Family Planning Spending Assessment (FPSA)

Reference Guide

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Contents

Abbreviations and Acronyms

ALOS	Average length of stay
DPT	FPSA Data Processing Tool
FP	Family planning
FP2020	Family Planning 2020 Initiative
FP2030	Family Planning 2030 Initiative
FPPF	Family planning production factor
FPSA	Family Planning Spending Assessment
FPSC	Family planning spending category
GHED	Global Health Expenditure Database
HIS	Health information system
HMIS	Health Management Information System
IEC	Information, education, and communication
M&E	Monitoring & evaluation
MIS	Management information system
MOF	Ministry of Finance
MOH	Ministry of Health
NASA	National AIDS Spending Assessment
NGO	Non-governmental organization
NHA	National Health Accounts
NIDI	Netherlands Interdisciplinary Demographic Institute
SHA	System of Health Accounts
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

Section 1. Introduction

1.1 About this Guide

This resource guide provides background on the Family Planning Spending Assessment (FPSA) approach, why it was developed, how results are used, and what the data collection and analysis process entails. It also provides information on technical concepts and the estimation process used in FPSA applications. While it describes the FPSA approach and tools involved, it is not a step-by-step user guide to the FPSA tools.

1.2 Background

The Family Planning Spending Assessment (FPSA) was developed by the Track20 project, which is implemented by Avenir Health. Track20 was funded by the Bill and Melinda Gates Foundation to advance the current family planning (FP) monitoring environment by introducing new tools and estimation methodologies that expand usage of existing country produced data (HMIS) and fill persistent data gaps to expand the data available to countries for decision making.

Expenditure data is critical to improving accountability and oversight for FP programs, though historically, little data has been available to guide strategic programming and budgeting. To fill this data gap, Track20 developed the FPSA methodology to collect FP-specific expenditures in key countries, which has prompted more transparency around FP expenditures and increased commitments to domestic FP funding.

The FPSA was first developed to inform one of the core progress indicators for the global Family Planning 2020 (FP2020) initiative: annual expenditure on FP from government domestic budget. FP2020, the first global initiative focused solely on FP, was an outcome of the 2012 London Summit on Family Planning where more than 20 governments and major donors made commitments to address the policy, financing, delivery, and socio-cultural barriers to women accessing contraceptive information, services, and supplies.

When FP2020 stakeholders were deciding which data/data sources would inform the FP2020 expenditure indicator estimates, the Performance Monitoring and Evidence Working Group discussed two existing sources of data.

1. WHO/SHA 2011: The World Health Organization (WHO) was working with member countries to prepare health accounts (HAs) annually using the System of Health Accounts (SHA) 2011 approach. This fairly new effort included training for national economists and technical assistance and quality review from WHO. Information on FP expenditures is on WHO's Global Health Expenditure Database (GHED) and can also be obtained through countries' Health Accounts. However, the GHED data is presented only as total health expenditures; detailing spending categories are not presented in the GHED summaries.

2. UNFPA/NIDI: The Netherland Interdisciplinary Demographic Institute (NIDI) was funded by UNFPA to estimate FP expenditures in UNFPA-supported countries and FP2020 priority countries through the "FP Resources Flow" project. These estimates were available approximately every three years.

At the same time that FP2020's follow-on initiative FP2030 was launching, UNFPA/HQ decided not to continue funding the FP Resources Flow Project, and asked Track20 to continue estimating countries FP expenditures. Hence, from 2020 onward, Track20 has supported efforts to track annual government FP expenditures in many FP2030 countries. GHED data is used in the FP2030 report when there are no FPSA data (or other FP specific country estimates).

Track20 and other global partners continue to track FP expenditures and monitor progress toward the goals of the FP2030 global partnership[1]. FP2030 has maintained an indicator tracking FP expenditures from government domestic resources, though the indicator no longer includes donors' funding and budget support, which were included in the FP2020 indicator.

