Working Paper June 2022

Identifying Innovative Approaches to Increase Domestic Resource Mobilization and Financing Contributions for Family Planning in Nigeria

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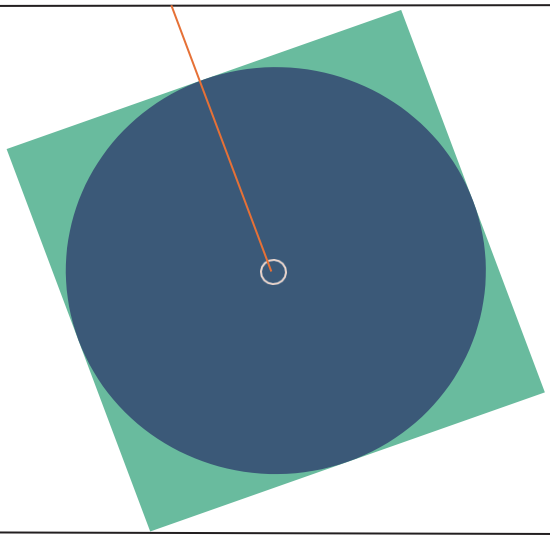

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Abbreviations

BHCPF	Basic Health Care Provision Fund
DRM	domestic resource mobilization
FP	family planning
FSA	fiscal space assessment
IGR	internally generated revenue
KII	key informant interview
MCH	maternal and child health
MMR	maternal mortality ratio
MOH	Ministry of Health
NPC	National Population Commission
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
SDG	Sustainable Development Goal
SOML PforR	Saving One Million Lives Program for Results
SSA	sub-Saharan Africa
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization

Abstract

Background: Improving domestic resource mobilization (DRM) for family planning (FP) can contribute to improving and sustaining maternal health outcomes, especially in such places as Ebonyi State, Nigeria, which has one of the highest unmet needs for FP in the country. This study explored the prospects for increasing government spending on FP in the short-to-medium term in view of the well-defined needs for improved FP service delivery and stocks of contraceptive commodities.

Methods: A fiscal space assessment was conducted in Ebonyi State. We applied the *Roadmap for Assessing Fiscal Space for Health* (Tandon & Cashin, 2010) to identify the need for additional funding for FP services in Ebonyi State and assessed the potential and feasibility of increasing funding for FP through DRM. Data collection entailed a document review and two key informant interviews. We performed descriptive trend analysis of financial data to determine change over time and to make assumptions (of increases or declines in the fiscal space) for the short-to-medium term (2016–2020). For the qualitative data, we performed a manual thematic analysis then triangulated the narratives with the quantitative data.

Findings: Statutory allocation constituted a considerably high proportion of the total revenue in Ebonyi State but there has been a downward trend since 2018. With the exclusion of the 2020 budget, the budgetary allocation to health in the past five years has been very poor, ranging from 2.7 percent to 3.2 percent, which is far less than the Abuja Declaration recommendation of 15 percent. The main sources of funding for FP in the past five years were the federal government's earmarked funds under the Saving One Million Lives Program for Results and donor contributions, specifically from the United Nations Fund for Population Activities. Although budgetary allocations for FP were made in the state government's budget in the past five years (2016–2020), releases were only made in 2016 and 2017, albeit very paltry sums. Therefore, in the past three years, FP services have been funded from external sources.

Conclusion: The fiscal space for FP services and contraceptives is very poor in Ebonyi State. It could be improved if the state government honors its commitment to allocate 15 percent of its budget to the health sector and if a proportion of the Basic Health Care Provision Fund is earmarked for FP services.

Background

Maternal mortality is a global health concern, with concerted efforts to reduce it to 70 maternal deaths per 100,000 live births by 2030, in accordance with Sustainable Development Goal (SDG) 3 (United Nations, n.d.-a). The global maternal mortality ratio (MMR) declined by 38 percent in 2017 to 212 maternal deaths per 100,000 live births, from the 2000 estimate of 342 maternal deaths per 100,000 live births (World Health Organization [WHO], 2019). Although this decline showed that some progress had been made in reducing maternal mortality, the estimated 2.9 percent average annual decrease in MMR between 2000 and 2017 revealed that the SDG maternal mortality target would not be achieved unless drastic measures were taken. Moreover, although the MMR was declining globally, there have been very wide variations and significant disparities between high- and low-income countries (WHO, 2019). In 2017, sub-Saharan Africa (SSA), specifically, had an MMR of 542 and accounted for 66 percent of maternal deaths in the world (Musarandega, Nyakura, Machekano, Pattinson, & Munjanja, 2021; WHO, 2019). SSA was also the only region that had an MMR higher than the global average. Nigeria had the highest maternal death burden globally, with an estimated 67,000 maternal deaths in 2017, accounting for 23 percent of global maternal deaths (WHO, 2019). This implies that about one in every five maternal deaths in 2017 occurred in Nigeria.

