Center for Global Development
Ideas to Action: Independent research for global prosperity

CGD Note
SEP 2020

Family Planning and The Global Financing Facility:

Current Evidence and a Learning Agenda

Rachel Silverman, Janeen Madan Keller, and Amanda Glassman

INTRODUCTION

To achieve the SDG 2030 milestone—"universal access" to voluntary, high-quality family planning (FP) services—international FP funders and advocates seek to increase and sustain FP financing in low- and middle-income countries (LMICs).

This vision faces fiscal and practical challenges. The COVID-19 pandemic and its associated economic contraction have led to declining public revenues in LMICs and new demands on the health budget.[1] This immediate crisis further complicates an already difficult context for FP, where many LMICs face the prospect of aid transition and FP must compete with other health priorities for scarce public spending. In this long-term context, the inclusion of contraception in public budgets and within national health benefits packages (HBPs) is essential for the sustainability of FP financing and provision. In the short term, donor support (accounting for half of all spending on contraceptive products in low-income countries[2]) will also need to be sustained and ideally expanded to mitigate the negative effects of the COVID-19 pandemic and prevent backsliding on access.

The Global Financing Facility (GFF), launched in 2015, aims to "create the conditions for sustainable financing and scale-up of high priority reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) interventions."[3] The GFF offers grants to countries for FP among other RMNCAH-N areas alongside routine World Bank lending for health—an opportunity to firmly embed FP within the continuum of care and in public budgets. The GFF has expanded to support 36 countries; implementation is currently underway in 19.[4]

The GFF—alongside other bilateral and multilateral financiers—can play a pivotal role in addressing the immediate and long-term challenges to sustaining and expanding quality FP services. In the short

[1] https://www.cgdev.org/publication/covid-19-and-budgetary-space-health-developing-economies
[2] https://www.rhsupplies.org/cga/#theme1
[3] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Expansion-Plan.pdf#page=4
[4] https://www.globalfinancingfacility.org/where-we-work

term, GFF resources can help expand budgetary space and ensure appropriate prioritization to sustain access to FP and provision of broader RMNCAH-N services. In the long term, the GFF can help entrench FP within national budgets and HBPs, creating a glide-path for sustainability. The extent of the GFF's impact on FP provision, in both the short- and long-term, will thus depend on its ability to channel GFF/World Bank and national resources toward FP, including through inclusion in country RMNCAH-N investment cases, World Bank projects, and national HBPs.

To understand the current role of the GFF and inform its next steps to best fulfill this mandate, this note takes stock of our collective knowledge on inclusion of contraception in HBPs; incorporation of FP in country RMNCAH-N investment cases and corresponding World Bank projects; and GFF influence over government and donor resource allocation for cost-effective FP services. It concludes with a research agenda to guide future policy.

WHILE MANY LMICS SUBSIDIZE FP (OFTEN WITH DONOR SUPPORT), FP SERVICES ARE WEAKLY DEFINED IN MOST HBPS

Vertical financing and delivery of FP—and the perception that it is a donor-financed activity—presents a challenge for its integration into national universal health coverage (UHC) schemes and benefits packages. Appleford and RamaRao (2019) note that "the vertical framing of FP financing tends to position FP as in competition with other essential health services. This often does not win sympathy with health financing counterparts."[5] Though a substantial body of evidence suggests that FP is cost-neutral or cost-saving to a single budget-holder (e.g., a national health insurance payer),[6] the FP community has not yet consistently leveraged cost-effectiveness, actuarial, and budget impact analysis to advocate on behalf of FP inclusion in the benefits package. Further, some within the FP community also promote a "total market approach"—a strategy that focuses on increasing access via the public sector as well as private channels where women often pay out-of-pocket—as a pathway for sustainable financing.

