Analysis of sexual and reproductive health and rights prioritization

in select Global Financing Facility focus countries

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Key abbreviations

AAP	Annual action plan
APEs	Agentes polivalentes de saúde (community health workers)
CHW	Community health worker
CSO	Civil society organization
DLI	Disbursement-linked indicator
GBV	Gender-based violence
GFF	Global Financing Facility
IDA	International Development Association
mCPR	Modern contraceptive prevalence rate
MMR	Maternal mortality ratio
MoH	Ministry of Health
MSP/P/AS	Ministry of Public Health, Population and Social Affairs
NGO	Non-governmental organization
OOPE	Out-of-pocket expenditure
PAD	Project appraisal document
PAP	Priority action plan
PESS	Plano Estratégico do Sector da Saúde (Health Sector Strategic Plan)
PforR	Program for Results
PHC	Primary health care
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
UHC	Universal health coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

1 Introduction

1. The Global Financing Facility

Launched in 2015 at the Financing for Development Conference in Addis Ababa, Ethiopia, the Global Financing Facility (GFF) is a mechanism aimed at catalysing the allocation of grant resources to scale up healthcare initiatives in low- and middle-income countries by leveraging domestic government resources, International Development Association and International Bank for Reconstruction and Development financing, aligned external financing, and resources from the private sector. Its primary focus is to direct evidence-based investments towards improving reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH+N) outcomes in countries with the highest maternal, newborn and child mortality burdens and large gaps in financing to address these challenges. Its core objective is to strengthen service delivery systems to save lives and contribute to the realization of universal health coverage (UHC) and the Sustainable Development Goals.

Central to the GFF's approach is the establishment and execution of a government-led, prioritized, and costed national investment plan. This plan outlines the strategy for expanding universal access to essential services related to RMNCAH+N. Through the facilitation of multi-stakeholder country platforms, the GFF assists partner governments in mobilizing and aligning both domestic and external resources in support of their national investment priorities. It first started in 2015 with four countries (Democratic Republic of the Congo, Ethiopia, Kenya, and Tanzania) and it now supports 36 low- and middle-income countries in Africa, Asia, and Latin America.

Multiple GFF strategic and policy documents highlight sexual and reproductive health and rights (SRHR) as a priority of the mechanism. These include the Protecting, Promoting and Accelerating Health Gains for Women, Children and Adolescents Strategy (2021–2025) (IBRD/World Bank, 2020), the Roadmap for Advancing Gender Equality (GFF, 2020), the SRHR Acceleration Plan (World Bank/GFF, 2021), as well as the GFF SRHR Approach Paper (GFF, 2022). Yet, in practice, the extent to which SRHR receives focus in GFF implementation is to a large degree dependent on prioritization processes at country level.

The GFF approach

The GFF adopts an innovative system-oriented approach that complements the strategies of other global health partners. It aims to generate more effective outcomes by assisting governments in expanding the provision of a comprehensive range of high-quality, affordable primary healthcare services to improve the health and nutrition of women, children and adolescents, which include SRHR services. The determination of the specific service package is guided by an evidence-based prioritization process, undertaken during the preparation of the country's investment case. The GFF's strategy papers for 2021–2025 do not prescribe specific service packages for SRHR, as the set of health services provided is tailored to each country's needs, depending on various factors such as the national disease burden and the primary causes of mortality and morbidity among women, adolescents and children, as well as the available resources. However, in 2021, a SRHR acceleration plan was introduced, calling for a gender-transformative approach and making SRHR "an important priority" (World Bank/GFF, 2021). This plan emphasises:

- expanding access to family planning
- strengthening the health system to ensure the integration of essential SRHR services
- advancing policy dialogue on SRHR
- increasing support for women and youth-led organisations and movements.

In the GFF Roadmap for Advancing Gender Equality (GFF, 2020), one of the key lines of action is: "Support the foundations for reforms that enable the integration of sexual and reproductive health and rights into universal health coverage policies and programs".

2. Case studies

The case studies presented in this report describe how two countries, Mozambique and Niger, have engaged with the GFF, and how in these cases SRHR was advanced within the broader framework of the GFF's objectives. The main objectives of the case studies were twofold:

- to describe how SRHR has been prioritized in the GFF country process, including in GFF country documents and funding allocations
- to understand and point to the drivers behind the prioritization of SRHR in the country process and associated challenges and lessons learned

Mozambique joined the GFF in 2015 and has had the opportunity to improve and reflect on country-led processes for the development of the investment case, including how SRHR gets prioritized as part of GFF investments, and capture lessons from its implementation. Niger is newer to the GFF and is currently in the early years of implementation of the investment case. However, cross-cutting insights and lessons can be learned from both countries to form a set of overall recommendations that address the objectives of the study.

Case study methodology

The two case studies prepared for this report adopted the same overall methodology. Both studies drew from various sources of information using a mixed-methods approach:

- Purposive literature and desk reviews were undertaken to synthesize information from diverse sources, including position and working papers, reports, policy briefs and datasets from the GFF and the World Bank, government documents, documents from donors and implementing agencies, non-governmental organizations (NGOs), and relevant findings in peer-reviewed literature and databases.
- Key informant interviews were conducted with a variety of stakeholders involved in GFF processes, such as government, civil society, and donor representatives.

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Mozambique case study

1. Country context

Mozambique is ranked 185th out of 191 countries on the Human Development Index. Although the country has been making progress in terms of social indicators, it has had to deal with range of political, economic, environmental, and social challenges. These include an ongoing conflict in the north, a series of natural disasters, a financial crisis in 2016 – the "Mozambique debt crisis" (Cortez et al, 2021) – and the COVID-19 pandemic. It was in this weakened and difficult context that Mozambique joined the GFF.

Despite the major challenges facing the national health system, **Mozambique has achieved noteworthy progress in SRHR**: the maternal mortality ratio (MMR) fell from 532 per 100,000 live births in 2000 to 127 in 2020 (World Bank, 2023). Regarding family planning, Mozambique has consistently been improving the modern contraceptive prevalence rate (mCPR) (Track20, 2023): the latest demographic and health survey report showed an mCPR of 25.4% for married women and 46.6% for unmarried women (INE, 2023), compared with 11.3% and 30.1% respectively in 2011 (MISAU and INE, 2013).

According to a civil society organization (CSO) representative involved in family planning programmes, there have been efforts by the Ministry of Health (MoH) and the health partners over recent years to support the promotion and provision of modern methods of contraception using different channels: ferias de saúde (health fairs in the community), strengthening of community health teams, and civil society initiatives carried out in the community. Government expenditure for SRH has increased in real terms (from US$ 5.0 million in 2019 to US$ 12.2 million in 2020), although this increase has not been constant (OCS, 2023). There are however some persistent challenges, especially for adolescents: for example, 52.9% of women aged 20–24 years were married or in a union before the age of 18 (2015). Additionally, Mozambique is one of six nations in the world where at least one in 10 girls (14%) had a child before the age of 15, and 57% before the age of 18 (Jaén-Sánchez et al, 2020). This is the highest adolescent fertility rate in the southern Africa region, with a rising trend over recent years. Moreover, sexual and gender-based violence (SGBV) remains a problem in the country: in 2018, 16.4% of women aged 15–49 years reported that they had been subject to physical and/or sexual violence by a current or former intimate partner in the previous 12 months (UN Women, 2023).

In terms of policy, Mozambique distinguishes itself through its progressive SRHR policies, in contrast to the growing global trend toward conservatism. The Mozambique government has developed several national guidelines explicating key SRHR priorities for the country: the MoH's SRHR priorities are mostly reflected in its Strategy for Gender Inclusion in the Health Sector 2018–2023 (MISAU, 2018). A Strategy for Family Planning and Contraception was revised and updated in 2020 (MISAU, 2020) and the Strategic Health Sector Plan (2014–2019) also describes SRHR priorities (MISAU, 2011). At the global level, Mozambique has ratified numerous regional and international agreements, such as the Maputo Protocol and the Southern African Development Community's Regional Strategy for SRHR 2019–2030, and it was part of the first group of countries to commit to the FP2020 partnership.

2. The GFF in Mozambique

Mozambique was part of the "second wave" of countries that joined the GFF in 2015. In December 2017, the World Bank granted US$ 105 million in non-reimbursable grants to support Mozambique's Primary Health Care (PHC) Strengthening Program. This funding included US$ 25 million from the GFF and US$ 80 million from the IDA (World Bank, 2017). An additional grant of US$ 90.16 million from the UK Department for International Development (DFID) (now the Foreign, Commonwealth and Development Office) and the government of Canada financed the programme through the Multi-Donor Trust Fund in 2019 (World Bank/IDA, 2019).

