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GUIDE FOR IDENTIFYING CATALYTIC INVESTMENTS TO RAISE DOMESTIC RESOURCES FOR FAMILY PLANNING

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Abbreviations

AFP	Advance Family Planning
CIP	costed implementation plan
FP2020	Family Planning 2020
HP+	Health Policy Plus
mCPR	modern contraceptive prevalence rate
SFI	Sustainable Financing Initiative
TCI	The Challenge Initiative
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

Introduction

As countries aim to develop strategies for sustainably financing their family planning programs, they may benefit from catalytic investments to (1) increase domestic resource allocation to the family planning program or (2) increase the execution of already allocated resources. This guide is intended to help countries identify and implement catalytic interventions for domestic financing of family planning across four broad types of interventions: *advocacy, capacity development, policy,* and *expansion of the market*. A framework and examples are provided to help countries combine and apply different types of investments based on a family planning program's unique characteristics as well as the country's broader health financing system maturity (see Tables 3–5 later in the guide).

A catalytic investment, as defined in Box 1, may be made by any entity, with the aim that it would increase domestic resource allocation to a family planning program or increase the execution of already allocated resources. For development partners, a catalytic investment would be any opportunity to apply targeted resources to unlock or "crowd-in" domestic resources, especially in favor of an overall transition toward a locally led and funded family planning program. Often, catalytic investments build on one another and more than one will be needed to have the intended output.

Box 1. Catalytic Investments for Domestic Resource Mobilization

- Refers to an activity, program, or mechanism that leverages existing political, social, and financial opportunities to increase the likelihood that decisionmakers will raise allocation of domestic resources or improve execution for domestic resources.
- Can include a range of actions, such as technical assistance, new public/private partnerships, and co-financing arrangements that bring together different funders.
- Can help spur domestic commitments and allocations to family planning when there is limited fiscal space and when external funding displaces government support, requiring additional actions to incite policymakers to invest in health.

This guide is divided into two sections. Part 1 provides a rationale for why catalytic investments are needed for family planning programs and explains the different types of program areas, barriers, and financing contexts that need to be considered when planning for catalytic investments. Part 2 describes catalytic investments that are suitable for different family planning program areas and country contexts, examples of catalytic investments from global practice, and guidance on the process for identifying and prioritizing the right investments.

Part 1. Understanding Catalytic Investments in the Context of Family Planning

Rationale for Catalytic Investments for Family Planning

On average, countries in sub-Saharan Africa have a low contraceptive prevalence rate (32 percent) and high unmet need for family planning (23 percent). This suggests that significant investments are needed to improve access to and utilization of family planning (KFF, 2019). Many of these countries have been proactive in scaling up family planning by signing Family Planning 2020 (FP2020) commitments and setting related targets under the Sustainable Development Goals. However, many family planning programs in low-income countries are under-funded when compared to the resource needs outlined in their family planning costed implementation plans (CIPs). As reflected in Table 1, domestic sources are not able to fully meet needs.

Table 1. Family Planning CIP Costs Compared to Domestic Spending in 2016

Country	CIP cost in 2016	Domestic spending on family planning in 2016	Percent domestically funded
Senegal	$6,190,441	$3,360,000	54%
Cameroon	$10,148,041	$2,770,000	27%
Guinea	$3,207,562	$1,100,000	34%
Uganda	$35,200,000	$2,260,000	6.4%

Source: FP2020, 2018

According to FP2020, 45 percent of family planning funding in the 69 priority countries of the initiative—mostly in sub-Saharan Africa—comes from development partners (FP2020, 2019). Yet, total external funding for family planning has steadily declined since 2014. The U.S. Government is the largest international funder for family planning, though its contribution has been inconsistent over the last several years. Funding ranged from US$638 million in 2015 to US$475 million in 2017, then back to $US631 million in 2018 (FP2020, 2019). Separately, from 2014 to 2017 the United Nations Population Fund (UNFPA)—the largest single funder of modern contraceptive commodities for low-income countries—saw a significant decline in contributions from donor governments, although there was a small increase in 2018 (Kates et al., 2019). Given these trends and ambitions under the Sustainable Development Goals and FP2020 commitments, many countries in sub-Saharan Africa will need to consider strategies for raising sustainable domestic financing for family planning.

Currently, most of these countries have limited fiscal space for health. Sector-wide policies are needed to reduce out-of-pocket spending and scale up access to primary healthcare and quality of services. Many countries also suffer from low budget execution rates for their health sector allocations. If overall spending on primary healthcare and commodities purchased by governments rises, and if execution of health budgets reaches 100 percent, resources for family planning would increase. However, in many countries, family planning struggles to compete with other priorities. Domestic resource mobilization for family planning is sometimes perceived as an externally driven priority.

Family Planning Program Areas and Funding Sources

Generating political will for allocating health sector budgets to family planning requires advocates to understand trends in external support and needs across all aspects of the program. Family planning programs can usually be categorized into four areas when discussing domestic funding.

1. Demand generation. This refers to increasing clients' desire to use family planning by changing their attitudes or perceptions about family planning or increasing their awareness or knowledge about family planning methods. Demand generation is needed when the modern contraceptive prevalence rate (mCPR) is low.
2. Service delivery. This refers to the provision of family planning services, information, and methods at public and private points of care. As mCPR reaches an accelerated growth phase, service delivery needs to be prioritized.
3. Supply chain. This refers to the storage and distribution of family planning commodities. In the early stages of mCPR growth, the supply chain requires an existing infrastructure, which needs to be reinforced as growth increases.
4. Family planning commodities. This refers to the procurement of contraceptives and commodities. As mCPR increases, procurement of a wider range of methods needs to be prioritized.

