

# Domestic resource mobilisation for sexual and reproductive health and rights

MODALITIES OF DONOR SUPPORT



# About Countdown 2030 Europe

Countdown 2030 Europe is a consortium of 15 non-governmental organizations in 12 European countries working to hold European donor governments and the European Union institutions to account for their policy and funding commitments on sexual and reproductive health and family planning.

## Acknowledgments

This report was researched and written by Alice Sabino from Options Consultancy Services Limited for Countdown 2030 Europe. It was reviewed and edited by Raffaella Dattler, International Planned Parenthood Federation.

Views expressed in this report do not necessarily represent those of individual members of the Countdown 2030 Europe consortium.

Published in June 2022

Author: Alice Sabino, Options Consultancy Services Limited  
Review and edit: Raffaella Dattler, International Planned Parenthood Federation  
Copy edit: Mags Allison  
Design: Sue MacDonald

#### Photos:

IPPF/Brenda Islas/Mexico (cover), IPPF/Victoria Milko/Bangladesh (p2), IPPF/George Osodi/Nigeria (p4), IPPF/Tommy Trenchard/Botswana (p6), IPPF/Alana Holmberg/Tonga (p8), IPPF/Anton Nixon/Barbados (p11), IPPF/Anton Nixon/Barbados (p12), IPPF/George Osodi/Nigeria (p14), IPPF/Gert Izeti/Albania (p15), IPPF/Adriane Ohanesian/Kenya (p16), IPPF/Alana Holmberg/Tonga (p23), IPPF/Camila Zevallos/Peru (p30-31), IPPF EN/Jon Spaul/Macedonia (p36), IPPF/Tommy Trenchard/Uganda (p40).

# Contents

Executive summary	3
Introduction	5
1. Domestic resource mobilisation: overview	7
2. Financing sexual and reproductive health and rights: context and funding trends	11
3. Domestic resource mobilisation mechanisms	17
4. European donors: a closer look	35
5. Domestic resource mobilisation at country level	37
Conclusions and recommendations	39
Key abbreviations	42
Selected references	43





# Executive summary

This report provides an overview of the main mechanisms used by donors to incentivise domestic resource mobilisation for sexual and reproductive health and rights in partner countries, presents a critical analysis of risks and opportunities associated with these mechanisms, and offers recommendations for advocacy efforts and global health programming.

The report comprises two main parts: an overview of the concepts of domestic resource mobilisation and sexual and reproductive health and rights (Sections 1 and 2) and an analysis of levers used by donors and strategies implemented at country level for domestic resource mobilisation (Section 3). Section 4 takes a closer look at support from European donors and Section 5 discusses key actors and financing functions at country level. The report concludes with key recommendations for donors, practitioners, and advocates.

The COVID-19 pandemic has affected fiscal space of both donor and partner governments, limiting the ability to increase investments across the many competing priorities in health and beyond. As countries move towards the recovery phase, it becomes even more urgent to strengthen the dialogue on domestic resource mobilisation for health, and sexual and reproductive health and rights in particular, and set realistic timelines and targets that leverage opportunities for increased efficiency of existing funding envelopes. Coordinated transition planning between donor and partner governments is key to avoid losing the gains made to date in sexual and reproductive health and rights and to continue expanding the coverage of services and realization of rights.

Domestic resource mobilisation is the process through which governments raise and collect funds for public spending. In global health, it has gained momentum since the early 2000s as a needed step to strengthen health systems and a key strategy in the transition away from aid. Domestic resource mobilisation is a government function, linked to the country's fiscal space and the political decisions governments make around raising revenues and spending public funds. Donors can incentivise domestic resources for sexual and reproductive health and rights in different ways: directly by including incentives for it in their programming, or indirectly by strengthening other parts of the health system or increasing the country's broader fiscal space or budgetary space for health. The mechanisms or levers used to incentivise domestic resource mobilisation are often used in combination, at different stages of programming and by different actors within donor governments.

The same lever can have different effects in two different health systems or when applied by different donors in the same setting or at the same time. Therefore, when estimating the possible impact of these levers on sexual and reproductive health and rights funding, it is important to analyse each lever's strength and directionality based on the context in which it is used, including in light of which other incentives are at play. In this report, the levers are grouped into three categories: direct monetary incentives or co-financing requirements, direct non-monetary incentives, and indirect improvement of the fiscal space.

Levers with stronger monetary incentives, often used to target specific sexual and reproductive health and rights components, such as co-financing requirements or earmarking, can increase visibility on resources allocated or spent, facilitate monitoring, and increase allocation in the short term. However, to ensure the increased investment is sustained over time it needs to result in an increased overall health envelope. This means mitigating the risk of finance authorities defunding other health priority areas that are not impacted by co-financing requirements or reducing health funding from other non-earmarked sources. General health financing or fiscal space reforms on the other hand tend to have longer lasting effects and can improve the overall conditions for health allocation and spending, including efficiency. But if they are not combined with other direct incentives for sexual and reproductive health and rights (for example programmatic indicators on outcomes or service use) they may not result in additional domestic resources being allocated or spent for sexual and reproductive health and rights.

Donors and advocates can play a role in maintaining sexual and reproductive health and rights priorities on the agenda, also during crises. Donors in particular can leverage adaptive programming and combine monetary and non-monetary levers to support a realistic and consistent improvement, not just increase, in domestic investments targeted at expanding access to sexual and reproductive health and rights. This should include responsive indicators to measure spending efficiency, the alignment between sexual and reproductive health and rights strategic plans, budgets and spending, and the ability to define and fund sexual and reproductive health and rights priorities.

## Summary recommendations for donors, practitioners, and advocates

1. Maintain a strong link between domestic resource mobilisation, allocation, and spending. Without efficient use of the funds, any effort to mobilise additional resources will not yield the intended results.
2. Combine different types of domestic resource mobilisation incentives in programme design to allow for country-level adaptation based on health financing structures and strategies, programmatic priorities on sexual and reproductive health and rights components, and broader macroeconomic conditions.
3. Expand dialogue on sexual and reproductive health and rights financing to include broader health advocates and experts, for example by embedding sexual and reproductive health and rights investments in larger donor priorities and commitments, such as on Sustainable Development Goal 3 and universal health coverage, focusing on sustainability of investments and progressive expansion of coverage and rights.
4. Ensure there is a clear and explicit equity focus in the design and application of financing mechanisms and incentives for domestic funding of sexual and reproductive health and rights.
5. Set realistic targets in terms of both financial contributions and time frames.
6. Strengthen the link between programmatic and financial targets in programme design and global commitments for sexual and reproductive health and rights. This requires improved metrics, disaggregated and transparent data on both health and financial indicators at different levels, and programmes that can learn and adapt while remaining accountable for the intended outcomes.
7. Strengthen the enabling environment for the expansion of sexual and reproductive health and rights. Increasing domestic investments is a political decision and it cannot happen in a vacuum. Donors can continue to support creation of an enabling policy and legal environment at global and country level, link financing levers with accountability measures and mechanisms in programme design, and support civil society participation in priority setting and budgeting processes.



# Introduction

This report provides an overview of the main mechanisms used by donors to incentivise domestic resource mobilisation for sexual and reproductive health and rights in partner countries and presents a critical analysis of risks and opportunities associated with these mechanisms. It concludes with recommendations for advocacy efforts and global health programming.

## Methodology

A **literature review** served to provide a big picture overview of domestic resource mobilisation and sexual and reproductive health and rights funding. It explored mechanisms through which domestic resource mobilisation can be improved and how donors have sought to incentivise domestic funding to the benefit of sexual and reproductive health and rights. A review of selected donors' public documents, budgets and statements was used to inform key informant interviews and the analysis.

**Key informant interviews** with representatives from select donor governments and institutions were used to understand what relationships exist between donors' programmatic priorities and their strategies to incentivise domestic resource mobilisation, their decision-making processes, and their expectations for domestic resource mobilisation for sexual and reproductive health and rights by recipient governments. Interviews included questions on plans and expectations for future donor investments as well as the ways in which the COVID-19 pandemic has impacted or may impact these plans.

The **analysis** of the findings critically assesses the funding mechanisms and highlights their implications for domestic resource mobilisation initiatives for sexual and reproductive health and rights, outlining risks and opportunities, including equity implications.

## Structure of the report

The first section provides an overview of the concept of domestic resource mobilisation and introduces key concepts. The second section provides a quick overview of sexual and reproductive health and rights in global health and trends in domestic and external funding. The third section brings these concepts together and presents the relations between selected external funding streams, the levers donors can use to incentive domestic resource mobilisation, and the country-level interventions to mobilise domestic resources. Levers and country-level mechanisms are then analysed in detail, from the perspective of sexual and reproductive health and rights. The following two sections complement the information presented so far by taking a closer look at European donors' funding support as well as key actors and financing functions at country level. The report ends with advocacy recommendations.







# 1. Domestic resource mobilisation: overview

**Domestic resource mobilisation refers to the process through which governments raise and collect funds from domestic sources for public spending.**<sup>i</sup> The sources of those funds can be private households, businesses, and other revenue streams that national and local governments can leverage. There are various mechanisms that can be used to raise and collect funds at national and local level. However, the choice of which mechanisms to prioritise to raise and collect funds and how to spend these funds are political decisions, usually made by finance and tax authorities, not health authorities.

There are many determinants of a government's ability to fund public spending, with economic growth and the ability to raise revenue being the main ones. Low- and middle-income countries raise on average 29.5 per cent of gross domestic product as government revenue, compared to 41.2 per cent in high-income countries.<sup>1</sup>

Domestic resource mobilisation for health and opportunities for sexual and reproductive health and rights are closely linked to the concept of **fiscal space**, that is the ability of governments to raise funds to cover public spending without impacting fiscal sustainability.

Fiscal space for health commonly refers to a government's capacity to spend **more** on health, and domestic resource mobilisation is a critical part of that. There are different definitions of fiscal space. Some are narrower, looking only at the budgetary room for **additional** public spending.<sup>2</sup> For the scope of this report, fiscal space is considered in its broader meaning, to include how governments decide to use **existing** domestic revenues as well as additional revenues.

Over the last few years, "the concepts of fiscal space and fiscal space for health have evolved to incorporate new views related to both revenue and expenditure".<sup>3</sup> The new term **budgetary space for health** has been defined as "potential resources to be budgeted and used for health, through the [public financial management] system".<sup>4</sup> This includes overall revenues, the budget share allocated to health, and public financial management improvements that are needed to improve efficiency of health spending. Efficiency gains can be understood as "increases in the volume or quality of outputs produced for a given level of inputs, or reductions in inputs while still producing the same or greater outputs".<sup>5</sup>

Fiscal space determines the overall available funding for public spending (or '**what**' can be generated in a given country), whereas domestic resource mobilisation mechanisms can indicate '**how**' resources for health can be mobilised. They leverage the opportunities to expand fiscal space and collect resources for health, linking public spending to financing of the health system.

## DOMESTIC RESOURCE MOBILISATION IN GLOBAL HEALTH

In global health, domestic resource mobilisation has gained momentum since the early 2000s as a needed step to strengthen health systems, and a mitigation strategy to donor dependency in many low- and middle-income countries, and even more so in the last five years as a response to the accelerated process of transition away from aid and the increasing costs of achieving the Sustainable Development Goals. In 2015, the Third International Conference on Financing for Development concluded with the Addis Ababa Action Agenda in which countries committed to increasing domestic resource mobilisation through various financing mechanisms, including widening the revenue base for national taxation.

<sup>i</sup> See USAID website, Domestic resource mobilization: <https://www.usaid.gov/what-we-do/economic-growth-and-trade/domestic-resource-mobilization>

Domestic revenues can lead to “improved development”, understood as improved economic indicators and outcomes, only if they are translated into productive and beneficial public expenditure.<sup>6</sup> Therefore, if the objective of domestic resource mobilisation is to improve the provision, availability, or coverage of sexual and reproductive health services, and the expansion of the enabling environment for the enjoyment of sexual and reproductive rights, domestic resource mobilisation is only one of two steps necessary to achieving it. The second step is the **efficient use** of the resources mobilised. Without efficient use of the funds, any effort to mobilise additional resources will not yield the intended results. The World Health Organization (WHO) estimates that between 20 and 40 per cent of all health spending is wasted due to inefficiencies,<sup>7</sup> so there is ample scope for achieving more also within the context of slower or limited additional resources mobilised.

The premise of the application of the concept of domestic resource mobilisation to health is that the need for additional investments in health is a determining factor for economic development,<sup>8</sup> not one of its indirect consequences. With 2030 being a milestone year in the transition away from aid and the end date for the Sustainable Development Goals, low- and middle-income countries face heavy pressure to mobilise unprecedented amounts of revenues to meet these targets. The COVID-19 pandemic and its impact on the economy have already begun reducing the likelihood of that funding gap being filled by additional resources alone. European donors’ strategies to incentivise domestic resource mobilisation for sexual and reproductive health and rights are therefore analysed from a systems perspective, taking into account their direct and indirect consequences for overall fiscal space for health and related trade-offs.





## Fiscal space for health and financing of health systems

Financing of health is one of the interdependent functions within a health system, and it includes multiple actions – from resource mobilisation, to pooling, and use.<sup>9</sup>

**Decisions on public spending and revenue sources are political**, and they are not decisions made independently by line ministries. The concept of domestic investments therefore goes beyond the financial mechanisms used to raise revenues, and includes issues related to governance and political choice, responsibility, and national priorities. Within the health sector, resource mobilisation is only partially under the sphere of influence of health authorities, and health competes with all other sectors for an increasing share of public spending every year.

The political context and broader system in which domestic resource mobilisation mechanisms intervene are critical to understand and measure the impact such mechanisms can have on service delivery and use. Health outcomes are in fact dependent on the amount of revenue mobilised as well as the efficient and harmonised use of both domestic and external resources.

Current health spending levels in most low- and middle-income countries are significantly below the estimated per capita spending needed to achieve the third Sustainable Development Goal.<sup>10</sup> **No single source of funding can fill the gap** in the short or medium term, which is why efforts to increase domestic investments will need to be closely aligned with a more harmonised use of external funds (whether Official Development Assistance [ODA], loans or blended financing) and a more efficient spending of available funds.

In a recent review of studies investigating the impact of different mechanisms to expand fiscal space for health, Barroy and colleagues provide a useful framework to think about domestic resource mobilisation and better target any advocacy effort towards relevant decision-makers at country level.<sup>11</sup> They build on research by Tandon and Cashin<sup>12</sup> that identified five sources or ways in which fiscal space can be gained.

