



**Funding for sexual and reproductive
health and rights in low- and
middle-income countries: threats,
outlook and opportunities**

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Executive Summary

Sexual and reproductive health and rights (SRHR) are essential for reaching the Sustainable Development Goals (SDGs) for health. The Guttmacher-*Lancet* Commission found that meeting the unmet need for contraception for 214 million women in developing regions would avert an additional 67 million unintended pregnancies in 2017. If combined with full care for pregnant women and newborns, this reduction in unplanned pregnancies would reduce maternal deaths by 73% (from 308,000 to 84,000) and newborn deaths by 80% (from 2.7 million to about 538,000).¹

Despite the substantial benefits of investing in SRHR, SRHR is a politicized topic in many countries. Anti-abortion advocacy organizations are active worldwide, across the United States (US) and Europe, as well as in many low- and middle-income countries, including in Africa, Latin America, and the Caribbean.^{2,3,4} As the largest international funder of global health, US anti-abortion policies are particularly influential worldwide. In 2017, President Donald Trump signed an executive order to implement the Protecting Life in Global Health Assistance (PLGHA) policy, an expanded version of the Mexico City policy, also known as the global gag rule.⁵ The policy prohibits US bilateral health funding for foreign non-governmental organizations (NGOs) that “perform or actively promote abortion as a method of family planning.”

To mitigate against the harmful effects of the Mexico City policy and other restrictions on SRHR, the donor community has made significant commitments to SRHR. However, three things remain unclear: (i) the recent trends in donor funding for SRHR, (ii) how meaningful the commitments are in terms of additionality of funding, and (iii) how SRHR funding will evolve over time. SRHR funding could be reduced due to other priorities arising within and beyond the health sector. At the same time, donors expect low- and middle-income countries to increasingly self-finance health needs, based on the assumption that these countries will experience significant economic growth. Yet the global economic outlook has changed in recent years, challenging this assumption. Finally, while the Guttmacher-*Lancet* Commission emphasized that all countries should include SRHR in their path towards universal health coverage (UHC), and many countries are including common elements of SRHR (primarily family planning, maternal, and newborn health) in their UHC packages and plans, inclusion of a full package of SRHR interventions is rare, and by no means guaranteed.

This report seeks to take stock of current and potential future investments in SRHR, to help inform discussions on how to ensure adequate support for SRHR. It provides analysis of SRHR funding by donors and low- and middle-income country governments, which is crucial as much of the needed growth in SRHR funding will have to come from domestic sources. More specifically, the report addresses the following questions:

- How has donor funding for SRHR developed in recent years? To what extent have donors increased their SRHR funding in response to the reinstatement and expansion of the Mexico City policy?
- What commitments have been made by donors in support of SRHR, and what will the future trend for SRHR donor funding look like?
- To what extent have governments of low- and middle-income countries increased their own funding for health and SRHR? How will domestic spending develop considering the most recent economic outlook?

The report is based on a mix of methods, including document and budget analysis, an assessment of major financial databases, key informant interviews, and quantitative modelling.

Key findings

1. Official development assistance (ODA) for SRHR and funding provided by the Bill & Melinda Gates Foundation amounted to US\$11.3 billion in 2017. While this is an all-time high, donors invested a lower share of their overall health funding in SRHR compared to previous years. In this sense, donors deprioritized SRHR funding: they allocated 42% of their overall health funding to SRHR in 2016 and 2017, compared with allocating 52% of their health aid on SRHR in 2011. Donor funding for non-HIV SRHR as a share of overall health aid also declined, from 14.7% in 2016 to 12.5% in 2017.
2. By far the largest share of donor funding provided for SRHR continues to be allocated to HIV (70% in 2017). In contrast, investments in other key reproductive health care services (e.g., antenatal and postnatal care including delivery, prevention and treatment of infertility, prevention and management of complications of abortion, and safe motherhood activities) only accounted for 16% of all SRHR donor flows in 2017. In comparison, 19% of all donor flows were invested in these other key reproductive health care services in 2015. In addition, family planning funding provided by donors only accounted for 9% of all SRHR donor funding in 2017.
3. Strong champions for SRHR in the donor community continue to support SRHR, among them the governments of Canada, Germany, the Netherlands, Norway, Sweden, and the UK. These donors increased their funding for SRHR in recent years. Many of these donors also accounted for the increase in ODA for family planning – a key sub-area of SRHR – which increased from US\$1.1 billion in 2011 to US\$1.4 billion in 2018. The US government remains the world's largest donor for family planning, accounting for 42% of all bilateral ODA for family planning in 2018.
4. Following the reinstatement and expansion of the Mexico City policy, donors made new commitments to SRHR, including at the SheDecides conference in March 2017. However, while some commitments were truly additional, others were essentially recommitments of existing pledges made at previous events and occasions. This “rebotting” of investments makes it hard to understand donors' future investments in SRHR.
5. Overall, the future of donor investments in SRHR beyond 2020 does not look bright – at best, key donors will slightly increase their SRHR investments, but it is as likely that funds will stagnate at current levels. There are five reasons for this prognosis: First, the International Monetary Fund just downgraded the growth forecast once again, which could result in cuts to overall ODA budgets as these are vulnerable to austerity measures. Second, key SRHR supporters have been maintaining or increasing SRHR budgets at relatively high levels, which makes further increases unlikely. Third, health ODA (and within that

SRHR) will compete with other emerging donor priorities, such as climate change. There is also evidence that the development agencies of major donors face increasing pressure to shift their funding from social sectors to economic productive sectors. Fourth, the US government's anti-abortion policies may further restrain available resources for SRHR, unless other donors continue to increase their investments. Fifth, while the UK government – the second largest health and SRHR donor worldwide – recently announced a new commitment, there is uncertainty around Brexit and how it will affect UK's ODA.

6. The Guttmacher-*Lancet* Commission estimated the cost for meeting all women's needs for contraceptive, maternal, and newborn care (the cost of HIV prevention and treatment was excluded). The costs for low-income countries (LICs) amounted to US\$13.0 per capita annually, which compares to current spending of US\$1.1 per capita. The Commission suggested that the annual costs in lower-middle income countries (LMICs) would be lower, amounting to US\$7.8 per head, compared to current average spending of US\$5.2 in 2016. However, data are only available for 13 out of 45 LMICs and as such might overestimate spending levels in 2016. Eleven of the 13 countries spent well below US\$7.8 in 2016 and only two countries spent more.
7. Due to the limited data on domestic SRHR spending, we assessed trends in overall domestic government spending for health. The Lancet Commission on Investing in Health found that the annual costs of an “essential package” of 218 interventions to achieve UHC would be about US\$100 per head, while a more basic package of 108 “highest priority interventions” would cost US\$50 per head. Many of these interventions are SRHR services according to the Guttmacher-*Lancet* Commission's definition. Based on 2016 data, only eight LMICs would be able to afford the essential UHC package and 13 the more basic package, while only one LIC could afford even the basic package.
8. Projections conducted for this paper indicate that in LMICs, average annual per capita spending by governments would double, from US\$59 in 2016 to US\$108 in 2030 if countries were to increasingly prioritize health within their own budget. There is, however, variation between countries – 20 of them would be able to self-finance the essential package with 218 interventions, while 30 would be able fund the highest priority interventions package (108 interventions). Fifteen LMICs would still not be able to self-fund any package. In LICs, average annual per capita spending would increase from US\$11 to US\$18, with only two out of 31 countries being able to self-fund the highest priority package. No LIC would be able to fund the essential package. This shows that most LICs will likely continue to rely on donor funding to finance health for the foreseeable future.

Recommendations

1. **A new global moment to mobilize political and financial support for SRHR is needed to sustain investments.** Global moments focusing on a particular issue have proven to be effective in mobilizing political and financial support by the donor community. The Family Planning Summits in 2012 and 2017 and the SheDecides conference in March 2017 were successful in mobilizing financial resources and creating momentum. For example, the Beijing +25 conferences in Mexico City and Paris in 2020, and the International Family Planning Conference in February 2021, provide opportunities to generate such momentum again for SRHR.
2. **Donors should include SRHR as an integral part of UHC efforts and protect health investments vis-à-vis other emerging priorities.** As part of their investments to help countries to reach UHC, donors need to explicitly include SRHR. Donors should work with countries to ensure that everyone has access to an essential package of health interventions to achieve UHC, many of which are SRHR-related interventions. The mantra should be “there is no UHC without SRHR.” In addition, donors should better integrate and more efficiently use their resources across HIV and SRHR.
3. **Donors should always make clear if their newly announced commitments include additional funding.** To improve accountability and transparency, donors should be clear as to whether their commitments are actually new and additional, and how they relate to their previous commitments.
4. **Political leadership for SRHR at the country level needs to be strengthened.** For donor and domestic investments in SRHR to be effective, there must be strong national political commitment to openly discuss SRHR issues, to advocate for comprehensive evidence-based SRHR interventions, and to fight gender-based discrimination. Political leaders can raise awareness among their governments about the high cost-effectiveness of investing in health and SRHR, and the large health, social, and economic returns that could result from increased domestic spending on SRHR.
5. **Countries need to prioritize health, including SRHR, in their domestic budgets.** Although the current economic outlook is less positive than two years ago, many LICs and MICs are still projected to experience substantial economic growth in the next decade. While these countries will increasingly be able to reduce their dependence on donor support and finance their health goals through domestic resources, economic growth alone will be insufficient; countries will need to make the decision to explicitly prioritize health within national budgets. In addition, countries need to reduce spending inefficiencies to avoid wasting resources for health.

