

DEVELOPING INVESTMENT CASES FOR TRANSFORMATIVE RESULTS

TOOLKIT

January, 2021



● Ending preventable maternal deaths ● Ending the unmet need for family planning ● Ending gender-based violence and all harmful practices, including child marriage and female genital mutilation

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United Nations Population Fund

This toolkit was drafted to support UNFPA offices to develop country investment cases in support of one or more of the transformative results. It offers a concise and practical guide on how to develop a national investment case, including a step-by-step guide on how to prepare for the investment case, how to estimate the cost of the investment using standardized tools, how to develop investment scenarios to determine the scale of the impact that can be attributed to the investment, how to frame the investment angle, and how to use the investment case in national advocacy efforts.

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FOREWORD

For the first time, the global community knows the cost and the new investments that must be made to achieve three world-changing transformative results: (a) ending preventable maternal deaths; (b) ending the unmet need for family planning; and (c) ending gender-based violence and harmful practices.

The world will not achieve these transformative results by 2030 without accelerating progress, and this acceleration will not happen without filling the resource gaps and stepping up political commitment at all levels.

While all categories of donors have a major role to play in this effort, ultimately national governments are the most reliable and sustainable source of funding for programmes that benefit their citizens. Early action by governments that demonstrates commitment to the three transformative results, identifies areas where the government can make additional investments and also identifies gaps where outside assistance is needed will mobilize and effectively target the most resources and help ensure success at the national level.

The level of new resources needed to achieve the three transformative results is substantial and increases rapidly year-on-year as coverage targets are projected to increase steadily. In order to achieve this level of sustained commitment, the transformative results need to be incorporated into public budgets and development cooperation efforts. It will be necessary to develop strategies to make this new funding available while maintaining current commitments.

Our vision is that each country in which UNFPA operates will have a national investment case by the close of 2021. I hope this toolkit will guide you in accomplishing this vision. I look forward to hearing your stories and the impacts of your efforts.

Jacqueline Mahon
Interim Director
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ABBREVIATIONS & ACRONYMS

CCA	Common Country Analysis
CGA	Commodity Gap Analysis
CHERG	Child Health Epidemiology Reference Group
CIP	Costed Implementation Plan
CMOI	Child Marriage Optimal Interventions
DALY	Disability-Adjusted Life Year
DHS	Demographic and Health Survey
EI	Economic Incentive
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GFF	Global Financing Facility
IGME	Inter-Agency Group for Child Mortality Estimation
ICPD	International Conference on Population and Development
INFF	Integrated National Financing Framework
IPD	Inpatient Days
IPTp	Intermittent Preventive Treatment of Malaria in Pregnancy
IPV	Interpersonal Violence
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Bednet
LiST	Lives Saved Tool
LMIS	Logistics Management Information System
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MMR	Maternal Mortality Ratio

ODC	Other Direct Costs
OPV	Outpatient Visits
PIN	Population in Need
RMNCH	Reproductive, Maternal, Newborn and Child Health
SDGs	Sustainable Development Goals
SOW	Scope of Work
Td	Tetanus Diptheria
TFR	Total Fertility Rate
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
USAID	United States Agency for International Development
WHO	World Health Organization
VLV	Value of Life Years

CHAPTER 1

INTRODUCTION

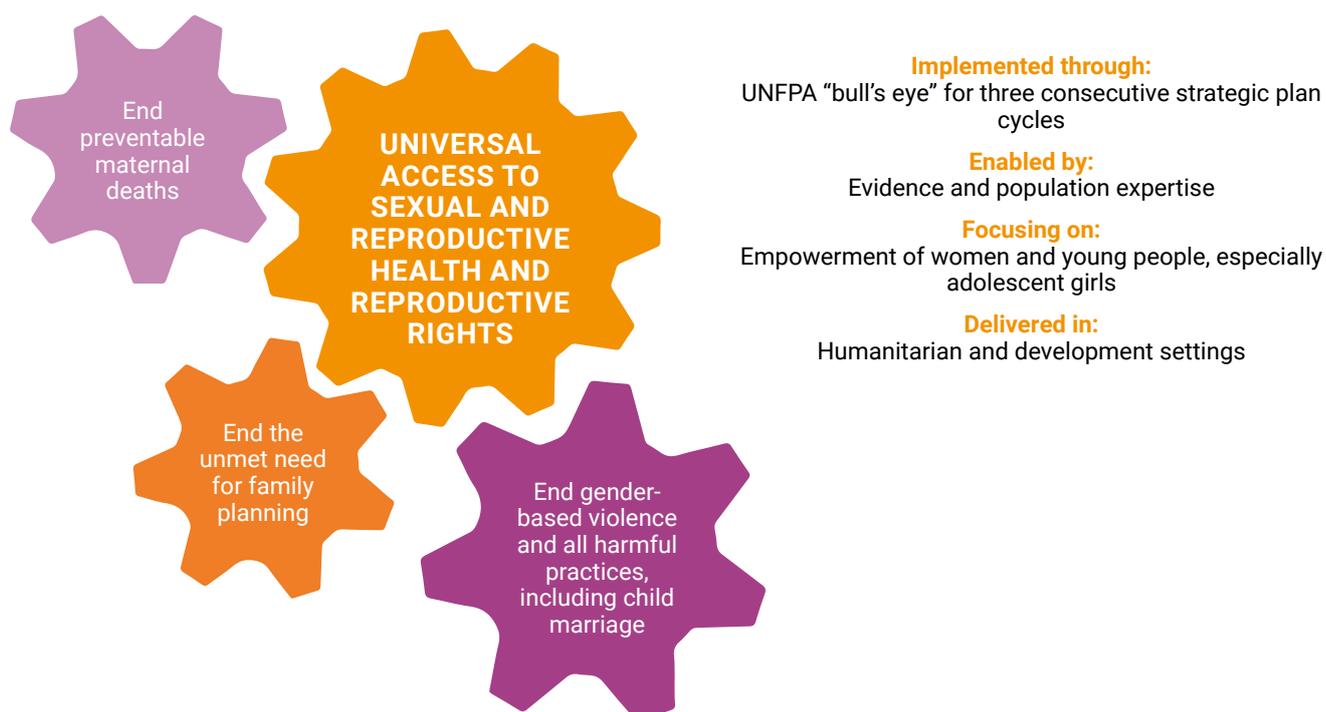
This toolkit is designed to support UNFPA regional and country offices to develop country investment cases in support of one or more of the transformative results. It provides a concise and practical guide on how to develop a national investment case, including a step-by-step guide on:

- How to prepare for the investment case
- How to estimate the cost of the investment using standardized tools
- How to develop investment scenarios to determine the scale of the impact that can be attributed to the investment
- How to frame the investment angle
- How to use the investment case in national advocacy efforts.

BACKGROUND

UNFPA embraces the vision set forth in the 2030 Agenda for Sustainable Development and the targets included in the 17 Sustainable Development Goals (SDGs) through its strategic plan (2018-2021) with the goal to, “*achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the International Conference on Population and Development (ICPD) agenda, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights, and gender equality*”, (UNFPA, 2019) (UNFPA, 2017). UNFPA’s work is organized around three transformative, people-centred results in the period leading up to 2030. These results include: (a) ending preventable

Figure 1. Universal and people-centred transformative results



maternal mortality; (b) ending the unmet need for family planning; and (c) ending gender-based violence (GBV) and harmful practices including female genital mutilation (FGM) and child, early and forced marriage (Figure 1).

These transformative results reflect UNFPA's mandate, comparative advantage, work experience, and capacity for advancing elements of the SDGs, and, in particular, are most closely aligned to Goal 3 (ensure healthy lives and promote well-being for all at all ages), Goal 5 (achieve gender equality and empower all women and girls), Goal 10 (reduce inequality within and among countries), Goal 16 (promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable, and inclusive institutions at all levels), and Goal 17 (strengthen the means of implementation and revitalize the global partnership for sustainable development) (United Nations, 2019). The transformative results reflect UNFPA's prioritization and commitment to achieving SDG 3 and SDG 5, and are aligned with:

- **Target 3.1:** By 2030, reduce the global maternal mortality ratio to fewer than 70 per 100,000 live births.¹
- **Target 3.7:** By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education and the integration of reproductive health into national strategies and programmes.
- **Target 5.2:** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- **Target 5.3:** Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (FGM).

- **Target 5.6:** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action, and the outcome documents of their review conferences.

UNFPA, together with its partners across the globe, plans to attain the three transformative results by 2030 through three consecutive strategic planning cycles: (a) Strategic Plan 2018-2021, which sets the vision and starts action; (b) Strategic Plan 2022-2025 to consolidate gains; and (c) Strategic Plan 2026-2030 to accelerate achievements.

COST OF THE TRANSFORMATIVE RESULTS UNFPA IS COMMITTED TO ACHIEVING BY 2030

In 2019, ground-breaking research by UNFPA and its partners determined the cumulative global price tag to achieve the three transformative results by 2030 for the first time (UNFPA, 2019). This analysis used aggregate country-level estimates from several different data sources and was guided by tailored tools and clear methodology. It revealed that achieving the three transformative results by 2030 in priority countries will cost \$264 billion, of which \$42 billion is currently projected to be provided by donors during this period in the form of development assistance. This means that new investments of \$222 billion are required to meet the three transformative results by 2030 (Table 1) to be raised from mostly domestic resources, including government expenditures.

Table 1. Achieving the three transformative results: Cost and funding gap

Transformative result	Total amount needed, 2020-2030	Projected amount available to spend, 2020-2030, as development assistance at the country level	New investment needed, 2020-2030
End preventable maternal death	\$115.5 billion	\$11.9 billion	\$103.6 billion
End the unmet need for family planning	\$68.5 billion	\$8.6 billion	\$59.9 billion
End female genital mutilation	\$2.4 billion	\$275 million	\$2.1 billion
End child marriage	\$35.0 billion	\$10.9 billion	\$24.1 billion
End gender-based violence	\$42.0 billion	\$9.5 billion	\$32.5 billion
Total	\$264 billion	\$42 billion	\$222 billion

¹ Ending preventable maternal deaths is also part of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

PURPOSE OF TOOLKIT

This toolkit follows UNFPA's Guidance to Country Offices Volume I (UNFPA), which provides a roadmap and the information required for management and staff at UNFPA headquarters and regional and country offices intending to develop thematic investment cases. This toolkit, or Volume II of the Guidance, builds on Volume I and provides UNFPA country offices and investment case implementers with a stepwise approach to develop thematic investment cases to meet the transformative results by 2030. There is an individual toolkit for each transformative result; based on the respective needs and priorities in their settings, countries can choose to develop investment cases for one or more of the transformative results.

The toolkit is divided into seven chapters to guide users through the process of developing their own country investment case(s), including how to use their investment cases in advocacy efforts with partners.

The toolkit is intended for use by UNFPA business unit management and staff, as well as those carrying out the costing portion of the investment case, and provides a comprehensive guide to help users prepare and plan for the development of the national investment case, ensuring technical consistency in the application of tools and across all phases of the approach including the validity of cost estimates, investment scenarios and the scale of impact attributable to the targeted investment (UNFPA).

WHAT IS AN INVESTMENT CASE?

An investment case:

- **Presents an argument for investing in a particular health area or intervention**
- **Offers an analysis of the value for money and the value for resources of investment in a range of interventions to meet desired goals**

Investment cases can be powerful tools to demonstrate the high returns that can be achieved by strengthening investments in the delivery of high-impact interventions, by presenting the full range of costs involved and the full range of benefits that flow from the interventions. Typically, investment cases are developed to influence decisions and catalyse transformative change; they are primarily aimed at donors or governments, but they can also target planners, donors and other interested stakeholders. They demonstrate the value of investment in monetary terms (e.g., productivity losses averted, benefit-cost ratios, etc.) and health outcomes (e.g., lives saved, disability-adjusted life years averted, etc.). These investment cases consider the current or status quo situation and the progress that can be achieved by evidence-based and high-impact interventions and identify key bottlenecks and gaps that limit sustained

“An investment case provides a compelling argument to potential investors¹ on the desired impact, benefits and/or returns accruing from targeted allocation, release and utilization of resources² for key priorities in a given context.”
(UNFPA)

1 Country governments, regional economic commissions, private sector, donors, multilateral development banks, international financing institutions, funds, foundations, individuals, etc.

2 Resources in this context may include financial, technical, logistics, in-kind, etc.

or further progress towards the desired goals. They include estimates of the cost required to meet the desired goals, as well as analyses of the available funding and financial gaps.

Global investment cases have been conducted in many different health areas. Several studies have estimated the cost of the investments required to increase the coverage of reproductive, maternal and child health interventions in developing countries and to estimate the expected impact of this scale-up (Stenberg et al., 2014) (Moreland & Talbird, 2006) (Keen, Begum, Friedman, & James, 2017). Similar analyses have also been conducted to make the case for investment in particular population groups, such as adolescents (Sweeny, Friedman, Sheehan, Fridman, & Shi, 2019). Investment cases have also been developed to support vaccine finance decisions for several immunization campaigns including polio, measles and rubella and maternal and neonatal tetanus (WHO, 2019) (WHO, UNICEF, 2018) (Thompson, Rabinovich, Conteh, Emerson, & Hall, 2011).

In the context of global health, an investment case presents an argument for investing in a particular health area or intervention. It offers an analysis of the cost-effectiveness (or the value for money) and the cost-benefit (or the value for resources) of investment in a range of interventions to meet desired goals. For vaccine-preventable diseases, investment cases typically describe the immunization resources needed to achieve and maintain high levels of population immunity, ideally at a level high enough to prevent transmission (Thompson, Pallansch, Duintjer Tebbens, Wassilak, & Cochi, 2012). Investment cases targeting infectious diseases might highlight the investment needed to prevent the occurrence of the disease and to protect individuals (Wolfson, Gasse, Lee-Martin, Lydon, & Magan, 2008). For other types of diseases (e.g., neglected tropical diseases), investment cases might illustrate the estimated disability-adjusted life years (DALY) averted and the effectiveness of interventions to benefit fully from economies of scale and scope (Conteh, Engels, & Molyneux, 2010).

PURPOSE OF A COUNTRY INVESTMENT CASE

- **Document country-level data related to current financing and commitments to achieve the transformative results and SDGs**
- **Define investments needed within the country's development framework(s) to achieve the transformative results and SDGs**
- **Present a compelling case, including return on investment, for a prioritized set of investments needed to achieve the transformative results and SDGs**

UNFPA recognizes that achieving the transformative results by 2030 will require significant investments as countries deal with difficult decisions related to competing health priorities. The development of country-level investment cases to determine the cost to achieve the transformative results presents an opportunity to focus on the unfinished business at the country level. It will allow countries to define the investments needed within their development

framework(s) and include proven, prioritized, high-impact, and cost-effective interventions towards achievement of the SDGs, and accelerate progress towards achieving the transformative result/s.

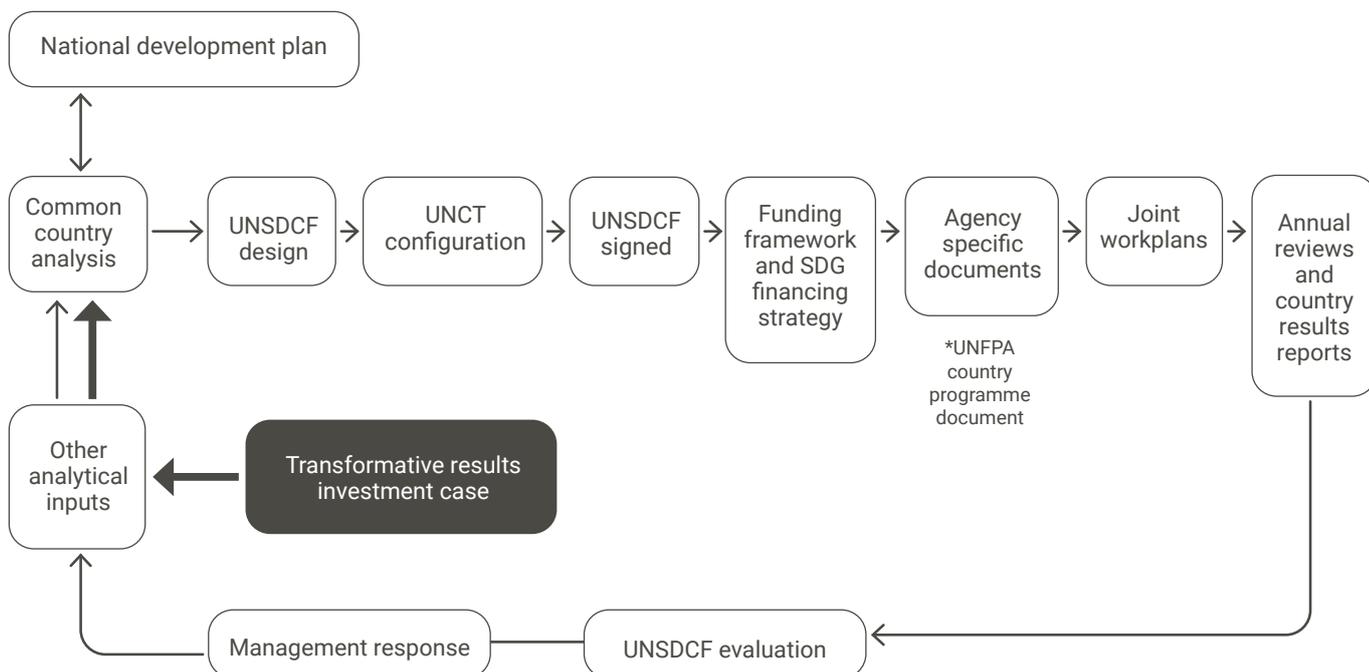
Ultimately, an investment case is essentially an advocacy tool that can be used to demonstrate the cost and value of the investment and identify financial gaps, and the necessary resources and commitment required, to shift public health management and planning towards the vision of this transformative result, and as a way to achieve the SDGs. At the country level, the investment case will present a compelling case for a prioritized set of investments needed to put the country on the path to achieve the transformative result by 2030. It can be a key advocacy tool to showcase the process by which priority interventions were identified and how the cost of these priority interventions were determined, and make the case for investing in them, as well as documenting complementary financing (through domestic and external financiers) – and gaps – to achieving the transformative result(s).

The country's investment case also offers an opportunity to position UNFPA within the United Nations Sustainable Development Cooperation Framework (UNSDCF). The UNSDCF ensures that the relationship between country governments and the UN development system is more accurately reflected in relation to achieving the SDGs. The UNSDCF is, *"the most important instrument for planning and implementation of the UN development activities at country level in support of the implementation of the 2030 Agenda for Sustainable Development"*, (United Nations General Assembly, 2018) and represents the UN's development system's efforts to support countries in addressing key SDG priorities and gaps.

To meaningfully contribute to the achievement of the 2030 Agenda, the UNSDCF is based on a United Nations Common Country Analysis (CCA), which is tailored to the UN system's role in a specific country and is reflective of an analysis of the country's context. The national investment case can feed into the CCA (Figure 2), an independent, impartial and collective assessment and analysis of the country's situation, now considered to be a living document that is responsive to an evolving country context. The CCA includes an analysis of the existing data and data gaps for national SDG indicators. It is anticipated that the CCA should go beyond official national statistics to use new sources of data and diagnostic tools, including, but not limited to, the use of big data, national surveys and assessments, targeted surveys using mobile technology, and others.

In particular, an investment case in support of achieving the transformative result can:

- **Feed into the sustainable development agenda** including the development of integrated national financing frameworks (INFF), which are planning and delivery tools to finance sustainable development at the national level and can be tools for governments to operationalize the Addis Ababa Action Agenda that provides a framework for financing the 2030 Agenda for Sustainable Development. Cases can also be used in

Figure 2. Transformative results investment cases within UNSDCF process

national Development Finance Assessments and health sector investment cases.

- **Support prioritization of interventions** within countries by determining the cost of the priority interventions needed to achieve the transformative result(s) by 2030, including identification of the available resources and gaps in support of these priority interventions.
- **Articulate the returns on investment** by making a compelling case for investment in priority interventions to achieve the transformative result(s).
- **Identify fragmentation and duplication** of financing of health priorities in a country. Analyzing the cost required to achieve the transformative result(s), and identifying complementary financing available and the resource gap, can help a country to come together behind a defined set of priorities to be implemented to achieve the transformative result.

HOW IS A COUNTRY'S INVESTMENT CASE DEVELOPED?

The development of the country investment case to meet the transformative result is meant to inform country policies, identify investment opportunities, guide resource allocation and financing, and enable UNFPA to better position the scale of investments required as well as the returns that can be accrued from investments. The process to develop a country investment case described below was developed through consultation with UNFPA headquarters and UNFPA country offices that have developed investment cases, and was based on UNFPA's guidance to country offices.

