

# Monitoring and Evaluating FP/RH Program Transition from Donor Support: A Proposed Conceptual Framework

Since the 1970s, the United States has been providing technical assistance and/or funding support to family planning/reproductive health (FP/RH) programs in many countries, and a number of them have since graduated and transitioned out of USAID's support. The transition process of bilateral support has varied—since 2004, the process has relied on demographic trigger indicators to inform USAID on the country's readiness for reduction in technical assistance and financial support. USAID would then begin working with stakeholders to assure sustainability of program outcomes. There have been several large-scale evaluations of FP/RH programs in these countries, for example, Bertrand et al. (2015), Chaudhry et al. (2012), USAID (2013), and Cromer et al. (2004). However, these evaluations were implemented retrospectively and ad hoc, without an a priori Monitoring and Evaluation (M&E) plan based on a guiding framework. This activity—a review of the current body of work on the evaluation of global health programs—aims to develop a conceptual framework to be used by donors and governments to inform plans for FP/RH program transition out of USAID's support, to monitor the transition process, and to evaluate the sustainability of FP outcomes.

## Methodologies

This brief was based on a review of 147 published and unpublished articles and documents, the latter including grey literature, reports, and presentations shared by USAID

staff. The literature search was conducted using key words including “family planning,” “donor,” “funding,” “graduation,” and “transition,” on PubMed, Google Scholar, and Google. Most documents were in English. We created a proposed conceptual framework to evaluate FP program transitions following a framework proposed by Bao et al. (2015) for monitoring and evaluating the transition of global health programs. However, institutionalization, a domain in Bao et al.'s framework, was incorporated into all domains in our framework since it is a critical component of capacity strengthening and sustainable development. Additionally, we proposed a list of indicators considered essential to measure each domain during three phases of the transition: pre-, during, and post-transition. We also included sub-domains that can be defined and operationalized in a specific context. An example includes the social behavioral change sub-domain. As it is a broad construct, specific activities and indicators can vary by context.

Main themes emerging from the articles were identified, and indicators used in various evaluations or mentioned in technical notes were listed. Key indicators were identified through the authors' professional experiences and in consultation with D4I and USAID staff.

## Conceptual Framework

The conceptual framework (Figure 1) is intended to guide donors and implementing partners in creating M&E plans prior to the transition,



monitoring the transition process, and evaluating the extent to which FP outcomes are sustained post-transition. The domains and indicators were organized into these three phases of the transition. Implementing partners and donors should develop a set of key milestones and indicators relevant to each country's FP program, as well as when a country can move on to the next phase of the transition, i.e., when the majority of these indicators have been met. The proposed indicators are quantitative and qualitative. We recognize that some indicators may be somewhat ambiguous and/or challenging to measure, such as transparency, and can be defined further in future work. The framework also includes some sub-domains (e.g., social behavioral change) that will allow countries to define, operationalize, and adapt to specific activities within each country. As such, the framework allows cross-country standardization of indicators and sub-domains, while facilitating country-level adaptation of them. Hence, the proposed framework does not dictate what should be monitored during and after program transitions but serves as a foundation for external donors and in-country implementing partners to develop a transition plan that can be agreed upon, with milestones and indicators appropriate and feasible for each country.

### **Domains and Key Indicators**

The conceptual framework includes three phases of the transition: pre-, during, and post-transition, each with specific domains and indicators. For example, total fertility rate (TFR) and modern contraceptive prevalence (mCPR) are two key trigger indicators for the transition (O'Hanlon, 2009; Selim et al., 2016; Gilbert et al., 2019). They are also among key indicators to measure outcomes of FP program transitions. During the transition period, indicators can be

grouped into four domains: leadership, financing, programming, and the provision of services and FP products. Within each domain, there are indicators at the policy and program levels. Each of these domains also incorporates indicators aimed to measure the institutionalization aspect. Specifically, these domains include indicators of activities and strategies that contribute to the "creation and implementation of policy/governance structures and norms to anchor established roles, rules, responsibilities, and accountability mechanisms for service delivery" (Bao et al., 2015). We define institutionalization as processes and efforts for norms, practices, rules, and regulations to become an integral part and routinely practiced by all stakeholders, including external and in-country partners within a health system. Institutionalization requires leadership, as well as policies and structures, and local resources and players within the system (Waiswa, 2020). Therefore, we incorporate institutionalization in the discussions of domains and sub-domains in this brief.