Domestic resource mobilisation is a sub-component of fiscal space and directly intervenes in the first three:<sup>13</sup>

1. conducive macroeconomic conditions
2. reprioritization of health within the government budget
3. increase in health sector-specific resources (e.g. earmarked funds from consumption or income taxes)
4. health sector-specific grants and foreign aid
5. increase in the technical and allocative efficiency of existing public spending for health

This report uses Tandon and Cashin fiscal space sources to analyse domestic resource mobilisation mechanisms at country level and the ways in which the donor community can or has tried to incentivise it. Efficient use of resources, though not a strict domestic resource mobilisation mechanism, is referenced throughout the report because of its role in both ensuring resources mobilised are used for the intended interventions and 'freeing up' existing resources otherwise wasted.

**FIGURE 1. Sources of fiscal space and contribution to domestic resource mobilisation**



Source: author, based on Tandon and Cashin framework

A clear picture of a country's fiscal space for health helps health financing decisions in different ways<sup>14</sup> that can be simplified as a 'reality check'.

Recent efforts by WHO to better align financial management and health financing include using fiscal space assessments to inform the development of health financing strategies and related domestic resource mobilisation mechanisms.<sup>15,16</sup> These assessments provide health authorities with a realistic picture of which policy or programmatic targets are realistically feasible within potential funding envelopes and within a certain time frame. The findings of the assessments can also include an indication of how much revenue can be generated by earmarked taxes compared to general taxation. This can help balance the appeal of earmarking against long-term sustainability and growth opportunities for broader taxation policies.

Evidence on fiscal space allows policy-makers to consider each individual revenue stream as one component of a domestic resource mobilisation strategy for a gradually expanding package of services (towards universal health coverage) and provide a reality check on the importance of efficiently using available resources to be able to do more with the current funding. It also gives them a stronger case to present to ministries of finance when requesting budget allocation in subsequent fiscal years.

When choosing financing mechanisms for health, it is critical to analyse revenue streams in light of the overall health services package that is to be provided and to whom, and each revenue mobilisation mechanism's ability to fund the achievement of expected health outcomes within the set time frame. Balancing revenues and their impact on the users of health services is essential to ensure the **equitable and efficient use of health resources**. For example, user fees are a mechanism to mobilise domestic and sector-specific revenues, but they also create significant barriers to access to services,<sup>17</sup> especially for people in lower income quintiles.



## 2. Financing sexual and reproductive health and rights: context and funding trends

### The concept

The concept of sexual and reproductive health and rights, and its application, varies significantly: from the policy and regulatory environment to the range, quality, and accessibility of services in each country context, from the language used to describe its elements to the funding allocated to its components both globally and locally.

There are two practical implications for the objectives of this report: first, the fragmentation of the concept and its applications affects the availability and comparability of data on services and funding. Second, decisions on and consequences of domestic resource mobilisation mechanisms are political and interdependent with the wider country and global health context. This means that a general assessment of domestic resource mobilisation mechanisms outside the specific country context in which they intervene is only a simplified picture of a more complex reality.

In 2018, the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights launched a report calling for renewed commitment to sexual and reproductive health and rights. It analysed and defined the four key dimensions of the concept (sexual rights, sexual health, reproductive rights, and reproductive health) and proposed an integrated definition for sexual and reproductive health: **“Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity.”**<sup>18</sup> The distinction between the four key dimensions reflects both the complexity and the political nature of the topic, and this strategic deconstruction has been used ‘for political positioning’<sup>19</sup> both in international negotiations and in-country practice. Despite clear and substantial benefits to promoting the realization of sexual and reproductive health and rights, government support for comprehensive sexual and reproductive health and rights packages is not common.<sup>20</sup> Over time, what is included under this umbrella has changed, and so have funding streams and international commitments.



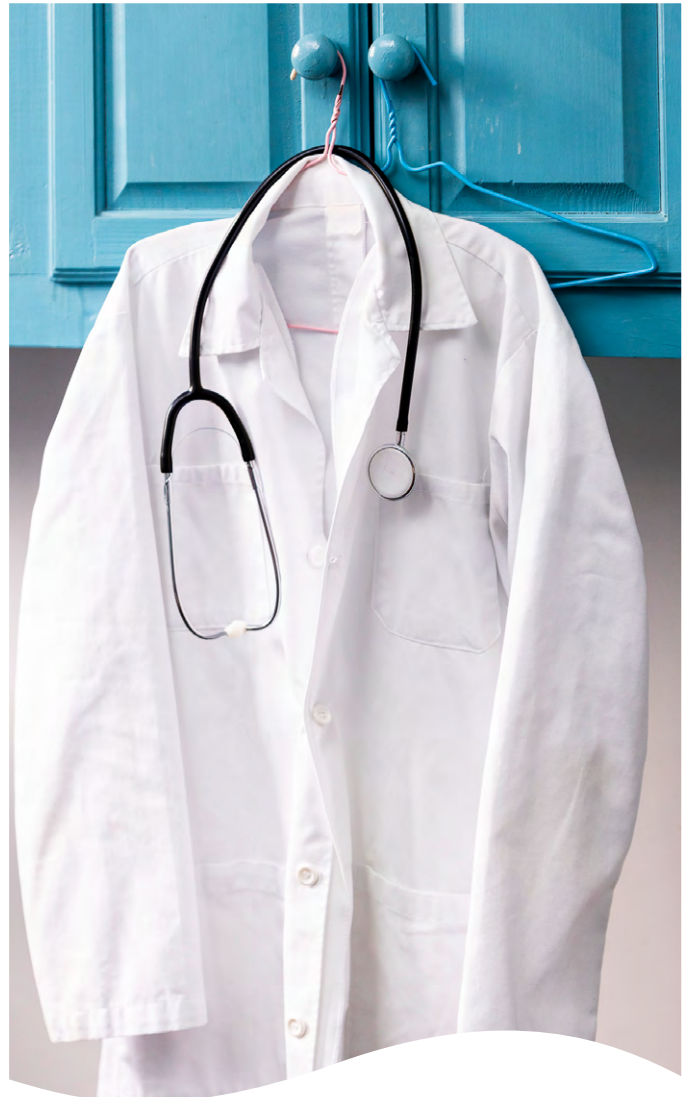
## Data availability and comparability

These differences in definitions and programmatic fragmentation are reflected in sexual and reproductive health and rights funding and data, both globally and at country level.

Data on funding for sexual and reproductive health and rights are fragmented. There are routinely updated estimates on funding needs,<sup>21</sup> whereas aggregate patterns of sexual and reproductive health and rights financing and spending are often outdated, available for a limited range of services (e.g. the 'costed package' of services as described in the International Conference on Population and Development Programme of Action), a single service,<sup>22,23</sup> a selected geography or set of commitments (e.g. FP2020/FP2030<sup>ii</sup> or Track20<sup>iii</sup>), or donor.

At the global level, donors have different priority areas and focus on different components of the broader sexual and reproductive health and rights umbrella. Data sets and classifications reflect historic priorities, such as by tagging activities related to sexually transmitted infections (STIs) treatment and prevention under the HIV/AIDS label. For example, the global health spending report published by WHO in 2020<sup>24</sup> includes sexually transmitted diseases (STDs) under HIV spending and only family planning under reproductive health. There is no reference to other components of sexual and reproductive health and rights.

At country level, data availability and the different classifications limit the visibility on who funds which components of sexual and reproductive health and rights, which ones are included in budget lines or responsibility areas of different authorities, or which share of a pooled budget they represent. Interventions to expand the recognition of sexual and reproductive rights are often spread across different budgets and do not fall under the responsibilities of a single line ministry or department.



ii See the FP2030 data hub at: <https://fp2030.org/data-hub#what-we-measure>

iii See Track20, Tracking Family Planning Expenditures: [http://www.track20.org/pages/our\\_work/global\\_analysis/expenditures.php](http://www.track20.org/pages/our_work/global_analysis/expenditures.php)



## Financing sexual and reproductive health and rights

The Guttmacher-*Lancet* Commission<sup>25</sup> estimated the cost for meeting all women's needs for contraceptive, maternal, and newborn care (excluding the cost of HIV prevention and treatment). Its analysis suggested a need for an investment in the order of US\$13.0 per capita annually for low-income countries, highlighting the wide funding gap compared to the current spending of about US\$1.1 per capita.<sup>26</sup>

At country level, different sexual and reproductive health services can be funded by different sources. For example, some services – like post-partum family planning – are commonly included in national health budgets, others in ministry of education or youth budgets (such as school-based activities), while family planning commodities tend to be funded through external funding and out-of-pocket payments. In 2012, in developing countries out-of-pocket payments accounted for almost two-thirds of all sexual and reproductive health expenditure.<sup>27</sup>

Domestic and external funding streams tend to target only selected areas of sexual and reproductive health and rights, leaving others underfunded or only available at a cost often prohibitive for poorer population groups. For example, rights and safe abortion components are the most commonly excluded or underfunded compared to other areas; the majority of donor funding is still going to HIV-related services, which in 2017 accounted for 70 per cent of all official development assistance (ODA) for sexual and reproductive health and rights (measured by using the Organisation for Economic Co-operation and Development [OECD] Development Assistance Committee [DAC]'s International Development Statistics databases and including reproductive health, family planning, STDs, and related administrative and management costs)<sup>iv, 28</sup>

## Domestic funding for sexual and reproductive health and rights

**Shares of national budgets allocated to the various components of sexual and reproductive health and rights are hard to measure, or even identify.**

While a ministry of health's sexual and reproductive health strategic plan may include different areas and specify priority interventions for sexual and reproductive health services, the annual budget may only include, for example, one line pooling all funding allocated to reproductive and maternal services, family planning services, and maybe post-abortion care. Family planning and safe abortion commodities may be included in one line of the national procurement or medical stores' budget, often together with safe delivery kits (such as in the case of Uganda<sup>v</sup>). This makes it difficult to monitor sexual and reproductive health spending and its efficiency, and to measure progress towards commitments made or responsiveness to need.

The realization of sexual and reproductive health and rights contributes to and benefits from **universal health coverage**, as reflected in Sustainable Development Goal targets 3.7 and 3.8. However, to date, commitments to universal health coverage have not been matched by adequate funding. Most countries rely on a mix of sources to fund their health systems ('revenue collection mechanisms'). The main ones include government revenues (raised, for example, from taxes or borrowing), health insurance schemes, external funding from bilateral and multilateral donors, and direct payments from those seeking care (out-of-pocket payments). A sustainable way to ensure availability of sexual and reproductive health services without major financial barriers to access would be to include them in the service list or benefit package provided through public funding. Currently, however, comprehensive sexual and reproductive health packages have not been included in essential services lists or universal coverage schemes' health benefit packages.<sup>29</sup>

iv From the technical annex in Schäferhoff et al, 2019: "To calculate global trends in SRHR ODA, we used the code 130 – specifically the codes 13010 (Population policy and administrative management), 13020 (Reproductive health care), 13030 (Family planning), 13040 (STD control including HIV/AIDS), and 13081 (Personnel development for population and reproductive health)."

v See the Republic of Uganda Health sector budget framework paper 2018–2023: <https://budget.go.ug/sites/default/files/Sector%20Budget%20Docs/08%20Health.pdf>

## External funding for sexual and reproductive health and rights

Donor programming can strengthen visibility of sexual and reproductive health and rights financial and programmatic data and their use to inform allocative decisions, create the right incentives to redirect domestic resources towards sexual and reproductive health and rights priorities, and support advocacy efforts by highlighting the contribution of sexual and reproductive health and rights to national development strategies. However, external funding mechanisms and conditions can also increase the risks associated with rapid transition away from aid, whereby limited domestic resources are expected to fund a larger share of services in a short period of time. For example, family planning has been undergoing various processes of aid transition,<sup>30</sup> with increasing pressure on domestic funding to cover an increasing share of commodities. Fungibility of investments and external pressure towards family planning commodities can influence domestic budgets and deprioritize the expansion of coverage for services not affected by transition.

When the United States administration reinstated the Mexico City Policy in 2016, European and other donors increased their funding for sexual and reproductive health and rights. In 2017, the combined ODA and Bill and Melinda Gates Foundation (BMGF) funding for sexual and reproductive health and rights reached a record high, in absolute amounts, of US\$11.3 billion. However, it represented a lower share of donors' health

**Distribution of external funding across sexual and reproductive health and rights areas is varied.** For example, USAID in 2018 was the single largest donor for family planning, covering 42 per cent of all external funding for it (see Schäferhoff et al, 2019).

funding than in previous years (42 per cent in 2016 and 2017, compared to the 52 per cent share it had in 2011)<sup>vi</sup>.<sup>31</sup>

When disaggregating donor funding for sexual and reproductive health and rights, as mentioned before, most funds are still tagged as HIV-related services. This reflects in part the difficulty in classifying funding based on its final use and in disaggregating resources shared across different components of the health system, but also the legacy of the main priorities in the global health agenda from the last two decades. Between 2016 and 2017, the share of donors' non-HIV-related sexual and reproductive health and rights funding declined from 14.7 to 12.5 per cent of the overall health portfolio. HIV-related funding made up 70 per cent of donors' sexual and reproductive health and rights funding in 2017, while donor support for family planning amounted to nine per cent. Other reproductive health care services accounted for only 16 per cent of all donor funding flows to sexual and reproductive health and rights in 2017 compared to 19 per cent in 2015.<sup>32</sup>

vi Sexual and reproductive health and rights in the cited report measures ODA programmes including reproductive healthcare, family planning, STI services including for HIV/AIDS, and related administrative and management costs.





## Trends in funding for sexual and reproductive health and rights

**In the last decade, external funding for health has begun to plateau or be channelled through new mechanisms carrying conditionality clauses including co-financing.** However, domestic investments for sexual and reproductive health and rights have not increased proportionally and continue to represent a limited share of the overall health investments in many countries.<sup>33</sup> Middle-income countries, in particular, are experiencing multiple transitions at the same time, which, coupled with the additional burden placed on health systems by the COVID-19 pandemic, raise a new and urgent need for financing reforms. The public resources available in these countries are under competing pressure from the reduction in donor funding in health but also other sectors (*transition away from aid*), the *epidemiological* transition<sup>vii</sup>, and the *demographic* transition<sup>viii</sup>. Health financing reforms and strategies designed to respond to these important changes will have to enable countries to gradually increase the domestic share of investments in sexual and reproductive health and rights, including to allow for progressive expansion of coverage for a wide range of sexual and reproductive health services.

