to monitor program implementation through resource tracking and service monitoring. In this case, such well-equipped CSOs could help provide

M&A training to the groups focusing on family planning. To complement and reinforce this, peer to peer learning could be implemented across several countries. A possible add-on to this option would involve experimenting with, evaluating, and documenting different strategies for resource tracking and service monitoring. Given the limited evidence base that exists for social accountability around family planning program implementation, documenting these cases and their results on an online platform would significantly contribute to knowledge in this area.

Potential Impact

Other countries' and sectors' experience with resource tracking, service delivery monitoring, and evidence-based advocacy have demonstrated the impact of this approach on the quantity, quality, equity, and effectiveness of public resources and services:

- The 1996 public expenditure tracking survey of the capitation grant in Uganda famously exposed colossal leakages of education funds and the information campaign that followed drastically increased the proportion of funds reaching intended recipients.¹³
- As part of the Transparency and Accountability Program (TAP), the Ghana Center for Democratic Development (CDD) tracked public school teachers' attendance and revealed widespread absenteeism and some of its causes. Informed by the organization's advocacy efforts, the government adapted its practices around teacher training and salaries, significantly reducing absenteeism.¹⁴
- The World Bank's Service Delivery Indicators (SDI) project is currently surveying the quality of service provision in education and primary health care in five African countries, using metrics for service availability, provider competence, and quality. In the first countries to take on the SDI project, Uganda and Kenya, the ministries of health and education have been motivated to take remedial actions after SDI published the poor results in certain dimensions of basic education and outpatient health care. Family planning indicators could possibly be added to the metrics currently being collected under SDI or collected through a parallel project effort.¹⁵

Such monitoring and accountability efforts around the FP program, for example tracking spending down to the facility level and measuring service quality, could have a major effect on national program performance, if coupled with active dissemination of results and dialogue with policy makers and funders. The example of how Option 2 could be applied to Uganda is explored in the box on the next page.

¹³ http://siteresources.worldbank.org/INTEMPowerment/Resources/15109_PETS_Case_Study.pdf.

¹⁴ <http://www.idea.int/resources/analysis/loader.cfm?csmodule=security/getfile&pageid=52015>, page 7.

¹⁵ <http://www.sdindicators.org/uncategorized/education-and-health-services-in-uganda-data-for-results-and-accountability-english.html> and http://www-wds.worldbank.org/external/default/WDSContentServer/WDS/IB/2013/07/25/000442464_20130725101359/Rendered/PDF/794420REVISED00untryReportOwAuthors.pdfv

Case Study: Uganda

While most high-burden countries would benefit from enhanced civil society monitoring and accountability around the implementation of the national FP program, Uganda would be a particularly good candidate for Option 2 given the relative strength of its civil society and key government officials' openness to independent oversight and input into program design and review. Uganda does not have a comprehensive FP plan, but the country's civil society is strong and collaborates with high-level officials in the Ministry of Health and Parliament, providing evidence and advocating for appropriate interventions and funding.

National and subnational CSOs could build on these skills and experiences and monitor the operationalization of the president's FP commitments, which include new funding for contraceptives and promises to reduce unmet need. Our interviews suggest that inadequate resources, insufficient method mix, and low quality of service provision are significant obstacles to enhanced FP uptake; all of these are suited for tracking and monitoring by CSOs in the country. In addition, CSOs could collect information about the existing FP program and build evidence about breakdowns and barriers to increased uptake of family planning.

Civil society groups are currently tracking the president's financial commitments for commodities to ensure that the funds are allocated and disbursed. While this work is important, it needs to be complemented by tracking of other resources that are essential to the delivery of FP (logistics, supplies, human resources, etc.).

Beyond resource tracking, groups could monitor service provision to determine the quality of services by assessing staff behavior and performance, counseling, choice, and respect for women's rights. Civil society organizations could leverage this evidence to call attention to issues limiting the supply and uptake of FP services and to work with the government to redress these issues. If the central government is not disbursing sufficient funds for human resources, engagement would take place at the national level, but if state and district officials are not allocating enough of their funds toward FP, CSOs would engage with them, rather than the national government.

Such a SAc intervention in Uganda would be designed and implemented by a coalition of organizations working in distinct spheres. Family planning and social accountability organizations are experienced in Uganda, but they do not typically collaborate. Networking these organizations and facilitating peer learning and joint implementation would leverage and expand their combined expertise. Additional capacity building could be provided through direct technical assistance, mentoring, and, where relevant, inter-country joint learning.

Monitoring using SMS and other mobile technologies could potentially be used to rapidly collect information on contraceptive stock-outs, FP worker absenteeism, and other problems at the facility level.

Option 3 – Building CSO capacity for citizen engagement and empowerment for family planning rights and client satisfaction

The ultimate goal of many social accountability efforts is to ensure that citizens themselves are empowered and able to monitor problems in their communities and advocate for change with the support of CSOs and other allies. Engaging communities in M&A is challenging, but examples from other sectors highlight the potential of this approach and lessons that can be applied to the FP sector.

The third M&A option is thus designed to build civil society actors' capacity to engage citizens around family planning monitoring and accountability and to resolve issues around rights, quality, and the appropriateness of FP service delivery. To design and launch this option, yet another combination of choices from our three-tiered framework would need to be brought together (see next page).

Description of Activities

In this option, the key activities would take place at the facility and community levels. The main issues to be addressed would revolve around poor quality and inappropriate family planning services and failure to uphold women's rights (e.g., contraceptive choice, informed consent, confidentiality, non-discrimination, etc.). In practice, these issues arise during the interaction between clients and health workers at the point of service and in the community.

Under this option, the key actions would entail citizen empowerment and engagement and community dialogue and problem resolution. While CSOs can play a critical role in M&A at the local level, regular monitoring and advocacy by community members can be especially powerful. Emphasis would therefore be placed on supporting existing community leaders and mechanisms (e.g., women’s self-help groups), backed by CSOs, to address shortcomings in FP services.

The capacity building model for citizen empowerment would be different from the models outlined for the two previous options. It would feature enhancing CSOs’ ability to foster citizen and community action, including through the provision of information about citizens’ FP rights and about channels to report and remedy issues. Capacity building for data collection, analysis, and advocacy would focus on leading focus group discussions and monitoring of issues like absenteeism, reviewing prominent problems and potential root causes, and advocacy to improve dialogue between providers and outreach workers at the local level.

The organizational structure for this option would be more complex than for the previous two M&A options because it would be implemented by a coalition of civil society partners working at national and community levels

rather than by individual CSOs. A mix of direct technical support and mentoring as well as training of trainers and intra-country joint learning would be required. Lead CSOs could also benefit from inter-country joint learning. For this option, experimentation with different approaches in different regions and evaluating and documenting the implementation and impact of these different approaches on an information and networking platform would enhance the effectiveness of the intervention in a given country, as well as in others, through peer-to-peer learning.

Potential Impact

Experience in India and other countries has demonstrated the impact of informing and engaging citizens around quality, rights, and satisfaction, facilitating dialogue between community and service providers, and leading evidence-based advocacy. Citizen report cards developed by India’s Public Affairs Center around services including water and sanitation, hospitals, and public transportation have engaged communities, government officials, and the media and produced service improvements and increases in user satisfaction.¹⁶ Specific gains reported by R4D’s Transparency and Accountability Program have included shorter waiting times in health centers, increased staff and budget allocation, reductions in informal and

What needs improving?	FP issue or bottleneck				
	Policies, regulations, and budgets	Implementation of policy and regulations	Resource flows	Quality & respect for rights	User experience – appropriateness and satisfaction
	Focus level				
	National	Subnational	Facility	Community or household	
What actions are needed?	Social Accountability approach				
	Evidence-based advocacy	Resource tracking	Monitoring service provision	Empowerment	Community/provider engagement
What modalities of support?	Capacity building area				
	Policy and budget analysis	Data collection	Data analysis	Advocacy	Community engagement
	Capacity building model				
	Technical training and mentoring	Intra-country joint learning	Inter-country learning and mentoring		Joint implementation
	Documentation and learning component				
	Support to experimentation, learning, and evaluation		Documentation and dissemination (Social Accountability Atlas)		Cross-country case studies and analyses

¹⁶ <http://internationalbudget.org/wp-content/uploads/Public-Affairs-Centre-Develops-Citizen-Report-Cards-in-India.pdf>

unofficial payments, and stronger government monitoring of health centers. Fine-tuning and expanding community engagement interventions around FP M&A could similarly enhance understanding of citizen needs, preferences,

and satisfaction, inform and empower citizens, and improve respect for women's rights, quality of care, appropriateness, and uptake. The power of this option is illustrated for India in the box below.

Case Study: India

India presents a strong case for development of the community-led M&A option for several reasons. First, the country's priority FP breakdowns occur at the point of service around respect for women's rights, quality of care, appropriateness, and choice. In addition, Indian civil society is experienced in developing and leading social accountability innovations. Government officials, particularly those leading the repositioning of FP, have been responsive to civil society's demands that citizens' M&A role be recognized and enhanced. In partnership with national and subnational civil society organizations, the National Rural Health Mission has, for example, been piloting community-based monitoring (CBM), an approach that involves communities in the planning, monitoring, and implementation of healthcare services.

India's FP2020 commitments include a shift from limiting and long-lasting methods to delaying and spacing methods with an expansion of method choice, focusing on IUDs. In addition, the pledge includes a commitment to greater equity and quality, with a new focus on more and better training of health workers. While the government's shift in strategy is important, there are widespread concerns that these commitments may not translate into adequate protection of women's rights and quality of FP services. At present, the government collects few data on quality of care, particularly for reversible methods. Citizen empowerment and independent data collection on respect for rights, quality of care, appropriateness and choice could therefore be particularly important in shedding light on these issues.

A first step in operationalizing community level M&A for family planning in India would be to conduct an in-depth review of India's experience with CBM and other community-centered M&A initiatives, compile emerging lessons, and select models with which to experiment further. Given the need to strengthen evidence around community M&A, particularly for FP, this option would initially test different approaches with subsequent adaptation and replication of those that demonstrate the most promising results. In addition, data about citizens' FP preferences and needs, levels of satisfaction, and barriers to uptake or continuation would be collected through focus group discussions or household surveys, and would inform the design and focus of M&A interventions.

The interventions selected would involve informing citizens of their FP entitlements, emphasizing rights, quality, and choice, improving complaint mechanisms, their utilization and effectiveness, and facilitating problem resolution at the community level through provider-community dialogue or at higher levels through either official channels or advocacy.

Relevant Indian CSOs working at different levels would be identified and appropriate training would be provided through a combination of direct technical support, peer learning, and joint implementation. As results emerge, lessons learned would be documented and shared, and interventions would be adapted and replicated in a wider set of Indian states.

V. Next Steps

The options outlined in the previous section present the building blocks for developing a cohesive and effective CS-led accountability system for family planning. Implemented in concert, these options would ensure that FP bottlenecks are identified and addressed, and that citizens are informed and empowered to voice their needs and shape FP programs and services.

This section outlines the steps required to operationalize these options. These steps include: 1) selection of the lead organizations; 2) country selection; 3) diagnosis of FP bottlenecks and identification of the relevant option or combination of options; 4) rapid assessment for the selection of partners at the country level; 5) design of a tailored intervention and development of a capacity building, documentation, and learning plan.

- 1. Selection of lead organizations.** The operationalization of the options requires some tailoring to countries' specific political and social context, priority FP bottlenecks, and civil society strength. Supporting the operationalization of these options in a group of countries should therefore be coordinated and led by a coalition of international organizations with substantial experience in both social accountability and family planning. The lead SAc organizations should have a deep understanding of context factors for SAc and experience designing and supporting CS-led accountability interventions, building the capacity of civil society groups, and fostering partnerships and joint learning, as it will be responsible for facilitating collaborations between different stakeholders both within and across countries. The lead FP organizations should have deep knowledge of programming for FP and common bottlenecks, as well as relationships with key FP stakeholders at the global and national levels.
- 2. Selection of countries.** As donors think about where to begin strengthening social accountability for FP, they should consider a number of factors including the commitment of the government to lower fertility and address unmet need, its openness to CSO engagement, the landscape and capabilities of existing CSOs, and basic demographic and family planning trends, such as fertility patterns and the size of unmet need for contraception.
- 3. Diagnosis of FP bottlenecks and identification of the relevant option or combination of options.** The next step is to diagnose the priority FP bottleneck(s) and select the corresponding option(s) or option combination. The options described in the preceding sections are presented as distinct approaches that

address different bottlenecks. In practice, however, countries often face multiple FP bottlenecks that occur at multiple levels. FP bottlenecks are rarely exclusively at the national level around policies, regulations and budgets, or exclusively around quality and respect for rights at the point of service delivery, for example. Rather, issues around program design are often accompanied by issues in implementation and resource flows, and/or around quality and respect for rights in service delivery. The most effective social accountability approach may therefore be a combination of the options presented above. Once the highest priority bottlenecks have been identified, the lead organizations can determine whether a single option is sufficient to address these breakdowns, or whether they require a combination of different elements of more than one option. The relevant social accountability approaches can then also be identified.