Across these four areas of family planning, low-income countries may experience similar challenges related to domestic resource mobilization. For example:

- *Demand generation:* Historically in sub-Saharan Africa, demand generation for family planning has been supported heavily by external funding. In the absence of external support, there is usually insufficient spending on this area by the government, which may relate to an overall lack of spending on public health or promotive interventions. In some contexts, socio-cultural concerns due to lack of engagement of religious and community leaders may make public funding for promotion of modern contraception challenging.
- *Service delivery:* The service delivery program area is typically funded by various domestic sources, including user fees paid out of pocket. A range of financing barriers can affect improved service delivery. Access to family planning services and information that ensures voluntarism and informed choice, as well as a full range of modern family planning methods and high-quality services, may be limited due to a lack of: trained health workers in the public and private sector, commodities, cultural competency of providers, and health facilities near population centers. These factors may be lacking due to inadequate funding from the government or inadequate development in the private market.
- *Supply chain:* The supply chain is usually funded by domestic public and private sources, with external funding for improvements or technical assistance. Across supply chain systems for free products (grant-funded or purchased by the government), social-marketed products, and commercial products, there may be varying levels of adequacy. Improved investment in warehousing and distribution systems would improve commodity availability and eliminate stockouts; cost savings from efficiency improvements could be passed on to clients to reduce the cost of products accessed through the commercial market.
- *Family planning commodities:* In low-income and even some lower-middle-income countries in sub-Saharan Africa, overall needs for modern method *commodities* continue to be

significantly funded by external sources. Procurement by national or local governments for modern methods is limited due to a lack of budget allocation as well as limited capacity for costing, forecasting, quantification, and tendering.

Barriers to Domestic Funding for Family Planning

As can be seen, levels of dependency on external funding vary. In some areas, there is already an expectation that governments will step in to fund key costs, especially as external partners taper or plateau their support, or the country rises in terms of income level and graduates from receiving significant foreign funds. Yet, as an intervention associated with fertility and sexual and reproductive health, family planning faces social, political, and systems barriers that inhibit domestic funding. Key barriers in this context can be organized into the following three categories:

1. Cultural and social: Beliefs or customs in a country that reduce family planning demand and provision by qualified providers. These include (a) *religious beliefs* that may advise against or prohibit use of modern family planning methods, (b) *pro-natalist beliefs* in which society and cultural customs promote having large families, (c) *gender attitudes* in which women do not have the same rights as men or women's autonomy to make decisions is limited, and (d) *cultural taboos* that warn or prohibit the use of modern family planning methods.
2. Socioeconomic and technocratic: Bureaucratic perceptions that the population needs to grow or that there is no need to limit population growth. These include beliefs that (a) there is a future *need for workers* in the country and no need to manage population growth, (b) *low literacy and education* prevent an increased demand for family planning due to the limited effectiveness of information, education, and communication materials, (c) *high labor mobility* makes it difficult for women to consistently access family planning, and (d) *high infant and child mortality* affects fertility choices as well as priorities in primary healthcare investment.
3. Health system financing and functioning: Under-developed and under-resourced systems that restrain service provision. These include systems with (a) *few public resources* due to low resource generation and collection, limiting ability to fund family planning, (b) *insufficient qualified human resources for health*, limiting those who can provide a diverse range of family planning services and methods across the country, (c) cadres of health workers at lower levels of the health system that can provide *short-acting methods only*, limiting access to other methods, and (d) lack of knowledge of the impact of *high out-of-pocket spending*, believing that those who need family planning services can access them from the private sector if needed.

Some of the barriers to domestic spending faced by family planning programs are not unique—they are shared by other vertically funded programs, such as HIV, that have received significant external assistance over the past decades. In low- and middle-income countries, global health practitioners have been considering how to motivate governments to mobilize increased domestic resources to family planning programs. One policy intervention involves specific rules requiring domestic co-financing for external grants—and providing technical assistance to execute this commitment—as practiced by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Another set of policy interventions involves removing evidence, capacity, or process barriers preventing domestic spending, as done under the U.S. President's Emergency Plan for AIDS Relief's (PEPFAR's) Sustainable Financing Initiative (SFI) for HIV, led by the U.S. Agency for International Development (USAID). In effect, these approaches attempt to "catalyze" domestic spending—which includes investments from health insurance, the private sector, and households that are able to pay out of

pocket—where none or very limited levels existed. There has been limited application of such thinking to family planning, although overall interest has surged in recent years.[1] Countries aiming to develop strategies for sustainably financing their family planning programs, especially to safeguard recent increases in modern contraceptive prevalence among the poor, may benefit from catalytic investments.

The S-curve and Health Financing Maturity

As a way to help prioritize whether a specific catalytic investment can be impactful, the planning process should begin with understanding where the country fits within archetypes based on (1) the health financing system's maturity and (2) recent growth in mCPR, also known as the "S-curve" (see Table 2). Health financing maturity is based on fiscal space for health, dependency on external financing, and level of health insurance coverage. The S-curve represents patterns for mCPR growth in a country, characterized by slow growth and little annual change when mCPR is low (stage 1), an opportunity for rapid growth during the transition from low to high mCPR (stage 2), and slowing growth as mCPR reaches its maximum (stage 3) (Track20, 2017).

Where a country lies along the S-curve is important to determine investments that are needed across the four main components of the family planning program (demand generation, family planning commodities, service delivery, and supply chain). For example, slow growth in mCPR may require more spending on demand generation. A catalytic investment could sensitize local government and community leaders on the need to fund community-level communication efforts. A country with a higher mCPR should focus more on equitable access to family planning and improved availability of the full range of methods. This may involve investments in advocacy for and development of new policy. There can be catalytic investments at every point along the S-curve and in every aspect of programming.