The concept of domestic resource mobilisation in the context of sexual and reproductive health and rights is closely linked to that of transition away from aid. Processes of transition have affected priorities and allocative decisions in-country both directly, by introducing co-financing requirements, and indirectly, by creating additional pressure on current health budgets. Family planning is one of the areas that is undergoing an explicit transition,<sup>34</sup> with different programmes explicitly aiming at increasing the share of domestic

investments for commodities and supplies (such as the UNFPA Supplies Partnership, or the BMGF's support to family planning commodities through matched funding for the Ouagadougou Partnership).<sup>ix</sup>

External funding for sexual and reproductive health and rights post-2020 was unlikely to increase even before the COVID-19 pandemic hit the global economy<sup>35</sup> for several reasons, including conservative projections for economic growth in countries providing ODA as a share of gross domestic product. The continuation of the pandemic and its economic impact across the globe bring a renewed focus on efficient use of resources, in donor and recipient countries.



vii Understood as the shift to high prevalence of non-communicable diseases and a reduction in incidence of infectious diseases.

viii Understood as the change in the age composition of the population, from a pyramid shape with a high proportion of young people and a very small ageing population typical of low-income countries, towards a rhomboid shape characterized by lower fertility rates, lower infant mortality, and a larger productive population in the middle. For further references see Ranganathan, S., Swain, R. B., and Sumpter, D. J. T. (2015). The demographic transition and economic growth: implications for development policy. Palgrave Communications, 1(150333). <https://doi.org/10.1057/palcomms.2015.33>

ix See Ouagadougou Partnership. (2018). How \$350 million funding will impact family planning. <https://partenariatouaga.org/en/how-350-million-funding-will-impact-family-planning/>







### 3. Domestic resource mobilisation mechanisms

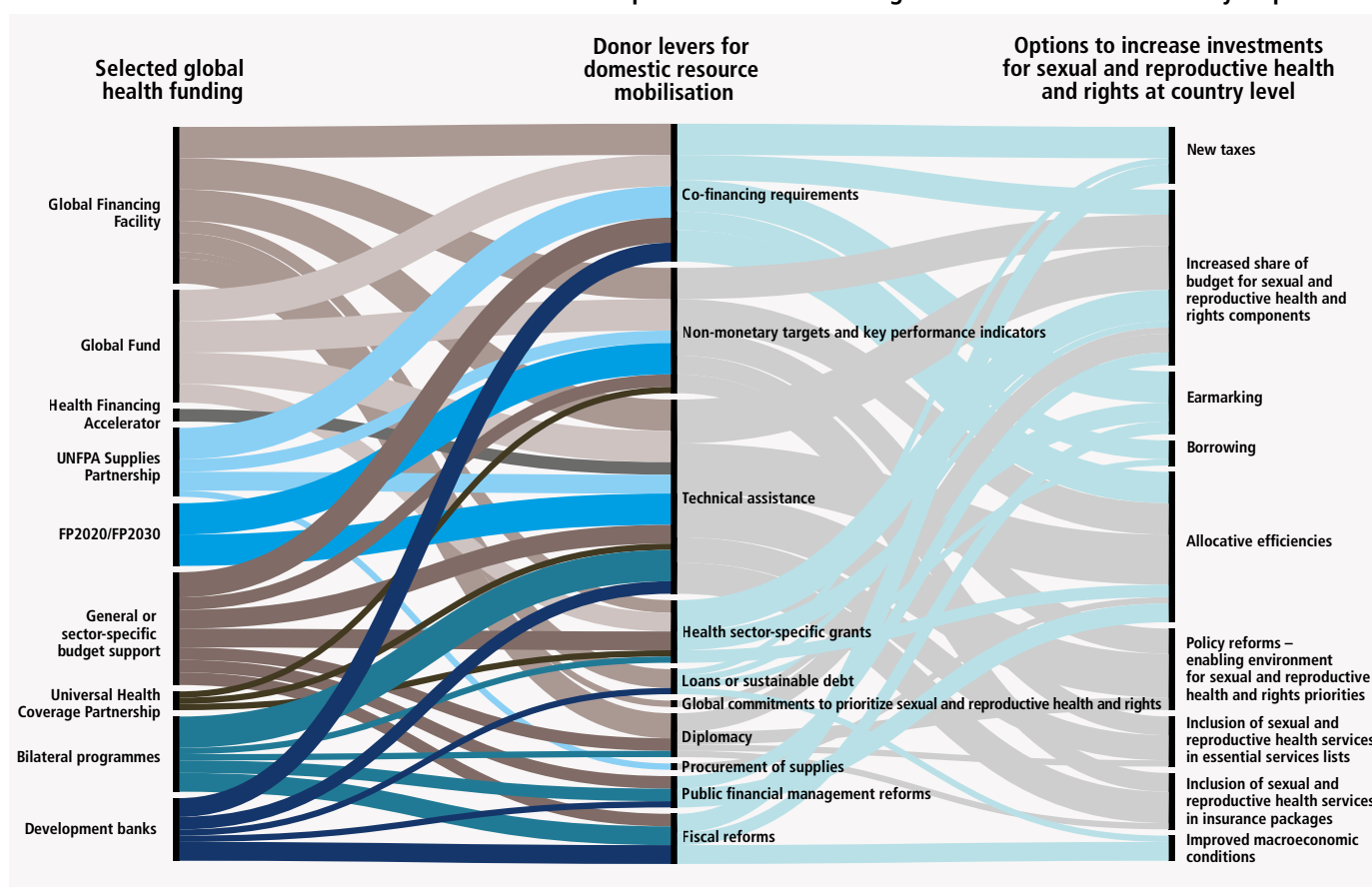
National finance authorities define and regulate the mechanisms used to mobilise domestic resources. In global health, donors have employed monetary, contractual, and diplomatic strategies (or levers) to incentivise the mobilisation of domestic resources for specific health areas.

This report focuses on the levers or strategies used by European donors (directly or through multilateral initiatives) to incentivise domestic resource mobilisation for components of sexual and reproductive health and rights in recipient

countries of donor funding. It also includes a selected number of other initiatives that, by expanding fiscal space, can indirectly influence the availability of resources for sexual and reproductive health and rights.

Figure 2 presents selected global health donors and initiatives (left-hand side), the levers they use to incentivise domestic resource mobilisation (in the centre), and the related domestic resource mechanisms available at country level (right-hand side).

**FIGURE 2. Domestic resource mobilisation in sexual and reproductive health and rights: donors' levers and country responses**



Source: author, based on literature review and key informant interview results

## Selected global health funding

The focus of this report is on mechanisms used to promote domestic resource mobilisation. This section introduces a selected set of individual global health actors and initiatives or external funding mechanisms relevant to such mechanisms. It does not provide a comprehensive list of all global health actors operating in the sexual and reproductive health and rights space. The classification chosen here helps to highlight the predominant type of levers used in each case to incentivise domestic resource mobilisation in general or for sexual and reproductive health and rights in particular.

Based on their role in incentivising domestic investments, actors and initiatives were grouped into three non-mutually exclusive categories:

1. **Initiatives where components of sexual and reproductive health and rights are the main focus**, which may or may not include domestic financing incentives. Examples of these are the Global Financing Facility (GFF)<sup>x</sup>, family planning-specific initiatives and partnerships (such as FP2020/FP2030<sup>xi</sup>, the Ouagadougou Partnership<sup>xii</sup>, the UNFPA Supplies Partnership<sup>xiii</sup>), or other initiatives to foster global commitments on sexual and reproductive health and rights (such as the Family Planning Summits or the International Conference on Population and Development and its follow-up processes).
2. **Initiatives focusing on health systems strengthening** that indirectly influence the health systems aspects or functions useful for sexual and reproductive health and rights or include sexual and reproductive health and rights components within a larger scope. Examples of these initiatives are The Global Fund to Fight AIDS, Tuberculosis and Malaria<sup>xiv</sup> or other funding streams supporting the building blocks of health systems, from supply chains to human resources for health.

3. **Initiatives indirectly influencing resources for sexual and reproductive health and rights by improving the financial or policy environment.** Initiatives and actors that intervene in the enabling environment have been included because they can create the necessary conditions for political decisions to fund sexual and reproductive health and rights to be made. This might be by creating fiscal space, such as programmes strengthening public financial management, defining the frameworks for public-private partnerships and other investments, or improving the overall financial management and economic strategy for the country, or by creating the policy conditions for expansion of sexual and reproductive health and rights.

Figure 3 outlines an example of the flows of external funding for health, going from broader initiatives to specific ones on sexual and reproductive health and rights. The impact of domestic resource mobilisation levers for sexual and reproductive health and rights depends on the overall financing environment and on the relationships and alignment between different initiatives, especially when they use a limited set of levers as shown in Figure 2.

## Relevant examples

**The Global Financing Facility (GFF)**<sup>xv</sup> is a multi-stakeholder global partnership, hosted at the World Bank, using blended financing to accelerate progress for reproductive, maternal, adolescent and child health and nutrition. By design, it intends to use catalytic grant funding to direct loans from the International Development Association or the International Bank for Reconstruction and Development, aligned donor funding, and public and private sector investments towards reproductive, maternal, child and adolescent health and nutrition priorities.

European donors are among the main funders of the Facility<sup>xvi</sup> and of supporting technical assistance programmes. The GFF does not prescribe which priority areas (or essential list of services) must be included among those funded by the loans and it does not contractually require the timely publishing of expenditure reports on the priority areas outlined in

x Global Financing Facility: <https://www.globalfinancingfacility.org/>

xi FP2020/FP2030: <https://fp2030.org/>

xii Ouagadougou Partnership: <https://partenariatouaga.org/en/>

xiii UNFPA Supplies Partnership: <https://www.unfpa.org/unfpa-supplies-partnership>

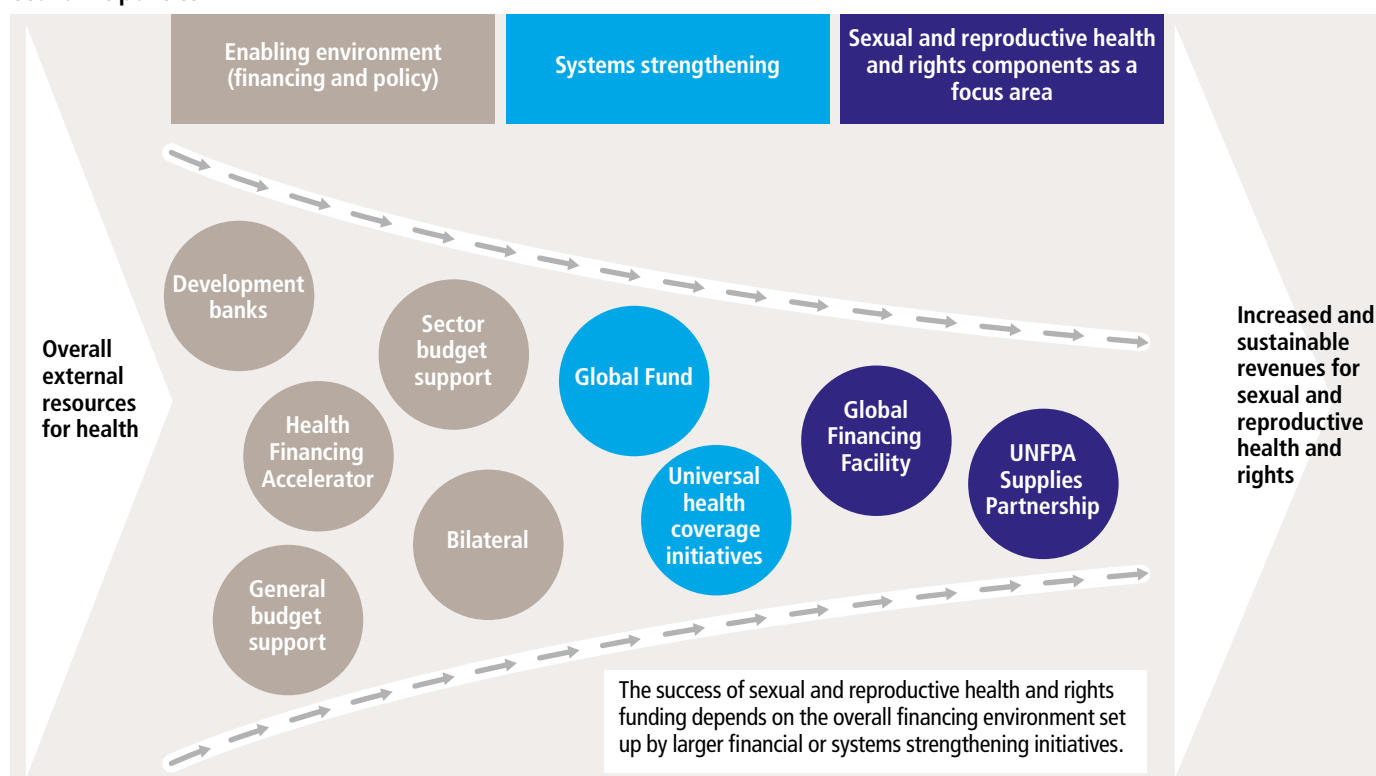
xiv The Global Fund to Fight AIDS, Tuberculosis and Malaria: <https://www.theglobalfund.org/en/>

xv See Global Financing Facility website, About us: <https://www.globalfinancingfacility.org/introduction>

xvi See Global Financing Facility website, Financiers: <https://www.globalfinancingfacility.org/our-partnership/financiers>



**FIGURE 3. Financing for sexual and reproductive health and rights depends on broader health and national financing and economic policies**



investment cases. The GFF uses monetary incentives and contractual requirements to promote domestic resource mobilisation, as well as non-monetary mechanisms to prioritize investments from all sources for reproductive health.