It is important to note that all domains and indicators should also be assessed at the sub-national and sub-group levels through an equity lens. Minimally, evaluations should include assessments of potential disparities by gender, age, marital status, socio-economic status (SES), and urban/rural residence. Such disparities may indicate that FP outcomes are not sustainable, or that some vulnerable groups may remain underserved. Finally, we included a cross-cutting domain of external factors that may contribute to or hinder the sustainability of FP programs and outcomes.

#### **Pre-transition**

Two key trigger indicators and corresponding thresholds that have been widely used in many countries are TFR and mCPR: O'Hanlon (2009)



reported that TFR of 3.0 or less and mCPR of 48% or more among married women of reproductive age were signals that a country may be ready for a transition (O’Hanlon, 2009; Selim et al., 2016; Gilbert et al., 2019). Other criteria for transition, including accessibility to at least three FP methods, the percent of methods and services subsidized by USAID, and that major service providers meet and maintain standards of informed choice and quality of care, have also been documented (O’Hanlon, 2009; Gilbert et al., 2019). These three indicators measure the extent to which FP programs are able to maintain a service environment that is accessible and of high quality, in order to ensure continued use of contraceptives in the population. While the percentage of methods and services subsidized by USAID and other donors can provide an assessment of the level of country’s institutionalization, the other two underline key aspects of the service and supply environment that local stakeholders need to sustain in any FP program. Although O’Hanlon (2009) also reported concrete thresholds that have been used for these indicators, including: (1) 30% or more of the population have access to 3 or more FP methods within a reasonable distance, and (2) no more than 30% of FP products, services and programs are subsidized by USAID or other external donors. Our review revealed that they have not been frequently considered in making decisions about transition. These indicators may not be readily available within existing routine data nor are they often reported by periodic population and facility surveys.

### **Transition process**

We propose four domains for the monitoring of the transition process. Each of these domains can be monitored at the policy and program level. We employed the domains proposed by Bao et al. (2015) using the same definitions.

These domains have been documented in other reviews as key for transitions from USAID’s support in the health sector (Chaudhry et al., 2012). However, instead of laying out activities within each domain like Bao et al. (2015), we propose a list of indicators and sub-domains to monitor these activities.

#### **Domain 1: Leadership**

Leadership can be measured at the policy level by efficiency, transparency, and accountability. Efficiency has been emphasized by governments and donors to provide services with greater results while lowering costs, as development assistance for health has stagnated globally, and each country faces challenges in domestic financing with regard to resources and competing priorities (Appleford and RamaRao, 2019). Increases in transparency and accountability of donors and stakeholders likely contribute to improved efficiency in FP programs. Transparency in the end goals of program transitions creates pathways to achieve these goals, rules, responsibilities, and financing allowing local stakeholders, as well as external partners, to be accountable for their decisions and activities. Both will facilitate a transition process in which donors and local stakeholders can maintain a shared vision with clear delineations of well-aligned responsibilities, cross-sector and cross-agency communication, and local capacity to be strengthened to ensure long-term sustainability. An essential element of this process is the understanding of diverse capacities among local stakeholders, so capacity development can be built upon existing capacities and aligned with priorities of local government and stakeholders—a key shift in USAID’s local capacity principles (USAID, 2021). Unfortunately, challenges remain where transparency and accountability have typically been an afterthought of global health programs



transitioning out of support (Bao et al., 2015). Additionally, wide variations in the definitions and measurements of these constructs require further work for country-specific definitions and operationalizations (Bao et al., 2015; Gotsadje et al., 2019). Communication and coordination between government and non-governmental stakeholders can create wide support for FP programs and ensure their efficiency and sustainability (Bertrand, 2015).