Introduction

Sexual and reproductive health and rights (SRHR) are essential for sustainable development and the realization of the 2030 Agenda for Sustainable Development. Sexual and reproductive health – defined by the Guttmacher-Lancet Commission as “a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity” – is dependent on the realization of sexual and reproductive rights, based on the principles of human rights.⁷ The Guttmacher-Lancet Commission calls for expanded access to an essential, integrated package of sexual and reproductive health interventions, made available without causing financial hardship (Annex 1). This is consistent with WHO recommended interventions and the principles of universal health coverage (UHC).⁸

The Guttmacher-Lancet Commission found that meeting the unmet need for contraception for 214 million women in developing regions would avert an additional 67 million unintended pregnancies in 2017. If combined with full care for pregnant women and newborns, this reduction in unplanned pregnancies would reduce maternal deaths by 73% (from 308,000 to 84,000) and newborn deaths by 80%, from 2.7 million to about 538,000 (please refer to Annex 2 for alternative impact estimates on the benefits of SRHR conducted by the Disease Control Priorities Project, DCP3). In addition, the Guttmacher-Lancet Commission highlighted the social and economic benefits of investing in SRHR. Declines in fertility contribute over the long-term to the demographic dividend – that is, “accelerated economic growth and development that arises from a change in the age structure of the population.”⁹

The need for sustainable SRHR financing

Despite the substantial benefits of investing in SRHR, progress is stalled in part by a lack of resources. The Guttmacher-Lancet Commission estimates that a minimum global investment of US\$54 billion (about US\$9 per capita annually) is needed to address the unmet need for contraceptive, abortion, maternal, and newborn health services in low-income countries (LICs) and middle-income countries (MICs). Although mobilizing sufficient and sustainable domestic financing is essential, finance from international donors and development partners is also important for countries with insufficient resources.

Political threats to SRHR funding

A major challenge to sufficient levels of finance is weak political will for SRHR in many countries. For example, anti-abortion advocacy organizations are active worldwide, across the United States (US) and Europe, as well as in many low- and middle-income countries, including in Africa, Latin America, and the Caribbean.

As the largest bilateral funder of global health, anti-abortion policies in the US are felt worldwide. In January 2017, four days after taking office, President Donald Trump signed an executive order to reinstate and expand the Mexico City policy, also known as the global gag rule and renamed the Protecting Life in Global Health Assistance policy (PLGHA).¹⁰ Originally created in 1984 under the Ronald Reagan administration to restrict abortion, the Mexico City policy has been rescinded and reinstated by presidential administrations along party lines ever since.¹¹ In the past, the policy required foreign non-governmental organizations (NGOs) that receive US

government funding for family planning to certify that they will not “perform or actively promote abortion as a method of family planning,” using funds from any source. Under the Trump administration’s PLGHA, the policy applies to the majority of US bilateral global health funding, including for HIV, maternal and child health, malaria, nutrition, and other programs – the policy could potentially affect US\$7.4 billion in global health funding in 2019, depending on the extent to which this funding is provided to foreign NGOs.¹² In March 2019, the Trump administration introduced new restrictions further prohibiting foreign NGOs from providing any financial support to other NGOs that perform or actively promote abortion.¹³

Although there is no comprehensive analysis on the financial impact of the Mexico City policy, significant evidence shows major global SRHR providers face severe funding losses (see Annex 3 for the harmful effects of the Mexico City policy). Many NGOs have refused to accept US funding in order to uphold SRHR and because the provision of access to safe, legal abortion is central to their mission. The largest global providers of global family planning services, Marie Stopes International and the International Planned Parenthood Federation (IPPF), both refused to comply with the policy and as a result suffer from a combined funding gap of US\$150 million through 2020.^{14,15} In 2017, the Trump administration also discounted all funding to UNFPA under the Kemp-Kasten amendment.¹⁶

Groups that oppose SRHR are expanding their influence worldwide. US-based conservative organizations have funded anti-abortion campaigns worldwide, including in Africa, Latin America, and the Caribbean.^{17,18,19} Europe has experienced a rise in advocacy against SRHR in recent years, backed in part by significant financing from US-based conservative organizations. Recent analysis finds that European anti-abortion organizations have spent €2.1 to €3.1 million annually to lobby or advocate in the European Parliament and other European institutions, and are gaining

legitimacy and access within European Union institutions.²⁰ Legal advocacy organizations have also filed legal suits in SRHR-related cases to many European courts, including the European Court of Human Rights. This changing landscape could potentially threaten European support for SRHR in domestic and international policies.

The resistance against SRHR is also taking on global dimensions, as was evident at the 74th United Nations General Assembly’s High-level Meeting on UHC. During negotiations of the UHC political declaration, some governments opposed the inclusion of SRHR and gender equality in the high-level meeting outcome document.²¹ However, a strong alliance of countries ensured that over 25 years of agreed upon standards regarding women’s rights and SRHR were protected and included in the political declaration.^{22,23}

About this new report

To mitigate against the harmful effects of the Mexico City policy, the international community has responded with new SRHR commitments and initiatives. For example, SheDecides is an international initiative to raise financial and political support for SRHR worldwide. On multiple occasions, major global health donors, including the governments of Canada, Germany, the Netherlands, Norway, Sweden, and the United Kingdom, among many others, have announced their continued and even increased financial and political support for SRHR.

However, while the donor community has made significant commitments to SRHR, three things are unclear: (i) the trends in donor funding for SRHR, (ii) how meaningful the commitments are in terms of additionality of funding, and (iii) how SRHR funding will develop over time. SRHR funding could be deprioritized due to other priorities arising within and beyond the health sector. At the same time, donors expect low- and middle-income countries to increasingly self-finance health needs, based

on the assumption that these countries will experience significant economic growth. Yet the global economic outlook has changed in recent years, challenging this assumption. Finally, while the Guttmacher-*Lancet* Commission emphasized that all countries should include SRHR in their path towards UHC, and many countries are including common elements of SRHR (primarily family planning, maternal, and newborn health) in their UHC packages and plans, inclusion of a full package of SRHR interventions is rare, and by no means guaranteed. This report addresses the following questions:

- How has donor funding for SRHR developed in recent years? To what extent have donors increased their SRHR funding in response to the reinstatement and expansion of the Mexico City policy and other restrictions on SRHR?
- What commitments have been made by donors in support of SRHR, and what will the future trend for SRHR donor funding likely look like?
- To what extent have LIC and MIC governments increased their own funding for health and SRHR? How will domestic spending develop considering the most recent economic outlook?

The report is based on a mixed methods approach, including document and budget analysis, an assessment of major financial databases, key informant interviews with senior policy makers and SRHR financing experts, and quantitative modelling.

This analysis was commissioned by the Partnership for Maternal, Newborn and Child Health (PMNCH) and was presented at the pre-Board meeting of PMNCH in the cross-constituency meeting on SRHR in Nairobi, Kenya, on November 9, 2019.

The report is organized into five further sections. Section 2 provides an overview of the methods. Section 3 discusses the trends in SRHR and health financing. Section 4 provides the findings of the short-term financial outlook for health official development assistance (ODA), SRHR ODA, and overall ODA. Section 5 shows trends in domestic health and SRHR financing and projects domestic health expenditures into the future. Section 6 provides conclusions and recommendations.

