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Comparative Analysis of the Funding Priorities and Best Practices in Family Planning Programming as Defined by Three Major INGO Funders: USAID, DFID and The Gates Foundation: A Special Studies Project

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Abstract

Comparative Analysis of the Funding Priorities and Best Practices in Family Planning Programming as Defined by Three Major INGO Funders: USAID, DFID and The Gates Foundation: A Special Studies Project

By Melissa Holmes

Introduction: There is a major need to address the unmet need for family planning in low-and-middle-income countries (LMIC). Many women of reproductive age in developing countries who want to avoid pregnancy are not using a modern form of contraception. This fact spurred an overwhelming commitment to family planning (FP) by the global health and international development communities. In 2012 and again in 2017, global leaders met in London and committed to providing voluntary FP services to 120 million women in the developing world. International non-governmental organizations (INGO) are major implementers of FP programs and projects. The three major donors that provide financial support for FP programs are the United States Agency for International Development (USAID), the UK's Department for International Development (DFID), and the Bill and Melinda Gates Foundation (BMGF).

Statement of Purpose: This project grew out of my work with CARE International in Atlanta, GA. As a part of my internship, I was tasked with conducting a comprehensive literature review that examined and highlighted USAID's best practices, key tools and approaches, and exemplar funded programs in a variety of topical areas. This project is an expansion of that work and is aimed at identifying the FP- and sexual and reproductive health (SRH)-focused priorities, key strategies, and approaches as defined by the three major international FP funders: USAID, DFID, and BMGF. The purpose of this project is to inform INGOs' program design and resource mobilization efforts as they work to develop proposals for these three donors. INGOs engage in a very competitive process to secure funding for their FP programs. In-depth knowledge of what funders deem important is key to submitting successful program proposals as a prime organization.

Methods: The literature review and results were based on searches of Google Scholar, PubMed, and donor funding databases, as well as, insight from CARE staff members. The data found were examined for keywords, recurring phrases, and direct statements related to FP priorities. Funding databases were used to examine previously funded international FP programs by the three donors.

Discussion: Through my review of the literature and funding databases, I found that all three organizations have similar overlapping priorities, including gender equality, increasing uptake of modern methods, and prioritizing adolescents. USAID emphasizes self-reliance and resilience and cannot currently support any program that advocates for safe and legal abortion. DFID is committed to ensuring access to safe, legal abortions in countries where they work. They also prioritize work with vulnerable and disabled populations, violence against women, and ensuring value for money spent on programming and interventions. BMGF is committed to finding novel contraceptive technology that is accessible to those who current methods are not useful for. The foundation is also very interested in work that adds to the evidence base and can be scaled up in other contexts.

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To my family and friends. Thank you all for the encouragement to keep going when it was hard for me. Thank you for always believing in me, supporting me, and loving me. I would not be where I am without you all. A special thank you to my mother and father who have sacrificed so much for me to be where I am today.

I would be remiss if I did not thank all of the doctors, nurses, nurse aides, cleaning staff, and all other essential workers on the frontlines every day during the COVID-19 pandemic. I feel prouder than ever to be in the field of Public Health at this monumental time in history and frontline workers give me motivation and inspiration to continue every day.

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Introduction

1.1 - Purpose statement

International non-governmental organizations (INGOs) are imperative components to the global system working to combat negative health and population outcomes around the world. These organizations rely on donor funding for the majority of their programs and operations. An area of paramount interest to the global health landscape is that of family planning (FP). This project grew out of my work with CARE International in Atlanta, Georgia. As a part of my internship, I was tasked with conducting a comprehensive literature review that examined and highlighted USAID's best practices, key tools and approaches, and exemplar funded programs in sexual and reproductive health and rights (SRHR). I then provided recommendations for how they could best align their strategy with that of USAID's to obtain funding. As an extension of that project, I decided to include two other donors in this paper. The purpose of this thesis is to provide a comparative analysis on the priorities, key approaches, and strategies as defined by the three largest INGO funders for FP: United States Agency for International Development (USAID), the UK's Department for International Development (DFID), and the Bill and Melinda Gates Foundation (BMGF).

This special studies thesis provides concrete guidance to INGO's preparing program proposals related to FP for one of these three major global funders. I begin with an introduction on international development, the centrality of FP to global health and economic development, the FP funding landscape, and the importance of knowing a funder's evolving priorities in order to obtain funding. Then I describe my search strategy, which utilizes funding databases and search engines to conduct a comprehensive literature review. I then discuss each of the three

funder's major strategies and describe exemplar programs. I end by providing clear recommendations for how INGO's can utilize this information to inform their programming.

1.2 - International Development and Global Health

Financial support is central to the success, continuation, and eventual phase down of international development when specific goals are achieved and maintained. Many low-and-middle-income countries (LMICs) rely on services, supplies, programming, interventions, and infrastructure from developed nations to help provide and sustain essential needs and services. The overarching goal of international development is to propel societies out of poverty and into resilient states that have the capacity and wherewithal to meet their citizens' basic human rights. Major international development funders include bilateral or individual government agencies, multilateral or multinational agencies, private foundations or individuals, businesses and corporations, and civil societies. In practice, donor governments channel most funds through INGOs (1). The field of global health research, practice, etc., although interwoven with all other aspects of development, constitutes a considerable sector of development, receiving large amounts of funding. According to the World Bank, donor funding for global health grew from US$2.5 billion in 1990 to almost US$14 billion in 2005 (2). Since the Sustainable Development Goals (SDGs) were set in 2015, global health spending has increased by the year, totaling US $16 billion in 2017 (3). In addition, private funding for health has grown substantially and is now thought to account for about a quarter of all development aid for health (2). The importance of this donor funding for health and human development cannot be overstated. In fact, 26 LMIC'S rely on donor funding for approximately one-fifth of their health spending (3). Until these countries become completely self-reliant, the paramount goal of international development, funding for health will continue to be necessary to save millions of lives and avert major

disastrous health outcomes. Governments in many high-income countries, as well as private organizations and INGOs realize the overwhelming need and have pledged time, money, and resources to achieving the common goal of health equity, including equitable access to sexual and reproductive health commodities and services.

1.3 - Importance of Family Planning

Women and girls' SRHR are a recognized cornerstone of health equity and a critical determinant of a number of downstream health and economic outcomes. As such, SRHR has become of high priority in the global health landscape in the last few decades. The International Conference on Population and Development (ICPD) in 1994 was a key meeting that emphasized the need to focus on women's SRHR. This meeting was the first time there was an official UN consensus that acknowledged women's human rights extends to matters of sexuality and reproduction and that all people should have access to comprehensive services and information (4). FP allows people to attain their desired number of children and determine the spacing of pregnancies (5). Of major concern to the global health is the fact that 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern form of contraception (5). This fact has major implications for not only a woman's autonomy and life trajectory, but also a country's ability and capacity to develop. Women trying to access FP services face many obstacles such as lack of access to information and health services, opposition from their husbands, family members, and communities, misperceptions and cost. If the demand for FP needs were met, 54 million unintended pregnancies, 79,000 maternal deaths, and more than a million infant deaths could be avoided (6). Promotion of FP is essential to securing the well-being of women and girls around the world. By reducing the number of births and unsafe abortions, FP also reduces maternal mortality and morbidity (7). The ICPD set targets

for donor funding to support FP programs and new initiatives, such as FP2020, have renewed focus on the need for adequate funding for voluntary and rights-based FP (7). In 2012, global leaders met in London for the London Family Planning Summit co-hosted by BMGF and DFID. Leaders from around the world committed to providing voluntary FP services to 120 million women in the world's poorest countries by 2020 (7). In 2018, donor governments disbursed $1.5 billion USD in bilateral funding for FP activities, an increase of 19% from 2017 (8). Approximately two-thirds of the increase was from the United States, the world's largest global health donor (8). However, FP has been and remains a controversial topic in most, if not all, areas of the world. A point that will be expanded on in subsequent sections is that a country's policies around reproductive health (RH) and FP have a major impact on the programs they institute and fund. Global health donors increasingly rely on INGOs as partners, especially in controversial policy domains such as RH (1). Given the importance of FP, many health focused INGOs have an ever-increasing desire to implement programs and interventions focused on women and girl's SRHR and on equitable access to contraception for all.

1.4 - The Funding Landscape

Although, some international donors manage and implement their own global health programs, it is much more common for them to fund INGOs and local NGOs in developing countries to plan, manage, and carry out work that aligns with the priorities of the donor, NGO, target country, and global development landscape. Since the early 1980s, donors have favored NGOs over governments as recipients of funding (9). This preference stems from the idea that governments favor political ends as opposed to development concerns (9). NGOs are the most common recipients of global health funding from bilateral and private organizations because they are able to efficiently deliver results, are cheaper than the private sector, and have values that

make them “suitable agents of inspired change” (9). INGOs, in particular, are major agents of change and global health development. The budgets of some of the larger INGOs have surpassed those of some Organization of Economic Development (OECD) donor countries and eight major INGOS (World Vision International, Oxfam International, Save the Children International, Plan International, Médecins Sans Frontières, CARE International, CARITAS International and ActionAid International) had a combined revenue of more than US$11.7 billion in 2011, nearly doubling since 2005 (10). These organizations are a vital part of the work being done in global health and FP.