- 4. Rapid civil society assessment for partner selection at the country level.** A rapid assessment of civil society capacity should be carried out to inform the selection of partners at the country level, the intervention design, and the capacity building, documentation, and learning plan. The rapid assessment should examine a number of dimensions, including CSOs' understanding of the family planning and social accountability contexts; their experience collecting data, building evidence for advocacy, and advocating; and their community and citizen engagement skills.
 - **Identification of design partners.** Operationalizing the options will require the lead organizations to identify and work closely with country-level partners. We recommend that a group of experts and organizations be identified and engaged in the planning stages of the intervention, including the in-depth country scoping and the intervention design, the rapid assessment, the selection of implementation partners, and the development of the capacity building plan. These "design" partners might include national FP research organizations, think tanks and service providers, government officials, groups with M&A expertise, and donors.
 - **Identification of implementation partners.** In addition to these design partners, each of the options requires implementing partners – organizations and institutions that will carry out components of the intervention such as collecting and/or analyzing data, engaging citizens, developing recommendations based on data, advocating for their uptake, and providing technical support and mentorship, among others.

In addition to the types of organizations mentioned above, these partners may be community groups, civil society organizations focused on FP or M&A, service providers, subnational government champions, journalists, etc. The type of partners required will vary based on the option or options selected. For Option 1, for example, partners will mainly be national level actors with experience analyzing existing data and interacting with government official. In Option 2, partners will include organizations with experience collecting and analyzing data at subnational levels, while in Option 3, local and community-based organizations or (inter)national organizations that work with communities will serve as key partners.

5. Design of a tailored intervention and development of a capacity building, documentation, and learning plan.

Based on the diagnosis of the specific FP bottlenecks and the identification of civil society's strengths and areas for development, a tailored intervention and connected capacity building, documentation, and learning plan can be designed. The plan should include the specific areas of expertise and approaches to be developed as well as the modalities for support and the documentation and learning components.

Annex 1: Drawing Lessons from the Past: a Review of Global Monitoring and Accountability Systems

Introduction

FP2020 leaders and partners have taken laudable steps to ensure that the initiative has a strong monitoring and accountability system. The establishment of this system represents a step forward for the family planning field and one that could benefit from the lessons learned (including mistakes made) by similar efforts in areas such as education, HIV/AIDS, women and children's health, and hunger eradication. In an attempt to capture some of these lessons, we conducted a review of several of these global initiatives.¹⁸ This review reveals that certain design elements can enhance the likelihood of effective monitoring and accountability.

Methodology

There are numerous global tracking systems from which we can draw lessons. After an initial broad scan, we elected to focus on three: the Every Woman Every Child Initiative (EWEC), the Global Partnership for Education (GPE), and the UNAIDS Global Aids Response Progress Reporting (GARPR). These were chosen because they fulfill three key criteria. First, each represents a truly global initiative which involves multiple stakeholders, including donors, civil society, private sector, etc. Second, each monitoring system tracks a mix of financial and programmatic commitments. Third, each of these have (with varying levels of success) attempted to promote accountability by building specific measures at both the global and country levels into their architecture. While the three systems mentioned above fulfill these criteria most fully, we also draw from some of the other systems that were probed, namely the Hunger and Nutrition Commitment Index (HANCI) and the London Declaration on Neglected Tropical Diseases (NTD) scorecard.

In order to evaluate the strengths and weaknesses of these systems, we analyzed their performance across six dimensions:

- **Commitment and progress indicators.** Clear commitments and indicators are vital elements of effective monitoring and accountability systems. We evaluated the extent to which commitments and corresponding progress indicators are well-defined and whether such indicators are consistent across donors and country governments.
- **Global-country coordination.** Ideally, measures of progress should be aligned at both the country and the global level. While countries may have reasons to track some indicators that are not tracked on the global level, there should be a minimum set of indicators that match at the country and global levels. We looked at the degree to which global and country monitoring and accountability processes are harmonized in these systems.
- **Data collection and reporting.** Evaluations of progress towards commitments can only be substantiated if good data is regularly collected. For each system, we judged the quality of data collection and reporting on the grounds of transparency, accessibility, completeness, timeliness and accuracy.
- **Data performance and analysis.** All of the systems make some attempt to synthesize and analyze the data that has been collected. We examined the systems to see if these analyses are high-caliber and credible.
- **Global accountability.** Quality data analysis is useful insofar as it leads to donors and other actors being held to account for their pledges or commitments. Our review looked at how well the M&A system achieved such accountability, in part by seeing whether it led to positive changes in the initiative, at the global level.
- **Country accountability.** Similar to the previous dimension, we looked at the extent to which data and analysis were used to make actors accountable and produce practical changes at country level.

¹⁷ While the term "monitoring and accountability system" lacks a standard definition, here we are referring to an explicitly defined process for tracking the progress of commitments that includes methods for holding commitment makers responsible for their pledges.

¹⁸ Note that this document focuses primarily on the "internal" monitoring and accountability system – i.e. that M&A process built into the initiative's governance strategy – but we have noted the presence of more independent M&A efforts in some instances. This may be an area for further exploration in the next version of this note.

Table One: Key Features of Initiatives

Name of initiative	Lead or host organization	Time period	Purpose/Mission	Key targets	Number of country participants
Global Partnership for Education (GPE), formerly the Fast Track Initiative	World Bank	2002 -present	To galvanize and coordinate a global effort to deliver a quality education to all girls and boys, prioritizing the most vulnerable	Accelerate progress towards the Education for All (EFA) goals	55 countries
Every Woman Every Child (EWEC)	UN	2010 - 2015	Enhance financing, strengthen policy, and improve service on the ground for the most vulnerable women and children	To save the lives of 16 million women and children by 2015	74 have made commitments (16 high income, 58 low and middle income)
United Nations General Assembly Special Session for AIDS	UNAIDS, United Nations General Assembly	2001 – present (enhanced system starting in 2011)	To drive progress in preventing new infections and save the lives of those infected	10 major goals (related to reducing new HIV infections, sustaining those infected on AIDS therapy, improving the lives of orphans, lowering discrimination, etc.)	186 out of 193 Member States reported in 2012

The information for this section was collected through a literature review, interviews with experts, and the authors' own analyses. Among those consulted to date (interviews continue with key stakeholders) were: Henrik Axelsson, Partnership for Maternal, Newborn and Child Health (Every Woman Every Child); Jean-Marc Bernard, Global Partnership for Education (GPE); Nick Burnett, Results for Development Institute (GPE); Dolf te Linteo, Insitute for Development Studies (HANCII); Taavi Erkkola, UNAIDS (GARPR); Paul Isenman, formerly of OECD (GPE); Ben Leo, ONE Campaign; Jacob Scherr, National Resources Defense Council; John Stover, Futures Institute; Annika Grever (NTD Scorecard); and Ben Tiede, Global Health Strategies (NTD Scorecard). In addition, this note draws from our conversations with family planning experts and our own experience with governance and health projects.

The Initiatives and Systems

The section that follows is intended to spotlight the initiatives (summarized in the table below) in more depth. Each section contains a description of the global initiative and its attendant M&A system. Our analysis of each system's performance according to the criteria listed

above follows each description. An annex that describes the key features of the monitoring and accountability systems underpinning these initiatives follows this report.

An Assessment of GPE's M&A System

Monitoring

Commitment and progress indicators. Countries are encouraged to select indicators of importance, provided that they are consistent with a recently developed set of 27 global indicators.¹⁹ However, the set of 27 indicators (which were only developed nine years after the advent of FTI/GPE) suffers from the absence of measures of educational quality and possesses few measures of learning outcomes.

Global-country coordination. GPE's commitment and progress indicators are undermined by a lack of standardization on a global level. While it is commendable that each country determines input on priority indicators, it is difficult to determine whether real global progress on

¹⁹ These indicators are currently being reviewed to match GPE's strategic objectives.

GPE at a Glance

In contrast to other sectors and initiatives, the field of education has suffered from a lack of well-administered, unified effort to mobilize and deploy resources – both financial and otherwise – towards education. Moreover, while civil society organizations, media and other non-state actors are becoming increasingly vocal about the need to improve global access and quality of schooling, their impact has not been felt on a scale similar to that of other campaigns, such as that of HIV/AIDS.

The Global Partnership for Education was established in 2002 under the name Fast Track Initiative (FTI). As originally conceived, FTI was a multi-donor initiative housed in the World Bank with the aim of mobilizing aid in support of primary education. Gradually, however, FTI evolved into a compact of southern governments, donor agencies, civil society organizations, private sector bodies and foundations, whose aim became broader: namely, to “galvanize and coordinate a global effort to deliver a good quality education to all girls and boys, prioritizing the poorest and most vulnerable” (GPE Strategic Plan 2012-2015). Donors now contribute to a central GPE fund, which is used for three central purposes: technical support and the development and implementation of education plans in developing countries, dissemination of knowledge and best practices in education, and financing of the Secretariat’s operations. By employing a central fund which is disbursed according to need, GPE strives to promote harmonization and aid effectiveness. Between 2002 and now, over \$2 billion has been pledged to the GPE fund.

GPE has distinct country and global governance structures. On the global level, the primary governing body is the Board of Directors which sets strategy and policy and targets and monitors global performance. This Board of Directors has nineteen seats, with representation from developing country partners, multilateral agencies, donor partners, civil society and teachers, the private sector, and foundations. The Board of Directors is supported by a small secretariat that manages the GPE grants, approves country plans and liaises between the Board of Directors and country governing bodies. On the country level, local education groups (LEGs) serve as the hub. LEGs are generally led by national governments, with participation by donor partners and the private sector, multilateral agencies and civil society. Informed by national education plans which they develop, LEGs are responsible for initiating policy dialogue and for planning and monitoring country-specific results.

As its partner composition changed, GPE’s monitoring and accountability system also evolved. According to our interviews with GPE’s Senior Education Specialist, Jean Marc Bernard, GPE’s current M&A framework has been influenced by a comprehensive 2010 evaluation which found that the then-instituted M&E system was both fragmented and lacking a results-oriented approach. As a result of the 2010 evaluation, the GPE secretariat ushered in a number of reforms to strengthen M&A. GPE’s monitoring and accountability strategy is premised upon the idea that countries should choose their own educational objectives and indicators, although it is suggested that these indicators match a set of 27 indicators. In consultation with the GPE Secretariat, countries also establish their own targets for these indicators. As Bernard emphasized, this is meant to stimulate country ownership of monitoring and evaluation and to ensure that GPE is not seen as a “top-down” initiative.

The main tool used to track progress against indicators is a Results Framework which provides information on a set of defined objectives, targets to achieve those objectives, and progress towards their achievement. Such information is gathered by country partners during Joint Sector Reviews (JSRs), which are mutual assessments of progress in national education. Because many of the indicators on the Results Framework are systematically gathered as part of JSRs, their completion requires little additional work for GPE country partners. However, some countries whose own targets differ from those on the Results Framework or who have weak monitoring capacity fail to provide this information.

The primary accountability tool – again a product of the 2010 review – is an Accountability Matrix that defines the roles, responsibilities and commitments of all stakeholders in achieving the targets articulated in the Results Framework. The Accountability Matrix, which relies upon the principle of mutual accountability, allows for assessments of the extent to which stakeholders fulfill their commitments (as measured by other stakeholders). The 2013 annual results report is expected to comment on the extent to which stakeholders have complied with their expected roles, as articulated in the Accountability Matrices. The Results Framework and Accountability Matrix comprise the twin pillars of GPE’s newfound commitment to M&A. All M&A activities will be administered by a recently instituted M&E unit within the GPE Secretariat.

education is being achieved if certain countries choose to report on some indicators but not others. A mandated, minimum set of indicators that all countries must report on might prove prudent.

Data collection/reporting. The GPE Secretariat encourages reporting on these priority indicators via the newly established results framework. This results framework is expected to be completed when countries perform joint sector reviews (described above). While GPE's intent of harmonizing reporting burdens with currently existing processes is laudable, some countries only conduct JSRs biannually or even less frequently.

GPE has made strides in global reporting by recently publishing the first of what will become an annual progress report entitled *Results for Learning*. This report demonstrates the progress that each country has made against the targets it has selected to track (thus making transparent which ones are not being tracked).

Data performance and analysis. Because 2012 was the first year in which GPE systematically analyzed and presented data from all 65 of its member countries (via the Results for Learning report), its body of analysis is thin. GPE should be praised for making this report widely available, including at a publically-available webinar. Furthermore, GPE should be commended for including civil society input in the production of this report.

Accountability

Country accountability. The main instrument to promote accountability at the country level is the Accountability Matrix, which relies upon the principle of mutual accountability to hold actors to account. Though it remains to be seen whether this particular tool will provide enough (for it is just that – a tool, rather than a robust accountability strategy), it represents a step forward from the previous absence of accountability processes. Additionally, as part of its now-annual results report, GPE is evaluating countries in a standard way on whether they have achieved country-specific targets. Each country will be given one of four ratings for each target: target achieved, improving trend, deteriorating trend, or no information.

Global accountability. The structure of the GPE Board of Directors – the main global governing body – is set up to encourage accountability. The Board of Directors is staffed by a cross-section of education actors, including 3 seats for civil society members. Additionally, the newly formed *Results for Learning* report is meant to spotlight global successes and failures in education. GPE deserves praise for making *Results for Learning* widely accessible, including during a webinar, which has been archived on GPE's main site. Finally, GPE has intelligently reserved some of its central funds to strengthen country M&A efforts.

An Assessment of UNGASS' M&E System

Commitment and progress indicators. The global targets established are extremely concrete and clear, as are the 32 indicators that correspond to these seven main goals. Time-bound country targets are the norm, and UNAIDS has been careful to establish standardized definitions to accompany each indicator. Moreover, the 32 indicators represent a good mix of qualitative and quantitative ones. The deliberate process by which the indicators were selected is reflected in their quality.

