ecdpm

DISCUSSION PAPER No. 366

European and African financing for health and universal health coverage

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May 2024

Universal health coverage (UHC) is fundamental to realising health as a human right under the Sustainable Development Goals, but its implementation is staggering, with 4.5 billion people lacking essential health services in 2021 and two billion facing financial hardships due to out-of-pocket health spending. Financing health systems is further complicated by conflicts, health crises and budget constraints, hindering investments in the face of growing health needs and changing priorities.

This paper provides an overview of current European and African commitments and efforts in financing health, including achieving UHC and supporting social health protection and sexual and reproductive health and rights. Building on this, it also provides recommendations for securing and increasing investments in health, both for European and African actors. Beyond merely increasing funding, the paper points out the importance of quality of financing, for instance, by ensuring alignment with local needs and priorities, avoiding fragmentation and better recognising the role of civil society.

The EU has demonstrated a clear added value as a global health actor, stemming from its influence in multilateral settings, its track record and its ability to pull together the resources and expertise from various member states. Going forward, it will be crucial to leverage these assets fully and recognise the potential of the support to health for the EU's partnership with Africa.

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Acknowledgements

This paper was produced under the partnership between ECDPM and the Belgian Presidency of the Council of the European Union 2024. The authors are grateful to the numerous individuals consulted who shared their insights and comments. The authors would like to thank Amandine Sabourin for her input and feedback on the document and Joyce Olders, Yaseena Chiu-van 't Hoff as well as Carlotta Maria Paschetto for the layout.

The views expressed in this paper are those of the authors only and should not be attributed to any institution or ECDPM. All errors remain those of the authors. Comments and feedback can be sent to Katja Sergejeff (ks@ecdpm.org) and Karim Karaki (kka@ecdpm.org).

Acronyms

4AQ	Affordable, available, acceptable and accessible with quality
AfDB	African Development Bank (Group)
AHAIC	Africa Health Agenda International Conference
AMATA	African Medicines Agency Treaty Alliance
AOP	Annual Operations Plans
APHRC	African Population and Health Research Center
AU	African Union
CBHI	Community-based Health Insurance Scheme
CDC	Centres for Disease Control and Prevention
CIVICUS	World Alliance for Citizen Participation (global alliance of civil society Organisations and activists)
COVID-19	Coronavirus disease 2019
CSO	Civil Society Organisation
DFI	Development Finance Institution
DRM	Domestic Resource Mobilisation
EFSD(+)	European Fund for Sustainable Development (Plus)
EIB	European Investment Bank
EU	European Union
EUR	EURO (European Monetary Unit)
FY	Fiscal Year
GDP	Gross Domestic Product
GFF	Global Financing Facility
GHI	Global Health Initiative
GHS	Global Health Strategy
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
IAPO	International Alliance of Patients Organisations
IDA	International Development Association
ILO	International Labour Organisation
IMF	International Monetary Fund

KfW	German Reconstruction Credit Institute (*Kreditanstalt für Wiederaufbau*)
LICs	Low-Income Countries
MFF	Multiannual Financial Framework
MICs	Middle-income Countries
MS	Member States
NDCs	Non-Communicable Diseases
NDICI-GE	Neighbourhood, Development, and International Cooperation Instrument - Global Europe
NGO(s)	Non-governmental Organisation(s)
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OHCHR	Office of the High Commissioner for Human Rights
OOP	Out-of-Pocket
PBF	Performance-based financing
PDB	Public Development Bank
PFM	Personal Financial Management
PHC	Primary Health Care
RBF	Results-based financing
RST	Resilience and Sustainability Trust
SDG	Sustainable Development Goals
SDRs	Special Drawing Rights
SHP	Social Health Protection
SRHR	Sexual and Reproductive Health Rights
TEI	Team Europe Initiative
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation

Executive summary

Ensuring universal health coverage (UHC) is a policy objective of both the European Union (EU) and Africa and is reflected at the multilateral level through the 2030 Agenda for Sustainable Development. Despite this commitment, progress toward UHC faces challenges, with 4.5 billion people lacking essential health services in 2021 and two billion facing financial hardships due to out-of-pocket health spending. Additionally, financing health systems is further complicated by conflicts, health crises, and budget constraints in both Africa and Europe, hindering investments in the face of growing health needs and changing priorities. In this context, it is important to understand how the EU and its Member States (MS) can provide more and better health financing to partner countries to support the strengthening of their health systems and sustainable domestic health financing by African countries.