1.3 FPSA Objective

The objective of the FPSA is to increase reliability, usability, and timeliness of financial data to provide a better understanding of FP expenditures level by answering the following questions:

- Who pays?
- Who manages the funds and up to what level?
- Who provides the FP services (i.e., who is ultimately spending the money)?
- What FP services were provided (cost category classification)?
- What are the inputs used (human resources, contraceptives, management, information, education, and communication (IEC), training, supervision, etc.)?

In general, FP tracking is aimed at obtaining the overall picture of the total spending on FP and FP services provided in the country by the various sources of financing. The objective of the FPSA is to determine the total domestic expenditures on FP in Financial Year "X" in country "Y", at the National level and sub-National level where applicable.

The FPSA methodology tracks the flow of resources and expenditures for the implementation of FP programming in a country. This method considers resource flow of both financial and non-financial resources from their origin to the end point of service delivery, among the different institutions involved, which reduces double counting and provides a more accurate and complete picture of FP spending.

1.4 FPSA Methodology

The FPSA uses a health accounts approach derived from the National AIDS Spending Assessment (NASA)[2,3] methods and applies it to FP. NASA itself is based on earlier versions of the National Health Accounts (NHA) methodology. Like NASA, FPSA's FP expenditure tracking considers resource flow of both financial and non-financial resources from their origin to the endpoint of service delivery (i.e., the beneficiaries receiving goods and services), among the different institutions involved.

[1] See the full list of FP2030 Indicators here: https://www.track20.org/pages/data_analysis/core_indicators/overview.php
[2] See NASA country reports here: https://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports
[3] National AIDS Spending Assessment (NASA): Classification and Definitions
https://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916_nasa_classifications_edition_en.pdf

In this adapted methodology, FP financial resource tracking is conducted using a comprehensive and systematic methodology to determine the flow of resources intended to support the provision of FP services in a country. Although the primary focus of the FPSA is domestic government FP expenditures, the FPSA data collection and data processing tools developed by Track20 have been used in a limited number of countries to also estimate FP specific expenditures from NGOs, out-of-pocket/household, and donor sources for all FP-related interventions, services, and activities. For the out-of-pocket/household expenditures, the Landscape & Projection of Reproductive Health Supply approach was used. By adapting the NASA methodology, this assessment follows the NHA framework and principles. It applies standard accounting methods to reconstruct all transactions in each country, 'following the money' from the funding sources to agents and providers and services provided.

The FPSA follows a process of expenditure tracking that involves the systematic capturing of the flow of resources by different financial sources to FP service providers, through diverse mechanisms of transaction. A transaction comprises all the elements of the financial flow, including the transfer of resources from a financial source to a financing agent or service provider who then spends the money on various budgetary items to produce FP services.

The FPSA applies both top-down and/or bottom-up techniques for obtaining and consolidating information. The top-down approach tracks sources of funds from financing sources down to the financing agents and FP service providers. In contrast, the bottom-up approach tracks expenditures from service providers' expenditure records and facility-level records, then follows them up to the financing agents, and eventually the financing sources.

Given that the service providers, especially health facilities, lack data on actual expenditures on FP, costing techniques are used to estimate FP specific expenditures based on internationally accepted costing/estimation methods and standards used to retrogressively measure past actual expenditure. Ingredient and step-down costing are used for direct and shared expenditure for FP, while shared costs are allocated on the most appropriate utilization factor. As part of its methodology, the FPSA employs double-entry tables or matrices to represent the origin and destination of resources, avoiding double-counting of the expenditures by reconstructing the resource flows for every transaction from funding source to service provider, rather than just adding up the expenditures of every agent that commits resources to FP activities.

1.5 Using FPSA Results

The estimates of government expenditures generated by the FPSA are essential to:

- inform global monitoring of spending on FP.
- inform the resource gap analysis at national and sub-national levels by comparing available resources and resource needs based on the strategic and operational plans.
- provide financial information that will inform policy dialogue.
- help in planning and budgeting at the national and sub-national level to strengthen the case for FP within the sub-national and national development agendas.
- advocate for increased funding for FP resources and monitor progress of existing policies by assessing alignment of expenditures with stated priorities.