Finally, we can also monitor strategic activities at the policy level to set the stage for other activities to be monitored under the programming and service delivery domains. Indicators can include those already in use, such as the FP Effort (FPE) Index (Ross and Stover, 2001) and the National Composite Index for FP (NCIFP) (Rosenberg, 2020). Their respective domains of Policy and State-Setting Activities (in FPE), and Strategy (in NCIFP) include indicators, mostly qualitative, that can be adapted for this purpose. For example, both FPE and NCIFP include a question about laws and regulations related to importing versus local manufacturing of contraceptives. At the program level, a key indicator identified in the literature was relative roles of local stakeholders in funding, technical implementation, and M&E of FP programs (e.g., Chaudry et al. 2012; Gotsadje et al. 2019; Silverman et al. 2020; Resch & Hecht 2018). Local stakeholders need to have clearly defined roles and responsibilities and the capacity to fulfill those responsibilities to institutionalize FP program design and implementation. Without the institutionalization of capacity for these responsibilities, a country may not be ready to transition from donor support or to sustain FP programs post-transition in the long term.

## Domain 2: Financing

The financing domain can be monitored at the policy level with two indicators: (1) the percentage of FP programs subsidized by donors (Chaudry et al., 2012; Silverman et al., 2020), and (2) the extent to which health insurance covers FP services (Appleford & RamaRao, 2019; Fagan et al., 2017). Both can be measured quantitatively. At the program level, financial sustainability can be monitored by the percentage of FP programs financed by domestic sources, which may include program recipients themselves (Bao et al., 2015). Domestic funding for FP programs, however, can be a challenge as countries need to align health programs and priorities, as well as set efficiency goals and work towards them (Resch and Hecht, 2018). While competing priorities make it difficult to decide a fair share of the budget for FP programs versus others, setting and achieving efficiency is difficult to realize because program managers often do not have the capacity or tools to measure technical efficiency (Resch and Hecht, 2018). With these challenges in the public sector, it is widely recognized that the private and non-profit sectors need to be part of FP programming and service provision. A healthy share of FP services, commodity sales, and distribution implemented by these sectors not only supports access to services and helps promote equity but also contributes to contraceptive security by ensuring supplies (e.g., Agha, Do & Armand, 2005 & 2006; Cromer et al., 2004; Foreit, 1992; Janowitz & Bratt, 1992). A critical enabling factor for these sectors to participate in FP service provision includes several activities within the leadership domain such as regulations with regard to manufacturing and importing contraceptives, relative roles of suppliers, and coordination across policy stakeholders which are two key indicators in the leadership domain. The close



inter-relationship and complementary roles between these two indicators, with the other indicators related to different sectors' roles in FP service provision under the programming and service delivery domains (discussed later), are often considered essential for institutionalizing FP service provision and commodity distribution to ensure program sustainability.

### Domain 3: Programming

The first indicator in the programming domain measures an enabling environment that allows the private and non-profit sectors to operate in coordination with the government in the broader context of health reforms (Drake et al., 2014). In this brief, we only defined it as an environment that is enabling for public, non-profit private, and commercial private sectors to have clearly defined roles and contribute to the provision of FP commodities. How such an environment is shaped depends on the country's strategies to ensure a sustainable contraception market. Indicators for this sub-domain will therefore need to be further defined at the country level. As mentioned earlier, sub-domains and indicators related to various sectors' roles in FP service delivery together measure the institutionalization aspects of FP programs, such as financial and technical parts and their contributions to contraceptive security at the program level.

Another aspect of the environment is the civil society sector. An enabling environment during donor support transition should allow civil society organizations (CSOs) to perform their roles, be accountable for them, and advocate for vulnerable populations to ensure access and equity in services (McDonough & Rodriguez, 2020).

Accountability, again, is an indicator to monitor FP programs during transition. Accountability

has been measured in NCIFP with three questions about the existence and operation of mechanisms to ensure that FP services are voluntary, non-discriminatory, and to report and review violations (Rosenberg, 2020).

At the program level, three key areas are proposed for M&E of FP programs during transition: social and behavioral communication, contraceptive commodity security, and local capacity in a wide range of activities from designing, planning, M&E, purchasing and distributing commodities, and policy and advocacy. These three sub-domains are considered essential to increasing demands for FP services and ensuring service supplies to meet such demands. Each of these sub-domains can be measured by multiple indicators. Bertrand et al. (2015) showed that strategic communication for behavior change has been widely used for the last five decades and is a critical tool to disseminate FP/RH information, change social norms, and promote the use of voluntary FP/RH services. However, how communication strategies are designed and implemented depends on the local political and cultural contexts, so defined indicators need to be relevant and appropriate for each setting. Contraceptive commodity security remains a challenge in most settings because the government and private sector, as well as other external donors, have not always agreed on the roles of the latter in the provision of free or subsidized contraceptives and the impacts of policies and regulations on the private sector (Cromer et al., 2004).