This paper provides an overview of current European and African commitments and efforts in financing health, including achieving UHC, supporting social health protection (SHP) and sexual and reproductive health and rights (SRHR). It draws a picture of the current state of play for both European and African health financing, highlighting some of the key issues and challenges as well as opportunities that can be taken forward.

In particular, the paper underscores the necessity for the EU and African policy-makers to not only ensure the current or increased funding for UHC and social protection but also to improve the allocation of funds to these priorities. In doing so, it lays out the following recommendations:

<table>
<tr><th>Recommendations for the EU and its Member States</th><th>Recommendations for the AU and its Member States</th></tr>
<tr><td colspan="2">Securing or increasing the volume of health financing</td></tr>
<tr><td>Use strategically the mid-term review and evaluation of NDICI-GE

Recognising the potential of support for health as a source of geopolitical clout, ensure that adequate official development assistance (ODA) resources for health are secured.</td><td rowspan="2">Boost domestic resource mobilisation

Being a priority for many African nations, Domestic Resource Mobilisation (DRM) could be strengthened, for instance, through tax reforms, the introduction of levies and taxes, social insurance contributions, and tackling illicit financial flow and corruption.

Any actions should be implemented in a way that is progressive to ensure that no one is left behind.</td></tr>
<tr><td>Leverage shareholder position to steer development finance for health

EU Member States can leverage their role in development banks to boost health sector investment, aligning with EU-African priorities and mobilising additional funds for 4AQ health care.</td></tr>
</table>

Explore the potential of SDRs rechanneling for health

EU member states have the option to redirect their Special Drawing Rights (SDRs) to partner countries for health financing, for instance, through international monetary fund (IMF) Resilience and Sustainability Trust (RST) expansion or MDBs like the European Investment Bank (EIB) for greater investment attraction.

On the quality of financing	
Better reflecting and responding to local needs and priorities - whilst thinking and acting politically The EU's support to UHC should align with the priorities and needs of African stakeholders and ensure local ownership. It is important to address political factors, capacity gaps, and corruption.	**Improving PFM practices** Support African countries in Personal Financial Management (PFM) efforts, including in the context of: i) budget formulation ii) execution and iii) monitoring Given the political nature of these efforts and reforms, using a political economy analysis could help identify reforms that are not only desirable but feasible in practice.
Foster a more coordinated and integrated approach Coordination is crucial and should be nurtured and strengthened both among the European actors but also between European and African stakeholders.	
Be more strategic Selecting funding modalities, whether grants, technical assistance, or financial instruments, is complex. It depends on the sector, political context, governance, economics, and actors involved, while considering visibility, geopolitics, and economic interests. The EU should balance strategic goals with development impact and adapt the mix as circumstances change.	

Embracing CSOs as political actors with a role to play in SHP and SRHR

Civil society, from local groups to global coalitions, plays a vital role in health initiatives. The EU and its member states should support it through consultation, partnership, and flexible funding to be part of the solution.

1. Introduction

Financing health systems to ensure universal health coverage (UHC) is a policy commitment of both the EU and Africa and is also reflected in the 2030 Agenda for Sustainable Development, which recognises health as a fundamental human right. However, moving from policy commitments to the practice provides a sobering reality check: progress towards UHC has been stalling, with 4.5 billion people not covered by essential health services in 2021, and about two billion experiencing financial hardship due to out-of-pocket (OOP) health spending (World Health Organisation (WHO) and World Bank (WB) 2023).