For now, there is limited visibility into country-level listing decisions for contraceptive services; recent efforts have shed some light on current practice.[7] Examining 20 countries in sub-Saharan Africa and Asia, Marie Stopes International found that most countries subsidize FP (often with donor support); however, contraceptive services are weakly defined in HBPs.[8] Where contraception is included in the HBP, it is typically funded through capitation or input-based financing rather than as a reimbursable service, reducing provider incentives for delivery. In a recent review of six countries[9], only Bhutan and the Philippines provide FP as part of the UHC benefit package. Indonesia provides

[5] https://www.popcouncil.org/uploads/pdfs/2019RH_HealthFinancingUHCBrief.pdf
[6] Sources (in order): https://aspe.hhs.gov/basic-report/cost-covering-contraceptives-through-health-insurance; https://www.businessgrouphealth.org/pub/?id=f3004374-2354-d714-5186-b5bc1885758a; https://www.cdc.gov/sixeighteen/pregnancy/index.htm; https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext; https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000264; https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017-latin-america-Caribbean; https://www.guttmacher.org/sites/default/files/pdfs/pubs/FB-contraceptive-services-SSA.pdf
[7] https://www.mariestopes-us.org/wp-content/uploads/2016/10/MSI-4Ps-matter-in-contraception-health-financing_UHC_Mazzilli-Appleford-….pdf and https://www.hfgproject.org/ephs-cross-country-analysis/
[8] https://www.mariestopes-us.org/wp-content/uploads/2016/10/MSI-4Ps-matter-in-contraception-health-financing_UHC_Mazzilli-Appleford-….pdf
[9] "A quick overview of RHS as part of public programs in iDSI countries" – PPT on file with CGD; see also https://idsihealth.org/where-we-work/

reimbursements for some methods (e.g., implants and injectables) via case-based payments.[10] India and Kenya offer FP through off-package programs; in Kenya, FP is subsidized through the National Health Insurance Fund covering 20 percent of the population, but only permanent methods are listed as a reimbursable service.[11] But Vietnam does not subsidize FP at all. In Ghana, FP was initially excluded from the National Health Insurance Scheme (NHIS) essential benefits package; a donor-funded pilot is now assessing the feasibility of including clinical methods using a case-based payment system.[12]

Often, actual purchasing/provision does not reflect listing decisions.[13] An assessment of 24 countries found that FP is almost always included in the essential packages of health services (EPHS), but the EPHS is not explicitly tied to funding, procurement, or payment/reimbursement. In countries which have both EPHSs and HBPs (where the latter directly informs funding), the HBPs are more oriented toward non-communicable diseases/secondary and tertiary care, with a relatively lower inclusion of RMNCAH services.

FP IS INCLUDED IN INVESTMENT CASES BUT GIVEN VARYING PRIORITY

The GFF describes the "Investment Case" as "a description of the changes that a country wants to see with regard to reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and a prioritized set of investments required achieve these results." [14]

Early investment cases have universally referenced FP, though both the approach to articulating priority interventions and the degree of prioritization vary widely across countries. A 2019 review by Health Policy Plus categorized investment cases for six countries (Bangladesh, Cameroon, Ethiopia, Kenya, Tanzania, and Uganda) as giving "high" priority to FP, meaning FP was explicitly identified as a strategic objective, priority, or program area. One investment case (Senegal) gave medium prioritization to FP, with FP included as an activity and listed in the service package. Four investment cases (Democratic Republic of the Congo, Guinea, Liberia, and Nigeria) included only limited mention of FP, typically as a subcomponent of other priorities/strategic areas.[15] However, this categorization methodology may not perfectly reflect actual budgetary priority; for example, the Democratic Republic of the Congo's investment case explicitly included FP within the performance-based financing service package.

[10] http://documents1.worldbank.org/curated/en/418491498057482805/pdf/116608-REVISED-PUBLIC-Maternal-Health-23-July-2018-lores.pdf#page=34
[11] https://pharosglobalhealth.com/wp-content/uploads/2020/04/40002_CGD-Report_FINAL.pdf
[12] https://pharosglobalhealth.com/wp-content/uploads/2020/04/40002_CGD-Report_FINAL.pdf
[13] https://www.hfgproject.org/ephs-cross-country-analysis/
[14] https://www.globalfinancingfacility.org/guidance-note-investment-cases
[15] http://www.healthpolicyplus.com/ns/pubs/13333-13610_CIPGFFBrief.pdf