As mentioned above, the grants arrived in a difficult context, just after the Mozambique debt crisis. This crisis had broad repercussions on Mozambique's economy, governance, and international standing, underscoring the importance of transparency and responsible borrowing. There were also several consequences for aid and support by donors and international financial institutions: donors lost their trust in the government systems, which made most donors decide to suspend all aid that was provided directly to the government, including the funding for PROSAUDE, a pooled fund mechanism based on the sector-wide approach for health. Funding allocations for PROSAUDE shrank from US$ 85 million in 2014 to US$ 25 million in 2017, with only 73% disbursed (MSF, 2017).

Donors urged Mozambique to implement economic and governance reforms to prevent future financial crises and regain trust. The World Bank suspended the Development Policy Financing and shifted its focus toward technical assistance to address governance issues. This technical assistance programme allowed initiation of essential policy discussions with the government and played a role in supporting local reform initiatives, including those in the health sector (Gebregziabher and Sala, 2022). It is often mentioned in different GFF documents and during the interviews that the crisis actually became "an opportunity for reform", and a number of donors that contributed previously to PROSAUDE from then on opted to work through the GFF financing mechanism. Indeed, the GFF was regarded by some as an attractive alternative to PROSAUDE, given its more specific focus on women and children's health and its attention to cost-effectiveness and result-based approaches (such as PforR, Program for Results) (Steurs, 2019) "in comparison to the more input-based PROSAUDE approach" (World Bank official).

Mozambique's five-year investment case (2017–2022) was developed in 2016 through a government-led process. The MoH Director of Public Health mobilized partners from the existing multi-stakeholder country platform, the Health Partners Group, and four technical working groups focusing on maternal health, child health, nutrition, and adolescents were set up to prepare a situation analysis and a list of interventions with the greatest potential for effectiveness. There was no dedicated working group focusing on SRHR. During the investment case design process, several rounds of consultations were held with specific interest groups: adolescents and young people, civil society, and the private sector (MISAU, 2017b). The Health Sector Strategic Plan (PESS) 2014–2019 was used as the basis for establishing the priorities of the investment case. Part of this prioritization exercise involved categorising Mozambique's 142 districts by their needs, such as availability of resources and coverage of services, and their potential for achieving results.

2.1 Prioritization of Mozambique's RMNCAH+N investment case

The investment case for GFF support in Mozambique is mainly based on co-financing of the MoH PHC Strengthening Program, which addresses the key priorities of the government's Health Sector Strategic Plan (PESS) (2014–2019). The PESS orients all interventions in the sector and defines primary healthcare as a guiding principle: "The health sector is guided by a set of principles consistent with core values held by Mozambicans, as well as principles guiding primary health care as this is the model used for the provision of health care in Mozambique" (MISAU, 2011). Among other things, the PHC Strengthening Program described in the investment case promotes:

- maintaining and eventually increasing the government's ratio of domestic health expenditure to total domestic expenditure
- increasing the number, reach and capacity of community health workers (CHW), who are delivering key RMNCAH+N interventions in prioritized districts
- collecting and using data for decision-making, and
- expanding the quality and coverage of RMNCAH+N services in districts that have both a high burden and high potential for results

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The programme focuses on transferring resources to the front line; more specifically, through transferring human resources to primary healthcare, shifting tasks to CHWs and increasing the availability of essential medicines for maternal and reproductive health in primary healthcare facilities (MISAU, 2017a). EQUIST[1] was used, with the support of UNICEF Mozambique, to obtain estimates of the potential impact of the interventions listed in the investment case implementation strategy and to define "impact" indicator targets (MISAU, 2017b).

The investment case prioritised high-burden districts in 10 provinces, for which different health system strengthening activities needed to overcome bottlenecks in providing RMNCAH+N services were identified. Three priorities for strengthening the health service at national level were also defined:

1. Improvements in coverage, quality, and access to essential primary healthcare services through a combination of supply- and demand-side investments that extend to sparsely populated and high-burden districts.
2. Systems-strengthening interventions, such as efforts to improve data collection and monitoring in the civil registration and vital statistics system.
3. Increases in the volume, efficiency, and equity of domestic and external health financing.

UNFPA played a critical role in the development of Mozambique's investment case, ensuring clear prioritization of family planning and adolescent SRHR (GFF, 2022), especially by complementing the EQUIST data with an assessment of the potential impact of the increased use of modern methods of contraception, undertaken by UNFPA in 2015. Two main areas have therefore been highlighted in the

1. The Equitable Impact Sensitive Tool (EQUIST) was developed in 2012 by UNICEF to assesses the cost-effectiveness of public health or nutrition strategies. EQUIST combines the Marginal Budgeting for Bottlenecks (MBB) tool and Lives Saved Tool (LiST): the MBB tool identifies the most effective interventions, enabling countries to cost and assess their potential impact on health coverage, while LiST draws estimates of the impact of services coverage change on mortality. It uses data analysis, scenario modelling, and equity analysis to help governments and organizations optimize resource allocation and improve equitable access to essential maternal, newborn, and child health services. EQUIST uses a systematic approach composed of four levels of prioritization: (i) level 1: prioritization of high-impact interventions, (ii) level 2: bottleneck analysis and prioritization of strategies, (iii) level 3: prioritization of vulnerable populations, (iv) level 4: prioritization of regions.

investment case and the project appraisal document (PAD), which outlines the investment case funding modalities as further explained in the next section:

- Reduction of teenage pregnancy, targeting adolescents, schools, and youth-friendly health services: adolescents represent a quarter of the total population in Mozambique, making them a significant demographic priority. In line with its FP2020 commitments, Mozambique expanded its prioritization of adolescent contraception "in prominent ways" (Chandra-Mouli et al, 2018), including the provision of contraceptives and comprehensive sexuality education in school health programmes, and referral arrangements between school-based health facilities and nearby public/private health facilities, aiming for national coverage by 2020 (FP2020, 2017). However, while adolescents are generally included within the broader RMNCAH+N framework of the GFF planning documents for Mozambique, attention to this group tends to dilute as one moves from programming content to indicators and investments.
- Family planning: building off the FP2020 commitments, the Mozambique investment case includes family planning as one of the key interventions, ensuring availability and provision regularization of a broad spectrum of contraceptive methods, and promoting demand, both in health facilities and in communities, through the mobilization of outreach teams and CHWs (*Agentes Polivalentes de Saúde*; APEs). But according to a UNFPA official, the investment mostly goes to equipment and training, with the provision of commodities, including modern contraceptives, being mostly ensured by UNFPA Supplies Partnership and USAID. There is also mention of piloting a stock management information system to minimize the occurrence of contraceptive stock-outs.

2.2 How priorities translate into funding

As in many other countries, in Mozambique the GFF has also supported an increase in the allocation of budgetary resources to front-line providers to strengthen primary healthcare services at community level (Chou et al, 2018). The primary healthcare system is central to the Mozambique investment case, out of recognition that it is impossible to improve and sustain RMNCAH+N outcomes without stronger and more resilient primary healthcare systems (Claeson, 2017). Mozambique demonstrates a commitment to gender inclusion across its national planning documents, highlighting collaboration between the Ministry of Health and the Ministry of Gender, Children and Social Action. To reflect this commitment, the PAD flags gender as a cross-cutting consideration, in terms of analysis, target groups, and specific interventions to address social norms and inequalities (George et al, 2021), with community-based interventions targeting male engagement, and gender-responsiveness included in the scorecard and community consultations.

Following the investment case, a PAD was developed to outline the funding modalities, (World Bank, 2017), and structured as follows:

- PESS-related activities, which includes on-budget and on-treasury single account health expenditure financed by government revenues, and external funds such as PROSAUDE
- vertical financing by health partners

The PAD includes 12 disbursement-linked indicators (DLI), which are used for the implementation of Program for Results (PforR), a World Bank performance-based financing instrument that the GFF is currently implementing in 28 countries around the world, including in Mozambique (Piatti-Fünfkirchen et al, 2021). GFF disbursement of funds depends on meeting predefined targets within those specific indicators. The SRHR priorities mentioned above are reflected in two out of four outcomes DLIs:

- DLI 2 is related to the expansion of SRH services through the school health platform: Percentage of secondary schools offering SRH services (information and contraceptive methods), based on visits by health professionals (at least monthly).
- DLI 3 is for the national family planning programme: Couple Years of Protection.