Financing health systems is also currently even more challenging owing to previous and ongoing conflicts, health, climate and food crises, which have significantly reduced the fiscal space for African economies to invest in health, in a context where needs are vast and growing (WHO 2023a). In Europe, member states also operate under tighter budget constraints, limiting potential investments in health - especially in an increasingly geo-fragmented context, and ever-changing geographical and sectoral priorities.

In this context, a better understanding of how the EU and its MS can provide more and better health financing to partner countries is crucial to strengthen health systems and contribute to UHC policy commitment. In particular, health financing should be provided in a coherent way that builds on, and complements domestic efforts and priorities of partner countries. Beyond governments, Civil Society Organisations (CSOs) have also played a key role in this endeavour given their proximity and knowledge of local communities' needs, and their advocacy work to ensure that resources are utilised as intended, and to achieve key health objectives.

Therefore, this paper provides a brief overview of current European and African commitments and efforts in financing health including achieving UHC, and supporting social health protection (SHP) and SRHR. In doing so, it analyses the key challenges that actors from the two continents face in this endeavour and highlights good practices. The concluding section provides a set of recommendations for EU policy-makers, to foster a more coherent approach, tapping into the expertise and resources of their institutions including their implementing agencies and financial institutions for development, as well as CSOs, in a way that supports efficient, effective and sustainable progress in the field of health financing.

This paper is based on literature review, interviews, and a mapping exercise that ECDPM carried out between June and September 2023. The internal mapping included an analysis of the EU's and member states' Official Development Assistance (ODA) disbursements in Africa for the year 2021 based on the data retrieved from Organisation for Economic Co-operation and Development (OECD) Creditor reporting system (CRS). To supplement the OECD data, ECDPM carried out a literature review to collect data on African health financing, as well as supplementary interviews with policy-makers in the EU and Africa, select EU member states, and European Development Finance Institutions (DFIs) and Public Development Banks (PDBs), think tanks and civil society.

2. Background

Africa is a continent with a high disease burden: it accounts for 23% of the global burden of disease while the continent has 17% of the world's population (AHAIC 2021). Infectious diseases including Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), tuberculosis and malaria (ATM), combined with antimicrobial resistance (AMR) and increasing disease burden caused by non-communicable diseases (NDCs) are widespread on the continent. This is not to ignore all of the gains and progress made by African countries when it comes to inter alia reducing maternal mortality and child deaths- though these remain above global averages (WHO 2023b).

To mitigate and deal with these issues, strong and resilient health systems are required. However, healthcare systems in many African countries are weak, as illustrated by the Coronavirus disease 2019 (COVID-19) pandemic, which highlighted inter alia weak emergency preparedness and response systems and capabilities, limited health infrastructures, and lack of access to medicines, diagnostics and therapeutics. Another key challenge is the limited availability of health workforce in the continent, which is undermining access and quality of health services (WHO 2022b).

As part of strong and resilient health systems, UHC plays a key role in ensuring that no one is left behind when it comes to the possibility of receiving affordable, available, accessible and acceptable health services of assured quality (4AQ). However, despite some progress in the past decades, only 48% of people in Africa received the healthcare services that they need, and the quality of healthcare service provided is inadequate and considered the least performing indicator of UHC (AHAIC 2021). Last, 38% delay or forgo health care due to high costs (Karamagi et al. 2023), and 8.2% of the population in Africa are incurring catastrophic health expenditures with out-of-pocket expenditure increasing across most countries in the past two decades (WHO 2023b) - undermining the implementation of a rights-based approach to social health protection and thus UHC (ILO 2020).

Achieving UHC often relies on a solid foundation of primary health care (PHC). One important component of PHC is SRHR services, including e.g. antenatal and postnatal care, contraception and abortion care - which should be part of the overall service coverage under UHC (WHO 2022a). Progress on SRHR in Africa remains limited and unequal: Sub-Saharan Africa has the highest unmet need for modern contraceptives, the highest adolescent birth rates, the highest child marriage rates, the highest burden of sexually Transmitted Infections (STIs) including HIV in the world and a high total fertility rate (KIT 2020). Coverage of service is hence limited, especially for women and girls, lesbian, gay, bisexual, transgender and queer and Intersex (LGBTQI) people (AHAIC 2021). In addition, the COVID-19 pandemic diminished the overall accessibility of services as well as their quality (APHRC 2021), undermining some of the fragile progress made in the past decade.