The GFF was launched in 2015 and, in 2022, a total of 67 countries globally are eligible for funding from the Facility, with 36 currently receiving it. Eligible countries can apply for funding and negotiate the loan. The overall programmatic priorities for the country are meant to be presented in an investment case,<sup>36</sup> while the GFF contribution to fund that plan is signed into the Project Appraisal Document contractually binding the government of the receiving country and the World Bank. The process was intended to be country led and include active participation from the private sector and civil society,<sup>37</sup> but country experiences have varied.<sup>38</sup>

**The Global Fund to Fight AIDS, Tuberculosis and Malaria** is a global partnership, created in 2002, to fund and accelerate progress against AIDS, tuberculosis and malaria. The vast majority of the funding for the Fund comes from donor governments and the remaining eight per cent from the private sector and foundations.<sup>xvii</sup> Currently, it invests around US\$4 billion a year in over 100 countries and supports countries to prepare for transition away from foreign aid for the three diseases. Domestic resource mobilisation is a key element in the Fund's sustainability and transition strategy<sup>xviii</sup> as well as one of the eligibility criteria for accessing the funding. Co-financing requirements for countries applying for funding are in fact dependent on both burden of disease and macroeconomic conditions, with higher income levels corresponding to higher shares of co-financing. Countries

xvii See The Global Fund website, Global Fund Overview: <https://www.theglobalfund.org/en/overview/>

xviii See The Global Fund website, Sustainability, Transition & Co-Financing: <https://www.theglobalfund.org/en/sustainability-transition-and-co-financing/>

must also demonstrate progressive domestic funding to cover programmatic areas previously funded through Global Fund grants. Each strategic plan for a disease area must be costed and prioritized and a gap analysis presented to the Fund during the application process showing all funding sources for the entire strategic plan.<sup>39</sup> Improving efficiency of health investment and debt-swap programmes are also among the Fund's strategies for innovative financing.<sup>xix</sup> The Global Fund is included here because it directly supports sexual and reproductive health services when integrated or linked to HIV care, and indirectly strengthens the health systems building blocks and the enabling environment for domestic resource mobilisation and sustainable planning.

**General or sector budget support** is a funding mechanism through which a donor government transfers funds directly to the Treasury of the recipient government and monitors it with programmatic and financial indicators. The use of the funding allocated to budget support is determined by the recipient country in negotiations with the donor. It is managed through public financial management systems, with additional monitoring functions from the donor.

This mechanism has been used since the early 2000s<sup>40</sup> by the World Bank and International Monetary Fund institutions, and European donors, including the European Commission and individual governments. It is useful to highlight how budget support combines monetary incentives for domestic resource mobilisation with non-monetary incentives (for example joint monitoring and agreed outcome level indicators) and immediately expands fiscal space allowing recipient governments the time to work on longer term reforms to mobilise and use additional revenues. Figure 4 shows how general budget support tends to fund longer term results, be more country driven compared to other foreign aid mechanisms, and have a stronger focus on governance rather than earmarking of funds compared to sector budget support.<sup>41</sup>

The **Health Financing Accelerator** is an example of broader financing initiatives that can have indirect effects on domestic resource incentives for sexual and reproductive health and rights.<sup>xx</sup> The Accelerator is a forum for donors to coordinate interventions and approaches to support countries with health financing as a means to accelerate progress towards Sustainable Development Goal 3 and universal health coverage. The objective of the Accelerator is to support countries to increase fiscal space for health.

Among the Accelerator's activities is advocacy for increased and more efficient domestic spending on health.<sup>42</sup> This presents an opportunity to link advocacy asks about increased spending to programmatic priorities, including on sexual and reproductive health and rights, and work together with international agencies as they deploy coordinated joint financing mechanisms to achieve this. Initiatives like the Accelerator are an opportunity for civil society and donors to engage in concrete discussions about the implications of different financing mechanisms on key health priorities, including the full enjoyment of sexual and reproductive health and rights. Expanding participation and engagement of sexual and reproductive health and rights advocates in health financing forums can help to link the sustainability of investments to the gradual yet consistent expansion of sexual and reproductive health services and rights, as an integral part of the progress towards universal health coverage, and to create the conditions for country-level prioritization and an improved enabling environment for sexual and reproductive health and rights.

xix See The Global Fund website, Innovative Finance: <https://www.theglobalfund.org/en/innovative-finance/>

xx See World Health Organization, SDG3 Global Action Plan, Accelerators: <https://www.who.int/initiatives/sdg3-global-action-plan/accelerator-discussion-frames>

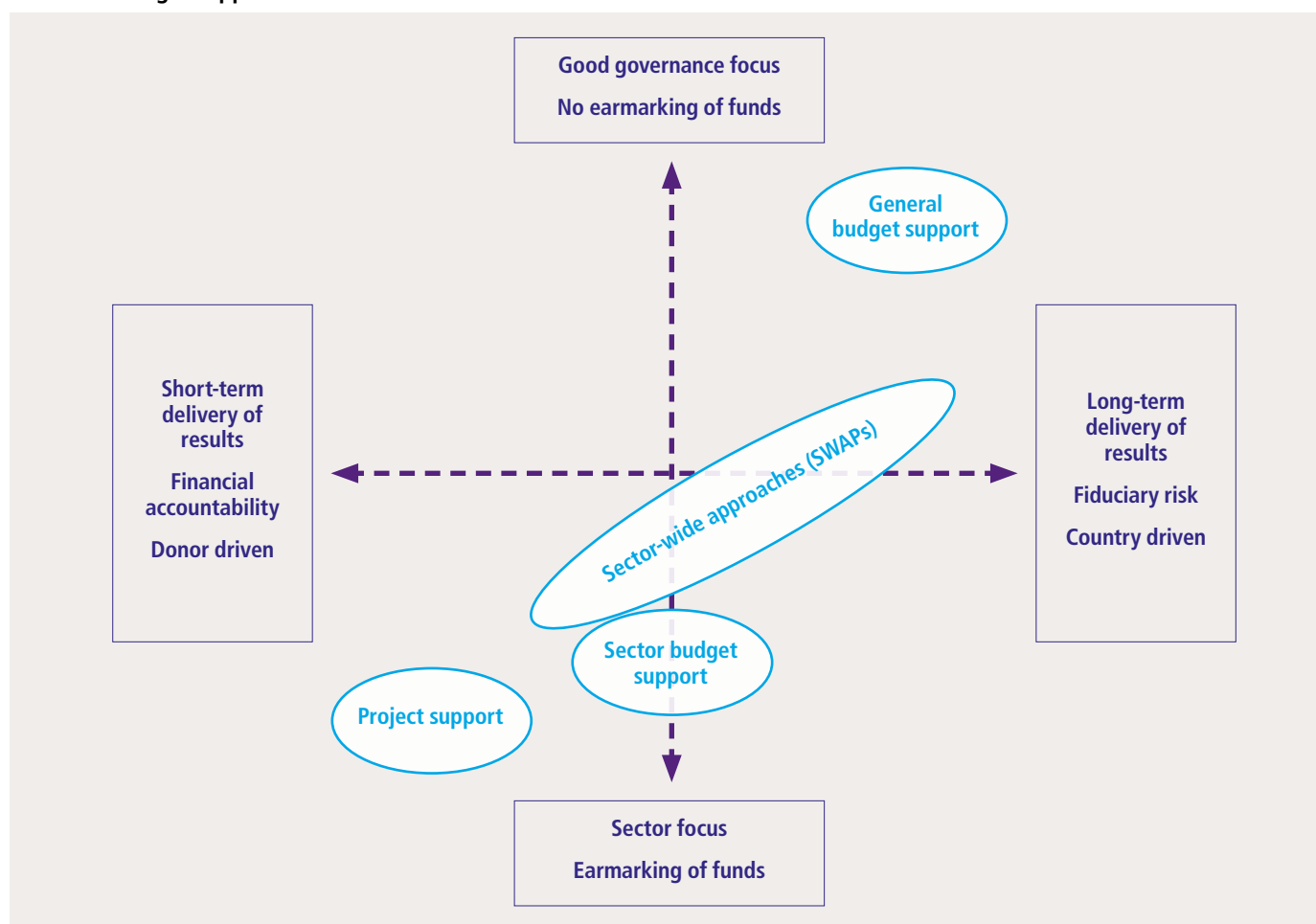


**Reducing fragmentation** in global health can contribute to improving efficiency of spending and reducing wastage, and there are many initiatives aimed at streamlining external support and managing the effects of transition away from aid on health sector investments. These initiatives are important in this context because they influence donors' priorities and provide direct support to the design and operationalisation of health financing reforms at country level. These broader financing reforms define the scope of and the space in which specific domestic resource mobilisation mechanisms can be used for sexual and reproductive health and rights.

As shown in Figure 2, there is a limited set of levers used by different donors and initiatives. At the country level, multiple levers are often operational at the same time, in health and other sectors, creating strong and at times conflicting pressure on domestic resources.

The next section provides an overview of these levers and how they can be applied to sexual and reproductive health and rights investments, and summarises possible advantages and risks. However, to fully understand the advantages and limitations of each lever on domestic resource mobilisation and use, it is necessary to carry out a country-level analysis assessing their combined impact on priority setting and budgetary decisions.

**FIGURE 4. Budget support overview**



## Levers used to incentivise domestic resource mobilisation

**The levers** available to global health donors to incentivise domestic resource mobilisation for sexual and reproductive health and rights can directly incentivise or require domestic resource mobilisation actions from the recipient government, promote the prioritization of investments in sexual and reproductive health and rights without monetary incentives by ‘setting or influencing the agenda’, or support a favourable financing environment for sexual and reproductive health and rights by indirectly increasing the fiscal space or ability to efficiently spend available resources.

Some levers are embedded in programming monitoring systems or contract and disbursement clauses, while many others are less visible, yet not less powerful, and have been summarised below under the umbrella term of ‘diplomacy’.

The research conducted for this report highlighted how contractual measures with financial targets for domestic resource mobilisation are more frequently used by multilateral donor initiatives, while diplomacy is one of the main levers used to influence prioritization decisions and indirectly domestic resource allocation and use by country-level operations of bilateral donors.

**Each lever or incentive has a degree of strength and intended directionality**, but because they do not operate in a vacuum and are dependent on the contexts in which they are applied, both strength and direction can vary. The same incentive can have opposite effects in two health systems using different purchasing arrangements, for example, or can interact differently when applied by multiple donors across sectors in the same country. Any donors’ programme or initiative aiming at incentivising domestic resource mobilisation can lead to different country-level responses, at different moments in time. The main causes of such variation, other than changes in macroeconomic conditions, can be summarised as a) changes in the health financing functions mix (revenue collection, pooling and purchasing), and b) the combination of other incentives and financial requirements influencing public spending priorities (such as co-financing thresholds or donor transition in health or another sector, a crisis, or simply a change in political priorities).

Looking at the components of sexual and reproductive health and rights, some of them are easier to disaggregate and can be more easily linked to direct monetary incentives or conditions (such as commodities or overall budget amounts), whereas others are more susceptible to a combination of ‘soft-power’ and monetary levers (such as diplomacy).

Especially in the context of transition from aid, governments can have stronger incentives to prioritize investments in sexual and reproductive health and rights components that are highly dependent on external financing, such as commodities. This can lead to distortions in the sexual and reproductive health budget and have repercussions on the overall health portfolio.

**Most initiatives and programmes use more than one lever**, as shown in Figure 2. As a consequence, the risks and strengths of each lever become less important than the incentive they create when combined. Advocates have a key role to play in discussing and analysing the overall directionality and strength of the incentives included in global health programmes. A frequent unintended consequence of incentives for domestic resource mobilisation for a specific health area, such as sexual and reproductive health and rights, is that the additional resources mobilised are simply substituted for the existing ones, in fact resulting in a stagnating level of investment in that area. This risk is exacerbated by the fact that the debate on domestic resource mobilisation in global health often focuses on sources of funding, rather than amounts needed to achieve a specific result.



Strategies to mitigate these risks span from expanding engagement beyond the health authorities to developing advocacy messages that present the links between specific health outcomes and secondary benefits to society and the economy as a whole. At global level this could mean having sexual and reproductive health and rights advocates participate in financing spaces, targeting advocacy messaging to a wider range of audiences and decision-makers within donor governments. At country level, this could mean for example including finance authorities, who ultimately have the power to approve and implement resource mobilisation strategies, in discussions around resource mobilisation for a specific health area in order to better align plans to increase domestic resource mobilisation for sexual and reproductive health and rights to broader national economic or fiscal strategies. If investments in sexual and reproductive health and rights are framed as integral parts of a broader national strategy, they will be less at risk of being cut or reduced with each budget or programmatic cycle. Both at global and country level, there is an opportunity to reframe advocacy for increased investment so that it does not position sexual and reproductive health and rights in competition with other health areas, and health in competition with other sectors for the same revenue stream.

Table 1 below summarises the main levers used in global health initiatives to incentivise domestic resource mobilisation, and how they can support or hinder investments for sexual and reproductive health and rights. The levers have been divided into three groups:

1. Direct monetary incentives or co-financing requirements
2. Direct non-monetary incentives
3. Indirect improvement of fiscal space



TABLE 1. LEVERS TO INCENTIVISE DOMESTIC RESOURCE MOBILISATION

Lever type: direct monetary incentive or co-financing requirement			
Lever	Description	Main advantages	Risks and limitations
<b>Co-financing thresholds included in contracts and programming</b>	<p>A specific amount or percentage is included as a contractual requirement or eligibility criterion in global health programmes, tying the disbursement of the funds to the recipient governments' contributions.</p> <p>Examples of this include The Global Fund's funding model launched in 2013,<sup>xxi</sup> or other matched funding mechanisms including those used by The Global Fund<sup>xxii</sup> or the BMGF for family planning commodities. The Global Fund for example includes co-financing requirements (whereby to access a Global Fund allocation, countries have to demonstrate progressive government expenditure on health and progressive uptake of key programme costs) and co-financing incentives (whereby at least 15 per cent of a country's allocation is an incentive made available if countries make and realize additional domestic commitments over the grant implementation period).<sup>xxiii</sup></p>	<p>Contractual requirements and thresholds create a direct powerful incentive to allocate domestic resources towards an agreed intervention and can be easily monitored and measured.</p> <p>For commodities-focused programmes, these types of levers can seek to ensure availability of commodities to sustain the expansion of coverage for sexual and reproductive health services while the country works towards generating sufficient domestic revenues. Procurement of supplies with contribution metrics is an in-kind front-loaded investment, often combined with technical assistance and policy support (such as in the case of the UNFPA Supplies Partnership).</p>	<p>Co-financing requirements create strong incentives but can skew the weight of priorities, altering the directionality of domestic investments. If the incentive is too strong it can push domestic resources towards items linked to co-financing requirements, resulting in domestic funding being diverted from other priority areas. This can be a risk to health systems' performance because domestic resources tend to cover recurrent costs, such as salaries and other system-strengthening costs, while in sexual and reproductive health many of the co-financing requirements focus for example on commodities. In-kind donations and procurement can cause domestic market distortions or generate perverse incentives including deprioritization of domestic (or private sector) investments in that area.</p>
	<p>This is a subset of the previous lever, used especially for sexual and reproductive health commodities and supplies. It applies co-financing requirements (most frequently in monetary value or a percentage of stock to be paid for) to the direct supply of commodities.</p>		

xxi See The Global Fund. (2013). Global Fund Launches New Funding Model: <https://www.theglobalfund.org/en/news/2013-02-28-global-fund-launches-new-funding-model/>

xxii See The Global Fund website, Catalytic Investments: <https://www.theglobalfund.org/en/funding-model/before-applying/catalytic-investments/>

xxiii See The Global Fund website, Co-Financing: <https://www.theglobalfund.org/en/funding-model/throughout-the-cycle/co-financing/>