Evidence has shown a relationship between maternal health and child mortality, especially neonatal mortality (Bhutta, Lassi, Blanc, & Donnay, 2010; Usman, Banerjee, & Srivastava, 2021). Newborns face regional inequalities in their chances of survival, with the highest mortalities occurring in SSA (You, et al., 2015). It is noteworthy that SSA was the only region in the world that failed to experience a regional decline in neonatal deaths between 1990 and 2019 (You, et al., 2015). In Nigeria, neonatal mortality increased from 1990 to 2003, and then again from 2013 to 2018 (Patel, et al., 2021).

Providing access to FP is an important public health intervention that is proven to reduce maternal and neonatal mortality. It reduces unsafe abortions by preventing unwanted pregnancies; prevents high parity, which is a risk factor for maternal and newborn morbidity and mortality; prevents high-risk early childbearing by delaying pregnancy; and enables child spacing, which is critical for the health of the mother and baby (Brown, Ahmed, Roche, Sonneveldt, & Darmstadt, 2015; Chola, McGee, Tugendhaft, Buchmann, & Hofman, 2015; Stover & Ross, 2010; Stover & Ross, 2013). This understanding has led to global action to improve access to contraceptives. The Family Planning 2020 Initiative (now renamed FP 2030) committed to ensuring that an additional 120 million women and girls in the world's 69 poorest countries would have access to high-quality and effective FP services and information by 2020 (FP 2030, n.d.). The achievement of this target will contribute to preventing 100 million unintended pregnancies, 200,000 maternal deaths, and 3 million infant deaths. In recognition of the critical role that access to FP services plays in overall health outcomes, the health-specific SDGs designated a FP target with the accompanying indicator, "met need for modern contraceptives" (United Nations, n.d.-a; United Nations, n.d.-b).

Globally, there has been very slow progress in the proportion of women with met need for modern contraceptives, with SSA having the highest burden of women with an unsatisfied need for FP (United Nations, 2019). In Nigeria, 19 percent and 48 percent of married women and sexually active unmarried women, respectively, reported an unmet need for modern contraceptives in 2018 (National Population Commission [NPC] [Nigeria] & ICF, 2019). Variations in unmet need for modern contraceptives existed across and within geopolitical zones, with some states having higher estimates than the national average. Ebonyi State had an unmet need of 23 percent among married women, one of the highest in the South East region of the country (NPC [Nigeria] & ICF, 2019).

FP Investments in Nigeria

The need for increased investment in FP services is underscored by high and unequal unmet need for modern contraceptives (Singh, Darroch, Ashford, & Vlassoff, 2009). In a bid to improve its modern contraceptive prevalence rate, Nigeria made a commitment to allocate US$4 million annually to FP services (Federal Ministry of Health [MOH], 2020). However, this barely scratched the surface of the cost of achieving the National Family Planning Blueprint for 2020–2024, which was estimated at US$252 million. Moreover, the federal government's failure to provide counterpart funds to match donor contributions to FP resulted in a 90 percent reduction in funds for FP services in May 2019, thereby causing a dramatic reduction in the fiscal space for FP in Nigeria (Advance Family Planning, 2017a). With the reduction in national spending on FP, state governments needed to begin to think about approaches to filling the funding gap and sustaining the supply of contraceptive commodities to primary health centers.

Improving DRM for FP service delivery and contraceptive supplies is an urgent need for the reproductive, maternal, newborn, child, and adolescent health (RMNCAH) program in Nigeria (WHO, 2016). However, reliable evidence is needed to support domestic resource mobilization by policymakers for FP services. One form of evidence that is needed is a fiscal space assessment (FSA). The FSA will highlight for decision makers the various potential domestic sources from which additional revenue can be mobilized for FP service delivery and contraceptive supplies in a manner that is consistent with the country's macroeconomic fundamentals.

The success of DRM efforts largely hinges on the ability to diagnose factors that mitigate against optimal allocation and execution of the budget, including the efficient use of resources, and to devise mechanisms to remove such obstacles. The end point of any resource mobilization endeavor is to mobilize more money for health and, ultimately, to achieve better health outcomes. Attaining such aspirations requires an understanding of the potential or feasibility of mobilizing additional resources for health, pushing the frontier of what is achievable in health outcomes for a given resource envelope, and converting such feasibility into reality.