This thesis focuses on INGOs and their role as recipients of donor funds for the development, evaluation, or support of FP. This includes programs or research related to behavior change, commodities, logistics, health-systems strengthening, provider training, and direct services. INGOs have global operations, with multiple autonomous offices around the world that operate together as global consortia, confederations, or affiliations (10). However, it is important to note that most INGOs are based in Europe or the United States. They typically have larger reach and scope, and a broader capacity to implement and evaluate than local NGOs as reflected by their larger budgets. These larger budgets are often due to headquarters in developed nations, increased capacity for fundraising, greater perceived legitimacy and influence with governments and donors, and the capacity to use funds at economies of scale (10). INGOs are usually non-profit entities and receive their funding only from governments, private foundations, philanthropic organizations or individuals. The majority of funding for NGOs in Europe comes from private foundations while many US-based NGOs receive funding from the US government (2). There are many environmental constraints that INGOs have to confront in their regular operation. They have to take into consideration donor expectations, the regulatory environment

of the state they are working in, and their own priorities. Figure 1, reproduced from Heiss, explains the environment an INGO faces (11). Here we focus on the link between donors and NGOS.

The process for obtaining funding from global health donors to carry out a FP-related project or program is intensive and competitive. INGOs can submit proposals as a prime organization, meaning they are the main program implementer, or a sub organization, meaning they are a secondary implementer assisting on a specified segment of the project. The goal for most, if not all, large INGOs is to secure funding for as many prime proposals as possible. In order to accomplish that goal INGOs must know the priorities, key strategies and frameworks, technical language, and best practices of each specific funder. This can be a complex task because donor priorities are ever-changing, resources can be hard to find, and INGOs have their own set of values and priorities that they strive to maintain. This complexity of this task led Mitchell and Schmitz to coin the term "principled instrumentalism," a strategy wherein INGOs pursue their principled objectives within the economic constraints and political opportunity structures imposed by their eternal environments (11). As donor organizations have grown to adopt a culture of professionalism, they have raised their demands for accountability and performance in the INGOs they fund (11). Heiss asserts that at the start of a new set of international development goals, the relationship between donor and INGO are crucial to understand (11). The three major donors for FP, as defined by amount of funds spent, are the USAID, the UK's DFID, and the BMGF (8). USAID and DFID are bilateral donors and BMGF is a private philanthropic organization.

Being that USAID and DFID are arms of the US and the UK governments, respectively, these institutions are subject to the policies of these two nations and an ever-changing political climate. BMGF is a philanthropic organization and thus, is not subject to any country's laws or policies beyond the countries where they work. This special studies project assesses the FP priorities of each organization and provides a comparative analysis of their funding trends and key tools and approaches. I end the thesis with recommendations on how INGOs can draft successful proposals that speak the language of these three major funders.

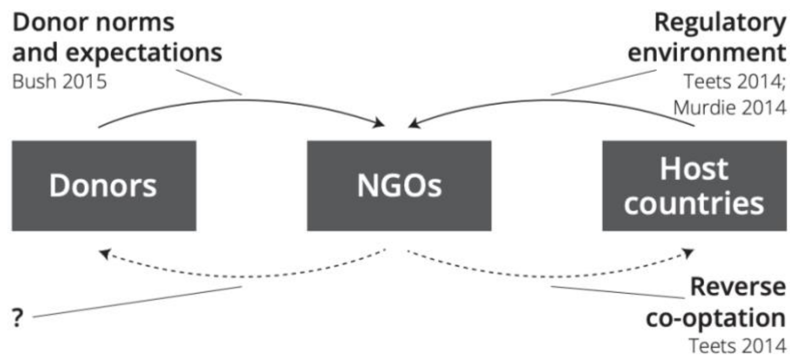

FIGURE 1. THE DUAL ENVIRONMENTAL CONSTRAINTS CONFRONTING INGOS, HEISS, 2017.

Methodology

This section outlines the methods used to search for and determine key approaches, strategies and tools essential for obtaining FP- and SRHR-related funding as described and suggested by the three largest INGO FP funders.

2.1 - Systematic search for articles for literature review inclusion

The first step in trying to understand each funder, their priorities, and their funding patterns in a comprehensive manner was to do systematic search of the literature to find both published and unpublished literature in the form of policy briefs, technical documents, program evaluations, toolkits, and editorials. The findings from these database searches were the basis of the literature review.

For USAID, I first explored the main website (usaid.gov) for any documents related to FP. Many of the documents referenced in the literature review can be found on the usaid.gov website under the global health and family planning tabs. I then used Google Scholar and USAID's Development Experience Clearinghouse (DEC) to identify additional documentation. The DEC is the largest online repository for USAID funded technical and program documentation, representing funding-related decision making for more than 50 years of USAID's existence. The search terms I used for DEC were "family planning," "family planning best practices," "family planning approaches," "family planning tools," "contraception best practice," "contraception approaches,", "family planning programs," "contraception programs," and "Sexual and Reproductive Health." In addition to the tools on the USAID website, I used Google Scholar to identify additional USAID funding-related documents. When using Google Scholar I used the search terms "family planning USAID," "family planning best practices USAID," "family planning approaches USAID," "family planning tools USAID," "contraception best practice USAID," "contraception approaches USAID," "family planning programs USAID," "contraception programs USAID," and "Sexual and Reproductive Health USAID." I chose articles for my literature review that were either written by USAID staff, were about projects funded by USAID, had contributing authors from USAID, or were referenced in a USAID document. While exploring articles I specified years 2010-2020, as to obtain information that was still relevant. I was looking for any mention of key frameworks, strategies, key definitions, or tools recommended or provided by USAID in terms of their general approach to programming and FP in specific. I also noted documents that went into detail about a specific USAID-funded program. Fourteen articles were selected for inclusion in the literature review.

For DFID, I used Google Scholar, PubMed, and the gov.uk website. This website provides information on government services in the UK. A segment of the website is dedicated to the DFID, the family planning funding mechanism of the UK government. I used the search terms “DFID family planning,” “DFID family planning best practices,” “DFID family planning approaches,” “DFID family planning tools,” “DFID contraception programs,” “DFID contraception approaches,” “DFID sexual and reproductive health.” In my database search I also searched from 2010-2020 and was looking for clear descriptions of DFID’s approach to programming and FP priorities. Sixteen articles were selected for inclusion in the literature review. They were either developed by DFID or funded, initiated, or supported by DFID.

As a private foundation, the BMGF is not obligated to post resources related to their policies, priorities, best practices, or frameworks and thus it was substantially harder to find supportive documents for the literature review. I started with a search of the gatesfoundation.org website to identify the foundation FP strategy and any related policies or programs. I also utilized Google Scholar and PubMed to pinpoint essential documents. I used the search terms “Gates Foundation Family Planning,” “Gates Foundation family planning strategy,” “Gates foundation family planning approaches,” “Gates foundation sexual and reproductive health,” and “Gates foundation contraception.” This led me to many articles authored or co-authored by Melinda Gates. I also found documents on work funded by BMGF and articles describing BMGF’s commitments and ideals. Eight articles and papers were selected for inclusion in the literature. Lastly, I interviewed a member of the foundations team at CARE International who was able to provide me with some additional insights based on her experience with BMGF and their most current presentation on FP strategies and priorities.

2.2 - Funding Databases

It is important for INGOs applying for funding to be familiar with past and current programs that a specific funder has invested in. This will give some insight into what the funder deems exemplary in regard to program design, implementation, and monitoring and evaluation. To find this information, I used a number of different funding databases.

I utilized usspending.gov for information on programs funded by USAID in the last fiscal years (FY). Usspending.gov provides information on contracts, awards, and grants broken down by combinations of agency and recipient. The website has a spending explorer function that enables you to do advanced searches of grants. For award type, I selected “grants only,” searched the keyword “Family Planning,” and selected FY 2015-FY 2020. This returned a result of 26 grants from varying prime organizations.

The development tracker for DFID funding decisions can be accessed at devtracker.dfid.gov.uk. This website allowed me to explore where DFID’s aid goes and how it is being used. The DFID funding browser allows searches of programming DFID is currently funding. You have the option to explore aid by sector, by location, or by UK government department. I explored aid by sector, selecting the health sector, and further specified “Population policies/Programmes and Reproductive Health”. From there, I selected “Family Planning” and was given a list of the current active projects. The development tracker gives you a breakdown of how much DFID is spending in each sector and sub-sectors. It allows you to filter by country, region, and implementing organizations. This search returned a result of 36 active projects. After filtering for a start date of 2015 to keep consistent with my US search, I was left with 29 active projects.

BMGF also has a database that allows searches of former and active projects through their main website gatesfoundation.org. The database includes grant payments made by BMGF from 1994 to the present. There are options to filter by program, issue, year, and region. I specified "Family Planning" for issue and explored years 2015-2020. Gates also has a research database that can be accessed through gatesopenresarch.org. This tool provides any peer-reviewed paper funded by the foundation. I searched "family planning" and "family planning indicators." Searching for programs from 2015-2020 provided information on the most current funded projects. Because of the changes to governments and to global goals for FP-related programs, I excluded funding decisions for programs before 2015 as these decisions would not provide current advice to guide INGOs in their approaches to these three key funders.