As of 2024, FPSA results are available for more than 50 countries. Reports are available for 2014-2019 (these are a longer format and include additional demographic and FP information). From 2020 onward, FPSA results are published in a more streamlined and standardized table format that allows for better comparison and swifter country approval of results. All FPSA data are validated and approved by country governments and stakeholders before publishing. For more information on FPSA results, visit the FPSA interactive database and available country reports and tables accessible on Track20's FPSA page.

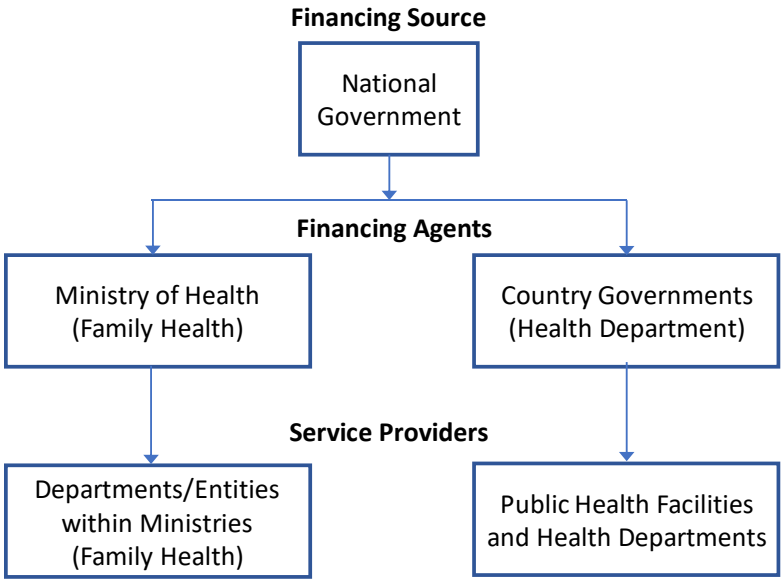
Section 2. FPSA Classification

The FPSA flow of funds covers the financing sources, the financing agents, and the service providers. Although FPSA financing sources are aligned with NHA's financing sources[4], which include Public, Private, and International sources, in most cases Track20 has conducted FP estimates with data provided by only Public sources due to the FPSA's focus on public/domestic government resources.

Details on Public/Government Categories used by FPSA	
Financing Sources From where funding originates	Broken down by National Government, Regional Government, Local Government
Financing Agents Channels for funding	Includes ministries and departments at national and regional government, state corporations
Service Providers Actors engaged in the production and delivery of FP services	Providers that are integrated in government. This would also include government agencies (such as Ministries/Department inside ministries, hospitals, schools, etc.)

[4] NHA Financing Source categories: Public (Ministry of Health, Social Security funds, etc.), Private (Households, Corporations, NGOs, etc.), and International (multilateral, bilateral, NGOs, foundations, etc.).

The figure below provides an example of the flow of resources for FP in a typical country. Also considered are the FP spending categories associated with implementing FP programs, which are described in detail in Section 2.3.



FP Spending Categories: Personnel; Outsourcing of service; Contraceptives; Monitoring & Evaluation; Policy Development & Advocacy; Information, Education & Communication; Capacity building/Training; Program Management; Management/Health Information System; Logistics/Transportation; Capital; Operational expenditures; Others

2.1 Financing

FP Financing Sources

Financing sources are entities that ultimately bear the expenses of financing FP services and related activities. Financing sources provide resources to the financing agents. Typical FPSA Public sources include Ministries (Finance, Health, Women and Youth, Social Welfare), and entities providing health/family planning funding at central and decentralized levels. Very few countries have been able to capture expenditures from social security.

FP Financing Agents

Financing agents or agent purchasers refer to institutional units/entities that manage and use the funds for payment or purchase of FP services, FP commodities, and other FP-related activities. They assist in responding to questions about who manages the financing arrangements for raising revenue, pooling/managing resources, and purchasing services. The financing agents also decide the type of activity funded and make programmatic decisions on the use of the resources they receive from the financing sources.