### Domain 4: Service Delivery

At the policy level of the service delivery domain, accountability is once again proposed as an indicator and a key indicator about the existence of national policies on quality and technical



protocols. Here, the NCIFP includes two questions about mechanisms to solicit and use feedback from clients and facilitate dialogues between providers and clients (Rosenberg, 2020). At the program level, service delivery can be measured by indicators with regard to method availability and quality of services. There is a vast number of such indicators in the field of FP, and this area of measurement continues to evolve and improve. The final indicator, market maturity, is defined in some studies as whether there are at least two contraceptive methods, each comprising of at least 10% of the market. Salim et al. (2016), however, suggested that this indicator should be used together with contraceptive mix (discussed below.) Other studies have found that if the share of contraceptives from free of subsidized sources was greater than 50%, the market may not be sustainable since it inhibits the participation of the private and commercial sectors (Mozumdar et al., 2019).

### **Transition outcomes**

The first three indicators—TFR, mCPR, and unmet need—are outcomes of the transition that are well understood by national and local leaders and are often readily measured in periodic and population surveys which allow long-term monitoring of sustainability without much additional effort. The proportion of demand for contraception satisfied by modern contraceptive use, the number of women of reproductive age who are in need of contraception and using a modern contraceptive method divided by the total number of women aged 15–49 in need of contraception, is a useful measure of FP outcomes (Choi et al., 2015; Ewerling et al., 2018), but not often reported by many population-based period surveys. Additionally, it is complementary to mCPR and unmet need, already included in the framework. Thus, we do

not include it as a key indicator in the framework. The other two indicators, contraceptive method mix and different sectors' shares of contraceptives among users, are proposed to monitor the sustained use of contraception in the population, as they measure the extent to which a variety of methods are used and accessible from different sources. A skewed method mix could also indicate insufficient access to alternate methods or provider biases, which could be due to personal preferences or higher-level policies and regulations (Bertrand et al., 2014). Previous assessments of sustainability after graduation from donor support indicated that it was possible to maintain the shares of non-public sectors in contraceptive use, but it would depend on several factors, including the level of contraceptive use, the commitment, and relative roles of non-public versus public sectors (e.g., Agha, Do, & Armand, 2005).

### **Equity considerations**

All components of the framework should also be assessed through an equity lens. At a minimum, FP program transitions should be monitored by gender, age, ethnicity, marital status, socio-economic status, and urban/rural residence to identify groups that may have been differentially impacted by the transitions. At the policy level, indicators may include the extent to which policies and regulations support FP services and commodity provision to vulnerable groups, such as adolescents, unmarried women, and the economically disadvantaged. Policies and policymakers' positions regarding men's involvement in FP/RH are also important to create an enabling environment for couples to access FP/RH information and services. At the program level, indicators can include administrative barriers and provider's attitudes, beliefs, and behaviors towards providing FP/RH



services to certain groups to monitor accessibility and quality of services among vulnerable groups.

### **External contributing factors**

Although it may not be practical and/or feasible to monitor certain equity factors as frequently as the others, they should be taken into consideration when developing M&E plans for FP program transitions and long-term sustainability. These factors can change quickly for many reasons and are often outside of the scope of FP programs, yet they can have important implications for FP policies and programs, as well as fertility and other outcome measures. For example, the Human Development Index (HDI) is a summary measure of development achievement, constructed by life expectancy, education of adults ages 25 or above, the expected number of years of schooling for children of school entering age, and income per capita (UNDP, n.d.). While it may have associations with FP outcomes, HDI can be impacted by many factors and can impact the FP/RH programs. A recent work by Goodkind et al. (2021) indicated some correlations between HDI and the timing of graduation in most countries. Cultural norms, infant mortality rate, and urbanization have been widely documented to have influences on an individual's fertility desires and demand for FP, while a population's age structure could influence FP service demands at the population level. Finally, political stability at the national and sub-national levels could directly affect the functioning of the government, local agencies, and organizations, influencing their capacity and abilities to implement health programs.