The health financing maturity of a country also matters when considering the appropriate catalytic investments. For example, if a country has higher health financing maturity and an existing health insurance scheme, it could mobilize domestic resources to reimburse service providers or pay for commodities. A catalytic investment in this context could focus on an opportunity to include family planning in the benefits of an insurance scheme, such as paying for an actuarial or costing study to build the case for scheme administrators to fund such services.

Barriers to financing family planning exist not only at the health financing level, for example, due to a country's limited fiscal space, but also at the programmatic level, for example, due to cultural or religious beliefs that limit access to family planning services. The intersection of these two dimensions, family planning context and health financing maturity, will help identify the appropriate type of catalytic investment for the specific country context, as explained later in this report.

[1] USAID held a regional meeting on family planning financing in January 2018. For more information on the "Attaining Sustainable Financing for Family Planning in Sub-Saharan Africa" meeting, see: http://www.healthpolicyplus.com/FP-SSA.cfm.

Table 2. Health Financing Maturity Levels and the Family Planning S-curve

	S-curve and mCPR*	Health financing maturity
Low	**S1. Slow mCPR growth**: very low mCPR. Efforts are needed to stimulate demand, shift social norms, and establish infrastructure to deliver family planning services.	**F1. Low maturity**: minimal coverage of pre-payment schemes, high level of dependency on external resources for priority health programs, and limited government revenue.
Emergent/ Moderate	**S2. Entering rapid mCPR growth**: demand and mCPR begin to increase, likely to see faster growth rate. Efforts are needed to change policies, strengthen commodity security and the supply chain, reinforce high-quality service delivery, and sustain demand.	**F2. Emerging**: some expansion of pre-payment schemes, significant dependency on external resources but with movement toward enhanced use of domestic resources and improving capacity in government revenue mobilization.
	S3. Period of rapid mCPR growth: mCPR is increasing; countries can sustain rapid growth by ensuring availability of commodities and services. Efforts are needed to change policies, strengthen commodity security and the supply chain, reinforce high-quality service delivery, and sustain demand.	**F3. Aspirational**: significant coverage of pre-payment schemes reaching multiple population groups; increased use of domestic sources, supported by increased government revenue; and established mechanisms to reimburse and leverage private health service delivery.
	S4. Exiting rapid mCPR growth: mCPR has grown, unmet demand begins to decline. Efforts are needed to sustain commodity security and the supply chain and sustain high-quality service delivery.	
High	**S5. mCPR growth levels off**: high mCPR, low unmet demand, mCPR growth rate slows, and programs focus on long-term sustainability. Efforts are needed to ensure mCPR equity, long-term sustainability including diverse funding streams and efficiency gains, continued service improvement, and expanded method choice.	**F4. Mature**: high insurance coverage among mostly middle-income countries with higher government revenue mobilization capacity and minimal dependence on external sources of financing.

* Low mCPR is when mCPR is fewer than 15 percent, emergent mCPR is when mCPR is between 15 percent and 40 percent, and high mCPR is when mCPR is greater than 40 percent.
S-curve source: Track20, 2017

Types of Catalytic Investments

After a review of relevant literature and country experiences mobilizing domestic resources, Health Policy Plus (HP+) proposes four main catalytic investments relevant to family planning:

1. Conduct targeted **advocacy** aimed at those responsible for or having influence over the budget (e.g., advocacy briefs and meetings with parliamentarians or staff at the national treasury)
2. Infuse specific **capacity development** activities into a domestic resource mobilization decision-making process (e.g., developing the capacity of civil society organizations to conduct budget advocacy or developing the capacity of parliamentarians to understand the return on investment of family planning)
3. Draft, revise, or implement a key **rule, law, regulation, or policy** that may promote domestic resource mobilization (e.g., a co-financing requirement for external funds or budget earmark for health)

4. Reduce the risk of investing in the **family planning market** (e.g., increase access to and uptake of loans for healthcare providers or introduce blended financing instruments)

The mix of catalytic investments that will have the greatest impact in a country for raising domestic funding for family planning will depend on the country context (as illustrated in the following section). However, **evidence generation** is a key cross-cutting component required for all catalytic investments to ensure evidence-based decision making.

Part 2. How to Prioritize and Implement Catalytic Investments

So far, this guide has discussed the rationale for and defined catalytic investments for family planning. This section presents the catalytic investments appropriate for different family planning program areas based on health financing maturity and mCPR, examples of catalytic investments, and the process stakeholders may follow to identify and implement investments.

Identifying Catalytic Investments for Family Planning Program Areas

In the first section of this document, three categories of barriers inhibiting greater domestic resource mobilization and use for family planning were introduced: (1) *cultural and social*, (2) *socioeconomic and technocratic*, and (3) *health system functioning and financing*. Context-driven analysis of these barriers will assist policymakers and supporters of the program to identify which catalytic investments are needed. For example, what works to unlock greater domestic funding may depend on the acceptance of socio-cultural norms that affect willingness to invest in demand generation or expansion of certain types of methods. Similarly, successful catalytic investments may depend on the complexity and severity of process and capacity gaps that impact the likelihood of domestically funded commodity procurement or enhancement of service delivery for family planning. Whether a short-term catalytic investment is sufficient to spark investment using domestic resources—compared to a much longer-term investment in technical assistance, capacity development, and evidence generation—depends on the nature of the barriers in a given context.

Table 3 considers different types of catalytic investments that may be needed for each of the four key family planning program areas, based on the general sources of financing for each and the barriers that may exist for increasing funding, especially domestic sources.