2.2 Provision

FP Service Providers

Providers are entities that produce and provide health care goods and services as they relate to FP. Service providers are entities that engage directly in the production of or are responsible for the provision and delivery of FP services against a payment for their contribution. FP services and interventions are provided by several entities (providers) that include public, private for-profit and non-profit domestic organizations, and international entities. Although providers are responsible for the final product, they can either subcontract services or personnel or the delivery of the product or buy the inputs necessary for producing it themselves. Providers consume the resources to produce goods and services (programmatic interventions/family planning spending category) for a beneficiary population.

2.3 FP Spending Category

A program is comprised of a set of tasks and activities to deliver a nationally coordinated package of interventions addressing the needs of a population – instructions to conduct integrated interventions and activities pursuing a desired coverage and outcome. In fact, a program defines a public health objective such as prevention or care.

The FP Spending Category (FPSC) reflects programmatic interventions/FP method, from policy and programs to interventions. For example, injectable provision is an *intervention* that an individual can take to reduce the risk of pregnancy; emergency contraceptive service is a *preventive program* to encourage this intervention. Thus, the expenditure categories reflect government decisions and public policies. The FPSCs used in the FPSA process are described in the table below.

FP Spending Category	Explanation	Sources
Personnel *(Service staff salaries and benefits for direct service provision in facilities and mobile/community services settings)*	Salaries for staff providing services (doctors, aides, nurses/matrons, assistants) Community health workers: generally small "salary" supplement" and stipends for their LOE	Human resources offices of Ministries of Health/Finance (MOH/MOF) or Treasury are the main source. For mobile/community services, the FP Program would most likely be able to identify the source of such financing.
Outsourcing of service	When the agent contracts services to NGOs and the private sector	Finance Department of MOH; MOF
Contraceptives	Contraceptives, medicine, and other FP consumables purchased by the Government	Central Medical Stores/other agencies in charge of buying, warehousing, and distributing medicines, consumables, and contraceptives
Monitoring & Evaluation (M&E)	All field work related to M&E (including meetings/workshops)	Discussions with FP Program about the best data source/could also check the budget

Policy Development and Advocacy	All the workshops conducted at national level on FP	Finance Department of MOH
Information, Education and Communication (IEC)	All IEC: airtime/TV, print, digital media, texting, as well as development of media	Generally, if Financial Management Information Systems does not have this type of data, use the budget for this activity.
Capacity building/Training	All meetings/workshops related to training in FP	If no data available, the budget for FP training is accepted.
Program Management (*for non-service delivery*)	The FP program at the Central level: management salary and expenditures (for travel, meetings, etc.)	The FP Program budget is the best source.
Management/Health Information System (MIS/HIS)	The MIS/HIS system collecting and storing health data	Use the national MIS/HIS budget.
Logistics/Transportation	Warehousing, transportation, and other logistics	Central Medical Stores//other agencies in charge of buying, warehousing, and distributing medicines, consumables, and contraceptives
Capital *(Medical & non-medical equipment, construction, and renovation, etc.)*[5]	Infrastructure (residential/non-residential); machinery and equipment, transport equipment, ICT equipment, machinery and equipment not elsewhere classified, intellectual property products (computer software and database)	MOH and MOF
Operational expenditures	Expenditures that cannot be directly traced to the provision of a service; sometimes referred to as "overhead" or "indirect" costs (e.g., rent, utilities)	From the general expenditure information. The Finance department of the MOH could be the most likely source.
Others	Any expenditures that cannot be classified in any of the categories above	From the general expenditures information

[5] Capital costs/expenditures are the assets held by the health system to include new acquisitions, and major renovation and maintenance of tangible and intangible assets used repeatedly or continuously in production processes of health care or of social amenities over periods of time longer than one year. The main categories of the classification features are buildings, capital equipment, and capital transfers.

Site and Above-site level

FPSA reports produced between 2012 and 2020 included the FP production factor (FPPF), that is goods and services which combine in a specific production function of the provider. From 2021 onward, this has been replaced with site and above-site level classification.

Site-level: Activities that occur at the point of service delivery or facility level and are categorized by the implementation of FP activities in specific communities or facilities. This includes both direct FP services to beneficiaries and non-service delivery (technical assistance, site-level training, mentoring (caring for individuals' long-term development) and supervision) at the site/community level.