Lever type: direct monetary incentive or co-financing requirement			
Lever	Description	Main advantages	Risks and limitations
<b>Blended financing, loans or sustainable debt</b>	<p>Blended finance can be defined as the “strategic use of public or philanthropic resources to mobilize new private capital for development outcomes”.<sup>43</sup> In global health, this refers to using public sector funding (including foreign assistance) in ways that help overcome barriers to private investments in healthcare systems in low- and middle-income countries.<sup>44</sup> Sustainable debt refers to different financing mechanisms designed to encourage domestic financing for health by converting debt repayments into domestic investments in health. They include initiatives to reduce or cancel debt for countries if they invest a certain percentage of their gross domestic product or national budget in health, or reach agreed health targets, or commit to earmark certain amounts to specific areas.</p>	<p>An example of debt swap is the Debt2Health initiative between Spain, The Global Fund and three African countries.<sup>xxv</sup> The BMGF has also conducted debt buydown to allow countries to spend more on social sectors including health.<sup>xxv</sup></p> <p>The Global Financing Facility (GFF) is one of the largest initiatives in sexual and reproductive health to include blended financing elements: it combines grants from the GFF Trust Fund with World Bank loans, while also facilitating the alignment of external financing and private sector investments against national priorities as defined in investment cases. The blended financing allows countries to front-load investments, while other financial reforms are implemented to generate more revenues. These levers are often used alongside other mechanisms to improve spending efficiency, targeting or attracting other investments from the public or private sector.<sup>xxvi</sup> The World Bank for example often links them to results-based financing to better target spending towards priority areas and improve the monitoring of investments.</p>	<p>Increasing debt to finance health can have unintended consequences on public spending both in the short term as well as the medium to long term. Funding health through debt does not automatically lead to an overall increase in resources allocated to health or sexual and reproductive health and rights. It could just lead to funding from other sources previously used for health being diverted, leaving the overall envelope unchanged.</p>

xxiv Under the Debt2Health initiative the government of Spain waives debt owed by Cameroon, the Democratic Republic of Congo and Ethiopia in exchange for investments in domestic health programmes supported by The Global Fund. See The Global Fund. (2017). Three African Countries and the Global Fund Launch New Debt2Health Initiative: <https://www.theglobalfund.org/en/news/2017-11-29-spain-three-african-countries-and-the-global-fund-launch-new-debt2health-initiative/>

xxv For an example of the use of debt buydown for polio eradication efforts, see Japan International Cooperation Agency. (2014). JICA signs innovative financing agreement with Gates Foundation for polio eradication in Nigeria: [https://www.jica.go.jp/usa/english/office/others/newsletter/2014/1409\\_10\\_02.html](https://www.jica.go.jp/usa/english/office/others/newsletter/2014/1409_10_02.html)

xxvi See, for example, Thwin, A. A. and Sharma, P. (2019). Mobilizing private capital for health, in World Bank Blogs: <https://blogs.worldbank.org/health/mobilizing-private-capital-health>



Lever type: direct non-monetary incentive			
Lever	Description	Main advantages	Risks and limitations
<b>Health sector specific grants and foreign aid</b>	Foreign aid programmes that directly fund sexual and reproductive health and rights interventions or results, or that add resources to other health sector areas.	Grants and ODA can increase resources available for sexual and reproductive health and rights directly or indirectly by supporting other health sector areas and 'freeing up' domestic resources for sexual and reproductive health and rights.	High-level dependency for certain areas or items (such as reproductive health commodities) on ODA can skew domestic investment priorities and allocative decisions.
<b>Programmatic non-monetary targets and indicators</b>	Indicators on health outcomes, health services and quality, included in monitoring and evaluation frameworks, can be linked to monetary measures. They can be agreed to for example by department heads within ministries, or as part of donor programmes, including budget support and multilateral programmes.	Identifying indicators allows targeting the focus of investments and interventions, providing varying degrees of granularity in targets to respond to specific needs. It also shifts the focus of investments on results without being prescriptive on 'how' to achieve them, thus promoting autonomy in the choice of strategies, for example between health districts. In contexts where public financial management rules or contracts allow for it, this can help health authorities adjust spending if they see that an intervention is not having the expected impact, and fund a different one. These indicators often include an incentive towards transparency and data use which can help justify increased domestic investments.	Depending on the way such targets and indicators are used, they can have limited power to influence spending, especially when they relate to areas not perceived as a priority by decision-makers or are used in contexts where budgeting and planning for sexual and reproductive health and rights are not closely aligned and the budgeted interventions are insufficient to achieve the programmatic targets. The power of targets as incentives for investments can decrease in cases where there is limited data availability or poor data quality, or where monitoring of targets' achievement is inconsistent and not linked to accountability measures.
<b>Global commitments on sexual and reproductive health and rights</b>	Like the previous lever, this includes high-level targets and indicators, but is linked to high-level or global commitments rather than individual programmes. Commitments are often agreed to in high-level meetings, involving heads of states or ministers. FP2020/FP2030 is an example of a partnership seeking global commitments for family planning, which are defined at country level and monitored jointly by an international secretariat or hub.	Global commitments can incentivise investments in specific sectors or targets, by generating competition or pressure both between countries and within national governments. They can also generate momentum for increased external investments or support in the sector/target areas. Global commitments can be linked to other incentives and monetary targets (such as co-financing thresholds).	While global commitments can create political momentum or pressure for increased investments in sexual and reproductive health (clear directionality), the frequent lack of binding measures limits the strength of these incentives, especially when they are not accompanied by additional measures.

Lever type: direct non-monetary incentive			
Lever	Description	Main advantages	Risks and limitations
<b>Diplomacy</b>	Diplomacy encompasses a wide range of soft-power measures, from high-level dialogue between a head of mission and a minister of health, and international negotiations to day-to-day technical assistance and policy dialogue at country level.	It can be tailored to specific objectives, messages and strategies, can be course-corrected based on the effects, and it can be applied in both public negotiations and private dialogue. It can introduce additional conditionality, not explicitly included in contractual agreements, or set the agenda for partnerships and investments.	Especially when used in bilateral settings, policy dialogue in sexual and reproductive health and rights can be affected by the broader relationships between two countries, including negotiations in other sectors.
<b>Technical assistance</b>	Technical assistance here is considered only to the extent that it relates to domestic resource mobilisation and levers donors can use to incentivise it. As such, it can include a wide range of interventions supporting a broad range of sexual and reproductive health and rights-related aspects. It can also include dedicated support for the implementation of health financing or fiscal reforms that accompany a funding stream for health or sexual and reproductive health and rights at national or sub-national level.	Technical assistance often complements other levers, such as external financing or global commitments. It offers flexibility to test reform options and their results and adapt monetary levers to the country-specific context. For sexual and reproductive health in particular, it has been used for example in results-based financing programmes, or to support purchasing reforms, or the inclusion of sexual and reproductive health services in health insurance benefit packages. It has also been used to combine technical expertise in service delivery and financing, supporting country-level governments to design and implement reforms and mobilise revenues for them.	Technical assistance can create adverse incentives and lead to reprioritizations based on both the funding and the focus of the technical assistance itself. This happens for example when the programmatic or financial priorities of the technical assistance are not aligned to national priorities. Technical assistance can reduce national authorities' 'ownership' on financial decisions and choice of interventions to be funded, creating parallel or informal information flows that can affect allocative decisions. It can also create dependency for specialised functions, especially when associated with external funding streams that are disbursed through parallel systems.

Lever type: indirect improvement of fiscal space			
Lever	Description	Main advantages	Risks and limitations
<b>Public financial management reforms</b>	Usually led by the Ministry of Finance or Treasury, they determine how public funding can be used, disbursed and managed.	They could for example grant health facilities more autonomy to manage their resources, including keeping revenues from user fees, which could better allow facility managers to adjust the way sexual and reproductive health services are funded and delivered based on the specific needs of the population they serve. Public financial management reforms could mean changes in the disbursement rules that allow for budgets to be disbursed in different ways or in a timelier manner, reducing wastage or underspend, or they could include changes in the procurement rules.	Such reforms are not specific to sexual and reproductive health and rights and do not have direct consequences on the choice of increasing the share of domestic resources for them. They can create favourable conditions for increased or more efficient spending on sexual and reproductive health and rights and remove barriers on both the demand and supply side, but alone are not sufficient to increase domestic investments for sexual and reproductive health and rights.
<b>Fiscal policy or reforms</b>	They refer to the adjustment of a country's spending levels and tax rates to monitor and influence the economy. They are usually led by the Ministry of Finance or Treasury.	They can directly increase the fiscal space for health, and indirectly increase the possibility for additional investments in sexual and reproductive health and rights. They can also contribute to cross-subsidisation (such as in the case of national health insurance funds) or redistribution of wealth across income groups.	
<b>Health financing reforms</b>	They can refer to comprehensive revisions to a country's health financing strategy, the introduction of an insurance scheme, or discrete changes in any of the three functions of revenue collection, pooling, and purchasing.	A financing reform can directly address barriers or bottlenecks that affect sexual and reproductive health and rights by for example changing the way providers are paid for the provision of selected services, by prioritizing measures that remove demand-side financial barriers to access to services (such as the provision of free services for adolescents), or by defining a realistic roadmap to gradually increase available funding for the expansion of the service package being provided to the population.	When health financing strategies are not linked to broader fiscal policies, they can remain on-paper only or not translate into concrete changes for front-line health providers, limiting their effectiveness. Health financing strategies also tend not to include specific health areas to be funded, so would not include specific references to sexual and reproductive health and rights.



## Country-level domestic resource mobilisation mechanisms

### **The mechanisms that countries can employ to increase investments in sexual and reproductive health and rights**

include resource mobilisation mechanisms and other non-financial mechanisms needed to create an enabling environment for the promotion of sexual and reproductive health and rights (see Table 2). These enabling environment interventions often are prerequisites for investments.

**Countries can raise revenues through taxation, borrowing or attracting investments.** What is important is how these mechanisms are combined and how they are implemented, taking into account equity<sup>45</sup> and poverty considerations.<sup>46</sup> The objectives of resource mobilisation mechanisms in fact are not simply about collecting more revenues but should include building a strong tax system able to sustain revenue raising in the long term by adapting to the changes in macroeconomic conditions in the country.

Tax reforms relate to both tax policy and tax administration.<sup>47</sup> Reforms can include increasing the types of taxes, broadening the tax base, increasing the rates for existing levies, introducing earmarked taxes, or measures to increase tax compliance (reducing avoidance and evasion). Looking at the health sector, domestic revenues commonly rely on general public revenues, household contributions (for both taxes and direct payments, such as user fees), external on-budget funding, and borrowing.

**General public revenues** may come from direct or indirect taxes and public enterprise revenues (such as those linked to oil production). Direct taxes are those levied on income or wealth (such as personal or corporate tax), whereas indirect taxes are levied on items consumed by households (such as VAT for goods and services). The main equity consideration here is that direct taxes are generally progressive (as the amounts due in tax increase as the income increases) while indirect taxes are regressive as they disproportionately affect those who have a lower income. Because indirect taxes are easier to implement, low-income countries tend to raise most tax revenues from taxes on goods and services,<sup>48</sup> making the prospect of further increasing them to generate more revenues a serious equity concern. Broadening the income tax base in low- and middle-income countries can be possible, by recognising the importance of direct taxes for higher revenues, increasing equity in taxation, and establishing mechanisms to collect revenues from those employed in the informal sector.<sup>49</sup>

**However, unless the revenues are used through budgets that have a clear pro-poor objective and a health financing system that prioritizes sexual and reproductive health in the health benefit package, the benefits of more domestic resources will not materialise.** Public financial management reforms and strong priority-setting systems and purchasing arrangements therefore are essential steps in ensuring that revenues mobilised are then spent on high-impact interventions, reaching the intended population groups and at the right time.

Irrespective of the revenue source, **domestic resources can be mobilised by reprioritizing them towards health**, from another sector for example. This can happen through an increased budget ceiling for the Ministry of Health, or by allowing decentralised authorities to directly fund health. However, studies have shown that the scope for reallocation in the short to medium term is very limited, and only countries with very small health budgets to begin with have been able to increase allocation to health this way.<sup>50</sup> The tendency to rely on ‘historic budgets’ (that is allocating amounts based on previous years’ allocation or spending) is both a cause and effect of the disconnect that exists between programmatic and financial planning in health. It means that even when a sexual and reproductive health strategic plan, or specific target, is developed based on need or intended outcomes, costed, and approved it is rarely translated into annual budgets that are disbursed in a timely manner. This is why public financial management and health financing functions must work together to ensure efficient use of the mobilised resources.

**Earmarking** tends to be proposed as a solution for specific health investments because it can create visibility for sexual and reproductive health and rights spending where budgets (line-item ones especially) do not provide any. Earmarking means separating all or a portion of revenues – overall or from a selected tax or group of taxes – and setting them aside for a designated purpose. The findings from an extensive review done by Cashin and colleagues<sup>51</sup> suggest that the results of earmarking for health are highly context specific and dependent on a country’s political priorities and budget process. In some cases, it has been an effective mechanism to raise some revenues in a short amount of

time (for example when South Africa had to fund part of its HIV response domestically, or when Ghana was looking to expand its National Health Insurance Scheme). In most cases however it did not bring a significant and sustained increase in health spending. Budget allocations are easy to change so earmarking to health one source of funding, for example a tax, can be met with a reduction in the share allocated to health from other revenue sources, leaving the overall available amount unchanged or at times reduced. An additional risk of earmarking that is important to flag, as it can manifest when earmarked revenues are used to purchase specific services, is that it can introduce rigidity in the budget process, by preventing health authorities, for example, from adapting their spending based on the needs of or different realities in health facilities, which can lead to inefficiencies and wasted resources.



