

# Domestic Public Financing

### What is the high impact practice in family planning for creating an enabling environment?

Increase allocation and efficient use of domestic public financing for voluntary family planning at national and sub-national levels.

#### Background

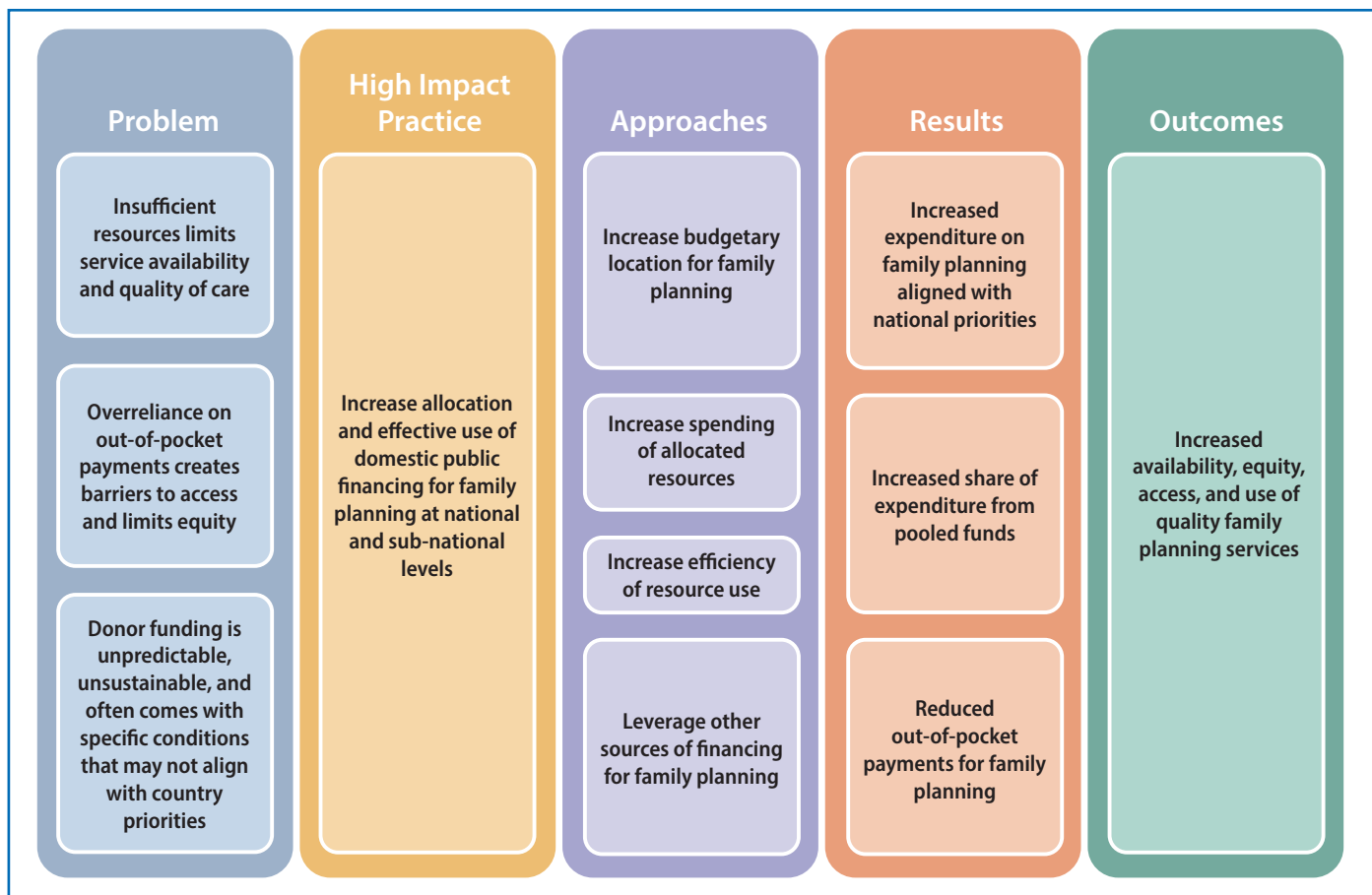
Family planning has been shown to be a “best buy” for governments: for each additional dollar spent on contraceptive services in developing countries, the cost of maternal and newborn health care could be reduced by \$2.20.<sup>1</sup> But in order for voluntary family planning programs to be successful and sustainable, there needs to be strong national capacity to implement and manage programs, including capacity to mobilize and spend the necessary financial resources for family planning commodities, service delivery, demand creation, and training.