Literature Review

United States Agency for International for International Development (USAID)

3.1 - US Family Planning History

USAID launched its first FP program in 1965 and by the end of the 60's the US government had emerged as a world leader committed to FP and providing condoms and contraceptives to a number of LMIC countries. In 2018, USAID was the largest bilateral donor to FP, providing $630.6 million or 42% of total bilateral funding from governments (8). Today USAID supplies 35 to 40 percent of donor-provided contraceptives to the developing world and supplies nearly 30 FP programs in 20 countries with technical and logistical support (12). In 1982 the United States issued a policy paper stating that their FP principles would be based on the "fundamental principles of volunteerism and informed choice and restrictions on abortion (12)." However, a bipartisan system in the United States has meant ever-changing policies around historically controversial RH topics. In 1984, President Ronald Reagan announced the

Mexico City Policy. This policy regulation prohibits INGOs from using their own or other non-USAID funds to provide or promote abortion as a FP method (13). Since then, the Mexico City Policy has been rescinded by every Democratic President and reinstated by every Republican President, most recently Donald Trump. Under the past conservative administrations, the policy has caused severe disruptions to FP efforts overseas. Also known as "The Global Gag Rule," President Trump's exacerbated rendition of the Mexico City Policy dictates that US supported international FP groups, programs, and projects abroad may no longer use their own money to provide safe and legal abortion services, information, or referrals to abortion (14). This has grave consequences for INGOs working in FP and which would benefit from access to US government funds. Any local NGO or INGO cannot mention or promote abortion as a FP measure, even if they are not using US government funds for that work. Between the Obama administration and the Trump administration's reinstatement of the policy, the government accountability office has documented 54 projects that have lost funding in the areas of FP or RH, HIV/AIDS, tuberculosis, nutrition, and maternal and child health (15). The Mexico City policy has drastic implications for the work that USAID is able to fund. While this policy is ever-changing and subject to the jurisdiction of the current president, there are many SRHR-related ideals that USAID has remained true to for many years.

USAID's Office of Population and Reproductive Health acts as the driving force behind USAID-supported flagship FP programs. This office supports programs encompassing the key components of FP: service delivery, performance improvement, contraceptive supply and logistics, health communication, biomedical and social science research, policy analysis, and planning, monitoring and evaluating (12). There are many countries in Latin America and the Caribbean that have reached "graduated" status, meaning they have achieved a desired level of

FP use and no longer are a priority for USAID. The current US government priority countries are Afghanistan, Bangladesh, DRC, Ethiopia, Ghana, Haiti, India, Kenya, Liberia, Madagascar, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Philippines, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen, and Zambia (15). These countries have total fertility rates (TFR) between 2.2 - 5.9. USAID defines TFR as the number of children per women 15-49 in age and the modern contraceptive prevalence rate (MCPR) as the percentage of married or in-union women in the same age range using any form of modern contraception (16).

3.2 - USAID Strategy

USAID's overall objective is to support partner countries on their "journey to self-reliance," the phrase used to describe countries that become capable of leading their own development efforts over time. USAID orients its strategies, partnership practices, and program practices to help end the need for foreign assistance in partner countries (17). USAID's policy framework for 2019 presents a vision for building a country's capacity and ensuring a commitment to see the solutions through (16). USAID stated their plans in the 2019 Policy framework to reorient their programs to foster self-reliance more effectively. Thus, a key component of their "Acting on the Call" Report - USAID's approach to pursuing the greatest improvements in maternal and child survival - is self-reliance. This strategy is USAID's approach to improving maternal and child survival by scaling up high-impact interventions to those that need it most (18). A large part of this strategy is building up a country's capacity to manage their own health care systems effectively with regard for those in the hardest to reach areas of the world. USAID believes the key to helping foster self-reliance in priority countries is to strengthen in-country capacity and to align with the private sector, civil society, and faith-

based organizations, prioritizing approaches that drive accountability, and placing mobilization of domestic resources at the center (16).

USAID's strategy to improve maternal and child health, including RH, is grounded in health care that is accessible, affordable, accountable and reliable as stated in the 2018 Acting on the Call Report (18). USAID defines accessibility as health care that is available when and where women and their families need it and can use it, accountability as a society working together to ensure it meets people's needs, affordable when cost does not prevent people from accessing it, and reliable when delivered in a timely manner that promotes dignity and respect for all patients and providers (18). USAID uses couple years protection (CYP) to estimate the protection provided by contraceptive methods during a one-year period based on the volume of contraceptives distributed free of charge to clients during that period (18). They also reference High-Impact Practice (HIP) briefs on their website, in their briefs, and led an interagency process to synthesize and disseminate HIP's to strengthen FP programs.

3.3 - Approach for Expanding Choice and Access to LARC's

USAID acknowledges that long-acting and reversible contraceptives (LARCs) and permanent contraceptive methods (PM) have the highest continuation rate of any other contraception form. Their approach for expanding choice and access to LARCs suggests voluntary use of LARCs can be appropriate for women and girls at any stage of life, and especially important for adolescents looking to delay their first birth (19). USAID's approach also suggests PM are a good choice for men, women, and families who have reached their desired number of children (19). The three key factors USAID identifies as essential to expanding access to LARCs and PMs are supply, demand, and an enabling environment. In regard to supply, utilization of LARCs and PMs require skilled, trained personnel, medical

instruments, and consumable supplies specific to each method (19). They note that many countries have transitioned to task shifting with supportive supervision and referrals to expand access to these methods (19). In regard to demand, the approach notes that uptake of LARCs and PMs benefit from behavior change communication to increase awareness of available methods and their efficacy and efficiency. To ensure an enabling environment, policies should ensure wide access to these methods to all women and that cost is not a barrier to use (19). USAID touts many effective approaches to expanding access to LARCs such as: mobile outreach, dedicated providers, task shifting. Sharing, social franchise private providers, and integrated services (19).

3.4 - Engaging Men, Boys, and the Community

Gender inequalities in RH was a key topic at the ICPD conference in 1994 (4). The emphasis led to programs among many organizations that strove to combat gender inequality and provide services for men and boys, as well as, women and girls. USAID recognizes that engaging men and boys is critical to improving FP outcomes for both women and men (20). They refer to males engaged in FP as clients/users, supportive partners, and agents of change. USAID suggests that "intentional attention to challenging unequal power dynamics and transforming harmful forms of masculinity" is an integral component of successful FP programs that involve men and boys (20). Programs must consider the unique needs of men and boys at different stages of life, provide male-friendly services that train providers and staff on men's FP needs, and consider policy changes that constrain men's use of services (20). USAID's essential considerations include adolescent-friendly health services, community-based distribution of information and condoms, and addressing method specific barriers. Social and behavior change (SBC) activities are essential for positioning men as supportive partners by addressing

knowledge of services and FP methods, reducing negative attitudes and inequitable gender norms, and increasing partner communication and joint decision making (20). USAID suggests programs use the Gender Integration Continuum, a framework created by the Interagency Gender Working Group, that provides guidance for integrating gender into FP- and other health- and development-related programming (21). Activities and interventions can either be *gender-blind*, not taking gender into account, or *gender-aware,* when they recognize gender-constructs (20). Most importantly, USAID specifies that programs should avoid being *gender-exploitative,* or reinforcing inequitable gender norms, and instead work towards being *gender-accommodating,* working around gender norms and *gender-transformative,* working to challenge and change inequitable gender norms (20)

3.5 - Healthy Timing and Spacing of Pregnancy

USAID believes investing in healthy timing and spacing of pregnancy (HTSP) improves the health and well-being of women and girls and accelerates the pace of improvements in child survival. Their strategy for improving health and well-being and improving child survival includes educating women, girls, and their families on FP's role in making sure pregnancies are timed and spaced to occur at the healthiest time (22). They also note that behavior change communication and counseling can help couples understand how FP can help reduce high-risk programs (22). The strategy also recommends expanding the mix of available contraceptives including LARCs and lactational amenorrhea, and enacting policies that support women and girl's FP health, and education needs to maximize the benefits of the demographic dividend (23). The demographic dividend is defined as the opportunity for rapid growth in the economy associated with a change in age structure when coupled with economic policies that promote job growth (23).

3.6 - Exemplar Programs

USAID has a number of programs dedicated to utilizing FP as a way to improve the health of women and their newborns, give women autonomy and the opportunity to live a life of their choosing, enact policy that is supportive and effective, and build capacity for more self-reliant countries. In this section, I describe several of USAID's successful FP-focused programs. These programs were effective in accomplishing their goals and are highlighted by USAID so may help INGO's develop their own successful funding proposals.

The Extending Service Delivery (ESD) model program managed by Pathfinder International was designed to address an unmet need for FP and increase the use of RH and FP services at the community level and among underserved populations. This program realized the importance of the influence that communities of faith and religious leaders have over the decisions that communities make in regard to FP. Their strategy was to engage Muslim religious leader as "champions" of RH and FP at the national and local level (24). The first step was to identify who leaders who were prominent, charismatic, and had a progressive interpretation of Islam (24). They built partnerships in the community and produced a facilitator manual for leaders to use. In the implementation phase they worked on capacity building and outreach services, where religious leaders encouraged the community to utilize services (24). In the last phase, implementers documented and disseminated results as well as performed monitoring and evaluation (24). Figure 2, reproduced from the ESD model, depicts all phases of the model (24). Surveys of community members in these populations found that ESD, implemented from 2010-2014 resulted in an increase of contraception among youth but it remains low indicating more work needs to be done (25).