Table 3. Family Planning Funding Sources, Barriers to Increased Domestic Funding, and Potential Catalytic Investments to Increase Domestic Funding, by Program Area

Key Family Planning Program Area:	Demand Generation	Supply Chain	Service Delivery	Family Planning Commodities
Typical sources of program funding in low- and lower-middle-income countries				
Government budget	✓	✓	✓	✓
External funds	✓	✓	✓	✓
Out-of-pocket spending			✓	✓
Private commercial		✓	✓	✓
Examples of potential barriers to domestic financing				
Cultural and social	• Religious beliefs • Pro-natalist beliefs • Gender attitudes • Cultural taboo		• Religious beliefs • Pro-natalist beliefs • Gender attitudes • Cultural taboo	• Religious beliefs • Pro-natalist beliefs • Cultural taboo
Socioeconomic and technocratic	• Need for workers • Low literacy and education • High infant and child mortality		• High labor mobility • High infant and child mortality	
Health system functioning and financing		• No public resources • Insufficient qualified human resources for health • Can only deliver short-acting contraception • Lack of knowledge of the impact of high out-of-pocket spending	• No public resources • Insufficient qualified human resources for health • Can only deliver short-acting contraception • Lack of knowledge of the impact of high out-of-pocket spending	• No public resources • Can only deliver short-acting contraception • Lack of knowledge of the impact of high out-of-pocket spending
Types of catalytic investment potentially needed to raise domestic financing				
Examples of catalytic responses to financing barriers	• Evidence-based advocacy • Engaging policymakers • Family planning policy • Engaging community and religious leaders	• Public-private partnership • Efficiency analysis • Cost analysis • Budget analysis • Capacity development	• Evidence-based advocacy • Public-private partnerships • Cost/financing analysis • Efficiency and integration	• Budget analysis • Financing analysis • Cost analysis • Capacity development • Integration

Tailoring Catalytic Investments to Health Financing Maturity and mCPR

The maturity of a country's health financing system also informs which catalytic investment would be most appropriate and have the highest impact on financing family planning. The financing environment relevant to family planning can be categorized into five main characteristics, each conducive to different domestic resource mobilization mechanisms and the catalytic investments that could incite them. A country context will often include more than one characteristic and will rely on a combination of catalytic investments—timed with strong political will and support from a broad range of stakeholders—to be successful. Each of the five financing environment characteristics offers different opportunities for catalytic action toward family planning financing (summarized further in Table 4).

1. **Low government contribution to family planning, high donor dependence.** Describes countries with low resource-generation abilities that, due to a limited budget, remain dependent on external resources to fund the health sector.

   This context presents an opportunity to develop a plan to steadily increase the national and subnational government contribution to health, including for family planning, over time to reduce dependence on external resources. Barriers to increasing the government budget allocation for family planning include (a) socio-cultural beliefs that are not supportive of family planning, (b) restrictive policies that limit how the government can fund family planning or how women can access family planning services, and (c) lack of information or data on the reliance on external funding, the needs of the program, and the benefits of financing family planning. To overcome barriers, it will be necessary to develop an evidence base to support advocacy activities on the health and economic benefits of family planning and the needs of the program in the long term. Civil society organizations may need support to develop their capacity to conduct advocacy activities with policymakers and the community on family planning. Policy revision or development may be necessary to ensure a strong legal and regulatory environment for the government to fund family planning. Lastly, incentives such as matching grants or co-financing arrangements may help motivate decisionmakers to make increased contributions to family planning.

2. **Low efficiency.** Describes many governments that face challenges increasing efficiency, particularly related to budget allocation and expenditure.

   In a resource-constrained environment, improved efficiency can become a main source of financing for the health sector while funding levels remain fairly flat. Efficiency can stem from improving budget execution rates, for example, or improving the integration of family planning into other health services. Barriers to improving efficiency could include lack of information on bottlenecks that prohibit (a) equitable allocations and (b) executing program budgets. For example, policy barriers may exist that limit funds a Ministry of Health can spend per quarter in the fiscal year or that require central-level procurement restricting budget execution at each level of the health system. To overcome barriers, it will be important to have an improved understanding of efficiency bottlenecks to inform potential policy revisions.

3. **Existing health insurance scheme.** Describes a country that has an established health insurance mechanism.

In this context, there is an opportunity to integrate family planning, including a diverse range of methods, into the scheme's benefits package. Barriers include (a) the lack of a standardized benefits package and (b) a law, regulation, or policy that restricts family planning from being covered by health insurance, provides exemptions, or restricts the use of public funds for family planning. In some cases,, evidence that shows the financial impact of including family planning in health insurance may be missing. To overcome barriers, evidence generation may be needed to develop the necessary advocacy messaging for policy development, or revision, to support the integration of family planning in health insurance.

4. **Significant private health sector contribution.** Describes an environment in which the private health sector provides more than 30 percent of health services.

   This context presents an opportunity to strengthen the private health sector to contribute to the family planning market and ease pressure on the public sector. Barriers tend to include (a) policy restrictions on private sector facilities, associations, and individual providers to be able to provide certain health services, (b) a low capacity or lack of qualified health workers to provide services, and (c) a general lack of coordination and communication between the public and private health sectors. To overcome barriers, there is need for capacity development and training for private sector providers. In addition, policy revision may be needed if, for example, there is a barrier to private providers providing care or being reimbursed for it through national insurance, and there is a need for access to loans to be able to scale up services.

5. **Engaged commercial sector.** Describes contexts in which private for-profit commercial companies outside of the health sector have strong relationships and public-private partnerships with the government.