Research Question

The main question that this study sought to answer was: Given the well-defined need for improved FP service delivery and stocks of contraceptive commodities, what are the prospects for increasing government spending for FP in the short-to-medium term in Ebonyi State? To address this question, we specifically examined domestic financial contributions to FP programs from 2016 to 2020, to strengthen the case for additional sources of funding for FP service delivery. We also identified potential avenues from which domestic resources could be mobilized. This information is useful to understand the factors that militate against optimal budget allocation, execution, and the efficient use of funds. Identifying these factors can guide more effective resource mobilization efforts and improve FP service delivery.

Methods

Study Area and Design

The FSA was conducted in Ebonyi, a state with the highest unmet needs for FP in the South East region of Nigeria (NPC [Nigeria] & ICF, 2019). Using the *Roadmap for Assessing Fiscal Space for Health* (Tandon & Cashin, 2010), the research focused on assessing the potential for and feasibility of increasing funding for FP through more DRM and proposing strategies for improving domestic funding for FP in Ebonyi State.

A systematic assessment of four FSA pillars was done to document the potential for increasing the fiscal space for health through DRM. The first pillar, **Conducive Macroeconomic Conditions**, examined how the state was performing in overall fiscal capacity, as derived from standard macroeconomic indicators. The second pillar, **Reprioritization of Health**, examined budgetary allocation to health and opportunities for raising health's share in the overall government spending, especially if the share for health in the government budget was lower than what could be obtained in contexts with similar income levels. The third FSA pillar, **Health Sector-Specific Resources**, examined existing and potential health-specific resources that could be an additional source of fiscal space for the sector, such as earmarked funds and social health insurance funds. The fourth pillar, **Health Sector-Specific Grants and Foreign Aid,** specifically examined external sources of funding that have proven to be sustainable and predictable. Last, we identified areas where the state had the greatest potential to increase the fiscal space for health and FP services.

Ethical Approval

The proposal was reviewed and approved by the Ethics Committee of Ebonyi State MOH.

Data Collection

Data were collected through the review of 15 government documents and two key informant interviews (KIIs).

Document Review

We sourced and retrieved Ebonyi State's financial documents covering the period 2016 to 2020. The initial list of relevant and useful financial documents was generated by stakeholders during a consultation workshop that was held in Ebonyi State in May 2021. The list was subsequently updated based on the recommendations of FSA experts and program officers in Ebonyi State.

A team of three female and one male researchers from Health Policy Research Group, Nigeria, conducted the data extraction. The researchers were divided into two groups with the documents shared between the groups. Each group had two primary data miners and a tiebreaker. Each document was first reviewed by two independent researchers (i.e., the primary data miners) and the findings were compared and merged. Inconsistencies in data records were managed by the primary data miners by forming a consensus or by the tiebreaker undertaking an additional review of the document.

We entered financial data in a Microsoft Excel template that was designed by the principal researcher and refined by two FSA experts from Center for Health Economics and Development, Lagos, Nigeria. The FSA experts trained the researchers over two days on how to find and extract financial data from the documents. Data extraction was carried out from October to November 2021.

KIIs

To fill the information gaps about donor funding for FP services in the state, two key informants from the State MOH were interviewed: the Head of the Family Planning Unit and the Director for Reproductive Health, who is also the State Coordinator for the Saving One Million Lives Program for Results (SOML PforR). They were purposively selected for the key roles they play in implementation of FP interventions and SMOL PforR. The interviews were conducted by one member of the research team and audio recorded with the consent of the respondents. A semi-structured interview guide was used to collect information from the key informants about donor funding for FP services, including the names of the funders, the proportion of all donor funds for FP contributed by each donor, and how the funds were allocated and/or used for FP services. Each interview lasted about 25 minutes.

Data Analysis

The FSA experts conducted two separate training sessions for the researchers on how to analyze and present financial data. Each training lasted two days.

Descriptive analysis was performed for all quantitative variables. Absolute numbers and proportions were presented in line graphs to show yearly trends for the following variables:

- State revenue and expenditures
- Budget performance (overall and health sector-specific budgets)
- Budgetary allocation to health (as a percentage of overall government spending)
- Budgetary gap relative to the Abuja Declaration[1]
- FP expenditures

The state budgetary envelop was determined using projected total revenues from internally generated revenue (IGR), statutory allocation, value-added tax, and special releases for the fiscal years under consideration.

The health budget and actual health expenditures were used to calculate the actual health expenditures as a percentage of what was budgeted for health. This was benchmarked against the 2001 Abuja Declaration of at least 15 percent of total government expenditures on health.

Absolute numbers were reported for earmarked funds and external sources of funding for FP.

Audio recordings of the KIIs were transcribed and relevant information on the external sources of funding for FP were extracted into an Excel template.