LESSONS LEARNED: RWANDA'S FAMILY PLANNING BUSINESS CASE

- **Decision to develop an investment case should come from the highest level of government; this is essential if it is to be used to advocate for resource mobilization**
- **Obtain buy-in and endorsement for the investment case at the ministry level**
- **Do not rush the process; take time to ensure buy-in, involvement and ownership from the relevant stakeholders (government, donors, partners, faith-based organizations, etc.)**
- **Consider translating the investment case into local dialects to promote advocacy**

Preparation for country investment cases is critical to successful implementation. UNFPA's guidance to country offices outlines a process for the development of country investment cases, which is elaborated below (Figure 3) and is guided by a checklist (see Annex A) to help countries as they develop their own case(s) (UNFPA). The process and timeframe below are illustrative and it is recognized that they might be influenced by several factors, including the availability of data and experienced technical experts to support the investment case, stakeholders' commitment, country priorities, etc., and should therefore be adapted to fit the needs of the country.

Figure 3. Process to develop transformative result investment case



Development of the investment case should be led by the government with active engagement and input from a dedicated reference or core group of stakeholders. Based on the availability of in-country expertise, the actual implementation of the investment case (i.e., estimation of costs, return on investment, resource gap, etc.) can be undertaken by national (highly recommended) and/or international consultants under the supervision and guidance of the core investment case team. This process can also be supported through global quality assurance provided through the regional offices of UNFPA, WHO and other organizations as needed.

Planning for the country investment case

Planning to develop a country investment case involves several elements, listed below.

- Build **consensus and secure commitment** among government and partners to undertake the indicated investment case. If necessary, the commitment can be documented in specific agreements; the contribution of the investment case to the National Development Agenda should also be documented.
- Develop a **Concept Note** to specify the scope and timeframe of the investment case. The timeframe can be

for a single case towards the 2030 goal, or multiple three to five-year cycles culminating in 2030. Document how quality assurance will be maintained during the process to develop the country investment case.

- Identify and secure **resources** to support the development of the country investment case, including human resources (within and outside UNFPA), financing, technical resources for modelling and analysis, logistics, and in-kind support.
- Conduct a **situation analysis**, including a desk review of existing costing and investment cases, to ensure that the development of the country investment case does not duplicate existing efforts and that the approach and methodology used in the investment case make use of information and data from existing in-country efforts.

Implementing the country investment case

Implementation of the country investment case involves several steps, including:

- Use specified tools to undertake costing and modelling for the investment case, including a hierarchy of high-impact and cost-effective interventions that should be prioritized with targeted investments.
- Data collection: use Annexes I and K as templates to collect all of the necessary data needed for the country investment case.
- Developing scenarios to model scale-up of the prioritized investments
- Generating cost and impact results
- Assessing current and projected financial envelope and expected resource gaps.

Documenting and advocating for the country investment case

Documenting the country investment case involves:

- **Documenting** efforts to estimate the costs of the investment, the impact, the financing gap, etc., by writing up the country investment case
- **Communicating** the results from the country investment case to government officials, donors and other key constituents and partners through standard communication channels
- Developing an **advocacy strategy** to communicate the results and encourage investment
- Developing a monitoring and evaluation plan to determine how the investment case has been used, to review the advocacy objectives and goals, to recraft messages as needed, and to reframe the investment case as appropriate.

COUNTRY INVESTMENT CASES: GUIDING PRINCIPLES

The following principles should guide the process to develop a country investment case to address a specific

transformative result (UNFPA). These guiding principles are critical to ensure that the development of the country investment case brings together essential stakeholders in a transparent manner and reflects the national context:

- **National ownership and contribution to the National Development Agenda:** Investing in maternal and reproductive health has significant benefits in the progressive realization of rights, health and other socioeconomic development outcomes in stable, fragile and humanitarian contexts. To facilitate sustainable pathways, the development of the country investment case should be country-led and should involve sectoral ministries such as Finance, National Development/Economic Planning, Gender, Education, Agriculture, Extractives, UN agencies, private sector investors, donors, non-governmental and civil society organizations, high net worth individuals, and other external financiers to represent legitimacy and ensure the investment case is endorsed by the appropriate in-country entities. The investment case should be situated within the larger framework of the SDGs and can include an analysis from a population dynamics perspective.
- **Consensus on intended impact results (What):** The level and scale of results is an important element to define as it will determine the scale and scope of investments and vice-versa. Ultimately the desired results are to end preventable maternal deaths, end the unmet need for family planning and end GBV and harmful practices. Country baselines for these results, and related intermediate outcomes, are important. The investment case must also clearly articulate the cost of achieving the transformative result(s) within the country's financial envelope.
- **Required high-impact and cost-effective interventions alongside intended effective coverage (Who and Where respectively):** To achieve the transformative results by 2030, it is critical to ensure that the investment case captures proven high-impact and cost-effective interventions that address the bottlenecks that might limit results. In addition, the key target population should be reflected to determine the reach of the investment. Finally, to ensure the equity perspective underscored by the SDG principle of "leaving no one behind" and "reaching the furthest behind first" is achieved, vulnerable population groups should be strongly reflected.
- **Effective implementation modality (How):** The investment case should include sufficient information on specific delivery mechanisms and approaches to ensure the desired results are achieved, while further leveraging and strengthening the performance of the health system across public and private sector providers of care.
- **Realistic timeframe (When):** In line with the timeframe of UNFPA's transformative results contributing to the SDGs by 2030, the investment case timeframe is recommended to be 2030 unless the government demands a shorter timeframe such as the timeline for the National Development Plan. Investment cases

therefore can be developed as a single case towards 2030 or in multiple three to five-year cycles culminating in 2030, where alignment with National Development Plans/UNSDCF is recommended.

- **Evidence-based risk management:** The possible impacts and trends of global, regional and country macroeconomic parameters and events, including economic outlooks, urbanization and climate change as well as risks of conflict, natural disasters and humanitarian situations may be considered. Guidance on how some of these items can be considered is presented later in this toolkit. In addition, many countries have already developed costed plans and investment cases to address different elements of the Reproductive, Maternal, Newborn and Child Health (RMNCH) continuum of care. On aggregation, there could be possible duplication of costs across cost-sharing items, leading to a limited coherence in presenting a compelling case. Efforts to prorate cost-shared elements are critical.
- **Robust quality assurance mechanism:** A quality investment case will clearly make the link between the intended results and the priorities, showing explicitly how the proposed investments contribute to the achievement of the results. The validity and reliability of the process is therefore critical, underscoring the importance of a rigorous quality assurance process across conceptualization and design of approach, prioritization, costing priority investments using a valid approach/tool, as well as the modelling and/or analytical tools used to compare between possible priorities and investment scenarios.
- **Capacity to develop and promote investment case:** The development of well-vetted country-level investment cases requires data availability, technical specialists (health economists, local data experts and policy advocacy experts), communication expertise (to share results), and capacity to supervise the overall investment case development.

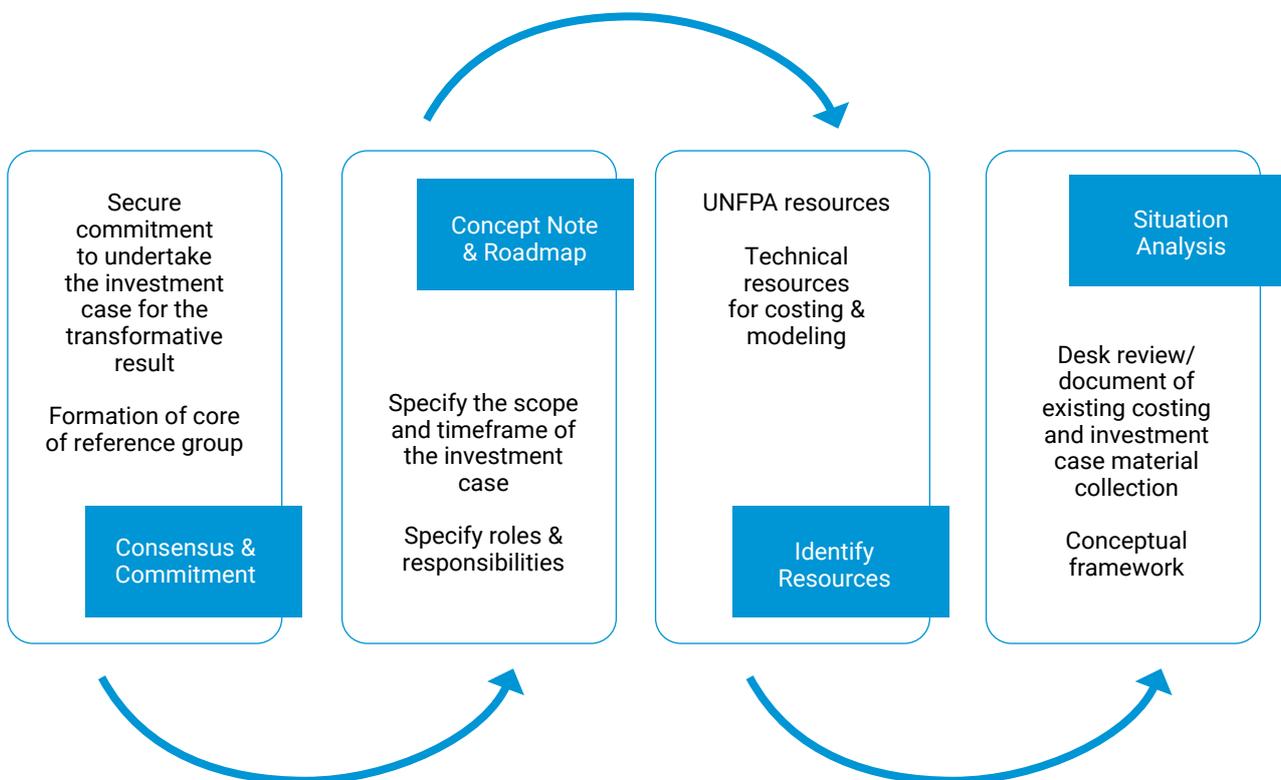
CHAPTER 2

PLANNING FOR THE COUNTRY INVESTMENT CASE

Planning to develop a country investment case requires several steps that involve different stakeholders; the checklist at Annex A can be used to guide the process for

developing investment cases. This process should be led by the government.

Figure 4. Planning steps



Box 1 provides an example of the planning process that guided the development of Rwanda's business case for investing in family planning.

Box 1. Planning for Rwanda's family planning business case

- The development of Rwanda's business case for investing in family planning was led by the Ministry of Health with extensive consultation and active engagement from a dedicated reference group.
- The reference group included members from the Ministry of Finance and Economic Planning, the Ministry of Health, the Rwanda Biomedical Centre, other ministries and government institutions involved in reproductive health and family planning, the Belgian Development Agency, UNFPA, UNICEF, USAID, WHO, Rwanda Parliamentarians on Population and Development, and Rwanda Health System Strengthening Activity, etc.
- A Terms of Reference was developed and agreed by the Ministry of Health and reference group to guide implementation of the business case.
- An international and national health economist were recruited as consultants to develop the business case under the direct supervision and guidance of the reference group.

CONSENSUS AND COMMITMENT

Building consensus and securing commitment from key stakeholders, including government officials and partners, are critical to ensure that there is buy-in to undertake the country investment case, as well as to ensure the required human and financial resources are made available. Consider using the questions in Box 2 as discussion points with stakeholders on the need for the investment case.

Box 2. Discussion points with stakeholders

- Which transformative result will the investment case address?
- What is the purpose of developing the national investment case? How will it contribute to the national development agenda?
- What is the timeframe for developing the investment case?
- Which key stakeholders should be involved in the process?

The templates at Annex B can be used to identify key stakeholders who should be involved in the development of the investment case(s) and their level of engagement in the process. The templates can also be used to determine the roles and responsibilities of each stakeholder.

CONCEPT NOTE

A Concept Note, Terms of Reference or Roadmap should be developed to specify the scope and timeframe of the investment case. The timeframe can be for a single case towards the 2030 goal or multiple three to five-year cycles culminating in 2030. The Concept Note should also document how quality assurance will be maintained during the process to develop the country investment case. Box 3 documents the elements that should be included in the Concept Note. A draft Terms of Reference from the Rwanda family planning business case is available at Annex C and can be used to guide the development of a Concept Note and Roadmap.

Box 3. Elements that should be included in the concept note

- Rationale and motivation for the investment case
- Scope and timeframe of the investment case
- Key stakeholders to be involved, including roles and responsibilities
- Process to be followed (including desk review)
- Resources needed (financial, technical)

IDENTIFY AND SECURE RESOURCES

Resources to support the development of the country investment case should be identified and secured, including human resources (within and outside UNFPA), financing, technical resources for modelling and analysis, logistics, and in-kind support. Depending on the particular country investment case being developed, it is important to ensure that the technical resource to estimate the cost of meeting the transformative result has expertise in estimating the costs using the models described in Chapter 2. The technical resource to estimate the cost, return on investment, resource gaps, etc. for achieving the transformative result can be an in-country institution familiar with this type of health economic experience or a consultant (international or national) familiar with the costing tools and approaches. A draft Scope of Work (SOW) that can be used to identify these technical resources can be found at Annex D.

SITUATION ANALYSIS

An in-depth situation analysis can help to frame the development of the investment case. This analysis should involve a desk review of existing costing and investment cases, in order to ensure that the development of the country investment case does not duplicate existing

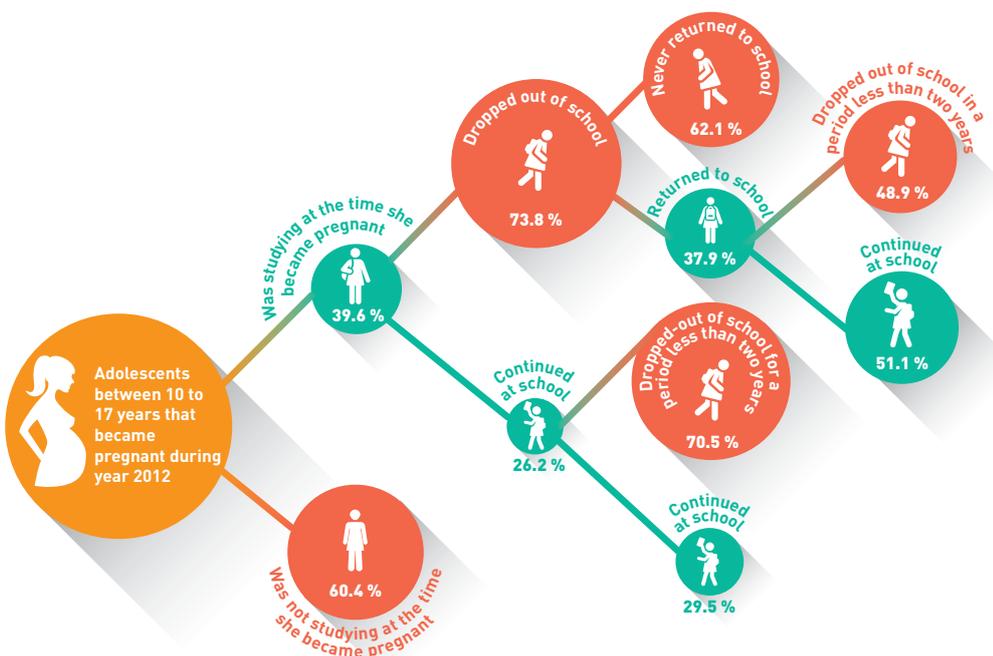
efforts and that the approach and methodology used in the investment case make use of information and data from existing in-country efforts. In addition, all relevant documents pertaining to each investment case being developed should be collected as part of the situation analysis. The tables at Annex E can be used to identify and document the relevant documents for each investment case being developed.

Now that this information has been collected, it can be used to develop a conceptual framework to guide the development of the investment case. The conceptual framework represents a way of thinking about the investment case in terms of the global and country context in which the investment case is being developed, the inputs required to achieve the transformative result and the potential outcomes from the investment.

Figure 5. Example of conceptual framework from the business case for family planning in Rwanda (Ministry of Health, Enable, UNFPA, 2019)

INVESTMENT IN FAMILY PLANNING			
	Intermediate output (Improved choice & equitable access)	FP needs are met Universal access to FP services achieved	Impact (Stabilised pop, health, economy wide impact)
COUNTRY CONTEXT (Family planning landscape)	FP services Available (adequate number and distribution) Affordable (direction and indirect costs) Acceptable (incl. discrimination free) High quality of services		Decreases Unintended pregnancies Maternal/ infant morbidity/ mortality Unsafe abortion Total fertility rate Dependency ratio Unemployment rate
GLOBAL CONTEXT Inequalities/ inequalities in using FP Current funding/ gap (ST/MT) Need for contraceptives/ gap (ST/MT)	Others Accountability systems in place Active community participation Individuals with effective agency Stakeholders actively engaged		

Figure 6. Example from El Salvador – Logical tree of girls and adolescents aged 10 to 17 years according to percentage of dropout or continuity in formal education after the occurrence of pregnancy



CHAPTER 3

ESTIMATING THE COST OF ACHIEVING THE TRANSFORMATIVE RESULTS

The ground-breaking research by UNFPA and its partners in 2019 to determine the cumulative global price tag to achieve the three transformative results by 2030 used aggregate country-level estimates from several different data sources and was guided by tailored tools and a clear methodology (UNFPA, 2019). This chapter outlines the recommended steps to estimate the cost of achieving the transformative

results. Each section describes the methodology used in the global investment case and breaks down similar methodology that can be adapted at the country level using existing tools and models. An overview of the tools that can be used to estimate the cost of achieving the transformative results can be found at Table 2 and are available on the [Impact40](http://www.impact40.org) website (www.impact40.org).

Table 2. Description of tools to estimate the impact and cost of achieving the three transformative results

Ending preventable maternal deaths	Ending the unmet need for family planning*	Ending harmful practices against women and girls		
		Ending female genital mutilation	Ending gender-based violence	Ending child marriage
Impact40.org LiST Impact Model Lives Saved Tool (LiST) Costing (via Spectrum)	Impact40.org FamPlan Impact and Cost Model FamPlan (via Spectrum) Impact 2 ImpactNow FP-SDG RAPID	User-downloaded spreadsheet**	Impact40.org GBV Impact model Impact40.org GBV Cost model	Child Marriage Optimal Interventions (CMOI) Model on Impact40.org **

* Note: for family planning, several tools exist; countries can determine the best tool to use based on in-country experience.

**Note: this spreadsheet will be automated on [Impact40.org](http://www.impact40.org) in 2021.

ESTIMATING THE COST OF ENDING PREVENTABLE MATERNAL DEATHS

Figure 7. Methodology for estimating impact of coverage in number of lives saved



Overview

The Lives Saved Tool (LiST)² is used to develop a country investment case to address the transformative result of ending preventable maternal deaths (Box 4).

Box 4. Description of the Lives Saved Tool (LiST)

- Developed by the Institute for International Programs at Johns Hopkins Bloomberg School of Public Health and funded by the Bill & Melinda Gates Foundation.
- Housed within Spectrum, a software package that includes other modules and is available at: <https://www.livessavedtool.org/listspectrum>.
- A mathematical modelling tool that allows users to estimate the impact of scaling up coverage of maternal, newborn and child health and nutrition interventions in low- and middle-income countries.

How does LiST estimate impact?

LiST calculates changes in cause-specific mortality based on intervention coverage change, intervention effectiveness for that cause and the percent of cause-specific mortality sensitive to that intervention (Figure 7).

How does LiST estimate costs?

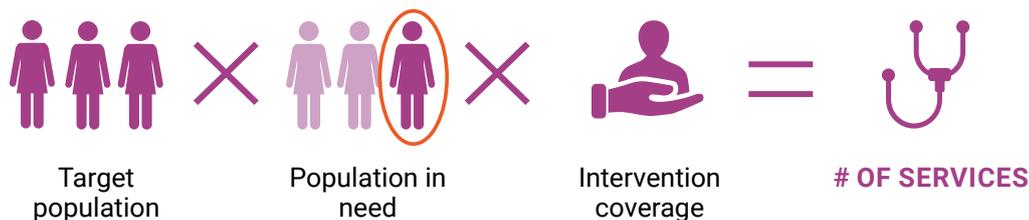
Within LiST, LiST Costing can be used to explore such questions as: How much funding is required to achieve the goals of a strategic plan? What goals can be achieved with the current resources? What is the impact of alternative patterns of resource allocation in terms of both the associated costs and achieved goals of the strategic plan? LiST Costing uses the methodology shown at Figure 8 to estimate the cost of interventions.

Figure 8. Methodology for estimating intervention costs in LiST Costing



LiST Costing uses the number of people receiving the intervention and the quantity of resources required to deliver the intervention per person to determine the cost of the intervention (Figure 9).

Figure 9. Methodology for estimating the number of people receiving the quantity of resources required to deliver the intervention per person



The determinants for intervention costs in LiST Costing are the number of people receiving the intervention and the quantity of resources required to deliver the intervention per person. In order to calculate the number of people

receiving the services, LiST Costing includes data fields for the following concepts: target population, population in need and coverage. These concepts are described in greater detail at Table 3.

