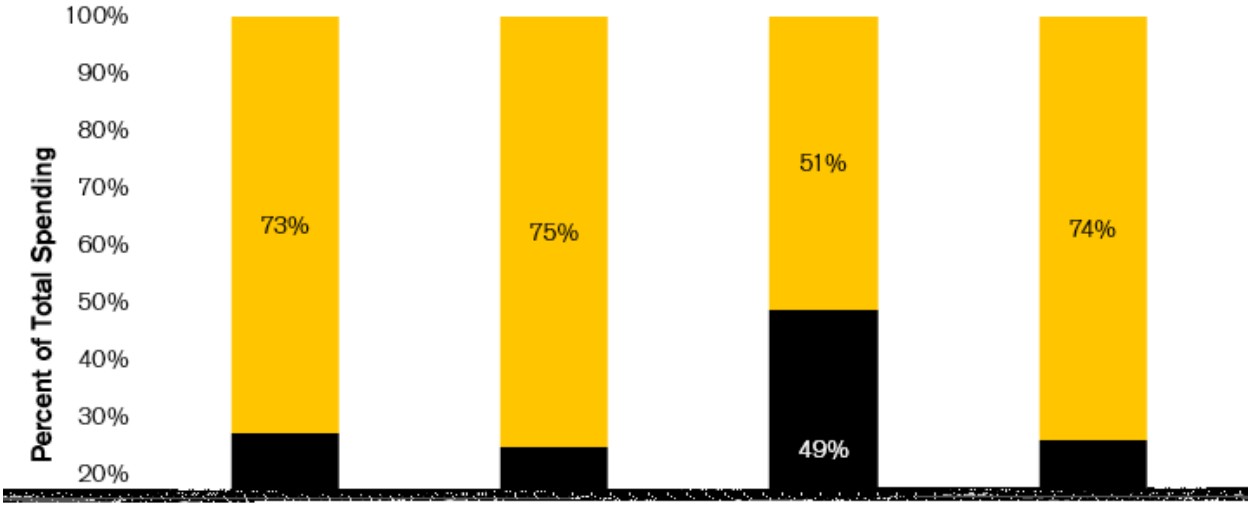
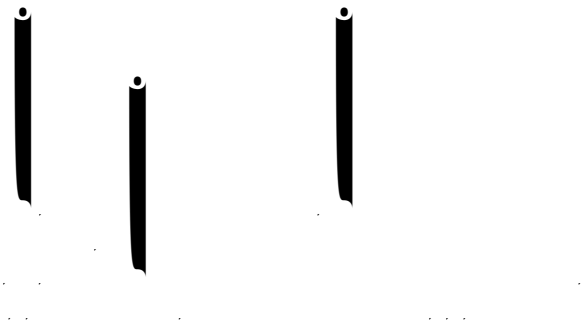
Allowing women and their partners to choose the size of their families and the timing of births is critical to reducing maternal and child mortality rates in humanitarian contexts. Research indicates that short birth spacing is associated not only with elevated risk of maternal death, but also increased neonatal, infant and under-five mortality, and child malnutrition. Family planning (FP) is an effective strategy for addressing these public health issues. The IRC makes a wide range of family planning methods available to clients, including short-acting methods, such as oral contraceptive pills and injectables, long-acting methods, like implants and IUDs and permanent methods, such as tubal ligation and vasectomy.

This analysis examines four family planning programs in the Democratic Republic of the Congo (DRC), Kenya, Libe-

Beyond the health staff or facilities required by a family planning program, such operations also require general support staff in order to work: finance managers, grant administrators, procurement coordinators, etc. The proportion of costs dedicated to support costs, versus program costs, ranged from 25 percent in Myanmar to almost 50 percent in the Liberia program. More than 40 percent of support costs in Liberia were dedicated to International Staff, who are more expensive than National Staff, explaining why support costs were higher in dollar value and proportion for this country.