Methods

This report is based on three key methodological approaches:

- **Database analysis:** Two databases were used to analyze trends in health and SRHR financing. First, to assess ODA, data from the International Development Statistics online databases were used.²⁴ These databases are owned by the Development Assistance Committee of the Organisation for Economic Cooperation and Development (OECD DAC). The OECD DAC databases also include funding from the Bill & Melinda Gates Foundation, the largest philanthropic donor in global health. Data on donor funding for health and SRHR is available until 2017 (see Annex 4 for methodological details). Second, data from the World Health Organization's (WHO) Global Health Expenditure Database (GHED) were used to estimate health expenditures of LICs and MICs. Country expenditures were available up to 2016 at the time of the analysis.
- **Document analysis and key informant interviews:** To provide an outlook on donor funding for health and SRHR, an analysis of donor government budgets and documents was conducted. The document analysis also included reports by external organizations, such as NGOs focusing on SRHR, as well as announcements by donors on their commitments (e.g., speeches, news articles). In addition, key informant interviews with 25 stakeholders were conducted by phone and in-person to inform the funding outlook (Annex 5). Interviews were conducted with officials from donor agencies and experts based in donor countries with in-depth knowledge of donor strategies and financing.²⁵ The interviews and the document analysis focused on the largest global health donor governments and the Bill & Melinda Gates Foundation, which together accounted for over 80% of all donor disbursements in 2017.
- **Projections of domestic health expenditures:** Based on the World Economic Outlook (WEO) data²⁶ from the International Monetary Fund (IMF) and the GHED dataset, government health expenditures of LICs and MICs were projected to the year 2030. The aim of this analysis was to estimate to what extent countries will be able to finance their own health needs and to inform discussions on the potential role of donor funding going forward (please refer to Annex 6 for more details).

Limitations: While some donors have multi-year budgets for their ODA (including for health and SRHR), other donors do not have future spending plans and even some 2020 budgets were not finalized at the time of writing. Budgetary systems and processes differ greatly across donor countries, as do the level and type of information on future spending (e.g., there are major variations in the granularity of financial data). These differences are an inherent limitation of any ODA forecast.

Trends in donor funding for sexual and reproductive health and rights

OECD figures show that in 2017, ODA for health reached US\$24.4 billion, and the Bill & Melinda Gates Foundation, the largest private funder, gave US\$2.6 billion in health aid, creating a combined total of US\$27.0 billion (Figure 1). Health aid reached its highest level ever that year, showing a rising trend after a period of stagnation between 2013 and 2015.

Total donor funding for SRHR also peaked in 2017, with disbursements of US\$11.3 billion. However, the share of donor funding for health going to SRHR gradually declined, from 52% in 2011 to 42% in 2016 and 2017. Donor funding for non-HIV SRHR as a share of overall health aid also declined, from 14.7% in 2016 to 12.5% in 2017.

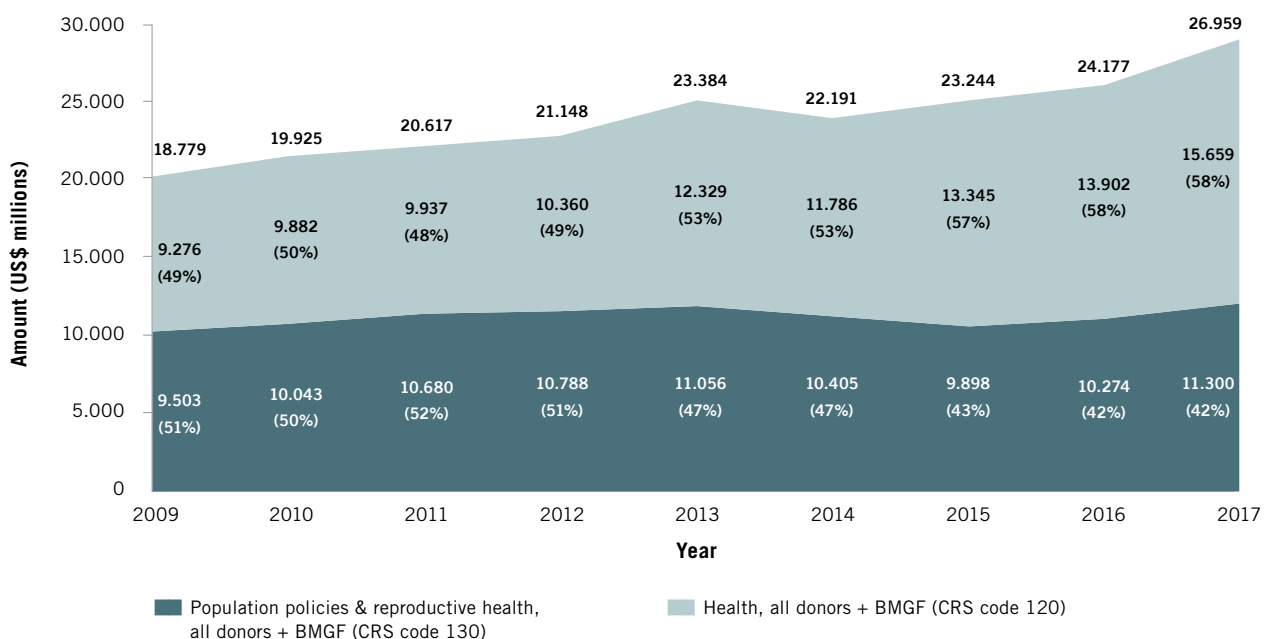
HIV accounts for a large majority of donor funding to SRHR. The share of donor funding for HIV out of all SRHR donor funds peaked

in 2011 at 78%, before it steadily declined to 66% in 2015. In 2016 and 2017, the portion of SRHR funding allocated towards HIV increased again to 70%.

In contrast, other critical reproductive health care services (e.g., prenatal and postnatal care including delivery, prevention, and treatment of infertility; prevention and management of complications of abortion; and safe motherhood activities) accounted for only 16% of all SRHR donor flows in 2017 – a decrease of three percentage points from the 2015 peak level (19%).

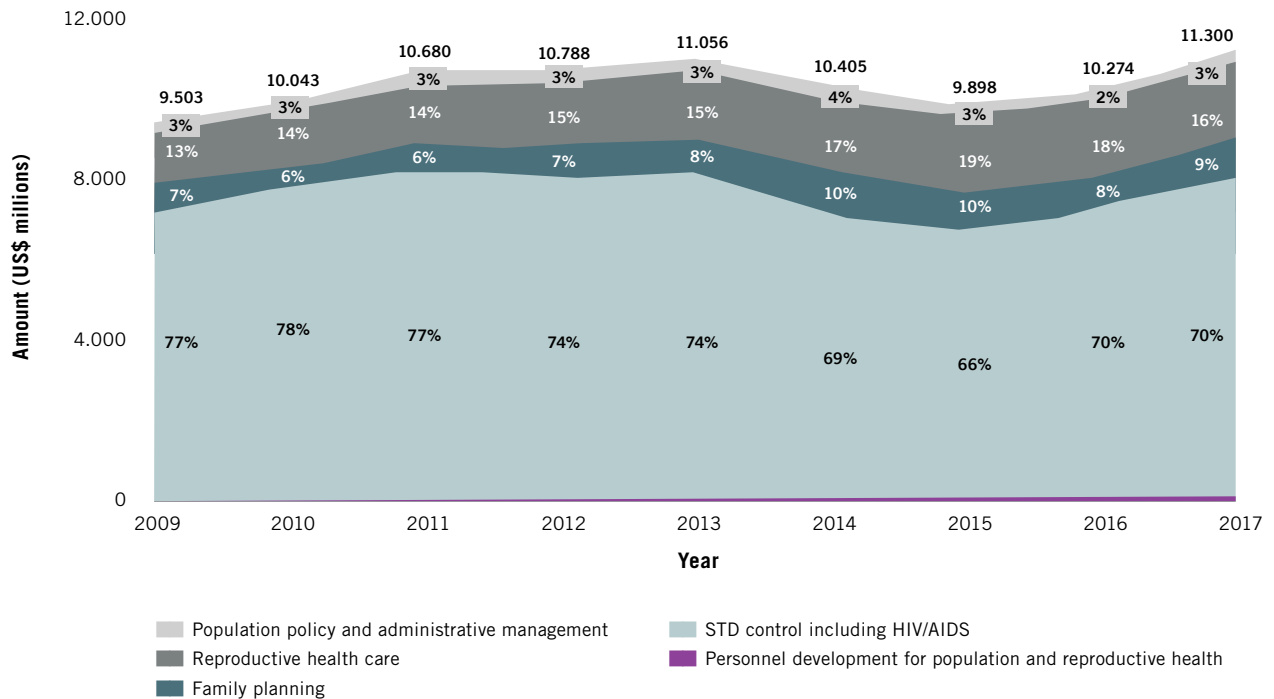
Donor support for family planning – a key sub-area of SRHR – is limited. The share of SRHR donor funding for family planning increased from 6% in 2011 to 10% in 2015 but it fell again to 8% and 9% in 2016 and 2017, respectively (Figure 2).