Above-site level: Activities that support the broader FP program or the health system, including program management, strategic information, surveillance, and health systems strengthening.

The site-level, above-site level, and FPSC are combined in a single table in the FPSA report, as shown below. Users only need to collect data on FPSC and the disaggregation by site and above-site level is automated on the interactive FPSA database.

	Spending Category
Site-Level	Personnel
	Outsourcing Services
	Consumables (contraceptives, medicine)
Above-Site	M&E and Research
	Policy Development and Advocacy
	Information, Education and Communication
	Capacity Building/Training
	Program Management
	Management/Health Information Systems
	Logistics/Transportation
	Capital Costs
	Operational Expenditures
	Other

Section 3. Details on Resource Tracking & Transactions

This section provides definitions and details related to FPSA resource tracking and transactions.

3.1 Resource Tracking

Because countries report expenditures in different ways or have different accounting systems, there is currently no standardized method of tracking FP spending. Therefore, we describe a comprehensive and systematic methodology used to determine the flow of resources intended for FP (actual expenditure: public, private, and international). The resource tracking is based on a methodology to reconstruct all the financial transactions related to the FP program. The FPSA tracking tool was developed using the NHA framework and principles, which apply standard accounting methods to reconstruct all transactions in each country, '*following the money*' from the funding sources to agents and providers.

3.2 Budget vs Budget Execution

Financial resources allocated or committed, and resource needs are usually not equal to the budget executed, or actual expenditures. FPSA tracks actual FP expenditures (goods and services delivered to a beneficiary population).

A *budget* is an itemized summary of estimated or intended expenditures for a given period along with proposals for financing them. Budgets and *budget execution* usually differ in important ways. The latter does not reflect total FP expenditure: some expenditures are not FP- budgeted (i.e., human resources, utilities, etc., and are not reflected in budgets since they are not FP-specific). A *pledge* is a promise to give/provide resources. A *commitment* is a contract/agreement on resources to give/provide.

3.3 Fiscal vs Calendar & Accrual vs Cash Accounting

The FPSA data collection has two key timing elements:

1. **Fiscal vs Calendar year:** A period must be chosen within which the activities took place. Most often this is a fiscal year or a calendar year. This choice may seem trivial, but in practice it can pose problems. For example, government entities may report spending based on a fiscal year, while private entities report based on a calendar year. Calendar year is preferred for the purposes of international comparability.

2. **Accrual vs Cash accounting:** The second element of the time boundary is the distinction between when the activity took place and when the transaction that paid for the activity took place. In practice, this involves a choice between accrual[6] accounting and cash[7] accounting. FPSA, like SHA, uses the accrual method of accounting to the extent possible, in which expenditures are

[6] ***Accrual Method:*** Accounting method that records revenues and expenses when they are incurred, regardless of when cash is exchanged. Income and expenses are recorded as they occur, regardless of whether cash has changed hands. For example, if a patient received a consultation at a private Clinic in December 2016 but pays for the consultation in January 2017, this must be accounted for as part of the 2016 expenditure.

[7] ***Cash Method:*** Income is recorded when received, and expenses are reported when they are actually paid, that is, whenever cash has changed hands.

attributed to the time period during which the economic value was created, rather than the cash method, in which expenditures are registered when the actual cash disbursements took place.

Section 4. Estimating Shared Expenditures

There is often a need to estimate FP expenditures and personnel/staff salaries because most expenditure categories are from 'whole' *health systems* or are *not FP specific expenditures*. Isolating FP-specific expenditures can be difficult. A clear understanding of what the funds were spent on (personnel/staff, delivering services, supervision, etc.) is necessary to determine if the expenditure is indeed FP-specific. For example:

- **Program Management:** Expenditures on HR, operational costs, etc. (essentially the "running" of the program) should be carefully reviewed to tease out what is specific to FP - may include HR estimated costs for the Reproductive/Family Health Division, etc.
- **Contraceptives:** Consider whether contraceptives like condoms are related to FP or other programming.
- **Logistics:** Cost of warehousing, transporting, and delivering contraceptives specific to FP programs.
- **Training:** Training of FP providers will likely include other reproductive health, and FP training will be estimated from the shared training cost.
- **Human Resources**: Internal service staff costs for direct service provision.
- **Monitoring & Evaluation:** All fieldwork related to continuous management function to assess if progress is made in achieving expected results (including meetings/workshops).
- **Supervision:** Task-oriented support of an individual.
- **Management Information Systems (MIS):** Information systems used for data access, management, analytics, and decision-making.