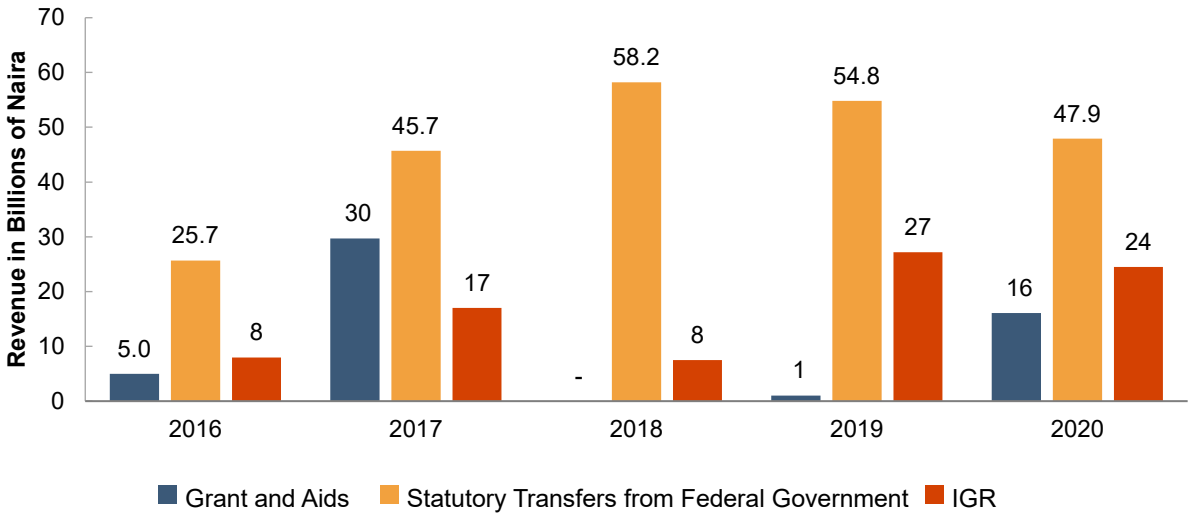
[1] Pledge made in April 2001 in Abuja, Nigeria by heads of state of the African Union countries to set a target of allocating at least 15% of their annual national budgets to the health sector.

Results

FSA pillar 1: Conducive macroeconomic conditions (fiscal profile of Ebonyi State)

An assessment of the fiscal profile of Ebonyi State revealed that the major sources of revenue for the state were statutory allocations from the federal government, IGR, and external grants and aid, in that order (Figure 1).

Figure 1: Fiscal profile of Ebonyi State from 2016-2020



Source: Ebonyi State financial statements 2016 – 2020

Statutory allocations are funds that are derived from the federation account. They are allocated monthly to all states. This funding constituted a very significant proportion of the state's total revenue. The share of statutory allocations as a proportion of total revenue more than doubled from 2016 to 2018, but declined afterwards, as shown in Figure 1. Although it increased from ₦25.7 billion in 2016 to ₦58.2 billion in 2018, subsequent years witnessed a decline from ₦54.8 billion in 2019 to ₦47.9 billion in 2020. [2]

Another significant source of revenue for the state was the IGR. This source of revenue has likewise been unstable over the years, with a marked decline from ₦17 billion in 2017 to ₦7.5 billion in 2018, a marked increase to ₦27.2 billion the following year, and a subsequent decline to ₦24.5 billion in 2020. Although the IGR has been irregular over the years, the actual tax revenue realized from 2018 to 2020 exceeded the yearly estimates for tax-based revenue. This was likely due to the recent drive by the state government to expand the tax base by capturing the large informal sector. The estimated tax revenues for 2018, 2019, and 2020 were ₦3.9 billion, ₦3.3 billion, and ₦2.9 billion, respectively. However, the actual tax revenues realized were ₦4.3 billion, ₦5.2 billion, and ₦6.3 billion, respectively. This was not the case for non-tax revenue; the actual non-tax revenues realized were below the budgetary estimates. The

[2] In 2020, US$1 equaled ₦360.

budgetary estimates for 2019 and 2020 non-tax revenues were ₦11 billion and ₦19.6 billion, respectively, whereas only ₦4.6 billion in 2019 and ₦9.5billion in 2020 were the actual non-tax revenues realized by the state in those fiscal years.

Although external funds from grants and aid are unpredictable sources of revenue, they contributed considerably to the total revenue of Ebonyi State. In 2017, it was estimated that external funds would generate revenue of about ₦6.4 billion. However, the actual revenue from external funds in the year was more than 4.5 times higher (₦29.7 billion). A similar increase in actual revenue was observed in 2020 when ₦16 billion was realized against the budget estimate of ₦12.5 billion. However, this was not the case in the other years. In 2019, the budget estimate for grants and aids (external funds) was ₦6.6 billion but only ₦1 billion was realized, underlining the unstable and unpredictable nature of external grants and aid.