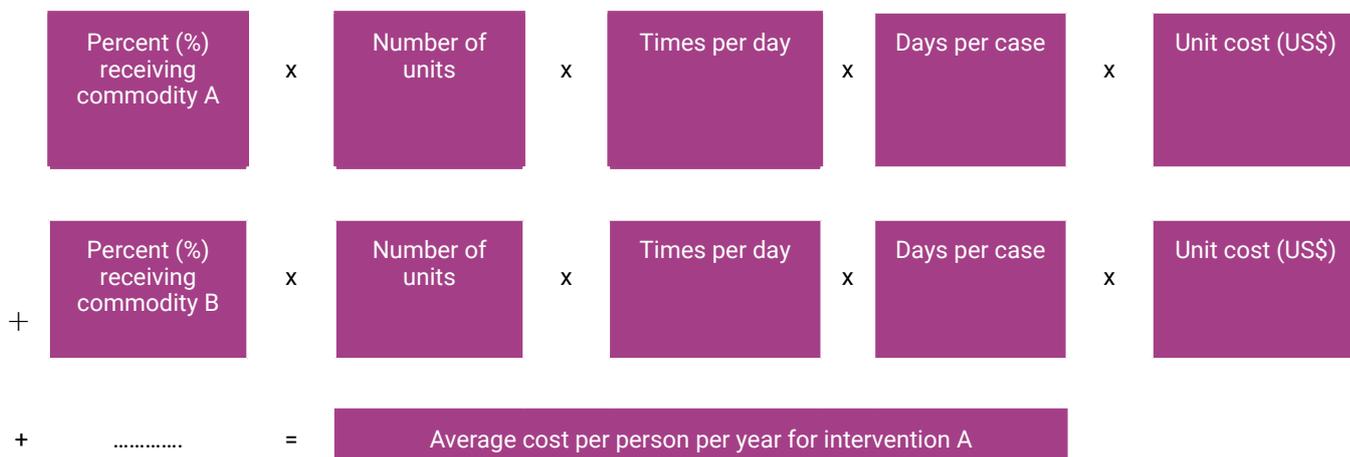
Table 3. Description of concepts used in LiST Costing (Bollinger, Sanders, Winfrey, & Adesina, 2017)

Concept	Description	Example
Target population	Population on which the health intervention is focused	Pregnant women; adolescents; children aged 1 to 59 months
Population in need	The percentage of the target population that requires the intervention; it is determined by incidence and prevalence of conditions, as well as treatment guidelines	For most preventive care interventions, the population in need is 100% (e.g., antenatal care). In some cases the population in need might be greater than 100% (e.g., treatment of malaria in pregnant women, where population in need is the percentage of pregnant women who will need treatment, per year)
Coverage	The percentage of the population in need that actually receives the service (i.e., effective coverage). This indicator is commonly found in household surveys (e.g., DHS, MICS)	Percentage of women receiving TT vaccination during pregnancy; percentage of skilled birth attendance

LiST Costing uses an ingredients-based approach to estimate the cost per person per year for a given intervention; this cost per person per year is used with the

number of services to arrive at the total cost of drugs and commodities for the intervention. The “cost per person per year” is estimated as shown at Figure 10.

Figure 10. Ingredients-based approach for estimating the “cost per person per year” for an intervention



The cost per person per year multiplied by the number of services gives an estimate of the total cost of the drugs and commodities for the intervention, as shown at Figure 11.

Figure 11. Methodology for estimating intervention drug and commodity costs



The sum of all intervention costs, including the health system costs and programme costs, provides the total cost of the programme.

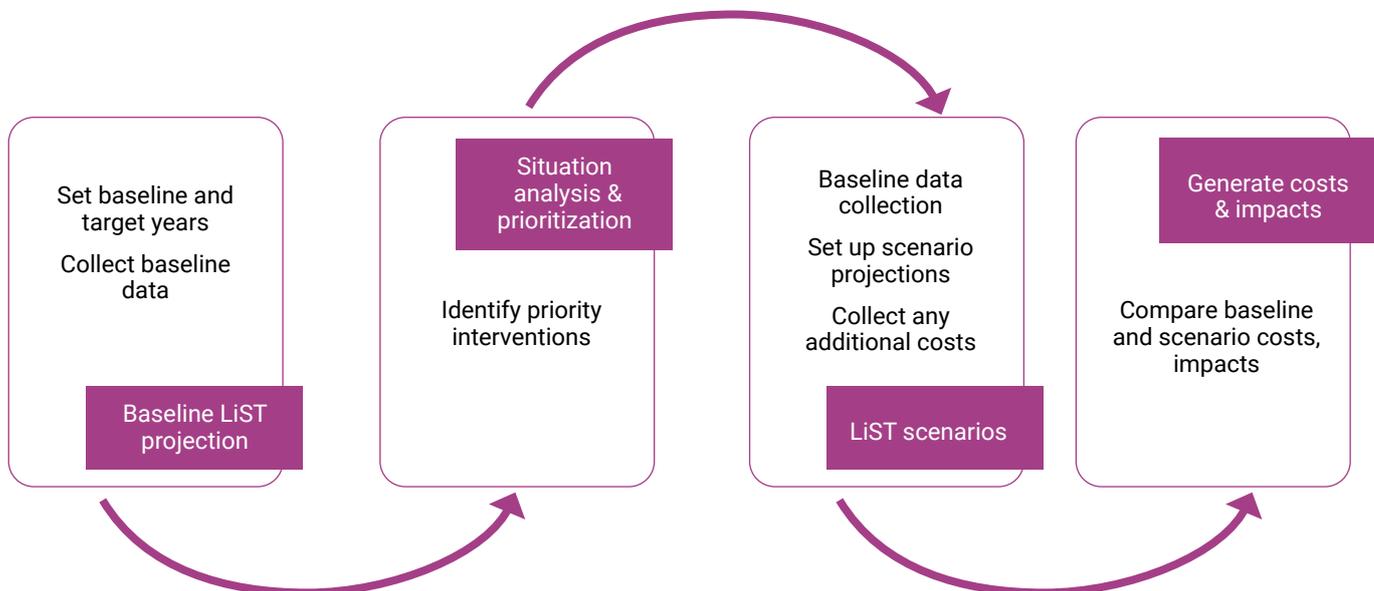
Process

The process of estimating the impact and cost of ending preventable maternal deaths involves setting up a LiST baseline projection, determining priority interventions needed to address the transformative result, determining and setting up modelling scenarios and generating cost results.

LiST Impact Model on Impact40.org

The LiST Impact Model on [Impact40](#) can be used to estimate the potential impact of scaling up key maternal health interventions from 2020 to 2030. Users begin by selecting

Figure 12. LiST process



their country of interest. The tool then communicates with the Spectrum database to pull the maternal mortality ratio (MMR) for that particular country and the default coverage of key maternal health interventions for which there are coverage values based on national level surveys (e.g., Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), etc.). Users can view the source for the MMR displayed and can edit this value as necessary.

The tool provides a list of key interventions that have been determined to be important for maternal health. These interventions have an impact on maternal mortality as well as on other outcomes (i.e., stillbirths). The definition of each intervention, as well as its effectiveness, can be viewed at the [LiST Visualizer](#) website. A baseline LiST scenario is created when users review and update the coverage of key maternal health interventions available for their particular country in the baseline year (e.g., 2020). Users can file these baseline intervention coverages by using the copy function and pasting the values into Excel.

To create scenarios, users determine which interventions to scale up and to what target coverage level by 2030. Users can use the right-click feature in the model to linearly interpolate intervention coverage from the baseline year to the target year. These intervention coverages can be copied into Excel so that users can create multiple scenarios to consider. The LiST Impact Model allows users to see the number of maternal deaths prevented by this increase in intervention coverage.

Creating a LiST baseline projection in Spectrum

Instructions for downloading and installing Spectrum can be found at Annex F.

The LiST tool within Spectrum can also be used to estimate the cost of achieving this transformative result. Users can create a country projection, which pulls together contextual indicators about maternal health status and intervention coverage, drawn from nationally representative surveys – typically DHS and MICS or global databases collated by

WHO and UNICEF. Default intervention effectiveness values included in LiST come from systematic reviews, meta-analyses, Delphi estimations, and randomized control trials. Annex G includes detailed instructions for those seeking to create their own LiST projections.

Situation analysis

Review maternal health status and mortality and economic status

The health status, mortality and economic status of the country projection, particularly in respect to maternal health, can be reviewed in the “Health status, mortality, and economic status” menu in LiST. Click through the various tabs to review the baseline indicators for maternal health status, maternal mortality, abortion, stillbirths, and economic status. Note the greatest causes of preventable maternal deaths in the country.

Intervention effectiveness

The effectiveness editor for interventions related to maternal deaths shows the default values for the effectiveness (i.e., the percent of deaths due to a specific cause that are reduced by the intervention) and affected fraction (the percent of deaths due to a specific cause which are potentially able to be impacted by a specific intervention) for each maternal or child health intervention. The affected fractions, or proportion of the cause-specific mortality, for each intervention are built using data from the Child Health Epidemiology Reference Group (CHERG); baseline mortality is drawn from studies undertaken by WHO and the UN Inter-agency Group for Child Mortality Estimation (IGME).

The internationally developed estimates are the best evidence, and it is unlikely that these should be changed.

Review the default values for effectiveness and/or affected fraction in the “Effectiveness” tab in the editor.

Preliminary summary of country maternal status

Another key feature offered by LiST is the LiST Visualizer (Box 5), which can be used to learn about the links between interventions, risk factors and causes of maternal deaths. The LiST Visualizer allows users to isolate specific causes of maternal mortality and the risk factors associated with this cause of death, as well as the interventions that are effective at addressing the risk factor. In the example below (Figure 13), maternal mortality due to antepartum haemorrhage has been isolated. This figure shows the risk factor (maternal anaemia) that contributes to it, as well as the interventions that either directly contribute to maternal mortality from antepartum haemorrhage or have an effect on maternal anaemia as a risk factor for maternal mortality due to antepartum haemorrhage. Clicking on the arrows between the boxes displays the effectiveness and sources.

Box 5. LiST Visualizer

LiST Visualizer is a tool to increase understanding of the conceptual framework that is the basis for the calculations performed by LiST. The LiST Visualizer displays the causal links between elements (interventions, risk factors, causes of death) as they are modelled in LiST. It also displays definitions for the elements and references to data sources for the linkages between them. The LiST Visualizer can be accessed at: www.listvisualizer.org.

Figure 13. Example: Risk factors and interventions associated with maternal mortality due to antepartum haemorrhage

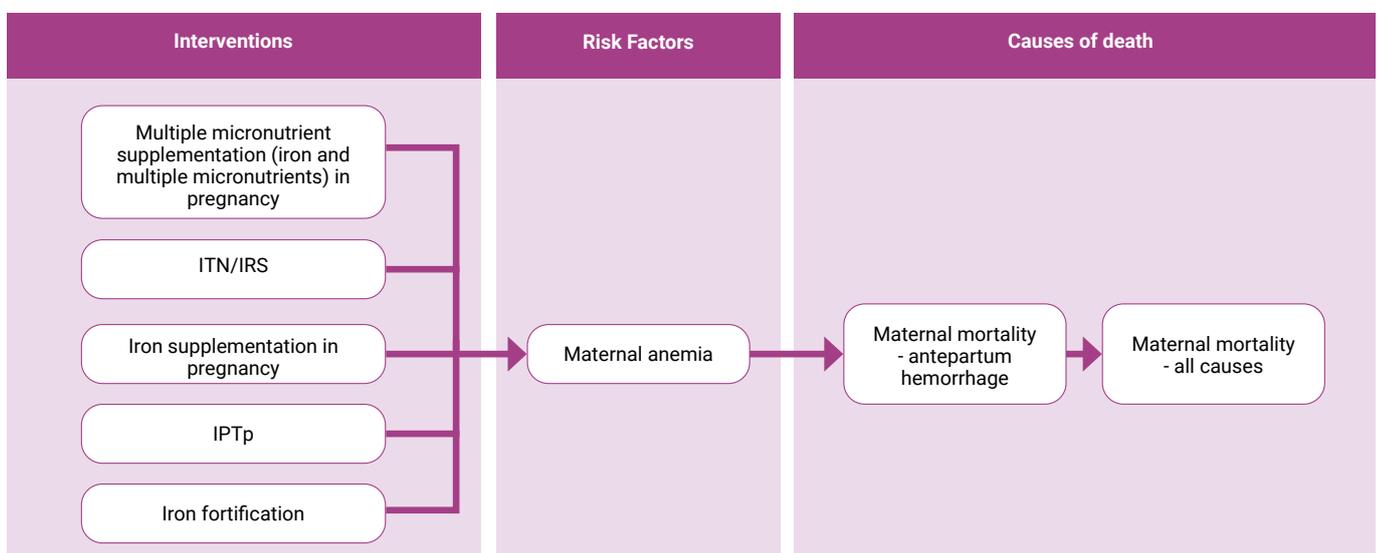


Table 4. Example of table to describe causes of maternal mortality

Cause of maternal mortality	% of mothers dying from this cause	Risk factor(s) for cause of maternal mortality	Interventions that address cause of maternal mortality	Description (direct link to cause of maternal mortality or through risk factor)	Intervention effectiveness	Affected fraction
Example: Postpartum haemorrhage	25.59%	Maternal anaemia	Intermittent preventive treatment of malaria in pregnancy (IPTp)	Direct link to maternal anaemia	0.17	% of women exposed to falciparum malaria
		Maternal anaemia	Iron supplementation in pregnancy	Direct link to maternal anaemia	0.67	% of anaemia due to iron deficiency

Using the information in the “Health status, mortality, economy status” and the “Effectiveness” tabs, determine the greatest contributors to maternal mortality in the country, the greatest risk factors and the most important interventions to address them. Adapt and use Table 4 to list and describe the causes of maternal mortality and interventions to address them. This information can be used to guide a discussion on the prioritization of interventions to end preventable maternal deaths.

Baseline coverage

Setting up the baseline LiST projection requires data collection of intervention coverages, which must be entered in LiST for the baseline year. The coverage of an intervention is used with the effectiveness of that intervention and the affected fraction to determine the probability of the outcome of interest – which can be cause-specific mortality or a risk factor for mortality. LiST assumes that mortality rates and the cause of death structure will not change dynamically in a country and that any differences are primarily in response to changes in intervention coverage (Walker, Tam, & Friberg, 2013).

The “Coverage” editor in LiST allows users to review and revise the coverage of interventions available in LiST. Each intervention is characterized either by the time in which it is delivered (e.g., pregnancy) or by the mode of activity (e.g., curative). Intervention coverage must be entered in LiST for all interventions in the base (or beginning) year. In the baseline projection, intervention coverage will remain constant (i.e., no change) from the baseline year to the end year of the projection. If using a baseline projection that has been downloaded from the impact40.org, there will be default intervention coverages in the base year, which will remain the same for each year of the projection; these should be reviewed and updated (if needed) based on data available at the country level.

Delivery channels

LiST Costing includes default distributions of interventions by delivery channels or levels of service delivery (i.e., community, outreach, clinic, and hospital-level care); these defaults are based on consultations by WHO experts. Review

the defaults and specify the distribution of interventions at each service delivery channel.

Staff baseline assumptions

The “Staff baseline data” tab in LiST Costing is pre-populated with assumptions for salaries drawn from [WHO CHOICE](#) (i.e., annual salary for a full-time person), benefits (i.e., calculated as a percentage of salary costs) and time utilization (i.e., days per year and time worked per day). These data points are used to estimate a cost per minute to estimate the labour costs for delivering the various interventions. Users can revise these assumptions if more accurate local information is available.

Treatment inputs

LiST Costing uses the number of people receiving the intervention and the quantity of resources required to deliver the intervention per person to determine the cost of the intervention. The latter part of this cost estimation is entered into the “Treatment inputs” editor in LiST Costing. Treatment inputs for each intervention specify the required drugs and consumable supplies (e.g., gloves, syringes), provider time and number of inpatient days and outpatient visits needed for the effective provision of an intervention. These are drawn from intervention assumptions developed for the OneHealth Tool (<http://www.who.int/choice/onehealthtool/en/>) and documented in the Intervention Assumptions Manual. These inputs were developed based on WHO norms and guidelines where available, with expert input where explicit guidance was not available. Drugs and consumable supply prices are extracted from international sources such as the [MSH Drug Price Indicator Guide](#), [UNICEF supply catalogue](#), and the [Global Price Reporting Mechanism](#).

LiST Costing includes default standards of care and unit costs at a global level, with no variation for different countries; these inputs are based on international standards, but can be adjusted to fit the country context if there are major differences between them and national standards. Users can specify different treatment inputs (drugs and supplies, personnel time and outpatient visits/inpatient days for each level), based on the different access to resources at different levels in the country. Results can also be produced by level, allowing analysis of the cost

implications in a shift of services between levels, as well as the amount of resources required to expand services.

For each maternal health intervention to be included in the investment case, the data at Annex I will need to be collected related to the necessary drugs and supplies required for the intervention, the required medical personnel and how the intervention is provided (i.e., inpatient day/s or outpatient visit).

Data collection

Templates at Annex H can be used and adapted to collect intervention baseline coverage.

Programme costs

Default programme cost categories and percentages are included in LiST Costing; these are based on [SUN nutrition plan costing exercises](#), the [EPIC immunization studies](#) and [National AIDS Spending Assessments](#). Programme cost categories can be configured or changed using the Add/Edit/Delete buttons; users are encouraged to adapt these cost categories and the assumed level of costs based on recent country-specific data if available.

These costs are intended to capture the above service delivery costs associated with the delivery of the maternal health interventions. Users can either enter costs as a percentage of direct costs or as an absolute number (each programme cost can be configured as a percentage or absolute number using the drop-down selection). If using the percentage format, programme costs are applied to all intervention costs.

Calibrating baseline LiST projection

Now that intervention coverages have been entered in LiST, use LiST to generate several different results and compare these to the currently known situation of maternal health in the country. In the Results tab in LiST, generate:

- The number of maternal deaths in the base year
- The maternal mortality rate and ratio in the base year

LiST scenarios

Scenarios used in the national investment case should build on a baseline or “status quo” scenario previously developed. These alternate scenarios should explore different ways to achieve the goal of ending preventable maternal deaths by the SDG target date. For each scenario, the investment case should specify the interventions being scaled up and the cost of this scale-up.

Determination of the alternative scenario(s) to model should be made with the Working Group. Upon presentation of the “status quo” or baseline scenario to the Working Group, discussions should be around:

- Total maternal deaths from 2020 to 2030 that need to be prevented
- Main causes of maternal deaths and interventions that need to be scaled up to address them
- Additional interventions needed to prevent maternal deaths

- Intervention scale-up required from 2020 to 2030
- Additional costs (medical personnel, infrastructure, health systems, etc.) needed for intervention scale-up

Document the interventions being scaled up and the scenarios to be modelled. For example, scenarios might include:

- Scale-up of interventions to 95 percent coverage in 2030
- Scale-up of interventions in regions with greatest burden
- Scale-up of most cost-effective interventions

LiST scenarios build on the baseline scenario. To create a scenario projection in LiST, save the baseline projection then rename it as “Scenario A” (or something similar); this will be the scenario projection in which interventions and coverage are scaled up.

The “Coverage” editor in LiST can be used to revise and scale up the coverage of maternal health interventions from 2020 to 2030. Interventions can be scaled up in four different ways in LiST: linearly, S-shaped, exponentially, and front-loaded. By highlighting the intervention coverage row from baseline to target year (i.e., 2020 to 2030) and right-clicking in the highlighted area, users can select an interpolation option.

Generate results from scenarios

Generate results and document findings for “status quo”

Now that the baseline projection has been set up, the narrative for the current state of maternal health in the country can be written up for the national investment case. LiST should be used to generate results related to maternal deaths by cause to describe the projected maternal deaths over the timeframe. The greatest contributors of maternal deaths can be noted and discussed, as well as the interventions that will need to be targeted to reduce these maternal deaths. These results and baseline data should be documented and presented to the UNFPA team for review.

In particular, the narrative for the baseline or “status quo” should include:

- A description of the current status of maternal health in the country
- Details about the greatest contributors of maternal mortality in the country
- Details about the current interventions targeting maternal health, including challenges and expansion or scale-up issues
- Discussions of the current trajectory of maternal mortality in the country (i.e., anticipated or projected maternal deaths during the time period, etc.), compared with SDG targets
- Documentation of the societal perspective and the cost of the interventions, as well as a forecast of the expected future investments needed along the current or “status quo” path

Generate results and document findings for each scenario

Now that the scenario projection(s) have been set up, the narrative for each scenario can be written up for the national investment case. Document the interventions for

which coverage was increased and the 2030 target coverage. Use LiST to generate results related to maternal deaths to demonstrate the reduction in deaths over the timeframe.