On the downside, while the country and global targets are quite clear, some donor commitments are quite vague and not well-suited for tracking.

Global-country coordination. There are strong lines of communication between UNAIDS and country offices/national governments. UNAIDS encourages countries to use the established indicators as the basis of their national monitoring and evaluation systems and provides many avenues for technical support – including online trainings and validation of data – to ensure that country reporting is credible and consistent.

Data collection/reporting. Among the systems that we studied, data collection and reporting in the GARPR represents the “gold standard.” Reporting rates are near 100% with many standard instruments – such as NASA and epidemiological surveillance instruments – contributing to the high caliber of reporting. All countries are expected to use a standard, user-friendly, UNGASS reporting platform to provide data, which helps streamline the collection process.

As with other systems, the pressure to demonstrate progress may bias reporting results. To combat this, UNAIDS validates progress reports with various global partners.

Data performance and analysis. In addition to their annual report summarizing country progress and analyzing trends, UNAIDS publishes a number of other, more targeted, reports analyzing progress on several sub-themes. For example, 2012 saw reports on the effect of the epidemic on women, progress made in Africa, and domestic versus donor funding. These reports are generally high-caliber and backed by credible empirical data.

An under-explored area for which more accountability work could be performed is in the area of efficiency or value for money.

Global accountability. Global accountability efforts are buoyed by widespread scrutiny by active independent groups and media. Global targets are not only presented

AIDS/UNGASS at a Glance

The global AIDS movement represents the best example in health of the power of a broad-based constituency to effect change. Civil society organizations— in the form of women’s groups, gay men’s groups, and human right organizations— have been active since the outset of the AIDS movement more than 25 years ago. Partly in response to momentum generated by these actors, annual global AIDS conferences began in the early 90s and 2001 saw the first “declaration of commitment” by heads in the United Nations General Assembly Special Session (UNGASS) on AIDS. This declaration of commitment was matched by estimates of baseline spending (approximately \$2 billion annually) and funding required to fight the epidemic (\$8-10 billion annually). Further UNGASS meetings have helped to solidify, expand, and refine the commitments made by donors, NGOs, and others.

At the global level, governments, donors and international organizations have committed to a number of collective targets (e.g. cutting sexual transmission by 50%, putting 15 million persons on AIDS drug therapy, etc.) by 2015, as expressed in the 2011 UN Declaration of Commitment. Particular donors have also committed to achieving specific levels of coverage or financial outlays – e.g. PEPFAR pledging AIDS treatment to at least 6 million persons worldwide. These commitments are generally laid out in the strategic plans of donor organizations. At the country level, commitments are built around 3-5 year AIDS national strategic plans against which NGOs and donors often commit to making specific contributions.

The responsibility for monitoring on a global level rests with UNAIDS, which publishes an annual progress report in December on global trends, challenges and opportunities. While UNAIDS coordinates the December report, other UN organizations lead in monitoring specific areas (WHO for AIDS treatment, UNICEF for mother to child transmission, etc.) and then channel their findings to UNAIDS. The report, whose release date is meant to synch with World Aids Day, is met with much fanfare by civil society and a large, well-trained body of journalists.

Additionally UNAIDS publishes a major report for the UNGASS meetings in September. The 2011 UNGASS identified seven main goals that are underpinned by 32 indicators, on which each country is expected to report every second year through the Global Aids Response Progress Reporting (GARPR) process; this report sums up the many national progress reports. As revealed in our conversation with Taavi Erkkola, the 32 indicators chosen were the product of a painstaking process in which characteristics of quality indicators were first selected and then applied to the selection of HIV-AIDS indicators by an inclusive set of actors. Compliance in the GARPR process has been quite high (nearly 100% in 2012).

Global monitoring efforts have also benefited from the work performed by a range of NGOs and academic institutions. For example, the AIDS Monitor at the Center for Global Development monitored the performances of the three largest donors – PEPFAR, the Global Fund and the World Bank. On a country level, official AIDS monitoring is generally led by the National AIDS Councils, which build targets for these standard indicators into their national AIDS plans.

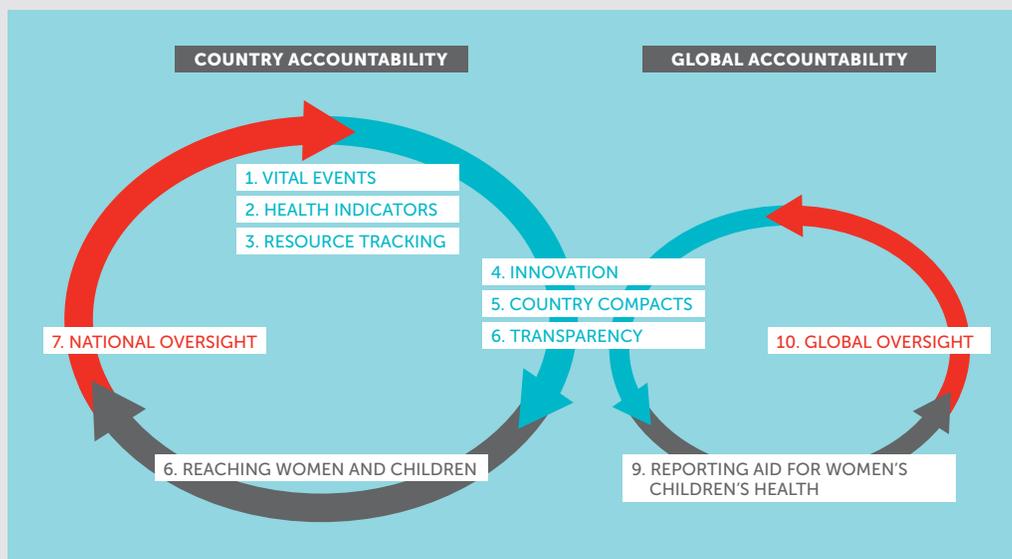
In terms of accountability, in addition to the global UNAIDS reports, country-specific UNGASS reports are submitted to “consensus workshops,” where government, donors, and civil society can discuss the data, findings and recommendations. Additionally, National Aids Spending Assessments, which have become routine every 3-5 years in the most severely-affected countries, and HIV sub-accounts of National Health Accounts (NHA) reinforce accountability by tracking and measuring AIDS expenditures by source channel and final use. Both NASA and NHA data are publicly available.

annually by UNAIDS annual reports but also through separate studies by NGOs, academics, and other actors who validate and challenge official results. In 2010, UNAIDS developed a scorecard to rank countries on several dimensions of performance. The effectiveness of using scorecards to incentivize performance was a theme echoed by many of those we interviewed for this this exercise.²⁰

Country accountability. Many countries hold in-country reviews of the annual progress reports to examine and question them. However, these are not always held in all countries, and, in some instances, accountability actors such as the NGOs, CSOs, and the media are not strong.

²⁰ For example, Ben Leo from ONE emphasized that scorecards and league tables are effective because countries have an interest in finishing ahead of peer countries and visual elements such as these are easily grasped by the general population and media.

EWEC at a Glance



In 2010, with the 2015 Millennium Development Goal (MDG) end year approaching, the global development community concluded that a much more concerted effort was needed in order to achieve the MDGs, especially those related to women and children. Consequently, during the 2010 United National MDGs Summit, UN Secretary-General Ban Ki-moon launched the Every Woman Every Child (EWEC) initiative, which resulted in the Global Strategy for Women's and Children's Health, a "roadmap for all global development stakeholders to enhance financing, strengthen policy, and improve service on the ground for the most vulnerable women and children." This plan laid out key areas for action, including: 1) Increased and sustainable investment for country-level plans, 2) integrated delivery of health services, 3) innovations in financing and efficient delivery of health services, and 4) improved monitoring and evaluation to ensure all actors are held accountable. With a focus on MDGs 1, 4, and 5, the ultimate goal of the EWEC movement is to save the lives of 16 million women and children by 2015. Since the launch of EWEC, over 250 partners, including 74 governments, have expressed support in the form of new financial commitments totaling \$20 billion. Since its inception, several key advocacy events and catalytic initiatives have fed into EWEC, including the Family Planning Summit, Commission on Vaccines, and Commission on Life Saving Commodities. For some of these initiatives reporting will be performed as part of the EWEC.

Monitoring the commitments made to date has proved challenging. The first step towards developing an M&A system for the movement was the establishment of a Commission on Information and Accountability for Women's and Children's Health which identified 11 indicators to be tracked in 74 countries with the highest burden of maternal and child mortality. The Accountability Commission also presented a general framework to inform the monitoring and reviewing process and proposed the establishment of an independent Expert Working Group (iERG) to develop annual reports on the global progress of EWEC. Additionally, the WHO organized a stakeholder meeting to create a workplan for implementing the COIA's recommendations.

Despite these plans, the first year of the initiative saw a disappointing level of reporting – a message expressed in the 2012 iERG report. In response to this report, the UN took the following steps:

- Countdown to 2015, a group established in 2005 to monitor progress on maternal, newborn, and child survival, was tasked with measuring country progress in a standardized manner. They developed a Country Countdown Toolkit that provides tools to assist with data collection. They also agreed to report annually on progress on 11 indicators in all 75 countries.
- A UNICEF-led group established a simple scorecard to monitor progress on maternal and child survival to be used in conjunction with Countdown's country profiles.
- WHO began leading country consultations in earnest, with a particular focus on acquainting countries with a standard Country Accountability Framework (CAF) and developing roadmaps to achieving the 11 indicators.

An Assessment of EWEC's M&A System

Commitment and progress indicators. While the 11 core indicators that were established by the Commission on Information and Accountability are clear, the commitments that were made as part of EWEC are fraught with problems. Many of them are ambiguous, and many are not represented by one of the 11 indicators, thus hindering the tracking of progress. Moreover, many of the commitments are not time-bound, further complicating monitoring and accountability efforts. Finally, it is difficult to distinguish the commitments made as part of Every Woman Every Child from country commitments to women and children's health more broadly.

Global-country coordination. The indicators expressed on the global level are not necessarily reflective of country priorities.

Data collection/reporting. To date, reporting has been spotty by countries and other actors – in part because of the lack of a standardized method for self-reporting and in part because of the ambiguous nature of the commitments. Efforts have been made to improve reporting, such as the development of the Countdown to 2015's monitoring toolkit.

Data performance and analysis. The Countdown to 2015 group will produce high-level, one-page analyses on each of the 75 countries' performances on the 11 indicators each year. Additionally, the iERG will provide annual updates that comment on progress of the initiative more broadly. The movement would likely benefit from validation of reporting results and analysis from external groups.

Country accountability. Recent efforts have been made to assist countries with accountability. A WHO-led group has led several country workshops to mainstream the Country Accountability Framework – a tool meant to assess and improve the actions of key country accountability actors. Because this tool is in the midst of being introduced, few results have been produced to date. This level of targeted, country-focused accountability support should be applauded.

Global accountability. A UNICEF-led consortium has developed a scorecard to rank all countries on progress towards woman and children's health. This scorecard is intended to complement an annual report produced by the Countdown group on progress made towards the 11 EWEC indicators. Relative to other initiatives, such as AIDS, there has been little media attention paid to this movement.

Lessons Learned

As mentioned above, our review of global monitoring and accountability systems reveals some common lessons about the proper design of an M&A system. A few of those lessons, along with their potential linkages to FP2020 follow below:

Consider building elements of mutual accountability into the M&A strategy

Accountability need not be unidirectional, in which some actors are expected to deliver on commitments while others track and ensure their progress. The operating principle behind mutual accountability is that all partners must contribute in specific ways to realize shared objectives and that they will be held to account by other partners if they do not. An example of an attempt to cultivate mutual accountability can be seen in GPE's Accountability Matrix. The Accountability Matrix is an outgrowth and expansion of the GPE Compact on Mutual Accountability (right), a framework which outlines broad responsibilities of developing countries and donors to achieving educational goals. The Accountability Matrix links stakeholders to specific roles within a set of five thematic areas: education policy and planning, education finance, aid effectiveness, data and M&E, advocacy and knowledge sharing. As part of the process for reviewing a country's educational sector plan, responsibilities under each of these thematic areas are agreed upon for the: GPE Board of Directors, GPE Chair, GPE Secretariat, Ministry of Education and Government, bilateral and multilateral donor partners, coordinating

GPE Compact on Mutual Accountability	
Developing-country governments	Donors and other partners
→ Sound education plans through broadbased consultations	→ Help mobilize resources and make them more predictable
→ Commitment to education through strong domestic support	→ Align with country development priorities
→ Demonstrate results on key performance indicators	→ Harmonize procedures as much as possible

Source: GPE 2011a.

agency, supervising managing entity, international civil society and national civil society, and private partners/ research entities/foundations. While the roles of partners are expected to change as progress is made, GPE's Mutual Accountability Matrix is meant to be revisited regularly to ensure that all parties are fulfilling expectations.

Additionally, mutual accountability is being fostered in AIDS prevention efforts at the country level through national consensus workshops on the UNGASS reports and through reviews by the Global Fund Country Coordinating Mechanisms.

The subject of mutual accountability is one that has received a considerable amount of attention; several studies suggest that it may be an effective tool for increasing the likelihood that commitments are realized. There are tangible ways in which FP2020 could institute a culture of mutual accountability. For example, as more technical assistance is deployed to countries to develop national reproductive health plans, leaders could ensure that stakeholder roles are (1) clearly defined and that (2) their performance can be regularly checked against expected roles by other stakeholders.