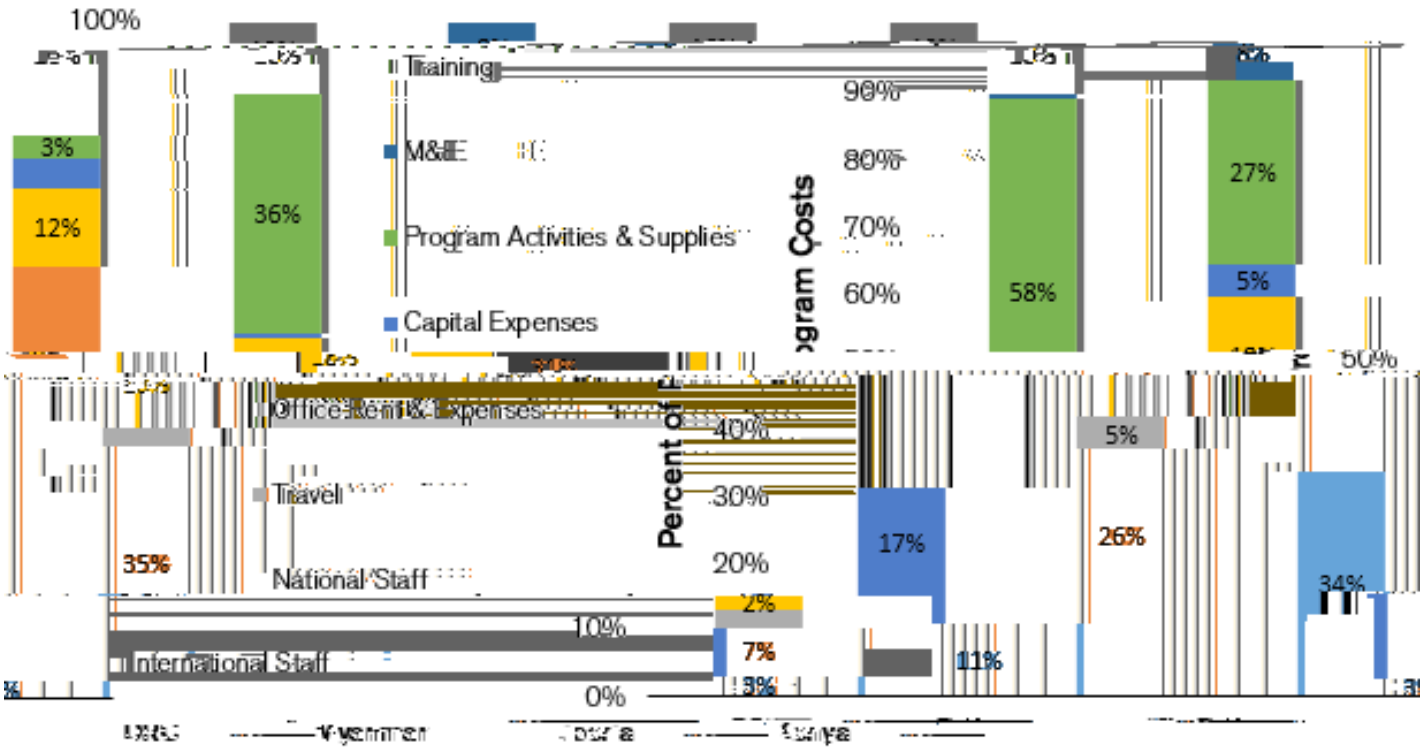


With support costs included, the cost per CYP ranged from $23 to $105 per CYP. These figures can be thought of in relation to the costs of the unintended pregnancies that family planning helps to prevent. Experts estimate that one out of every four years of unprotected sex will result in an unintended pregnancy in the developing world , this suggests that it cost the IRC only $188 on average per unintended pregnancy averted.[2]

Past tudies have shown that different family planning methods can achieve quite varied cost efficiency, because they provide protection for different periods of time and require different resources to administer . This helps to explain some of the variation in cost efficiency across the four countries examined—in refugee camps in Kenya, acceptance of contraceptives was low and those FP methods that were distributed tended to be short-acting methods. Low acceptance of contraception means that the IRC was able to distribute fewer FP methods through the

The DRC program provided the highest number of CYP of all of the programs in this brief, and in order to achieve such large scale the program funded not only medical and outreach staff, but also rehabilitation of health facilities' rooms and extensive staff training. Additionally, the majority of clients in the DRC accepted long-acting methods, the provision of which requires more training and support than short-acting methods, which were included in the program activities cost category.

Thus, while the costs of training and facilities rehabilitation were high, they were outweighed by the large scale that these investments allowed the IRC to reach. Not only were many individuals reached, but these individuals were able to choose long-acting methods of contraception because of the available facilities and staff.



The IRC is committed to maximizing the impact of each dollar spent to improve our clients' lives. As the IRC's CEO wrote in a 2015 article in *Foreign Affairs*, "Donors need to not just double the amount of aid directed to the places of greatest need but also undertake reforms that seek to double the productivity of aid spending." The Best Use of Resource initiative is focused on improving the reach and impact of the IRC by using internally available data to better understand the cost of delivering key IRC interventions. Generating evidence about cost efficiency and cost effectiveness will enable the IRC to cost and compare different approaches and their related impact, ultimately allowing decisions that achieve the best use of resources.

"Cost efficiency analysis" compares the costs of a program to the outputs it achieved (e.g. cost per latrine constructed, or cost per family provided with parental coaching), while "cost effectiveness analysis" compares the costs of a program to the outcomes it achieved (e.g. cost per diarrheal incident avoided, cost per reduction in intra-family violence). Conducting cost analysis of a program requires two types of information:

1) Data on what a program achieved, in terms of outputs or outcomes, and
2) Data on how much it cost to produce that output or outcome.

Units across the IRC produce a wide range of outputs, from obvious items like nutrition treatment or shelter kits to more intangible things like protection monitoring or case management. Cost analysis requires us to focus in on one output (for cost efficiency) or outcome (for cost effectiveness), such as the number of items produced or the number of people provided with a service. Such outputs will not necessarily encompass all the work that a program has done. For example, a WASH program may build water pipelines, latrines, and solid waste disposal pits; each of which could be defined as a single output. The Best Use of Resources initiative focuses on analyzing the IRC's key outputs, such as access to sanitation in refugee camps, malnutrition treatment, and case management services. The focus is not to dismiss other dimensions of our program's work, but to concentrate on one output, allowing for comparison of cost efficiency across programs and contexts in ways not possible if budget data at the program level was the only factor considered. The Best Use of Resources initiative team works together with IRC's Program Quality Unit to identify the most important outputs and understand how