In the investment case and in the PAD, there is also a strong emphasis on community-based programmes, such as the APE programme. This agenda has been pushed by the Department of Health Promotion, supported by UNICEF, highlighting its potential role in achieving RMNCAH+N objectives and as a solution for human resources gaps in the health sector. In line with the Strategy for Family Planning and Contraception, APEs and mobile teams are also mentioned as an outreach and expansion strategy for family planning services. As a consequence, their range of action has been widened, so their package of services includes the distribution of contraceptive pills, condoms and HIV antiretrovirals at community level. A whole DLI, out of the 12, is dedicated to the APEs: through a countrywide platform for community-based service delivery, there is a national plan to train and assign APEs to provide RMNCAH+N services. Further investment through the APE programme is also provided to support this mobilization, particularly in disseminating awareness of legislation against early marriage and to promote family planning.

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3. Methodology

The case study research followed the methodology outlined in the introduction.

For the interviews, key informants were selected through a snowball sampling method. Informants interviewed included civil society representatives and officials from the GFF/World Bank and UNFPA. Unfortunately, no officials from the government could be included among the key informants due to issues of availability. This constitutes a limitation to the case study as the perspective of government representatives involved in the elaboration of the investment case is missing.

Semi-structured interviews were conducted, focusing on three core areas: in-country GFF processes, Mozambique's SRHR priorities, and the drivers behind the RMNCAH+N prioritization. The discussions also focused on associated challenges and lessons learned in order to develop a set of recommendations for SRHR prioritization at country level that could also be relevant in other settings.

4. Findings

In its first five years, the GFF has demonstrated how its approach is working to improve the health of women, children and adolescents in its partner countries and helps to close equity gaps. Nearly all GFF partner countries saw positive trends in SRH (IBRD/World Bank, 2020), including Mozambique.

4.1 Progress observed by key informants

CSOs observed that coordination within the MoH has improved. A decentralization process, a key strategy mentioned in the PESS, has been underway since the 1990s (Vîlcu et al, 2022). The contribution of the GFF in supporting the decentralization process through the PHC Strengthening Program was perceived by interviewed CSO representatives to be a positive outcome. One aspect that was recognised by all key informants was the alignment of the investment case with the national health strategy, which enabled better coordination of development aid, and complementarity across donor-funded programmes, such as with GAVI:

> ***"It ensures continuity of actions [...] and less dispersion of resources."*** CSO representative

> ***"The issue of SRH is [now] a whole programme within the MoH."*** CSO representative

> ***"Before, donors, particularly when they implement through NGOs, they only implement some parts of the programme, i.e. providing contraceptives, materials for preventing pregnancy, not in a comprehensive and coordinated manner."***
> CSO representative

Another positive outcome, as a World Bank official underlined, is the fact that, **despite an unfavourable economic and financial context and a decrease in the overall government budget, the share of the government budget allocated to health has been maintained, and even slightly increased.** Indeed, DLI 5 aims to ensure that total share of domestic health expenditure is at least 8.5% of total domestic government expenditure in the first years of the programme, and incentives are provided to further increase the share in later years (Chou et al, 2018). The share of general government health expenditure has increased from 5.6% in 2017 to 8.5% in 2021 (GFF, 2023).

> ***"In Mozambique, the macro-fiscal landscape is quite volatile. In 2014–2015, the GDP/habitant was 4%, then near 0% and now negative. So overall the government budget decreased, and therefore the***

one of the health sector as well. But in terms of public expenditure, overall, the health sector part has increased slightly [...]. So I would say it is a positive effort." World Bank official

As reported by the GFF, **indicators have started to show improvements in healthcare provision and delivery as well,** such as the percentage of pregnant women who had four or more antenatal consultations increasing from 49% in 2018 to 63% in 2021 (GFF, 2023).

4.2 Remaining challenges

The prioritization process in the development of the investment case and the PAD was often seen as a "centralised" process. Despite the multi-stakeholder platform, there were still concerns from CSO representatives about their limited involvement in GFF processes. Some viewed consultation processes as tools for legitimising decisions between beneficiaries and the GFF/World Bank (N'weti, 2019). Others complained about the late involvement of CSOs in the prioritization process. Despite the Civil Society Engagement Strategy (GFF/World Bank, 2017), the GFF has no platform in Mozambique for regular interaction with CSOs and relies only on the government channels. One of the opportunities for CSOs to engage in GFF processes was the Joint Learning Agenda, a two-year capacity-building programme for civil society on advocacy and accountability in favour of health financing for UHC (Cordaid, N'weti, and Wemos, 2023).

"Some organizations were involved in the production of the investment case, but it seems that this involvement was not prepared or organized in the best way. [...] So there was confusion, at least frustration, on the civil society side. In relation to the PAD production, the feeling of exclusion is as much for the civil society organizations as the [technical] health partners themselves." CSO representative

"[...] the initial definition, the priorities, I think, were more technically defined by the Ministry of Health, much more than the involvement of other stakeholders." CSO representative

Regarding SRHR, the exclusion of other critical services has often been stressed. Although a pooled funding mechanism such as the GFF contributes to the inclusion and prioritization of SRH services within a broader health system strengthening programme, several concerns were raised. These included the focus on maternal health and family planning services, to the exclusion of other critical services, such as safe abortion and SGBV (IPPF, 2018), which are seldom mentioned in GFF country documents. Some seemed to agree that this has been the case for Mozambique as well: as a CSO representative mentioned: "[abortion] should be part of the investment case. It is important and should have a very clear budget [...] especially for the equipment that would be needed to provide this service". In addition, the GFF investment for family planning is mostly allocated to equipment and training. **Despite other funding for family planning commodities being available, there is still a gap to cover,** and government expenditure for modern methods has drastically declined since 2020. Although government financing had increased from 1.7% in 2018 to 3.2% in 2019 (USAID, 2021), it fell to 1% in 2021 according to the Family Planning Spending Assessment (Track20, 2021), and expenditure mostly covered condoms. If the government's ratio of domestic health expenditure to total domestic expenditure has slightly increased over the past couple of years, it did not affect the expenditure for family planning commodities.

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Linked to the implementation challenges, monitoring processes are a substantial component of the PforR programme implementation: they represent two out of the 12 DLIs. Rural and district hospitals, as well as rural health centres, "receive performance-based allocations according to at least two scorecard assessments in the previous fiscal year" (World Bank, 2017). The GFF SRHR theory of change mentions that one of the expected outputs is to have real-time disaggregated data to inform decision-making (GFF, 2022). But there was a consensus among key informants that, **despite efforts, the monitoring and evaluation (M&E) system is inefficient**, which in turn affects the DLI-related disbursement of funds. As reported by most key informants, the capacities in M&E and data collection are low and the information management system needs to be strengthened, especially at district and primary healthcare levels. Furthermore, the quality of data has been a significant issue (GFF, 2020; GFF/World Bank, 2017). Due to the lack of M&E capacities, regular stock-outs of family planning commodities occur at different levels, with significant implications for access and uptake:

> *"Collecting real data in rural areas is still a challenge. It's one of the challenges of implementing the investment case through the national health strategy. The process of monitoring and evaluation is inefficient."* CSO representative

> *"[...] when there are stock-outs of the preferred contraceptive method, women do not go to their second preferred method. They just stop."* World Bank official

In the Mozambique context, activities are also monitored using health facility scorecards as well as community scorecards to assess both service providers' and users' perceptions of service quality. Doubt was expressed about scorecards, especially the community ones, and how they are used: community scorecards have been collected by CSOs, but there is uncertainty about whether and how these have been taken into account and contribute to the DLIs.

One of the criticisms that can be found in the published literature but which was not mentioned during the interviews with key informants is the **lack of consideration of out-of-pocket expenditure** (OOPE): neither the Mozambique investment case nor the PAD addresses the issue or suggests measures to mitigate OOPE. In fact, during the revision of health financing strategies, the importance of reducing OOPE has rarely been stressed, and sometimes there have even been proposals for increased co-payment schemes: in the health financing strategy it was recommended that user fees be increased significantly (MSF, 2017). Few actors have warned about how such a measure would further erode access to care and burden patients with additional OOPE, and without proactive measures to reduce user fees, additional resources towards increased provision of health services are unlikely to benefit the most vulnerable and those most in need of care, including in Mozambique (Bomfim et al, 2020; Seidelmann et al, 2020). In the absence of viable domestic public funding, it can also have repercussions for SRHR, with the risk of domestic financing shifting the burden of financing SRHR services and products to OOPE by the poorest and most vulnerable groups (IPPF, 2015; Mutunga and Sundaram, 2015; Ravindran and Govender, 2020).