Explicitly include civil society organizations as part of the M&A governance structure

Civil society and other accountability actors have an important monitoring and accountability role to play as independent, external entities. The AIDS movement has demonstrated that independent voices can move donors and national actors to follow through on promises – e.g. through the publication of national shadow reports.

In addition, the systems we have studied suggest that civil society can also play a central part in whatever “internal” system emerges. The GPE governance structure reserves seats for civil society on the Board of Directors and CSOs play critical roles in the composition of LGEs. Our conversation with Jean-Marc Bernard from GPE underscored the fact that CSOs have played an important role in formalizing accountability measures such as the Accountability Matrix. UNAIDS has embraced from its inception the role that CSOs and other accountability actors can play – reflected in the presence of a formal civil society and private sector division within the organization, in the participation of civil society representatives in the UNAIDS governing board and in Global Fund Country Coordinating Systems.

As it currently stands, the FP2020 Reference Group has seats dedicated to civil society representatives, and the four Working Groups include civil society representatives among their members. FP2020 leaders should be commended for involving civil society and should be diligent about continuing to do so.

Provide resources to countries to bolster their monitoring and accountability capacity

In order to ensure global-country alignment of monitoring, it is important that countries have the capacity to perform effective monitoring and accountability. Our conversations with key experts from each of the systems suggest that the ability to collect and report on data varies considerably among countries. Encouragingly, nearly all of the central governing bodies in the global initiatives that we evaluated provide some level of technical support to bolster country capacity. For some systems, this takes the form of financing of monitoring and accountability activities, as is the case in the targeted Global Regional Activities (GRA) funding within the larger GPE fund. The GRA fund was established in 2010 with \$65 million available to support the objective of developing capacity and knowledge sharing at the country level including to “improve partnership accountability by strengthening availability and quality of data²¹.” A currently proposed activity, for example, involves developing an improved measurement tool for identifying and counting out-of-school children that can be used in multiple countries.

After initially struggling with both the frequency and quality of country reporting, Every Woman Every Child tasked the Countdown to 2015 to help improve reporting. In February 2013, they released comprehensive guidelines on how countries should report, including from where they should draw data. Additionally, WHO has taken the lead in hosting multi-stakeholder country accountability workshops across the globe to assist countries in both creating roadmaps to achieve EWEC targets and acquainting them with a template for assessing national accountability actors. Furthermore, UNAIDS has invested an impressive amount of resources in training country teams on how to report on the UNGASS indicators.

FP2020 does not have a Global Fund-like central pool of resources, though it did recently launch a Rapid Response Mechanism²² to support rapid response grants that fill urgent gaps and unforeseen time-bound opportunities to accelerate progress towards FP2020's goal. Initiatives

²¹ <http://www.globalpartnership.org/finance-and-funding/global-partnership-for-education-fund/>

²² <http://www.familyplanning2020.org/about-us/fp2020-rapid-response-mechanism>

funded by FP2020 commitment-makers such as Track20, which is training M&E officers to work with Ministries of Health in high-need countries on reporting of FP2020 indicators, may be worthy of further investment.

Develop indicators in an inclusive and systematic manner

A common refrain from interviewees is that global indicators should be developed in an inclusive, methodical manner. Inclusivity is critical to ensuring that reporting requirements do not become “top-down” mandates that do not reflect national and subnational monitoring priorities.

The UNAIDS process for developing indicators may prove instructive. Prior to the 2011 UNGASS meeting, previously used indicators were systematically reviewed by a UNAIDS Monitoring and Reference Group (MERG). The review took the form of a series of consultations, each led by a civil society partner and UN organization, which focused on four themes: prevention, care and support, the enabling environment, and the health sector. According to our conversations with Taavi Erkkola, a senior advisor with UNAIDS, objective criteria for future indicators were determined through a lengthy process, but the result was a relevant set of indicators which engendered “buy-in” from those who report on them.

Similarly, our conversation with Dolf te Linteo from the Institute of Development Studies (IDS), who is leading efforts to develop the Hunger and Nutrition Commitment Index (HANCI), a scorecard that measures governments’ commitment²³ to reduce under-nutrition, revealed that this tool was developed through a series of multi-stakeholder focus groups in several countries. These focus groups gave insight into the right metrics to be used for the HANCI; this process represents a mild departure from scorecards such as the London NTD one, in which developing countries exerted a smaller influence on both indicators and targets.

FP2020 leadership would be wise to take note of these experiences and rely upon a wide set of stakeholders to develop a list of indicators that reflect the priorities of multiple constituencies, with a particular focus on country actors. Early indications suggest that this has been the case, as a diverse set of experts have been consulted to develop these metrics.

Ensure that there is a vehicle or process for periodically assessing and improving monitoring and accountability efforts

Developing a robust, well-administered M&A system is a challenging and dynamic process. In each system studied, the initial M&A framework has evolved considerably since its inception, with early mistakes and shortfalls being addressed as the global initiative matures. For example, the initial EWEC monitoring and accountability approach failed to recognize the varied capacity of countries to regularly collect and report high-quality data. To address this, it has developed a series of regular workshops and guidance documents to aid in the collection process. Similarly, Annika Grever from the Gates Foundation, a key person in the design of the London NTD scorecard, emphasized that the look and feel of the scorecard is being re-evaluated after the first year of data. GPE recently created an M&E Unit within its secretariat in 2012 to help bolster lagging monitoring efforts – an initiative that grew out of the recommendations of an independent review.

In order to continually strengthen the caliber of a global initiative’s M&A, it is critical that there is independent oversight and review of data collection, reporting, presentation, etc. as appears to be the case with FP2020’s Performance Monitoring & Accountability Working Group.

Bolster the capacity of independent watchdogs

Independent watchdog efforts can have a large, positive impact at global and national levels, if watchdog organizations are well-equipped to collect and analyze data and to make their findings widely known, including through the media. Their impact can be seen clearly in HIV, where a multitude of organizations play important oversight roles. Such efforts can be effectively nurtured by independent funding and technical organizations.

With respect to FP2020, a logical next step may involve scoping the independent actors that exist in the family planning space and investing strategically in a subset of them with an eye towards optimizing M&A impact.

²³ In the HANCI, the term commitment is used to describe perceived political commitment to reach hunger and under-nutrition rather than discrete commitments made at a global event, such as the London Declaration on NTD or Family Planning Summit.

Table Two: Key Features of M&A Mechanisms

Dimensions of M&A	AIDS Commitments under UNGASS		EWEC		GPE	
	Global	National	Global	National	Global	National
Quantitative targets that are being monitored against	Many: e.g., 50% reduction in new infections, increase in numbers on ART to 15 million, another \$7 billion in funding for LMICs	Countries follow same indicators and may add others	Save lives of 16 million women and children, prevent 33 million unwanted pregnancies, end stunting in 88 million children, and protect 120 million children from pneumonia by 2015	Specific targets are established in the country-led national health plans.	27 Indicators are listed across 5 objectives	Specific targets are established in national ESP (Education Sector Plans)
Agent(s) tasked with achieving these benchmarks	Donors, GFATM, country governments, INGOs, private companies	Country governments, donors, service providers – governments are supposed to lead	Governments/ policy-makers, donor countries and institutions, UN and other multilateral organizations, CSOs, business community, healthcare workers, academic and research institutions	National governments (with technical and programmatic support from WHO and other multi-lateral agencies)	Board of Directors	Local Education Groups (LEGs)
Designer(s) of the original benchmarks	UNAIDS with widespread input from other UN agencies, major donors, country governments, and civil society					
National AIDS councils and their international and CSO partners	WHO, PMNCH	National governments (with technical and programmatic support from WHO and other multi-lateral agencies)	GPE Secretariat	LEGs, as validated by GPE Secretariat		
Timeline for achieving the benchmarks	2015	2015	2015	2015	N/A	As determined by the ESP
Agent(s) responsible for collecting data	Data assembled by UNAIDS on behalf of the larger community; data reported by countries to UNAIDS	Data assembled by National AIDS council or ministry of health	No single agent tasked with data collection. Data for progress reports is taken from various global systems already in place.	National governments	GPE Secretariat	LEGs
Data source (DHS, reporting from facilities, etc.)	Country reports augmented by reports from donors	Multiple routine systems, special surveys, AIDS spending assessments, etc.	Country governments, NHAs, WHO, OECD DAC, UNICEF	Already-existing country monitoring and data-collection efforts, which are being improved	The UNESCO UIS database and UNESCO EFA Global Monitoring Report	ESPs, JSRs, GPE grant applications

Table Two: Key Features of M&A Mechanisms

Dimensions of M&A	AIDS Commitments under UNGASS		EWEC		GPE	
	Global	National	Global	National	Global	National
Frequency of data collection	Every two years	Varies from indicator to indicator. Service delivery coverage may be annual, spending numbers less frequent	Commitments made as part of this global strategy are tracked and reviewed by the iERG every 2 years.	Annually	Annually	During JSRs
Agent(s) responsible for reporting	UNAIDS, to the General Assembly	National governments	Multiple: country governments, donors, multilaterals	National governments, NGOs, private sector, etc.	M&E sub-group of GPE Secretariat	LEGs
Frequency of reporting	Annual	Annual	iERG report every 2 years. Countdown to 2015 annual report, A Promise Renewed (UNICEF) publishes annual global child survival reports.	No official reporting mechanism	Annually, as presented by the Results for Learning report	During Joint Sector Reports (JSRs)
Public presentation of data/ monitoring (yes/no; datasets, country reports, global reports, score cards, league tables etc.)	Global Report with many tables and charts	Country report plus some national consensus meetings, vetting by in-country donor group for AIDS, UNAIDS country coordinating mechanism	iERG bi-annual report	Countdown to 2015 will publish country profiles and an annual report. Also, A Progress Renewed is currently developing a country scorecard for maternal and child survival	Results for Learning annual report	Results frameworks to be published on GPE site
Mechanism to ensure that monitoring feeds into policy and plans	UNAIDS and its partners may use findings in shaping country programs.					
Finding may stimulate global initiatives, e.g., universal coverage of PMTCT	Consensus workshops and annual joint reviews may be used	iERG	New partnerships with Countdown and A Promise Renewed are to strengthen the link between monitoring and policy changes at the national level	M&E Unit of the Secretariat is responsible for working with LEGs	LEGs are expected to ensure that this occurs during JSRs	

Annex 2: Country Summaries

India

April 2013

This note summarizes the findings of the Results for Development Institute (R4D) team comprising Robert Hecht, Caroline Poirrier, and Aarthi Rao, who visited India April 8 – 16th, 2013.

During our ten-day visit, we met with key family planning government officials including Arunadha Gupta, the National Rural Health Mission (NRHM) Additional Secretary & Mission Director, and the Deputy Commissioner for family planning, Dr. Sushma Dureja. We also spoke with family planning advocates and service providers, research organizations, journalists, non-governmental organizations and civil society organizations focusing on family planning and monitoring and accountability.

The visit helped us to understand the country's key family planning and accountability issues, the context for Mrs. Gupta's public commitment at the London Summit last July, and the progress made since. We learned about the many social accountability initiatives, their potential to strengthen service delivery, as well as the many challenges to scaling up and sustaining these efforts.

Context, Commitments and RMNCH+A Strategy

FP context in India

Launched in 1951, India's family planning program was initially designed to achieve population stabilization with long-lasting and permanent methods, particularly female sterilization. Starting in the 1970s, the program involved forced sterilization. In 1996, India adopted a target-free approach to family planning and in 2000 affirmed its commitment to informed choice and consent. However, in practice, incentives still encourage officials and health providers to reach "expected levels of outcome." Schemes continue to discriminate against those who are not sterilized or who have more than two children, and in many cases, financial or in-kind compensation is reportedly given to those accepting sterilizations through public providers, often without the provision of full information about the procedure and alternative methods. More recently, family planning was seen as having been deprioritized by government and donors. The current basket of choice through the public system includes condoms, IUDs, and oral contraceptives, but there are significant gaps in awareness and use of these alternative methods.

Unlike some of the other FP2020 countries, India's FP program is very much couched within the country's broader efforts to extend healthcare to the poor and is not seen as a distinct program.

Key Findings

- While the objectives of FP2020 are integrated into other international and national policy initiatives, awareness of the LFPS and India's commitment is low
- The Government of India (GOI) is acting on its London commitment
- The GOI's main focus in family planning is reducing the total fertility rate in high populous northern states and expanding the provision of post-partum IUDs
- Policy directives from the center, such as a move away from sterilization targets, lose steam at the state and district levels
- Health data, especially on the quality of family planning services provided, is weak, and quality of care remains a significant concern among India's family planning stakeholders
- Community-based monitoring (CBM), which has been piloted through NRHM, is a promising way to draw on India's rich base of CSOs and improve the quality of health services, but there is a need to study differing models and formulate a programmatic approach for bringing it to scale

London

Additional Secretary Arunadha Gupta presented India's commitment at the London Family Planning Summit. At the center of India's new approach is a shift from limiting and long-lasting methods to delaying and spacing methods with an expansion of method choice, focusing on IUDs. In practice, the new approach will emphasize training of health workers in IUD insertion, training of community health workers (ASHAs) to distribute FP "at the doorstep," and enhanced counseling services, particularly after childbirth. The government pledged to enhance its expenditure on FP as part of Reproductive, Maternal, Newborn and Child and Adolescent Health (RMNCH+A) while focusing on equity, quality, integration into the continuum of care, and reaching adolescents. The commitments made in London were not "new," to the extent that they reflected the "Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health" designed prior to the Summit and officially launched in February 2013.