When talking about increases in sexual and reproductive health budgets, it is important to consider budget formats and purchasing arrangements (for further details on purchasing see Section 5), particularly because of the different definitions and the tendency to aggregate, under the same programme or department's budget, sexual, reproductive, and maternal health services. **Strategic purchasing reforms** have been used in the last decade to create closer and more visible links between funding allocated to health and the health services purchased (and then provided) with that funding. Strategic purchasing with general budget revenues involves linking the transfer of funds to providers, and, at least in part, to information on aspects of their performance and the health needs of the population they serve.<sup>52</sup> This can be done for sexual and reproductive health services, for example, by making an explicit list of services to be provided at each level of the health sector and assigning budgetary amounts to each along with a set of indicators to monitor performance. Another

example is contracting accredited private sector facilities to provide specific sexual and reproductive health services.

To conclude the country-level overview, and to tie the expansion of sexual and reproductive health services and rights back to the broader context of progress towards universal health coverage and the financing measures needed for that, it is important to mention efficiency of spending once again. Without a clear **efficiency agenda**, revenues mobilised will not yield the intended results. An efficiency agenda includes measures to enable the better and more flexible use of funds (such as through public financial management reforms), for example by enabling providers to directly manage all their funds, including not just user fee revenues but also general budgets.<sup>53</sup> From a revenue perspective, efficiency measures that produce better spending (including for example increased execution rate of available budgets) can influence the fiscal space for sexual and reproductive health and rights. A well-spent budget and clearly communicated results can support budget negotiations within ministries of health (to prioritize sexual and reproductive health within health) and with ministries of finance (to prioritize health among other national spending options).





TABLE 2. SUMMARY OF DOMESTIC RESOURCE MOBILISATION MECHANISMS – MOBILISING REVENUES OR ENABLING ENVIRONMENT

Domestic resource mobilisation			
Focus	Mechanism	Possible role in sexual and reproductive health and rights	Main risks
	<b>New taxes</b>	Revenues from taxation have to be allocated to line ministries and then to specific interventions or sub-sectors. An increase in public revenues does not directly mean increased investments in sexual and reproductive health and rights but can create the conditions for it.	Income tax is the most progressive form of taxation and allows for income cross-subsidisation. It is a sustainable funding source and its allocation can be flexibly adjusted based on need and priorities. However, allocation to sexual and reproductive health and rights is linked to political decisions made at each budget cycle, including parliamentary approval.
	<b>Increased share of budget for sexual and reproductive health and rights components</b>	Reaching an increase for sexual and reproductive health and rights components in a budget depends on both the fiscal space in the country and political priorities.  Once an increased allocation for sexual and reproductive health and rights has been decided, how it will manifest depends on the budget format (e.g. line item, output, or programme based). Where investment visibility is limited, earmarking or dedicated budget lines can be used to mitigate that, but it is harder to include specific sexual and reproductive health and rights references in a line-item budget for example.	Electoral and budgetary cycles can affect the amounts allocated to specific areas, economic crises can influence willingness and ability to increase investment, and visibility of these changes depends on the budget format. The main risk in increasing the allocation to sexual and reproductive health and rights in one budget cycle is the 'substitution effect' where funding already allocated to health is moved from one area to another without an increase in the overall share of public spending allocated to the sector and reversal of allocations in subsequent fiscal years.
	<b>Earmarking</b>	A specific amount or revenue stream could be earmarked for sexual and reproductive health services. This would enable revenue protection for sexual and reproductive health services, create a closer link between taxes and services, which can increase public support for them, and improve cost-awareness and accountability. It could allow for the revenues to remain off-budget thus increasing their flexibility and efficiency in spending because of the more direct link between spending and services.	The allocation of the protected revenue can be changed away from sexual and reproductive health. Earmarking for sexual and reproductive health also fragments the health budget risking the creation of a silo for sexual and reproductive health, which coupled with budget rigidity could prevent the government's ability to respond to changes in need or revenues. Earmarked streams can be unpredictable or inconsistent, reducing the government's flexibility to manage a downturn, for example, leaving service continuation at risk.
	<b>User fees</b>	From a revenue generation perspective, fees can provide a flexible revenue stream for a service provider to reinvest in the facility and respond to specific needs (for example procuring additional commodities when stocks are low), but only when providers are allowed to keep the revenues instead of returning them to treasury.	From a service access perspective, direct payments at the point of use create severe barriers to access to sexual and reproductive health services, especially for women in lower income quintiles or with inconsistent or seasonal income.
	<b>Borrowing</b>	Blended finance and borrowing have become more common in health in recent years, the GFF being a main example. Borrowing allows for large and rapid increases in fiscal space and can 'buy time' to provide services while longer term sustainable financing reforms come into effect.	Borrowing, even at low interest rates, to cover sexual and reproductive health services costs, which are mainly recurrent, can be risky especially for low-income economies. The crowding-in of private sector investments that was expected from the GFF, for example, has not happened to the extent intended. <sup>54</sup>

Focus	Mechanism	Possible role in sexual and reproductive health and rights	Main risks
Domestic resource mobilisation	<b>Efficiencies</b>	<p>Efficiency measures can ensure the optimal mix of health services and goods, and incentivise performance improvements. Allocative efficiencies, in particular, refer to the way funding is allocated to maximise intended outputs in sexual and reproductive health and rights. They are included here, among domestic resource mobilisation mechanisms, because by reducing wastage they can increase the amount of available funding. Examples can include prioritization processes to decide how and which interventions are being funded, how providers are paid for sexual and reproductive health services, or how services are delivered.</p> <p>They can free up existing resources to be used for more effective interventions and can be a necessary condition to make a successful case for increased funding, for example during budget negotiations. The alignment between public financial management and health financing functions is critical to ensure efficiency of spending,<sup>55</sup> including spending autonomy for facility managers.<sup>56</sup></p>	<p>Efficiency gains free up existing resources but do not, alone, directly lead to the mobilisation of additional resources or their allocation to sexual and reproductive health and rights. Amounts gained through efficiency (or 'not-wasted') do not explicitly contribute to the co-financing amounts required for example in multilateral funding mechanisms (including The Global Fund, GAVI, or the GFF). This creates a negative incentive for national governments to improve efficiency when under pressure to demonstrate additional funding from donors. Including efficiency incentives among the domestic resource mobilisation levers in donor programmes could mitigate some of the risks of focusing only on increasing revenues and help reduce wastage.</p>
	<b>Improved macroeconomic conditions</b>	<p>Health authorities have no control over macroeconomic conditions, but an overall increase in available public revenues could create favourable conditions for targeted increases in sexual and reproductive health and rights spending, for example by increasing the sexual and reproductive health budget, or by creating special funds for sexual and reproductive health by pooling a percentage of total revenues or gross domestic product, or contributing that percentage to an existing fund – such as an insurance – to cover sexual and reproductive health services specifically.</p>	<p>There are no examples to date of a <i>direct</i> connection between improved macroeconomic conditions and sexual and reproductive health and rights spending. Like a favourable enabling environment, positive macroeconomic conditions are necessary for a significant increase in public spending, but they cannot alone ensure that spending is directed towards sexual and reproductive health and rights.</p>

Focus	Mechanism	Possible role in sexual and reproductive health and rights	Main risks
Enabling environment	Inclusion of sexual and reproductive health services in essential services lists	<p>Including sexual and reproductive health services in essential services lists or benefits packages is an essential prerequisite to being able to allocate funding towards them, can increase visibility on service entitlements, and more closely link funding to services.</p> <p>For example, the inclusion of family planning and medical abortion in essential services lists during the COVID-19 pandemic were critical steps to ensure that provision continued and to prevent the diversion of funding to other services.<sup>57</sup> In countries where not all sexual and reproductive health services were included in the essential services list, service provision stopped or funding was redirected.<sup>58</sup></p>	<p>The inclusion in such lists does not guarantee the allocation of sufficient funds to provide the services and reach all those who want to access them. New insurance agencies, for example, do not have strong processes to develop and gradually expand benefits packages, which can mean that services are included but the funding allocated is not sufficient, resulting in services not being available or lacking quality.</p>
	Inclusion of sexual and reproductive health services in universal health coverage or insurance benefits packages		
	Policy and financing reforms (enabling environment for sexual and reproductive health and rights priorities)	<p>This includes a wide range of interventions and reforms, from the development of health workforce curricula to the adoption of legislation decriminalising abortion. They can create the conditions to put sexual and reproductive health and rights issues on the agenda and into budgetary discussions, expand the space for the enjoyment of sexual and reproductive rights, and promote social norms change.</p> <p>This can also include health financing strategies that set up a framework, for example for private contributions to be made in an equitable way that contributes to filling the funding gap, rather than diverting scarce resources towards higher income groups; or define an efficiency agenda. Without an enabling environment for sexual and reproductive health and rights, direct incentives to increase investments cannot have the intended effect or sustain it over time.</p>	<p>This is a prerequisite for financial decisions (on mobilisation of resources, allocation, and spending) but not by itself sufficient to ensure additional investments.</p>



## 4. European donors: a closer look

European donors provided €2.614 billion of funding for sexual and reproductive health and rights in 2020.<sup>59</sup> European donor funding contributes to global initiatives including Gavi, the Vaccine Alliance, the Global Financing Facility (GFF) and The Global Fund to Fight AIDS, Tuberculosis and Malaria, all of which aim to incentivise domestic resource mobilisation through technical assistance, co-financing conditions, and financial support to assess feasibility of financing reforms and initiatives, such as the introduction of new tax revenue streams. Bilateral funding is also used to support domestic resource mobilisation through tax reform, improved public financial management, and initiatives focused on the health sector, including strengthening accountability around the budget and planning process.

Mapping the ways in which European donor governments seek to support and incentivise domestic resource mobilisation is critical to understanding how resilient sexual and reproductive health services are in the face of declining external funding, and what opportunities there are to further support and incentivise domestic resource mobilisation. Both at country and global level, advocates can play a significant role in collating evidence and improving understanding of funding flows and mechanisms used for sexual and reproductive health and rights by different donors.

European donors intervene in the sexual and reproductive health and rights space in different ways: from development cooperation or foreign affairs ministries, by holding seats in multilateral organisations and initiatives, and through in-country diplomatic missions. A political economy analysis of each European donor would begin by presenting a heterogeneous group of stakeholders both within and across the three levels. The institutional arrangements and budget distribution of the global health portfolios within each donor government (for example, which ministry oversees the global health budget or how development and humanitarian programming is managed) determine the scope, size, and type of engagement with each investment. Sexual and reproductive health and rights experts in donor ministries are in most cases not directly involved in decisions on domestic resource mobilisation incentives for specific partner countries but they may contribute to global negotiations around multilateral mechanisms that include domestic resource mobilisation incentives in their funding models. Experts in diplomatic missions may be involved in domestic financing reform

processes or implementation of sexual and reproductive health and rights interventions, but do not have the ability to influence high-level decisions made on domestic resource mobilisation incentives and expectations set by their ministry. There are also varying degrees of alignment on domestic resource mobilisation expectations between political and technical officials within donor governments.

Typically, experts at ministry level tend to define sexual and reproductive health and rights priorities and strategies and contribute to overall budget preparation and monitoring for the donor's sexual and reproductive health and rights portfolio. They also participate in or engage with global initiatives and partnerships. Experts in missions manage the country funding portfolio and implementation, as well as engage with partners in the country, from government to civil society organisations and implementing partners. Soft-power incentives can be very effective at this level, both to promote an enabling environment for sexual and reproductive health and rights components that are less accepted or prioritized in domestic investments, and to influence policy decisions.

European donors have different expectations for and roles in domestic resource mobilisation for sexual and reproductive health and rights. These differences are not limited to different donor governments but include heterogeneous perspectives among different officials within each government, technocrats, and politicians. From a sexual and reproductive health and rights perspective, domestic resource mobilisation tends to be seen as closely linked to donors' contribution to multilateral initiatives (such as The Global Fund or the GFF) and to the work done by their experts in-country, through technical assistance or diplomacy. The organisational structure of each donor government determines the extent to which programmatic priorities for sexual and reproductive health and rights and financing objectives, such as on domestic resource mobilisation, are connected. For example, many donor governments have different teams working on financing and sexual and reproductive health and rights. One team defines health financing priorities or participates in global partnerships to stimulate domestic resource mobilisation, while others define and manage the sexual and reproductive health and rights portfolio. In the sexual and reproductive health and rights portfolio, financing elements tend to be determined by the mechanisms funded, such as the GFF or the UNFPA Supplies Partnership, or the bilateral agreements

made at country level (such as in the case of budget support). Furthermore, technical experts tend to highlight the importance of spending efficiency and of government ownership or responsibility for their sexual and reproductive health strategy and investments. However, these issues are not always linked to the donor governments' broader strategies or objectives for ODA and foreign assistance.

Within the spectrum of sexual and reproductive health and rights priorities for European donors, some countries link sexual and reproductive health more closely to the health sector, while others see it as more linked to gender equality and adopt a more holistic approach, looking to address people's sexual and reproductive health and rights needs beyond direct service delivery. Experts in different donor governments warn against the frequent reduction of sexual and reproductive health and rights to family planning, including in media narratives and multilateral mechanisms. Improving availability of disaggregated data on funding and outcomes across the spectrum of sexual and reproductive health and rights interventions can provide a common language, increase visibility on commitments and their realization, and contribute to a better understanding of the remaining gaps.

The COVID-19 crisis, with reduced fiscal space in both donor and partner countries, has brought a renewed focus on efficiency and prioritization of investments. For example, the Access to COVID-19 Tools (ACT) Accelerator,<sup>xxvii</sup> set up to help coordinate the response to the COVID-19 pandemic, includes an investment case and budget,<sup>60</sup> and a systems strengthening connector. The systems strengthening connector has led country-level rapid assessments on service disruption and readiness and has a strong focus on efficient use of health resources. It is also in the context of the Accelerator that donors are discussing domestic resource mobilisation alongside concepts such as 'national ownership', 'national responsibility', 'efficient use of resources', and 'innovation'. European donors participate in and fund such new COVID-19-related mechanisms. This offers an opportunity for advocates to ensure sexual and reproductive health and rights priorities are embedded in the emergency responses and that broader financing interventions (such as strengthening public financial management to reduce wastage) are not exclusively targeted at the COVID-19 response. For example, the Accelerator push to track spending on key COVID-19 response elements can be leveraged by sexual and reproductive health and rights advocates at global and country level to promote financial data transparency, or to make the case for routine expenditure monitoring that links financial data to service delivery and health outcome indicators.

xxvii See World Health Organization, The Access to COVID-19 Tools (ACT) Accelerator: <https://www.who.int/initiatives/act-accelerator>



# 5. Domestic resource mobilisation at country level

## Key actors and financing functions

Health authorities usually have direct control over pooling and purchasing functions, and partial involvement in revenue collection, with Ministries of Finance or Treasuries defining the mechanisms through which revenues are collected and the overall amount of public funding that is allocated to the health sector.<sup>61</sup>

**Finance authorities** and other government agencies define the policies and regulatory frameworks for domestic resource mobilisation, as well as the systems and rules on how to spend those resources (for example public financial management rules). **Health authorities**, on the other hand, can influence the reprioritization of health or the choice of resource mobilisation mechanisms to leverage favourable macroeconomic conditions, but do not have any independent decision-making power in these areas. Health authorities could promote or request the use of sector-specific revenue sources (for example by presenting a proposal for an insurance policy or earmarked taxes or requesting to keep user fee revenues at the facility level) but again would not be able to implement them without approval and the necessary changes to the country's fiscal policy and spending plans. The two functions health authorities have more control over, though again not completely unchecked, relate more to the use of resources than mobilisation. However, if pooling and purchasing arrangements are defined and operationalised so that resources are efficiently used (including spending the available budget in a timely manner and on the planned activities), health authorities can leverage that in budget negotiations the following fiscal year and advocate for additional resources either from existing or new revenue sources (reprioritization and sector-specific revenues).