4.1 FP Allocation Ratio

In general, the financial management information systems provide information for the general health system. Except for a few categories – such as contraceptives – very few systems provide FP-specific expenditures information.

To isolate FP-related expenditures from those related to whole health system expenditures, the FPSA methodology applies a 'uniform' methodology across countries to find the ***FP allocation ratio***, and the best approach is to use an **equivalency ratio**. This technique was first developed to estimate an allocation key for shared expenditures at the facility level for male circumcision.[8] Because circumcision is an outpatient procedure, an equivalent case in terms of resources used at the facility is calculated using an "equivalency ratio", a ratio that translates one in-patient day to a certain number of out-patient visits. The equivalency ratio varies by level of hospital as well as by country; here we use an average across all hospital levels to calculate one equivalency ratio per country:

[8] Bollinger, L., W. DeCormier Plosky, and J. Stover. 2009. *Male Circumcision: Decision Makers' Program Planning Tool, Calculating the Costs and Impacts of a Male Circumcision Program*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Equivalency ratio =
Average *(cost per bed day primary hospital/cost per outpatient visit at primary hospital, cost per bed day secondary-level hospital/cost per outpatient visit secondary-level hospital, cost per bed day tertiary-level hospital/cost per outpatient visit tertiary-level hospital)* for country X.

To ensure consistency of the equivalency ratio calculations across all countries, Track20 developed an **FP allocation ratio calculator tool** using the 2010 WHO-CHOICE[9] cost estimates as default data that generates the equivalency ratio.

Instead of calculating FP allocation ratios for each level of health facilities, the FP allocation ratio calculator greatly simplifies this by automatically calculating the total number of outpatient visits irrespective of the facility level (primary, secondary, and tertiary), and generates an FP allocation ratio to be used to disaggregate shared expenditures.

For more detail on how to use the FP allocation ratio calculator see **Appendix 1**: **Using the Track20 FP Allocation Ratio Calculator Tool to Calculate Shared Expenditures**.

Section 5. FPSA Tools and Report

The tools developed by Track20 to conduct an FPSA are available upon reasonable request.

5.1 Data Collection Tool

The FPSA Data Collection Tool provides a standardized way to collect data for the FPSA. The Excel tool has two tabs on which data are entered:

1) FP Service Provider Tab
2) Finance Source- Agent & FPSC Tab

The **FP Service Provider Tab** is used to capture data from an FP service provider. Note that a service provider can be a source and an agent, in which case both tabs will need to be completed.

The **Finance Source- Agent & FPSC Tab** is used to collect data from either a financial source or a financial agent and the FPSC. In a situation where the financial source is also a financial agent, this tab should be completed twice, once capturing data as a source only and again capturing data as an agent. The FPSCs are captured on this tab as well.

Note: The classification reference which includes the list of potential FP expenditures financial sources, financial agent, service providers and FPSC are provided in a hidden sheet.

[9] The CHOICE (Choosing Interventions that are Cost-Effective) project is a WHO initiative developed in 1998 with the objective of providing policy makers with evidence for deciding on interventions and programs that maximize health for the available resources. https://www.who.int/news-room/feature-stories/detail/new-cost-effectiveness-updates-from-who-choice

5.2 FP Allocation Calculator Tool

The FP Allocation Ratio Calculator tool was developed to simplify the calculation of the FP allocation ratio described previously in section 4.1. When users select their country on the "Equivalency ratio" tab and enter their required country data on the "FP allocation ratio" sheet, their country specific FP allocation ratio will be automatically generated. They will then use this ratio to apportion shared expenditures to FP expenditures categories as applicable.