FIGURE 1 Trends in overall health and SRHR ODA



Source: OECD CRS

FIGURE 2 Distribution of SRHR donor funding (all official donors plus the Bill & Melinda Gates Foundation)

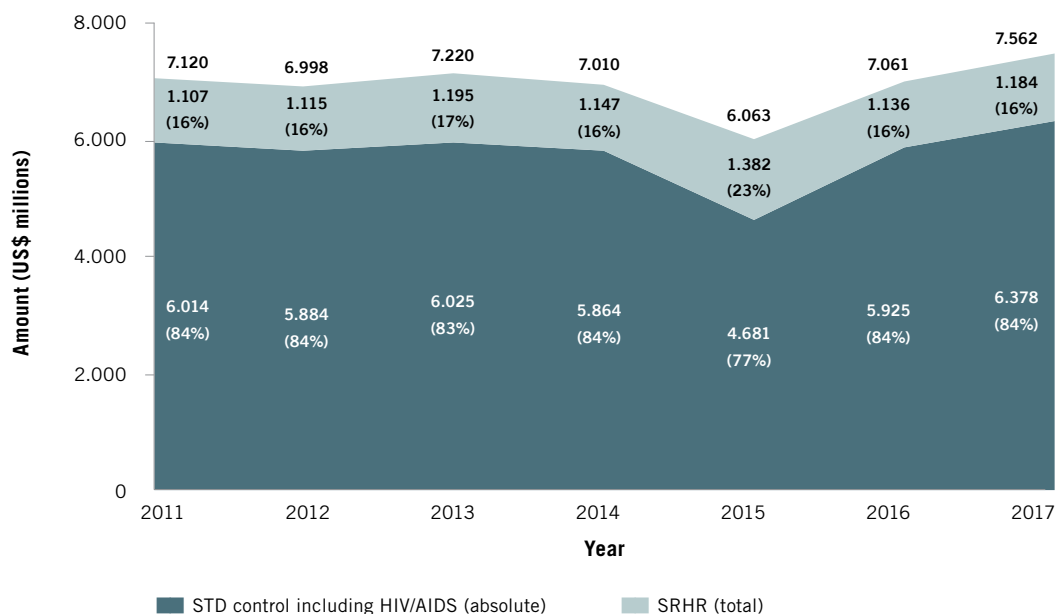


Source: OECD CRS

Of the US\$11.3 billion in SRHR funding in 2017, the US government alone accounted for US\$7.6 billion (67%). Of the total contributions by the US government in 2017,

84% (US\$6.4 billion of the funding) was targeted at HIV, and US\$1.2 billion (16%) was allocated to other SRHR services (Figure 3).

FIGURE 3 HIV and SRHR ODA by the US government

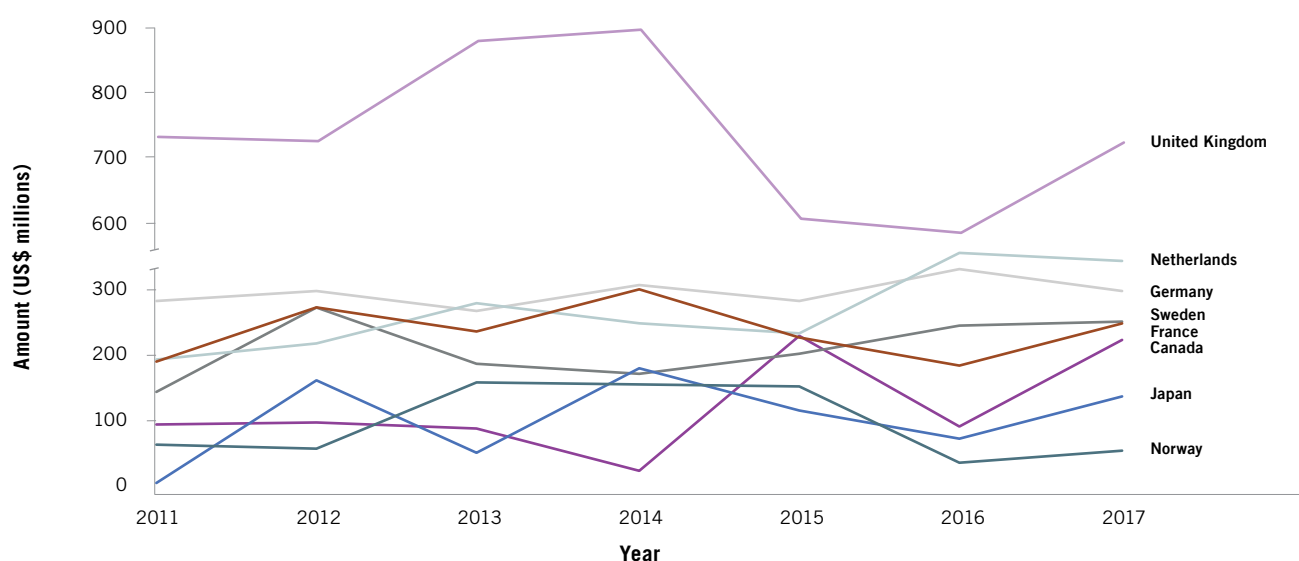


Source: OECD CRS

Other donors also increased their spending on SRHR. After a couple years of decline, there was a major increase in UK ODA for SRHR in 2017 compared to 2016 levels, but the 2017 spending levels were still below the 2014 peak. In 2017, ODA for SRHR from Canada, France,

Norway, and Sweden also increased from 2016 levels. Germany and the Netherlands increased their SRHR funding in 2016 over 2015 levels, but then their funding slightly declined from 2016 to 2017 (Figure 4).

FIGURE 4 SRHR ODA provided by top government donors (apart from the US)



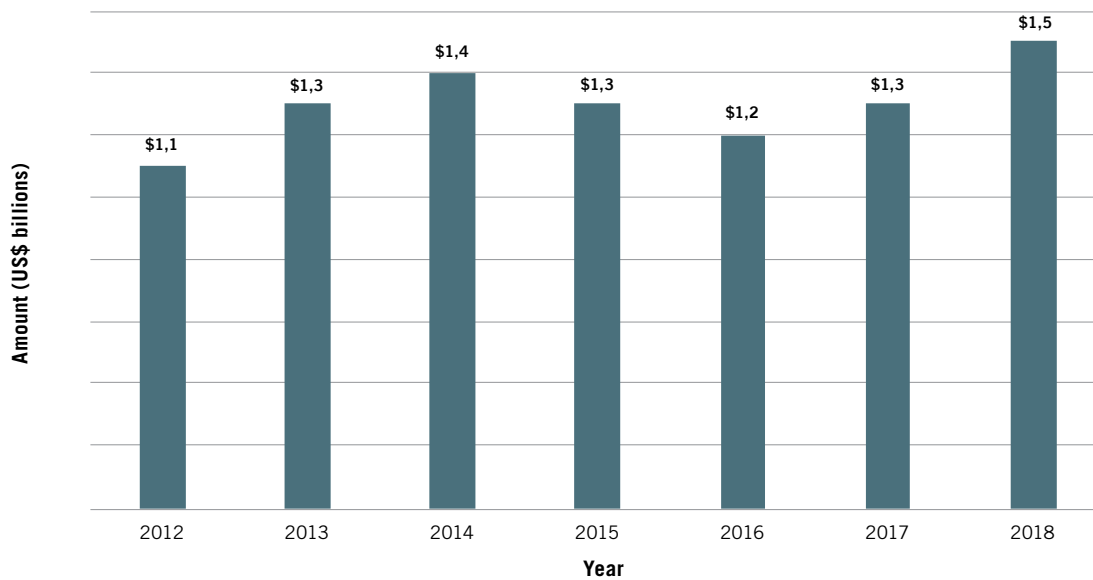
Source: OECD CRS, core contributions to multilateral institutions from DAC table.

According to a new analysis by Kaiser Family Foundation (KFF), donor disbursements for family planning increased from \$1.2 billion in 2016 to US\$1.5 billion in 2018 (Figure 5). This marks a new peak level, which may have also been triggered by new commitments made at the 2017 London Summit on Family Planning (FP2020).²⁸

Since the 2012 London Summit on Family Planning, eight out of ten donors profiled by KFF have increased their funding for family planning (Canada, Denmark, Germany, the Netherlands, Norway, Sweden, the UK, and the US), and overall annual funding has increased by more than US\$400 million.