In particular, the narrative for each scenario should include a:

- Description of the scenario goal
- Description of each intervention being scaled up, as well as issues or challenges with scale-up

- Discussion of what happens with maternal deaths over the time period as the coverage of these interventions is scaled up; compare this with the SDG targets
- Documentation of the societal perspective and the cost of the interventions, as well as a forecast of the expected future investments needed for each scenario
- Documentation of costs in terms of lives saved

IMPACT OF COVID-19

The health impact of COVID-19 among pregnant women is unclear. However, there has been documentation of a reduction in care-seeking behaviour and in the utilization of maternal health services; this is expected to have adverse consequences as an indirect effect of the pandemic. The LiST Impact model on Impact40 can be used by countries to consider the impacts of COVID-19 on achieving the transformative result to end preventable maternal deaths. Countries might begin by:

- Determining the maternal health interventions that are believed to be most impacted by

COVID-19 (consider whether interruptions are systemic – workforce and supply chain issues; interventions are impacted by movement restrictions; interventions are impacted by women not seeking care due to fear of nosocomial infection).

- Considering the timeframe in which the interventions were most impacted by COVID-19 (e.g., only in 2020? in 2021?)
- Making coverage adjustments to interventions impacted by COVID-19.

ESTIMATING THE COST OF ENDING THE UNMET NEED FOR FAMILY PLANNING

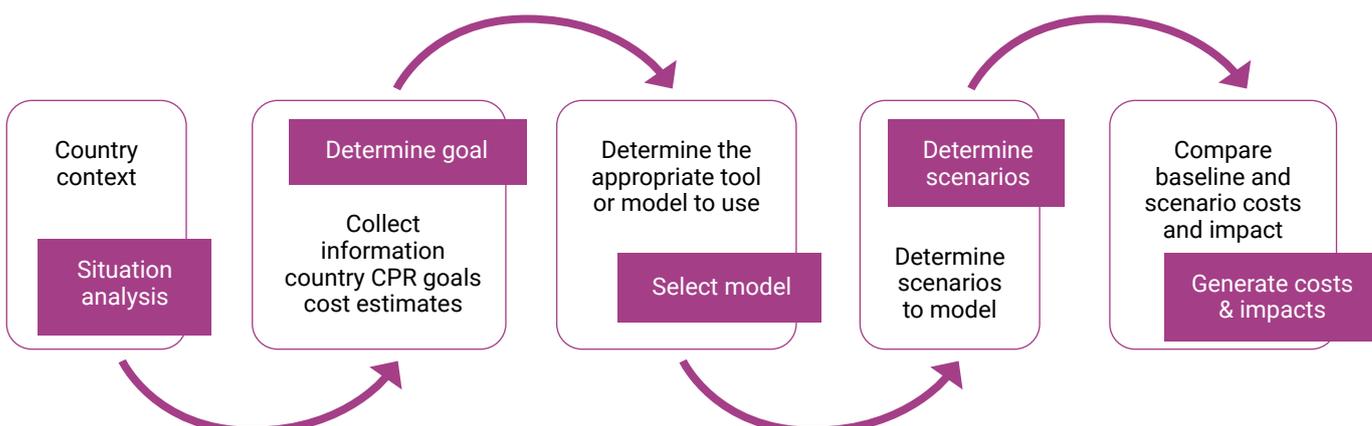
The unmet need for family planning is defined as the percentage of women of reproductive age (aged 15 to 49 years) who want to end or delay childbearing, but are not using a modern contraceptive method, plus women who are currently using a traditional method of family planning (who are assumed to have an unmet need for modern contraception).

To estimate the global price tag to end the unmet need for family planning by 2030, UNFPA and partners made the assumption that the use of modern contraception would increase to the level of the current unmet need plus the current use of all methods. In effect, this means that by

2030 the modern contraceptive prevalence rate (mCPR) in each country would increase by the amount of the current unmet need and the current use of traditional family planning methods (i.e., those assumed to have an unmet need for a modern method) (UNFPA, 2019). Total expenditure by countries on family planning programmes published by FP2020 (Family Planning 2020, 2018) were used to estimate the expenditure per modern method user for each country.

For each country seeking to develop a family planning investment case, there are several tools that can be used, but the process is primarily the same: Determine the country's contraceptive prevalence rate (CPR) goal, select the model to use, determine scenarios to model, and finally generate costs.

Figure 14. Costing steps



Situation analysis

The investment case will reflect the current family planning context in the country. Therefore, it is important to gather

critical information about family planning, fertility and reproduction in the country. A few such indicators are documented at Table 5.

Table 5. Relevant family planning contextual data and potential sources

Indicator	Definition	Potential source
Total population (disaggregated by sex and age); annual population growth rate	Number of people in the country by year, disaggregated by sex and age	https://population.un.org/wpp/Download/Standard/Population/ or country census and population resources
Total fertility rate (TFR)	In a given year, the total number of children that would be born to each woman if she were to live to the end of her childbearing years and gave birth in line with prevailing age-specific fertility rates.	National surveys (DHS, MICS, etc.)
Modern contraceptive prevalence rate (mCPR)	Percentage of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time	www.track20.org
Demand satisfied	Percentage of women (or their partners) who desire either to end or postpone childbearing and who are currently using a modern contraceptive method	www.track20.org
Unmet need	Percentage of women of reproductive age who want to end or postpone childbearing, but are not using a contraceptive method, plus women who are currently using a traditional method of family planning	www.track20.org
Unintended pregnancies	Number of pregnancies that occurred at a time when women (and their partners) either did not want additional children or wanted to delay the next birth	www.track20.org
Method mix	Percentage of total family planning users using each modern method of contraception	DHS, MICS, PMA2020 or national surveys
Stockouts	Percentage of facilities stocked out for each type of modern contraceptive offered, on the day of assessment	UNFPA facility surveys; other facility surveys and LMIS data
Method availability	Percentage of service delivery points that have at least three modern methods of contraception available on the day of the assessment	UNFPA facility surveys; PMA2020 facility surveys; HMIC; USAID

Determining the family planning goal

Most countries already have goals related to family planning. The investment case should build on these goals and begin by identifying and documenting them. Potential

sources to locate these goals are documented at Box 5. These documents will be useful to determine the overall family planning goal that the investment case is seeking to achieve.

Box 5. Potential sources of country family planning goals

Costed Implementation Plan (CIP): A multi-year roadmap to help governments achieve their family planning goals by the most effective, efficient means possible. CIPs document programme activities and associated costs necessary to meet a country's family planning goals; they define human, financial and technical resources, as well as commodities and equipment needed.

FP2020: A global partnership to empower women and girls by investing in rights-based family planning. Many countries have made commitments to FP2020, some of which include an mCPR goal. The website allows users to search for family planning indicators and data by country and has many other resources organized by country. <https://www.familyplanning2020.org/>

Global Financing Facility (GFF) Investment Cases, RMNCH Strategies, country health sector strategic plans, essential services plans, etc.

It is important to be clear what the stated goal is in order to interpret it correctly. Generally, there are two important considerations:

- 1. Population:** Some countries set goals for contraceptive use among married women, while others set goals for contraceptive use among all women. This distinction is important because in most countries contraceptive use among married women is *higher* than among all women. It is also important when multiplying the goal by a population to estimate the total number of users.
- 2. Methods:** Generally, goals are set for mCPR, meaning that traditional method use is not included in the goal. However, some countries have set goals for a total CPR, which may need to be converted to a goal for mCPR for use in the investment case.

Select model

There are several different tools that can be used to estimate the cost of ending the unmet need for family planning, as well as determining the associated impact. The choice of the most appropriate tool to use will depend on the goal of the investment case, as well as the expertise available in-country to support the tool's implementation. These tools are described at Table 6 and more details can be found in the document "Crosswalk of Family Planning Tools: A Guide to Costing, Planning, and Impact Analysis Tools"³ (Godbole & Smith, 2012).

Table 6. Overview of family planning tools

Tool	Description
FamPlan ⁴	Within the Spectrum suite of policy tools, FamPlan projects the family planning requirements needed to reach national goals for addressing the unmet need or achieving desired fertility.
FamPlan impact and costing models on Impact40.org ⁵	The Impact40 website has an impact and cost tool that can be used to estimate the impact and cost of ending the unmet need for family planning. After selecting the country, users can review baseline details about the CPR and method mix, then specify the target mCPR and method mix in 2030. The cost of using modern methods is estimated based on the number of modern method users.
Impact 2 ⁶	A tool that estimates past, current, and future contributions to family planning use.
ImpactNow ⁷	An Excel-based model used to estimate the health and economic impacts of family planning in terms of reproductive health metrics and economic metrics.
FP-SDGs Model ⁸	An Excel-based tool that projects the medium- and long-term effects of three different family planning uses on 13 health and non-health SDG indicators by 2030 and 2040.
RAPID ⁹	Within the Spectrum suite of policy tools, RAPID projects the social and economic consequences of high fertility and rapid population growth for various sectors (education, labour, health, etc.).

3 http://www.healthpolicyproject.com/pubs/117_CrosswalkofFamilyPlanningToolsGuideFINAL.pdf

4 <https://avenirhealth.org/software-spectrum.php>

5 <https://www.impact40.org>

6 <https://www.mariestopes.org/what-we-do/our-approach/our-technical-expertise/impact-2/>

7 <http://www.healthpolicyplus.com/impactnow.cfm>

8 <http://www.healthpolicyplus.com/pubs.cfm?get=7170>

9 <https://avenirhealth.org/software-spectrum.php>

FamPlan Impact and Cost Models on Impact40.org

The FamPlan Impact and Cost Models on [Impact40](https://www.impact40.org) can be used to estimate the potential impact and cost of ending the unmet need for family planning. In the FamPlan Impact model, users begin by selecting their country of interest. The tool then communicates with the Spectrum database to pull the CPR and method mix for the baseline year (i.e., 2020). Users have the option of adjusting these values.

Next, users consider how they might meet the 2030 target of ending the unmet need for family planning. They can choose to manually enter a specific value for the 2030 value of mCPR. Alternatively, users can select to have the model automatically calculate the mCPR, in which case the model will automatically change the target 2030 method mix so that any unmet need and traditional use in the baseline year is converted to modern method use by 2030.

The FamPlan Impact and Cost Models display results in terms of the number of unintended pregnancies averted, the number of maternal deaths averted and the number of unsafe abortions averted due to modern method use, as well as the number of modern method users and the cost of using modern contraceptive methods.

Determine scenarios to model

There are a few different scenarios that can be modelled to make the case for investment in family planning. These might include the different levels of CPR scale-up, different levels of unmet need and/or different fertility rates.

Countries might also consider the method mix and design scenarios around holding this constant or changing it. A useful resource for creating method mix scenarios is the Reproductive Health Supplies Coalition (RHSC) Commodity

Gap Analysis, which is available by country at: <http://www.rhsupplies.org/cga/>.

Generate costs

If the model is set up to generate costs, these costs, and other indicators of interest, can be generated once the scenarios have been set up. Alternatively, costs can be generated in a separate Excel file set up by the investment case implementer, based on the model outputs. Cost estimation can be approached in a few different ways; some examples are highlighted at Box 6:

- Unit cost per user x number of users each year.¹⁰
- Ingredients-based costing: many CIPs use this approach.

Box 6. Potential costs and indicators to generate from scenarios

- # of modern contraceptive users
- # of additional contraceptive users
- # of unintended pregnancies averted
- # of abortions averted
- # of maternal deaths averted
- # of DALYs averted

Steps from the family planning investment cases in Rwanda and Pakistan are provided as examples and reference points at Box 7.

Box 7. Example: Rwanda and Pakistan

Item	Rwanda	Pakistan
Situation analysis	One of the most densely populated countries in sub-Saharan Africa TFR ranges from 3.6 to 4.3 Approximately 19% of women and families want to delay, space, and end childbearing but are not using family planning methods	High rate of population growth Need to address CPR and TFR
Goal	Family Planning and Adolescent Sexual Reproductive Health/Family Planning Strategic Plan 2018-2024: Increase CPR to 60%	Goal of reducing population growth rate from 2.4% to 1.5% per annum by 2024 and to 1.1% by 2030 Goal of increasing CPR to 50% by 2025 and 60% by 2030 Goal of reducing TFR to 2.8 by 2025 and to 2.2 by 2030
Tool	Impact-Now FP-SDG Model	Impact 2 Model
Scenarios	Status quo Modest progress: Scale-up of mCPR from 49.4% to 60% Ambitious progress: Scale-up of mCPR from 50.7% to 70%	Status quo CPR increase to 50% by 2025

¹⁰ This approach is used in the model at <https://www.impact40.org>. Here the unit cost per user is based on family planning expenditure estimates by the Track20 project, Kaiser Family Foundation, UNFPA, Netherlands Interdisciplinary Demographic Institute, and the World Health Organization, which include costs associated with service delivery, programme management, research, training, data systems, and other components of family planning programmes.

IMPACT OF COVID-19

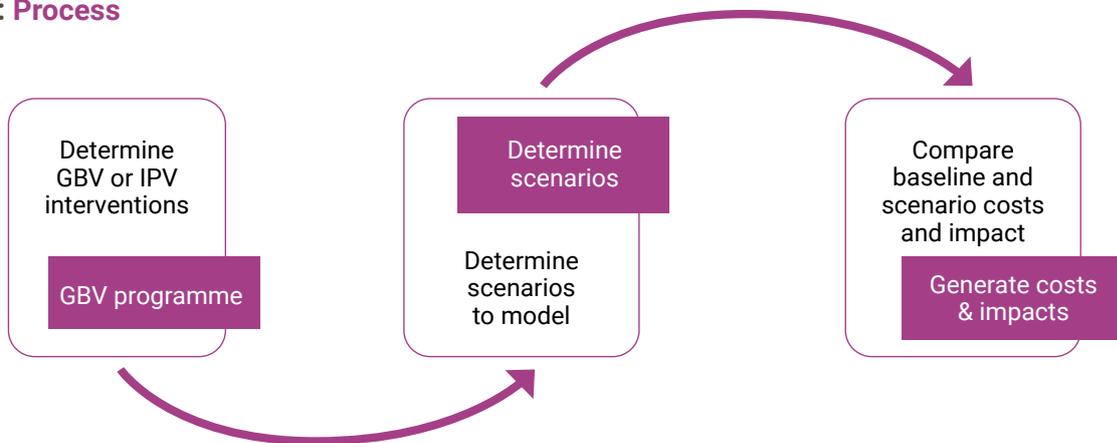
The Impact40 site has a link to guidance on how countries might estimate the impact of COVID-19 on meeting the transformative result of ending the unmet need for family planning. The link provides an Excel spreadsheet and instructions for using the FamPlan module within Spectrum.

In the spreadsheet, users can enter country-specific data on the CPR and method mix. Next,

users can adjust assumptions on women's risk for family planning service disruption as well as on the proportion of women who might switch to traditional methods of family planning due to these disruptions. The tool outputs a table for each scenario showing the impact of COVID-19 on the CPR, the mCPR and the method mix in 2020 and 2021; these values can also be entered into the FamPlan in Spectrum to run additional results.

ESTIMATING THE COST OF ENDING GENDER-BASED VIOLENCE

Figure 15: Process



Since there is not a large body of research on the effectiveness of interventions to address GBV, the global price tag methodology assumed that to meet this transformative result, a range of anti-GBV programming would be scaled up to impact 80 percent of women in 132 target low- and middle-income countries by 2030. The analysis identified a basic package of prevention and treatment interventions for intimate partner violence (IPV). Information on the cost of programmes to

prevent GBV is also limited. The unit costs used in the global analysis were identified from literature reviews and a 2007 study¹¹ undertaken for UNAIDS of resource needs that estimated the incremental cost of reaching people with a combination of interventions that would either be implemented independently or be added to existing HIV interventions.

The population reached by the intervention is calculated as:

$$\text{Population reached}_{s,t} = \text{Target population}_{s,t} \times \text{coverage}_{s,t}$$

Where s = prevention or treatment service

t = time

The cost of the programme is estimated by multiplying the number of people reached with each service by the unit cost of providing that service. To this base cost, \$100,000 per country is added for non-governmental organization (NGO) strengthening

and 15 percent for support functions such as administration, research, training, and monitoring and evaluation (M&E). Therefore, the cost of the programme is estimated as:

$$st = (\sum_s \text{population reached}_s \times \text{unit cost}_s + \$100,000) \times 1.15 \text{ (s = prevention or treatment service)}$$

11 UNAIDS, Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support, September 2007.

The gender-based violence programme

The GBV Impact and GBV Cost tools on [Impact40.org](https://www.impact40.org) include a basic package of GBV interventions that countries can use to estimate the potential impact and cost of scaling up to meet the transformative result of ending GBV. This package is not intended to be a recommendation of what each country or regions/provinces within countries should do; instead it represents the types of services and costs that are required in GBV programmes. Depending on the country selected, the unit cost of each intervention will be adjusted, but the unit costs can be edited and customized by users based on available information in-country.

Once users select their country of interest from the dropdown menu, they can tailor the actual package of interventions to each country's context, by determining which of the GBV or IPV interventions are available in the country, and by documenting baseline coverage levels and target coverage in 2030.

Determine scenarios to model

There are a few different scenarios that can be modelled to make the case for investment in efforts to end GBV. These might include scaling-up existing interventions or starting interventions that are not yet taking place in the country.

Generate costs

Once the scenarios have been set up, costs and other indicators (Box 8) can be generated through the tool for each scenario.

Box 8.

- Percent experiencing IPV in the last year
- Number experiencing IPV
- Cases of IPV averted
- Cumulative cases of IPV averted

IMPACT OF COVID-19

The Impact40 site has a link to guidance on how countries might estimate the impact of COVID-19 on meeting the transformative result of ending GBV. The instructions direct users to create two scenarios using the GBV impact and cost tools on Impact40: One scenario without COVID-19 and

another scenario that includes the impact of COVID-19. In this latter scenario, country users can consider whether there might be a delay in the scale-up of GBV prevention interventions (and the length of this delay) and whether there has been an increase in violence as a result of COVID-19 lockdowns/mitigation measures.

ESTIMATING THE COST OF ENDING FEMALE GENITAL MUTILATION

Female genital mutilation (FGM) is a violation of a girl's human rights. It is often a precursor to early marriage and usually ends a girl's education and curtails her economic prospects. The causes of FGM are varied and may include social, religious and economic elements. Programmes to promote the abandonment of FGM commonly focus on changing social norms around the harmful

practice at the community and institutional levels, enabling girls, women, men, and families to more easily abandon the practice. In the global price tag, ending FGM will occur when all communities with majority approval for FGM in the 31 high-incidence countries are reached with direct or indirect community empowerment programming to promote abandonment of the practice. The global analysis identified and estimated the cost of implementing prevention, protection and care and treatment interventions that would result in ending FGM in these countries (Table 7).

Table 7. Global estimated costs

Intervention	Target population	Unit cost (range among countries)
Prevention		
Community programmes	Community	\$2,603 to \$37,577
Mass and social media for prevention	Community	\$5 to \$120
Provider training for prevention	Provider	\$77 to \$2,013
Protection		
Mobile courts	Community	\$6 to \$154
Legislation development (if none exists)	Country	\$22,314 to \$431,998
Capacity building for legal personnel	Country	\$1,478 to \$38,584
Care and treatment		
Psychosocial support	Individual	\$31 to \$868
Provider training for care and support	Provider	\$33 to \$2,013

The methodology to estimate the cost and impact of ending FGM is shown at Figure 16.

Figure 16. Methodology to estimate the cost and impact of ending FGM



The process for developing the investment case is as follows: Determine FGM interventions available in the country, determine scenarios to model and finally, generate costs.

Female genital mutilation programme

The FGM Impact and FGM Cost spreadsheets on Impact40.org can be used by countries as they develop investment cases to address this transformative result. The spreadsheets are user-friendly; they were developed to support countries to analyse the potential impact of scaling up prevention programmes on the incidence and prevalence of FGM in high-burden countries, as well as the costs of scaling up protection, care and treatment and programme support alongside prevention programmes.

Users begin by identifying the percentage of communities with majority positive views of FGM to be reached with

direct programming and estimating how many additional communities will be affected indirectly by sensitization from the direct programmes. They then specify the number of years it will take to achieve these goals. The spreadsheets are pre-populated with defaults that are consistent with the global FGM analysis completed by UNFPA, but these defaults can be revised and customized by country users.

Next, users enter the baseline coverage of the prevention, protection, and care and treatment programmes in their country (Table 8). Defaults are provided based on Joint Programme spending, but can be edited by the user based on available data in the country. At this point users can specify other inputs, including whether there is currently legislation against FGM, the proportion which is type 3, overheads and materials costs.