5.3 Data Processing Tool

The FPSA data processing tool was developed to facilitate and harmonize the data required for the tables in the report. Once the data are collected, they are processed using the FPSA Data Processing Tool (DPT). The DPT is an Excel spreadsheet into which the user enters the data collected from the Data Collection Tool. Each line or row in the Data Entry sheet records the entire flow of expenditure or resource from source to agent to service providers, and spending categories (activities). Therefore, transaction flows as well as the FP allocation ratio must be done before data are processed in this file. The transaction flow provides information on expenditure by source, by agent, and by service provider. Data in each row should capture a spending category. The DPT automatically generates the four standard pivot tables included in all FPSA reports.

5.4 FPSA Reports & Tables

FPSA results are available for more than 50 countries and are presented as Reports or Tables depending on when the FPSA was conducted. Reports are available for 2014-2019 (these are a longer format and include additional demographic and FP information). From 2020 onward, FPSA results are published in a more streamlined and standardized FPSA Table format that allows for better comparison and swifter country approval of results. These tables are automatically generated in the Data Processing Tool. All FPSA data are validated and approved by country governments and stakeholders before publishing.

The new FPSA Table is generated using a standardized format that includes six sections.

1. Table 1: Financing sources from government: central and decentralized/local levels
2. Table 2: Family planning expenditures by financing agents
3. Table 3: Family planning expenditures by provider type
4. Table 4: Family planning expenditures categories
5. Flows of family planning service funds from government
6. Estimation Method - FP Shared Expenditures

Section 6. Validating and Disseminating FPSA Results

Once the FPSA process is complete and FPSA Tables are produced, the FPSA consultant typically works with the Track20 Monitoring & Evaluation Officer to validate and disseminate results. Track20 M&E Officers are generally Ministry of Health employees who act as FP2030 focal points. If no Track20 M&E Officer is in place in the country, the consultant should coordinate with appropriate representatives of the Ministry of Health.

FPSA results are commonly validated at the FP Program's Annual Data Consensus Meeting, to which Track20 provides technical support. During the Consensus Meeting, Track20 M&E Officers present annual estimates and other data on the status and impact of the FP country program, as well as the set of key indicators that are reported to FP2030, one of which is FP Domestic Expenditures. Typically, the FPSA consultant is invited to the Consensus Meeting to present the FPSA results.

The purpose of the Consensus Meeting is to get the FPSA results validated by the country before officially submitting to Track20 as part of the country's FP2030 reporting. Once validated, the FPSA will inform the FP2030 Indicator, "*Government Expenditure on FP from domestic resources."*

Consensus meetings are a good opportunity to present timely data to FP stakeholders on the status of FP programming and progress toward national goals and FP2030 commitments. It is important that FPSA Consultants and Track20 M&E Officers participate in these meetings so they can respond to questions about the FPSA process, data analysis (methodology), and results and provide context for how to best interpret and use the data.

However, in many of the FPSA countries, there are no M&E Officers and the FPSA consultants link with the appropriate stakeholders to present the FPSA results, get the results validated and send them to Track20.

Appendix 1: Using the Track20 FP Allocation Ratio Calculator Tool to Calculate Shared Expenditures

To isolate FP-related expenditures from those related to whole health system expenditures, the FPSA methodology applies a 'uniform' methodology across countries to find the ***FP allocation ratio***, and the best approach is to use an **equivalency ratio**. To ensure consistency of the equivalency ratio calculations across all countries, Track20 developed the **FP Allocation Ratio Calculator Tool** using the 2010 WHO-CHOICE[10] cost estimates as default data that generates the equivalency ratio. This tool is available from Track20 upon reasonable request.

There are five steps for calculating shared expenditures:

Step 1: Gather all the shared expenditures.

- Staff/Personnel/HR
- Other areas that may be part of health systems
- Supervision
- Monitoring and Evaluation
- Training: may be FP-specific

Step 2: Gather all health visits.