Financing or rather the lack of it, is one of the key issues affecting the development of strong and resilient health systems and ensuring UHC. In Low-Income Countries (LICs) and Middle-

Income Countries (MICs), the annual financing gap to reach the sustainable development goals (SDG) health targets has been estimated to be more than USD 370 billion (WHO 2023d). For Africa alone, the annual health financing gap is estimated to be about USD 66 billion, illustrating the scale of the challenge (Roby 2019). The following sections will dive into this issue, from both an African and European perspective.

3. State of play of African health financing

Advancing UHC and strengthening health systems is a shared political commitment for both Europe and Africa. These regions have made key commitments to promote UHC in multilateral fora, the latest one being in the high-level meeting on UHC at the United Nations General Assembly (UNGA) 78. The draft political declaration not only reaffirms the commitments to UHC, but also recognised the slow progress and financing gap as it comes to SDG 3.8 on achieving UHC. This chapter discusses the state of play of African financing towards UHC.

3.1. African health financing

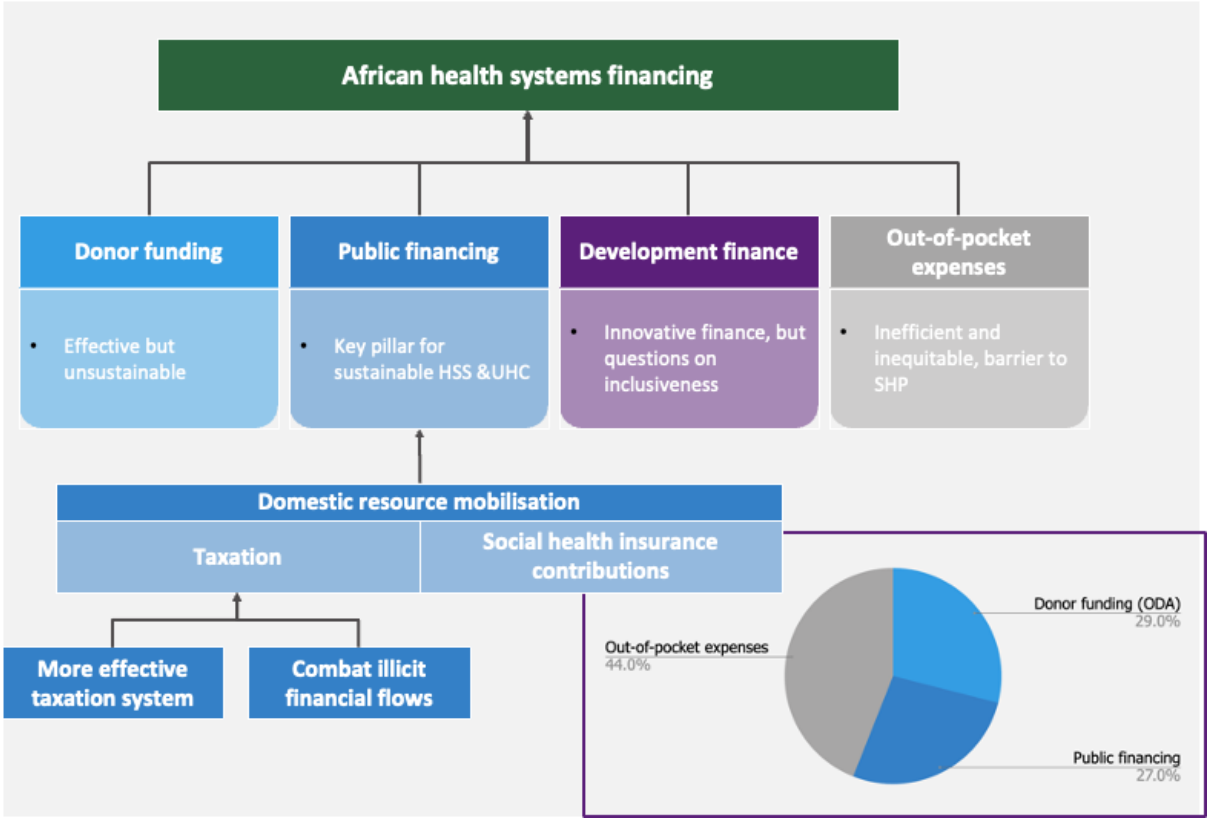
AU heads of state in the 2001 Abuja Declaration pledged to allocate at least 15% of annual expenditure to the improvement of the health sector (AU 2001). 22 years later and even if public health expenditures increased in some countries, following the advent of COVID, this commitment has been largely unmet, with only a handful of countries meeting it over the years (see Annex 1) . At the same time, it is public financing that contributes most to the health system and the provision of 4AQ healthcare, in comparison to other sources of financing - and is hence a determinant for UHC (Karamagi et al. 2023). Beyond growing (Gross Domestic Product) GDPs (which could translate in more resources for health), several factors affect the capacities of governments to honour their commitments:

- Ineffective taxation: in 2020, the average tax-to-GDP ratio in Africa was 16.0%, in comparison to 33.5% across OECD countries (OECD et al. 2022) pointing to the need for more effective and transparent tax systems. The issues of the informal sector and illicit financial flows are further limiting the effectiveness of taxation and thereby the amount of resources that can be mobilised for health. The IMF estimates that low income developing countries can raise their tax-to-GDP ratio by, on average, 6.7 percentage points to achieve their full potential by strengthening institutions capacities, rethinking the tax architecture and implementing institutional reforms (Benitez et al. 2023).
- Inherent limits of social health insurance contributions, which are limited due to the large informal sector and the important share of people having low contributory capacity (Ly et al. 2022).
- Competing priorities, which pose even more challenges in a context where i) post COVID-19, there is less attention paid to the health sector and ii) the needs arising from several parallel crises (food crisis, debt crisis, climate crisis, fragility etc.) are such that health is not necessarily a key priority. Some countries currently spend more in servicing their debt than strengthening their health systems (UN 2023). In Zambia, between 2018 and 2021, debt repayments increased from 20% to 38% of the country's national budget, just as the

allocation of funds towards the health sector declined from 9.5% in 2018 to 8% in 2022. Historical budget under-execution in health is estimated to limit budgetary space by 20–40% in Sub-Saharan African countries (Barray and Gupta 2020).

As a result, health spending in low income countries (many of which in Africa) is financed mainly by OOP spending (44%) and external aid (29%) , compared to high income countries with higher levels of government spending (70%) (WHO 2021) (figure 1).

Figure 1: Overview of African health financing



Source: From the authors.

This also links to vast inequalities in access to health services in African countries. High levels of OOP - as a consequence of inadequate or lack of social health protection - is directly linked to catastrophic health expenditures and impoverishment. OOP is also highly inefficient (because it is highly fragmented) and is an unequitable source of funding (Karamagi et al. 2023). In addition, OOP costs are compounded by the widespread occurrence of corruption in accessing health services. For instance, in Uganda in the first year of the rollout of COVID-19 vaccines, 10% of respondents reported having to pay a bribe to obtain the vaccine (Transparency International 2023).

African countries' health systems are partly relying on donor funding to function - a recent study shows that the share of external financing for health increased by 17 percentage points from 12.3% in 2000 to 29.5% in 2020 (ONE 2020). While donor funding has had the merit of

expanding access to critical health services in Low-Income Countries (LICs) and Low and/or Middle-Income Countries (LMICs), it cannot be considered sustainable (priorities and needs may shift and creates donor dependencies) and may have adverse consequences including a more challenging and costly coordination or difficulties in reconciling donors' public health priorities than those of partner countries. For instance, the health system in South Sudan is almost entirely dependent on external aid, which is responsible for 64% of the total health expenditure, and with minimal government expenditure (8%) (GHED n.a.). The large dependence on donors has also put them in the drivers' seat on defining health priorities through control of financial resources and technical expertise and given rise to sustainability and ownership concerns (Widdig et al. 2022). On the other hand, in Kenya, the share of external aid to health has decreased over time, as the government has progressively taken over - albeit more slowly than hoped for. In 2000 the government was responsible for 23% of total health funding, whereas in 2020 the share had doubled to 46% in 2020 (GHED Kenya Country profile).