Figure 17: Steps for FGM costing

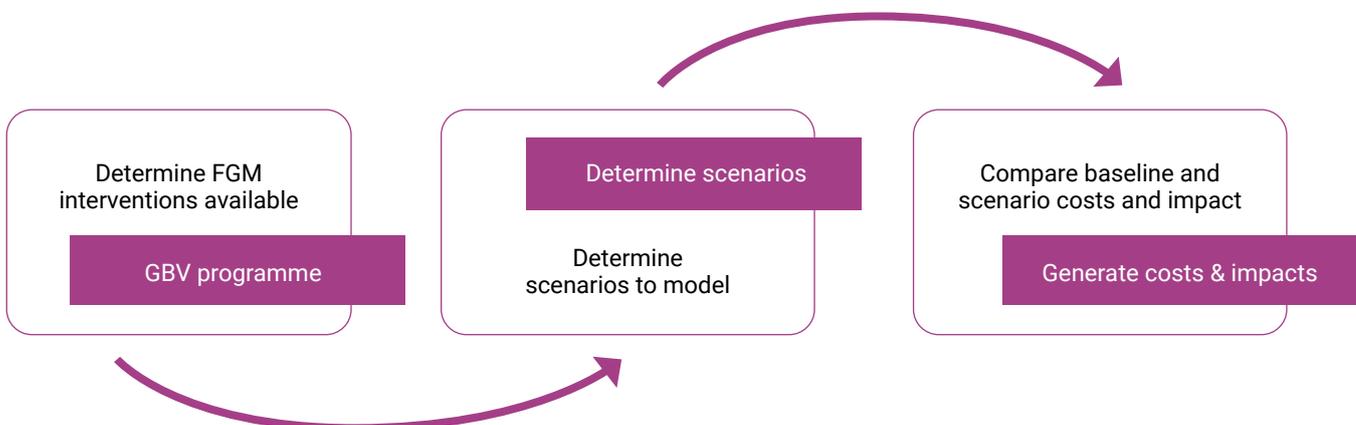


Table 8. Interventions and costs

Inputs	Coverage (baseline, target year)	Other	Unit cost
Prevention programmes Community programmes Mass and social media Provider training		X	
Protection programmes Mobile courts Legislative development Capacity building for legal personnel		X	
Care and treatment programmes Psychosocial support Provider training		X	
Legislation banning FGM exists?	X	Yes/No	X
% of FGM that is Type 3	X		X
Overhead costs	X	X	
Material development costs	X	X	
Coverage of direct programme interventions		X	X
Number of communities impacted indirectly by each community	X		X
Years for complete coverage scale-up	X		X

Determine scenarios to model

Generate costs

The tool will generate the following costs and impact (Box 9); countries can develop multiple scenarios by changing the defaults in the impact and cost spreadsheets to consider different combinations of prevention programmes and costs.

Box 9. Costs and impact

- Cost of prevention, by year
- Cost of protection, by year
- Cost of care and treatment, by year
- Above service delivery costs, by year
- Total costs (by year)
- # of FGM cases, by scenario
- # of FGM cases averted
- Cost per case averted

IMPACT OF COVID-19

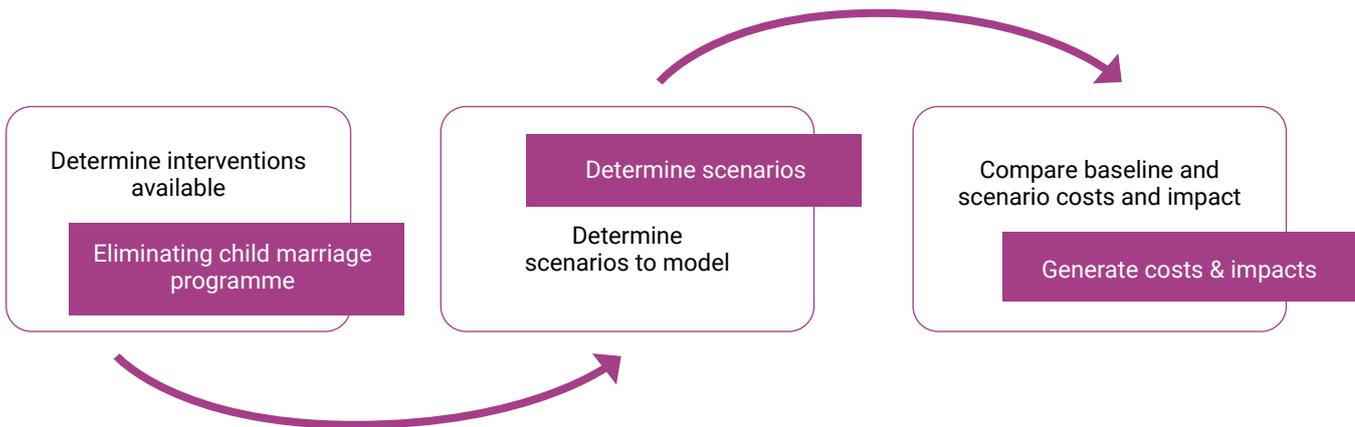
The Impact40 site has a link to guidance on how countries might estimate the impact of COVID-19 on meeting the transformative result of ending FGM. Implications on meeting this transformative result hinge on the delay in FGM prevention programmes, such as social mobilization and community empowerment programmes, which might not be possible in the context of COVID-19. For the 31 countries included in the original analysis of the impact of meeting this transformative result, to consider the impact of COVID-19, countries can consider a two-year delay in the scale-up of FGM prevention interventions. Results are available on the Impact40 site for the 31 countries included in the analysis.

ESTIMATING THE COST OF ENDING CHILD MARRIAGE

Figure 17. Interventions to reduce child marriage



Figure 18. Steps in costing child marriage



The Child Marriage Optimal Interventions (CMOI) Model was used to estimate the global price tag to end child marriage; it includes evidence-based interventions (Figure 17) necessary to achieve this transformative result as well as country and regional trends on child marriage rates. The CMOI model uses current rates and trends of child marriage, population forecasts, intervention costs, and urban/rural splits to determine the optimal mix of interventions for each country to reduce child marriage to no more than 5% by 2030 at the minimum cost.

For countries seeking to develop an investment case on the cost to end child marriage, the CMOI model can be found on the Impact40.org website; this tool can be used to estimate the cost and impact of interventions to end child marriage. The process for developing the investment case is as follows: Determine the interventions available in the country, determine scenarios to model and finally generate costs.

Interventions to eliminate child marriage

The CMOI Model includes several intervention programmes; the entire package is not intended to be a recommendation of what each country or regions/provinces within countries should do, neither is it an exhaustive list of the interventions countries should undertake. Instead it represents the types of interventions and costs that are generally associated with programmes to end child marriage (that have been evaluated and costed). To tailor the actual package of interventions to each country context, the first step is to determine the interventions available in or most important to the country, i.e., those interventions that will be included in the modelling. Table 9 documents the intervention programmes and their costs.

Table 9. Interventions and costs

Intervention programs	Description	Cost
Life Skills (LS)	Community-based group education for girls covering life skills as well as topics from comprehensive sexuality education such as relationships, values, rights, GBV, and sexual and reproductive health.	Average cost per girl: \$99 for South Asia, \$85 for sub-Saharan Africa, and \$107 for Latin America
Community Mobilization (ComM)	To drive positive, transformative change around gender and social norms held by parents and the community through reflective dialogue in order to delay marriage and create a supportive environment for girls who choose to do so.	Average cost per girl: \$14
Conditional Economic Incentives (EI)	To delay marriage, this programme incorporates an animal reward as a financial incentive for not marrying. Different countries should consider culturally and financially appropriate economic incentives, conditional on school completion and/or delaying marriage.	Average cost per girl: \$69.50

The CMOI also considers education interventions which impact on child marriage rates; these include: increase the provision of schools in rural areas to give rural girls greater access to education; improve the educational infrastructure such as the provision of girls' latrines, cash transfers to encourage girls to remain in school, or pedagogical changes/teacher training, and malaria control.

Determine scenarios to model

In addition to a counterfactual (or "do nothing") scenario, there are a few different scenarios that can be modelled to make the case for investment in efforts to end child marriage. These might include the scaling-up of existing interventions, or starting interventions that are not yet taking place in the country.

Generate costs

The CMOI Model has a number of variables that can be changed by the user. These include:

- Costs of interventions
- Effectiveness of interventions
- Selection of interventions
- Country/State/Province
- Total/urban/rural area
- Discount Rate (preset at 3 percent)
- Target rate by 2030 (preset at 5 percent)
- Start year (preset at 2020)
- Full implementation year (preset at 2030)

Once the scenarios have been set up, costs and other indicators (Box 10) can be generated through the tool for each scenario.

Box 10. Results from CMOI Model

- # of child marriages averted annually
- Annual cost of interventions
- Cost per child marriage averted

The WHO [FGM Cost Calculator](#) is also a useful tool to estimate the current and projected financial health care costs associated with FGM in specific countries, as well as the potential cost savings to health systems of reducing new cases of FGM.

IMPACT OF COVID-19

The Impact40 site has a link to guidance on how countries might estimate the impact of COVID-19 on meeting the transformative result to end child marriage. The CMOI model has been adapted to consider two factors: the delay in the introduction of interventions to prevent child marriage by one to two years; and increases in child marriage due to economic downturns (i.e., a 10 percent decline in GDP per capita).

CHAPTER 4

IMPLEMENTING THE INVESTMENT CASE

This chapter links the financial needs, impacts and financing of interventions to end preventable maternal deaths in a way that is necessary to support the investment case. In particular, it will help countries to document the:

- Estimated investments needed to achieve this transformative result
- Financial needs to achieve the transformative result
- Financial gaps and necessary resource mobilization needed to achieve the transformative result.

ESTIMATING NATIONAL EXPENDITURES

Depending on the investment case being developed, national estimates of total spending to address the particular transformative result will need to be collected. This includes domestic (i.e., government and out-of-pocket) spending and donor spending. Potential data sources for government spending by transformative result can be found at Table 10.

Table 10. Potential data sources for obtaining government spending estimates

	Description	Source
Family planning		
Reproductive health subaccounts	Total, out-of-pocket, government	https://www.prb.org/rhsubaccounts/
System of Health Accounts	Spending on reproductive health and contraceptive management (total, out-of-pocket, government)	DIS2, DIS 2.3 https://www.who.int/health-accounts/methodology/sha2011.pdf
Domestic government family planning expenditures	Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.	https://www.familyplanning2020.org/
Commodity Gap Analysis (CGA 2019)	Current spending in reproductive health, consumption quantities, costs and gaps in the public and private sectors	https://www.rhsupplies.org/cga/ Use the "Country Explorer" and "Data Annex" to pull out country data
Costed Implementation Plan	Activity and commodity costs	https://www.familyplanning2020.org/cip
Maternal health		
System of Health Accounts	Spending on maternal conditions and perinatal conditions (total, out-of-pocket, government)	DIS2.1, DIS 2.2 https://www.who.int/health-accounts/methodology/sha2011.pdf
Financing Global Health	Health financing by source and channel	https://vizhub.healthdata.org/fgh/

ESTIMATING THE RETURN ON INVESTMENT

There are several ways to estimate the return on investment for the achievement of the transformative result.

Family planning

Economists and demographers have attempted to make the economic case for family planning by estimating the monetizing impacts. These estimates have used several different approaches to assess the costs and benefits of the provision of family planning. Table 11 illustrates several different approaches and tools for making the case for investment in family planning

Table 11. Family planning return on investment (Source: FP2020)

Model	Outcomes		
	Short-term	Intermediate	Long-term
<p>ADDING IT UP Purpose: To inform policymakers, advocates and funders of the benefits and costs of contraception and maternal and newborn health care Key Takeaway: Meeting the unmet need for contraception reduces the cost of maternal and newborn health services, by reducing the number of unintended pregnancies Note: This model assumes an instantaneous jump from current coverage to total coverage and therefore is not suitable for planning purposes</p>	Every additional \$1 above the current level invested in meeting the unmet need for contraceptives saves \$2.20 in pregnancy-related care	<i>Not analyzed in this model</i>	<i>Not analyzed in this model</i>
<p>MILLENNIUM DEVELOPMENT GOALS Purpose: To advocate for family planning in a multisectoral environment Key Takeaway: The cross-sector benefits (measured by savings in meeting MDG targets) resulting from meeting the unmet need for family planning exceed the costs</p>	Across 16 countries for which the model was run, every \$1 invested in meeting the unmet need for contraceptives saved anywhere from \$2 to \$6 in costs to achieve MDG targets		<i>Not analyzed in this model</i>
<p>COPENHAGEN CONSENSUS Purpose: To compare the cost-effectiveness of different development interventions Key Takeaway: Family planning is among the most cost-effective development interventions – long-term benefits accrue from avoiding unintended pregnancies and averting infant and maternal deaths, putting countries on a path toward a demographic dividend</p>	Every \$1 invested in meeting the unmet need for contraceptives yields \$120 in the long term in accrued annual benefits: \$30 to \$50 in benefits from reduced infant and maternal mortality yields \$60 to \$100 in long-term benefits from economic growth Note: this very high return on investment was due to an incomplete account of the costs (ignoring most of the health system costs) as well as some economic assumptions		
<p>SUSTAINABLE DEVELOPMENT GOALS Purpose: To advocate for investing in family planning to help achieve the SDGs Key Takeaway: Countries will be in a better position to meet the SDG target related to family planning</p>	Not analyzed in this model; other potential sources include: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4982245/ https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32540-1/fulltext	Applications of this model show that improvements in socioeconomic status along with investments in family planning maximize progress towards the SDGs, including reducing poverty and food insecurity and increasing income growth	
<p>DEMOGRAPHIC DIVIDEND Purpose: To generate support for family planning and reproductive health investments among high-level policymakers outside the health sector Key Takeaway: Investments in family planning, education and the economy increase per capita GDP</p>	<i>Not analyzed in this model</i>	Reduced fertility leads to reduced maternal and child mortality and improved maternal and child health outcomes; increased labour market productivity results in increased GDP per capita	

Maternal health

There are several different ways to consider the returns on investments from ending preventable maternal deaths. Benefits can be estimated in terms of lives saved, the improved health and welfare of mothers and children and the benefits from increasing the ability of women to plan their pregnancies, etc. A country investment case on the cost to end preventable maternal deaths might consider the estimate of costs with respect to:

- The economic and social benefits of value of life years saved (VLY, an economic value used to quantify the benefit of avoiding a fatality).
- The benefits from maternal and child morbidity averted.
- The benefits of reduced fertility rates due to a reduction in the number of children born to the average woman during her lifetime, which affects growth in GDP per capita and thus reduces the dependent population, increases labour supply per capita and increases productivity.

CHAPTER 5

WRITING UP THE COUNTRY INVESTMENT CASE

This chapter can be used as a guide for writing up the country investment case. Refer to Annex J for an outline of what should be included in a country investment case.

SUMMARY

This should be an executive-style summary of the national investment case, providing a brief introduction about the purpose of the investment case and a brief description of the country context related to the transformative result it addresses. It should include a few details about how the cost of the transformative result was estimated and present a few key messages related to these costs and potential impact (see Figure 19 for an example).

Figure 19. Summary from Rwanda's family planning business case

Implications of the Business Case of Rwanda

- ▶ Infant and maternal health care costs save **\$332 million** by **2050**
- ▶ Maternal mortality ratio reduced from **210** to **40 per 100,000** live births by **2050**.
- ▶ Under-5 mortality rate reduced from **50** to **27 deaths per 1,000** live births by **2050**.
- ▶ Over **2.5 million** Rwandans lifted out of poverty by **2050**.
- ▶ Investment in **Family Planning** will yield more **benefits across sectors**.

INTRODUCTION

The national investment case should begin with a concise introduction to the transformative result, including its importance globally and nationally. This section should briefly describe the objective or purpose of the investment case and also clearly mention the scope and time horizon of the analysis.

Figure 20. From Rwanda's family planning business case

Why act now ?

ISSUE Rwanda is the second most densely populated country in Africa. With the current fatality rate, its population will reach 16.3 million, and population density will increase to over 660 inhabitants per square kilometer by 2032.

OPPORTUNITY Government of Rwanda is committed to harnessing the Demographic Dividend and managing its population growth.

Demographic dividend is an important component of the NST1 development strategies.

Investing in Family Planning brings high returns across Sectors.

READINESS Political will is present. Total demand for Family Planning is 72%. Unmet need for Family Planning is 19%.

CONTEXT

This section provides critical context about the motivation and objective for the investment case for the particular transformative result. It should present the state of maternal health in the country, including progress made and documentation of the remaining challenges.

This section might include:

- Documentation of the country’s health status related to the transformative result

- Discussion of the country’s strategy or plans to address the SDGs
- Description of the challenges around the achievement of the transformative result (e.g., maternal mortality in the country, including greatest contributors of maternal mortality)
- Discussions of challenges to meet SDGs and other challenges as well as the implications of these challenges

Examples from investment cases in El Salvador, the Federal Democratic Republic of Ethiopia and Rwanda are shown below at Figures 21, 22 and 23.

Figure 21. Context of the National Costed Roadmap to End Child Marriage and FGM/C 2020-2024 in Ethiopia

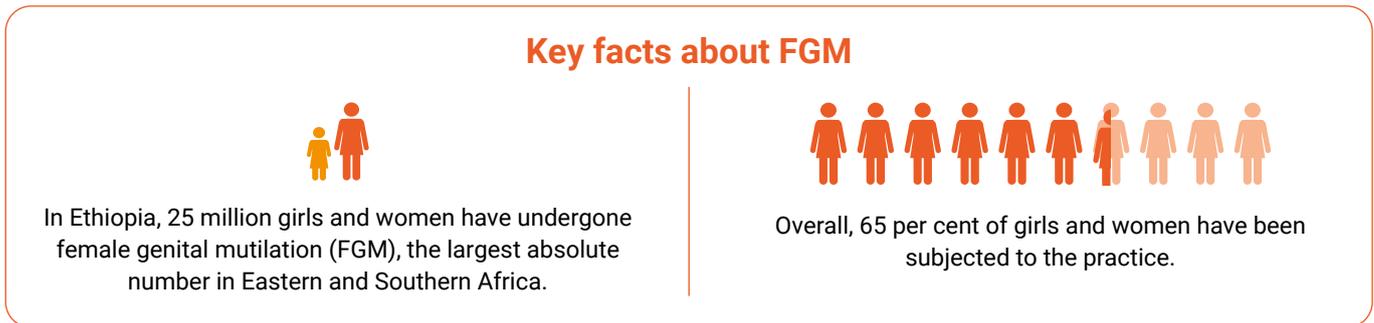


Figure 22. Number of girls and adolescents between 10 to 17 years classified according to their abandonment or continuity in formal education after experiencing a pregnancy, from El Salvador (Source: The economic cost of pregnancy in girls and adolescents)



Figure 23. Rwanda context (reference: Rwanda family planning business case)

Context of Rwanda *



Source: Population Census 2012, DHS 2014/2015.

CURRENT STATE OF MATERNAL HEALTH

This section includes a discussion of the current state (or baseline or “status quo”) of maternal health in the country. It should:

- Provide details about the assumptions that were used to address impact and cost
- Discuss the current trajectory of maternal mortality over the time period if current interventions remain the same through to 2030
- Characterize the costs associated with maintaining the status quo through to 2030
- Highlight three to five key messages

Examples are provided at Boxes 11 and 12.

Box 11. Example from Rwanda family planning business case

	2000	2005	2010	2014/15
INDICATORS OF MATERNAL HEALTH AND MORTALITY				
Maternal Mortality Ratio (per 100,000 live births)	1071	750	487	210
Antenatal attendance - 1 ANC visit (%)	92	94	98	99
Antenatal attendance - 4 standard visits (%)	10	13	35	44
Deliveries assisted by a skilled health worker (%)	31	39	69	91
Contraceptive prevalence among married women (%)	7	17	52	53
Modern contraceptive prevalence among married women (%)	4	10	45	47.5
Fertility rate	5.8	6.1	4.6	4.2

Box 12. Example (UNFPA, Johnson & Johnson, International Confederation of Midwives, Family Care International, 2014)

KEY MESSAGES

The report shows that:

- The 73 Countdown countries included in the report account for more than **92% OF GLOBAL MATERNAL AND NEWBORN DEATHS AND STILLBIRTHS** but have only **42% OF THE WORLD'S MEDICAL, MIDWIFERY AND NURSING PERSONNEL**. Within these countries, workforce deficits are often most acute in areas where maternal and newborn mortality rates are highest.
- ONLY 4 OF THE 73 COUNTRIES** have a midwifery workforce that is able to meet the universal need for the 46 essential interventions for sexual, reproductive, maternal and newborn health.
- Countries are endeavouring to expand and deliver equitable midwifery services, but **COMPREHENSIVE, DISAGGREGATED DATA** for determining the availability, accessibility, acceptability and quality of the midwifery workforce **ARE NOT AVAILABLE**.
- Midwives who are educated and regulated to international standards can provide **87% OF THE ESSENTIAL CARE** needed for women and newborns.
- In order for midwives to work effectively, **FACILITIES NEED TO BE EQUIPPED TO OFFER THE APPROPRIATE SERVICES**, including for emergencies (safe blood, caesarean sections, newborn resuscitation).
- Accurate data on the midwifery workforce enable countries to plan effectively. This requires **A MINIMUM OF 10 PIECES OF INFORMATION THAT ALL COUNTRIES SHOULD COLLECT**: headcount, percentage time spent on SRMNH, roles, age distribution, retirement age, length of education, enrolments into, and graduation from education, and voluntary attrition from the workforce.
- Legislation, regulation and licensing of midwifery allow midwives to provide the high-quality care they are educated to deliver and thus protects women's health. High-quality midwifery care for women and newborns saves lives and **CONTRIBUTES TO HEALTHY FAMILIES AND MORE PRODUCTIVE COMMUNITIES**.
- The returns on investment are a “best buy”:
 - Investing in midwifery education, with deployment to community-based services, could yield a **16-FOLD RETURN ON INVESTMENT** in terms of lives saved and costs of caesarean sections avoided, and is a **“BEST BUY” IN PRIMARY HEALTH CARE**.
 - Investing in midwives frees doctors, nurses and other health cadres to focus on other health needs, and contributes to achieving a grand convergence: reducing infections, **ENDING PREVENTABLE MATERNAL MORTALITY** and **ENDING PREVENTABLE NEWBORN DEATHS**.