FSA pillar 2: Reprioritization of health

An examination of budget allocations for health in Ebonyi State showed that the health sector's share of the budget in 2017 was 4.8 percent, decreasing to 2.3 percent in 2018, and then increasing significantly from 7.9 percent to 20.8 percent in 2019 and 2020, respectively. In 2017, the share of the actual health expenditures was 2.9 percent, which increased to 3.2 percent in 2018, and declined to 2.7 percent in 2019. A remarkable increase of 16 percent was observed in 2020 (Table 1).

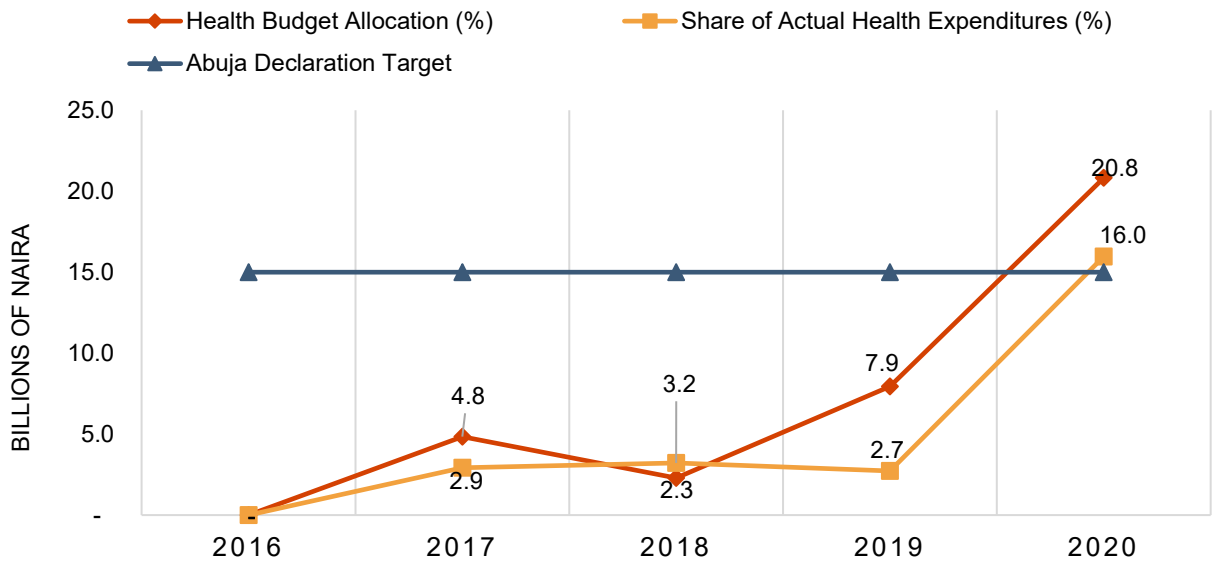
Table 1: Budgetary allocation to health and actual health expenditures in relation to the state budget and total expenditures

Health spending budget, expenditures, or target	2016	2017	2018	2019	2020
	Amount in billions of Naira (₦)				
Health Budget	3.22	6.97	5.51	14.93	27.48
Total State Budget	0.0	143.92	240.51	188.18	132.00
Health Budget Allocation	-	4.8%	2.3%	7.9%	20.8%
Actual Health Expenditures	10.69	2.09	2.35	5.12	18.95
Total State Expenditures	0.0	71.28	73.01	188.18	118.69
Share of Actual Health Expenditures	-	2.9%	3.2%	2.7%	16.0%
Abuja Declaration Target	15.0%	15.0%	15.0%	15.0%	15.0%

Between 2016 and 2019, Ebonyi State did not achieve the 15 percent allocation to health as agreed in the Abuja Declaration (Figure 2). However, in 2020, the state surpassed the 15 percent allocation. This achievement can be attributed to the increased share of funding for the health sector to address the COVID-19 pandemic. The state received additional funding from the federal government and other grants from the Coalition Against COVID-19, a private sector task force aimed to address COVID-19 in Nigeria. However, a large proportion of the COVID-19 budget was funded by the state government. It is important to highlight that of the ₦18.95 billion for health expenditures in 2020, about ₦13.8 billion (approximately 73%) was used for

COVID-19. This spending on COVID-19 was used to purchase face masks and other personal protective equipment; to disinfect public places; to pay frontline workers; to construct, renovate, and equip/furnish COVID-19 treatment and isolation centers; and for other COVID-related activities. This showed that the government had the capacity to spend more on health.