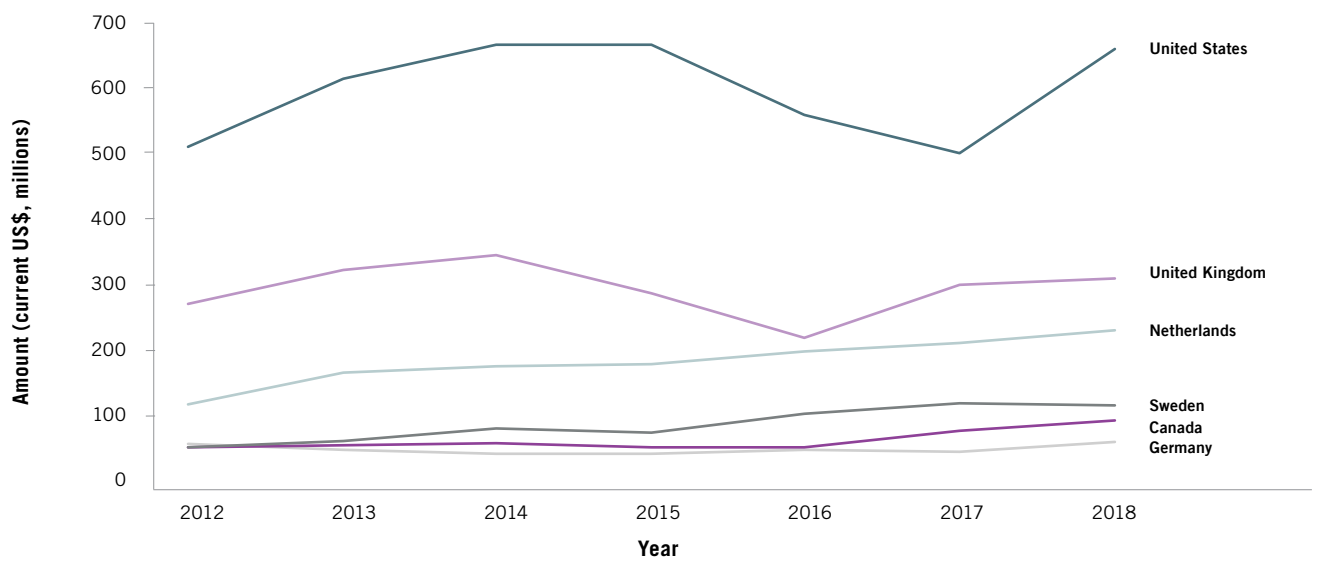
The US is the largest bilateral donor to family planning, representing 42% of total bilateral funding provided by governments in 2018. The next largest donors for family planning were the UK (19%), the Netherlands (14%), Sweden (7%), and Canada (5%). Bilateral funding for family planning by the US increased in 2018. However, the increase in US funding in 2018 was largely due to the timing of disbursements and does not reflect an actual increase in US appropriations by Congress, which have been flat for several years (Figure 6).

FIGURE 5 Total bilateral government funding for family planning



Source: Kaiser Family Foundation: Donor Government Funding for Family Planning in 2018.

FIGURE 6 Donor government bilateral disbursements for family planning



Source: Kaiser Family Foundation: Donor Government Funding for Family Planning in 2018.

Forecasting ODA for health and SRHR

Donors made a series of new funding commitments for SRHR since the 2017 reinstatement and expansion of the Mexico City policy. Some commitments involved new funding for SRHR, while other pledges “rebottled” previous commitments. This repackaging of existing investments for SRHR makes it hard to understand the future investments of donors to SRHR.

- SheDecides:** The SheDecides initiative has galvanized donor countries to increase their funding for SRHR to support NGOs adversely affected by the Mexico City policy (Box 1). In 2017, over US\$250 million was committed by Belgium, Denmark, Finland, France, the Netherlands, Norway, and Sweden.²⁹ Commitments by Sweden, the Netherlands, Denmark, and Belgium were additional – meaning they were new commitments beyond what was already committed. Other donor countries repurposed existing commitments. Canada pledged US\$20 million as part of its previous commitment to spend an additional US\$500 million to improve the SRHR of women and girls from 2017-2020.^{30,31} Finland’s pledge was mainly part of planned SRHR measures.³² Up until now, US\$453 million has been pledged as part of the SheDecides initiative by public donors, private foundations, and an anonymous individual. SheDecides also had a positive ripple effect beyond pledges, for example by inspiring the Netherlands to begin supporting the Global Financing Facility for Women, Children and Adolescents (GFF).³³
- 2017 Family Planning Summit:** Donor governments and foundations pledged a total of US\$2.6 billion at the July 2017 Family Planning summit. While new commitments were made at the summit by a number of donors (e.g., UK, Norway) and part of the US\$2.6 billion raised was from new financial commitments, other donors referred to their pledges made earlier in 2017, including at the SheDecides conference (e.g., Sweden) or at other occasions (e.g., Canada³⁴).
- GFF replenishment:** In November 2018, donors pledged US\$1 billion to the GFF to improve health and nutrition for women, children, and adolescent girls in LICs and MICs.³⁵ The government of Norway, which hosted the conference in Oslo, was the biggest single donor, pledging US\$360 million through 2023. Contributions were also made by Denmark, the European Commission, Germany, Japan, the United Kingdom, Canada, and Qatar, as well as MSD for Mothers and Laerdal Global Health. These pledges were not focused solely on SRHR (but on SRMNCAH+N more broadly).
- Global Fund replenishment:** In October 2019, the Global Fund to Fight AIDS, TB and Malaria raised US\$14 billion for the period 2020-2022. To date, the Global Fund has allocated about 50% of its annual disbursements of US\$4 billion to HIV. While the Global Fund reached its replenishment target, the pledged amount is only US\$1 billion more than the previous three-year period and is thus expected to result in only modest increases in its HIV disbursements.
- Nairobi Summit:** This analysis was conducted before the Nairobi Summit on ICPD25 [International Conference on Population and Development] took place between November 12-14, 2019. It was therefore not possible to provide a detailed analysis of the pledges made at the Summit in this report. However, as reported by Devex, only 6% of the 1,200 commitments made at the summit were focused on financing and only a few donors made significant financial commitments.³⁶ The two largest donor commitments were made by Norway and the United Kingdom but the pledges involve a continuation of

funding at current levels for the period 2020-2025 rather than additional funding (Table 1). Smaller financial pledges were made by the European Commission's (US\$31 million), Germany (US\$22 million), and Denmark (US\$15 million).

Table 1 summarizes the prognosis for future donor funding for health and SRHR. This prognosis is based on key informant interviews, budget documents, commitments announcements and external reports on health and SRHR spending trends. The forecast shows that at best small increases in health and SRHR ODA (but also in overall ODA) can be expected (Table 1). There are five reasons for this gloomy forecast:

- First, the IMF just downgraded the growth forecast once again, which may negatively impact on overall ODA budgets as these are often tied to economic growth. ODA budgets are vulnerable to austerity measures if national economies slow down.
- Second, key SRHR supporters already significantly increased their SRHR spending in recent years, which will make it more difficult and unlikely that SRHR will see further growth in donor spending,

especially given potentially shrinking overall ODA budgets.

- Third, health ODA (and within that SRHR) will compete with other growing donor priorities, such as climate change. More generally, there is evidence that the development agencies of major donors face increasing pressure to shift their funding from social sectors to economic productive sectors and to use aid for economic diplomacy.³⁸ In addition, donors focus on new topics within the health sector, for example on antimicrobial resistance.
- Fourth, the US government's anti-abortion policies may further restrain available resources for SRHR – unless other donors continue to increase their investments.
- Fifth, while the UK government – the second largest health and SRHR donor worldwide, just made a new commitment, there is uncertainty around Brexit and how it will affect UK's ODA.

The future outlook for SRHR donor funding is insecure. Joint action will be critical to ensure that donors make new commitments and provide additional funding for SRHR.

BOX 1 SheDecides

The reinstatement and expansion of the Mexico City Policy gave rise to SheDecides, an international initiative to raise financial and political support for SRHR worldwide. Initiated in early 2017 by the Dutch Minister of Foreign Trade and International Development, Lilianne Ploumen, SheDecides is “a movement to support the rights of girls and women to decide freely and for themselves about their sexual lives, including whether, when, with whom and how many children they have”.³⁷

SheDecides mobilizes funding for organizations that became ineligible for US government funding because they provide information about and access to safe abortion. Four European countries (The Netherlands, Belgium, Denmark, and Sweden) co-organized the first SheDecides conference in March 2017, and created a wider movement to mobilize political and financial support for SRHR. The conference was attended by more than 50 governments and 450 participants from across the world with shared concern of the attack on SRHR globally. Pledges have since been made by multiple country governments and foundations.