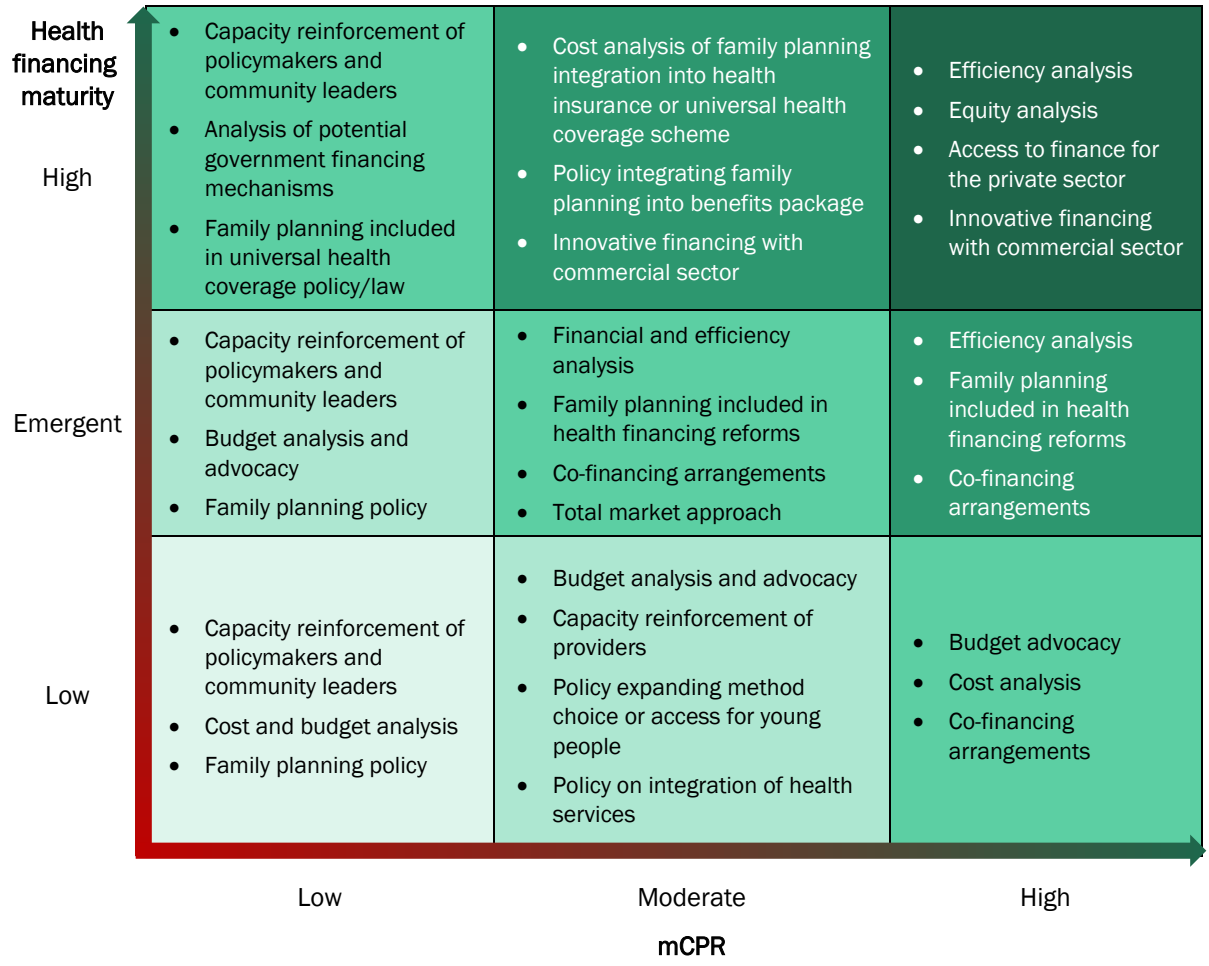
   This context presents an opportunity for innovative financing mechanisms, such as development impact bonds or airline levies earmarked for health. Barriers could include (a) cultural beliefs that are not supportive of family planning and, therefore, family planning-specific financing mechanisms and (b) lack of capacity or understanding of potential innovative financing mechanisms and how to develop them. To overcome barriers, improved understanding of the importance and impact of family planning, as well as increased capacity to identify and initiate innovative financing mechanisms, may be needed.

Table 4. Catalytic Investments for the Five Types of Health Financing Environments

Health financing maturity	Financing environment characteristics	Areas for domestic resource mobilization	Barriers to domestic resource mobilization	Recommended type of catalytic action	Example of catalytic actions
Higher	• Engaged commercial sector	• Explore innovative financing	• Lack of supporting information/data • Lack of capacity	• Advocacy • Capacity development • Market solutions	• Build understanding of family planning and benefits • Advocate to develop partnerships
Emergent	• Significant private sector contribution	• Strengthen the private sector	• Restrictive policy, law, or regulation • Lack of capacity • Lack of coordination	• Policy • Capacity development • Market solutions	• Enable access to loans • Train private sector providers • Develop public/private procurement policy
	• Existing health insurance schemes	• Integrate family planning into a benefits package	• Restrictive policy, law, or regulation • Lack of supporting information/data	• Advocacy • Policy	• Conduct financial analysis and advocacy to support policy to include family planning in a universal health coverage benefits package
Lower	• Low efficiency	• Improve efficiency	• Restrictive policy, law, or regulation • Lack of supporting information/data	• Policy	• Conduct cost-efficiency or bottleneck analysis to inform policy to integrate family planning into other health program areas
	• Low government contribution to family planning; high donor dependence	• Increase national and subnational government contribution	• Unsupportive socio-cultural beliefs • Restrictive policy, law, or regulation • Lack of supporting information/data	• Advocacy • Policy • Capacity development	• Create advocacy plan for implementation • Conduct analysis of potential mechanisms for domestic resource mobilization • Develop civil society capacity • Enable co-financing arrangements

The previous discussions elaborate on how catalytic investments can address programmatic family planning barriers as well as how to identify a catalytic investment depending on the overall health financing context in the country. Figure 1 provides examples of catalytic investment options based on the two measures (mCPR and health financing maturity) and can be used as a base or reference for determining what is appropriate in a country.