Figure 2: Budgetary allocation to health and actual expenditures in relation to the Abuja Declaration



Source: Ebonyi state financial statements 2016 – 2020

FSA pillar 3: Health sector-specific resources (earmarked funds)

The health sector earmarked funds, as indicated in the annual budgets. Moreover, the health sector benefitted from the SOML PforR intervention, which was earmarked for health, and is currently benefitting from the Basic Health Care Provision Fund (BHCPF), which is also earmarked for health.

SOML PforR: This was the major source of FP funding in Ebonyi State for three consecutive years (2018–2020). The SOML PforR was implemented by the Federal MOH using a World Bank loan. The project aimed to improve the use and quality of MCH services, and of nutrition interventions, with set targets (World Bank, n.d.). FP was a critical component of the package of interventions, with the modern contraceptive prevalence rate being a key indicator for monitoring progress and program results. The state government received more than ₦30 million over three years (Table 2). However, after the SOML PforR ended, the state experienced a major decline in FP funding.

BHCPF: This fund comprises at least 1 percent of consolidated federal revenue and has been earmarked for health. FP services are included in the basic minimum package of health services that are covered by the fund. Although Ebonyi State started receiving its share of the BHCPF one year ago, we were unable to access data to estimate how much money was being allocated to FP services. However, the BHCPF is a potential source of revenue from which funds can be earmarked for FP.

FSA pillar 4: Health sector-specific grants and foreign aid (external/donor funds)

Ebonyi State has attracted several external donors due to its poor performance on maternal health indicators. There are currently three development partners supporting FP interventions in the state: the United Nations Fund for Population Activities (UNFPA), Marie Stopes, and the United States Agency for International Development (USAID). The core activities carried out by these donors are aimed at capacity strengthening for service providers, supplying FP commodities, demand creation, service delivery, and research. UNFPA primarily funds procurement of commodities and capacity building, Marie Stopes focuses on service delivery and capacity building. USAID supports demand creation activities in the health sector through the Breakthrough Action-Nigeria project, the provision of FP services through the Integrated Health Project, procurement and supply chain management of FP commodities through the Global Health Supply Chain Program-Procurement and Supply Management project, and FP research through the Data for Impact project.

Expenditures Specific to FP

The major sources of funding for FP in Ebonyi State over the past five years have been the federal government's SOML PforR; official development assistance, mainly from UNFPA; and the state health budget. The primary source of FP funding in Ebonyi State has been the fund from the federal government allocation through the SOML PforR basket fund. This program, implemented by the Federal MOH, usually released funding to states to use in the health sector to cover FP services. The Ebonyi State government showed no documented FP expenditures for three consecutive years (2018 to 2020); rather, it relied solely on SOML PforR funds and official development assistance. Although budgetary estimates for FP were made in the State's health budget from 2016 to 2020, as shown in Table 2, actual releases were only made in 2016 and 2017. They appeared to constitute 100 percent of the total expenditures on FP in these two years because we could not find evidence of expenditures from other sources, especially from the federal government and donors.

The total expenditures for FP from all sources in the five years under study were ₦846,458 in 2016, ₦5,683,100 in 2017, ₦18,148,000 in 2018, ₦20,315,700 in 2019, and ₦7,044,600 in 2020 (Table 2).

The federal government contributed the bulk of the total expenditures on FP in 2018 (81.53%) and 2019 (74.57%), and almost an equal proportion as donors in 2020 (48.59%). The remaining expenditures on FP in 2018 and 2019 were from official development assistance. Moreover, it appears that the Ebonyi State government did not make any contributions to FP expenditures in the three years (2018, 2019 and 2020) because we could not find any documented evidence of the state's expenditures on FP. Therefore, the state relied solely on the federal government and foreign aid to fund FP interventions. This indicates that there is a huge gap to cover to achieve sustainability.

Findings from the KIIs revealed that the available funds for FP were used for commodities, demand creation, health worker training, and other quality improvement activities, and that these activities constitute the major drivers of FP service use.

Table 2: FP budget estimates and specific expenditures from various funding sources

FP Budget Estimate and Actual Expenditures	2016	2017	2018	2019	2020
	Amount in Naira (₦)				
Budget Estimates	**414,000,000**	**6,879,000**	**512,644,036**	**305,494,284**	**254,176,118**
Total Expenditures	**846,458**	**5,683,100**	**18,148,000**	**20,315,700**	**7,044,600**
Actual FP Expenditures - State Government	846,458	5,683,100	-	-	-
Actual FP Expenditures - Federal Government (SOML PforR)	-	-	14,796,000	15,150,000	3,423,000
Total Government Expenditures on FP (State and Federal)	846,458	5,683,100	14,796,000	15,150,000	3,423,000
Actual FP Expenditures - Official Development Assistance (Donors)*	-	-	3,352,000	5,165,700	3,621,600

* Documented funding from UNFPA only was readily available and accessed.