COST OF MEETING THE TRANSFORMATIVE RESULT

This section includes a discussion of the scenario(s) modelled to demonstrate how the transformative result was achieved. It should:

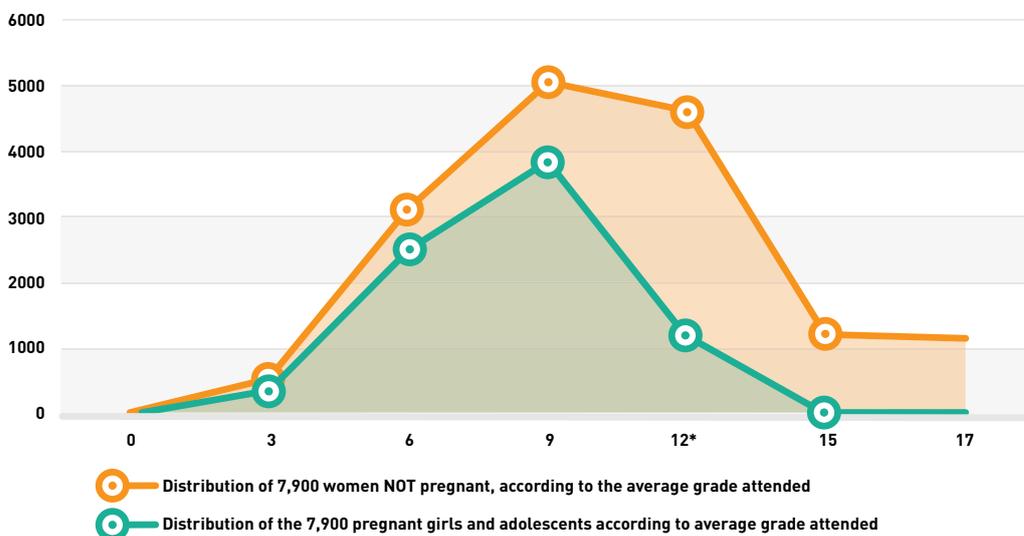
- Provide details about the assumptions that were used in the development of the scenario(s)
- Discuss the costs of each scenario

- Compare the shift in maternal deaths by scenario(s) over the baseline or “status quo” scenario through to 2030
- Highlight the impact of these maternal deaths by considering DALYs averted, return on investment, etc.
- Highlight three to five key messages (i.e., around the cost and impact of this investment)

Examples are provided at Box 13.

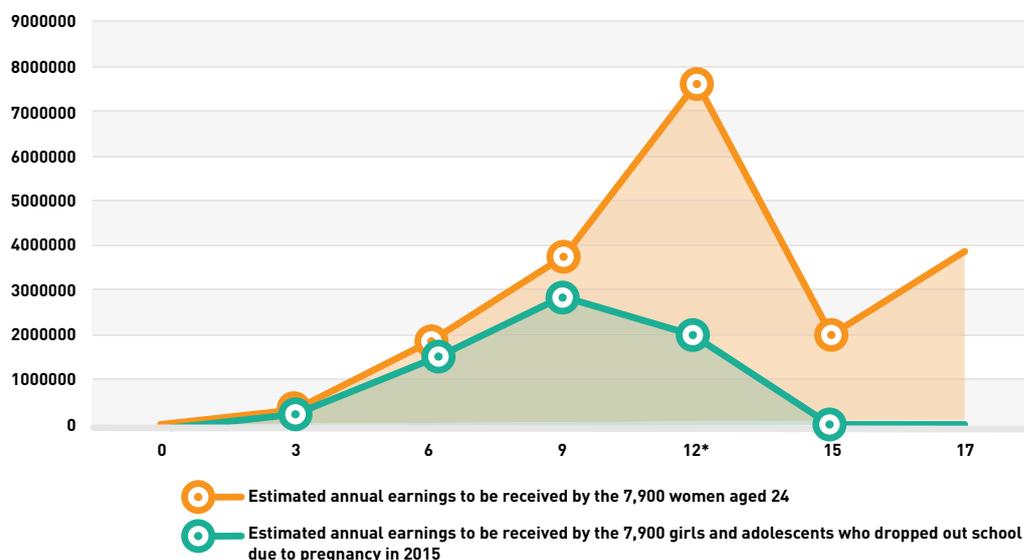
Box 13. Example (UNFPA, 2017)

Chart 9. Distribution of 7,900 girls and adolescents that experienced motherhood during year 2015 by average grade attended compared with the same group if they would have postponed motherhood after 20 to 24 years of age.



Source: Own preparation based on EHPM 2015

Chart 10. Estimate of annual earnings from 7,900 girls and adolescents that experienced motherhood during year 2015, by level of education compared with annual earnings of the same group if they would have postponed motherhood after 24 years of age.



Source: Own preparation based on EHPM 2015

RESULTS

This section includes the main findings and results from the investment case, including key figures and diagrams to highlight the key messages.

IF CPR INCREASED TO 50% BY 2025.....

Starting with an investment of US \$23.6 million in 2019 and increasing gradually to an investment of US \$38.4 million by 2025, the Government of Pakistan could avert almost US \$1.1 billion in direct health care costs over 2019-2025.

**1.1 BILLION
SAVED**

A total investment of around US \$214 million in contraceptive commodities and services over the period of 2019-2025 would therefore return a total net saving of around US \$885 million by 2025 for the Government of Pakistan.

**214 MILLION
INVESTMENT**

For every US \$1 dollar invested in contraceptive commodities and services, the Government would save US \$4 dollars on average over 2019-2025 in direct healthcare costs.

\$1 SAVES \$4

RESULTS AT A GLANCE - 2019 to 2025



**\$4 : \$1 Return on
Investment**



**- 19,000 maternal
deaths averted**



**- 190,000 child
deaths averted**

**16.9 million
abortions averted**



**27.7 million unintended
pregnancies averted**

CHAPTER 6

ADVOCATING FOR THE INVESTMENT CASE

Once the national investment case has been developed, it needs to be used as an advocacy tool to get partners on board to invest in the transformative result. This chapter focuses on the critical step of translating the investment case into an advocacy plan to be used in advocacy efforts. It provides practical suggestions on how to develop an advocacy strategy and advocate for the investment case.

WHAT IS ADVOCACY?

“Advocacy” is the process of building support for a cause or an issue; it is a process of influencing others to take action in support of a specific issue or change.

The transformative result investment case can be a powerful advocacy tool to:

- Create support and consensus among stakeholders about the importance of investment in the transformative result
- Ensure that key decision makers and partners are informed about the value of the transformative result
- Ensure that sufficient resources are allocated in support of the transformative result.

ADVOCACY GOAL AND OBJECTIVES

The advocacy goal is a general statement of what a country hopes to achieve in the long term, while the advocacy objective is a short-term, specific and measurable achievement that will contribute towards the advocacy goal.

Advocacy objectives should include three parts: the change needed, by whom and by when. For example: “By 2030, Country X will have scaled up interventions A, B, and C in order to end preventable maternal deaths.”

Translating cost & impact into advocacy objectives

Consider the key messages identified in the national investment case. How can these be turned into concrete advocacy objectives? Use Table 12 to translate the key messages in the national investment case into advocacy objectives.

Table 12. Translating key messages into advocacy objectives

Number	Key message	Advocacy objective
1		
2		
3		

IDENTIFYING AND ANALYZING TARGET AUDIENCES

Investment cases can be aimed at many different target audiences, including donors, national government policy makers, public health policy makers, civil society, the media, etc. (Table 13).

Table 13. Categories of target audiences (Thompson & Tebbens, 2012)

Category	Audience
Financial	Donors, funders, international partners, government development agencies, bilaterals, multilaterals, private sector
Public health policy makers	Policy makers, governments, policy leaders, programme managers
Technical	Technical advisors, academic institutions, national government staff, researchers
Health systems	Medical providers, professional medical associations
Intervention producers	Manufacturers, supply chain managers
Civil society	Religious groups, civil society groups, NGOs, educators, special interest groups, community mobilizers
Lay audiences	Media, interest groups

For each audience, consider the following questions:

- What is their level of knowledge about the transformative result? Are they well informed about the issue, or do they lack information about the topic?
- What is their level of support for this transformative result? Have they supported this area or issue in the past? Has this support been active or public?
- What is their level of opposition for this transformative result? Have they actively or publicly opposed the issue?
- What is the potential benefit to the target audience by investing in this transformative result? Think about how the target audience might benefit from supporting achievement of the transformative result and in particular the advocacy goal and objectives stated above.

Use Table 14 below to analyse the target audiences for your advocacy efforts.

Table 14. Analyzing target audiences

Audience	Knowledge about the transformative result	Previous support or opposition to the transformative result	Potential benefits to audience from the issue

DEVELOPING ADVOCACY MESSAGES

In this section, tools to help users craft messages will be shared, along with some examples.

Advocacy messages should be concise, consistent and should also be tailored to the audience for which they are intended. In order to do this, it is essential to understand the target audience so that advocacy messages reflect the audience's interests and appeal to them.

Resource mobilization requires strong partnerships and alliances to support consensus around the investments identified in the country investment case. It is important to have a broad range of donors and partners, including the involvement of both the public and private sectors, as potential resources and partners in support of the investment case. Table 15 can be used to identify potential donors and partners for possible collaboration and resource mobilization.

CONVERTING A NATIONAL INVESTMENT CASE TO A RESOURCE MOBILIZATION STRATEGY

The purpose of resource mobilization is to ensure sufficient funding for effective programme implementation to achieve stated public health goals. An investment case, with its vision, goals and programmatic priorities, presents a unique opportunity to clearly articulate the weaknesses, gaps and needs for additional resources.

Table 15. Template for determining potential resources and partners

Name of organization/partner	Organization's priorities	Areas for possible collaboration
Ex.: Bill and Melinda Gates Foundation	Global health, family planning, education	

DEVELOPING ADVOCACY PLANS

An advocacy plan is a tool that can be used to articulate how the investment case will be used for action and advocacy. The plan includes specific activities to be implemented to achieve the advocacy objective for the investment case. It also presents an opportunity to bring together input and consensus from all those involved in the investment case

and to create a sense of shared ownership and commitment to making use of the investment case for advocacy efforts. Annex N can be used as a template to develop an advocacy plan for the country investment case.

A country investment case can have many uses. It can contribute to components of the UN Common Country Analysis (CCA) (Table 16).

Table 16. UN Common Country Analysis components and potential for investment case contribution

CCA Component	Description	Investment case can contribute
Country context	Analysis of the political, economic, environmental and social trends and challenges and their interlinkages	✓
National Vision for Sustainable Development	Analysis of national development priorities and needs, SDG implementation	✓
Country progress towards 2030 Agenda	Country progress	✓
Commitments to human rights, gender equality and women's empowerment	Analysis of the country's commitments to global norms and standards	✓ (norms particularly for transformative results related to GBV, FGM and child marriage)
Risks, gaps and challenges in achieving 2030 Agenda	Analysis of the multi-dimensional risks and threats, gaps & bottlenecks to achievement of the SDGs	✓
Financing and landscape opportunities	Analysis of financial landscape and opportunities for resource mobilization	✓

CHAPTER 7

MONITORING AND REVIEWING THE INVESTMENT CASE

Progress toward the achievement of the transformative result(s) should be assessed annually. Ideally, the same stakeholder group involved in the planning and development of the investment case should be involved with monitoring its progress. Monitoring can rely on many different data sources, including nationally representative household surveys (e.g., DHS) and local-level surveys as well as quality surveys, service and administrative statistics. Stakeholders should review the data collected on an annual basis, and review - and revise as necessary - targets for achieving the transformative result(s).

The monitoring plan developed by the stakeholder group should identify key indicators to monitor on an annual basis that track progress toward each transformative result for which the country investment case has been developed. For each indicator, the monitoring plan should identify the source for that particular indicator, how it will be tracked (e.g., annually, every five years, etc.) as well as indicator sources.

A sample monitoring framework that reviews the status of key indicators included in the country investment case can be seen at Table 17.

Table 17. Sample monitoring framework

Indicator	Value (baseline year)	Value (year)	Variance from Target >100% met/exceed target 90-99% on track 70-89% gaining traction 50-69% building momentum 0-49% delayed No data	Comments/ adjustments needed for investment case
Ex.: Maternal mortality ratio	176 (2020)	150 (2025)	Gaining traction	
Skilled birth attendance	53% (2020)	54% (2025)	Delayed	
mCPR	68% (2020)	72.1% (2025)	On track	

Guiding principles for monitoring and reviewing progress to achieving the country investment case include:

- Using a participatory approach that involves numerous stakeholders and partners in the development of the monitoring plan as well as the analysis of indicators and progress. Local experts should also be involved in the development of indicators, collection of data and review of annual progress.
- The monitoring plan and framework should clearly indicate the link between the indicators being tracked and the particular transformative result being achieved.
- The indicators included in the monitoring plan should be based on existing indicators that can be collected on an annual basis from existing sources.

ANNEXES

ANNEX A. CHECKLIST FOR INVESTMENT CASE DEVELOPMENT

The checklist below is based on UNFPA's Guidance to Country Offices Volume 1 (UNFPA) and a common approach to guide the developing country investment case. The checklist can be revised as needed in-country; it is meant to serve as a tool to support each element of the investment case process and can be used several times during the process until the steps have been completed.

Item no.	Description	Notes	Check <input type="checkbox"/> when complete	Comments
Planning the Investment Case				
1	Desk review of national costing and investment cases: Any national technical resource material related to costing, investment cases, financing strategies and instruments/tools developed in the country by UNFPA and/or other partners	Use template at Annex X to document existing resources and material		
2	Document consensus and commitment among government and partners to undertake the indicated investment case	Document commitment in a specific agreement Document the contribution of the investment case to the National Development Agenda		
3	Concept Note and Roadmap describing the scope and timeframe of the investment case (i.e., interventions to be included, existing financing sources, the cost elements to be included, etc.). Document quality assurance process for developing the investment case, including supervision, review, monitoring and evaluation.	Document: Country context Scope and timeframe of investment case Process for developing the investment case (timeline, responsibilities, deliverables, etc.) Quality assurance process Use Annex C		
4	Identify and secure resources needed for the investment case	Financing Technical resources for analysis Logistics and in-kind support Human resources within and outside of UNFPA		
5	Situation analysis	Document the context and challenges related to achievement of the transformative result		
Implementing the investment case				
1	Estimate costs			
2	Prioritize interventions			

3	Develop scenarios to model	Document scenarios (i.e., intervention coverage, etc.)		
4	Resource mapping			

Making the investment case

1	Write up the investment case (Note: a draft template can be found in Chapter 6 and Appendix C)	Document the costs, impact, scenarios, financial resources available, financial gaps, etc.		
---	--	--	--	--

Advocacy and communication

1	Advocacy plan			
2	Communicate the findings from the investment case			

Guiding principles

1	Clear prioritization of proven high-impact and cost-effective interventions that will address the underlying factors or bottlenecks limiting significant progress toward the intended results	Include required systemic and structural changes, health system performance actions, etc.		
2	Theory of change confirming the cause and effect relationship linking investments, interventions and delivery mechanisms to advancing the country's transformative agenda to achieve the SDGs			
3	Gender, equity, and rights perspective and provisions are adequately reflected in the investment case			
4	Determination of target populations and geographic coverage based on a realistic assessment of resource availability (or scenarios for different levels of resource availability)			
5	Modelling to compare options of intervention mix, service delivery approaches, impact scale, etc.	Documentation of scenarios modelled		
6	Complementary multisectoral determinants are adequately explored and reflected as required			
7	Valid and reliable cost estimates and scale of impact			
8	Approach is appraised and confirmed to be technically sound			
9	Participatory approach during the development of the investment case that underscores transparency and accountability			
10	Explores and includes a wide range of financing for development options	Include new sources of sustainable financing, innovative financing, greater proportions of domestic resources where institutional guidance will need to be developed regarding financing approaches based on national needs and income		

ANNEX B. STAKEHOLDERS & ROLES/RESPONSIBILITIES

Name	Organization	Contact details	Type of stakeholder (e.g., donor, government, multilateral, partner, etc.)	Area of expertise (e.g., postpartum, family planning, etc.)	Role in investment case (e.g., quality assurance, supervision & monitoring, manager, data collection, costing, modelling, etc.)

Stakeholder	Roles and Responsibilities
Project Manager	Lead and manage the investment case development Develop communication and advocacy plans Monitor and review the progress
UNFPA country office	Appoint Project Manager Advise on the purpose of the investment case
Regional UNFPA office	Provide quality assurance and monitor impact of the country investment case
UNFPA headquarters	Provide quality assurance, tools and guidance
Ministry of Health	Provide overall guidance and endorsement of investment case

ANNEX C. TERMS OF REFERENCE

Note: The text below is adapted from the Terms of Reference used to develop Rwanda's family planning business case. It can be modified and adapted by countries to fit their needs.

1. OBJECTIVE AND SCOPE

The investment case will help better understand the needs, funding flows and gaps pertaining to transformative in-country plans and provide a clear and up-to-date analysis of family planning services needs and gaps, in-country plans and options of how to step up efforts to meet needs in a sustainable manner. The output document will be used to engage with government and other stakeholders to bolster progress to the achievement of the FP2020 objective and beyond to the achievement of the SDGs and Agenda 2030.

The specific objectives are to:

- Summarize aggregate country-level data related to current financing and commitments to family planning
- a. Identify options on how to fill the gap for modern contraception (for 1 and 5 years)
- b. Develop options for increased national investment in family planning-reproductive health commodity security (FP-RHCS)
- Develop an implementation plan of family planning business case towards financial sustainability along with its monitoring and evaluation framework

2. ACTIVITIES

To **reach the above objectives**, the consultants will undertake **activities** including the following:

- Make an analysis of the family planning landscape in Rwanda, including major (ongoing) policy shifts (global and national) and their implications
- Analyse the current funding situation of modern contraceptives through analysis of in-country funding flows for modern contraception disaggregated into:
 - Overall need
 - Current support/availability of modern contraceptives
 - Gap between overall need and current availability (define the current resource gaps for modern contraceptives and for 5 years)

- Develop study tools in which key study questions may include (without being exhaustive): How is family planning contributing to economic growth? How could failure to invest in family planning increase social demand and fail development initiatives? What are the financial resources going to family planning in the country? What will happen if donors stop funding contraceptives in the country today?
- Determine projected scenarios at the national and subnational level to address the inequalities in accessing and utilizing family planning services across the country.
- Outline potential innovative strategies and options to meet needs, to increase and to sustain funding for family planning in the country.
- Clarify the economic benefits of investing in family planning in the mid- and long-term; estimate the return on investment for the specific case of Rwanda (including with an analysis of innovative financing approaches that would facilitate tapping into domestic/household finance as contributions to meeting overall needs).
- Develop a roadmap for financing family planning at the national level taking into account the fiscal space in the country, identifying who, when, how, and what affects the decision making of domestic resource allocation for family planning services and commodities.
- Develop an implementation plan of the family planning business case towards financial sustainability along with its monitoring and evaluation framework.

The consultant team (national and an international) will work under the leadership of the Ministry of Health (MoH) and in close collaboration with the core team composed of representatives from main stakeholders involved in family planning. There will be several consultative meetings to ensure inclusion of all key players including the Ministry of Finance and Economic Planning. It is expected that the development of the Business Case should take 7 to 10 weeks.