Despite the multiple financing modalities that create complexity in the health sector (N'weti, 2023), improvement in coordination within the MoH, especially regarding the decentralization process, has been observed by most key informants. However, some agreed on the importance of multi-sectoral actions, and that **the involvement of other sectors had not been sufficiently emphasised and there were therefore coordination challenges.**

> *"When a woman goes to give birth [at the health facility], she needs water for her basic care. In some health centres it's the pregnant women themselves who have to wash their own sheets. So we still have a long way to go, but this problem of water is not a problem that has to do with the health sector, it has to do with the issue of intersectoral coordination. This brings us to another discussion of the extent to which the GFF point manages to improve interaction between the Ministry of Health and other sectors in order to guarantee that services are provided with quality."* CSO representative

> *"In Inhambane, none of the schools were providing SRH. There is a need of better coordination with MoH and the Ministry of Education. [SRH] is an add-on for teachers. When they give activities that are sex labelled, there are some discomforts among teachers, students and parents. It should be integrated in something broader, such as life-skills [...]."* World Bank official

Multi-sectoral action is indeed addressed in investment case and PAD documents, especially in relation to the decentralization process and being "critical for areas like nutrition and family planning, and for strengthening domestic sector financing and public financial management (PFM) systems" (World Bank, 2017). However, this has not been reflected in concrete investments, and indicators related to this objective are lacking.

Finally, **although gender is flagged in the PAD as a cross-cutting consideration, it could be further strengthened.** As a World Bank official observed:

"there is always this assumption that because we work on MNCH and SRH and with adolescent girls, that gender is systematically included. I think it is not enough. It is a missed opportunity to look at the underlying social norms, influences". Examples were given, such as a backlash from parents regarding the provision of contraceptives for adolescents, or nurses who can have judgemental attitudes towards youth. As one research study in Mozambique found out, even in youth- and adolescent-friendly services, there can be significant deficiencies in information and communication with adolescent users." (Bomfim et al, 2020).

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5. Discussion

5.1 Lessons learned

To enhance the sustainability of SRHR in Mozambique, it is imperative to increase government investment in comprehensive SRHR services. This includes family planning, STI/HIV testing, safe abortion and post-abortion care, GBV counselling and referral, comprehensive sexuality education etc. It is important that government prioritizes a comprehensive definition within strategic documents and ensures their accessibility and availability through adequate public budget allocation and expenditure. The GFF, which is designed to support the mobilization of domestic resources for RMNCAH+N, presents a promising opportunity to strengthen these crucial elements.

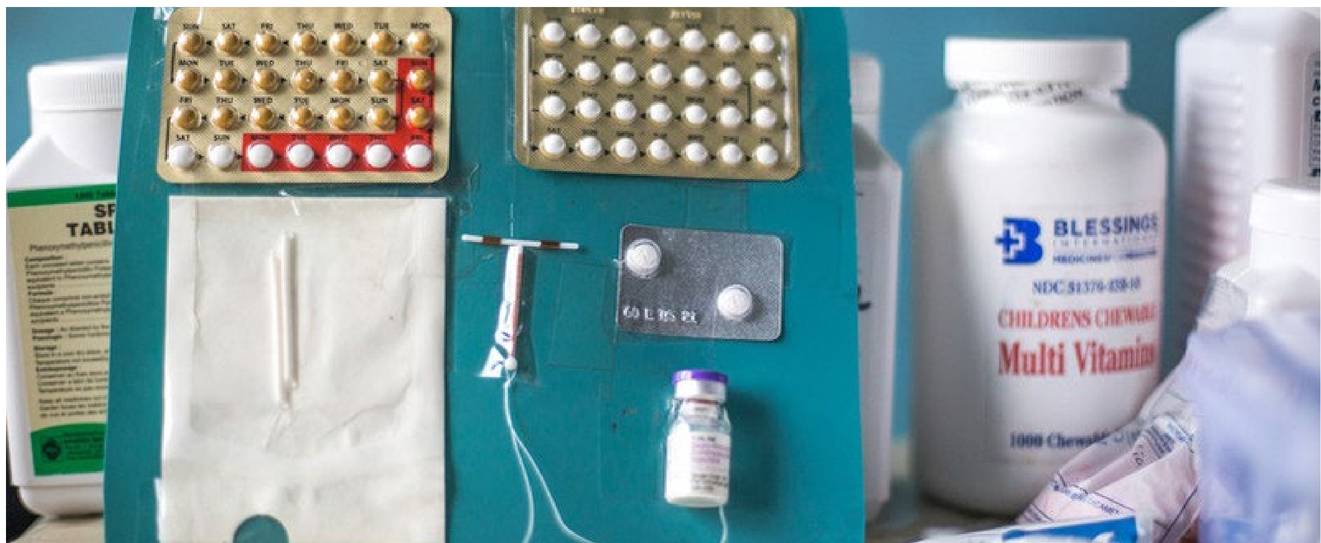
There is a call for consistency in stakeholder engagement and the need for the GFF to consistently address SRHR in planning processes and engage all stakeholders effectively to translate its theory of change into practice (George et al, 2021), especially to ensure the scaling-up process.

Additional efforts to address social norms and underlying social determinants of SRHR are needed in order to have a more transformative approach, as called for by the GFF SRHR Acceleration Plan (World Bank/GFF, 2021).

5.2 Areas for further support

Inefficiencies in M&E implementation for DLIs and PforR: at the time of writing this case study, the process to develop the PAD for the next GFF phase was ongoing and there has been a particular concern for the development of DLIs, as they have major implications for budget allocations at sub-national levels. If there were no particular criticisms of the PforR approach, concern was expressed about the implementation of this instrument. Further support is needed to improve the current monitoring system and to strengthen capacities, especially at primary healthcare and district levels, as fund disbursement is linked to the indicators.

Need for multi-sectoral coordination: it is important that there is multi-sectoral action, especially when tackling adolescent health in schools, where coordination with other sectors is essential. In this aspect, the involvement of other sectors is not sufficiently emphasized in the investment case and PAD, without concrete investments, processes, focal points, or indicators to ensure that action follows. This multi-sectoral action will need to be given greater attention in future PAD and GFF investment case development processes.



IPPF/Kathleen Prior/Vanuatu

Niger case study

1. Country context

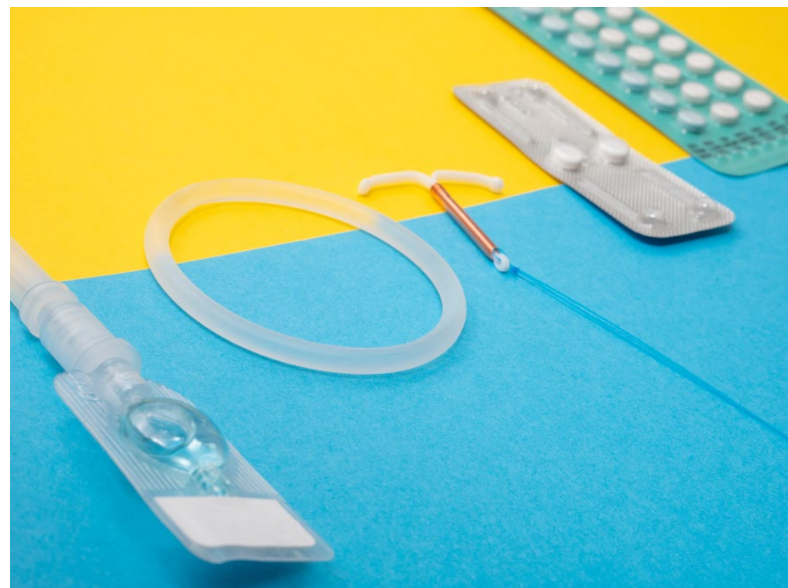
Niger is ranked 189th out of 191 countries on the Human Development Index. Niger faces substantial socioeconomic hurdles, including issues of poverty, food insecurity, and political instability. The security context particularly affects the provision of SRHR services, with health centres closed in some localities and insecurity among healthcare staff, who fear aggression, ongoing violence against civilians or attacks on infrastructure. Access to health services, including SRHR services, has particularly deteriorated in the Diffa and Tillabéri regions (MSP/P/AS, 2023). Political instability across the region also has an impact on demand, with a growing population of refugees coming from Nigeria and Mali and close to 350,000 internally displaced persons (UNHCR, 2022).

The SRHR landscape in Niger presents a multitude of challenges and disparities. Maternal health is a primary concern, with a national maternal mortality rate of 520 deaths per 100,000 births. Moreover, significant regional disparities persist, with rural areas experiencing a rate six times higher compared with urban regions (INS, 2016). This is closely linked to Niger's exceptionally high fertility rate, with an average of 6.2 children per woman in 2021, ranking among the highest in the world. The contraceptive prevalence increases with the level of household economic wellbeing, ranging from 6% for households in the lowest quintile to 24% for the highest quintile (INS, 2022).