There is also a clear **equity element** to domestic resource mobilisation and the ways in which funding for health is collected. Funding mechanisms are not neutral: they affect different population groups' income, health-seeking behaviours, and service use. For low- and middle-income countries to progress towards universal health coverage that ultimately includes access for all people to a comprehensive package of sexual and reproductive health services, it is essential that health systems move away from direct payment at the point of use and towards mandatory prepaid pooled funds.<sup>62</sup> This shift requires coordinated actions from finance and health authorities at country level, and supportive and aligned global mechanisms to promote high-performance health financing.<sup>63</sup>

Global health programming and investments can interact at different levels with both finance and health authorities. An example of this is the GFF, where health authorities and technical assistance providers tend to be involved in the development of investment cases or programmatic targets and interventions, but then it is Ministries of Finance or similar agencies who negotiate the terms of World Bank loans, including how they will be spent, and then determine the envelope of domestic resources to be allocated to the Ministry of Health in the national budget.



## HEALTH FINANCING FUNCTIONS OVERVIEW

Domestic resource mobilisation influences the amount available for health and who contributes to it. In most countries finance authorities have decision-making powers on broad resource mobilisation strategies, while health authorities have more control over the three health financing functions.

**The financing functions** manage the resource envelope that has been defined for the sector, from how funding is collected from each source to how services are paid for.

**1. Revenue collection**<sup>xxviii</sup> is the financing function in a health system that interacts more directly with domestic resource mobilisation. It refers to the source of funds for healthcare, indicating:

- who healthcare contributions are collected from (for example employers' contributions, share of general taxation, or user fees)
- how those contributions are structured (for example proportional to income, as a percentage of the overall bill up to a capped amount)
- which organisations collect them (for example an insurance agency, a tax revenue authority or a healthcare provider)

The macroeconomic conditions, the political choice to prioritize health within the national budget, and sector-specific revenue sources influence the scope for resource mobilisation mechanisms that can be used in a country, and this in turn will determine whose contribution can be collected and how. It is important to highlight how these three concepts are interdependent and how decisions made on each one of them have direct implications for the others. For example, if a decision is made in the health sector to reduce or remove user fees for sexual and reproductive health services, the health authorities and the national

government need to identify mechanisms to mobilise additional resources to fill the gap. If the existing mechanisms are not enough, broader economic and fiscal changes will have to be made by the financial authorities, for example by allocating a higher share of existing public revenues to health or by introducing new taxes.

**2. Pooling** is both an instrument and an objective of financing policy: an instrument as it describes for example the way in which prepaid funds are accumulated, and an objective as it pools the risk of falling ill and having to pay for medical care and spreads it over time and across a group of people as diverse and numerous as possible. For risk pooling to work individuals have to contribute on a regular basis to a pooled fund and when they fall ill the fund covers their costs, relying on the fact that not all people will fall ill at the same time. Funds can be pooled from revenues collected in different ways, from insurance to general taxation.<sup>64</sup>

**3. Purchasing** is the process through which the pooled funds are transferred to healthcare providers to ensure that the selected package of services is available to the population. This is the financing function where, for example, decisions are made about the definition of sexual and reproductive health and which services it includes, the cadres and types of facilities allowed to provide specific services, the way in which providers are paid for those services (which in turn has direct consequences, for example on stock availability), and who can access them at what cost (for example whether post-partum contraception is offered for free to women who have delivered in a public or contracted health facility).

All three financing functions have a direct impact on equity, demand for and access to services, and the protection households have from unexpected medical expenses (referred to as 'financial protection'), and their merits have been covered in detail elsewhere.<sup>65,66,67</sup>

xxviii The description of the three financing functions is built on Smith, R. D. & Hanson, K. (2012). Health systems in low and middle income countries. An economic and policy perspective. Oxford University Press.

# Conclusions and recommendations

Donors and global health initiatives can use different levers to incentivise domestic resource mobilisation for sexual and reproductive health and rights. These levers span from direct monetary incentives and contractual requirements for domestic investments in sexual and reproductive health and rights, to direct non-monetary incentives such as indicators related to sexual and reproductive health and rights, and indirect interventions that influence the policy environment for sexual and reproductive health and rights, or the fiscal space for health, or the country's ability to allocate and spend funding. Bilateral and multilateral programmes can include different types of levers and apply them differently. Each lever offers opportunities for investments in sexual and reproductive health and rights and carries some risks, as summarised in Section 3, and their impact is ultimately dependent on how the target government responds to said incentives and the broader country context in which they are applied.

Levers with stronger monetary incentives, often used to target specific sexual and reproductive health and rights components, such as co-financing requirements or earmarking, can increase visibility on resources allocated or spent, facilitate monitoring, and increase allocation in the short term. However, to ensure the increased investment is sustained over time it needs to result in an increased overall health envelope. This means mitigating the risk of finance authorities defunding other health priority areas that are not impacted by co-financing requirements or reducing health funding from other non-earmarked sources. General health financing or fiscal space reforms on the other hand tend to have longer lasting effects and can improve the overall conditions for health allocation and spending, including improving efficiency. But if they are not combined with other direct incentives for sexual and reproductive health and rights (for example programmatic indicators on outcomes or service use) they may not result in additional domestic resources being allocated or spent for sexual and reproductive health and rights.

Blended financing mechanisms can quickly expand fiscal space for sexual and reproductive health and rights, allowing for a faster expansion of coverage and services, and can be used to stimulate additional investments from the private sector. However, they need to be accompanied by longer term health financing strategies and broader reforms to expand fiscal space in an equitable and progressive way that accounts for the increased debt.

The sexual and reproductive health and rights components targeted by domestic resource mobilisation incentives also tend to vary, with commodities for example being more frequently included in direct monetary incentives and co-financing requirements. Global commitments and programmatic targets can facilitate prioritization within health investments but require strong monitoring systems that link financial and programmatic data to incentivise increased domestic investments. The ability of donor programmes' levers on domestic resources to influence all sexual and reproductive health and rights components depends on both the targeting included in the design of the levers and the typology of budgets and policy space for sexual and reproductive health and rights in the partner country. For example, co-financing requirements tend to be used to increase domestic investments on commodities rather than promote legislation to prevent gender-based violence. At country level, aggregate budget formats and the frequent distribution of responsibilities for sexual and reproductive health and rights components between different ministries and agencies contribute to limit the directionality of individual levers. Donors can mitigate those risks by including a combination of levers in programme designs and tailoring their application in each context through country dialogue with health and finance authorities.

The fragmentation of responsibility for sexual and reproductive health and rights components and the presence of multiple incentives on domestic financing at country level call for particular attention to the equity implications of the financial mechanisms chosen to fund sexual and reproductive health and rights. User fees remain one of the main funding sources for sexual and reproductive health services in low- and middle-income countries without large pooling systems. Longer term planning and systems approaches can help donors and country governments jointly plan for the progressive increase in domestic funding and donor transition in a way that allows for the continuous expansion of the services package funded through public sources as well as of the population coverage.

Longer term planning and systems approaches are also required to ensure that all sexual and reproductive health and rights components are equitably funded and universally available, whether they fall under the responsibility of the health or justice ministry or are delivered by different agencies and providers. Embedding sexual and reproductive health and rights into national priorities and strategies creates a

stronger case to ensure investments and services are also protected during crises. Donors and advocates can play a role in keeping sexual and reproductive health and rights priorities on the agenda. Donors in particular can leverage adaptive programming and combine monetary and non-monetary levers to support a realistic and consistent improvement, not just increase, in domestic investments targeted at expanding access to sexual and reproductive health and rights. This should include responsive indicators to measure spending efficiency, the alignment between sexual and reproductive health and rights strategic plans, budgets and spending, and the ability to define and fund sexual and reproductive health and rights priorities.

Data quality and availability on sexual and reproductive health and rights priorities and investments remain limited. Domestic budgets do not always disaggregate sexual and reproductive health and rights components, making it difficult to measure and monitor how eventual additional investments have been used. Global initiatives often focus on one component and use monitoring metrics with different definitions or methods. Both domestic and donor financial data are not always published, often available only in aggregate form, or not timely. Donors and advocates can play an important role in improving data transparency, availability, and use. Donors can for example include conditionality in their programmes, such as a requirement for timely release of budget data; the improvement of participatory budgetary processes that include civil society representatives; or the disaggregation of financial data linked to sexual and reproductive health and rights outcomes or programme areas, especially in countries with output-based budgeting formats. Advocates can contribute to generate evidence and priority setting, for example by unpacking interventions and funding streams to highlight sexual and reproductive health and rights components or gaps; develop and use common monitoring methods and tools to promote alignment across donors and in-country; and continue to push for more transparent and disaggregated data on funding streams for all components of sexual and reproductive health and rights.

The COVID-19 pandemic has affected fiscal space in both donor and partner governments, limiting the ability to increase investments across the many competing priorities in health and beyond. As countries move towards the recovery phase, it becomes even more urgent to strengthen the dialogue on domestic resource mobilisation for health, and sexual and reproductive health and rights in particular, and set realistic timelines and targets that leverage opportunities for increased efficiency of existing funding envelopes. Coordinated transition planning between donor and partner governments is key to avoid losing the gains made to date in sexual and reproductive health and rights and to continue expanding the coverage of services and realization of rights.





## Summary recommendations for donors, practitioners, and advocates

1. Maintain a strong link between domestic resource mobilisation, allocation, and spending. This can happen in programme design as well as advocacy messages. Without efficient use of the funds, any effort to mobilise additional resources will not yield the intended results. Linking domestic resource mobilisation to efficient use has three main advantages: 1) it anchors the debate on outcomes and how to use resources to fund intended interventions; 2) it can help free up resources that could otherwise be wasted; and 3) it can help strengthen arguments for prioritization of sexual and reproductive health and rights, and health overall, in subsequent fiscal year budgetary negotiations.
2. Combine different types of domestic resource mobilisation incentives in programme design to allow for country-level adaptation based on health financing structures and strategies, programmatic priorities in sexual and reproductive health and rights components, and broader macroeconomic conditions.
3. Expand dialogue on sexual and reproductive health and rights financing to include broader health advocates and experts, for example by embedding sexual and reproductive health and rights investments in larger donor priorities and commitments, such as on Sustainable Development Goal 3 and universal health coverage, focusing on sustainability of investments and progressive expansion of coverage and rights.
4. Ensure there is a clear and explicit equity focus in the design and application of financing mechanisms and incentives for domestic funding of sexual and reproductive health and rights. This includes for example assessing whether the levers used may contribute to additional regressive taxation in the partner country.
5. Set realistic targets in terms of both financial contribution and time frame. By combining levers to mobilise and better use resources for sexual and reproductive health and rights, engaging with finance authorities and having equity as a key objective of resource mobilisation and use, donors can support countries to reap the benefits of short-term resource mobilisation solutions while investing in longer term fiscal policy reforms.
6. Strengthen the link between programmatic and financial targets in programme design and global commitments for sexual and reproductive health and rights. This requires improved metrics, disaggregated and transparent data on both health and financial indicators at different levels, and programmes that can learn and adapt while remaining accountable for the intended outcomes.
7. Strengthen the enabling environment for the expansion of sexual and reproductive health and rights. Increasing domestic investments is a political decision and it cannot happen in a vacuum. Donors can continue to support creation of an enabling policy and legal environment at global and country level, link financing levers with accountability measures and mechanisms in programme design, and support civil society participation in priority setting and budgeting processes.