Figure 1. Non-exhaustive Examples of Potential Catalytic Investments based on mCPR and Health Financing Maturity



As an example, Madagascar has a relatively high mCPR—above 35 percent for all women (FP2020, n.d.b). This means that family planning efforts should focus more on ensuring that there is sustained access to family planning (including a diverse mix of methods) and sustainably financing high-quality service delivery. However, Madagascar's health financing system remains nascent and underdeveloped. Under 10 percent of the population has access to a health insurance mechanism and, as the government budget remains restrained, dependence on external resources is high. In this context, there are two possible tactics for sustainably financing family planning. The first is reducing out-of-pocket spending on family planning, especially at the point of service delivery, through reductions or removal of user fees. A catalytic investment could include conducting budget advocacy activities to gradually increase the government's contribution to family planning. The second tactic would be to apply market segmentation to better target public and private sector resources for family planning. A catalytic investment could include reinforcement and integration of the private sector using a total market approach. Such an approach would reduce the financial burden on the public sector.

Ghana on the other hand, has moderate mCPR growth, with an estimated mCPR of 22 percent in 2019 (FP2020, n.d.a). This indicates that there is a need to sustain investment in the contraceptive supply chain and reinforce service delivery to ensure high-quality care and demand generation.

Unlike Madagascar, Ghana has a more developed health financing system, having developed its National Health Insurance Scheme in 2003. However, because the country still relies on external funding support for its health sector, although reduced from previous years, it can be categorized as having emerging health financing maturity. Given this, one tactic to improve sustainable financing could include employing performance-based financing interventions to incentivize the availability of modern family planning methods and high-quality family planning services and information. Another tactic would be to engage the private sector in family planning service delivery to expand availability of services. Given that family planning is not being offered within Ghana's health insurance benefits package, a catalytic investment could be to cost the implications of including family planning in the benefits package and/or to develop a policy to create accountability for its inclusion.

Examples of Catalytic Investments

This section highlights some examples for each of the four main types of catalytic investments drawing from different areas of health, particularly HIV.

Advocacy

Analysis and advocacy to catalyze domestic resources for HIV in Kenya. In 2015, SFI invested US$7.4 million in Kenya. As part of this investment, the Health Policy Project supported evidence generation and advocacy efforts with the National Treasury and Parliament. This resulted in the equivalent of US$89 million allocated in national budgets for antiretroviral drugs and related commodities in fiscal years 2015/16 ($20 million), 2016/17 ($22 million), 2017/18 ($26 million), and 2018/19 ($21 million) (Muchiri, 2020). In addition, a line-item was added in Kenya's Medium-Term Expenditure Framework for antiretroviral drugs and related commodities in the amount of US$85 million for a three-year period. Evidence generated on the resource funding gaps for HIV commodities contributed to the development of advocacy tools, which were used by the government's HIV program with Parliament, national government staff, and county government staff to explain why they should allocate and protect funds for HIV. With support from HP+ (and its predecessor Health Policy Project) policy champions met with the National Treasury's budget team and select members of the Parliamentary Committee on Health to reach an agreement on funding HIV commodities. Policymaker understanding of funding gaps and the economic benefits of ensuring that people living with HIV are on treatment was key to the success of the arguments.

Appropriate for:

Health financing maturity level:
Low to Emergent

mCPR:
Moderate to High

Analysis and advocacy to catalyze the inclusion of people living with HIV into existing financial protection mechanisms for health in Cambodia. With strong economic growth over the last decade, Cambodia reached lower-middle-income status in mid-2016. This precipitated a decline in donor resources and the urgent need to transition to sustainable domestic sources to fund the HIV response. Between 2017 and 2019, SFI invested US$2 million to support domestic resource mobilization efforts for HIV at the national level. The funding focused on improving technical capacity to conduct analyses, generate evidence, and develop advocacy strategies to support increased domestic funding for HIV. Under SFI, HP+ worked with key partners, including the Ministry of Economy and Finance and National AIDS Authority, to develop their capacity and generate evidence on the HIV epidemic, financing trends and sources, and potential implications of inclusion

Appropriate for:

Health financing maturity level:
Emergent to High

mCPR:
Moderate to High

of HIV into existing health financing strategies. This evidence was used to produce advocacy briefs for national-level policymakers. In February 2019, the Council of Ministers, with the Prime Minister's approval, ratified a policy circular (SCN 213) that increases the allocation of resources for HIV through six key measures. The measures focus on (1) integration of HIV activities and funding into commune council plans, (2) designation of all people living with HIV as vulnerable and eligible for inclusion in the Health Equity Fund, (3) authorization of the use of a health facility's own funds for HIV, (4) support for public financing of civil society organizations to support the HIV response, (5) assessment of the fiscal space for HIV financing, and (6) integration of HIV into health systems (Jain and Prabhakaran, 2019).

Capacity Development

Civil society capacity development to advocate for and mobilize family planning funding. Family planning civil society advocates have been trained by Advance Family Planning partners to apply a SMART (specific, measurable, attainable, relevant, and time-bound) advocacy approach. The approach has been key to success in advocating for family planning and engaging decisionmakers at both local and national government levels. Using the approach's techniques, local civil society organizations have been able to advocate for family planning in 17 FP2020 countries, resulting in major achievements.