Abortion is legally restricted in the country and permitted when the continuation of the pregnancy endangers the life and health of the pregnant woman and in cases of congenital malformation. While there are no national estimates of the abortion rate, one recent study estimated that while reported abortion numbers in Niger may be low, almost all of them are considered unsafe and put women's physical safety at great risk (Bell et al, 2023).

Child health is also a matter of concern, with an **under-five mortality rate exceeding the West African average,** reaching 123 per 1,000 live births in 2021 (INS, 2022). Mortality rates in rural areas are twice as high as those in urban regions, with half of these fatalities attributed to chronic malnutrition (MSP/P/AS, 2022a). The adolescent population, constituting a significant proportion of Niger's demography (51.6% of the population is aged under 15) has a higher fertility rate (133‰) and maternal mortality rate (4.9‰) than other age groups (INS, 2012, 2022). Adolescents experience enormous difficulties in accessing health services, due to low access to quality information on reproductive health and sociocultural factors.

Gender inequality remains a challenge in Niger, with a high gender inequality index of 0.611 in 2021, ranking the country 153rd in the world (UNDP, 2022). Niger has the highest rate of child marriage in the world: one in four women aged between 25 and 29 was already married before the age of 15. Gender-based violence (GBV) is also widespread, affecting 38.2% of women and teenagers (INS, 2022).



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2. The GFF in Niger

In 2019, Niger made a significant step forward in advancing its commitment to RMNCAH+N by joining the GFF. The GFF Country Platform was established in Niger in August 2020 under the leadership of the General Secretariat of the Ministry of Public Health, Population and Social Affairs (MSP/P/AS), and includes partner ministries (Finance, Planning, Promotion of Women and Children), civil society organizations, the private health sector, and technical and financial partners. It acts as the coordination mechanism and decision-making entity for the development, implementation, and monitoring of key RMNCAH+N strategies at the country level.

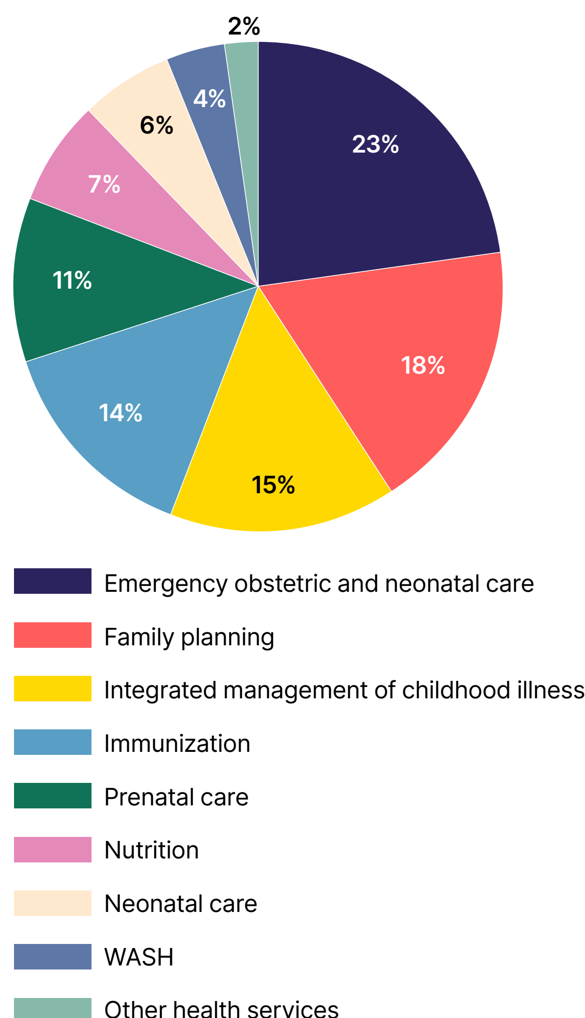
Niger's first RMNCAH+N investment case was published in March 2022 and covers a five-year period from 2022 to 2026. The investment case is an advocacy document that aims to support mobilization strategies and improve alignment of funding towards Niger's priorities and is designed to guide strategic decision-making for all actors working in RMNCAH+N in the country. It is intricately linked to existing frameworks and strategies and aligns seamlessly with the broader national planning and budgeting processes. Indeed, the investment case was constructed as an extension of the Health Sector Strategic Plan (PDS 2017–2021) and served as a reference point for the elaboration of its subsequent version (PDSS 2022–2026) (MSP/P/AS, 2022a).

2.1 Prioritization of Niger's RMNCAH+N investment case

The prioritization of the RMNCAH+N investment case was done using EQUIST, following a methodology used previously in several GFF focus countries. EQUIST uses a systematic approach composed of four levels of prioritization.

Level one: Prioritization of high-impact interventions. 88 high-impact interventions, based on their respective potential impacts in terms of lives saved, were identified and organized into nine service packages. The top three priorities identified were: (1) emergency obstetric and neonatal care, (2) family planning, and (3) integrated management of childhood illness. Together, these represented more than half of the high-impact interventions (see Figure 1) (MSP/P/AS, 2022b).

Figure 1: RMNCAH+N high-impact interventions



Level two: Bottlenecks analysis and prioritization of strategies. The three main priority bottlenecks identified related to the determinants of sociocultural acceptability of RMNCAH+N services, accessibility to these services, and availability of products (MSP/P/AS, 2022b). The analysis of bottlenecks led to the identification of a set of 21 strategies defined as high-priority and grouped in six thematic areas: service delivery; demand for services; governance and leadership; nutrition; water, sanitation, and hygiene; and quality of care.

Level three: Prioritization of vulnerable populations. Based on the cost-effectiveness and expected impact on survival rates of each of the high-impact interventions, five population groups were prioritized: (1) women of childbearing age (aged 15–49), (2) pregnant and breastfeeding women, (3) newborns, (4) children aged 0–5, and (5) adolescents and young people. It is estimated that 6.5 million people, including refugees and displaced persons, will benefit from the implementation of the RMNCAH+N investment case by 2026 (MSP/P/AS, 2022b).

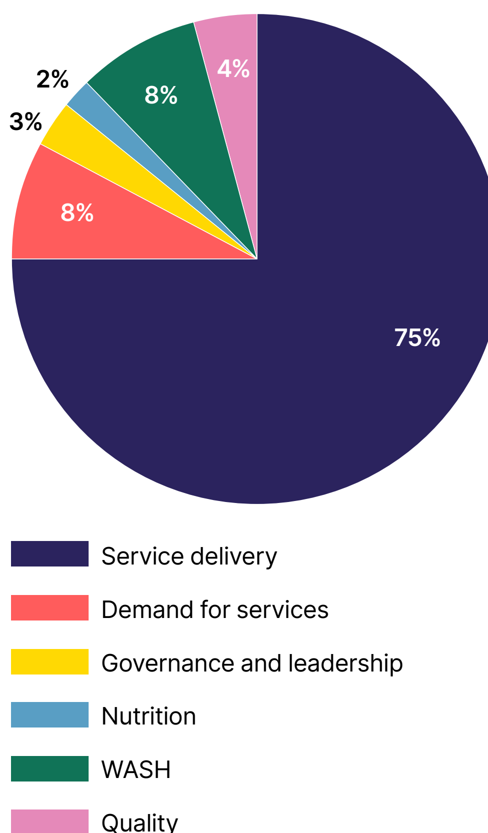
Level four: Prioritization of regions. The eight regions of Niger were prioritized using a composite indicator (MSP/P/AS, 2022b). Three regional priority groups were defined. The first priority group contained four regions: Diffa, Tillabéri, Zinder, and Maradi, representing about 60% of the population of Niger. The second priority group included the first priority regions, with the addition of Tahoua and Dosso regions, representing 91% of the population of Niger. The third priority group included the second priority regions, with the addition of Niamey and Agadez regions, hence covering all eight regions of Niger.

2.2 How priorities translate into funding

To support resource mobilization towards implementation of the RMNCAH+N investment case, three financing scenarios were established using WHO's strategic planning OneHealth[2] Tool, building on the regional prioritization. The financing need for the high-priority scenario, comprising the first regional priority group of four regions, was estimated at XOF 386 billion (US$ 630 million) over five years. The budget need for the second priority scenario (six regions) was estimated at XOF 586 billion (US$ 957 million) over five years. And the third priority scenario (national scale) was estimated at XOF 644 billion (US$ 1 billion) over five years (MSP/P/AS, 2022b). These estimates have been used for advocacy purposes, and they are also used to guide donor investment as the funding is being mobilized.