# Key abbreviations

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>BMGF</b>	Bill and Melinda Gates Foundation
<b>DAC</b>	Development Assistance Committee
<b>FP2020/2030</b>	Family Planning 2020/2030
<b>GAVI</b>	Gavi, the Vaccine Alliance
<b>GFF</b>	Global Financing Facility for Women, Children and Adolescents
<b>HIV</b>	Human immunodeficiency virus
<b>ODA</b>	Official Development Assistance
<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>SDG</b>	Sustainable Development Goal
<b>STD</b>	Sexually transmitted disease
<b>STI</b>	Sexually transmitted infection
<b>UNFPA</b>	United Nations Population Fund
<b>USAID</b>	United States Agency for International Development
<b>VAT</b>	Value-added tax
<b>WHO</b>	World Health Organization

# Selected references

- 1 The World Bank. (2019). High-Performance Health Financing for Universal Health Coverage. Washington, DC. <https://openknowledge.worldbank.org/bitstream/handle/10986/31930/138096.pdf?sequence=4&isAllowed=y>
- 2 Barroy, H., Sparkes, S. & Dale, E. (2016). Assessing fiscal space for health in low and middle income countries: a review of the evidence. Geneva, World Health Organization. <https://www.who.int/publications/i/item/WHO-HIS-HGF-HFWorkingPaper-16.3>
- 3 Barroy, H., Cylus, J., Patcharanarumol, W., Novignon, J., Evetovits, T. & Gupta, S. (2021). Do efficiency gains really translate into more budget for health? An assessment framework and country applications. *Health Policy and Planning*, 36(8), 1307-1315. doi: 10.1093/heapol/czab040. <https://academic.oup.com/heapol/article/36/8/1307/6225866>
- 4 Barroy, H. & Gupta, S. (2020). From Overall Fiscal Space to Budgetary Space for Health: Connecting Public Financial Management to Resource Mobilization in the Era of COVID-19. Washington, DC, Center for Global Development. <https://www.cgdev.org/publication/overall-fiscal-space-budgetary-space-health-connecting-public-financial-management>
- 5 Barroy, H., et al. (2021). Op. cit.
- 6 Junquera-Varela, R. F., Marijn, V., Shukla, G., Bernard, H., Awasthi, R. & Moreno-Dodson, B. (2017). Strengthening Domestic Resource Mobilization. International Bank for Reconstruction and Development/The World Bank. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/Strengthening-Domestic-Resource-Mobilization-DRC.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/Strengthening-Domestic-Resource-Mobilization-DRC.pdf)
- 7 World Health Organization. (2010). The world health report: health systems financing: the path to universal coverage. Geneva, Switzerland. <https://apps.who.int/iris/handle/10665/44371>
- 8 Kaboré, R. M. C., Solberg, E., Gates, M. & Kim, J. Y. (2018). Financing the SDGs: mobilising and using domestic resources for health and human capital. *Lancet*, 392(10158), 1605-1607. doi: 10.1016/S0140-6736(18)32597-2. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)32597-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32597-2/fulltext)
- 9 Ottersen, T., Elovainio, R., Evans, D. B., McCoy, D., McIntyre, D., Meheus, F., et al. (2017). Towards a coherent global framework for health financing: recommendations and recent developments. *Health Economics Policy and Law*, 12(2), 285-296. doi: 10.1017/S1744133116000505. <https://pubmed.ncbi.nlm.nih.gov/28332466/>
- 10 The Global Financing Facility. (2018). Beating the DRUM in Lower-Income Countries: Domestic Resource Use and Mobilization for SDG3. Oslo. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Beating-the-DRUM-in-Lower-Income-Countries\\_English.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Beating-the-DRUM-in-Lower-Income-Countries_English.pdf)
- 11 Barroy, H., Sparkes, S., Dale, E. & Mathonnat, J. (2018). Can low-and middle-income countries increase domestic fiscal space for health: A mixed-methods approach to assess possible sources of expansion. *Health System and Reform*, 4(3), 214-226. doi: 10.1080/23288604.2018.1441620 <https://pubmed.ncbi.nlm.nih.gov/30081685/>
- 12 Tandon, A. & Cashin, C. (2010). Assessing Public Expenditure on Health From a Fiscal Space Perspective. Health, Nutrition and Population (HNP) discussion paper. Washington, DC, World Bank. <https://openknowledge.worldbank.org/handle/10986/13613>
- 13 Tandon, A., Bonilla-Chancin, M. E. & Bloom, D. (2019). Joint Learning Network: Mobilizing domestic resources for health. World Bank Blogs. <https://blogs.worldbank.org/health/joint-learning-network-mobilizing-domestic-resources-health>
- 14 Barroy, H., Kutzin, J., Tandon, A., Kurowski, C., Lie, G., Borowitz, M., et al. (2018). Assessing Fiscal Space for Health in the SDG Era: A Different Story. *Health System and Reform*, 4(1), 4-7. <https://openknowledge.worldbank.org/handle/10986/29305>
- 15 World Health Organization. (2017). Aligning public financial management and health financing: a process guide for identifying issues and fostering dialogue. Geneva, Switzerland. <https://apps.who.int/iris/handle/10665/259247>
- 16 Cashin, C., Bloom, D., Sparkes, S., Barroy, H., Kutzin, J. & O'Dougherty, S. (2017). Aligning public financial management and health financing: sustaining progress toward universal health coverage. Geneva, Switzerland, World Health Organization. <https://apps.who.int/iris/handle/10665/254680>
- 17 Qin, V. M., Hone, T., Millett, C., Moreno-Serra, R., McPake, B., Atun, R., Lee, J. T. (2018). The impact of user charges on health outcomes in low-income and middle-income countries: A systematic review. *BMJ Global Health*, 3, 1-12. doi: 10.1136/bmjgh-2018-001087. [https://gh.bmj.com/content/3/Suppl\\_3/e001087](https://gh.bmj.com/content/3/Suppl_3/e001087)
- 18 Starrs A. M., Ezech, A. C., Barker, G., Basu, A., Bertrand, J. T., et al. (2018). Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *Lancet*, 391(10140), 2642-2692. doi: 10.1016/S0140-6736(18)30293-9. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)30293-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext)
- 19 Thijssen, B. S., Bossuyt, J. & Desmidt, S. (2019). Sexual and reproductive health and rights: opportunities in EU external action beyond 2020. <https://ecdpm.org/publications/sexual-reproductive-health-rights-opportunities-eu-external-action-beyond-2020/>
- 20 Schäferhoff, M., Van Hoog, S., Martinez, S., Fewer, S. & Yamey, G. (2019). Funding for sexual and reproductive health and rights in low- and middle-income countries: threats, outlook and opportunities. <https://pmnch.who.int/resources/publications/m/item/funding-for-sexual-and-reproductive-health-and-rights-in-low-and-middle-income-countries-threats-outlook-and-opportunities>
- 21 Sully, E., Biddlecom, A., Darroch, J., Riley, T., Ashford, L., Lince-Deroche, N., et al. (2020). Adding it up. Investing in Sexual and Reproductive Health 2019. New York, Guttmacher Institute. <https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019>
- 22 Grollman, C., Cavallaro, F. L., Duclos, D., Bakare, V., Álvarez, M. M. & Borghi, J. (2018). Donor funding for family planning: levels and trends between 2003 and 2013. *Health Policy and Planning*, 33(4), 574-582. doi: 10.1093/heapol/czy006. <https://academic.oup.com/heapol/article/33/4/574/4925381>
- 23 Lissner, C. L. & Ali, M. (2016). Systematic Reviews of Mechanisms for Financing Family Planning: Findings, Implications, and Future Agenda. *Studies in Family Planning*, 47(4), 295-308. doi: 10.1111/sifp.12008. <https://onlinelibrary.wiley.com/doi/full/10.1111/sifp.12008>
- 24 World Health Organization. (2020). Global spending on health: Weathering the storm 2020. Geneva, Switzerland. <https://www.who.int/publications/i/item/9789240017788>



- 25 Starrs, A. M., et al. (2018). Op. cit.
- 26 Schäferhoff, M., et al. (2019). Op. cit.
- 27 Ravindran, T. K. S. & Govender, V. (2020). Sexual and reproductive health services in universal health coverage: a review of recent evidence from low- and middle-income countries. *Sexual and Reproductive Health Matters*, 28(2). doi: 10.1080/26410397.2020.1779632. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7887992/>
- 28 Schäferhoff, M., et al. (2019). Op. cit.
- 29 Appleford, G., RamaRao, S. & Bellows, B. (2020). The inclusion of sexual and reproductive health services within universal health care through intentional design. *Sexual and Reproductive Health Matters*, 28(2). doi: 10.1080/26410397.2020.1799589. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7887933/>
- 30 Pharos Global Health Advisors. (2019). Transitions in Family Planning: Challenges, Risks, and Opportunities Associated with Upcoming Declines in Donor Health Aid to Middle-Income Countries. Boston, MA. [https://pharosglobalhealth.com/wp-content/uploads/2020/04/40002\\_CGD-Report\\_FINAL.pdf](https://pharosglobalhealth.com/wp-content/uploads/2020/04/40002_CGD-Report_FINAL.pdf)
- 31 Schäferhoff, M., et al. (2019). Op. cit.
- 32 Ibid.
- 33 Ibid.
- 34 Pharos Global Health Advisors. (2019). Op. cit.
- 35 Schäferhoff, M., et al. (2019). Op. cit.
- 36 The Global Financing Facility. (2016). Guidance Note: Investment Cases. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/Investment%20Case%20Guidance%20Note\\_EN.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/Investment%20Case%20Guidance%20Note_EN.pdf)
- 37 The Global Financing Facility. (2019). GFF Country Implementation Guidelines. <https://www.globalfinancingfacility.org/gff-country-implementation-guidelines>
- 38 E&K Consulting. (2020). Comparative Analysis of Selected Global Financing Facility-related Investments. <https://e-kconsulting.co.ke/2020/05/21/comparative-analysis-of-the-global-financing-facility/>
- 39 The Global Fund. (2020). Guidance Note: Sustainability, Transition and Co-financing. [https://www.theglobalfund.org/media/5648/core\\_sustainabilityandtransition\\_guidancenote\\_en.pdf](https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf)
- 40 Knoll, M. (2008). Budget support: a reformed approach or old wine in new skins? Discussion Paper, No. 190. UNCTAD. [https://unctad.org/system/files/official-document/osgdp20085\\_en.pdf](https://unctad.org/system/files/official-document/osgdp20085_en.pdf)
- 41 Fernandes Antunes, A., Carrin, G. & Evans, D. B. (2008). General budget support in developing countries: ensuring the health sector's interest. Geneva, Switzerland, World Health Organization. <https://apps.who.int/iris/handle/10665/340524?locale-attribute=ru&>
- 42 World Health Organization. (2018) Accelerator Discussion Frame: Accelerator 1. Sustainable Financing. Geneva, Switzerland. <https://www.who.int/docs/default-source/global-action-plan/accelerator1.pdf>
- 43 USAID. (n.d). Greater than the Sum of its Parts: Blended Finance Roadmap for Global Health. Washington, DC. <https://www.usaid.gov/cii/blended-finance>
- 44 Ibid.
- 45 Meheus, F. & McIntyre, D. (2017). Fiscal space for domestic funding of health and other social services. *Health Economics, Policy and Law*, 12(2), 159-177. doi: 10.1017/S1744133116000438. <https://pubmed.ncbi.nlm.nih.gov/28332459/>
- 46 Lustig, N. (2018). The Sustainable Development Goals (SDGs), Domestic Resource Mobilization and the Poor. [https://www.g20-insights.org/policy\\_briefs/the-sustainable-development-goals-sdgs-domestic-resource-mobilization-and-the-poor/](https://www.g20-insights.org/policy_briefs/the-sustainable-development-goals-sdgs-domestic-resource-mobilization-and-the-poor/)
- 47 Junquera-Varela, R. F., et al. (2017). Op. cit.
- 48 World Health Organization. (2002). Mobilization of domestic resources for health. Geneva, Switzerland. <http://apps.who.int/iris/bitstream/handle/10665/42547/9241590114.pdf?sequence=1>
- 49 Junquera-Varela, R. F., et al. (2017). Op. cit.
- 50 Barroy, H., et al. (2016). Op. cit.
- 51 Cashin, C., Sparkes, S. & Bloom, D. (2017). Earmarking for health: from theory to practice. Geneva, Switzerland, World Health Organization. <https://www.who.int/publications/i/item/9789241512206>
- 52 Rajan, D., Helene, B. & Stenberg, K. Budgeting for health. In: *Strategizing national health in the 21st century: a handbook*. (2016). Geneva, Switzerland, World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/250221/9789241549745-chapter8-eng.pdf>
- 53 Sparkes, S., Durán, A. & Kutzin, J. (2017). A system-wide approach to analysing efficiency across health programmes. *Health financing guidance*, no. 2. Geneva, Switzerland, World Health Organization. <https://www.who.int/publications/i/item/9789241511964>
- 54 Seidelmann, L., Koutsoumpa, M., Federspiel, F. & Philips, M. (2020). The Global Financing Facility at five: time for a change? *Sexual and Reproductive Health Matters*, 28(2). doi: 10.1080/26410397.2020.1795446. <https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1795446>
- 55 World Health Organization. (2017). Aligning public financial management and health financing: a process guide for identifying issues and fostering dialogue. Geneva, Switzerland. <https://apps.who.int/iris/handle/10665/259247>
- 56 Barroy, H., Piatti, M., Sergent, F., Dale, E., O'Dougherty, S., Mtei, G., et al. (2019). Let managers manage: a health service provider's perspective on public financial management. *World Bank Blogs*. <https://blogs.worldbank.org/health/let-managers-manage-health-service-providers-perspective-public-financial-management>
- 57 World Health Organization. (2020). Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance. Geneva, Switzerland. <https://apps.who.int/iris/handle/10665/332240>
- 58 Ahmed, S. A. K. S., Ajisola, M., Azeem, K., Bakibinga, P., Chen, Y-F., Choudhury, N.N., et al. (2020). Impact of the societal response to COVID-19 on access to healthcare for non-COVID-19 health issues in slum communities of Bangladesh, Kenya, Nigeria and Pakistan: results of pre-COVID and COVID-19 lockdown stakeholder engagements. *BMJ Global Health*, 5(8), e003042. doi: 10.1136/bmjgh-2020-003042. <https://gh.bmj.com/content/5/8/e003042>
- 59 Countdown 2030 Europe. (2022). European Donor Support to SRH/FP – with a spotlight on SRHR: Trends Analysis 2020-21. <https://countdown2030europe.org/resources/european-donor-support-srhfp-spotlight-srhr-trends-analysis-2020-21>
- 60 World Health Organization. (2021). ACT-Accelerator Prioritized Strategy & Budget for 2021. Geneva, Switzerland. <https://www.who.int/publications/m/item/act-a-prioritized-strategy-and-budget-for-2021>
- 61 The World Bank. (2019). Op. cit.
- 62 Ottersen, T., et al. (2017). Op. cit.
- 63 The World Bank. (2019). Op. cit.
- 64 Jowett, M. & Kutzin, J. (2012). Raising revenues for health in support of UHC: strategic issues for policy makers. Geneva, Switzerland, World Health Organization. <https://apps.who.int/iris/handle/10665/192280>
- 65 Smith, R. D. & Hanson, K. (2012). Health systems in low and middle income countries. An economic and policy perspective. Oxford University Press.
- 66 Palmer, N., Mueller, D. H., Gilson, L., Mills, A. & Haines, A. (2004). Health financing to promote access in low income settings – how much do we know? *Lancet*, 364(9442), 1365-1370. doi: 10.1016/S0140-6736(04)17195-X. <https://pubmed.ncbi.nlm.nih.gov/15474141/>
- 67 Meessen, B., Gilson, L., & Tibouti, A. (2011). User fee removal in low-income countries: Sharing knowledge to support managed implementation. *Health Policy and Planning*, 26, Suppl. 2, 1-4. doi: 10.1093/heapol/czr071. <https://pubmed.ncbi.nlm.nih.gov/22027914/>



web: [www.countdown2030europe.org](http://www.countdown2030europe.org)  
twitter: @C2030Europe  
email: [countdown2030europe@ippfen.org](mailto:countdown2030europe@ippfen.org)