The London commitment's emphasis on delay and spacing, enhanced training, counseling, and quality of care were significant and widely embraced by India's FP community. Prior to the Summit, extensive CSO consultations were organized by India's Family Planning Association (FPA), at the state and national level, to draw out recommendations that would influence the content of the London declaration. The general sense from civil society is that the government was very receptive to these recommendations and that they were broadly included into the Assistant Secretary's statements.

After the Summit

According to the Additional Secretary, the Summit helped energize FP's re-launch in India. The Additional Secretary, in turn, is seen as extremely energetic and committed to issues of reproductive, maternal, and newborn health. During our meeting, she made clear that the new strategy is being implemented, that the mission gets frequent updates on the newly revised and ongoing health provider trainings, and that the new financial and other commitments will be met. FP2020 is widely credited with bringing the sometimes divided donors together and the government seems to be moving forward with the operationalization of its commitments.

Challenges and Concerns

Translating Policies into Change

One of the most important concerns is that the significant policy changes at the center may get diffused as they filter down through the states and districts. For the new approach to reach all the way down to the village level,

states must design Program Implementation Plans (PIPs) that prioritize FP, request corresponding funding, and actually spend funds according to new priorities. Similarly, officials and health providers at the state, district, block, health center and village level must understand and support the new approach. Unfortunately, experience attests to the difficulty of putting policy changes into practice. For example, even though the move away from targets was made official years ago, in reality the FP program is still very much driven by numbers or "expected levels of outcome" at the state and sub-state level.

Others worry that the government's main priorities remain population stabilization and lower TFR and that delaying, spacing, and greater choice and quality of care will only be a secondary focus. This suspicion is bolstered by the fact that the renewed FP push is very much focused on the northern "priority" states where TFR is highest. In Southern states, where TFR is lower but sterilization remains the dominant method, delaying and spacing are rare and maternal mortality is still high.

Another concern is that the post-partum IUD push is only targeting couples who are already pregnant; the government is therefore missing the opportunity to delay the first birth. In addition, the policy in practice is still largely focused on married couples, failing to reach unmarried adolescents.

Finally, some have reported that financing is not the main issue for FP and that, in fact, many states are not able to utilize their current health allocations. States' limited ability to absorb federal funding may limit the potential impact of the new financial commitments.

Method Mix, Human Resources, and Quality of Care

Civil society is also concerned that the method mix expansion is too modest. The government "basket of choice" is still limited to birth control pills, condoms, emergency pills, and IUDs, with other methods only available in the private sector, inaccessible to the most rural and marginalized population. Compounding this, IUDs, the focus long-lasting and reversible method, will only be available at district and sub-district hospitals, again failing to reach the most remote populations.

The final concern is that the Indian system is not set up for delaying and spacing methods and that the new emphasis on training and IUDs will be insufficient to overcome these issues. Health workers are not adequately trained, leading to health worker reluctance to deliver such methods or to delivery with insufficient screening, counseling, and follow-up. Field health workers may also be overburdened; ASHAs, for example, are primarily focused on increasing the rates of institutional delivery

but have been progressively tasked with more and more responsibilities, including family planning. This, along with the limited method mix offered in the public sector, is seen as very much constraining choice and quality of care.

Civil Society and Development Partners

Given these advances and outstanding issues, civil society and development partners are focusing their advocacy on two main issues: expansion of contraceptive choice, including in the public sector, and enhanced quality of care. A number of organizations monitor services and are looking to develop more robust quality of care guidelines for sterilization as well as guidelines for reversible methods.

Unlike governments in the other countries on which this study focuses, the Indian government does not face significant budget constraints. For this reason, development partners are increasingly focusing on technical rather than financial assistance and service delivery, and implementing pilots that the government can replicate if they are shown to be successful.

Monitoring and Accountability

Challenges

One of the basic challenges to monitoring and accountability (M&A) of India's renewed commitment to FP is the lack of available data. The different surveys – the National Family Health Survey (NFHS), the District Level Health Survey (DLHS), and the Annual Health Survey (AHS) – are carried out irregularly; the last NFHS was carried out in 2005-06 and the data from the AHS are not widely available. The public data are used, but many have reservations about their quality, and some organizations conduct their own baseline surveys whenever possible to ensure that the data are reliable. In addition, private health data is not publically available, meaning there is no information about contraceptives accessed through the private sector, even from well-known franchises such as Janani and Marie Stopes International. Another obstacle is the lack of quality of care indicators. Government collects very little data on quality of care, particularly for reversible methods, and India's commitment does not include quality indicators. CSOs document select adverse events resulting from the low quality of care delivered through public sector "camps" or clinics, but these instances are not systematically documented. There is a general sense that India and FP2020 need to design and track quality indicators.

Our interviewees generally perceive accountability to be weak across sectors, and some of the institutional mechanisms for monitoring and accountability are ineffectual. Quality of care committees at the state and sub-state levels, for example, reportedly often only exist on paper, and where they do exist, they do not include civil society and are rarely effective. At the service delivery level, patients and local government officials have no direct channels for voicing concerns about the quality of care. Panchayat Raj²⁴ members, for example, can make complaints to district medical officials, but in general this requires a certain threshold of citizen complaints to be reached, as opposed to just individual cases. Furthermore, where complaints are made, district action rarely results.

Independent monitoring is constrained by the paucity of disaggregated public information. Budget information is scarce at the subnational level, and citizens have insufficient information about the services, human resources and commodities that should be available at health facilities. Compounding this, expectations for both public services and the impact of citizen action are generally low. Another constraint is that local NGOs need significant support from central NGOs to engage in effective M&A.

Opportunities

Beyond these challenges, India has a number of unique advantages and opportunities which are outlined below.

Active civil society

Indian civil society has been at the forefront of social accountability innovations and experimentation, focusing on informing citizens of their rights and responsibilities, creating channels for registering complaints and seeking redress, budget analysis and advocacy, facilitating communication and problem resolution between citizens and service providers, community planning and monitoring, and advocating for citizens' rights, including the right to information, work, quality services, etc. In other sectors, such as malnutrition and education, civil society groups with independent support have made significant strides in implementing rigorous surveys to spot check government services and citizens' health status and have widely publicized the findings.

Government's growing embrace of transparency and accountability

In large part thanks to the strength and persistence of civil society, the government is increasingly receptive to community participation, monitoring, and accountability. A number of government missions and schemes,

²⁴ Elected district and village level government committees.

including the National Rural Employment Guarantee Act (MNREGA), the Integrated Child Development Services (ICDS) and the National Rural Livelihood Mission (NLRM), now include social accountability elements such as social audits, community monitoring, and public hearings. Those leading the FP repositioning are particularly attuned to the importance of transparency and accountability. The strategic approach states that “Responsiveness, transparency and accountability are critical to demonstrating results at a time when increasing investments are being made into the health sector” and calls for incentivizing transparency and accountability initiatives. The document defines transparency initiatives as “any attempt to place information in the public domain, directly accessible to those concerned with the same, and where enough information is provided for citizen groups, providers or policy makers to understand and monitor health matters,” and examples of accountability initiatives include grievance redress systems and community monitoring and remedial systems. Chapters are devoted to “Monitoring, Information and Evaluation Systems” as well as to “Community Participation.”

An interesting innovation presented in the Strategic Approach is the introduction of an HMIS-based dashboard monitoring system focusing on a range of outputs and service delivery indicators. While the dashboard does not currently include indicators looking at the quality of FP care, it is a laudable effort to: 1) encourage states to utilize HMIS data for improved decision-making, 2) facilitate comparisons across states and districts, and 3) improve accountability in the public health system. This innovation could be enhanced by the inclusion of quality of care indicators and comparisons below the district level.

Community-based monitoring

Community monitoring was first piloted by NRHM and NGOs in 9 states in 2007-09 as a way to involve communities in planning, monitoring, and implementation of healthcare services and thus improve community participation, accountability and service delivery. The process was led by a national secretariat composed of the Population Foundation of India (PFI) and the Center for Health and Social Justice (CHSJ) and built on a partnership between the community (including NGOs and Community-Based Organizations [CBOs]), health providers, and Panchayat Raj Institutions (PRIs). Planning and Monitoring Committees were created at public health center, block, district and state levels, and at the village level Village Health and Sanitation Committees (VHSC) were set up. NGOs played a key role; they were members of monitoring committees at all levels and led capacity building and facilitation.

NGOs and CBOs mobilized communities, enhancing community members’ understanding of their health entitlements and of community monitoring. The

community then monitored the need for, coverage, access, quality, effectiveness, behavior, and presence of healthcare personnel at service points, as well as possible denial of care and negligence aspects against a standardized checklist. The results were shared at the village level in the form of a scorecard and compiled at the PHC, block, district, and state levels. Both public dialogue and public hearings were facilitated, with the goal of resolving problems at each level or, alternatively, communicating them to the appropriate level of government.

The process and results varied across locations. However, the process reportedly had a number of positive outcomes; where CBM was most effective, citizens became better informed and more engaged, meetings between citizens and public health officials were institutionalized, and health providers and officials heard citizens’ needs. Citizens were given information that helped them understand the constraints faced by providers; problems were resolved; satisfaction levels increased, and the system was perceived as being more responsive. Finally, the government became more open to collaborating with CSOs and communities.

Community-based monitoring (CBM) of health services is now a key strategy under the National Rural Health Mission (NRHM), and the national ministry is pushing states to include it in their Program Implementation Plans for funding by NRHM. In some places, CBM has been adopted by the state and is being scaled up, while in others, it has floundered. These mixed results can be explained by the importance of political commitment as well as by the obstacles to sustainability. CBM is quite intensive, requiring resources and significant involvement from the NGOs and CBOs leading it. This requires an investment on the part of the government and/or these organizations. In addition, it makes the process highly dependent on the quality of the organizations involved; where organizations are strong, CBM is likely to work, but where they are weaker, it is typically less successful and sustainable. Part of the issue is that the country lacks a single and strong, pan-Indian health organization such as Pratham which has succeeded in leading a national survey of educational outcomes embraced by the government.

Government involvement. The involvement of the government and how CBM should be funded are divisive issues. While some believe strong government support is the only way to sustain the process and ensure that issues are addressed, others fear government involvement will dilute the process. Weak accountability means complaints by community groups to the district do not necessarily lead to change, which is problematic to the extent that in the long run, community engagement will depend on whether communities experience improvements in services.

Adaptations and other models. One of the issues identified in the pilot phase is that the tool for collecting data was excessively complicated and that communities

should initially work with a simpler, "lighter" tool looking at fewer indicators. This practical recommendation is a real challenge to efforts to include additional indicators to assess the quality of FP services.

Interviewees suggested that efforts to empower self-help groups around issues that affect them very directly are a more effective and sustainable approach to citizen engagement than the resource- and participation-intensive community monitoring of a specific government service. A number of the groups we met with do actually support such initiatives and argue that organizing and empowering citizens to access specific entitlements, for example, is effective because citizens have clear incentives to engage. Further down the line, when citizens are organized and mobilized around an issue of immediate importance to them, it is possible to broaden their work to health monitoring and advocacy. This approach is seen as effective and sustainable because it focuses on citizen and community empowerment broadly rather than on a narrow issue that may limit communities' engagement across issues and over time.

Building on the government standards for quality of services in sterilization camps, other organizations are laying the groundwork for monitoring of FP services by developing more elaborate quality of care indicators which are applicable to a range of methods including consent, privacy, dignity and choice.

Two other sets of actors have a role in supporting monitoring of health services by bridging the information gap between the national and local level. The first is the Indian Association of Parliamentarians on Population and Development (IAPPD) which bring members of parliament from all parties together to sensitize other MPs, Members of the Legislative Assemblies, and PRI members on population issues, including FP. IAPPD informs these individuals of new policies at the national level to help ensure that policy change at the center filters down to communities. They identify potential population advocates at each level and train them on the importance of delaying and spacing as well as help them develop action plans that will enhance citizen understanding of FP, improve the quality of FP services, and increase uptake. They also encourage their advocates to monitor health centers and report issues to the appropriate government official. The second group of actors is journalists, who can participate in community public hearings and report on the quality of services and satisfaction to a broader audience and thus help stimulate government response. Journalists said it was difficult to get such stories into the national media but said local media stories could have high impact and also gave examples of where television news series supported by institutions such as the Gates Foundation, focusing on maternal and child health, had produced real responses from the public and government.

Recommendations

Program

- Coordinate different community health workers – ASHAs, ANM, and Angawali. Study showed greatly improved FP uptake when their efforts were coordinated, and all talking about FP.
- Continue and bolster training and mentoring of health workers and develop innovative Behavior Change Communication approaches.
- Support greater involvement of Panchayat Raj members, especially female members. Can help with demand creation and the design and monitoring of health interventions. Can also help finance improvements in services and register complaints with the government.
- Support studies that evaluate whether publicly supported social franchising is an effective way to stimulate demand for reversible and spacing methods and whether patients hold higher expectations for quasi-private services.
- Fund advocacy groups to push for greater relevance of new and under-utilized reversible methods in state and central programs, especially for emerging government schemes like the Urban Health Mission.
- Invite state level health officials to discuss domestic and international family planning trends to imbue FP2020 momentum at the state level.