Out of the budget allocated to the 21 high-priority strategies identified in the RMNCAH+N investment case, 75% is going towards strengthening RMNCAH+N service delivery. The three main strategies in terms of budget are: (1) improving the availability of drugs and other inputs at healthcare delivery points (32% of total budget); (2) strengthening the quantity and quality of human resources and community relays, including in rural and remote areas (22%); and (3) strengthening infrastructure and sustainable facilities (20%). The other thematic strategies represented minor shares of the total budget (see Figure 2) (MSP/P/AS, 2022b).

Figure 2: Percentage of RMNCAH+N investment case total budget by thematic areas



To identify resources available for RMNCAH+N, a resource mapping exercise was undertaken in 2020 as part of the investment case. Resources available for implementation of the RMNCAH+N investment case were estimated at XOF 251 billion (US$ 410 million), which, when compared with the highest-priority scenario of XOF 386 billion (US$ 630 million), leaves a funding gap of XOF 135 billion (US$ 220 million) over five years. The findings highlighted that the financing of RMNCAH+N interventions relies on external

2 The OneHealth Tool is a software tool designed to inform national strategic health planning in low- and middle-income countries. While many costing tools take a narrow disease-specific approach, the OneHealth Tool attempts to link strategic objectives and targets of disease control and prevention programmes to the required investments in health systems. The tool provides planners with a single framework for scenario analysis, costing, health impact analysis, budgeting and financing of strategies for all major diseases and health system components. It is thus primarily intended to inform sector-wide national strategic health plans and policies.

donors, with two-thirds of external financing coming from four multilateral donors: the World Bank, the Global Fund, the World Food Programme and GAVI, the Vaccine Alliance. While the exact share of domestic funding is difficult to calculate based on the state budget, due to the programme-based budget coding and the multisectoral nature of SRHR, the share of domestic funding remains low.

The catalytic funds coming through the GFF financing agreement represent a major contribution to RMNCAH+N financing in Niger (World Bank, 2021a). The GFF investment is organised around a 15-year programme vision with a financing envelope of US$ 521 million from the IDA for the period 2021–2035. The first phase of the programme-based approach called Lafia-Iyali has a total budget of US$ 125 million for the period 2021–2026, which represents one-third of the funding needs for the implementation of the high-priority scenario of the RMNCAH+N investment case. The investment is focused on two priorities: reducing the stunting rate and reducing the adolescent fertility rate in two regions, Zinder and Maradi, which are two of the RMNCAH+N investment case high-priority regions (World Bank, 2021b). Regarding adolescent health, the project supports the existing school health clubs, joining with the United Nations Population Fund (UNFPA) and UNICEF in implementing health and nutrition activities (see Box 1 for details) (World Bank, 2021b).

Other technical and financial partners have pledged to support implementation of the RMNCAH+N investment case through their country offices, based on their cooperation programmes and agreements with Niger's government, but at the time of writing this case study none of them has yet announced a dedicated budget for its implementation.

As the RMNCAH+N investment case is being implemented, it will be possible to monitor RMNCAH+N funding flows based on expenditure data. Indeed, the Reproductive Health sub-account of the National Accounts present yearly expenditure data from all sources of funding. Analysis of the period 2017–2021 showed that the current share of SRHR expenditure varies between 6% and 12% of total health expenditure (all sources of funding combined). In 2021, SRHR expenditure amounted to XOF 53 billion (US$ 87 million), including 44.7% for maternal care, 26.3% for family planning and 5.8% for perinatal care. This could serve as a baseline for future analysis.

School health package

1. **Menstrual health hygiene:**
   - Menstrual health education
   - Supply of menstrual hygiene products
2. **Adolescent sexual and reproductive health:**
   - Family planning
   - Comprehensive sexuality education
3. **GBV and sexual exploitation and abuse (SEA):**
   - Prevention, mitigation and response GBV/SEA
   - Linkages to a referral system for additional social services

3. Methodology

The case study research followed the methodology outlined in the introduction.

Key informants were selected through a snowball sampling method and included a wide variety of stakeholders involved in GFF processes, including the head of the Monitoring and Evaluation Division of the Mother and Child Health Department at the MSP/P/AS, the GFF Liaison Officer, one of the investment case UNICEF consultants, and civil society representatives: the Executive Director and the Monitoring and Evaluation focal point of the Niger Association for Family Welfare and the Niger youth representative to the GFF Investors Group. Where participants wished to remain anonymous with no affiliation to organization or sector, we have labelled them "study participant".

Semi-structured interviews were conducted, focusing on three core areas: in-country GFF processes, Niger's priorities, and the drivers behind the RMNCAH+N prioritization. The discussions also focused on associated challenges and lessons learned to develop a set of recommendations for SRHR prioritization at country level that could also be relevant in other settings.

4. Findings

4.1 Progress observed by key informants

The elaboration and prioritization of Niger's RMNCAH+N investment case was perceived as highly inclusive and collaborative by study participants. The process was led by the MSP/P/AS and engaged about 90 public health experts, including members of the GFF platform, as well as regional representatives and clinical experts. Civil society was included in the process, represented by four organizations: one working on RMNCAH, one focused on nutrition, one representing youth ambassadors, and one representing religious leaders. The country received technical support from a team of UNICEF consultants and benefited from the expertise of other technical and financial partners in country. All key informants of this study particularly appreciated the participative nature of the approach and the clarity of the evidence-based methodology employed.

All key informants agreed on the importance of aligning the different existing RMNCAH+N strategic documents and valued the fact that the RMNCAH+N investment case was in line with the health sector strategic plans. This avoids duplication of efforts, minimizes gaps, and helps mobilize all actors towards the same priorities and objectives.

> ***"The investment file is not a stand-alone programmatic document. The previous PDS 2017–2021 provided input for the investment case, then the investment case informed the new PDSS 2022–2026. The RMNCAH part is basically a copy/paste."*** Study participant

Several key informants emphasized the importance of strategies targeted towards adolescents because this group is a main driver of the high fertility and high maternal mortality in the country. Priorities identified for adolescents included ensuring access to quality information about RMNCAH, protection against STIs and unwanted pregnancy, and access to modern contraceptive methods. CSO representatives also underlined the importance of menstrual health.

> ***"Many girls don't know their cycle, some girls even drop out of school. Therefore, learning how to manage their menstruation would enable girls to take charge of their lives. A girl can do her family planning without going to the health centre because she knows her cycle and she can practise abstinence if she doesn't have access to FP products."*** CSO representative

4.2 Remaining challenges

Although the use of EQUIST was perceived positively, several stakeholders noted that the high data requirement of the tool had been slowing down the process. In fact, the most recent demographic survey conducted in 2017 had not yet been validated at the time of the study, and the previous survey dated back to 2012, which was outdated. As a result, a small technical team had to be formed to collect data from a combination of more recent surveys and studies to feed into the tool, and it took several iterations to finalise.

> ***"[This process was] time-consuming, sometimes forcing us to use preliminary data."*** Study participant

Representatives from the MSP/P/AS objected to the reliance on the external expertise of international consultants to run the tools. Indeed, the process of elaborating the RMNCAH+N investment case was slowed down partly as the international consultants' team was unable to travel during the global COVID-19 pandemic. This was seen as major reason for delaying the process and underlined the need to provide in-country training on EQUIST.

> ***"They were supposed to train a small team of the Ministry on OneHealth so that we could do the costing ourselves, but that didn't happen."***
> MSP/P/AS representative

When reflecting on the prioritization of the RMNCAH+N investment case, one CSO representative objected to the insufficient focus on gender issues, underlining that SRHR and gender are closely linked:

> ***"Niger is a patriarchal society, where men wield significant decision-making power over the family. Men provide financial support to pay for care, decide if a daughter goes to school and when she is to be married, etc. A positive masculinity approach could contribute to tackling issues such as gender-based violence and early marriage."*** CSO representative

Although gender was included in the situation analysis, it did not emerge as a priority bottleneck, so gender was not included in the RMNCAH+N investment case priority strategies.

Another CSO underlined the limitation of the regional prioritization, arguing that it presented regions as homogeneous rather than having their own complexities and urban/rural disparities.

> ***"Even in the region of Niamey, the outskirts are under-served and should be prioritized."***
> CSO representative

One CSO representative noted the insufficient involvement of civil society representing young people, despite the issues identified for this high-priority target group. Indeed, only one youth representative contributed to the RMNCAH+N investment case elaboration process, and found it challenging to influence decisions:

> ***"I was the only one representing young people, and I am a woman. It was quite hard to have my voice heard. [...] Strategies towards adolescent and youth in Niger are underfunded, and funding is not aligned to the priorities, [...] and priorities are given by documents rather than by what is happening in the clinic."*** Youth CSO representative

Finally, some participants observed that there is a need to advocate for legal reforms, including the Reproductive Health Law. For instance, there has been consideration of prioritizing long-acting contraceptive methods in the RMNCAH+N investment case, but this would be in contradiction with current provisions from the Reproductive Health Law. Moreover, the current law also strictly restricts access to abortion and leads women to seek alternative and often unsafe abortion, which is considered worldwide as a major driver of maternal mortality.

