2.2 Financing women's, children's and adolescents' health

Domestic resources are by far the biggest source of financing for health services in all countries, regardless of income level. Most low- and lower-middle-income country governments have pledged to increase public expenditure on health as a share of overall public expenditure to 15%. Progress towards this target is vital: government spending on health is below this level in many countries, mostly in Africa and Asia.[136]

The Africa Health Budget Network recently analysed the 2015 Open Budget Survey. Looking at 27 countries in sub-Saharan Africa, it found the majority were reasonably transparent about health budgets, but far fewer were transparent about actual spending – or outcomes. And while half the countries communicated budget information well, only Kenya, Rwanda and South Africa allowed the public to participate in the budgeting process.

The Global Financing Facility (GFF) in support of EWEC was launched in 2015 by the UN, in partnership with the World Bank Group (see Box 4). It is the financing arm of EWEC, and aims to close the financing gap for reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) by making more efficient use of existing resources, raising additional domestic resources (public and private) and further mobilizing and better coordinating external assistance. By the end of 2016, 16 of 62 eligible countries were receiving GFF support.

Box 4.

GFF: adding value to countries' efforts to improve the health and well-being of women, children and adolescents[137]

The GFF, using a new financing model, works to reduce preventable deaths and accelerate advancements in the health of women and children through the highest-impact interventions, addressing system barriers and tackling the social determinants of poor health. The GFF is a country-led multistakeholder partnership, and draws on the expertise and resources of the World Bank Group, UN agencies including the H6 Partnership, PMNCH, Gavi, the Global Fund, the Bill & Melinda Gates Foundation, bilateral donors, civil society organizations and private sector partners.

The GFF prioritizes quality and equity issues, such as sexual and reproductive health and rights, nutrition, newborn survival and adolescent health, and populations that have been neglected and underfunded. It also focuses investments in fragile settings: four of the current 16 GFF-supported countries are classified as fragile, one is just emerging from Ebola, and three contain fragile regions.

The GFF's approach involves prioritization, coordinated health financing, and tracking progress and learning, with country leadership. Prioritization involves identifying both key investments needed to improve RMNCAH-N outcomes in an efficient, equitable, feasible and affordable manner (typically through the development of an investment case) and health financing reforms that will result in scaled-up and more sustainable and equitable financing.

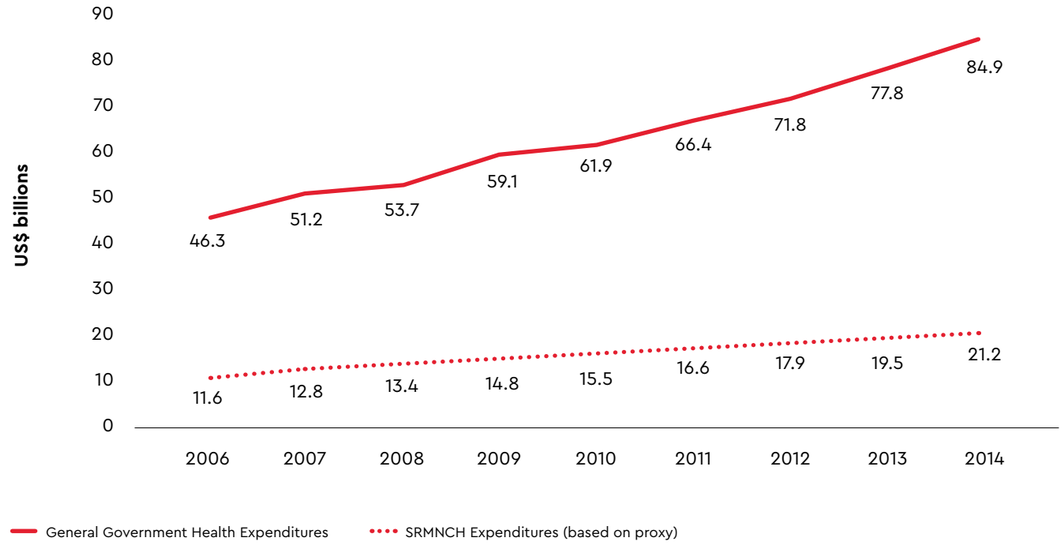
These investment cases are then implemented in a coordinated manner, with GFF catalysing improved efficiency, increased domestic resources, more and better harmonized external assistance, including concessional financing, and leveraged private sector resources.