### **Conclusions**

The proposed conceptual framework includes key domains for M&E of FP transitions from donor's support that can be used from before the transition for planning purposes to after the transition for sustainability evaluation. This framework sets up a key first step, an agreed upon framework, for donors and governments to establish plans and mechanisms to ensure transparency and accountability in the transition (Gotsadze et al., 2019; McDade et al., 2020). However, there is no one-size-fits-all approach to evaluating transitions. The proposed framework allows a level of standardization of key indicators and sub-domains for M&E across countries, while facilitating country-level adaption. Some domains and sub-domains may be more important and/or more clearly defined in some contexts than others, so they will need to be operationalized depending on specific activities within those domains in a country. Donors and local stakeholders can adapt the framework by identifying and defining indicators to reflect each domain and sub-domain as needed. Once donors and local stakeholders agree upon a framework, domains and related indicators allow donors and governments to develop clear and explicit transition approaches ahead of time, accurately assess progress, align program components with government and non-government structures, and strengthen local capacity to ensure a successful and sustainable transition of FP programs.



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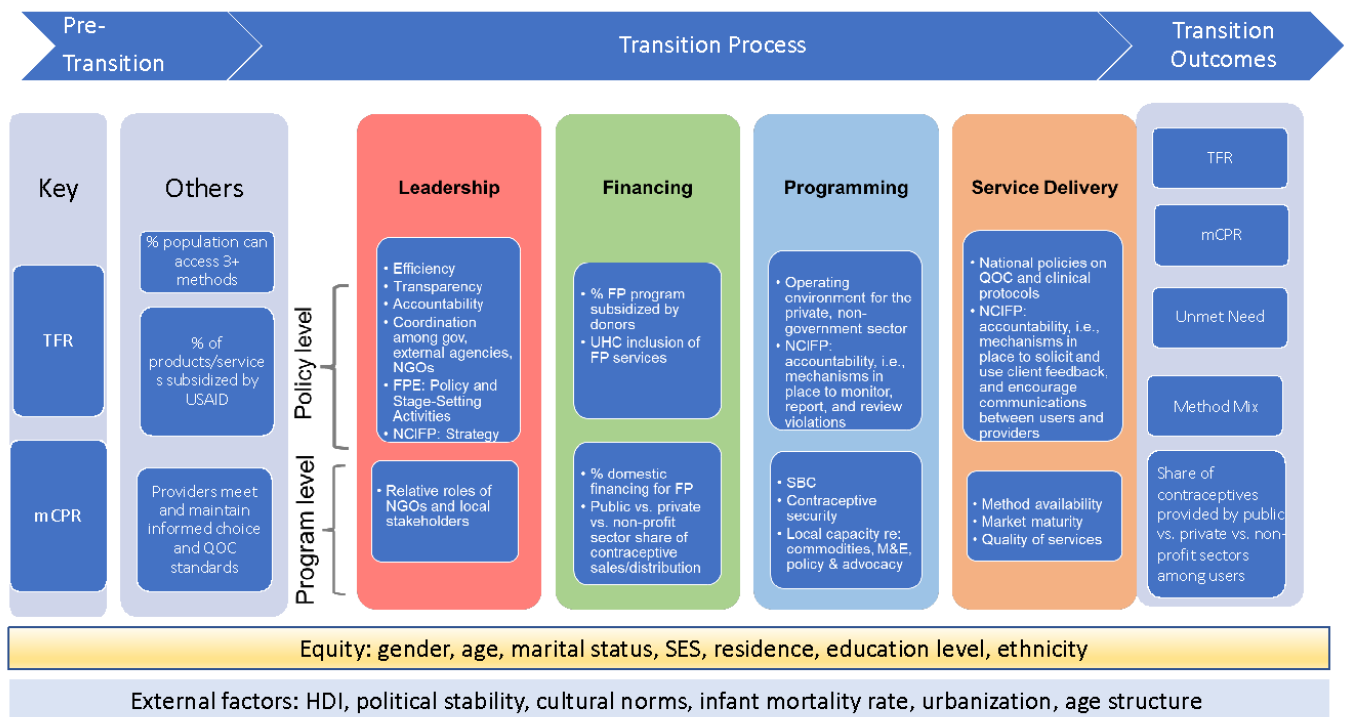




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Figure 1. A conceptual framework for FP program transition evaluation