Data

- Enhance HMIS data and build the capacity of frontline service providers and government officials at all levels to report data accurately and to use data in policy design and service provision.
- Collect data on contraceptives distributed through the private sector, perhaps through mid-level distributors, to form an initial sense of the magnitude and trends; mainstream private data into HMIS.
- Display easily understandable information about the services available and prices in facilities, including pictorial representations that can encourage queries from illiterate patients. This will help citizens understand the services they should have access to and help them hold providers and government to account.
- Enhance HMIS' dashboard – include quality of care indicators and data at the sub-district level.

Community monitoring

- Fund work that helps collect lessons from various ongoing community monitoring initiatives and lays the groundwork for scale-up and replication in other districts and states.

- Examine strategies and tools for scaling up community based monitoring approaches (protocols, training guides, program design tools, etc.).
- Examine the impact of government involvement and funding (as opposed to independent monitoring). Would community monitoring work best when funding comes from the national government to monitor states, from state governments to monitor districts, from independent third party funders, etc.?
- Consider lessons for generating community support from HIV/AIDS: access to medicines, experience, and the role of India's National AIDS Control Organization.
- Support the design and pilot of a "light" CBM tool that includes FP indicators.
- Pilot CBM that focuses on building trust between communities and service providers and government officials.
- Sensitize communities to providers' constraints, and train communities and advocacy organizations to approach the government in a less confrontational and more productive way.
- Build capacity of service providers to engage with citizens.
- Organize self-help groups and strengthen existing ones for long-term community mobilization and advocacy and to support a focus on FP in existing groups.
- Engage local language journalists in monitoring entitlements and family planning and reproductive health issues.
- Examine the strength of health/FP NGOs and CSOs; identify central level CSOs/institutions that can train and leverage a network of smaller CSOs around the country.
- Strengthen weaker CSOs, focus on instilling approaches that allow CSOs to have a productive, rather than antagonistic, relationship with the government.
- Support a pilot and/or large-scale survey to provide real-time information on family planning quality similar to Pratham's ASER or the more recently launched Hunger and Malnutrition Survey.
- Media – sponsor media programming on FP & QOC.

FP2020: Final List of Interviewees – India

Name	Organization	Position
Anuradha Gupta	Ministry of Health and Family Welfare	Additional Secretary
	National Rural Health Mission	Mission Director
Sushma Dureja	Ministry of Health and Family Welfare	Deputy Director, Family Planning
M.E. Khan	Population Council International	Senior Program Associate
Saroj Pauchari	Population Council International	Distinguished Scholar
Avinash Chaudhary	Advocating Reproductive Choices	ARC Coordinator
Tultul Hazra Das	Advocating Reproductive Choices	
Poonam Mutterreja	Population Foundation India	Executive Director
K. Saadat Noor	Population Foundation India	State Programme Manager in Bihar
James Browder	USAID	Deputy Director of Health Office
Amit Arun	USAID	Reproductive Health and Family Planning Advisor
Sharmila Ghosh NEogi	USAID	Advisor for Maternal Health
Bitra George	FHI 360	Country Director
Billy Steward	DFID	Senior Health Advisor
Suneeta Sharma	Futures Group	HPP Project Director
Don Douglas	Janani	Country Program Director
Rakesh Sinha	BREAD	
Suraiya Parveen	Associate for Social Research and Action	President
Arun Kumar	Public Health Resource Network	Senior Programme Coordinator
Swapam Mazumder	Bihar Voluntary Health Association	Executive Director
Panchayat Raj Institution Members		
Aparajita Ramakrishnan	Bill and Melinda Gates Foundation	Senior Programme Officer
Rederika Meijer	UNFPA	UNFPA Representative
Anders Thomsen	UNFPA	Deputy Representative
Manmohan Sharma	Indian Association of Parliamentarians on Population and Development	Executive Secretary
Shai Venkataraman	NDTV	Former Reporter
Vishwanath Koliwad	Family Planning Association of India	Secretary General
Kalpna Apte	Family Planning Association of India	Assistant Secretary General
Madhavi Rajadhyaksha	Times of India	Special Correspondent

Indonesia

April 2013

This note summarizes the findings of the Results for Development Institute (R4D) team comprising Courtney Tolmie and Mark Roland who visited Indonesia in April 2013.

During our three days of visits, we met with a wide range of stakeholders, including representatives from civil society, NGOs and academia. We decided to perform less extensive consultations in Indonesia than in the other countries.

What emerged from these conversations was a consistent depiction of a once-strong family planning program that is in need of considerable reorganization and revitalization. Encouragingly, our visit also suggested that there is significant potential for civil society to bolster family planning efforts, particularly in the area of monitoring and accountability.

Historical Context

Our visit highlighted that Indonesia's recent history has shaped the current family planning climate. Under the centralized Suharto regime of the 70s through most of the 90s, Indonesia made impressive improvements in contraceptive use and total fertility rate. While the product of multiple inputs, interviewees emphasized that this progress was largely driven by the authoritarian government's coordinated promotion of family planning. In particular, the government orchestrated a "Two Children is Enough" campaign and established a well-resourced, highly competent National Family Planning Coordinating Board (BKKBN) to help drive the fertility rate to 2.6 as reflected in the 2012 DHS.

However, with the ushering in of a democratic regime in 2000 and the advent of decentralization, the pace of improvement began to lessen and ultimately stagnate. These political changes manifested themselves, for example, in a shift from a "Two Children Is Enough" campaign to a softer, more democratic "Two Children is Better" campaign. Many of the challenges mentioned below are an outgrowth of Indonesia's shifting political landscape.

Current Challenges

Despite the fact that Indonesia's family planning is further advanced than many of those in the countries that our team has visited, the challenges remain many. Some of these are listed below:

Decentralization

While decentralization holds great potential to allow localities to implement policies, including family planning, that are tailored to their needs, the system can only work if localities have adequate authority, capacity, and accountability systems within which to operate. As such, decentralization has produced a host of challenges in Indonesia. With more than 400 districts and 33 provinces, quality of services tends to vary considerably. Some provinces, such as West Java, are cited as exemplars in terms of services and governance around FP provision, but many others lag behind in the scope and quality of service provision. Among the chief problems linked to decentralization is the procurement system. Commodities are procured at a central level from either BKKBN or the Ministry of Health and passed down through the provincial and district levels. Individuals we spoke with expressed concerns that leakage occurs in many cases by the time commodities reach the local level, leading to frequent stock-outs in certain facilities. Moreover, there is a lack of institutional support at the district level to implement and ensure the quality of family planning services. For example, district family planning/BKKBN offices that had once been commonplace are now largely non-existent or limited in their effectiveness. Further, the roles and numbers of village family planning workers seem to have declined. In short, decentralization has brought tremendous challenges in terms of coordination and resourcing which have adversely affected the supply and quality of family planning services.

Lack of reliable monitoring and accountability efforts

The responsibility for monitoring of family planning services and commodities falls under the auspices of both the Ministry of Health and BKKBN, using a set of processes that interviewees believe causes confusion around reporting for facilities and districts. Facilities provide data on a monthly basis on a number of domains such as number of clients served and contraceptive availability, yet our interviewees suggested that this data is often not credible. This inaccuracy is due in part to lack of capacity to monitor and report accurate results. Staff may be under-resourced or under-trained; as one interviewee mentioned, a "facility" can be comprised of a single person. Additionally, some staff do not report data accurately, particularly when minimal numbers of clients were seen or commodities distributed, etc. Unfortunately, since this data is self-reported with little oversight from independent actors, there is little reason to think that data quality will improve in the short term. Further undermining efforts to promote transparency as well as improved services is the lack of accountability for actors focusing on FP. Very little work appears to be being done using what data exists to hold service providers and policy makers to account.

Choice of methods

According to the people we interviewed, some in Indonesia are eschewing long-lasting methods of contraception (like IUDs) in favor of short-term contraception – a shift that could have implications for the TFR. This may be both a messaging and a capacity issue – some we spoke with believe that many health workers do not have the capacity to administer long-acting methods or deal with the related complications.

Opportunities

- **Partnering strong provinces/districts with weak ones.** This peer learning model could be applied to FP-specific organizations or to government officials and accountability organizations. For example, one interviewee mentioned that the new governor of Jakarta has implemented unique institutional methods through which citizens can strengthen governance, both in his current position and in his former position as mayor of Solo. One such initiative is making public the video of key meetings on YouTube. Such methods, while not family planning specific, could be utilized to improve accountability mechanisms in the family planning sector if taken up by other actors.
- **Link accountability focused CSOs with family planning focused ones.** While this strategy seems important across countries, there may be a particular need for this approach in Indonesia. Our discussions with family planning stakeholders suggested that there are few, if any, CSOs in the country working on family planning monitoring and accountability; instead, those CSOs that work in family planning focus largely on advocacy around increasing the budget or delivering services. As such, it is critical to develop the capacity of

organizations that understand the family planning sector to do monitoring and accountability work, and one potential way to do this would be to pair family planning organizations with those focused on transparency and accountability.

- **Link government and civil society monitoring and accountability.** While many argue that the most effective monitoring and accountability efforts take place when civil society takes the lead and works in partnership with government, in practice this depends on the willingness and openness of government. Indonesia may be in a unique position to implement M&A that represents a true collaboration between a willing but under-resourced national planning office (BKKBN) and civil society organizations that are in many ways better equipped to monitor services at the regency level. Such partnerships should be explored.
- **Improve monitoring by piloting small initiatives.** Given the relative lack of experience of family planning focused organizations in monitoring, it might prove wise to start with small-scale pilots. For example, civil society could do routine checks on whether facilities have posters or signs that identify a range of contraceptive methods, including long-lasting ones.
- **Focus on important actors that pushed forward the first wave of family planning.** Many interviewees indicated that improvements in TFR during the final few decades of the 20th century were greatly helped by the support of key religious groups and leaders. On the other hand, a handful of interviewees suggested that key religious leaders have now come out in opposition of family planning. Working with these types of stakeholders to shift messaging around family planning could hold great promise in helping to pick up the progress towards FP2020 targets.

FP2020: Final List of Interviewees – Indonesia	
Name	Organization
Eddy Hasmi	BKKBN
Budi Utomo	University of Indonesia - Depok
Various staff members	International Planned Parenthood Foundation (IPPF)
Esty Febriani	Chief of Party CEPAT (Community Empowerment for People Against Tuberculosis) USAID - LKNU
Fitri Putjuk	Advanced Family Planning (AFP)
Mayun Pudja	Advanced Family Planning (AFP)
Inne Silviane	Advanced Family Planning (AFP)
Mela Hidayat	United Nations Population Fund (UNFPA)
Dini Mentari	PATTIRO

Senegal

February 2013

This note summarizes the main findings and some possible recommendations by a team from Results for Development (R4D) comprising Caroline Poirrier and Robert Hecht, who visited Senegal during February 17-23, 2013.

The visit was extremely informative. Within the five days, we met with the country's key family planning actors – government officials, including the Director for Reproductive Health and the Minister of Health herself, donor agencies, service providers and civil society – as well as with non-governmental actors involved in government monitoring and accountability (a list of the people we met is attached). We also spent an afternoon at a family planning clinic. We learned about the process through which the country's action plan ("plan d'action") was developed and about plans for monitoring, evaluation, and accountability. While we identified real obstacles to the successful implementation of the action plan and related monitoring and accountability (M&A) activities, we also found exciting opportunities to work with family planning and accountability actors to support FP2020 in Senegal.

Senegal's Action Plan

Among countries that made commitments at the London Family Planning Summit in July 2012, Senegal is one of the few that had a finalized FP plan prior to its public commitment. This is largely thanks to Senegal's participation in the Ouagadougou Partnership, a group of nine Francophone West African countries (Benin, Burkina Faso, Cote d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal and Togo) and a number of donors, including the United States Agency for International Development (USAID), the French government, the Bill & Melinda Gates Foundation, and the William and Flora Hewlett Foundation, who jointly committed to increase the uptake of family planning in the nine countries.

As part of the partnership, Gates hired McKinsey & Company to support these countries as they develop national FP plans. Senegal was the first country to engage in this process, starting in the spring of 2012 and finalizing its plans shortly before the Summit. As such, Senegal's family planning Action Plan is in fact the plan the country developed as part of the Ouagadougou Partnership.

All the FP actors we met with spoke highly of the Action Plan, the process through which it was developed, and the McKinsey team that led it. McKinsey managed a very participatory process and succeeded in bringing Senegal's main FP players to the table, including the Ministry of Health's Directorate for Reproductive Health (Dr. Daff and his team

at the DSR), civil society and service providers, international NGOs, research groups, and bilateral and multilateral development organizations. Stakeholders met in working groups focusing on different aspects of the plan (demand creation, improvements in supply, contraceptive security). Interviewed stakeholders described the plan as robust, with clear and coherent objectives, approaches, and activities to create new demand for contraceptives, improve public and private delivery, and ensure contraceptive security.

The Challenges of Implementing the Action Plan

While the FP action plan is impressive in terms of its process and content, there appear to be a number of obstacles to its successful implementation and to the achievement of the ambitious target of more than doubling the Contraceptive Prevalence Rate from 12% in 2012 to 27% in 2015.

Plan and budget estimates

One of the most troubling concerns interviewees expressed is that the plan's activities and budget were not developed based on what would be needed to achieve the desired CPR but rather on what was expected to take place. Activities are those that existing FP partners intend to carry out, and the budget may reflect the amounts that donors are expected to provide rather than the true cost. Some providers reported that the budget underestimated the cost of certain activities, and all stakeholders (including the government) agreed that the plan lacked elements that would be crucial to the plan's success, for example personnel and operational costs and expenses related to monitoring and accountability. Some are concerned that the plan does not significantly depart from "business as usual," and that it will therefore fail to realize its ambitious CPR goal.