A mix of financing from a variety of sources, including funds from dedicated revenue sources (e.g., earmarked taxes) and prepayment schemes (i.e., contributory insurance), loans for health, and the private sector, is required to achieve predictable, adequate, and sustainable financing for family planning. However, this brief focuses primarily on **public financing from general tax revenues**, which are typically the primary source of domestic financing for health in low- and lower-middle-income countries. The purpose of this brief is to aid ministries of health and family planning programmers, including implementers and advocates, in these countries to increase the value of public expenditure by improving (Figure 1):

- **Budget allocation:** securing sufficient resources in national and sub-national budgets to purchase family planning commodities and supplies, service delivery, social and behavior change activities, and other core components of the family planning program
- **Budget execution:** ensuring the approved budget is fully spent in line with stated priorities and within appropriate timelines
- **Efficiency:** using available resources in the most cost-effective way to maximize their impact

Domestic public financing is one of several “high impact practices in family planning” (HIPs) identified by a technical advisory group of international experts.<sup>2</sup> The purpose of these HIPs is to present the available evidence to support countries in achieving high-quality, voluntary, equitable, and sustainable family planning. For more information about other HIPs, see <http://www.fphighimpactpractices.org/overview>.

**Figure 1: Improved Domestic Public Financing: Theory of Change**  
*Assumption: Family planning services are heavily dependent on donor and/or out-of-pocket expenditures.*



### Why is domestic public financing of family planning important?

**Current domestic allocations and expenditure in many low- and middle-income countries are insufficient and the growing demand for voluntary family planning will require a substantial increase in financial resources.** Many low- and middle-income countries continue to rely heavily on donor financing for family planning and other health areas. Domestic financial commitments, including those made as part of the Family Planning 2020 (FP2020) initiative, have not always translated to increased spending on family planning. For example, in 2012 Nigeria committed to increase budget allocations for contraceptive commodities from \$3 million to \$11.35 million annually.<sup>3</sup> However, this funding never materialized and in 2017 Nigeria revised its commitment for contraceptives to just \$4 million annually (though the Federal Government has committed to disbursing \$56 million from International Development Association [IDA] loans accessed through the Global Financing Facility [GFF]). Even when countries have successfully allocated funds to family planning, these funds have not always been spent for their intended purpose. In Guatemala, for instance, between 2012 and 2015 just 64% of funds earmarked for family planning and reproductive health were executed for that purpose.<sup>4</sup>

At the same time, growing populations coupled with higher rates of modern contraceptive use will greatly increase the number of contraceptive users supported by national health systems. Between 2012 and 2017, FP2020 focus countries supported 38.8 million additional modern contraceptive users.<sup>5</sup> Yet, in 2017, an estimated 214 million women in low- and middle-income countries still want to limit or spaces births but are not currently using a modern contraceptive method.<sup>1</sup> If current trends in increased contraceptive use in 135 low- and middle-income

countries continue, the funding gap for commodities alone will be \$290 million in 2020 and a cumulative \$793 million for 2018–2020, which reflects only a portion of the total cost of providing family planning services.<sup>6</sup> Furthermore, countries that rely on donor financing of family planning are already experiencing a decline in donor funding.<sup>7</sup> To continue to promote and sustain higher levels of modern contraceptive prevalence, low- and middle-income countries will need to increase the value of domestic public financing for family planning.

**Inadequate public financing contributes to inequities in access to voluntary family planning services and financial hardship for the poor.** The lack of public financing for family planning and limited coverage of prepayment mechanisms means that individuals often rely on out-of-pocket (OOP) expenditure to pay for contraceptives and services. Although mobilizing OOP among groups with the ability to pay is often part of a strategy to support sustainable, domestic financing for family planning, many low- and middle-income countries, including Ethiopia, have acknowledged that “heavy reliance on OOP payments ... can make healthcare inaccessible to vulnerable households.”<sup>8</sup> The need to pay OOP for contraception can propose a particularly significant barrier for adolescents and women who lack financial autonomy.