**Table 1. Domains and key indicators**

Domain	Indicators
Pre-transition	<ul style="list-style-type: none"> <li>● Total Fertility Rate</li> <li>● Modern Contraceptive Rate</li> <li>● Percent population that can access 3 or more methods within a reasonable distance</li> <li>● Percent of FP products, services, and programs offered in the public and private sectors that are subsidized by USAID</li> <li>● Major service providers (public sector, NGO, private commercial sector) generally meet and maintain standards of informed choice and quality of care</li> </ul>
During transition process: Leadership	<ul style="list-style-type: none"> <li>● Efficiency</li> <li>● Transparency</li> <li>● Accountability</li> <li>● Coordination and communication among governmental, external agencies, NGOs, and civil society</li> <li>● FPE: Policy and Stage Setting Activities               <ul style="list-style-type: none"> <li>○ Government's official policy or position concerning fertility FP and rates of population growth</li> <li>○ Favorable statements by leaders</li> <li>○ Level of FP program leadership</li> <li>○ Age-at-marriage policy</li> <li>○ Import laws and legal regulations</li> <li>○ Advertising of contraception in mass media is allowed</li> <li>○ Other ministries or government agencies involved</li> <li>○ In-country budget for program</li> </ul> </li> <li>● NCIFP: Strategy               <ul style="list-style-type: none"> <li>○ Does the National FP Action Plan include defined objectives over a 5-to-10-year period, including quantitative targets?</li> <li>○ Does the National FP Action Plan include objectives to reach the poorest and most vulnerable groups with quality FP information and services?</li> <li>○ Does the National FP Action Plan include projection of the resources (material, human and financial) required to implement the strategy, as well as sets forth a plan to secure the resources?</li> <li>○ Does the National FP Action Plan include a mechanism and funding to support meaningful participation of diverse stakeholders?</li> <li>○ High level of seniority of the director of the national FP program and whether director reports to a high level of government.</li> <li>○ Extent to which import laws and legal regulations facilitate the importation of contraceptive supplies or extent to which contraceptives are manufactured locally.</li> </ul> </li> <li>● Relative roles of local stakeholders in funding, technical implementation, and M&amp;E of FP programs</li> </ul>



Domain	Indicators
During transition process: Financing	<ul style="list-style-type: none"> <li>● Percent of FP programs subsidized by external donors, including USAID</li> <li>● The extent to which universal health insurances covers FP methods and services</li> <li>● Percent of domestic financing for FP commodities, facility, supplies and maintenance, provider training, information/communication, research, etc.</li> <li>● Public versus private versus nonprofit sector share of contraceptive sales/distribution</li> </ul>
During transition process: Programming	<ul style="list-style-type: none"> <li>● Operating environment for the private, non-government sector</li> <li>● Accountability measured through NCIFP's questions:               <ul style="list-style-type: none"> <li>○ Are there mechanisms in place to monitor if access to FP is voluntary and non-discriminatory?</li> <li>○ Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds or coercion?</li> <li>○ Are violations reviewed on a regular basis?</li> </ul> </li> <li>● Strategic communication for behavior change</li> <li>● Contraceptive security</li> <li>● Local capacity for commodities, monitoring and evaluation, policy, and advocacy</li> </ul>
During transition process: Service Delivery	<ul style="list-style-type: none"> <li>● National policies on quality of care and clinical protocols</li> <li>● Accountability measured through NCIFP's questions:               <ul style="list-style-type: none"> <li>○ Are there mechanisms in place at facility level to solicit and use feedback from clients?</li> <li>○ Is there a system encouraging dialogue and communication between users and providers about availability, accessibility, acceptability, and quality?</li> </ul> </li> <li>● Market maturity: two or more methods, each comprising at least 10% of the market</li> <li>● Method availability</li> <li>● Quality of services</li> </ul>
Transition Outcomes	<ul style="list-style-type: none"> <li>● Total Fertility Rate</li> <li>● Modern Contraceptive Prevalence Rate</li> <li>● Unmet need</li> <li>● Contraceptive method mix</li> <li>● Shares of contraceptives provided by public versus private versus non-profit sectors among users</li> </ul>



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## For more information

D4I supports countries to realize the power of data as actionable evidence that can improve programs, policies, and—ultimately—health outcomes. We strengthen the technical and organizational capacity of local partners to collect, analyze, and use data to support their sustainable development. For more information, visit <https://www.data4impactproject.org/>