3. EXPECTED OUTCOMES AND DELIVERABLES

- An inception report that clearly illustrates how the consultancy will be executed
- Development of a situation analysis of the family planning landscape in Rwanda
- Data on current financing and funding commitments to family planning, critical funding gaps and strategies to reduce the funding gap available, and documented
- Business case options, including suggestions for required funding, innovative financing strategies and expected results such as return on investment related to and associated with family planning; present scenarios
- Implementation plan of business case towards financial sustainability of family planning, along with the monitoring and evaluation framework developed

4. METHODOLOGY

The prospective team of consultants will be composed of the lead consultant (international) supported by the national consultant throughout the whole process. They will outline methodologies to achieve the mentioned deliverables (situation analysis, current funding commitments versus projected gaps and scenarios for return on investment in the specific case of the Country). The methodology should at a minimum contain:

- A desk review of available documentation on national data (reports from MOH, policies and strategies related to health financing, family planning, Human Resource Tracking Tool, National Health Accounts, Netherlands Interdisciplinary Demographic Institute Surveys, etc.)
- Primary qualitative data collection through key stakeholders' interviews
- An in-depth analysis of family planning funding trends including current and projected funding requirements

5. ROADMAP

Activity	Deliverable
Preparation	
Review relevant data sources and prepare inception report for review. Inception report should include: methodology availability of data and tools for primary data collection workplan (activities & timeline)	Draft inception report
Submit final inception report integrating comments received	Final inception report
Data collection	
Literature review of the available data on family planning financing strategies, commodity needs, family planning donor landscape, and government-led initiatives to address resource gaps	Map of existing data on family planning financing and existing gaps
Consultation workshop with stakeholders	Views and perspectives of stakeholders on family planning
Interview with key stakeholders	Individual concerns and insights from stakeholders
Data entry and processing	Dataset
Data analysis & reporting	
Analyse data and prepare draft report, share for input	Draft report
Integrate comments into draft report	Draft report incorporating comments
Draft report shared for validation	Draft report
Final report	Final report

ANNEX D. SAMPLE SCOPES OF WORK FOR INVESTMENT CASE IMPLEMENTER

Note: the text below is adapted from the Terms of Reference used to develop Rwanda's family planning business case. It can be modified and adapted by countries to fit their needs.

Technical resources skilled in relevant fields are required as part of the team to develop the investment case. Skills for this technical resource include:

- Technical expertise in Economics, Health Economics, Health Financing, Public Health, Health Planning, Health Systems Management
- Analytical skills in sector-based and/or development programme dimensions
- Proficiency in the use of standard costing tools (One Health Tool, LIST, WHO Choice, etc.) and investment case approaches
- Proficiency in writing and speaking the UN Official Language that is used in the national office
- Registered and prequalified in the UNFPA costing/ investment case/financing pool of technical experts (call to be announced for indication of interest and prequalification)

The prospective team of consultants will be composed of the lead consultant (international) supported by the national consultant throughout the whole process.

QUALIFICATION OF INTERNATIONAL CONSULTANT:

- Advanced university degree in health economics, health financing and related field
- At least 10 years of progressive professional experience in development, design of health financing and health economics-related documents in developing countries
- Demonstrated successful experience in developing evidence-based publications, investment cases, financial sustainability plans, policy briefs, strategies, guidelines, reports
- Experience in working in Africa, especially with Governments or UN systems, will be an asset
- Fluency in English with excellent writing, analytical and communication skills.

QUALIFICATION OF NATIONAL CONSULTANT:

- Advanced university degree in public health, medicine, and other related field
- Experience in health economics will be an asset
- At least 10 years of progressive professional experience in development, design of public health strategies, policies, and related documents in developing countries
- Demonstrated successful experience in completing consultancy assignments with the health sector of Rwanda and developing evidence-based publications, survey reports, strategic plans, policy briefs, strategies, guidelines, reports
- Fluency in English with excellent writing, analytical, and communication skills.

DATES OF CONSULTANCY: X TO X

X consultancy days for the International consultant

ANNEX E. TEMPLATES FOR SITUATION ANALYSIS

The template below can be used as an example to guide the desk review to document existing costing and investment case material that might exist in the country.

Scope	Year performed	Output product	Tool(s) used	Geographic scope	Cost components scope	Output scope	Key contact person
Ex.: Family planning	2014	Report & model	OneHealth Tool	National	Commodities, programme and system costs	Cost and impact	Dr. X

	Ending the unmet need for family planning	Ending preventable maternal deaths	Ending child marriage	Ending GBV	Ending FGM
Laws					
Policy documents					
Strategic plans					
Evaluation reports					
Surveys					
National goals					
International commitments					
Others					

ANNEX F. DOWNLOADING AND INSTALLING SPECTRUM

LiST is in the public domain and available in the Spectrum suite of policy models (see example). To use LiST, Spectrum must be installed.

Spectrum Downloads

Latest General Release for Windows

 Spectrum v. 5.89 (06 Nov 2020)

[Direct Link](#) | [Mirror](#)

 Country Data Pack 2019 (1 Oct 2020)

[Direct Link](#) | [Mirror](#)

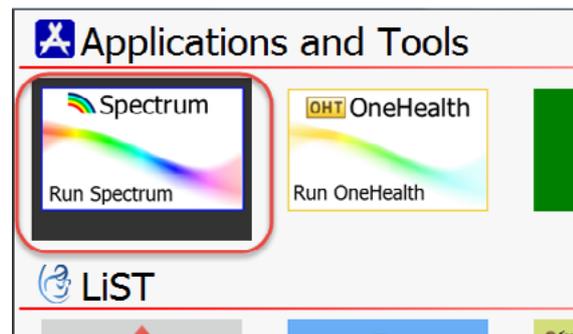
* Mirror links to an alternate site.

Spectrum can be downloaded at the website: <https://avenirhealth.org/software-spectrum.php>

- Click on “Direct Link” to launch the Spectrum download and follow the directions.
- Be sure to download the country data pack by clicking on “Direct Link” as seen in the image.

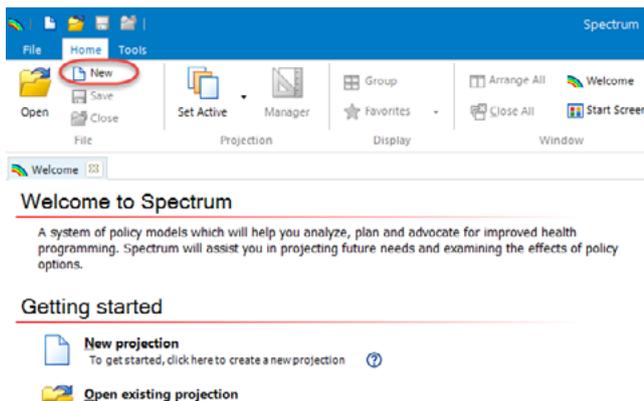
To launch Spectrum:

- Click on the Spectrum link to launch Spectrum.



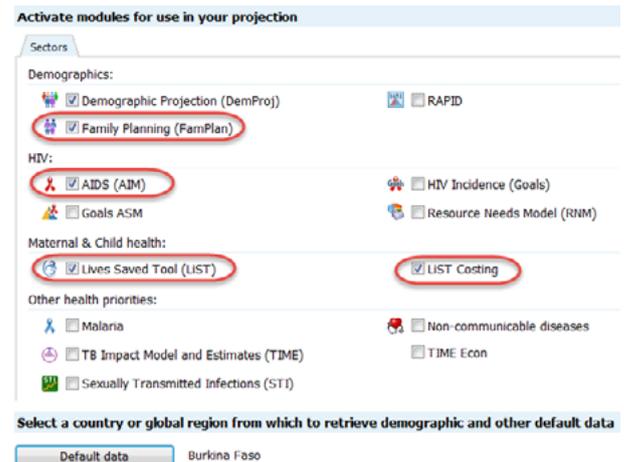
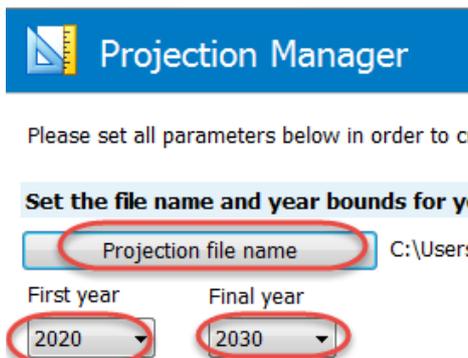
- Click on “Run Spectrum”.

ANNEX G. INSTRUCTIONS FOR NEW LIST USERS



To create a new projection:

- Click on “New” to open the Projection Manager.
- Name the projection.
- Set the first year of the intervention programme using the dropdown menu. This is the starting point from which DemProj will begin to project future population. This is also the starting point from which intervention coverage can be entered in LiST to project future child and maternal survival.
- Set the final year of the projection.
- Activate the following modules: DemProj, FamPlan, AIM, LiST, LiST Costing.
- Select the default country for your projection.

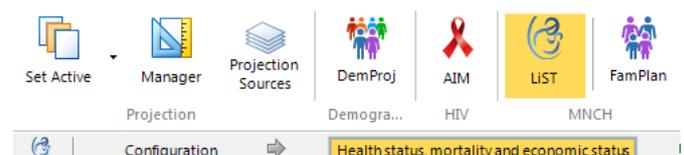


CONFIGURE THE LiST BASELINE PROJECTION

Configure the LiST projection to represent the current status of maternal health in the country. This projection will be used as the basis for developing additional scenarios. It is also referred to as the “do nothing” scenario (or a theoretical counterfactual scenario) in which intervention coverage does not change from the baseline year to the target end year.

1. REVIEW MATERNAL HEALTH STATUS, MORTALITY, AND ECONOMIC STATUS

Now we need to review the health status, mortality, and economic status of the country projection, particularly with respect to maternal health. The “Health status, mortality, and economic status” menu is used as a first step to customize the baseline LiST projection for a specific country. Click on this menu and a dialogue box with several tabs will open.



Health status, mortality and economic status - Ending preventable maternal deaths projection

Baseline child health status | Baseline maternal health status | Nutrition status distributions | Pathogens | Baseline child mortality | Baseline maternal mortality | Abortion

Baseline year: 2020

a. Review maternal health status

Click on the “Baseline maternal health status” tab to review the default data about maternal health in the country for which the investment case is being developed. The default data in the menu come from several sources and should only be revised if users feel that there is more accurate and up-to-date data available. Check the box if intermittent preventive treatment of malaria during pregnancy (IPTp) or sleeping under an insecticide treated bednet (ITN) is recommended in the country. Accordingly review the percent of women exposed to falciparum.

- Review the percent of women of reproductive age with anaemia
- Review the percent of pregnant women with severe anaemia
- Review the percent of women of reproductive age with low body mass index (BMI) (<18.5)

These data can be modified if more appropriate or updated data sources are available. To change the data, click on that box to highlight it and type in the data. If you have changed the base year from the default, ensure that the values are appropriate for the year of interest. LiST allows users to document any changes made to the data sources and assumptions: Right click on the table and select “All sources” or “Data Source (row)”.

Baseline child health status | **Baseline maternal health status** | Nutritic

Baseline year : 2020

Check the box below if IPTp or sleeping under an ITN is recommen

IPTp

Percent of women exposed to falciparum	100.00
--	--------

Anemia among women of reproductive age (WRA)

Percent of pregnant women with anemia	57.50
Percent of pregnant women with iron-deficiency anemia	23.71
Percent of non-pregnant women with anemia	48.70
Percent of non-pregnant women with iron-deficiency anemia	18.98

Severe anemia

Percent of pregnant women with severe anemia	0.349
--	-------

Low BMI among WRA

Percent of women with low BMI (<18.5, WRA)	14.74
--	-------

Percent of women exposed to falciparum	100
--	-----

Anemia among women of reproductive age

Percent of pregnant women with anemia	
Percent of pregnant women with iron-deficiency anemia	
Percent of non-pregnant women with anemia	
Percent of non-pregnant women with iron-deficiency anemia	

Severe anemia

Percent of pregnant women with severe anemia	
--	--

Low BMI among WRA

Percent of women with low BMI (<18.5, WRA)	
--	--

Context menu:

- Undo Ctrl+Z
- Redo Ctrl+Y
- Cut Ctrl+X
- Copy Ctrl+C
- Paste Ctrl+V
- Decrement Decimal Ctrl+L
- Increment Decimal Ctrl+R
- Copy all Ctrl+A
- Duplicate across rows Ctrl+D
- Duplicate down columns Ctrl+O
- Interpolate
- Normalize Ctrl+N
- Multiply Ctrl+M
- Data Source (Row) Shift+Ctrl+D**
- Comments Shift+Ctrl+A

b. Review baseline maternal mortality

In the “baseline maternal mortality” tab, review the default values for each indicator in the same way:

- Maternal mortality ratio
- Percent of maternal deaths by proximate causes

Note the greatest causes of preventable maternal deaths in the country.

Baseline child health status Baseline maternal health status Nutrition status distributions Pathogens Baseline child mortality **Baseline maternal mortality**

Baseline year: 2020

Maternal mortality ratio (maternal deaths per 100,000 births)

Maternal mortality ratio (maternal deaths per 100,000 births)	320
---	-----

Percent of maternal deaths by proximate causes

Antepartum hemorrhage	8.76
Intrapartum hemorrhage	0.84

c. Review abortion status

In the “abortion” tab, review the default values for each indicator in the same way:

- Percent of pregnancies ending with spontaneous abortion
- Abortion incidence ratio

Baseline child health status Baseline maternal health status Nutrition status distributions Pathogens Baseline child mortality Baseline maternal mortality **Abortion**

Baseline year: 2020

Percent of pregnancies ending with spontaneous abortion

Percent of pregnancies ending with spontaneous abortion	13.00
---	-------

Abortion incidence ratio (abortions per 100 live births)

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Abortion incidence ratio (abortions per 100 live births)											

Calculate abortion rates based on FamPlan outputs

d. Stillbirth

In the “stillbirth” tab, review the defaults for:

- Stillbirth rate
- Percent of stillbirths by proximate causes

Baseline child health status Baseline maternal health status Nutrition status distributions Pathogens Baseline child mortality Baseline maternal mortality Abortion **Stillbirth**

Baseline year: 2020

Stillbirth

Stillbirth rate (stillbirths per 1,000 total births (live and stillbirths))	21.24
---	-------

Percent of stillbirths by proximate causes

Antepartum	48.90
Intrapartum	51.10
Total	100.00

e. Review economic status

In the “household status” tab, review the defaults for poverty/food security and average household size. Make any necessary modifications and document the revisions.

Baseline year: 2020

Poverty/food security

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Percentage of the population living below \$1.90 per day	43.700	43.700	43.700	43.700	43.700	43.700	43.700	43.700	43.700	43.700	43.700

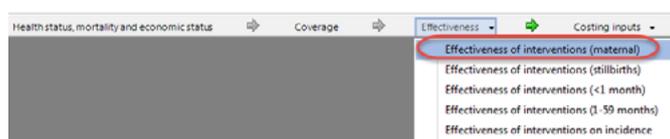
Average household size

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Average household size (number of persons per household)	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0

INTERVENTION EFFECTIVENESS

The effectiveness editor for interventions related to maternal deaths shows the default values for the effectiveness (i.e., the percent of deaths due to a specific cause that are reduced by the intervention) and affected fraction (the percent of deaths due to a specific cause which are potentially able to be impacted by a specific intervention) for each maternal or child health intervention. The affected fractions, or proportion of the cause-specific mortality, for each intervention are built using data from the Child Health Epidemiology Reference Group (CHERG), and baseline mortality is drawn from work by WHO and the UN Inter-agency Group for Child Mortality Estimation (IGME).

Review the default values for effectiveness and/or affected fraction by clicking the “Effectiveness” tab in the editor (see figure below). These default values are based on rigorous scientific study and are unlikely to need alteration. In most cases the internationally developed estimates are the best evidence; changes should only be made to these values if you have scientifically derived country-specific evidence to revise either the effectiveness or affected fraction.



Effectiveness editor

Antepartum hemorrhage			Intrapartum hemorrhage			Postpartum hemorrhage			Hyper		
Effectiveness of interventions (maternal)											
Maternal											
Effectiveness											
Affected fraction											
Childbirth											
Manual removal of placenta	0.300		1.000								
Parenteral administration of uterotonics	0.000		1.000								
Removal of retained products of conception	0.300		1.000								
Blood transfusion	0.500		1.000								

PRELIMINARY SUMMARY OF COUNTRY MATERNAL STATUS

Another key feature offered by LiST is the LiST Visualizer (Box 4), which can be used to learn about the links between interventions, risk factors and causes of maternal death. The LiST Visualizer allows users to isolate specific causes of maternal mortality and the risk factors associated with this cause of death, as well as the interventions that are effective at addressing the risk factor. In the example below (Figure 6), maternal mortality due to antepartum haemorrhage has been isolated and it is possible to see the risk factor (maternal anaemia) that contributes to it, as well as the interventions that either directly contribute to maternal mortality from antepartum haemorrhage or have an effect on maternal anaemia as a risk factor for maternal mortality due to antepartum haemorrhage. Clicking on the arrows between the boxes displays the effectiveness and sources.

Using the information in the “Health status, mortality, economy status” and the “Effectiveness” tabs, determine the greatest contributors of maternal mortality in the country, the greatest risk factors and the most important interventions to address them.

SITUATION ANALYSIS AND PRIORITIZATION

This information can be used to guide discussions with the UNFPA team on the prioritization of interventions to end preventable maternal deaths.

DATA COLLECTION

Setting up the baseline LiST projection requires data collection of intervention coverages, which must be entered in LiST for the baseline year. The coverage of an intervention is used with the effectiveness of that intervention and the affected fraction to determine the probability of the outcome of interest – which can be cause-specific mortality or a risk factor for

mortality. LiST assumes that mortality rates and the cause-of-death structure will not change dynamically in a country, and that any differences are primarily in response to changes in intervention coverage (Walker, Tam, & Friberg, 2013).

Intervention coverage must be entered in LiST for all interventions in the base year. Once this is done, users can create another projection (i.e., a scenario) in which intervention coverage is scaled up over a time period. LiST has several default intervention coverages already built into the tool; these coverages should be reviewed and updated (if needed) based on data available at the country level. Data collection is also required for interventions for which there is no default in LiST. Use Appendix F as a template to collect this coverage data.

BASELINE LIST PROJECTION

Review and edit intervention coverage data

The “Coverage” editor in LiST allows users to review and revise the coverage of interventions available in LiST. Each intervention is characterized either by the time in which it is delivered (e.g., pregnancy) or by the mode of activity (e.g., curative). Since you are working with the baseline projection, coverage will need to remain constant (i.e., no change) from the baseline to the target years.

Review and edit “Periconceptual” coverage data

Click on the “periconceptual” tab. Review the default values listed for each intervention. Edit the coverage in the baseline year per the data that have been collected and agreed to with the Working Group:

- Contraceptive use
- Folic acid supplementation/fortification
- Safe abortion services
- Post-abortion case management
- Ectopic pregnancy case management
- Blanket iron supplementation/fortification

Since this is the baseline projection and this projection will be a “do nothing” scenario (or a theoretical counterfactual scenario for the intended coverage changes), make the intervention coverage remain constant from the base year to the target year.

Review and edit “Pregnancy” coverage data

Click on the “pregnancy” tab. Review the default values listed for each intervention. Edit the coverage in the baseline year per the data that have been collected and agreed to with the Working Group:

- Tetanus toxoid vaccination
- Intermittent preventive treatment of malaria during pregnancy (IPTp)

- Calcium supplementation
- Micronutrient supplementation
- Hypertensive disorder case management
- Malaria case management
- MgSO₄ management of pre-eclampsia

Review and edit coverage data for “place and level of delivery” in the “Childbirth” tab

In the “childbirth” tab, users can choose to have LiST automatically calculate the distributions of delivery levels and coverage levels of childbirth interventions or can manually enter coverage for the level of deliveries at home and facility.

- If you want LiST to automatically calculate the distribution of delivery levels and coverage levels of childbirth interventions, check the box “Allow LiST to calculate place and level of delivery”. Then review the default coverage for skilled birth attendance and health facility delivery and update as required.
- To manually enter coverage for childbirth interventions, uncheck the box “Allow LiST to calculate intervention coverages”.

Now specify the percent of deliveries at home (unassisted and assisted) and at facilities (essential care, basis emergency obstetric care (BEmOC) and comprehensive emergency obstetric care (CEmOC)) in the baseline year. Note that these percentages must all sum to 100 percent.

Review and edit coverage data for “intervention coverages” in the “Childbirth” tab

Also in the “childbirth” tab, users can choose to have LiST automatically calculate the childbirth intervention coverages or can manually edit the coverage of childbirth interventions.

- If you want LiST to automatically calculate childbirth intervention coverages, check the box “Allow LiST to calculate intervention coverages”.
- To manually enter coverage for childbirth interventions, uncheck the box “Allow LiST to calculate intervention coverages”.

Next specify the availability of each intervention at each level of delivery and then review and revise the coverage of each intervention by delivery level accordingly.

Review and edit coverage data for other maternal health interventions

In the “Curative” tab, review and edit coverage of “maternal sepsis case management”; in the “Preventive” tab, review and edit coverage of “ITN/IRS – households protected from malaria”.

CALIBRATING BASELINE LIST PROJECTION

Now that intervention coverages have been entered in LiST, use LiST to generate several different results and compare these to the currently known situation of maternal health in the country. In the Results tab in LiST, generate:

- The number of maternal deaths in the base year
- The maternal mortality rate and ratio in the base year

Setting up a baseline LiST Costing projection

In the Configuration menu and the “Currency and Inflation” tab, set the exchange rate and designate the currency in which costs will be entered (US\$ or local currency) and finally enter an inflation rate.