Source: Ebonyi State FP expenditure summary, annual work plan, and birth spacing costed implementation plan from 2016–2021.

Discussion

The objective of this analysis was to review the health financing landscape in Ebonyi State to identify potential sources of additional funding for FP services and contraceptives, within the context of increasing funding for FP services to improve access to contraceptive commodities for those who need them (Advance Family Planning, 2017b; Dhalla, Guyatt, Stabile, & Bayoumi, 2011, WHO, 2016).

Ebonyi State's IGR has been unstable over the years. However, our findings revealed that from 2018 to 2020, the state generated higher actual revenue from taxation than the budgetary estimations made for tax revenue for those years. The current yearly IGR could be a source for additional fiscal space for health, and for FP programs, in particular. However, this revenue could be inadequate and will require a review of the state revenue generation mechanism to expand both tax and non-tax revenue generation. Improved IGR would cause the state's fiscal space to expand and could filter down to the health sector and FP interventions.

At current levels of state government health expenditures, the realization of health goals may be impossible. Therefore, the state urgently needs to invest more on health to accelerate progress on health indices. The low level of state government investment in FP is a threat to the successful implementation of its FP interventions and goals. From our findings, it can be deduced from the last three years of data analyzed, FP funding from the Ebonyi state government has been almost zero. There was overreliance by the state government on federal government funding, specifically on the SOML PforR. This fund lacked sustainability because it ended in 2020, resulting in a major setback for FP funding and the need to explore other potential domestic sources for FP funding.

Because only meager amounts are set aside by the state government for FP, there is a need to increase the state's annual budget for FP as a line item and also ensure an annual release of the FP program expenditure funds. Other states' broader health sector fund should be disaggregated to enable FP to get a fair share. There is also a need for high-level advocacy from the MOH and its partners to both arms of government (state and local government area), the Ministry of Finance, and the Ministry of Budget and Planning to ensure that there is high budgetary allocation and expenditures for health and FP interventions. The advocacy team should clearly identify the need for and importance of prioritizing FP interventions to key stakeholders.

Ebonyi State has started accessing the BHCPF. The state could follow the federal government's example by earmark a percentage of the state's consolidated revenue for FP. This earmarked fund could be enhanced with contributions from local governments, a contributory social health insurance scheme that has been fully operationalized by the state, and other sources. An earmarked fund is a legislatively backed fund with clearly defined resources set aside for a specific purpose, such as healthcare services or specifically FP. This fund is one of the most reliable and predictable pillars for increasing budgetary resources for specific healthcare services. Studies typically reference potential revenues for health from taxation and social health insurance contributions as sources of earmarked funds (Dhalla, et al., 2011; Ozer, et al., 2020; Yazbeck, et al., 2020). However, few studies provide an in-depth assessment of what could be

generated by introducing earmarking as a revenue source for health (Dhalla, et al., 2011; Ozer, et al., 2020; Webb, 2001; Yazbeck, et al., 2020). Rather, they provide references to the possibility of exploring these mechanisms.

Limitations

A major limitation of this study was that we had limited access to budget and financing contribution data from implementing partners and donors. The donor-specific FP funding results were accessed from the UNFPA Ebonyi State FP expenditure summary sheet. The non-availability of data from implementing partners affected the interpretation of donor-specific FP funding evidence in the state. There was also a lack of disaggregation of FP from broader health areas, such as reproductive health, RMNCAH, or MCH, making it difficult to find FP-specific data in the state budget.

Recommendations

Based on our research findings, we make the following recommendations to stakeholders:

1. Implementing partners and donors should be more transparent about their budgets so that those working in the fiscal space can perform more accurate budget analyses and projections to assist decision makers who are guiding policies and programs.
2. Implementing partners and donors should lead high-level advocacy and negotiate for government's financial commitment to FP interventions, including counterpart funding for FP services, to ensure continuity and ownership of programs when donor funding ends.
3. FP allocations and expenditures should be disaggregated from broader health areas, such as reproductive health, RMNCAH, or MCH, for ease of access to FP-specific data in the state budget.
4. State governments should increase budgetary allocations for health and for FP interventions, specifically, and should ensure the actual release and spending of the money. High-level advocacy can be done with state and local governments to help them understand the need for and rewards of increased investment in FP.
5. The Ebonyi State government should earmark a percentage of the state's consolidated revenue to the health sector to increase the fiscal space in the health budget for FP-specific spending.
6. A percentage of the BHCPF should be earmarked specifically for FP services.
7. There should be expansion of both tax and non-tax revenue because an increase in the state's IGR could lead to an increase in the fiscal space for health and, therefore, FP interventions.