Box: FP2020 Costed Implementation Plans and the GFF Investment Cases

FP2020 introduced costed implementation plans (CIPs) as a notionally country-led process to define a set of FP interventions—and related costs—that a country can implement to achieve its FP goals. Broadly, CIPs were intended to help direct donor funding flows and leverage domestic resources for FP. Most early CIPs represented more of a "wish list" rather than a prioritized set of activities defined within a realistic budget constraint. As such, they generally set aspirational rather than realistic targets with little basis in rigorous modeling or historical trends. Costing and activities did not align with real-world funding levels, modes of funding, or other health-sector strategy documents. In practice, early CIPS were not used to prioritize spending and donors largely continued business-as-usual funding practices.

In theory, GFF investment cases should include a subset of FP interventions set out in the CIP, but the relationship is complicated. A Health Policy Plus review of eleven countries found that just five had developed their CIP prior to the investment case (Democratic Republic of the Congo, Cameroon, Guinea, Nigeria, and Senegal). Three countries had developed the investment case before the CIP (Kenya, Liberia, and Tanzania). In the final three countries (Bangladesh, Ethiopia, and Uganda), the investment case and CIP were developed in parallel.

Among the five countries that developed the CIP before the investment case, there is generally broad alignment between FP priorities across both documents; most FP interventions included in a country's investment cases were also prioritized in its CIP. However, there is no process through which one strategic document informs the other.

See also, CGD's Working Group Report, "Aligning to 2020: How the FP2020 Core Partners Can Work Better, Together."

THE LINK BETWEEN THE INVESTMENT CASE AND GFF/IDA FINANCING IS INDIRECT AND INCONSISTENT

Both by design and in practice, the investment case offers an aspirational vision, informed through an inclusive consultative process, for a country's investments in RMNCAH-N. The investment case does not directly serve as an operational document to guide resource allocation within a set budget constraint. To inform resource allocation, a subset of the priority areas outlined in the investment case must be incorporated into Project Appraisal Documents (PADs), which specify the individual activities and components that will be included in a World Bank project covered with GFF/IDA financing, or be reflected in other donor grant operations or public budget processes.

Early experience in the GFF suggests inconsistent use of the investment case in guiding the development and content of PADs. Several countries (including Rwanda, Malawi, and Tanzania) received GFF financing before finalization of an investment case.[16][17] Even in countries that completed the investment case prior to developing the PAD, representation of FP can differ substantially between the two documents. In Kenya, for example, the investment case spent considerable energy identifying

[16] https://pai.org/wp-content/uploads/2016/11/PAI-GFF-and-FP-Brief-110116.pdf
[17] https://www.csogffhub.org/wp-content/uploads/2019/12/Comparative-Analysis-of-the-Global-Financing-Facility-Enhancing-inclusivity-transparency-and-accountability-2019.pdf

and differentiating 20 priority high-need counties for service scale-up,[18] but the PAD does not reflect this distinction; the World Bank project was ultimately rolled out nationwide.[19]

GFF/IDA FUNDS ARE FINANCING FP, BUT THE SCALE OF OPERATIONS REMAINS UNCLEAR

Evidence on the extent of FP financing through GFF/IDA operations remains limited. GFF leadership has identified several major investments in FP across GFF countries, including disbursement-linked indicators tied to FP goals ($33 million in Bangladesh; $17 million in Ethiopia; $27 million in Mozambique); contraceptive supplies ($30 million in DRC; $20 million in Kenya; $6 million in Uganda); and FP provision through results-based financing or fee-for-service platforms ($13 million in Cameroon; $1 million in Liberia; unspecified inclusion in Afghanistan, Guinea, Nigeria, Rwanda, and Tanzania).[20] However, it is not immediately clear whether—or what share of—these investments run through the GFF, other trust funds, or relate to pre-existing IDA or Health Results Innovation Trust Fund (HRITF) operations. Disentangling exact dollar amounts or financing streams from integrated service packages or disbursement-linked indicators may be neither possible nor desirable. Further, there has been little analysis of the execution and impact of the GFF/IDA operations to date.