Leadership and coordination

Another serious obstacle to the realization of the plan is that there seems to be confusion as to whether and how activities have been assigned and financed. Some groups reported knowing exactly what their tasks were as part of the plan, while others stated that their contributions remained undefined. Similarly, there was disagreement as to whether the plan was fully financed or not. All of this points to the need for stronger leadership, coordination, and communication.

DSR resource constraints and their impact on M&A

Central to many of these issues is that the DSR is short-staffed and resource-constrained, with only a couple of individuals focusing on the operationalization and

implementation of the Action Plan. The Reproductive Health Division was recently promoted to a Directorate, but the increased human and other resources that should accompany such a promotion have yet to materialize. This is concerning not only for the implementation of the plan but also for the monitoring and evaluation that will be required for the FP efforts to be reviewed, adjusted, and fully realized.

Data Issues for M&A

The monitoring and evaluation of the FP Action Plan will also be complicated by issues in the quality and timeliness of data. The first issue is that data is supposed to be collected by a number of different actors (subnational officials, public and private providers, non-governmental organizations, research partners) in different areas of the country. The DSR will need to obtain this data from regional and district officials and be able to cross check this with information from implementing NGOs and from the development partners who are financing the large majority of the costs. The diversity of data collectors, collection areas, and methodologies raises issues around coherence and quality. In addition, some of these actors have been reluctant to share data; the regional health officials responsible for compiling and transmitting subnational data to the national government have been withholding this data for over a year as part of a labor union “data retention strike.” Similarly, private providers are known for under-reporting their activities to limit their tax liability. At the national level, reports on actual government expenditure lack detail and are produced with significant delays. Surveys such as the DHS generate immensely important data on fertility and contraceptive prevalence but are carried out too infrequently to be useful in the management and adjustment of a three-year plan. The DHS will need to be supplemented by annual surveys of contraceptive prevalence.

Global FP2020

While this needs to be checked closely, Senegal does not seem to have benefitted from new funding committed in London. The organizations backing the national plan are those that have been supporting FP work in Senegal for years; apart from USAID (which did not pledge new funding at the London Summit), funding for FP in Senegal does not appear to have increased significantly with the new plan. There are several new organizations involved, including MSI and the Hewlett and Gates Foundations, but both started their work in Senegal prior to the London conference. USAID indicated that their financing for FP in Senegal increased over the past year or two (representing a large share of total FP expenditures for the country), but again this was not related to FP2020.

Opportunities

While there are significant challenges to the implementation and effective monitoring of the Action Plan, there are also important strengths and interesting opportunities that should be examined and possibly leveraged.

Widespread engagement and interest

The FP actors in Senegal are very engaged. With support from McKinsey, the government has been leading a participatory process, seeking to have all key stakeholders involved and contributing to its success, and many non-governmental actors seem to be quite active and supportive of the plan. The launch of the new action plan has created renewed energy and enthusiasm around FP which should be leveraged rather than left to fade.

Networks and NGOs

Senegal can also benefit from its multiple networks that reach from the regional and national level all the way to the community levels. Senegal has national and regional networks of women, youth, journalists, midwives, etc. The Bajenu Gox (“Marraines de Quartier” or “neighborhood godmothers”), for example, are a national network of volunteer women chosen by their communities for their respectability and wisdom, who promote healthy behaviors and advise women on health, and who are at the forefront of FP education. These and other networks, quite active but sometimes under-coordinated, supported, and trained, could play an important role in promoting monitoring at the community level.

NGOs in monitoring and accountability

Some of the NGOs involved in FP in Senegal, such as ENDA-Sante, are developing ideas to monitor FP activities and commitments at all levels. We visited another CSO federation, located in a low-income suburb of Dakar, which aspires to monitor health and family planning activities in its catchment area. One proposal currently being floated and supported by the government’s DSR would be to create “Observatories” in different localities to ensure that partners are aware of their responsibilities and objectives and to identify and remedy FP issues rapidly.

Growing citizen engagement

Another exciting opportunity is the recent rise in citizen engagement in the country, accelerated during the latest presidential elections when former President Abdoulaye Wade was driven from power. Citizens are increasingly active participants in public life and are willing to critically assess their government’s performance and push for improved governance. Beyond individual action, civil society groups such as Forum Civil and ECO-PN are developing

tools to monitor government's performance and to push for enhanced accountability at the community, district, regional, and national level. Though these groups and tools are not currently focused on FP, the tools could be adapted and governance groups could be trained in FP or FP groups in the use of such tools. Assessments could focus on aspects including government accountability, quality of service, and customer satisfaction.

Senegal as a leader among the Francophone countries

Finally, as one of the first countries to design and implement a new FP action plan and as a member of the Ouagadougou Partnership, Senegal has the opportunity to test different approaches that may be adapted and adopted by other countries in the region as well as the broader FP2020 movement. In this regard, it is important that the Ouagadougou secretariat has the capacity and means to share the Senegal experience with other countries in the sub-region. At the same time, there may be lessons from the ongoing work in countries like Burkina Faso, Niger, and Togo (which have completed or nearly completed their FP action plans) that could help Senegal to advance faster if such inter-country sharing is facilitated.

Recommendations

As we were only able to spend one week in Senegal, our findings and recommendations need to be presented with some caution. The points we make below require further discussion with the stakeholders in Senegal and with prospective external funders, including the Hewlett Foundation. If they are to be pursued, further scoping work will be needed.

Based on such an understanding, a few suggestions and ideas for projects that could help to strengthen the implementation of Senegal's FP action plan and its M&A system are listed below.

Overall action plan implementation

- The consortium of government, donors, and CSOs involved in implementation urgently need annual operational plans and budgets that reflect the integrated efforts of all parties, thus matching what is laid out in the action plan. This is a responsibility of the Ministry of Health's DSR. One of the donors engaged in Senegal may need to step up and help the DSR to produce such annual planning and budgeting tools.
- Overall coordination of the different components of the action plan by the DSR is also badly needed. To do this, the minister must at least fill some of the key vacant posts in the DSR, including the three division heads under the director. Again, interim technical support from

donors may be required during 2013, but such support should be predicated on unalterable commitments from the ministry to fill the key posts by the end of the year.

- Our impression is that more funding, additional organizations, and a greater level of effort will be needed on the ground to achieve the service delivery and CPR targets subscribed to in the action plan. There is a potential mismatch between the human and financial resources currently available and the FP goals to be achieved. This requires re-examination during the course of 2013, so that necessary adjustments can be made.

FP monitoring and accountability

- A credible "official" monitoring and accountability system must be established as soon as possible to fill the current void in this area. Without such a system, it will not be possible to monitor progress toward the action plan targets, make mid-course corrections, or hold various parties accountable for their performance. Such an official system should be located under the DSR. It should monitor results against the annual operating plans and budgets that are also lacking. Major externally-funded technical assistance is urgently needed to complement the accelerated efforts of the Ministry of Health in setting up the embryonic M&E division in DSR.
- A number of CSO organizations or networks could also be supported in developing the capacities and systems needed to monitor FP performance and to use this information for advocacy and program improvements. In particular, these groups could help gather data around service appropriateness and quality as well as user satisfaction.
- One option would be to create a regional technical support facility for Monitoring and Accountability, possibly under the Ouagadougou Partnership, to assist the governments and CSO networks in Senegal and in other Partnership countries likely to move ahead in 2013-14, such as Burkina Faso, Niger, and Togo. Alternatively, such support could be targeted exclusively at organizations within Senegal.
- Such a technical support facility for M&A could be supplemented by a series of learning activities across practitioners, building on the kinds of experience that R4D has had elsewhere in bringing countries together to learn from one another in areas such as universal health coverage and private sector delivery of basic health care.
- In addition, there could be considerable payoff to supporting organizations, such as the Forum Civil and others, on improved budget transparency and analysis, focusing on health and family planning budgets. Senegal's fledgling organizations working in this area are full of enthusiasm but do not yet have adequate expertise in analyzing expenditures in health, education, and other social sectors to be effective.

List of Interviewees – Senegal

Name	Organization	Position
Pape Arona Traore Fada Diop	Réseau Jeunesse, Population et Développement du Sénégal (RESOPOPDEV)	Sécrétaire Exécutif National
Victoria Ebin	Population Reference Bureau	Consultant
Fatimata Sy	Ougadougou Partnership	Coordination Unit Head
Elhadji Babacar Gueye	Intrahealth	Chief of Party
Maaïke Van Min	Marie Stopes International (MSI)	Country Director, Senegal
Dr. Cheikh Tidiane Athié	Action et Développement Santé Communautaire (ACDEV)	Directeur
Mbarka Ndaw	Action et Développement Santé Communautaire (ACDEV)	Chargée de Suivi des Projets
Dr. Bocar Mamadou Daff	Direction de la Santé de la Reproduction et de la Survie de l'Enfant, Ministère de la Santé et de l'Action Sociale	Directeur
Dr. Papa Amadou Diack	Ministère de la Santé et de l'Action Sociale	Directeur général de la santé
Awa Marie Coll-Seck	Ministère de la Santé et de l'Action Sociale	Ministre de la santé et de l'action sociale
Dr. Siga Diop	Ministère de la Santé et de l'Action Sociale, FHI 360	Senior Technical Advisor of RH services
Dr. Balla Moussa Diédhiou	Association Sénégalaise pour le Bien-être Familial (ASBEF)	Directeur exécutif de l'association
Moussa Mane	Association Sénégalaise pour le Bien-être Familial (ASBEF)	Directeur des programmes
Daouda Diouf	ENDA Santé	Directeur
Nafissatou Diop	Population Council	Country Director
Ibrahima Lo	ECO/PN (Espace de Concertation and Orientation Pikine North)	Coordonateur
Abdoulaye Sow	ECO/PN (Espace de Concertation and Orientation Pikine North)	Président
Barbara Sow	FHI 360	Country Director
Bryn Sakagawa	Office of Health, USAID/Senegal	Director
Dr. Elhadji Amadou Mbow	USAID Senegal	Maternal and Child Health Specialist, Consultant
Cheikh Mbacke	William and Flora Hewlett Foundation	Consultant
Mr. Bakary Djiba	Ministère de l'Economie et des Finances	Directeur de la Population et de la Planification du Développement Humain, Direction Générale du Plan
Omar Saip Sy	Forum Civil (Senegalese section of Transparency International)	Director of Studies

Uganda

February 2013

This note summarizes the findings of the Results for Development Institute (R4D) team who visited Uganda February 25 – March 1st, 2013.

During our five-day visit, we met with Uganda's main family planning actors – including Ministry of Health officials, current and former parliamentarians, service providers and civil society – as well as with non-governmental organizations monitoring expenditure and services in the health sector.

We learned about the process that led to President Museveni's speech at the London Family Planning Summit as well as the family planning community's efforts to build on these statements. Whereas our interviewees revealed significant hurdles to accelerating the uptake of family planning services in the country, we also observed the presence of civil society initiatives that that can be strengthened to both leverage the president's public commitment to family planning and further improve FP data and services.

President Museveni's Commitments and the National Action Plan

London commitment

Whereas for some countries the commitments made in London reflected an existing governmental commitment to family planning, President Museveni's speech signaled a significant shift in his rhetoric around family planning. Traditionally not a strong advocate for family planning, Museveni was convinced to make a public pledge at the Summit by the country's family planning community.

In the lead-up to the Summit, a national consultation process managed by the Family Planning / Reproductive Health Commodity Security (FP/RHCS) working group produced eleven commitments that were proposed for adoption by the president. Because President Museveni did not cover all of the proposed commitments, his statements at the Summit are widely considered to be the official commitments that the government can be held accountable for. Some of the declared commitments are quite broad and seen as encompassing some of those that were not articulated by the president; however, the fact that they were not stated explicitly may make it harder to hold the government accountable for them. Further, a number of the eleven commitments not made by Museveni would have helped strengthen monitoring and accountability. These include the commitments to "carry out a robust evaluation of all family planning investments in Uganda" and to "conduct half-yearly RH/FP review by the Minister of

Health and the Permanent Secretary, and quarterly reviews by the Director General for Health services." While for external audiences the president's speech did not reflect the strongest endorsement of family planning, it was seen by those working in Uganda as a significant breakthrough, the fruit of decades of work, and a real opportunity to move family planning forward in the country.

National action plan

After the London Summit, the Ugandan Family Planning Technical Working Group (bringing together Ministry of Health [MOH] officials, service providers, donors, and other partners) agreed to develop a national action plan to facilitate attainment of the FP2020 objectives, under the leadership of the Assistant Commissioner for Health Services / Reproductive Health (ACHS/RH) with close involvement of the RHCS Coordinator, the Population Secretariat (PopSec), Partners in Population and Development - Africa Regional Office (PPD-ARO), Uganda Health Marketing Group (UHMG), Reproductive Health Uganda (RHU), and FHI360. The hope is that the plan will be accepted and owned by both the government and civil society.

Key Challenges

Uganda faces a number of real challenges in its efforts to realize its FP2020 commitments and significantly increase its contraceptive prevalence rate.

Government leadership

Rather than proactively leading the FP2020 effort by designing a new and comprehensive approach to family planning, President Museveni has provided an opportunity for others to move family planning forward. The family planning community inside and outside of the government will need to work hard to translate the president's commitments into real and significant change in family planning services and utilization.