> ***"The existing law does not adequately protect health workers when providing services to unmarried individuals and because of that the prioritization ultimately leaned toward condoms."***
> CSO representative

5. Discussion

5.1 Lessons learned

The elaboration of the investment case has had a great impact on the alignment and prioritization of RMNCAH+N in Niger. The collaborative and inclusive approach has helped to unite all actors, including civil society, around the same plan and country priorities.

While visibility on SRHR priorities per se is limited due to the wide scope of the investment case, the RMNCAH+N priorities are considered relevant compared with country needs. One caveat is the insufficiency of gender-specific strategies addressing GBV and early marriage.

Feedback on the use of EQUIST for prioritization has been largely positive. The methodology employed was clear, and the iterative process allowed for the refining of priorities. It would be important to provide in-country training on the tool for a small team at the MSP/P/AS, with the aim of strengthening in-country capacity and ensuring sustainability of the process.

5.2 Area for further support

In the future, there will be a need to further support policy development and advancing legal reforms so that they align closely with the evolving needs and best practices in SRHR. GFF has supported key legal reforms, including the institutionalization of school health clubs and enabling married teenagers to access family planning services without being accompanied by a parent or husband (Calimoutou, 2022; GFF, 2022). However, there remains a clear need to advocate for additional policy reforms, especially regarding the Reproductive Health Law in Niger, to remove legal and institutional barriers to access to reproductive health services for all.

To maximise the impact of the RMNCAH+N investment case, it will be essential to make the link between national and sub-national planning and budgeting processes. Indeed, the Health Sector Strategic Plan (PDSS), where the investment case is nested, is translated into Priority Action Plans (PAPs), then into Annual Action Plans (AAPs). AAPs are elaborated through all levels of the health pyramid to implement the priorities identified nationally. Ensuring the alignment between national and sub-national planning would facilitate monitoring of the implementation of the SRHR priorities and be key for the success of the RMNCAH+N investment case.

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Overall recommendations

Drawing on insights and learnings from Mozambique and Niger, the following set of recommendations suggests ways to improve the prioritization of SRHR and processes around it related to the development of GFF investment cases, that could be relevant and applicable in other settings.

Government-driven processes and alignment with national health strategies

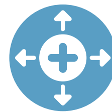
The GFF offers an opportunity to reinforce and advance the SRHR agenda within the framework of national health system strengthening programmes, in an integrated manner, and in support of national health strategies. Collaborative and inclusive government-led processes for the development of GFF investment cases enable greater alignment of health sector stakeholders, including donors and civil society, around RMNCAH+N priorities and programmes, including SRHR.

The GFF provides an opportunity to support countries to adopt a comprehensive definition of SRHR

There is a need to do more to actively translate the goals of the GFF SRHR Acceleration Plan into action at country level, ensuring that users have access to a broad range of services including prevention and treatment of HIV and STIs; GBV counselling and referrals; infertility services and counselling; prevention, detection, and management of reproductive cancers; access to safe abortion care.

Push for further stakeholder engagement

There is a call for consistency in stakeholder engagement and the need for the GFF to consistently address SRHR in planning processes through effectively engaging a wide range of stakeholders, including CSOs with relevant expertise in SRHR and youth actors, to translate the GFF's theory of change into practice. Moreover, technical partners such as UNFPA and UNICEF provide critical technical assistance to country teams, and there is call for further capacity building and skills transfer to build national stakeholders' understanding and ownership of tools and processes to develop GFF investment cases.



Expand the SRHR dataset on which the GFF investment case is based to enable consideration of a wider range of interventions and areas for prioritization

Currently, SRHR interventions in GFF investments are mainly restricted to contraceptive use and antenatal care, childbirth, and postnatal care. This will require stronger investment in the collection, collation, aggregation, and analysis of broader SRHR datasets. It is also important to complement the EQUIST data with further SRHR needs and interventions assessment carried out by other UN agencies, particularly UNFPA and WHO.

Invest in strengthening in-country capacity on EQUIST as a tool to support prioritization

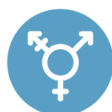
The tool supports a clear approach to prioritization and the iterative process allows for refining of country priorities throughout the process. It is important to ensure that a number of stakeholders in country understand and are trained on the tool to strengthen in-country capacity, ownership, and sustainability of the process.

Domestic resource mobilization

The GFF is designed to support mobilization of domestic resources for RMNCAH+N at country level. The GFF should continuously engage with governments for them to deliver on their commitments for increased public funding and expenditure for SRHR to ensure sustained expansion of accessibility and availability of services.

Harness the potential for policy reforms

There is a need to further support policy development at country level, so that national legal frameworks closely align with the evolving needs and best practices in SRHR. GFF has already supported key legal reforms in countries such as Niger and Mozambique; however, there is a need to further advocate for the removal of legal and institutional barriers to ensure access to a wide range of reproductive health services for all.



From gender-responsive to gender-transformative interventions

Further efforts to address social norms and underlying social determinants of SRHR are needed to foster a more transformative approach, as called for by the GFF SRHR Acceleration Plan (World Bank/GFF, 2021), and there is a role for the GFF to play in pushing this agenda through national investment cases.

Looking beyond the prioritization and development of the investment cases, and in order to support their effective implementation and monitoring, there is a need to ensure that GFF investments are cascaded down at all levels of the health systems

To maximize the impact of RMNCAH+N investment cases, it is important to ensure that national and sub-national plans and budgets align with investment case priorities and, more specifically, that priorities, investments, and key indicators agreed upon at national level are translated into costed implementation plans and annual budgets at sub-national level. This will also strengthen M&E systems and contribute to the effective monitoring of progress towards the expected results of investment cases, as well as inform and trigger fund disbursement based on achievements of select DLIs.

References

Introduction

GFF (2020) *Roadmap for Advancing Gender Equality.*

GFF (2022) *Global Financing Facility SRHR Approach Paper.* Fourteenth Investors Group Meeting, June 7–8, 2022.

IBRD/World Bank (2020) *Protecting, Promoting and Accelerating Health Gains for Women, Children and Adolescents: Global Financing Facility 2021–2025 Strategy.* Washington, DC: IBRD/World Bank.

World Bank/GFF (2021) *Sexual and Reproductive Health and Rights Acceleration Plan. July 2021.*

Mozambique

Bomfim E., Mupueleque M.A., Dos Santos D.M.M., *et al*. (2020) Quality assessment in primary health care: Adolescent and Youth Friendly Service, a Mozambican case study. *The Pan African Medical Journal* 37: 1. Available here.

Chandra-Mouli V., Plesons M., Sullivan E., *et al*. (2018) 38.8 million additional modern contraceptive users: this, in fact, is “a never-before opportunity to strengthen investment and action on adolescent contraception”. *Reproductive Health* 15: 17. Available here.

Chou V.B., Bubb-Humfryes O., Sanders R., *et al*. (2018) Pushing the envelope through the Global Financing Facility: potential impact of mobilising additional support to scale-up life-saving interventions for women, children and adolescents in 50 high-burden countries. *BMJ Global Health* 3(5). Available here.

Claeson M. (2017) The Global Financing Facility – towards a new way of financing for development. *The Lancet* 389(10079): 1588–1592.

Cordaid, N’weti and Wemos (2023) *Together for Stronger Health Systems: A Comparative Analysis of the Coordination and Alignment of the Global Fund, Gavi and GFF in the Democratic Republic of the Congo, Mozambique and Rwanda*. Policy Brief, June 2023.

Cortez E., Orre A., Fael B., *et al*. (2021) *Costs and Consequences of the Hidden Debt Scandal of Mozambique.* Maputo and Bergen: CIP and CMI.

FP2020 (2017) Family Planning 2020 Commitment: Government of Mozambique. London: FP2020.

Gebregziabher F.H. and Sala A.P. (2022) *Mozambique’s “hidden debts”: Turning a crisis into an opportunity for reform*. World Bank Blogs. Available here.

George A.S., Jacobs T., Kinney M.V., *et al.* (2021) Are rhetorical commitments to adolescents reflected in planning documents? An exploratory content analysis of adolescent sexual and reproductive health in Global Financing Facility country plans. *Reproductive Health* 18(Suppl 1): 124. Available here.

GFF (2020) *GFF Portfolio Update: April 2020*.

GFF (2022) *Global Financing Facility SRHR Approach Paper.* Fourteenth Investors Group Meeting, June 7–8, 2022.

GFF (2023) Mozambique. Country Profile. Available here.