COLLECTING DATA NEEDED FOR LIST COSTING

Delivery channels

LiST Costing includes default distributions of interventions by delivery channels or levels of service delivery (i.e., community, outreach, clinic, and hospital-level care); these defaults are based on expert consultations by WHO experts. Review the defaults and specify the distribution of interventions at each service delivery channel. Note that the delivery channels editor allows users to enter base and

target distributions of services (i.e., what proportion of each intervention is delivered at each level in the first and final years of the projection). A linear interpolation takes place between these points to fill in the interim years.

Staff baseline assumptions

The “Staff baseline data” tab in LiST Costing is pre-populated with assumptions for salaries drawn from [WHO CHOICE](#) (i.e., annual salary for a full-time person), benefits (i.e., calculated as a percentage of salary costs) and time utilization (i.e., days per year and time worked per day). These data points are used to estimate a cost per minute, which is combined with information from Treatment Inputs editors to estimate the labour costs for delivering the various interventions. Users can revise these assumptions if more accurate local information is available.

Target population and population in need

LiST Costing uses the number of people receiving the intervention and the quantity of resources required to deliver the intervention per person to determine the cost of the intervention. To estimate the number of people receiving the intervention, LiST Costing uses the target population, population in need and coverage of that intervention. Therefore, for each intervention, the following data will need to be collected:

Data needed to calculate number of people receiving an intervention

Intervention	Target population	Population in need (%)	Baseline year coverage (%)
Td vaccination during ANC	Pregnant women	100%	76%

The target population is the population that could possibly receive the intervention; these are age-determined groups that are drawn from the DemProj module within Spectrum. Global defaults exist for each maternal health intervention included in LiST; users can also choose to select a target population based on age and sex or can enter the target population manually. The population in need is the share of the target population that requires the intervention, per year. For most preventive care interventions, the share is 100 percent.

Treatment inputs

Treatment inputs for each intervention specify the required drugs and consumable supplies (e.g., gloves, syringes), provider time and number of inpatient days and outpatient visits needed for the effective provision of an intervention. These are drawn from intervention assumptions developed for the OneHealth Tool (<http://www.who.int/choice/onehealthtool/en/>) and documented in the Intervention Assumptions Manual. These inputs were developed based on WHO norms and guidelines where available, with expert input where explicit guidance was not available. Drugs and consumable supply prices are extracted from international sources such as the [MSH Drug Price Indicator Guide](#),

[UNICEF supply catalogue](#), and the [Global Price Reporting Mechanism](#). Users can specify different treatment inputs (drugs and supplies, personnel time and outpatient visits/inpatient days for each level), based on the different access to resources at different levels in the country. Results can also be produced by level, allowing analysis of the cost implications in a shift of services between levels, as well as the amount of resources required to expand services.

LiST Costing includes default standards of care and unit costs at a global level, with no variation for different countries; these inputs are based on international standards, but can be adjusted to fit the country context if there are major differences between them and national standards. For each maternal health intervention to be included in the investment case, the following data will need to be collected related to the necessary drugs and supplies required for the intervention (Table 4), the required medical personnel to provide the service (Table 5) and (Table 6), and whether the intervention is received as an outpatient visit or inpatient day (Table 7). The example illustrated in the tables below is for tetanus diphtheria (Td) vaccination during antenatal care; similar data collection templates can be set up for each intervention for which costs will be estimated.

Table 5. Intervention treatment inputs: drugs and supplies

Drugs and Supplies	Percent receiving this aspect of the treatment	# of units	Times per day	Days per case	Unit cost
Td vaccine (10-dose vial)	100	1	1	2	\$0.317
Syringe, needle + swab	100	1	1	2	\$0.05

Table 6. Intervention treatment inputs: medical personnel

Medical personnel type	Percent treated by	Minutes	Number of days/visit
Midwives	100	3	2

Table 7. Intervention treatment inputs: outpatient visits and/or inpatient days

Outpatient visit or inpatient day	Percent receiving	Units per case
Outpatient visit	100	2

Other recurrent and capital costs

Note the default other recurrent and capital costs. These costs per outpatient visit and inpatient day (OPVs/IPDs) have been calculated by WHO at the country level and are available from the [WHO-CHOICE website](#). They represent the “hotel” cost portion of both OPVs and IPDs, i.e., all costs except drugs and laboratory costs. The OPV and IPD costs, therefore, contain both other direct costs (ODCs) and indirect costs, as well as personnel costs and the cost of consumables. Make any adjustments that are necessary based on the country context.

LiST Costing automatically calculates the costs associated with ODCs and indirect costs for each intervention, by using the number of OPV/IPD for each intervention and multiplying it by the proportion of the country-specific cost of one OPV/IPD that is attributable to ODCs and indirect costs.

PROGRAMME COSTS

Default programme cost categories and percentages are included in LiST Costing; these are based on [SUN nutrition plan costing exercises](#), the [EPIC immunization studies](#), and [National AIDS Spending Assessments](#). Programme cost categories can be configured or changed using the Add/Edit/Delete buttons; users are encouraged to adapt these cost categories and the assumed level of costs based on recent country-specific data if available.

These costs are intended to capture the above service delivery costs associated with the delivery of the maternal health interventions. Users can enter costs either as a percentage of direct costs or as an absolute number (each programme cost can be configured as a percentage or absolute number using the dropdown selection). If using the percentage format, programme costs are applied to all intervention costs.

Logistics and wastage

Default rates for logistics and wastage are included in LiST Costing and applied to the total cost of drugs used in costed interventions. Review the defaults and revise if country-specific data are available.

Infrastructure investment

To account for the cost of infrastructure investments needed to support service expansion, LiST Costing uses default ratios that vary by country income level and build on previous efforts to estimate the cost and impact of packages of health services, which rely on a WHO model to estimate programme area and health system requirements and costs (Stenberg et al., 2014). The default ratios in LiST are from a secondary analysis of the outputs of the WHO model reported in the 2014 RMNCH investment case to estimate these costs based on a percentage over and above the intervention costs (Stenberg et al., 2014), and the ratio is

applied to the incremental cost of service delivery. Review the defaults and revise if country-specific data are available.

Other health system costs

Meeting the transformative result will require additional investments for health systems strengthening in order to bring health systems to at least a minimum degree of functionality in terms of availability of hospital beds and health workers. LiST Costing includes ratios of other health system costs to the commodity, labour and service delivery cost associated with the interventions; these ratios vary by country income level and build on previous efforts to estimate the cost and impact of packages of health services, which rely on a WHO model to estimate programme area and health system requirements and costs (Stenberg et al., 2014). The default ratios in LiST are from a secondary analysis of the outputs of the WHO model reported in the 2014 RMNCH investment case to estimate these costs based on percentage over and above the intervention costs (Stenberg et al., 2014), and the ratio is applied to the incremental cost of service delivery. Review the defaults and revise if country-specific data are available.

Inefficiencies

LiST Costing includes a default for inefficiencies of 17.5 percent that is added on to labour, service delivery, infrastructure, and other health system costs based on the 2010 World Health Report, with estimates of inefficient spending (Chisholm & Evans, 2010). This can be revised based on the country context if sufficient data exist.

ANNEX I. DATA COLLECTION: TREATMENT INPUTS

The example illustrated in the tables below is for tetanus diphtheria (Td) vaccination during antenatal care; similar data collection templates can be set up for each intervention for which costs will be estimated.

Intervention	Drugs and supplies	Percent receiving this aspect of the treatment	# of units	Times per day	Days per case	Unit cost
Td vaccination during ANC	Td vaccine (10-dose vial)	100	1	1	2	\$0.317
	Syringe, needle + swab	100	1	1	2	\$0.05

Intervention	Medical personnel type	Percent treated by	Minutes	Number of days/visits
Td vaccination during ANC	Midwives	100	3	2

Intervention	Outpatient visit or inpatient day/s	Percent receiving	Units per case
Td vaccination during ANC	Outpatient visit	100	2

Note the default other recurrent and capital costs. These costs per outpatient visit and inpatient day (OPVs/IPDs) have been calculated by WHO at the country level and are available from the [WHO-CHOICE website](#). They represent the “hotel” cost portion of both OPVs and IPDs, i.e., all costs except drugs and laboratory costs. Thus the OPV and IPD costs contain both other direct costs (ODCs) and indirect costs, as well as personnel costs and the cost of consumables. Make any adjustments that are necessary based on the country context.

LiST Costing automatically calculates the costs associated with ODCs and the indirect costs for each intervention, by using the number of OPV/IPD for each intervention and multiplying it by the proportion of the country-specific cost of one OPV/IPD that is attributable to ODCs and indirect costs.

ANNEX J. COUNTRY INVESTMENT CASE FORMAT AND STYLE GUIDE

COUNTRY INVESTMENT CASE FORMAT

Executive Summary

- Concise summary of investment case, pulling out key points

Introduction

- Describe the context including the motivation and objective for the investment case
- Document the purpose of the investment case
- Identify the scope and time horizon for the analysis

Context: Description and significance of challenges facing the achievement of the transformative result in the country

- Description of health priorities (national and global)
- Description of country goals and priorities
 - National plans to achieve the transformative result and/or SDG targets
- Description of current efforts (e.g., interventions, programmes, etc.) to address the transformative result
- Description of challenges that remain

Methodology: Description of:

- Process taken to develop the country investment case
- Methodology and tools used to estimate costs and impact
- Scenarios modelled

Making the investment case: Documentation of:

- Costs and impact by scenario
- Available financing to reach the transformative result
- Funding gap by scenario
- Return on investment

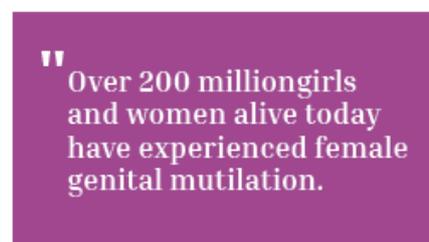
Conclusion

- Summary of results/findings from analysis

STYLE GUIDE

Publication identity

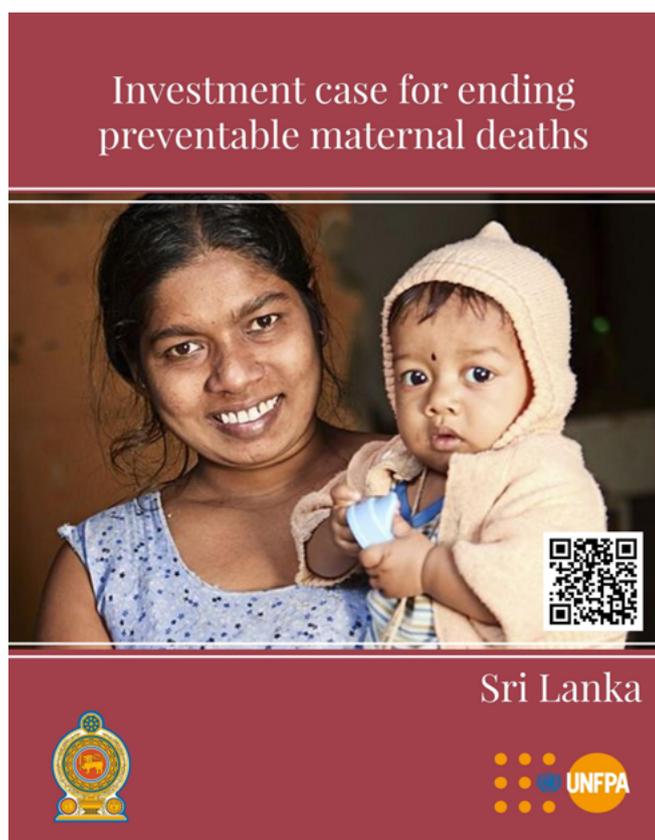
- Key colour:** Main colour of publication. The “key colour” may be sourced from the country’s flag or official national colour.
- Recommended Fonts:** (Font files can be downloaded in this folder, with a sample)
 - UNFPA: For general text, regular titles.
 - INRIA SERIF: This is an “accent font”, which means it should be used for key information, such as highlighting main findings on the side of a page, subtitles and quotes. See an example below of a quote from the publication, “Costing the Three Transformative Results”, highlighting a key piece of information from the general text.



Quotations

INSIDE AND CONTENT

- Cover Visuals:** Front and back covers should be in the Key Colour and feature a relevant high-resolution photo on the middle of the front cover. A double line in black or white can be added in the limit between the photo and the cover colour on both sides (see the example below). The cover page must include the transparent logos of key government institutions and UNFPA. The logos can be positioned as in the below example. If the investment case is developed jointly with another United Nations organization, their logo may be included in the same line. For more information about the positioning of the UNFPA logo, please follow the UNFPA [style guide](#).



Front cover



Back cover

- b. Cover text:** The cover should feature the name of the investment case on the top left of the page, in black or white text, centred, size 45, UNFPA Font. The country name should be added in Inria Serif, below the picture aligning to the right side, in size 40. If your publication is available online, include the QR code as highlighted in the example above.
- c. Back cover:** May feature a small-sized version of the country's Coat of Arms, centred on the lower third of the page. May also include a main address for the publication reference.
- d. Title page:** Cover page may contain the country's coat of arms, a brief description of the publication's purpose (i.e., description of the three transformative results) and the logos of ministries and other collaborating partners including donors and other United Nations organizations (UNFPA and any other partners to be credited).
- e. Publication information page:** The page opposed to the title page should briefly feature acknowledgements or contact information, as well as key information about the publication – ISBN number, copyright note, print copies request channel, etc.
- f. Foreword:** It is highly recommended to obtain the foreword from high-level government officials. UNFPA Representative or Director may also add a message in the investment case.
- g. Table of contents:** should be entitled "CONTENTS", and list section titles on the left, all capital letters, and page numbers on the right.
- h. Recommendation:** UNFPA Font, size 18 for "CONTENTS" title, size 14 for the list and numbers.
- i. Regular Pages:** Black text in UNFPA font, size 12. Header separated by a thin line in the Key Colour.
- All margins should be 1 inch wide.
 - Headers should feature the publication title on the left page, and the chapter title on the right page (the inverse is true for publications in languages that read from right to left).
 - Page numbers should be featured on the top, outer end of the page, far left on left pages, far right on right pages.
 - Titles for chapters should be written in all capitalized letters, size 18, left-aligned, at the top of the page. A subtitle may be added to a short title, in Inria Serif, 14.
- j. Visual Information:** Infographics, icons, and table outlines should be accented in the Key Colour (see examples in Costing publication). This helps in highlighting content and marking the pace of the publication to readers. Additional colours may be drawn from the publication, "Costing the Three Transformative Results".

ANNEX L. SAMPLE TERMS OF REFERENCE: WORKING GROUP

A Working Group is essential to coordinate national efforts to develop an investment case to address the transformative result of _____. The purpose of this Working Group is to oversee and coordinate the activities related to the development of the national investment case. This includes ensuring the process to develop the investment case is technically sound, enjoys broad public and expert support and results in the creation of an investment case to guide achievement of the transformative result in the country.

Roles & responsibilities:

- Agree on the transformative result(s) for the investment case(s)
- Identify an entity or consultant to implement tools required for the investment case(s)
- Provide overall guidance to the work of the entity or consultant to implement the tools required for the investment case(s), including:
 - Data (epidemiologic, cost, coverage, etc.) and assumptions being used
 - Review results generated

ANNEX M. SAMPLE LIST DATA COLLECTION TEMPLATE

Indicator	Definition	Baseline	Data source	Notes
Baseline maternal health status				
% of women exposed to falciparum	% of women exposed to falciparum malaria during pregnancy			
% of pregnant women with anaemia	% of pregnant women with haemoglobin levels < 110 g/L			
% of pregnant women with iron-deficiency anaemia	Among pregnant women with haemoglobin levels < 110 g/L, the % where anaemia is amenable to iron supplementation			
% of non-pregnant women with anaemia	% of non-pregnant women aged 15-49 with haemoglobin levels < 120 g/L			
% of non-pregnant women with iron-deficiency anaemia	Among non-pregnant women aged 15-49 with haemoglobin levels < 120 g/L, the % where anaemia is amenable to iron supplementation			
% of pregnant women with severe anaemia	% of pregnant women with haemoglobin levels < 50 g/L			
% of women with low BMI	% of women aged 15-49 years with BMI <18.5			
Baseline maternal mortality				
Maternal mortality ratio	The ratio of the number of maternal deaths per 100,000 live births			
% maternal deaths – antepartum haemorrhage				
% maternal deaths – intrapartum haemorrhage				
% maternal deaths – postpartum haemorrhage				
% maternal deaths – hypertensive disorders				
% maternal deaths – sepsis				
% maternal deaths – abortion				
% maternal deaths – embolism				
% maternal deaths – other direct causes				
% maternal deaths – indirect causes				

Indicator	Definition	Baseline	Data source	Notes
Abortion				
% of pregnancies ending with spontaneous abortion	The spontaneous end of a pregnancy at a stage where the embryo or foetus is incapable of surviving independently, generally defined in humans as prior to 20 weeks of gestation. Spontaneous abortions are not easily measured and are thus assumed to average 13% of pregnancies in all countries.			
Abortion incidence ratio	The abortion incidence is expressed as a ratio of abortions per 100 live births			
Economy				
% of population living below \$1.90 per day	Percent of the population living on less than \$1.90/day according to purchasing power parity (adjusted to 2011 international dollars)			
Average household size	Average number of people living in a household			

ANNEX N. TEMPLATE FOR INVESTMENT CASE ADVOCACY PLAN

Advocacy Objective: (e.g., increase resources available for family planning)

Target audience	Activity	Sub-activities	Responsible	Resources needed	Timeframe
Ministry of Finance	Advocate for increased domestic resources allocated to the health sector	Advocacy workshop to explore avenues for increasing domestic financing for family planning			

REFERENCES

- Bollinger, L. A., Sanders, R., Winfrey, W., & Adesina, A. (2017). Lives Saved Tool (LiST) costing: A module to examine cost and prioritize interventions. *BMC Public Health*, 17(Suppl 4): 782.
- Chisholm, D., & Evans, D. B. (2010). *Improving health system efficiency as a means of moving towards universal coverage*. Geneva: WHO.
- Conteh, L., Engels, T., & Molyneux, D. H. (2010). Socioeconomic aspects of neglected tropical diseases. *Lancet*, 375: 239-247.
- Keen, S., Begum, H., Friedman, H. S., & James, C. D. (2017). Scaling up family planning in Sierra Leone: A prospective cost-benefit analysis. *Women's Health*, Vol 13(3) 43-57.
- Moreland, S., & Talbird, S. (2006). *Achieving the Millennium Development Goals: The contribution of fulfilling the unmet need for family planning*. Washington DC: USAID.
- Stenberg, K., Axelson, H., Sheehan, P., Anderson, I., Gulmezoglu, A. M., Temmerman, M., . . . Bustreo, F. (2014). Advancing social and economic development by investing in women's and children's health: A new Global Investment Framework. *The Lancet*, 383(9925), 1333-1354.
- Thompson, K. M., & Tebbens, R. J. (2012). Development of investment cases for globally-coordinated management of infectious diseases. *J Vaccines Vaccin*, 3:8.
- Thompson, K. M., Pallansch, M. A., Duintjer Tebbens, R. J., Wassilak, S. G., & Cochi, S. L. (2012). Modeling population immunity to support efforts to end the transmission of live polioviruses. *Risk Anal*.
- Thompson, K. M., Rabinovich, R., Conteh, L., Emerson, C. I., & Hall, B. F. (2011). Group report: Developing an eradication investment case. In S. L. Cochi, & W. R. Dowdle, *Disease eradication in the 21st century: implications for global health* (pp. 133-148). Cambridge, MA: MIT Press.
- UNFPA. (2017). *Strategic Plan 2018-2021*. New York: UNFPA.
- UNFPA. (2017). *The economic cost of pregnancy in girls and adolescents*, El Salvador. UNFPA.
- UNFPA, Johnson & Johnson, International Confederation of Midwives, Family Care International. (2014). *Making the Case for Midwifery: A toolkit for using evidence from The State of the World's Midwifery 2014 Report to create policy change at the country level*. UNFPA.
- United Nations. (2015). Transforming our world: The 2030 Agenda for Sustainable Development. *Resolution adopted by the General Assembly*. United Nations. Retrieved from Transforming Our World: The 2030 Agenda for Sustainable Development.
- United Nations. (2019, November 29). *Sustainable Development Goals*. Retrieved from www.sustainabledevelopment.un.org/.
- United Nations General Assembly. (2018). 72.279: Repositioning of the United Nations development system in the context of the quadrennial comprehensive policy review of operational activities for development of the United Nations system. *United Nations General Assembly*. New York.
- WHO, UNICEF. (2018). *Achieving Elimination of Maternal and Neonatal Tetanus by 2020: Investment Case*. WHO, UNICEF.
- Wolfson, L. J., Gasse, F., Lee-Martin, S. P., Lydon, P., & Magan, A. (2008). Estimating the costs of achieving the WHO-UNICEF global immunization vision and strategy, 2006-2015. *Bull World Health Organ*, 86: 27-39.
- World Health Organization. (2019). *Global Polio Eradication Initiative investment case 2019-2023*. Geneva: WHO.

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