TABLE 1 Prognosis on future trends in ODA, health ODA, and SRHR/FP by donor

Donor	Prognosis
Bill & Melinda Gates Foundation	<p>The foundation's funding for family planning is expected to be US\$280m annually from 2020 onwards – roughly the same level as in 2017 (US\$258m) and 2018 (US\$296m). The foundation increased its support to the Global Fund from US\$600m (period 2017-19) to US\$760m (period 2020-2022).³⁹</p> <p>Prognosis: Family planning contributions will remain at similar levels. Annual SRHR funding will increase due to Global Fund pledge.</p>
Canada	<p>In 2017, Canada committed an additional CAD650m (US\$500) over three years.⁴⁰ Since 2017, Canada increased annual SRHR funding from CAD208m to about CAD500 (US\$160-380m). Canada's SRHR ODA is expected to further increase from CAD500m to CAD700m (US\$535) in 2023. Health ODA is projected to increase from CAD1.1bn (FY2018/19) to CAD1.2bn (FY2020/21) and CAD1.4bn (US\$1.1bn) in 2023.⁴¹</p> <p>Prognosis: Prime Minister Justin Trudeau was reelected in October 2019 and will form a minority government. As such, there will be an increase in annual SRHR ODA (CAD200m or US\$150m) and health ODA in 2023, if the commitment is met.</p>
France	<p>There is a presidential commitment to increase ODA to 0.55% of GNI by 2022. In line with this pledge, France's development budget is set to reach US\$12.4bn (€1.0bn) or 0.44% of GNI in 2019, with gradual increases from 2020 onwards: 0.47% in 2020, 0.51% in 2021, and 0.55% in 2022. Two-thirds of the ODA increase will be channeled bilaterally. Health, education, and gender equality are among the five top development priorities of France. France committed to increase its contribution to the Global Fund by 20% to reach US\$1.4bn (period: 2020-22). The Global Fund is and will remain the main multilateral channel related to SRHR. Bilateral SRHR contributions are small.</p> <p>Prognosis: SRHR ODA (or more specifically HIV ODA) will increase by 10% per year (assuming that 50% of Global Fund disbursements are for HIV).</p>
Germany	<p>In 2019, Germany's core funding to UNFPA grew from US\$24 to 36m (€22m-€33m), and funding to IPPF increased from US\$7 to 14m (€6m-€12m).⁴² Germany's contribution to the Global Fund increased by 18% (a total of US\$1.1bn or €1.0bn, period: 2020-2022). The government made a commitment to spend US\$110m (€100m) per year for a special SRHR initiative until 2023 (but this commitment was first made in 2011 and will not increase SRHR funding in future).⁴³ A slight increase in Germany's total ODA is expected in 2020, with overall health ODA remaining stable (~US\$1.1bn or €1bn). The finance plan for 2019-23 includes a decline in ODA budget, from US\$11.3bn (€10.2bn) in 2020 to US\$10.2bn (€9.2bn) in 2023.⁴⁴</p> <p>Prognosis: SRHR funding will be stable over the short-term. Longer-term reductions due to cuts in overall ODA budget are possible but not likely.</p>
Netherlands	<p>The annual SRHR ODA budget amounts to US\$490m (€445m) and US\$465m (€420m) in 2019 and 2020 respectively. The government's annual SRHR budget for the period 2021-2024 amounts to US\$465-470m (€420-425m) per year.⁴⁵</p> <p>Prognosis: SRHR ODA will remain at a similar level as in 2019.</p>

Donor	Prognosis
<p>Norway</p>	<p>Norway committed to an increase in SRHR ODA of NOK700 (US\$80m) over 2017-2020 – this commitment was already met in 2019 (including through increases in core-support to UNFPA, to UNFPA Supplies, and to international SRHR NGOs). In 2018, Norway’s total SRHR ODA amounted to NOK1.6bn (US\$177m). At the Nairobi Summit, Norway pledged NOK9.6bn (US\$1.1bn) to SRHR for the period of 2020-2025, which – if annualized – is slightly below 2018 spending level. In addition, Norway committed NOK1bn (US\$110m) for the period 2019-2021 for protection against sexual and gender-based violence and provision of SRHR services in humanitarian situations.⁴⁶</p> <p>Norway’s 2019 ODA budget totals NOK37.8bn, an increase of 8% compared to 2018. The 2019 ODA budget included NOK4.8 bn (US\$525m) for global health. Cross-party commitment to maintain ODA at 1.0% of GNI.</p> <p>Prognosis: SRHR ODA will remain at a similar level as in 2018 if the pledge made at the Nairobi Summit is met.</p>
<p>Sweden</p>	<p>Sweden’s SRHR ODA increased from US\$235, in 2014 to US\$307m in 2018 (MSEK2,275-2,963), including substantial increases to UNFPA.^{47,48} Health ODA increased from US\$465m to US\$550m (MSEK4,487-5,287). Going forward, Sweden’s total ODA will likely continue to be at a high level (1% of GNI) and as such will slightly rise due to economic growth. Major shifts within the ODA budget are unlikely.</p> <p>Prognosis: Future SRHR ODA will likely remain at a similar level as in 2018, with potentially small increases due to overall ODA growth.</p>
<p>US</p>	<p>The US Senate Appropriations Committee approved the FY 2020 State & Foreign Operations, including for global health. Bilateral family planning/reproductive health funding totals reached US\$633m, which is US\$58m above the FY19 enacted level.⁴⁹ Overall health ODA will likely remain constant at about \$10bn.</p> <p>Prognosis: SRHR ODA will be at a similar level in 2020 as in previous years. Forecast beyond 2020 difficult to predict.</p>
<p>UK</p>	<p>The UK committed to spend an average of at least £225m (US\$290m) on family planning every year from 2018-2022 (a 25% increase and 2-year extension of the original 2012 FP2020 commitment). The new commitment made at UNGA 2019⁵⁰ and again at the Nairobi Summit⁵¹ (£600m or US\$775m for 2020-2025, covering six years) is within the minimum funding target of £225m. About two-thirds of the new commitment will be allocated to continue the UK’s support to UNFPA Supplies, which received £356m between 2013-2020 (about £50m annually). The new pledge will increase the annual funding provided by the UK to UNFPA (an estimated £425m will be for a reformed UNFPA Supplies). The remaining funding will be used for new access initiatives for new and underused products.</p> <p>Prognosis: Future SRHR ODA will slightly increase compared to baseline spending. However, substantial uncertainties exist due to Brexit (potentially weaker economy; devaluation of the Pound Sterling).</p>

Note: m = million; bn = billion.

Government expenditures for SRHR and health in low- and middle-income countries

Donor funding for health is an important source of finance in LICs, where it represents 30% of current health expenditure. In lower-middle income countries (LMICs), donor funding accounts for only about 3% of all health expenditures. Donor funding is only about 1% of health expenditures in upper-middle income countries (UMICs).⁵²

This section analyzes spending of LICs and MICs for SRHR and health. One limitation is that data for reproductive health spending is limited to a relatively small number of countries. To make the analysis more robust, we assess overall health expenditures of LICs and MICs.

Government expenditures for reproductive health in low- and middle-income countries

Data on reproductive health expenditures in LICs and MICs is limited. The WHO's GHED database provides data on reproductive health expenditures for 28, 29, and 35 LICs and MICs in 2014, 2015, and 2016 respectively. Data for previous years is much more limited, with 14 LICs and MICs reporting in 2012 and 21 countries in 2013.

Domestic government expenditures for reproductive health increased in LICs and LMICs between 2012 and 2016. In LICs, mean per capita government spending for reproductive health increased from US\$0.8 in 2012 to US\$1.1 in 2016 – an increase of 38% in four years (current expenditures).⁵³ In LMICs, government per capita spending for reproductive health amounted US\$5.2 in 2016.⁵⁴ The GHED database has a separate category for HIV and STIs. If these

expenditures are added to the reproductive health expenditures, LIC government spending increases from US\$1.1 to US\$1.8 per capita, while the per capita spending by LMIC governments rises from US\$5.2 to US\$6.3.

However, while the overall trend is positive, there are large differences between countries in both income groups. In LICs, per capita spending for reproductive health ranged from US\$0.5 to US\$3.0 in 2016. The range was even higher in LMICs (\$1.5-20.0). Per capita government spending for reproductive health in Nigeria – a LMIC – declined from only US\$1.9 in 2012 to US\$1.5 in 2016. In addition, reproductive health spending only accounted for 10% of all government health expenditures in LICs in 2016. In LMICs, the share of reproductive health spending out of all government health expenditures stood at 16%.

The Guttmacher-*Lancet* Commission estimated the cost for of meeting all women's needs for contraceptive, maternal, and newborn care (cost of HIV prevention and treatment was excluded).⁵⁵ The costs for LICs amounted to US\$13.0 per capita annually, which shows that LIC government funding for SRHR has to grow substantially (by a factor of 12). The Commission suggested that the annual costs in LMICs would be lower, amounting to US\$7.8 per head, compared to current average spending of US\$5.2 in 2016. However, data is only available for 13 out of 45 LMICs and as such might overestimate spending levels in 2016.⁵⁶ Eleven of the 13 countries spent well below US\$7.8 in 2016, and only two countries spent more.