In addition, the family planning movement in Uganda has recently suffered from high staff turnover in key positions at the Ministry of Health. Both the Assistant Commissioner for Health Services (Reproductive Health) and the Principal Medical Officer in Charge of Family Planning, for example, are relatively new to their positions. To make matters worse, the FP teams within the Ministry are quite small. This lack of continuity and staff shortage has been and will continue to be a constraint to moving the FP2020 effort forward.

Commitments and action plan

Another challenge faced by the FP community in the country is the lack of a clear target and coordinated action plan to guide its work. Rather than a comprehensive and

costed national plan, Uganda currently has three sets of commitments: 1) the eleven commitments produced by the FP/RHCS working group as recommendations to the president before the Summit, 2) Museveni's speech, and 3) the workplan developed by the FP technical working after the Summit, based on the president's speech (and the combination of two documents, one prepared under the leadership of ACHS/RH and the other by PPD-ARO). Of these three documents, the third (which incorporates pieces of the first two) is the one that can be considered a "plan." However, this plan does not describe what the government and its partners will jointly do to advance family planning but rather the activities a select group of FP partners inside and outside of the Ministry will carry out to ensure that the government fulfills its pledges. In some ways, it is a monitoring and advocacy plan more so than an FP strategy and implementation plan.

The only quantified commitments made by Museveni and included in the plan are to reduce unmet need for family planning from 40% to 10% by 2020 (a target that many reported to be less than ambitious) and 10 million additional dollars per year for five years for contraceptives (half of that amount from the government and the other half to be raised from donors). It is unclear what the target number of new users is, where the increases are expected to take place in the country, and how many new users each FP provider is responsible for. There are no targets for demand creation or improved qualifications of service providers, and no specific plans for improving the method mix and quality of services. International and national level actors seem to want the government to set these, while the government expects guidance from those leading the global FP movement. The only new funds committed are for the provision of contraceptives, yet our interviews revealed that accelerating the uptake of family planning services would require significant effort and funds for communication and demand creation as well as to enhance the quality of services.

A number of the individuals we spoke with indicated that a true commitment to re-launching family planning would require strong leadership from the government, broad consultation and agreement on an ambitious target, the development and costing of comprehensive strategic and programmatic plans, and fundraising to cover funding gaps.

Gap between the national and subnational levels

Beyond the lack of a clear target and plan at the national level, stakeholders expressed their concern about the significant disconnect between the national level and the district and community levels, where the real change needs to take place to move family planning forward. There seemed to be very limited exchanges – if any –

between the different levels of government around FP2020 and what was needed and expected.

Data issues

The availability, accessibility, and quality of data in Uganda are mixed. On the one hand, the country has a right-to-information act (the Access to Information Act of 2005), and according to the Open Budget Survey 2012, it produces "significant" budget information to the public (it is ranked 18th of 100 countries surveyed and highest in East Africa). However, data on how funds are utilized below the national level is incomplete and hard to analyze, in part because much of the district health budget goes toward "integrated activities." This is problematic given that most of the FP funds not earmarked for contraceptives go through the district.

Uganda's Health Management Information System (HMIS) seems to be relatively strong, especially compared to other countries in the region. Government officials and parliamentarians report having access to data around contraceptive supply and stock-outs, as well as to annual reports on health spending. Recently, the Uganda Bureau of Census started carrying out household panel surveys annually to complement DHS data with more frequent estimates.

One of stakeholders' main concerns is that the quality of data depends on the varying capacity of the individuals responsible for collecting and reporting it at health centers and at the District Health Office. Another worry is that the HMIS data does not necessarily reflect service provision by Village Health Teams (VHTs) and private providers (both of which should be reported to the district) and that it describes inputs and outputs, for example the number of contraceptives distributed rather than service quality and actual utilization. The lack of information about the quality of services is problematic given that the most critical obstacle to increased uptake of FP seems to be on the demand rather than the supply side. Identifying and addressing quality issues will be essential to improving FP utilization.

Lastly, public information is not disaggregated enough to be useful to citizens, monitors, and advocates interested in comparing the performance of different facilities or districts.

Opportunities

While the obstacles to accelerating family planning in Uganda are many, FP actors in the country can leverage the active reproductive health community, the relatively open budget process, and the country's vibrant civil society and networks.

Budget data and tracking

While Uganda is far from being a model of transparency and accountability, its budget at the national level is relatively accessible, and parliamentarians and CSOs have experience tracking spending at the national level and, in some cases, through different levels of government. Parliamentarians plan to track the contraceptive budget line, and CSOs have been involved in expenditure tracking work for a number of years. This experience will be very useful because increases in the uptake of family planning will require significant spending – and therefore also tracking – at both the national and district level to create demand and enhance service delivery. Budgets for these two areas are outside of the president’s commitments and are therefore not being tracked as closely by parliamentarians.

In addition, Uganda is benefitting from the Open Health Initiative currently piloted by the East African Community and particularly from the creation of a sub-account for reproductive health that will help stakeholders get a fuller picture of how RH services are financed. Budget and spending tracking could be enhanced with capacity building and further disaggregation of the National Health Accounts.

Engagement and coordination of non-state FP actors

One of Uganda’s key advantages is its extremely engaged family planning community within and outside of the government. While there is no national strategic or implementation plan, the Ugandan Family Planning Coalition (UFPC), formed by private FP service providers and partners in 2010, is designing a project (pending funding from UNFPA) that would map all family planning activities in the country, broken down by service provider, location, targeted population, etc. This consolidated report would help identify gaps and avoid duplication, and, by presenting both current and expected service provision, it would enable the larger community to track progress and identify challenges as they emerge. Given the current lack of information sharing, this tool would greatly enhance coordination and mutual accountability among service providers and with the ministry. UFPC and other non-state FP groups are also actively following government action to ensure that commitments are being realized and directly contributing to FP2020 – for example, by implementing the alternative distribution strategy for RH commodities.

Activist parliament

In addition to an active civil society, Uganda benefits from a very engaged parliament, organized through the Network for African Women Ministers and Parliamentarians (NAWMP) and Uganda’s Women’s Parliamentary Association (UWOPA) as well as through groups focused

on social services, maternal and child health, and youth and population issues, among others. Working closely with PPD-ARO, these groups are very engaged and influential, particularly around budget allocation, execution, and review. Last year, a number of them advocated for an increase in the budget for health workers, and when the executive refused, they blocked the approval of the budget, thus forcing a compromise.

Parliamentarians and PPD-ARO have set themselves an ambitious agenda as part of FP2020. They plan to advocate for an enabling environment for family planning, to ensure that the \$5 million USD are allocated, released and expended annually on contraceptives and RH commodities by the government and that an additional \$5 million USD are mobilized from donors for 5 years, and to advocate for higher quality health providers and services, including monitoring FP supplies available in their districts. Members of parliament as well as others described parliamentarians as key drivers of FP2020 in Uganda.

Early findings

The monitoring led by parliamentarians and civil society has so far shown positive developments. The national budget reflects the increased funding for contraceptives (though some are concerned that it is partially supported by a World Bank loan rather than “pure” government funds) and half of it has been disbursed to the National Medical Store. The tax on contraceptives has been waived (groups are now advocating for a permanent policy change), and the public and private contraceptive supplies have been separated, which is seen as enhancing the efficiency of distribution.

Quality and satisfaction

The final and perhaps most exciting opportunity in Uganda is the broad consensus that access to information about the quality of services and user satisfaction would be useful. Stakeholders among all of the groups we interviewed – ministry officials, parliamentarians, service providers and civil society – agreed that such information would be instrumental in the identification and resolution of issues in service delivery, quality and appropriateness, and thus would help enhance demand for and utilization of family planning services.

During our visit to Uganda, we met with some of the civil society organizations (CSOs) that we work with as part of the Transparency and Accountability Program (TAP) to discuss their projects and their views on what would be needed to enhance monitoring and accountability of family planning services. Our colleagues reported that district officials were very receptive to their Quantitative Service Delivery Survey (QSDS) and Citizen Report Card (CRC). While these groups have been advocating for improved health services for years, officials responded much more

positively to these results because they were seen as quantitative and representative, and therefore rigorous and reliable. In addition, they clearly highlighted service providers' constraints and concerns, on the one hand, and users' satisfaction and complaints on the other. District officials saw this data as very useful to them, as it helped them to identify major issues in service delivery and either to develop solutions to address them at the district level or to push for additional support from the national level. While our partners do not currently focus on family planning issues, these tools and lessons are likely transferable.

Citizen engagement and participation

Efforts to engage and empower citizens around health rights and accountability are also multiplying. In addition to TAP partners' work to mobilize citizens with tools such as CRCs and Community Score Cards, groups such as the White Ribbon Alliance (WRA) and DSW are working to inform communities about their roles and responsibilities, explain the political and budget process, and facilitate dialogue between communities and the district. This increased citizen and CSO engagement around budget-making, monitoring, and accountability is a great opportunity to promote improvements in health services, including FP services.

Recommendations

The recommendations below are ideas for how family planning activities and monitoring and accountability can be strengthened in Uganda. They are tentative and need to be validated with stakeholders in Uganda as well as potential funders.

Family planning implementation

- Provide technical assistance for the design of a comprehensive and costed national FP plan that involves all of the country's key family planning actors. This plan should set clear CPR and other targets as well as strategies for demand creation and improved quality of services. This national plan should be a guide for all FP actors and initiatives in the country, and responsibilities for different activities and targets should be assigned. If a funding gap emerges, the FP community should fundraise to bridge this gap.
- Provide support to district officials and subnational organizations. These actors are essential to increasing utilization in FP, but they have so far largely been left out of the national discussions and decisions. They should be

included in the national planning process and supported in developing subnational FP objectives and plans. Technical assistance should be provided for the drafting of district plans and budgets prioritizing FP as well as to facilitate collaborations between the district and CSOs and CBOs (as is being done by PPD-ARO in two districts).

Recommendations for M&A

- Provide technical support to the government to enhance the quality of data collection and analysis around FP. This would likely involve capacity building of monitoring and evaluation officers at the national, district, and facility level (once they are recruited) on data collection and analysis and on how to utilize data for discussions with other levels of government as well as for policy and/or program design and review.
- Strengthen the Health Management Information System (HMIS). This would involve enhancing the quality and reliability of the data collected as well as broadening the type of data collected to reflect quality issues, better indicators of contraceptive use (the data currently reflects distribution rather than actual use), and other data identified as important by actors at the subnational level.
- Disseminate information about and build an understanding of existing accountability systems and actors in the country. While the accountability system in Uganda needs strengthening, avenues exist for reporting issues and advocating for change. Citizens should be made aware of these and encouraged to utilize them.
- Connected to this, support efforts to engage and empower citizens around FP service monitoring and accountability.
- Support CSO monitoring and accountability work around family planning. While we did not hear of groups focusing on monitoring FP spending and services at the subnational level, civil society is active in Uganda and external actors should provide financial and technical support for relevant groups to track FP expenditures and supplies and collect data on the quality of FP services and citizens' satisfaction with services. Funders may want to finance and coordinate the collection of nationally comparable data by CSOs, since such nationally representative data would be more likely to be seen as credible.
- Reinforce links between CBOs, CSOs, district and national government officials to enhance collaborations and increase coordination of these different actors around data collection and utilization for policy and program design or reform.

FP2020: Final List of Interviewees – Uganda

Name	Organization	Position
Jackson Chekweko	Reproductive Health Uganda (RHU)	Executive Director
Hasifa Naluyiga	Reproductive Health Uganda (RHU)	Advocacy Coordinator
Moses Muwonge	Consultant	
Kenneth Mugumya	Uganda Family Planning Coalition (UFPC) Program for Accessible health, Communication and Education (PACE)	Coordinator
Anthony Mbonye	Ministry of Health (MOH)	Former Director of Reproductive Health
Janet Jackson	United Nations Population Fund (UNFPA)	Uganda Country Representative
Wilfred Ochan	United Nations Population Fund (UNFPA)	Assistant Representative
Betty Kyaddondo	Ministry of Finance (MOF)	Head of Family Health Department, Population Secretariat
Diana Nambatya	Partners in Population and Development Africa Regional Office (PPD ARO)	Program Officer
Aziz Agaba	Uganda National Health Consumers' Organization (UNHCO)	Communications Officer
Denis Kibira	Coalition for Health Promotion and Social Development (HEPS)	HEPS Uganda Medicines advisor
Robinah Lukwago	Department for International Development (DFID)	Health Advisor
Grace Namata Sagi	Department for International Development (DFID)	Deputy Program Manager
Hon. Sylvia Ssinabulya	Parliamentarian, Mityana District	Chairperson of the Network of Women Ministers and Parliamentarians
Anne Alan Sizomu	DSW (Deutsche Stiftung Weltbevoelkerung)	National Team Coordinator: Advocacy
Dr. Zainab Akol	Ministry of Health (MOH)	
Angela Akol	FHI360	Country Director
Hon. Beatrice Rwakimari	Former Parliamentarian	Board member of WRA-Uganda and NMS
Kelsi Kriitmaa	Marie Stopes Uganda (MSU)	Consultant
Lois Nantayi	Marie Stopes Uganda (MSU)	M&E Manager
Steven Baveewo	Marie Stopes Uganda (MSU)	
Jennifer Wanyana	Uganda Health Marketing Group (UHMG)	Head Reproductive and Child Health
Albert Kalangwa	MOH/UNFPA	Reproductive Health Commodity Security Coordinator
Robina Biteyi	White Ribbon Alliance Uganda (WRA-U)	National Coordinator



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