Another successful aspect of the ESD program was their approach for promoting private-public partnerships in FP. Their strategy included creating a training workshop which applied principles of corporate social responsibility (CSR) to remove some of the barriers the private sector, public sector, and NGOs face when trying to work together (25). The workshop was three days and led participants through a series of participatory exercises and skills-development sessions. The immediate results of the workshop showed it was an effective strategy for getting NGOs and businesses to effectively network and identify ways to work together, as well as, shifting participant perspectives to see each other as partners(25). In a brief explaining the approach, ESD implementers note that they learned multi-sector workshops on forming partnerships have great potential for creating public-private partnerships, that it is most effective to have workshops focused on "partnerships in health" rather than tailored to RH and FP, and a critical mass of participants from each sector is required for success (25).

USAID's flagship maternal and child health program, the Maternal and Child Survival Program (MCSP) ran from 2014-2015 in over 50 countries. Their integrated program (MCHIP), worked to integrate FP along the Maternal, Newborn, and Child Health (MNCH) continuum of care. Their approach was aimed at reducing the spacing between births and they took advantage of the frequent contact women have with healthcare providers while pregnant and in the two years prior to pregnancy and integrated FP counseling and services when feasible during these contacts (26). They defined postpartum FP (PPFP) as

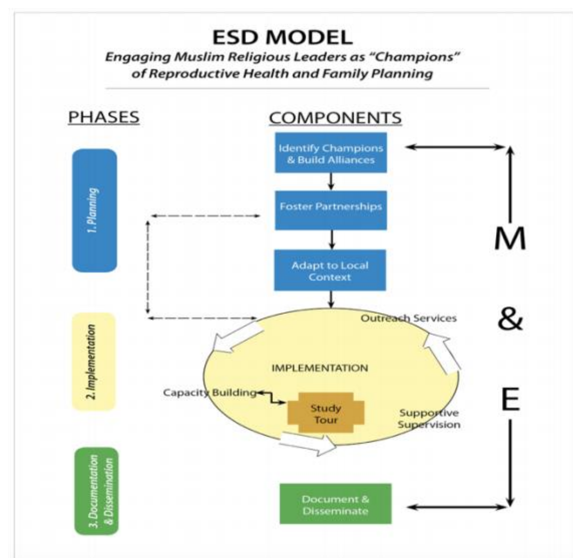

FIGURE 2. ESD MODEL: ENGAGING MUSLIM RELIGIOUS LEADERS AS "CHAMPIONS" OF REPRODUCTIVE HEALTH AND FAMILY PLANNING.

the safe initiation of an effective method of contraception prior to the return to fertility and continuing to use a method for at least 24 months (26). To promote PPFP, MCHIP assured proactive counseling to women, implemented PPFP at the facility and community level, fostered an enabling environment for PPFP (26).

Department for International Development (DFID)

3.7 - DFID and Family Planning

DFID, founded in 1997, leads the UK's work to end extreme poverty, and has quickly become a key player in RH and FP. In 2012 and again in 2017, DFID, along with BMGF hosted the London Summit on Family Planning. Partners from all over the world came together to support the right of women and girls to decide, freely and for themselves, if, when, and how many children they will have (27). DFID's role as a host partner is a testament to their dedication to FP and positioned them as a world leader in FP. In 2018, DFID was the second largest country donor to FP, contributing 19% of total bilateral disbursements, only second to the United States (8). Since 2016 the amount of aid DFID contributes to FP has increased, totaling US $292.2 million in 2018 (8). In 2010, the UK government announced it was going to put FP at the heart of its approach to women's health in the developing world by increasing the availability of FP to meet the demands of the world's poorest women (28). This consultation highlighted a range of issues DFID would be working on including FP, adolescent fertility, unsafe abortion, and antenatal care (27). In 2019, DFID pledged to spend an extra £600m to support FP programs in some of the world's poorest countries (29). Most of the money will be given to the United Nations Population Fund (UNFPA) between 2020-2020 (30). This increase in funding is likely related to the funding shortfall UNFPA experienced as a result of the US decision to defund them upon reinstatement of the Mexico City Policy. Over the next 5 years, DFID asserts this funding

will give over 20 million women and girls access to FP, prevent more than 5 million unintended pregnancies, prevent at least 1.5 million potentially fatal unsafe abortions, and save an estimated 9,000 women's lives per year (28). DFID invests in research that support the UK government's framework for results on improving reproductive, maternal, and newborn health in the developing world. The government's commitment to FP is a strategy to reduce maternal mortality, slow population growth, empower women, and accelerate development progress (31). DFID uses contraceptive prevalence rate (CPR) to measure the percentage of women aged 15-49 years who are using, or whose partners are using, contraception (30). It may be reported for modern and traditional methods or just modern methods, for all women or just women married or in a union.

3.8 - DFID's Priorities and Responsibilities

DFID's main priorities are strengthening global peace, security and governance, strengthening resilience and response to crisis, promoting global prosperity, tackling extreme poverty and helping the world's most vulnerable, and delivering value for money (32). Their single departmental plan lays out their objectives and how they plan to achieve them. Important to them is delivering value for money, which they assert will be achieved through driving efficiency and effectiveness of programs and tough independent evaluation of programming (32). Two of their seven main responsibilities are improving the lives of girls and women through better education, a greater choice in FP, and preventing violence against girls and women in the developing world. In 2010 they published their framework for results for improving reproductive, maternal and newborn health in the developing world entitled "Choices for Women: planned pregnancies, safe births, and healthy newborns." Their two strategic priorities were to prevent unintended pregnancies by enabling women and adolescents to choose whether,

when and how many children they have and to ensure pregnancy and childbirth are safe for mothers and babies (33). The four pillars for action for the framework are: empower women and girls to make healthy reproductive choices, remove barriers that prevent access to quality services, particularly for the poorest and most at risk, expand the supply of quality services, and enhance accountability (33). The focus of this framework was on reaching the poorest 40% of women, adolescent girls and women of reproductive age and their newborn babies, and those affected by conflict and crises. Figure 3, repurposed from the RMNCH strategy document, displays their framework for results (33). To empower women and girls DFID emphasizes the importance of education and economic literacy, as well as, locally driven social change activities to change norms that prevent women and girls from having control (33)To help remove barriers to access they suggest making services free at the point of use, cash transfers, cash incentives, vouchers for use of a particular services, and subsidized FP products (33). In the framework they mention that DFID does not support abortion as a FP method but can support services and make abortion more accessible where it is permitted. DFID has a long history of supporting research into maternal and newborn health within its overall strategy on FP making contributions through knowledge generation and building evidence of cost-effectiveness. At the London family planning summit in 2017, the secretary of state announced DFID's demand for humanitarian partners to deliver the minimum initial service package (MISP) for RH services when it is required. They also placed an emphasis on FP in humanitarian and refugee settings. The MISP is the international standard for RH care in crisis settings, it defines a set of life-saving priority activities (27).

3.9 - Abortion

DFID does not promote abortion as a method of FP but realizes that safe abortion reduces the incidence of unsafe abortion and saves women and children's lives (34). Their policy position on safe and unsafe abortion highlights that notion that often sexual intercourse takes place in circumstances that are not chosen or without consent and that youngest and poorest women are the least able to fulfill their reproductive needs (34). DFID's belief is that the best way to eliminate unsafe abortion is to improve access to comprehensive FP information, services and supplies, and ensure women and girls have more control over the circumstances in which they have sex. DFID supports programs that make safe abortion more accessible where abortion is permitted in order to reduce the number of women who die from complications of unsafe abortion. Some examples of what DFID is prepared to support in the context of abortion-related programming are: training of health personnel in safe abortion techniques, including medical abortion and counseling for comprehensive abortion care, life-saving post-abortion care, the provision of drugs and equipment for health facilities, improving the conditions under which services are rendered, and the provision of information to health personnel and women, improvement of service quality, and research to monitor progress in improving health outcomes (34). In 2019, DFID announced a new UK aid package for the safe abortion action fund (SAAF). This fund provides access to safe abortion for some of the world's poorest and most vulnerable women (35). DFID emphasizes that they do not shy away from difficult issues, when there is clear evidence that addressing these issues (like ending unsafe abortion) works towards health equity and ending maternal mortality. A recent Lancet study showed that stopping funding to an organization that offers abortion did not stop abortions but actually led to an increase (35). SAAF works to educate women in need of abortion services and offer them modern contraceptive

methods, address myths and stigma regarding abortion in communities, offer counseling, and campaign for safer legislation and services on safe abortion and rights (36).