While many governments have committed to increased SRHR investment, progress is slow, which, according to the Guttmacher-*Lancet*

Commission is not only due to limited resources but also weak political commitment, persistent gender-based discrimination, and an unwillingness to address issues related to sexuality openly and comprehensively.

Government expenditures on health in low- and middle-income countries

Health expenditure per head increased in real terms between 2008 and 2016, from \$205 to \$227 in UMICs and from US\$50 to US\$59 in LMICs (based on World Bank income classification in 2016 and unweighted country averages). In LICs, average government spending per head increased from US\$9 in 2008 to just US\$11 in 2016.

Government spending on health is rising, but health spending remains low in many countries. The Lancet Commission on Investing in Health found that the annual costs of an “essential package” of 218 interventions to achieve UHC would be about \$100 per head, while a more basic package of 108 “highest priority interventions” would cost \$50 per head.⁵⁷ Many of these are essential SRHR interventions, according to the Gutmacher-Lancet Commission.⁵⁸

However, out of the 45 LMICs with 2016 data, only eight can afford the essential package of interventions and only 13 additional countries can afford the more basic package. Twenty-one countries can afford neither.

WHO data suggest that the growth in public spending was largely driven by economic growth and fiscal expansion, rather than by giving priority to health.⁵⁹ Governments are not yet making health a high enough priority, as measured by the proportion of all government spending devoted to the health sector (a commonly used metric of prioritization). In LMICs, government health spending as a share of general expenditure grew in real terms from only 7.6% in 2000 to 8.3% in 2016. In LICs, the picture was even bleaker:

government health expenditures fell as a share of general government spending, from 7.9% in 2000 to 6.8% in 2016. Indeed, LICs became increasingly reliant on ODA for health from 2000-2016 according to WHO. Rising ODA for health in LICs may have led governments to reallocate their own domestic health spending to other sectors, a phenomenon known as aid fungibility. Given the limited growth in public spending, median out-of-pocket spending on health represents more than 40% of total health expenditures in LICs.⁶⁰

Forecasting government expenditures for health

The IMF has downgraded its growth projections several times in recent years, most recently on October 15, 2019.⁶¹ In 2017, the global economy was in a synchronized upswing. Measured by GDP, 75% of the world was accelerating. In 2019, the IMF expects slower growth in 90% percent of the world due to rising trade and geopolitical tensions, which have increased uncertainty about the future of future economic growth and international cooperation more generally. Mobilizing domestic resources for health will likely be more challenging. Furthermore, the evidence shown above points to health receiving lower budgetary priority in many countries.⁶²

Still, many LICs and MICs are projected to experience substantial economic growth over the next two decades. The IMF estimates that emerging markets and developing economies will see a GDP growth of 4.6% in 2020. Countries should as such still increasingly be able to finance their health goals through domestic resources alone.

We used the new IMF WEO data (October 15, 2019) to project out economic growth until 2030. In addition, we assumed that the share of government health expenditures out of total government expenditures would increase by 2% per year up until 2030. In other words, we assumed that countries would further prioritize health in their own budgets.

In LMICs, average per capita spending would double, from US\$59 in 2016 to US\$108 in 2030. There is, however, variation between countries – 20 of them would be able to self-finance the essential package with 218 interventions, while 30 would be able fund the highest priority interventions package (108 interventions). Fifteen LMICs would still not be able to self-fund any package. In LICs, average per capita spending would increase from US\$11 to US\$18, with only two out of 31 countries being able to self-fund the highest priority package. No LIC would be able to fund the essential package. This shows that most LICs will likely continue to rely on donor funding to finance health.

Figures 7 and 8 show the distribution of per capita spending for LICs and LMICs in 2016 and the projected values from 2020 to 2030 as box and whisker plots. The relatively more compressed first and second quartiles (areas below the median) in each box suggest the uneven distribution of spending in both country groups, more noticeable for LICs than for LMICs.

Discussions about domestic resource mobilization for health need to consider the realities of recent trends and of projected increases in government health expenditures. Economic growth alone will be insufficient – countries also need to more strongly prioritize health in their own budgets. As Saxenian and colleagues argue, “dialogue on domestic resource mobilization needs to be more balanced, with emphasis on overall economic growth and growth in the tax base as well as share of health in [the] government budget.” A recent WHO report on UHC also includes a call on governments to allocate at least an additional 1% of GDP to primary health care.⁶³

Experts also argue that countries need to improve the spending side of their budgets as inefficiencies undermine efforts to strengthen health.⁶⁴ The World Health Report 2010 estimated that about 20-40% of all health sector resources are wasted.⁶⁵

FIGURE 7 Public spending on health per capita in LICs in 2016 and projected spending 2020-2030

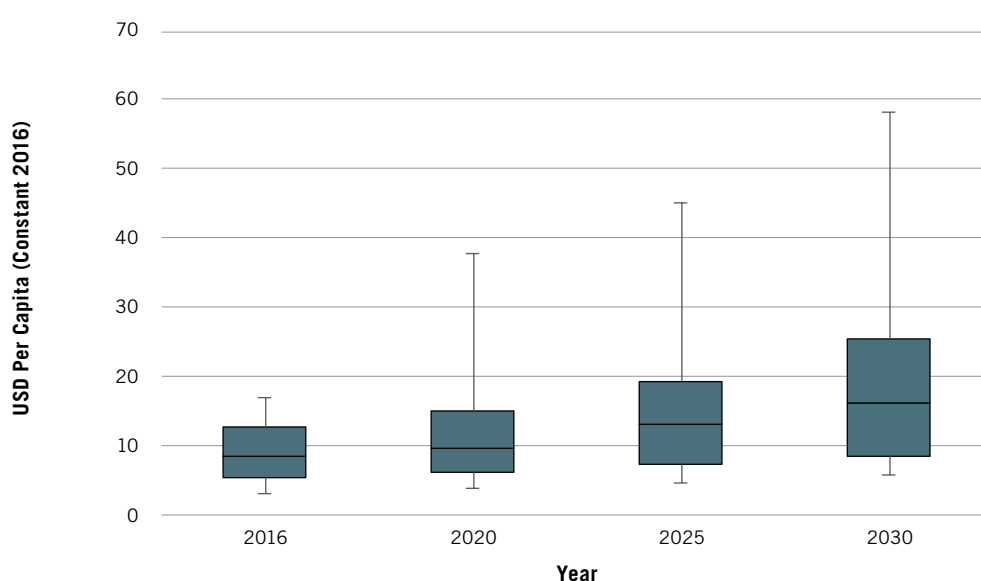
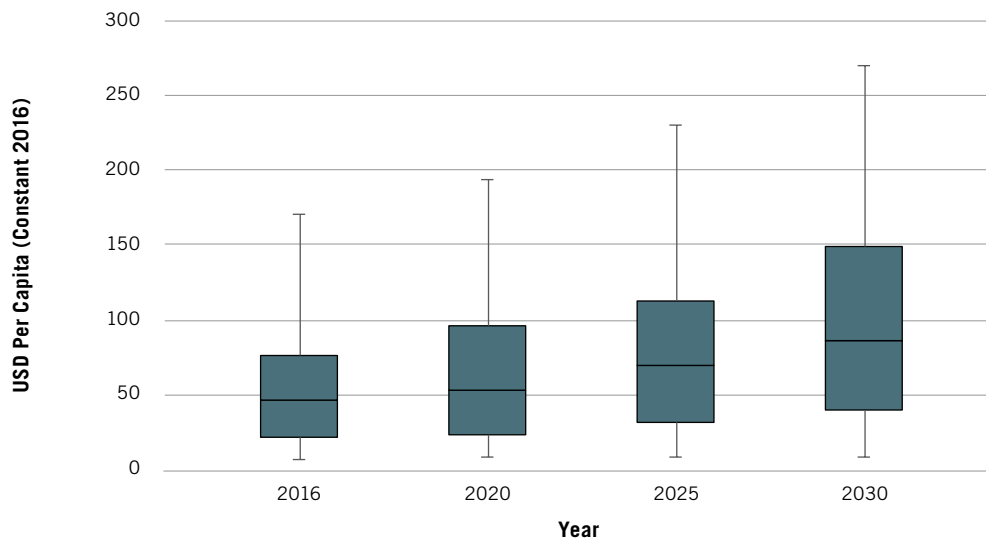


FIGURE 8 Public spending on health per capita in LMICs in 2016 and projected spending 2020-2030



Note: Boxplots show the interquartile range of values with the median marked by a line inside the bar. The lines from the bars extend to the maximum and minimum values with outliers excluded. Current health expenditures.