Appropriate for:

Health financing maturity level:
Low to Emergent

mCPR:
Moderate

- Countries like Mauritania and Burkina Faso made their first-ever budget allocations for reproductive health supplies and family planning, respectively (AFP, 2016).
- From September 2017 to March 2018, 17 communes in Togo committed 5 percent of their annual health budgets for sexual and reproductive health and family planning. The total allocated funding from 16 of the 17 communes is estimated at US$32,000 (AFP, 2018).
- The Ministry of Health in Niger signed a budgetary reallocation estimated at US$335,000 for the purchase of contraceptives in 2019, in line with Niger's commitments made at the FP2020 London Summit (HP+, 2019).

Rule, Law, Regulation, and Policy

Co-financing arrangements to catalyze increased national-level government contribution to health. For 2020–2022, the Global Fund has a reserved incentive pool of US$317 million for matching funds that are available to a select number of countries to incentivize domestic contribution for fighting HIV, tuberculosis, and malaria (Global Fund, n.d.). This funding includes investments in high-priority populations such as adolescent girls and young women. In addition, 15 percent of the Global Fund's grant allocation is reserved as a co-financing incentive. To receive it, a low-income country must show spending on health equal to at least 7.5 percent of the grant amount, while lower-middle-income countries must show 15 percent. Countries also need to show increased programmatic targets and coverage, resultant from using the funds. However, implementation of the co-financing requirements has been weak; some countries

Appropriate for:

Health financing maturity level:
Low and Emergent

mCPR:
Moderate

have not been held accountable for unsupported data on co-financing spending nor faced repercussions when funds go unused.

Appropriate for:

Health financing maturity level: **Emergent**

mCPR: **Moderate**

Matching grants to catalyze increased funding for family planning at the subnational level. As of September 2018, the Bill & Melinda Gates Institute for Population and Reproductive Health has provided The Challenge Initiative (TCI) with overall funding of about US$59.5 million through 2021. The Initiative, which currently works in 14 countries, provides matched funding for city governments that chose to make family planning commitments. TCI engages and advocates to mayors to invest in family planning programs. If interested, mayors/city governments submit an expression of interest, then TCI and the city work together to design a program in which interventions are chosen from TCI's menu of high-impact options. As part of the agreement, mayors/city governments must make a commitment to increase funding for family planning in order to be eligible to receive the matching grant. While the matching grant is successful in catalyzing commitments from local governments, holding local governments accountable for those commitments has proved to be a challenge. In two years, three towns in Senegal have mobilized US$54,000 for family planning in cash and kind as a result of this initiative. However, the amount mobilized remains below the cities' original commitments and requires significant donor investment to initiate and support, providing little to no return on investment (Lang et al., 2019).

The Gates Foundation, through UNFPA, also started a matching fund in 2019 to catalyze domestic funding for contraceptives. The matching fund, open to all Ouagadougou Partnership countries, will match US$2 for every $1 of domestic funding for contraceptives, with a total ceiling of $15 million over a three-year period. As a requirement, all countries will need to develop family planning business cases to serve as advocacy tools to engage support from high-level policy decisionmakers.

Appropriate for:

Health financing maturity level: **Low**

mCPR: **Low to Moderate**

Policy development, advocacy, and capacity development to earmark funds for family planning in Guatemala. In 2001, USAID and UNFPA announced their intention to gradually reduce support for commodity procurement in Guatemala. Within 10 years the government assumed full financial responsibility for procuring contraceptive commodities (Carr et al., 2017). The 2005 Law of Universal Access [to Family Planning] formally made contraceptive procurement the responsibility of the government, stating that the government must provide sufficient resources to guarantee the availability of family planning methods. The law was passed only with the galvanized support of local partners who received technical assistance from USAID partners. Also in 2005, Guatemala established an earmark for family planning and reproductive health consisting of 15 percent of alcohol tax revenue. Subsequent laws in 2006 and 2010 respectively established a reproductive health/family planning line-item and designated 30 percent of the alcohol tax earmark specifically for family planning commodities, establishing a sustainable funding mechanism for family planning (Carr et al., 2017; Reyes et al., 2013). Technical assistance to the National Reproductive Health Program, Association for Family Wellbeing, National Commission for Contraceptive Security, and the Reproductive Health Observatory allowed these organizations to provide the evidence and advocacy messaging needed to not only establish the earmark but hold the government accountable for its implementation.

Market Solutions

Engagement and participation of the private sector in funding family planning remains a developing field. In 2018, HP+ held a forum with commercial sector companies in Dakar to introduce them to the importance of financing family planning and what is needed to do so. As a result, several private companies made small commitments and partnered with private clinics or nongovernmental organizations to provide family planning services to populations in need at low cost or for free. But these were one-off social corporate responsibility contributions.

Appropriate for:

Health financing maturity level:
Emergent to High

mCPR:
Moderate

Other catalytic investments have included developing tools and strategies to establish a total market approach to family planning. HP+'s *Total Market Approach Projection Tool* (2019) provides stakeholders with evidence to better define the role of the private sector in family planning, with the intent of reducing the burden on the public sector and allowing for more targeted and efficient programming. In September 2017, HP+ applied the Total Market Approach Projection Tool in Uganda to inform the country's goal-setting for its Family Planning Total Market Approach Strategy. As a result, the Ministry of Health and key family planning stakeholders developed a better understanding of the financial and health impacts that a total market approach could yield. The tool shows that when those with the ability to pay for services access family planning through the private/commercial market, it allows for an equitable allocation of limited donor and public sector resources to be targeted to the poor. Expanding the family planning market increases the overall fiscal space for family planning and promotes sustainability.