3.10 – Gender Equality and Young People

DFID has become the biggest funder of programs to prevent violence against women (37). Their newly funded 'What Works to Prevent Violence: Impact at Scale,' program is a scale up of a 2014 initiative. This project gathers evidence about the scale and impact of violence against women and girls and ways to stop it (37). DFID would like to pilot programs specifically focused on adolescents and those with disabilities. In their strategic vision for gender equality, DFID asserts they recognize a wholesale system-wide change is needed to achieve gender equality. They call development partners to action to uphold the highest standards of safeguarding and protection, preventing sexual exploitation and abuse of beneficiaries, staff, and volunteers (38). They also state the importance of development partners using their diplomatic leverage and partnerships to support women's rights organizations and wider civil society to promote gender equality (38). Their vision includes challenging and changing unequal power relations, protecting and empowering women in conflict, integrating gender equality in all work, leaving no women behind including those with disabilities, and working across women's lifecycle to meet their needs, with particular attention to adolescents (38) In 2016, DFID published their youth agenda entitled "Putting young people at the Heart of Development." DFID believes their aid strategy will be impossible to achieve if young people are not engaged seriously (39). DFID takes a "lifecycle approach" to youth and adolescents, mostly considering individuals aged 10-24, but recognizing young people outside that bracket will also be transitioning into adulthood (39). DFID believes this lifecycle approach enables them to go beyond age when defining young people and include those most likely to be excluded, including

young people with disabilities, lesbian, gay, bisexual, and transgender (LGBT) youth, and young people with mental impairments (39). DFID places young people at the center of their framework for working with youth, surrounded by positive transitions, advocates, and change agents (40) Key focus areas for DFID include: education, SRHR, and challenging social norms (39).

3.11 - Flagship Programs

In line with DFID's commitment to "leave no one behind," the Women's Integrated Sexual Health (WISH) program is a multi-country SRH initiative that promises to benefit a significant number of women, particularly youth under 20, the very poor, and the marginalized (people with disabilities, people who have been displaced or affected by humanitarian crisis, and those in hard-to-reach areas) (41). The WISH program began in 2018 and is being implemented by the International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI). WISH aims to deliver sustainable multi-country improvements through four key outputs: individual choice, national ownership, access to services, and global goods (41). Central to their approach is supporting governments to prioritize SRHR and FP through domestic financing (29).

Another current DFID program that DFID highlights as successful is the Family Planning by Choice Program in Ethiopia. This program began in 2017 and is set to run until 2021, MSI and the Ministry of Health (MOH) in Ethiopia are the implementing partners. The program addresses unmet need of couples by improving the availability of modern FP and safe abortion, reducing disparities in access to voluntary, rights-based uptake of FP services, and supporting capacity building and activities to increase provision and quality of public sector FP (42). As mentioned in the 2019 annual review, the program also aimed to identify gaps in RH service for disabled people to inform development guidelines to better respond to their needs (42). This

program measures increase in modern methods of FP using the modern contraceptive prevalence rate (MCPR), improved method mix among FP users by increase in uptake of LARCs and reduced regional disparities by comparing data between regions (42).

Preventing unintended pregnancies		**Safe pregnancy and childbirth**	
Women and newborn lives saved [target at least 50,000 women during pregnancy and childbirth and 250,000 newborns by 2015]			
Numbers of women/couples using modern methods of family planning calculated from Contraceptive Prevalence Rate – for all, poorest 40% of women, those aged 15-19; **Number of unintended pregnancies prevented –** modelled from Couple Years of Protection of family planning		**Number and percentage of births attended by a skilled birth attendant** - for all women and the poorest 40%	
Target groups: Those at greatest risk, especially growing numbers of young people, the poorest, those affected by conflict and natural disaster. **Programme focus:** Based on comparative advantage, where short, medium and long term impact can be delivered, on budget, with demonstrable results and value for money			
Framework for results			
Pillar 1 **Empower women and girls to make healthy reproductive choices**	**Pillar 2** **Remove barriers that prevent access to services**, particularly for the poorest and most at risk.	**Pillar 3** **Expand the supply of quality services**	**Pillar 4** **Enhance accountability for results at all levels**
Political commitment to girls and women and their health at all levels **Legal frameworks** for girls' and women's rights and protection	**Financial barriers to services removed**, increasing purchasing power, choice and incentives where appropriate through services free at point of use, cash transfers, vouchers, cash incentives, social health insurance *(see para 55 for important considerations)*.. Including for family planning.	**Increased coverage and integration of health services that provide high impact, cost effective interventions** for family planning, safe abortion, antenatal care, safe birth, emergency obstetric care, postnatal care, newborn care, with PMTCT, HIV prevention, nutrition, malaria, water, sanitation and hygiene	**Data and information systems** for registering births/deaths, better planning and tracking of results
Girls' education, including to lower secondary level			**Enhanced accountability and transparency** between citizens, communities, civil society and providers
Economic opportunities including employment, income, assets, financial education and savings	**Innovative approaches to referrals and transport** (to emergency obstetric care)	**Health workers** –especially midwives/equivalent and community health workers – trained, deployed, motivated, managed and supervised	**Accountability for better performance** in RMNH services
Locally-led social change of norms that constrain women's choice, control over resources and body (eg early marriage, FGM/C, violence, cultural preferences for sons); working with men and boys	**Tackling discrimination** and treatment of women in services. **Services that are appropriate for adolescents,** including married and unmarried girls at risk.	**Commodities** – product innovation (eg for long acting and reversible methods of family planning), getting supplies in the right place at the right time, making them affordable and available, social marketing	**International agencies** more accountable for better reproductive, maternal and newborn health outcomes
Girls', womens' and wider communities' action for RMNH	**Action for those affected by conflict and natural disaster** to improve reproductive, maternal and newborn health *(Note: action to remove many social and cultural barriers is covered in Pillar 1)*	**More efficient and effective delivery of quality services by public or private providers** through quality assurance, management, regulation, performance based funding	
Culturally sensitive information especially about family planning, to meet unmet need and stimulate demand		**Delivery through a range of non state providers (private and NGOs) whenever appropriate,** cost effective and pro-poor - through social marketing, accreditation, innovation.	

FIGURE 3. DFID'S FRAMEWORK FOR RESULTS FOR RMNCH

The Bill and Melinda Gates Foundation (BMGF)

3.12 - BMGF Beginnings

BMGF was founded in 2000 by Bill and Melinda Gates and is the largest private foundation in the world. In 2012 and 2017 they co-hosted the London Family Planning Summit along with DFID (27). The foundation operates under the belief that every life has equal value and focuses on improving people's health and giving them the chance to lift themselves out of hunger and extreme poverty (43). BMGF has spent 45% of their total budget on global development and 29% on global health over the past 20 years. At the 2017 London Family Planning Summit, BMGF committed US$375 million in FP funding over three years, a 60% increase in the foundation's funding for FP (44). This came after the US decided to cut funds for FP and withhold funding from INGOs that provide information about abortion or facilitate them.

Melinda Gates said in a blog post that she was deeply concerned about the White House budget cuts and that this increase in funding won't fill the gaps but will instead create a bridge to the women and girls yet to be reached (45). In this same blog post, Melinda Gates stated the foundation's prioritization of adolescents and young girls. In Bill Gates' annual letter he writes that gender equality has emerged as a priority for the foundation (46). Melinda Gates wrote that the foundation is "exploring new ways to ensure women and girls remain a priority as the world works towards the SDGs (47) . The foundation is looking for big ideas that empower women and girls and examining policies and laws that make the greatest difference to women's health and development (47) .

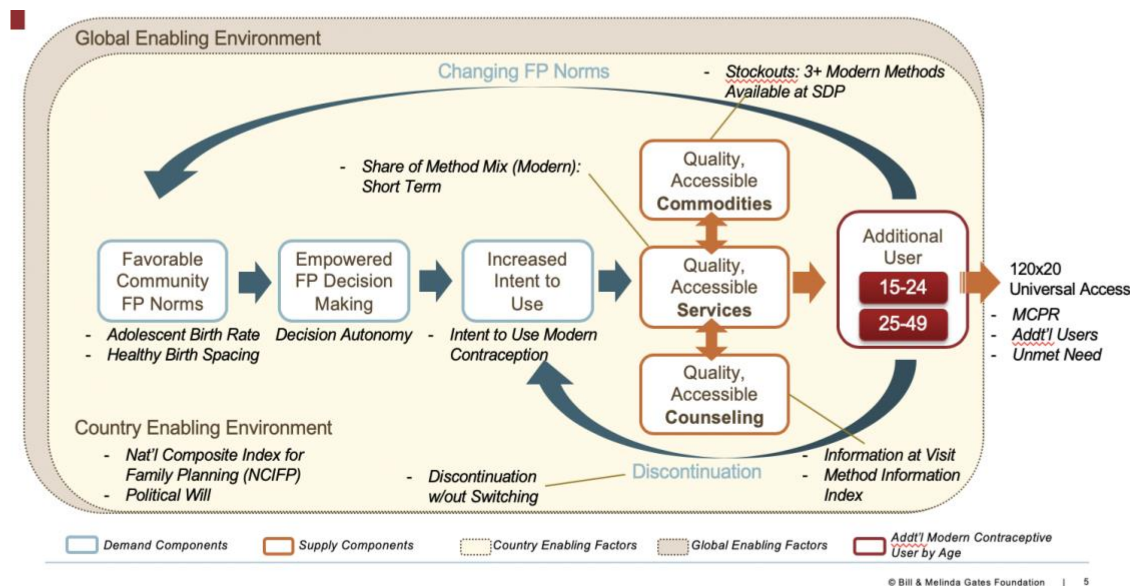

FIGURE 4. THE BILL AND MELINDA GATES FAMILY PLANNING THEORY OF CHANGE

3.13 - FP Strategy

BMGF is currently working on a FP strategy refresh with no current anticipated release date, but their current strategy is still very relevant for INGOs seeking FP funding. Their goal was to bring high-quality contraceptive information, services, and supplies to an additional 120 million women and girls in the poorest countries by 2020 without coercion or discrimination