In 2017, women in low- and middle-income countries spent an estimated \$2.09 billion on contraceptive commodities in the private sector.<sup>6</sup> OOP expenditure places financial burden on the poor, in particular, and may pose a financial barrier to family planning access. A recent survey of nine countries in Latin America and the Caribbean found that OOP expenditure was a significant source of family planning financing in all seven countries for which data were available.<sup>9</sup> In Guatemala, Honduras, and Peru, countries where there is theoretically free, universal access to family planning services and commodities, OOP expenditure accounted for roughly two-thirds of total expenditures on family planning. This implies that even in countries where family planning is theoretically free, there is an overreliance on OOP expenditure. Although there is a dearth of literature examining the effects of OOP expenditure on access to and use of family planning, research indicates that OOP expenditure on health in general can have impoverishing effects on individuals regardless of the country where they live or their income levels.<sup>10</sup> This highlights the need to increase financial protection for all health services, including family planning, through increased mobilization and pooling of public funding.

### **What is the evidence that increased domestic public resources are high impact?**

Although many low- and middle-income countries have yet to transition from donor to domestic financing for family planning, there are encouraging examples of those that have been able to increase the share of domestic public financing for family planning through greater allocations, better execution, and improved efficiency. The following sections present selected examples of successes at the national and sub-national levels.

**Increased allocation of public revenues to family planning.** At the national and local levels, governments have committed budgetary resources to family planning, most commonly for the purchase of contraceptive commodities and supplies. While it is recognized that investments in family planning need to go beyond commodities and supplies to include all core components of an effective program, the examples below reflect the fact that other elements of family planning programs are often not explicitly stated in line-item budgets.

- Kenya increased its allocation for family planning commodities from \$2.5 million in fiscal year 2005/2006 to \$6.6 million in 2012/2013, and national government commitments to family planning overall grew to \$8.0 million.<sup>11</sup> As of 2017, all 47 counties in the country have committed to having a budget line for family planning by 2020.
- In 2016, Tanzania increased its national family planning budget from \$1.1 million to \$2.3 million.<sup>12</sup>
- Five districts in Indonesia increased their family planning budget allocations by an average of 76% to a total of \$3.6 million between 2014 and 2016.<sup>12</sup> In addition, the Government of Indonesia announced significant

additional funding assistance for health programs, including family planning, to local governments in its renewed FP2020 commitment in July 2017.

- In Lagos State in Nigeria, contraceptive methods are provided free in public facilities, but user fees for consumables such as syringes and gloves were found to be a barrier to family planning uptake. Through engagement in the budget preparation process, civil society successfully advocated for the inclusion of a budget line for family planning consumables in the 2017 budget.<sup>13</sup>

**Increased execution of funds allocated to family planning.** Budget underspending in the health sector is common and estimated to be between 10% and 30% of approved budgets in African countries.<sup>14</sup> This represents a missed opportunity to deliver priority programs such as family planning. It also weakens the Ministry of Health's case for increasing the budget in subsequent years. While advocacy is often targeted at increasing budget allocation, it is critical to also ensure that the allocated budgets are spent fully and on time. There are a wide variety of reasons why execution rates of family planning budgets may be low, including that funds are not released or they are released too late; funds are redirected to other uses; or cumbersome procurement processes cause delays. Tackling these issues often requires changes to the public financial management system and are therefore not usually specific to family planning budgets.

- Guatemala increased its allocation of public-sector funds for contraceptive procurement from \$0.43 million in 2006 to \$3.5 million in 2016. Despite an earmarked tax on alcohol to pay for family planning and reproductive health, which raised \$4.3 million in 2006 and increased to \$7.3 million in 2016,<sup>15</sup> use of these funds was difficult to track and they were often used for general programming by the Ministry of Health.<sup>16</sup> The creation of a family planning and reproductive health line item and a specific allocation for contraceptives, as well as the creation of the National Commission for Contraceptive Security tasked with tracking the use of family planning spending, increased accountability in the use of these funds.
- In Swaziland, the Ministry of Health has succeeded in increasing budget execution through routine budget performance monitoring. Through the use of understandable dashboards drawn from routine budget execution information, senior management proactively identify and address underspending. This process informed the reprogramming of funds at the end of the fiscal year 2014/2015 for the purchase of antiretroviral drugs, improving budget utilization from 92% to 98%.<sup>17</sup> A similar process could be implemented to address underspending on family planning line items.