Innovative blended financing solutions, such as access to finance, are also being considered to fund family planning programs. Private healthcare providers need capital to expand their business and improve the quality of services they provide. However, it is often challenging for them to obtain a loan because they lack credit history, accounting capacity, and/or assets that can serve as collateral often needed to secure a loan. The Medical Credit Fund has been partnering with local banks and other financial institutions in Africa to be able to fund or guarantee loans to healthcare providers, including those who work in family planning. A donor could possibly support the Medical Credit Fund by financing a portion of a loan amount and acting as a first-loss investor. The loan could provide financing to facilities that provide family planning services with the expectation that the borrowers would use part of the loan capital to strengthen family planning provision (Lee and Klein, 2020). This kind of mechanism limits the risk for the Medical Credit Fund and other investors. It provides an increased incentive and security in the investment, which could potentially be implemented long term to secure sustainable financing for family planning.

Process for Identifying the Right Investments

As seen from the examples in the previous section, each country has different opportunities for catalytic investments depending on the financing, family planning, and enabling environments. One country context often requires a combination of investments to see a return on investment. So far, this guide has illustrated different ways to analyze the country context and identify the appropriate catalytic investments. This section outlines the *process* for identifying these opportunities.

The first step is to set up a collaborative multisectoral technical working group—with stakeholders from the public and private sectors as well as civil society—to lead the process. Once a working group is formed, stakeholders should review existing documents to understand the barriers and enablers

to investing in and mobilizing domestic resources for family planning. Documents to review include any national universal health coverage plan; health financing strategy; health sector strategic plan; family planning and/or reproductive, maternal, newborn, child, and adolescent health strategic plan; costed implementation plan for family planning; and annual health and financial performance reports. Stakeholders should identify the country's S-curve and health financing maturity level, which will provide insight into potential domestic resource mobilization opportunities in the public and private sector. USAID's Family Planning Financing Roadmap can be used to conduct this type of situational analysis. Stakeholders should then conduct key informant interviews to better understand the enabling environment for family planning financing, public and private sector domestic resource mobilization opportunities, and motivations of the various stakeholders.

Next, stakeholders can use the five different investment assessment criteria outlined in Table 5 to evaluate potential catalytic investment options. The evaluation process should include consideration of the qualitative information gathered from key informants and technical working group discussions. Considerations should include: how difficult it will be to implement the investment (financially and technically); the likelihood of government support of the initiative and the associated domestic resource mobilization mechanism; and whether the investment links with an appropriate family planning program area requiring financing, based on the country's place on the S-curve. The evaluation should also consider quantitative and qualitative estimations of the potential return on investment from both a financial point of view and a health statistics point of view. For example, "Are the upfront costs of the investment lower than the resources its implementation could potentially raise?" and "How is it going to improve equity, quality, affordability, efficiency, or access?" It is essential for the evaluation to be done collaboratively among a diverse group of stakeholders. The technical working group should review and evaluate several opportunities and prioritize those to take forward. From there, they should develop a roadmap that outlines responsibilities and a timeline to execute it.

Table 5. Investment Assessment Criteria

Feasibility	• How complex and time-intensive is the investment? • Is the fiscal space available for the investment? • Is the financial market and/or private sector mature enough to support this investment?
Acceptability	• Is there political will to implement this investment? • How likely are stakeholders to be in favor of this investment? Does it align with their priorities and incentives?
Alignment with family planning needs	• Is this investment appropriate for the country's health financing maturity level and family planning financing characteristics? • Will this investment address demonstrated family planning resource gaps? • Will this investment address family planning needs based on mCPR categorization?
Financial impact	• What amount of resources could be catalyzed by this investment? • Will the potential resources raised because of the investment come from a sustainable financing source? • What is the return on investment versus the investment risk?
Health impact	• How and to what extent will this investment contribute to equity, quality, affordability, efficiency, and access?

Summary and Conclusion

In the changing and unstable donor funding landscape for family planning, low- and middle-income countries need to identify pathways to increase domestic allocation to, and spending on, family planning. Catalytic investments offer an opportunity to spur domestic resource mobilization. A catalytic intervention can be an activity, program, or mechanism that leverages existing political, social, and financial opportunities to increase the likelihood that decisionmakers will raise allocation of domestic resources or improve execution for domestic resources. The purpose of this framework is to support family planning advocates, development partners, and technical assistance organizations to work with country governments to identify context-specific opportunities to leverage existing and additional resources to unlock significantly more domestic financing for family planning.

The framework identifies four types of catalytic investments—*advocacy, capacity development, policy,* and *expansion of the market*—that require an evidence base to be implemented effectively. The appropriate mix of catalytic investments that each country can employ is based on two main measures: a country's progress along the S-curve and its health financing maturity level. To be effective in spurring domestic resource mobilization, catalytic investments need to be designed with consideration of the barriers to domestic resource mobilization, given the country's family planning programming needs (e.g., investments in service delivery or demand generation) and its health financing context (e.g., existence of a health insurance scheme). In summary, catalytic interventions provide an opportunity to stimulate domestic resource mobilization but will only be effective if designed considering the specific country context.

Family planning stakeholders should use the resources in this guide to identify and evaluate appropriate catalytic interventions for their specific context. This review should be conducted in an inclusive and consultative manner. Stakeholders can use this guide's investment assessment criteria to evaluate potential catalytic options before prioritizing which ones to pursue and developing a concrete plan for implementation.

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