- Total # of outpatient visits
- Total # of in-patient visits or bed days
- Average length of stay (ALOS). If the number of in-patient visits is provided as the number of hospitalizations instead, collect the average length of hospital stay (this will be entered in cell D5, otherwise, keep the "1" in cell D5 and move to the next). Note: The conversion of in-patient bed days to out-patient / ambulatory visits considers the equivalency ratio and the ALOS; that is, the in-patient to out-patients visits = in-patient bed days (# days of hospitalization) x Equivalency ratio x ALOS.
- Total # of family planning visits

Step 3: Open the **FP allocation ratio calculation tool** "Equivalency ratio" tab and select your country. This will automatically generate the equivalency ratio. If no data appear, or your country is not listed, select a "proxy" country which has similar characteristics as yours. For example, Somalia has no data to generate the equivalency ratio and proxy countries to be used are either Eritrea of Djibouti. Then, move to the next sheet.

Step 4: Open the "FP allocation ratio" tab. The selection of the country in the previous tab will automatically populate your country equivalency ratio in cells C10 and F10 on this tab. Then, enter the total statistics data (health visits) for all the facility types (see sample table below).

[10] The CHOICE (Choosing Interventions that are Cost-Effective) project is a WHO initiative developed in 1998 with the objective of providing policy makers with evidence for deciding on interventions and programs that maximize health for the available resources. https://www.who.int/news-room/feature-stories/detail/new-cost-effectiveness-updates-from-who-choice

Table 2: Sample table from the "FP allocation ratio" tab

	Fill the yellow cells only
Type of visit	**# visits**
In-patient bed days (hospitalization)	
General out-patient visits (including FP visits)	
Other visits (please specify)	
Other visits (please specify)	
Other visits (please specify)	
Other visits (please specify)	
Family planning visits	
Equivalency ratio (to convert in-patient bed days to out-patient visits)	
In-patient to out-patients visits	
Total number of visits	
FP allocation ratio	

Note that the inpatient bed days will automatically be converted into its equivalent number of outpatient visits (outpatient visits = inpatient bed days X equivalency ratio x ALOS).

There is no need to distinguish the facility types, and the FP allocation ratio will be calculated in C15 or F15 depending on the option used. If the number of FP visits are NOT included in the total number of general out-patient visits, use Option A, otherwise, use Option B.

The *FP allocation ratio* is also automatically calculated (as *FP allocation ratio* = Family planning visits / Sum of all outpatient visits).

Step 5: Calculate the FP-specific portion of the shared expenditures as:

- FP-specific contraceptives expenditures = Contraceptives expenditures x *FP allocation ratio*
- FP-specific personnel expenditures = Staff expenditures x *FP allocation ratio*

Below is an illustrative example.

Example. Suppose the data below have been collected from country X that has an equivalency ratio of 2.1, calculate the FP specific expenditures:

Reproductive health expenditures including FP:

- Personnel = $1,483,510,735 (all service providers)
- Other operational expenditures = $272,430,885
- Visits: General outpatient visits is 48,659,810
- MCH outpatient visits is 11,850,009,
- Family planning visits is 3,182,430
- Inpatient (bed) days is 5,264,988

First, we translate inpatient (bed) days into outpatient visits:

- The equivalency ratio for "*country X*" is 2.1 (in general, this is not arbitrary, but extracted from the FP allocation ratio calculator tool described above).
- In-patient to out-patients visits = inpatient bed days x equivalency ratio x ALOS = 5,264,988 x 2.1 x 1 = **11,056,475**. Note that the ALOS here is "1" because the number of in-patient bed days is provided. If this number was instead the number of hospitalizations, and the average length of stay per patient is 2.5 days, then the ALOS should be changed from "1" to "2.5".

Total equivalent outpatient visits = 48,659,810 + 11,850,009 + 3,182,430 + **11,056,475** = 74,748,724

- FP allocation ratio = (3,182,430/74,748,724) = 0.043 or 4.3%. This ratio is used to allocate personnel and other shared costs to FP.

FP specific expenditure will be allocated as

- Personnel = $1,483,510,735 x 0.043 = $ 56,406,380
- Operational = $272,430,885 x 0.043 = $ 10,358,429