**Improved efficiency in the use of funds.** Regardless of the size of the family planning budget, it is essential to scrutinize how funds are used to deliver the best results for the cost. Many countries have made significant strides in ensuring that the best price is received for commodities and that service delivery is provided efficiently. The following examples highlight some of the ways in which countries have achieved cost savings through improved efficiency:

- **Investing in evidence-based programming** by prioritizing high-impact, cost-effective interventions, drawing on evidence of programs that have cost-effectiveness assessments.<sup>18</sup>
- **Implementing strategic purchasing reforms**, including promoting a payer-provider split by contracting out services to private or nongovernmental organizations or implementing performance- or results-based financing programs in the public sector.<sup>19,20</sup>
- **Procuring in bulk** across delivery sites and programs at the national or sub-national level to reduce commodity prices.<sup>21</sup>
- **Using pooled or coordinated buying** across countries, as has been done in West Africa through the West African Health Organisation, enabling countries to negotiate reduced prices with manufacturers.<sup>22</sup>
- **Organizing service delivery to optimize the health workforce**, such as through (1) **task shifting**, which may reduce the cost of family planning services,<sup>23-25</sup> and (2) **integration**, or offering family planning services

as part of standard care for other related health services, such as delivery care, childhood immunization, and postabortion care, which may reduce the marginal cost of family planning services by reducing health worker time required and achieving economies of scale in training and supervision.<sup>26</sup>

- **Adopting a total market approach** to family planning by (1) **targeting government expenditure/subsidies** to the poor or, in more mature health financing systems, pro-poor insurance programs,<sup>27,28</sup> and (2) **engaging the private sector** to expand access to services and leverage OOP expenditure from those with ability to pay.<sup>29,30</sup>

It should be noted that the above illustrative approaches are not silver bullets and that realizing efficiency gains depends on a range of contextual factors including current contraceptive use dynamics and sexual and reproductive health practices as well as the size and design of family planning programs.

**Additional financing mechanisms leveraged.** Other non-budgetary mechanisms may be used to fund health services, particularly in countries with more developed health financing systems. In these countries, family planning advocates should ensure that family planning has a dedicated financing stream or that contraceptive commodities and services are included within health benefit packages.

- **Integration of family planning into national and social health insurance** can provide a reliable and substantial source of funding for family planning and promote long-term sustainability of family planning financing. In a study of 16 countries with social health insurance, 14 included some modern contraceptive options in their benefits package.<sup>9</sup> Civil society has played an important role in advocating for the inclusion of contraceptive methods in such schemes.<sup>31</sup>
- **New government loans** have been used to increase investment in family planning. For example, the GFF was launched in 2015 as a mechanism to catalyze access to new international and domestic sources of financing for reproductive, maternal, neonatal, and child health (RMNCH), through the provision of modest grants. So far, a number of governments have accessed these loans alongside their GFF grant, including Kenya, which allocated \$20 million for RMNCH strategic commodities, especially family planning commodities.<sup>32</sup>
- **Earmarking** a percentage of tax revenues to family planning can increase the share of domestic funding for family planning. For example, in Guatemala 15% of alcohol tax revenues are earmarked for family planning and reproductive health, of which 30% is specifically designated for contraceptive procurement, thereby increasing the share of contraceptive funding from domestic sources from 5% in 2002 to 100% in 2011.<sup>15</sup>

## How to do it: Tips from implementation experience

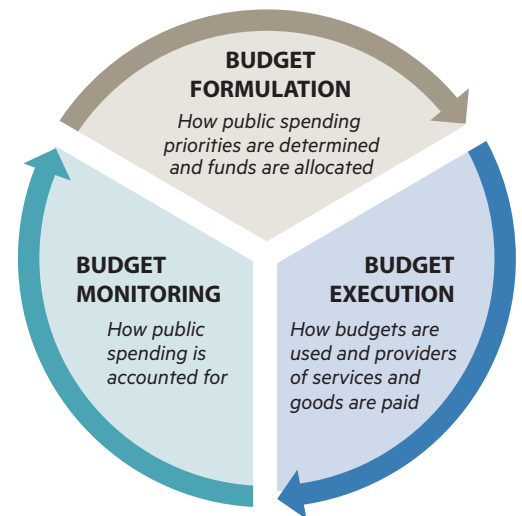
**Include family planning in key strategic documents at the national and sub-national levels.** The first step to ensuring that family planning is prioritized in the national budget is to clearly articulate family planning priorities and targets in government policies and strategies, including those focusing on RMNCH. In decentralized health systems, strategies developed at the sub-national level may be more relevant for influencing budget allocations.