Finally, the GFF adds value by creating a feedback loop that enables course correction during implementation, by ensuring investment in the systems needed to monitor and evaluate, and so provide reliable data to track progress in, areas such as civil registration and vital statistics systems, health management information systems, and household surveys.

Independent analysis commissioned by PMNCH for this report found that overall spending by the 62 countries eligible for GFF financing has increased continuously since the launch of the first EWEC *Global Strategy* (the latest year available is 2014).[138] Previous studies have assumed that 25% of total government health expenditures benefited sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) (see the dotted line in Figure 22).[139,140] While these are substantial increases, they still fall short of the sums needed.

In 2015, the GFF estimated the incremental resource gap for eligible countries, the amount needed to scale up coverage of services from current levels to coverage needed to ensure better health outcomes, at US$ 33.3 billion (US$ 9.42 per capita).[141] This gap needs to be filled by improved efficiency and additional domestic and donor funding to achieve the goals of the EWEC *Global Strategy*.

Figure 22. Government health expenditures in the 62 GFF-eligible countries, 2006–2014

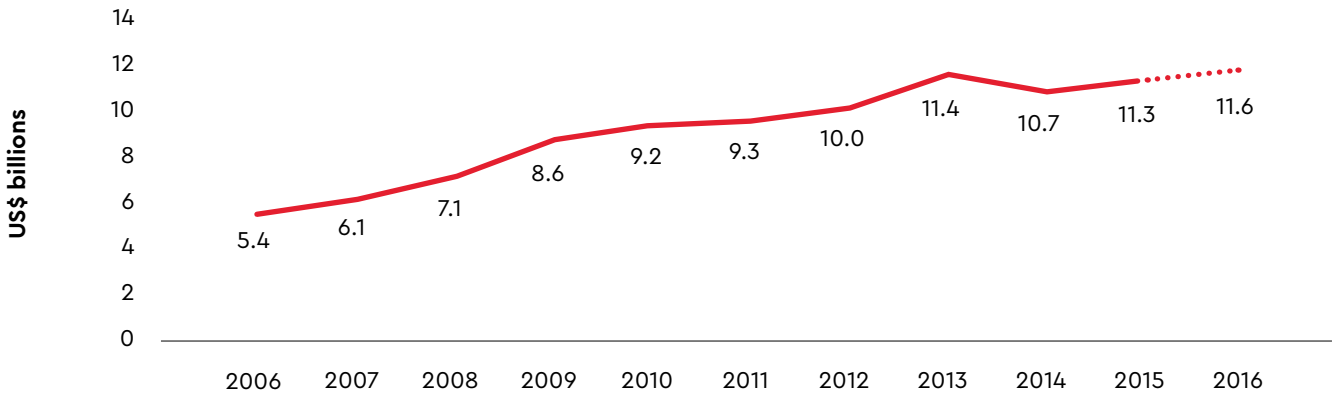


Note: Expenditures in US$ billions, constant 2010 prices.
Source: WHO Global Health Expenditure Database.

An analysis of broader SRMNCAH financing trends was conducted to contextualize the financial commitments to the EWEC *Global Strategy*, and to estimate how these commitments affected SRMNCAH financing overall.[142] The analysis shows that official development assistance (ODA) by international donors for SRMNCAH in the 62 GFF-eligible countries increased by 6.6%, from US$ 10.6 billion in 2014 to US$ 11.3 billion in 2015.[143] Compared with 2010, when the first EWEC *Global Strategy* was launched, 2015 donor flows to SRMNCAH were 22% higher.

Provisional financial data collected for this report signal further growth in SRMNCAH financing in 2016, reflecting donors' continued support. These data indicate that a number of key donors increased their SRMNCAH funding in 2016 and that the funding of most others remained stable. Overall, it is estimated that donors disbursed a total of US$ 11.6 to GFF-eligible countries, reaching a new peak in 2016, with an increase of 3% from 2015. Increases were also driven by major commitment-makers to the EWEC *Global Strategy* (e.g. Canada and Sweden) which indicates its positive influence on overall SRMNCAH financing trends (Figure 23). However, funding for some critical intervention areas is stagnating or even declining: after steady increases since the 2012 London Summit, donor country funding for bilateral family planning activities remained flat in 2015 in real terms. However, in current US dollars, 2015 funding was 6% below the 2014 level.[144]

Figure 23. ODA disbursements for SRMNCAH to the 62 GFF countries, 2006–2015, and provisional 2016 spending



Note: Expenditure in US$ billions – constant 2015 prices.
Source: OECD Common Reporting Standard (2006–2015) and 2016 provisional estimate.