DEFINING A FORWARD-LOOKING RESEARCH AGENDA

Further analysis is needed to answer the following outstanding questions about FP—and broader RMNCAH-N—financing through the GFF and UHC packages within the context of the current COVID-19 crisis:

- Is the GFF financing model (including on-budget IDA lending) helping to shift domestic health expenditure to the most cost-effective priorities?
- To what extent does the investment case inform resource allocation by other donors? Are other donors aligning behind the investment case to fund areas not covered by GFF/IDA financing? What operational incentives do other donors have to align behind the investment case?
- Are LMIC governments—with support from multilateral development banks (MDBs)—prepared to protect public spending on the health benefits package (or a prioritized set of services) given the likelihood of a COVID-19 recession and subsequent contraction in public revenues?

[18] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Kenya%20RMNCAH%20Investment%20Framework_March%202016.pdf
[19] http://documents.worldbank.org/curated/en/215261467995371106/pdf/PAD1694-PAD-P152394-IDA-R2016-0122-1-Box396259B-OUO-9.pdf
[20] GFF Technical Briefing for FP2020 Reference Group, 2019

- Have countries incorporated counter-cyclical financing arrangements[21] into their UHC financing system?

- To what extent should MDB lending in response to the COVID-19 shock include appropriate conditionalities to protect expenditure on the most cost-effective health priorities, including FP and vaccination?

INITIAL RECOMMENDATIONS TO SUSTAIN AND BEST ALLOCATE FP FINANCING

1. In the context of a contraction in public revenues, FP advocates must offer a compelling case to LMIC governments to sustain and expand expenditure on contraceptive services. Cost-effectiveness, actuarial, and budget impact analyses offer a promising path forward. Despite existing gaps, available global evidence strongly suggests that contraception is likely to offer cost savings (or at least budget neutrality) from the perspective of national healthcare payers and insurers, implying it will not be in competition with other spending priorities, at least over a medium-term time horizon.[22] The FP community should leverage locally-appropriate analyses as leading strategies to engage with country decision-makers.

2. To be most useful, planning and strategy documents, including the country RMNCAH-N investment case, should be developed using a set, realistic budget constraint. The investment case should not be conceptualized as a fundraising document to present a "wish list" of activities; instead, it should offer a prioritized blueprint, reflecting actual, ex-ante funding flows from GFF/IDA, other bilateral and multilateral donors, and national and subnational governments. "Crowding in" other donors and funding sources behind a coherent vision will only occur if the investment case reflects their actual funding decisions and modes of financing. Likewise, an inclusive multi-stakeholder process to inform the investment case is an important and welcome step; however, to serve as a meaningful planning document, it is donors and other funders who must ultimately endorse the contents and align behind a budget. The timing of such a recommendation can be difficult and possibly infeasible in the short-term in the context of COVID-19 as public spending is under extraordinary pressure, and IBRD/IDA loans will be needed to fill gaps quickly. Additional thinking is necessary to determine alternatives and their respective pros and cons.

Given the weak track record of ad hoc, "vertical" investment cases and plans in informing resource allocation, a medium-term alternative would be a country-run, on-going, and formally regulated priority-setting function and process, underpinned by analyses and evidence, that informs and drives budgets, purchasing, and procurement decisions via HBPs or related mechanisms.[23]

[21] This may include a reserve fund in any insurance or coverage arrangement that would cover shortfalls in revenue and enable same levels of coverage during an economic shock.
[22] See "Evaluating Contraception for Inclusion in Health Benefits Packages for UHC" – PPT on file with CGD.
[23] This vision underpins previous and ongoing work by CGD and the International Decision Support Initiative (iDSI); see, for example CGD's 2012 working group report on priority-setting in health; the 2017 book on evidence-based design of HBPs; and other resources on strengthening health systems to make better decisions and health technology assessment.

Stay tuned for more commentary and analysis on the Global Financing Facility over the coming months.

***

WWW.CGDEV.ORG

RACHEL SILVERMAN is a policy fellow at the Center for Global Development.

JANEEN MADAN KELLER is a senior policy analyst and assistant director of Global Health Policy at the Center for Global Development.

AMANDA GLASSMAN is executive vice president and senior fellow at the Center for Global Development.