**Set a realistic number of goals with cost estimates.** Plans that clearly set out program objectives in a measurable way provide a road map for program implementation. These plans should prioritize high impact interventions and should include a detailed assessment of the funding needed for their implementation and any gaps. The more detailed the costing, the more useful the plan will be to inform domestic financing needs. Costed Implementation Plans (CIPs) are one approach to develop such a plan (see the Tools section below).

**Develop a clear understanding of the annual budget cycle.** It is important to have a good understanding of each stage of the budget process to be able to identify points in the process at which to most effectively engage with decision makers at national and sub-national levels. At the beginning of the financial year, a budget calendar should be issued outlining the intended timing of each step (see Figure 2).

**Invest in advocacy to galvanize commitment to family planning.** In some contexts, family planning does not appear in the budget and is instead subsumed under one of the other budget line items for health. In such cases, the first step is to advocate for the inclusion of a separate budget line item for contraceptive commodities as this is the easiest way to identify and track family planning investments (see the [Galvanizing Commitment HIP brief](#)). Advocacy efforts may focus at the national or sub-national level, depending on the extent of fiscal decentralization in the country. In Nigeria, for example, an analysis of the approved budget for 2017 found that family planning was omitted from the federal budget despite the government’s ambitious FP2020 commitments to invest \$11.35 million annually in contraceptive commodities.<sup>3</sup> Using these commitments as the focus of messaging, civil society successfully advocated for the reinstatement of this budget line item by participating in the budget hearing and engaging directly with the parliamentary budget committee for health (personal communication, Evidence for Action, 2017). Once the budget line item is included, advocacy efforts can focus on ensuring that the amount allocated is in line with needs and stated priorities.

**Figure 2. Illustrative budget cycle**



Source: Cashin et al., 2017

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### Tips for Effective Budget Advocacy

- **Use your understanding of the political economy to shape how you communicate.** When designing your engagement approach, think about who the key decision makers are. What motivates them? What are their interests? What pressures do they face? Who influences them? What is the distribution of power between different actors?
- **Make the case for investing in family planning.** Make a more compelling case for investment by setting out the evidence of how investments in family planning will ultimately generate savings (e.g., on primary education costs); contribute to development goals such as lives saved, poverty reduction, or educational attainment; or reap the demographic dividend to achieve economic growth.<sup>33-35</sup>
- **Provide sustained pressure over time.** Effective advocacy efforts often require multiple engagements so that decision makers fully understand and support the need to invest in family planning. It can also be helpful to engage the media and civil society, ensuring that all advocacy efforts are aligned around the same advocacy ask.
- **Link the “ask” to an established development goal.**<sup>36</sup> Advocates should highlight the contribution of family planning to other sectors and broader development targets, such as a country’s Sustainable Development Goals.<sup>36</sup> This tactic can be part of a broader strategy to promote health as an investment.<sup>37</sup>

For more information, see the [Galvanizing Commitment HIP brief](#).

**Use past spending to build an evidence base.** As part of National Health Accounts, some countries have produced reproductive health subaccounts, which include an assessment of expenditure on family planning. The World Health Organization Global Health Expenditure Database includes family planning expenditure data for 12 countries up to 2014 (up to when the latest data are available). Expenditure data are also available from the UNFPA-Netherlands Interdisciplinary Demographic Institute (NIDI) Resource Flows Project.<sup>38</sup> Where these expenditure data exist, they can provide a useful source of evidence to support advocacy and accountability. In Rwanda, for example, the 2002 reproductive health subaccount found that 80% of reproductive health

expenditure was funded by donors. The Ministry of Health used this information to advocate for greater domestic financing for family planning.<sup>39</sup>

**Increase budget transparency and public participation.** Only when there is free exchange of public information and citizens have the opportunity to effectively engage in the budget process can the government be held accountable for its budget.<sup>40</sup> In Malawi, a self-assessment tool was used to sensitize district health authorities and local politicians on the budget system, including processes for public participation and information sharing, as outlined in the Public Financial Management Act, 2003. The assessment results were used to develop biannual district scorecards, which helped facilitate dialogue among district stakeholders and track progress relating to transparency and participation over time.<sup>41</sup>

**Strengthen public financial management capacity in the health sector.** The public financial management (PFM) system refers to the institutions, policies, and processes that govern the use of public funds. Within ministries of health, there is often limited awareness of how PFM processes and reforms can be used to improve program expenditures. PFM reforms such as the move from input- to program-based budgeting (i.e., moving from input line items to budgets based on programs), as well as the establishment of multiyear revenue and expenditure frameworks (i.e., a government-wide spending plan that links policy priorities to macroeconomic and revenue forecasts over a 3–5-year period), if well implemented, can build capacity of health officials beyond the finance unit and gain buy-in for productive engagement in PFM processes. This understanding can help to address some of the blockages in the disbursement of funds.