Conclusion

In Ebonyi State, most funds allocated for FP were received from the federal government and donors, through implementing partners. The FSA for improved FP funding provides options for sustainable financing for health and, specifically, for FP interventions in the state. The findings and recommendations from this research provide evidence for government policymakers and executives to make budgetary decisions to ensure an optimal and sustainable health and FP budget allocation. The execution and efficient use of an allocated FP budget will lead to effective resource mobilization efforts, thereby increasing the modern contraceptive prevalence rate in Ebonyi, reducing the unmet need for FP, and improving the health of women and children in the state.

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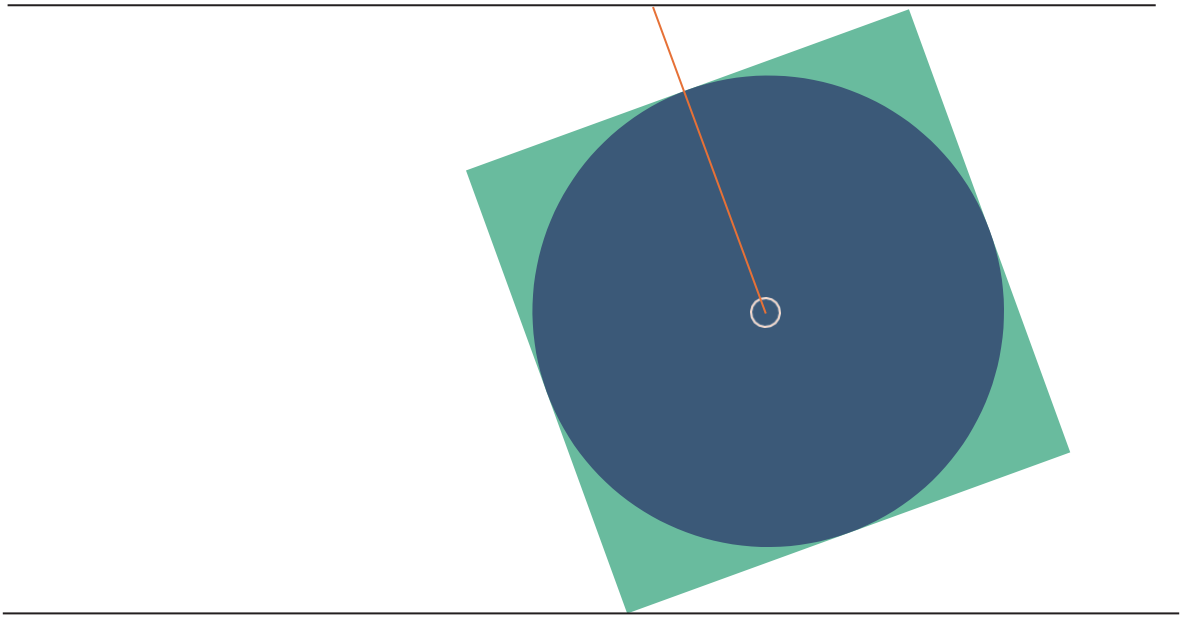
Appendix

Table A1. List of documents and sources

Research Questions	Documents Available and Accessed	Sources
Examine domestic financial contributions to FP programs	• Report of the Accountant General with the Audited Financial Statements – For 2019 • Report of the Accountant General with the Audited Financial Statements – For 2020 • Ebonyi State Revised Appropriation Law 2020 • Ebonyi State Appropriation Law 2021 • Consolidated Budget Summary – Ebonyi State Government 2016 Budget Approved Estimates • Ebonyi State Government 2017 Budget • Ebonyi State Government Approved 2018 Budget • Ebonyi State Government Approved 2021 Budget • Health Financing Landscape: Ebonyi State, Nigeria • Ebonyi state health insurance scheme health benefit package	State Ministry of Health Ministry of Finance Ministry of Budget and Planning Organizational websites
Produce evidence to strengthen the case for additional sources of funding for FP services and contraceptive supplies	• Ebonyi State Strategic Health Development Plan II (2018–2022) • Annual Work Plan with Ebonyi State Planning Commission (UNFPA) for 2016, 2017, 2018, 2019, 2020, 2021 • Ebonyi State Saving One Million Lives Revised Implementation Plan for Initial Investment Funds (Submitted in March 2017) • Maternal and Newborn Health Costed Implementation Plan 2019–2021 • National Strategic Health Development Plan II (NSHDP II) - Annual Implementation Planning (AOP) Tool - 2021	State Ministry of Health UNFPA State Primary Health Care Development Agency
Identify innovative approaches to increase domestic financial contributions for FP and contraceptives	Literature review	Online



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