(43). Their priorities include assessing FP needs among the poorest and most vulnerable, identifying access barriers and funding gaps, improving policies for FP, creating public-private partnerships to expand contraceptive access, and rights and develop innovative and affordable contraceptive technologies (43). Their strategy acknowledges activities must be planned and implemented in partnership with developing country governments, NGOs and other funders (41). Their five focus areas include: accelerating country action, strengthening policy and advocacy, monitoring performance and promoting accountability, closing knowledge gaps, investing in new contraceptive technologies, and incorporating the needs of adolescents and youth in everything with a focus on gender equity and empowerment (43). These initiative areas incorporate the principles of voluntarism, equity, and protection against coercion. Figure 4, repurposed from a presentation by Gates' staff, depicts the foundation's FP ToC which is rooted in a global enabling environment that works towards favorable community norms leading to empowered FP decision making and increased intent to use (48). BMGF's hypothesis was that there would be a relationship between the indicators and understanding the relationship was key to identifying ways to accelerate MCPR (43). The ToC emphasizes indicators that are essential to programmatic investment. BMGF's deepest engagements are in Nigeria and India but also have investments in Indonesia, Pakistan, Ethiopia, Kenya, Democratic Republic of the Congo, Senegal, and Niger. BMGF's long term goal, beyond 2020, is universal access to voluntary FP. Their key components to FP programming include political will, stakeholder alignment, national plan and policy, funding, platforms for scale, local adaptation, performance monitoring and evaluation (44). The foundation uses evidence-based investments to solve problems and overcome barriers that have multi-country, regional, and or global implications. The evidence initiative focuses primarily on the local adaptation component of the FP programming wheel but

contains aspects of the platforms for scale (44). The key research areas the foundation expressed a need for further evidence that improves understanding are: how to improve equitable access to quality FP based on the principles of voluntarism and data informed choice, the role of community engagement and social networks in driving demand and use of FP services, how to create more efficient strategies for serving youth, the role of the public-private sector partnerships in increasing access, reducing discontinuation rates, and innovative and transformative ways to improve supply chain and disseminate and facilitate use of proven and promising solutions (44). Of utmost importance to the foundation is ensuring efficient and sustainable ways of routinely collecting data that can be disaggregated by age and sex (49).

3.14- Contraceptive Technology

The foundation believes continued innovation in contraceptive technology is needed to address barriers to access and meet the demands of women in different circumstances and at different stages of their lives. Their goal is to develop transformative contraceptive technologies to address barriers to use among priority groups . BMGF supports the discovery, development, and distribution of new technologies that address reasons for non-use (48). The focus is on improving acceptance and use among women who have reached their desired family size, young women, and those who cannot use other methods because of side effects (48). Investments include development of new technologies such as: longer-acting injectables, non-hormonal methods, biodegradable implants, very-long acting methods, on-demand technologies, and exploration of novel delivery for both sexes (48). Given that 70% of unmet need in FP is due to method-related issues, BMGF believes breakthrough technologies are needed to reduce discontinuation and dissatisfaction (48). The foundation has identified a portfolio framework for

contraceptive technology investments. In the first bucket, products are important because they solve specific problems and these investments have lower risk but a lower impact (48). In the second bucket, existing formulations are used but require innovation on how to improve their deliverability, either through a different application or longer durations (48). In the third bucket, BMGF is looking for completely novel methods or delivery innovations that change the way users interact with the health system (48). BMGF's strategy is not just to produce new methods of contraception but to also expand the mix of appropriate and acceptable methods. They continue to invest in research that helps to understand product side effects and user acceptability, and technology improvements to reduce costs and help bring generics to market (48).

3.15 - Adolescents and Youth

As mentioned, adolescents and youth are a major priority for BMGF's FP strategy. A key principle of their investments for youth FP is nothing for young people, without young people (45). The foundation realizes that young people have a critical role to play in gathering insights of their peers, designing, implementing, evaluating programs, and engaging in advocacy with local decision-makers (45). Through the BMGF experience with the Adolescents 360 Program and through the foundation's work talking with adolescents, it became apparent that beyond combatting access to contraception, FP had to be positioned "as a tool in service of young people's dreams and aspirations (45)."

The BMGF's plan is to work with country governments, donors, and civil society organizations to ensure first-time parents have access to quality FP and the support they need for adequate spacing of births (48). BMGF has begun accumulating evidence on the health and well-being of people aged 10-14 years especially (47). They pledge to invest in programs that are designed to meet the diverse needs of youth through a human-centered design and include new

technologies designed to connect youth to quality information and services (48). Investments in learning agendas that lead to an understanding of early social norms interventions on long-term FP outcomes is also of interest to the foundation (48). These investments, however, must be driven by youth preferences, needs, and choices (48). The foundation created a strategic framework for adolescents and youth, reproduced in Figure 4. This framework builds on social and structural determinants and supports the continuous involvement of young people through three key areas: building the evidence base to understand long-term impact of early interventions, pilot and assess new models to address system and user barriers, and strengthen service delivery and scale-up of evidence-based interventions (48). The bold areas in the Figure represent areas of focus for investment. Of priority in this area is delaying first birth in adolescents, service delivery for married adolescents and first-time parents, and integration with nutrition, MNCH, and broader development agendas (48). In addition to involving adolescents, the foundation is also supporting initiatives that draw on behavioral and cognitive science (46).

3.16 - Model Programs

Adolescent 360, mentioned above, is a BMGF-funded initiative launched in 2016 that aims to increase voluntary, modern contraceptive use and reduce unintended pregnancy among adolescent girls between the ages of 15-19 in developing countries (50). Adolescent 360 applies a user-centered approach, with youth involvement throughout (50). The grant was awarded to Population Services International and other consortium members in 2016 as a four-year award (50). The user-centered approach generates insights into how adolescents think and feel in each country and cultural context (50). The project encourages youth to be actors and assets to the project and to co-create with adult allies in order to build collective efficacy and ownership (50).

The Bill and Melinda Gates Institute for Population and Reproductive Health is based at the John Hopkins Bloomberg School of Public health. In 2016, the institute launched “The Challenge Initiative” (TCI) (51), which is a global urban RH program supported by a three-year grant from the foundation. This program is a scale up of the Urban Reproductive Health Initiative (URHI), a comprehensive approach to improve contraceptive access in select cities in Kenya, Nigeria, Senegal, and India (51). TCI takes a demand-driven approach; rather than being chosen, participating cities self-select and were asked to bring their own resources to the table (51). These self-selecting cities work with TCI’s in-country partners and accelerator hubs, to develop proposals for implementing packages of FP interventions that are cost-effective and customized to meet urban needs (51). Participating cities also have access to TCI’s global community of practice, where they are able to exchange lessons learned and share best practices in delivering health and FP services to model cities (51). TCI’s approach encourages cities to assume an active role in project design and implementation and local and global partners take supporting roles (51).

3.17 - How Funding Decisions are Made

The importance of understanding donor’s priorities is critical for any INGO looking for funding. Equally as important is knowing how funding decisions are made for each donor organization. Each organization has a unique way of selecting programs to partner with and support. For USAID, the process begins with USAID field Missions, tasked with country-level agenda setting, program design, implementation, and evaluation (52). The missions develop an overarching country development cooperation strategy (CDCS) with input from country government and civil society to understand challenges and resources (52). In the next step,

USAID works to define the results they hope to be accomplished under discrete activities and produce Annual Program Statements (APS) or Notice of Funding Opportunities (NOFO) that interested organizations can submit an application in response to (52). These solicitations will have information regarding how USAID will evaluate and select the successful applicant. USAID will then conduct market research to determine how best to implement development objectives that may include reaching out to applicants and use grants.gov to collect feedback on proposed programs (52). USAID posts their solicitations on grants.gov. For the technical proposal review, evaluation criteria include past performance, technical approach, personnel, corporate capability, and management plan (52).

DFID and UK Aid have different processes depending on the grant type, however, typically they will produce background information on the grant and terms of reference on their website. The terms of reference will contain themes set out in the background and the process for submitting the proposal (53). They may also host a series of open meetings to discuss the thematic areas of the grant, information from these meetings would be provided in the information note. Most calls for proposals will also include information on preparing the budget, a budget template, and guidance on the ToC (53).

BMGF uses a standard four-phase process to develop grants. The first step is concept development, where program officers work to identify ideas that support their strategic priorities (54). BMGF goes about solicitation for grants in three ways; direct solicitation occurs when they know an organization is well suited to perform the work, discussion is when they invite multiple organizations to discuss the concept and explore their interests and capacity to perform the work, these organizations may then be invited to submit a proposal (54). The last option, similar to USAID, is when BMGF issues a Request for Proposal (RFP), public RFPs are posted on their

website and private RFPs are directed to specific organizations (54). Applicants are given guidelines and templates for developing the proposal and, after their proposal is reviewed by a program officer, they work with the organization to implement necessary changes (54). A foundation executive makes the final decision on whether to fund an applicant or not and then discusses with them how the two organizations will work together to achieve desired results (54).

Discussion

4.1 – Comparative Analysis

The primary goal of this literature review was to provide key frameworks, strategic priorities, and the essential components for each individual organization's FP strategy. By reviewing in-depth, current information on donor priorities for FP funding and donor perceptions of successful funded FP programs, INGOs can align their strategies and programs to the donors and be successful recipients of proposal solicitations. The literature review clearly demonstrates that, while each organization has slightly different priorities, all three donors recognize the importance and urgency of work in FP in developing nations.