GFF/World Bank (2017) *Civil Society Engagement Strategy.* Available here.

IBRD/World Bank (2020) *Protecting, Promoting and Accelerating Health Gains for Women, Children and Adolescents: Global Financing Facility 2021–2025 Strategy.* Washington, DC: IBRD/World Bank.

INE (Instituto Nacional de Estatística) (2023) *Moçambique Inquéritos Demográfico e de Saúde 2022–2023*. *Relatório de Indicadores-Chave*. Maputo and Rockville, MD: INE and ICF.

IPPF (2015) *Financing Demystified*. London: IPPF. Available here.

IPPF (2018) *Taking Stock: IPPF Recommendations on the Global Financing Facility (GFF)*. Available here.

Jaén-Sánchez N., González-Azpeitia G., Saavedra-Santana P., *et al*. (2020) Adolescent motherhood in Mozambique. Consequences for pregnant women and newborns. *PLoS One* 15(6): e0233985. Available here.

MISAU (2011) Plano Estratégico do Sector da Saúde PESS 2014–2019. Direcção de Planificação e Cooperação. Available here.

MISAU (2017a) *Global Funding Mechanism in Support of All Women and All Children: Investment Case Proposal – Version IV.*

MISAU (2017b) O Processo de Preparação do Caso de Investimento. In: *Global Funding Mechanism in Support of All Women and All Children: Investment Case Proposal – Version IV*. Annex 1.

MISAU (2018) *Estratégia de Inclusão de Género no Sector da Saúde 2018–2023*. Unidade do Género.

MISAU (2020) *Estratégia De Planeamento Familiar e Contracepção 2011–2015 (2020)*. Maputo: Direção da Saúde Publica.

MISAU and INE (Instituto Nacional de Estatística) (2013) *Moçambique Inquérito Demográfico e de Saúde 2011*. Calverton, Maryland, USA: MISAU, INE e ICFI.

MSF (Médecins Sans Frontières/Doctors Without Borders) (2017) *Taxing the Ill: How user fees are blocking universal health coverage*. Brussels: MSF.

Mutunga A. and Sundaram P. (2015) *How will the global financing facility deliver for sexual and reproductive health and rights?* Bretton Woods Project, 31 March 2015.

N'weti (2019) *Global Financing Facility (GFF): An Alternative Health Sector Financing Model?* Policy Brief 08. Maputo: N'weti.

N'weti (2023) *Health Sector Financing in Mozambique: Analysis of Institutional, Financial and Political-Economic Issues*. Policy Note 02. Maputo: N'weti.

OCS (Observatório Cidadão para Saúde) (2023) *Analysis of the Balance of the Economic and Social Plan to evaluate the performance in the execution of sexual and reproductive health activities of adolescents in the priorities budgeted in the Investment Case approved in Mozambique (2010–2022)*.

Piatti-Fünfkirchen M., Hadley S. and Mathivet B. (2021). *Alignment of Performance-Based Financing in Health with the Government Budget: A Principle-Based Approach*. World Bank: Health, Nutrition, and Population (HNP) Discussion Paper. Washington, DC: Word Bank Group.

Ravindran T.K.S. and 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): 1779632. Available here.

Seidelmann L., Koutsoumpa M., Federspiel F. and Philips M. (2020) The Global Financing Facility at five: time for a change? *Sexual and Reproductive Health Matters* 28(2): 1795446. Available here.

Steurs L. (2019) European aid and health system strengthening: an analysis of donor approaches in the DRC, Ethiopia, Uganda, Mozambique and the global fund. *Global Health Action* 12: 1614371.

Track20 (2021) *Family Planning Spending Assessment – Mozambique*. Available here.

Track20 (2023) Projected trends in mCPR. Available here.

UN Women (2023) Mozambique. Available here.

USAID (2021) Landscape Analysis of Family Planning in Mozambique. Available here.

Vîlcu I., Lourenço S., Cueteia E., *et al.* (2022) *Decentralization Reforms in Mozambique: How This Has Shaped Health Financing Arrangements and Public Financial Management Practices in the Health Sector*. Case Study. Maputo: ThinkWell.

Word Bank (2017) *Program Appraisal Document on a Proposed Grant from the International Development Association SDR 57.00M (US$ 80.00M Equivalent) and a Proposed Grant from The Global Financing Facility (US$ 25.00M) to The Republic of Mozambique for a Mozambique Primary Health Care Strengthening Program*. Report No: 120958-MZ. The World Bank. Available here.

World Bank (2023) Maternal mortality ratio (modelled estimate, per 100,000 live births) – Mozambique. Available here.

World Bank/GFF (2021) *Sexual and Reproductive Health Rights Acceleration Plan*. July 2021.

Word Bank/IDA (2019) *Program Paper on a Proposed Additional Grant to the Republic of Mozambique for the Mozambique Primary Health Care Strengthening additional financing*.

Niger

Bell S.O., Oumarou S., Larson E.A., Alzouma S., Moreau C. (2023) Abortion incidence and safety in Niger in 2021: Findings from a nationally representative cross-sectional survey of reproductive-aged women using direct and indirect measurement approaches. *PLOS Glob Public Health* 3(10): e0002353. Available here.

Calimoutou E. (2022) *How new laws are protecting women and girls, and changing mindsets in Niger*. World Bank Blogs. Available here.

GFF (2022) *Advancing Health for Women, Children, and Adolescents Amid Overlapping Crises. GFF Partnership Annual Report 2021–2022*. Available here.

INS (2012) *Recensement Général de la Population et de l'Habitat 2012*. Available here.

INS (2016) *Etude Nationale d'Evaluation d'Indicateurs Socio-Economiques et Démographiques (ENISED) 2015*. Available here.

INS (2022) *Enquête Nationale sur la fécondité et la mortalité des enfants de moins de cinq ans (ENAFEME) 2021*. Available here.

MSP/P/AS (Ministère de la Santé Publique, de la Population et des Affaires Sociales) (2020) Arrêté N°000754/MSP/SG du 18 août 2020 portant création, missions, composition et fonctionnement d'un Comité Technique chargé de superviser l'élaboration et la mise en œuvre du Dossier d'Investissement pour la Santé Reproductive, Maternelle, Néonatale, Infantile, Adolescent et Nutrition (SRMNIA/Nut).

MSP/P/AS (2022a) *Plan de Développement Sanitaire et Social (PDSS) 2022–2026*. Available here.

MSP/P/AS (2022b) Dossier d'investissement du Niger pour la santé reproductive, maternelle, néonatale, infantile, adolescent et la nutrition (SRMNIA-Nut) 2022–2026. Available here.

MSP/P/AS (2023) *Plan stratégique intégré santé reproductive, maternelle, néonatale, infantile, adolescente et jeune / Nutrition (SRMNIAJ-Nut) 2022–2026*.

MSP/P/AS (2023) Comptes de la Santé 2021.

UNDP (2022) *Report on Human Development Index 2021/2022*. Available here.

UNHCR (2022) *Niger Operational Update August 2022*. Available here.

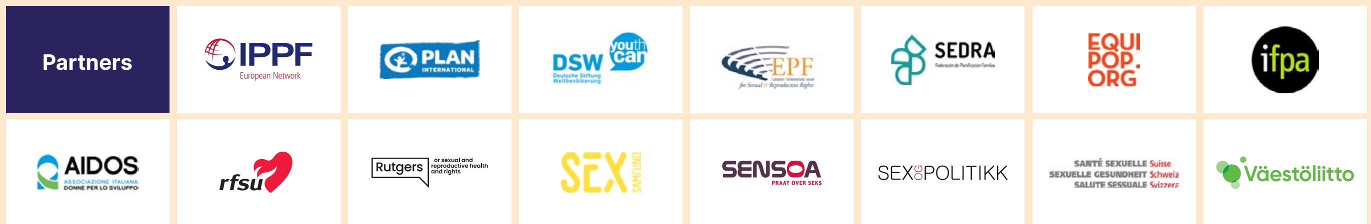
World Bank (2021a) Niger to Improve Women and Girls' Access to Nutrition and Health Services. Available here.

World Bank (2021b) *Niger, Improving Women's and Girls' Access to Improved Health and Nutrition Services in the Priority Areas Project* – LAFIA-IYALI (Phase 1).

About Countdown 2030 Europe

Countdown 2030 Europe is the 'go-to' cross-country sexual and reproductive health and rights (SRHR) expert Consortium in Europe seeking to increase European SRHR funding in international cooperation and strengthen political support for sexual and reproductive freedom worldwide. The Consortium is made up of 15 leading European non-governmental organisations and is coordinated by IPPF European Network.

Consortium



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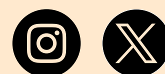

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