This also means that the role of technical support and political advocacy will become increasingly important to expand fiscal space and revenues for health in LICs and MICs. Providing this support requires increased

global capacity and the ability to work both with ministries of health and treasuries within countries.⁶⁶

Conclusion and recommendations

This report aimed to take stock of current and future investments in SRHR to support a discussion on how to ensure adequate investment in SRHR from both donors and from low- and middle-income countries. It assessed recent trends in SRHR funding, discussed donor commitments made to SRHR, and reviewed LIC and MIC investments in health and SRHR, using a mix of methods.

In summary, donors have invested a lower share of their overall health funding into SRHR since 2012. The largest share of the funding provided to SRHR was allocated to HIV. Family planning saw larger investments in 2018, yet it remains unclear how investments in family planning will develop in 2020 and beyond. While donors have made new commitments to SRHR, it is unclear how much of that funding is new money. Strong champions for SRHR in the donor community continue to support SRHR, yet overall the future outlook of SRHR investments beyond 2020 does not look bright. While many governments of LICs have committed to increase SRHR investments, progress has been slow due to lack of resources, lack of political will, and an unwillingness to address issues related to sexuality openly and comprehensively.

The report puts forward five recommendations:

1. A new global moment to mobilize political and financial support for SRHR is needed to sustain investments.
2. Donors should include SRHR as an integral part of UHC efforts and protect health investments vis-à-vis other emerging priorities.
3. Donors should be clear about their financial commitments to SRHR. When announcing commitments to SRHR, donors should always be fully transparent to what extent the pledges are additional and how they related to their previous commitments.
4. Political leadership for SRHR at the country level needs to be strengthened.
5. Countries need to prioritize health including SRHR in their domestic budgets.

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Annexes

Annex 1: Integrated definition of SRHR by the Guttmacher-Lancet Commission

Panel 3: Integrated definition of sexual and reproductive health and rights

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing.

All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;

- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health.²⁸ The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers

Annex 2: Benefits of investing in SRHR

Investments in SRHR are estimated to deliver dramatic health benefits. The Disease Control Priorities Project 3rd edition (DCP3) found contraceptive services to be one of the most effective interventions in reducing maternal, child, and newborn mortality.⁶⁷ Addressing 90% of the 2015 unmet need for contraceptive services could reduce annual births by 28 million, which would, in turn, prevent 67,000 maternal deaths, 440,000 neonatal deaths, 473,000 child deaths, and 564,000 stillbirths from avoided pregnancies.⁶⁸ Further, provision of essential maternal and newborn health interventions, would avert an estimated 2,574,000 deaths: 849,000 stillbirths, 149,000 maternal deaths, 1,498,000 neonatal deaths, and 78,000 child deaths.⁶⁹

Nearly all of the essential reproductive, maternal, and newborn interventions reviewed by DCP3 can be delivered by health workers in the community at the primary health centers. Further, many are among the most cost-effective of all health interventions – for example, DCP3 found that improved access and quality of care around childbirth can generate a quadruple return on investment by saving maternal and newborn lives and preventing stillbirths and disability.⁷⁰

Annex 3: Impact of the Mexico City policy

Evidence suggests that the Mexico City policy has been ineffective and harmful. Researchers examining the Mexico City policy over a 20 year period found that when the policy was in effect, abortion rates substantially increased in sub-Saharan African countries.⁷¹ A study in Ghana found that the Mexico City policy resulted in reduced contraceptive supplies and outreach in rural areas, which in turn increased fertility and abortion rates among women in rural and poor populations.⁷² Further, analysis of NGOs found that the policy led to termination of

services, including from leading health care providers; drastically reduced community-based outreach; contraceptive stock-outs and cuts in contraceptive supplies, including condoms; and fear of advocating for or sharing information about legal abortion among NGO staff and health workers.^{73,74}

As many NGOs provide integrated health services, the Mexico City policy risks negatively impacting health services beyond family planning and abortion. Early data shows the Trump Administration's PLGHA policy has had ripple effects through health programs and systems, and researchers expect further disruptions.⁷⁵ For example, a 2018 survey of US President's Emergency Plan for AIDS Relief (PEPFAR) implementing partners found a reduction in the provision of non-abortion related services such as HIV, contraception, cervical cancer screening, and adolescent health counselling due to the policy.⁷⁶

Annex 4. Methods to track donor funding for health and SRHR (YRS 2009-2017)

First, we used the OECD DAC's International Development Statistics databases to calculate donor disbursements for ODA, health ODA, and SRHR ODA between 2009 and 2017. To calculate health and SRHR ODA, we used the Creditor Reporting System (CRS) database, which covers aid activity data provided by 30 DAC donor countries, 20 non-DAC donor countries, and 46 multilateral donors.⁷⁷ It also includes funding from the Bill & Melinda Gates Foundation, which we thus included in the analysis.⁷⁸ The CRS also provides information about ODA recipients (a total of 143 eligible recipient countries).⁷⁹ The CRS "covers bilateral ODA, i.e. activities undertaken directly between a donor and recipient (or executed by a by a national or international non-governmental organizations active in development on behalf of the donor); and promotion of development awareness and other development-related spending in the donor country (e.g. debt

reorganization, administrative costs).”⁸⁰ We used the September 30th, 2019 update of the CRS. We downloaded the data on October 5th, 2019.

To calculate trends in global health ODA, we assessed three sector codes for “aid to health”: “health, general (code 121),” “basic health (code 122),” and “population policies/programmes and reproductive health” (code 130). To calculate global trends in SRHR ODA, we used the code 130 – specifically the codes 13010 (Population policy and administrative management), 13020 (Reproductive health care), 13030 (Family planning), 13040 (STD control including HIV/AIDS), and 13081 (Personnel development for population and reproductive health).

To estimate health and SRHR disbursements of individual donors, we also used data on donors’ core contributions to multilateral institutions from the DAC table titled, “members’ total use of the multilateral system.” For health ODA, we used first the bilateral government funding from the CRS (codes 121, 122, and 130). Second, we used the DAC’s “imputed multilateral contributions to the health sector” estimates⁸¹ to calculate which the share of core funding counts towards health. In summary, we used the bilateral funding from the CRS plus the relevant core contributions to the relevant multilaterals working on health. To calculate SRHR ODA by individual donors, we used the bilateral funding from the 130 code, plus 100% of core funding to UNFPA and UNAIDS, 50% of funding to the Global Fund, and 28% of funding for the GFF. This method provides a conservative estimate of SRHR financing. Key strengths of the method include that the results can be fully replicated and that it allows for a comparison of investment based on official data reported by donors to the OECD DAC.

Annex 5: Projection of health expenditures

The projections were based on an approach that is similar to that used by the Lancet Commission in Health.⁸² The IMF WEO data from October 15, 2019 was used to project economic growth (i.e., GDP growth). The IMF provides data until 2024. To project out economic growth until 2030, we applied the average annual growth for 2019-2024 for the years 2025-2030.

From the GHED dataset, we downloaded data on “General Government Health Expenditure - Domestic as a percentage of Gross Domestic Product” (GGHE-D%; YR2016). We then projected GDP data from the IMF and multiplied these values by the GGHE-D% to get the “General Government Health Expenditure - Domestic”, GGHE-D. For the projected years, we assumed that the share of government health expenditures out of gross domestic product would increase by 2% per year up until 2030. We used the UN data for population,⁸³ which allowed the calculation of GGHE-D Per Capita through 2030.

Annex 6: Consulted stakeholders

Name	Affiliation
Romina Boselli	Global Affairs Canada
Kelly Cholvat	Global Affairs Canada
Austen Davis	Norwegian Agency for Development Cooperation
Fabrice Ferrier	Focus 2030, Paris
Paul Fife	Norwegian Agency for Development Cooperation
Emma Foster	UK Department for International Development
Sanjeev Gupta	Center for Global Development (previously IMF)
Ini Huijts	Ministry of Foreign Affairs, the Netherlands
Jen Kates	KFF
Guy Mainville	Global Affairs Canada
Maher Mamhikoff	Global Affairs Canada
Gudrun Nadoll	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
Steffie Neyens	Deutsche Stiftung Weltbevölkerung (DSW)
Tamara Nierstenhoefer	Plan International Germany
Anders Nordstrom	Ambassador for Global Health, Sweden
Franziska Pflüger	Plan International Germany
Elisabeth Richter	Federal Ministry of Economic Cooperation and Development, Germany (BMZ)
Anja Sletten	Norwegian Agency for Development Cooperation
Kate Somers	Bill & Melinda Gates Foundation
Ann Starrs	Bill & Melinda Gates Foundation
Alexandra Stefanopoulos	Global Affairs Canada
Peter St-John	Global Affairs Canada
Nina Strom	Norwegian Agency for Development Cooperation
Adam Wexler	KFF

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