**Strengthen dialogue between ministries of health and finance.** Establishing more productive engagement between the two government authorities will enable the ministry of health to better take advantage of PFM reforms and to better communicate about sector needs including the need for in-year adjustments to the budget to take advantage of efficiency savings<sup>42</sup> as well as how investments in family planning will contribute to economic growth. (See Box on Tips for Advocacy.) The ministry of health can gain the confidence of the ministry of finance by demonstrating that family planning programs are planned and budgeted for based on evidence, that there are systems for monitoring and accountability, and that family planning investments are linked to the government's midterm expenditure framework. This can help to combat perceptions that the ministry of health is ineffective and inefficient, which often leads to reluctance by the ministry of finance to increase investment in the health sector.

**Track budgets to assess whether the budget for family planning is being implemented per the approved budget and timelines.** Tracking exercises can take on various forms, with the simplest being an annual comparison of the approved/enacted budget to the total spending during the fiscal year. Where actual spending information is available during implementation, through quarterly expenditure reports for example, tracking exercises can be carried out more regularly, allowing discrepancies to be identified as they arise. More extensive tracking exercises, such as a Public Expenditure Tracking Survey (PETS), can be used to track the flow of funds from each level of government in order to identify the bottlenecks in the system. These exercises require primary data collection and a greater understanding of the national PFM system. In addition, Track20 has undertaken Family Planning Spending Assessments in several countries including Bangladesh, Indonesia, Kenya, and Senegal. These assessments collect data on family planning expenditures using a modified version of the National Health Account that focuses strictly on family planning.

**Advocate for inclusion of family planning in formal health insurance schemes, including social, national, and private health insurance schemes.** Civil society organizations, in collaboration with ministries of health, play an important role in engaging with politicians and decision makers, participating in technical working groups, and developing targeted position papers to raise awareness about the importance and value of family planning. In Ghana, civil society organizations successfully advocated for the inclusion of family planning in the *2012 National Health Insurance Act*.<sup>31,43</sup> While this is yet to be operationalized, as of May 2018 a pilot was being rolled out whereby national health insurance card holders in selected districts could access clinical contraceptive methods for free using their health insurance card.<sup>44</sup>

## Tools and Resources

**Family Planning Financing Roadmap:** An interactive tool that provides country specific financing options based on context. <http://www.fpproject.org/financing-roadmap/>

**A Toolkit for Ministries of Health to Work More Effectively with Ministries of Finance:** presents a set of strategies, self-assessment methodologies, and performance management processes to help MOHs better manage their own resources and effectively communicate with MOFs. <https://www.hfgproject.org/wp-content/uploads/2014/10/Introduction--A-Toolkit-for-Ministries-of-Health-to-Work-More-Effectively-With-Ministries-of-Finance.pdf>

**Budgeting for Health:** outlines the role of the MoH and other stakeholders in providing timely inputs into the national budgeting process. <http://who.int/healthsystems/publications/nhpsp-handbook-ch8/en/>

**Develop a Strategy:** features a tool to understand your context and assess the likelihood of influencing policy development; and a 9-step approach to developing an advocacy strategy. [https://www.advancefamilyplanning.org/sites/default/files/2017-07/2%20Develop%20a%20Strategy\\_Nov%202015\\_0.pdf](https://www.advancefamilyplanning.org/sites/default/files/2017-07/2%20Develop%20a%20Strategy_Nov%202015_0.pdf)

For more information about HIPs, please contact the HIP team at [fhip@k4health.org](mailto:fhip@k4health.org)

## References

A complete list of references used in the preparation of this brief can be found at: <https://www.fphighimpactpractices.org/briefs/domestic-public-financing>

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The World Health Organization/Department of Reproductive Health and Research has contributed to the development of the technical content of HIP briefs, which are viewed as summaries of evidence and field experience. It is intended that these briefs be used in conjunction with WHO Family Planning Tools and Guidelines: [http://www.who.int/topics/family\\_planning/en/](http://www.who.int/topics/family_planning/en/).