USAID and DFID contribute the largest financial contributions of any bilateral donors in the world. USAID has been in existence for longer than DFID which may partially explain why the US is the largest donor. Of importance to both organizations is building resilience in the countries they are working in. We see this emphasized in USAID's "journey to self-reliance" and DFID's strategic priority of strengthening resilience and response to crisis. This is of significance to both governmental organizations because they realize sustainability is key to reduction in the need for international assistance. DFID defines resilience as "the ability of countries, communities, and households to manage change by maintaining or transforming living standards in the face of shocks and stresses without compromising their long term prospects (40)." USAID

defines resilience as “the ability of people, households, communities, countries, and systems to mitigate, adapt to, and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth (40).” Both definitions mention shocks and stresses, however, USAID’s conceptual framework emphasizes women’s empowerment as a factor impacting the programmatic elements that they believe should be targeted in order to achieve resilience, reduction in vulnerability, and inclusive growth as shown in Figure 5, repurposed from the resource guide on resilience produced by UK Aid (40). DFID’s resilience framework is a more simplified and places the emphasis on disturbances and a country’s capacity to deal with those disturbances as seen in Figure 6, repurposed from the resilience resource guide (40).

Of utmost importance to DFID is providing FP services to the most marginalized, hard-to-reach, and those with disabilities in the developing world. One of DFID’s main priorities is helping the world’s most vulnerable. Their framework for RMNCH places a special emphasis on removing barriers to FP for the poorest, and those at the highest risk of unintended pregnancy, maternal mortality, or other adverse SRH-related outcomes (33). Their FP program in Ethiopia includes a component on identifying reproductive needs for those with disabilities so they are better able to accommodate them. BMGF, similarly, highlights the need to work with and for the most marginalized populations. One of BMGF’s major priorities in their FP strategy was assessing the FP needs of the poorest and most vulnerable (43). This framing for working with the most vulnerable is not as evident, nor is it highlighted in USAID’s framework. A major difference between the two governments, is that DFID can support safe abortions, while USAID cannot support safe abortions under the current administration. It is important to note that this distinction may change if there is a change in administration in the coming year.

All three donors recognize the impact working towards gender equality and women's empowerment can have on, not only, increased use of contraception but also on economic development more generally. USAID's policy for gender takes an inclusive approach to fostering equality, taking women, girls, men, and boys into account without regard to age, gender identity, ethnicity, socioeconomic status, etc. (21). USAID focuses on the need to harness science, technology, and innovation to reduce gender gaps and empower women (21). BMGF takes a slightly different approach with a focus on financial inclusion and making sure women have more access and digital use of financial services and connecting women to new market opportunities to increase their profits and income (55). DFID's strategy is unique as well with a focus on increased educational opportunities, political and economic empowerment, ending violence against women and increasing SRHR rights (38). USAID is the only funded that mentions inclusion of men and boys in FP programs, consistent with their messaging on the importance of engaging men and boys to increase FP outcomes.

BMGF is unique from DFID and USAID due to its increased focus on contraceptive technology and desire to build evidence to support service-delivery (43). Key to the foundation's FP funding priorities is finding and sharing evidence supporting best-practices including FP method development. BMGF believes a solid evidence base is fundamental for continued improvement, as illustrated by the Gates Open Access Database. USAID and DFID do not have mentions of building strong evidence for service-delivery embedded in their FP strategies. Of importance to all three organizations is changing the social norms surrounding FP in developing nations. USAID's flagship maternal health program worked to foster an enabling environment for women seeking FP services (26). They led an interagency program to synthesize and disseminate HIPs. The HIPs they tout as effective for producing an enabling environment are:

domestic public financing, educating girls, galvanizing commitment from governments and private-sector, leaders and managers that work in tandem to effect positive change at all levels of the health system, laws and policies that can protect individual reproductive rights, and supply chain improvements that enhance quality of care and support choice of methods. The first step in BMGF FP ToC is favorable community FP norms and a country-enabling environment comprised of political will and a National Composite Index for Family Planning (NCIFP) (43). They also supported research by Engender Health to develop a conceptual framework entitled "Voluntary Family Planning Programs That Respect, Protect, and Fulfill Human Rights." This Gates-supported framework contains actions to create an enabling environment by developing, revising, and eliminating policies that create unnecessary barriers to access (56). DFID's approach lies within locally driven social change activities that change norms preventing women and girls from accessing FP services (57). Although, the organizations each have a slightly different way of framing their approach to FP programs, it is evident that they all support social and environmental changes at the community and policy levels to increase uptake of FP services and overcome harmful norms.

While BMGF and USAID mention violence against women as a major concern, the biggest funder of programs to prevent violence against women is DFID (37). Their program launched in 2019, "What Works to Prevent Violence: Impact at Scale," builds on a 2014 initiative that gathered evidence about the scale and impact on violence against women. A few initiatives related to FP are one stop centres (OSC) that victims of violence can go to for emergency contraception (37). There is good qualitative evidence that women who visited these OSCs felt more empowered and were satisfied with their service (58).

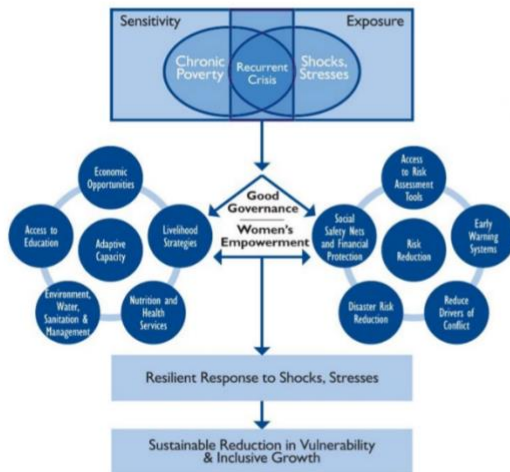

FIGURE 5. USAID RESILIENCE FRAMEWORK

The reasoning behind focusing solely on these three funders for this thesis was because they collectively contribute the most monetary and programmatic support to FP in the developing world. There are many other bilateral and private funders looking to support INGOs in FP programming. Early research examined how INGOs shift their priorities away from their core missions, values, and constituents in order to secure funding (11). The goal of these recommendations is to encourage INGOs to explore the priorities they already have in common with the three funders and better align their strategies focusing on similarities between their values and the values of each funder.

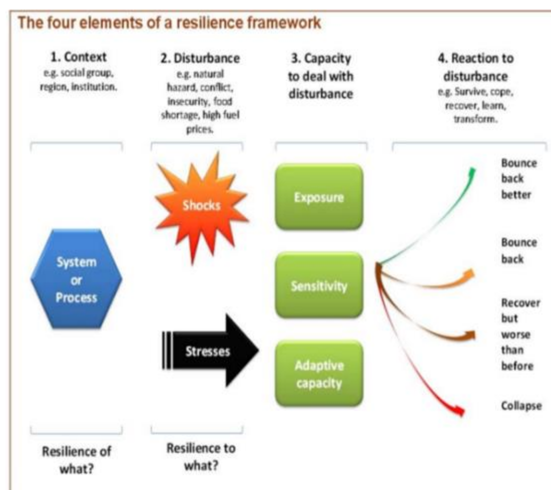

FIGURE 6. DFID RESILIENCE FRAMEWORK

4.2 – Strengths and Limitations

A major strength of this literature review and analysis was that focusing on only three funders allowed me to gain in-depth knowledge of what is important to them and how they plan to go about achieving their goals. This made me well-equipped to offer viable recommendations. Another strength is that this literature review focused on each organization's overall strategy, as well as, specific FP strategies. Having a holistic look at the nuances of each organization will assist INGOs with aligning their strategies where appropriate and understanding and accepting when it is not. Having access to staff at CARE

International to provide first-hand insight into work with these organizations greatly informed the recommendations I was able to make.

Some limitations of this work are that I inly focused on three funders. While this is a strength, it can be limiting to smaller INGOs who do not feel they are competitive enough for the most competitive donors. Another limitation is that this literature review covers a lot of very important points, but it is not all-encompassing. Each donor has an internal process for selecting which INGOs and programs to fund and following these recommendations does not guarantee success but instead should act as an aid. Lastly, funders priorities change over time given the climate of the global landscape and changing times. While these recommendations may be relevant today, they may not be as relevant in a few years. Therefore, it is encouraged INGO's keep up to date with resource mobilization efforts and conduct literature reviews on key areas within FP every year.

Recommendations

5.1 - USAID

The following recommendations were written with the purpose of aiding INGOs in writing successful FP grant proposals for submission to USAID.

Recommendation 1 - *Proposed programming, interventions, or biomedical and social research should be focused in one of USAID's 25 priority countries: Afghanistan, Bangladesh, DRC, Ethiopia, Ghana, Haiti, India, Kenya, Liberia, Madagascar, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Philippines, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen, and Zambia.*

USAID classifies the countries it works with for FP as priority, assisted, and graduated. Many countries in Latin America and the Caribbean have reached graduated status, meaning they have

reached a desired level of contraceptive use and no longer. These countries are as follows and programs based in these countries are unlikely to receive FP funding: Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, and Peru (16).

Recommendation 2 - *Proposed programming, activities, or interventions should include evidence or a framework for how it will contribute to a more self-reliant population and country.*

USAID's journey to self-reliance is imperative to their development work. In regard to FP, contributing to self-reliance can include training of community leaders, administrative, and healthcare workers, improvements to the health system, and partnering with local NGOs and civil society. USAID looks for approaches that drive accountability (18). In a framework for programming, USAID staff notes that a focus on growing jobs for youth, women, and socially excluded groups is beneficial because inclusive development is a driver of self-reliance (59). For FP, jobs could include administrative roles, program managers and assistants, community health workers, FP counselors, etc. Identifying ways of expanding employment and capacity is an urgent development priority (59).

Recommendation 3 - *Ensure FP programming includes ways to make FP more accessible, affordable, accountable, and reliable.*

By USAIDs definitions accessible, affordable, accountable, and reliable healthcare providers limit barriers to obtaining care including monetary barriers, social barriers, or interpersonal barriers (12). In programming involving healthcare providers it is important to note how care will be delivered in a way that is respectful for all patients and providers.

Recommendation 4 - *Programming involving LARCs and PMs should utilize behavior change communication to increase uptake.*

USAID believes that LARCS and PMs are the best approaches to FP. Condom use is discussed as more of a strategy to combat and prevent HIV and other STIs. Behavior change communication can increase awareness about the methods and their attributes to inform clients where they can access quality, affordable care (19).

Recommendation 5 - *Propose gender-accommodating and gender-transformative activities and interventions.*

Gender and gender norms are salient to FP programming for USAID. They recommend using the gender-integration continuum as a framework for how to incorporate gender into programming (21). Men and boys should also be included as FP clients, users, partners, and agents of change (20). SBC activities can position men as supportive partners by addressing knowledge of services and FP methods, reducing negative attitudes, and increasing joint decision-making (20).

5.2 - DFID

The following recommendations were written with the purpose of aiding INGOs in writing successful FP grant proposals for submission to DFID.

Recommendation 1 - *Target programs, activities, and interventions to the poorest 40% of women, the most vulnerable, and those of highest risk.*

DFID’s RMNCH framework prioritized the poorest 40% of individuals in the populations they work with. Some interventions to make care more accessible to women in this group are making services free at the point of use, cash transfers, cash incentives, vouchers for use of a particular services, and subsidized FP products (33). They are also concerned with vulnerable populations as evidenced by the WISH program that sought to help the most marginalized and disabled. DFIDs single departmental plan aims to consistently embed disability inclusion in everything they do (32).

Recommendation 2 - *Include activities, programs, and interventions that address adolescent specific FP needs using a lifecycle approach.*

Adolescents are one of the priority groups focused on in DFID's RMNCH framework. DFID takes a "lifecycle approach" to youth and adolescents and defines them as those ages 10-24, but recognizes those outside this bracket may be transitioning from childhood to adulthood as well (39). Their lifecycle goes beyond defining young people by age and includes those who may otherwise be excluded because of multiple discrimination (20). Key focus areas are education and SRHR. Programs and interventions with a focus on adolescents or a youth and young people component will be well regarded.

Recommendation 3- *Use diplomatic leverage and partnerships to support women's rights organizations and civil society to promote gender equality.*

Gender equality is at the heart of DFIDs mission to end global poverty. Gender equality often results in uptake of FP services and these have wide-ranging benefits for women, their families, and their societies (39).

Recommendation 4 - *When applicable in programming advocate for safe abortion by campaigning for legislation, educating women and girls, and providing life-saving medical care and counseling for women in need of an abortion.*

While DFID does not deem abortion as a method FP, they are committed to ensuring women around the world can access safe abortions when they need to. UK aid supports the Safe Abortion Action Fund (SAAF). SAAF works to educate women in need of abortion services and offer them modern contraceptive methods, address myths and stigma regarding abortion in communities, offer counseling, and campaign for safer legislation and services on safe abortion and rights (36).

Recommendation 5 - *Describe with clear examples how the program, intervention, or research is going to achieve value for money spent.*

DFID aims to drive value for money in design, delivery, and monitoring for funded programs (32). They aim to do this by driving efficiency and effectiveness in all programs and building greater commercial capacity and management of supply partners (32).

5.3 – Bill and Melinda Gates Foundation

The following recommendations were written with the purpose of aiding INGOs in writing successful FP grant proposals for submission to BMGF.

Recommendation 1 - *Propose programming, interventions, or research that focuses on adolescents and young girls with a focus on gender equity and women's empowerment and continuously engages youth for their perspective.*

Of high priority to BMGF is ensuring adolescents and young women have access to quality, safe, and respectful FP care. A study funded by the foundation found FP programs concerning adolescents and young women should focus on women with no education and those that are illiterate (60). Adolescents and youth living in rural areas often have worse maternal health outcomes and are at higher risk of early childbirth. Another study funded by BMGF found FP messages through mass media is evidenced to be associated with modern contraceptive use among rural adolescents (61). There is a need for policies and programs that empower adolescents and youth through improving information about access to and utilization of RH services. The Adolescent 360 program reinforced the importance of including youth in program design. This point is important to BMGF and any programming proposed for adolescents should include them in the design, implementation, or evaluation in some way.

Recommendation 2 - *Propose novel contraceptive technology or innovation on improved deliverability of existing formulations.*

BMGF strongly believes in funding new contraceptive technology that is going to make accessing care and utilization for women in the developing world who may experience hardship with currently available methods. They believe transformational technology will revolutionize the way users interact with the health system and with their contraceptive method (48). New technology can best serve women who have already reached their desired family size, non-users who have infrequent sex, young women (15-24), non-users who are harder to reach, and those not using any method because they experience side effects). Programming or interventions related to CT should target one or more of these groups.

Recommendation 3 - *Propose research or programming informed by clear evidence or with strong potential to add to the evidence base.*

BMGF feels strongly about collecting the best evidence possible to inform future programming, policies, and way of life. Their goal is to break down barriers to FP use and uptake by investing in and diffusing innovative, disruptive evidence-backed solutions that improve service delivery creation efforts (48). The foundation will develop and commission innovative research investments to inform the development of effective, efficient, and scalable solutions to drive FP uptake and access (48). They feel it is of utmost importance to build evidence of what works and then document and disseminate that information.

Recommendation 4 - *Include indicators on supply, demand, quality, equity, and the enabling environment, and clearly show how they will lead to an increase in MCPR.*

BMGF's ToC for family is based on a causal pathway that relates indicators to reaching additional contraceptive users (48). They believe understanding the relationship between these

indicators and countries' MCPR is key to accelerating MCPR growth (48). The ToC is used to inform their investment approach in each country (48).

Recommendation 5 - *Propose novel programs or scale-up programming in India, Nigeria, Indonesia, Pakistan, Ethiopia, Kenya, and the Democratic Republic of the Congo, and other countries in Francophone West Africa.*

BMGF's work on FP has its deepest investments in India and Nigeria (43). They also work with the private and public partners to make selected investments in Indonesia, Pakistan, Ethiopia, Kenya, and the Democratic Republic of the Congo. Gates is a member of the Ouagadougou Partnership for Family Planning and supports Senegal and Niger to implement supply and demand approaches that can inform practice across countries in that region (43). Although these are countries of focus to the foundation, they will support work in any of the 69 countries decided upon for the FP2020 goals.

Conclusion

There is no refuting the fact that voluntary and comprehensive FP saves lives and improves the economic, cultural, and social well-being of countries. USAID, DFID, and BMGF all agree with the need to ensure women all over the world have access to a range of services and decide, based on their own discretion, what is best for them. These three organizations have emerged over the last few decades as world leaders in funding INGO efforts to improve FP and women's empowerment with millions in funds to support programming, interventions and research that contributes to their global mission. Many ideals among the three donors are similar, albeit, their approaches and strategies are different. INGOs, also, have their own ideals and strategies and the best course of action is examining a donor's strategy to look for commonalities

that can be expanded upon in a proposal or request for funding. USAID is determined to get all of the countries it works with on a pathway to self-reliance, which includes building up health systems and infrastructure that can sustain itself. They cannot currently support any program, NGO, or organization that supports or provides abortion due to policy restrictions. They do, however, tout LARCs and PMs as effective and useful forms of contraception and encourage their uptake. Proposed programming or research regarding FP should take place in one USAID's 25 priority countries, ensure it is contributing to building self-reliance, include ways to make contraception more affordable, accessible, accountable, and reliable, and focus on gender-transformative activities that include men, boys, and the community. DFID is committed to strengthening resilience, assisting the world's most vulnerable including adolescents and those with disabilities, ending violence against women, and ensuring value for money spent. Proposed programming and research should target the poorest and most at risk in communities and adolescents, promote gender equality advocate for safe abortion, and ensure value for money spent. BMGF is committed to women and girls and aims to ensure every women and girl around the world has access to contraception that works for them. They are dedicated to producing novel contraceptive technology or improving existing contraceptives in ways that make them more accessible. Proposed programming or research can be successful in acquiring funding if INGOs target some of the countries where BMGF has its deepest investments, focuses on adolescents and gender equality, delineates how the evidence base was used in planning and design, and how the work will add to the evidence base. In this thesis, I have highlighted the most prominent strategies and priorities for INGOs to successfully fund FP-investments in relation to three key funders. The hope is that these recommendations can be of use to INGOs looking to secure funding to change the individual lives of millions of women and girls around the world.

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