Last, development finance plays a minor, though increasing role in financing African health systems. The African Development Bank (AfDB) and AfreximBank play a key role in this context, by providing not necessarily grants but rather financial instruments to African governments and private healthcare service providers (which cannot be overlooked, given that they provide up to 50% of healthcare services in the continent (Attridge and Gouett 2020). The AfDB has developed a strategy targeting the health sector, the "Strategy for Quality Health Infrastructure in Africa - 2022-2030" and has approved three operations in health in 2022, amounting to Euro (EUR) +31 million. The AfDB provided a 120 million loan to Morocco to finance the Inclusive Access to Health Infrastructure Support Programme (PAAIIS) (AfDB 2023), using a results-based financing instrument. AfreximBank also aims to support the health and pharma sector by inter alia providing trade and export finance to health businesses - a key bottleneck to pharma trade (Karaki and Ahairwe 2022), and, like the AfDB, collaborates with European institutions such as KfW and the EIB in health financing (see e.g. the health resilience initiative (EIB 2023)). At the same time, the financial products offered do not necessarily target the more challenging contexts, and have limited reach when it comes to targeting the health needs of the poorest - more information in the section below (Karamagi et al. 2023).

Health financing is often geared towards achieving national level priorities, some of which are reflected at the continental level. A review of health strategies of African Union (AU) and AU institutions including CDC and African Union Development Agency - New Partnership for Africa's Development (AUDA NEPAD) show that the health priorities of the continent revolve around strengthening African institutions for public health, achieving UHC (box 1), strengthening the public health workforce, expanding local manufacturing of health products and increasing domestic investment in health infrastructure and research and innovation. When it comes to UHC, 50 out of 54 (93%) African countries either had a health sector UHC policy or had included UHC as a goal in their health sector policies and strategies in 2020 - though only 37% had a formal high-level political commitment prioritising UHC as part of their development agenda, whilst 38% had active monitoring processes for UHC (AHAIC 2021).

Beyond adequate financing of health sectors, financing for social protection is also crucial for achieving UHC in African countries, to ensure that quality health services are accessed by the whole population without financial hardship. While social protection in the context of health and beyond is reflected in key AU strategies, in practice, there is still room for improvement. Only 17% of people in African countries are covered by at least one social protection benefit. The coverage gap in Africa is associated with significant underinvestment in social protection; average social protection expenditure in Africa is less than 5 percent of GDP (ILO 2021). However, several good practices on social protection - including social health protection - exist (see Box 1 for examples).

Box 1: Good practices on financing social protection for health

- In Sub-Saharan Africa, **Botswana** has been singled out for consistent high levels of expenditure on health, and has quite a strong social protection scheme (Ntseane and Solo 2023). This indicates that with strong political backing, countries are able to increase spending on health. That being said, it is important to highlight that figures from the last few years are skewed by costs incurred due to the COVID-19 pandemic, so it will be important to monitor the next few years.
- **In Rwanda,** *Community-based health insurance scheme (CBHI)* was introduced in 2004 to support UHC and it has been a significant factor in the country's high level of health insurance coverage (Lenhardt 2023), covering 86 % of the population. Rwanda introduced the CBHI in early 2000s and it quickly developed into a model that is closer to public health insurance than CBHI: it is managed by civil servants and it has been a public fund since 2015 (Ly et al. 2022). The success has been driven by societal consensus, government investments, effective legislation, and a comprehensive national program for equal access to healthcare (Conde et al. 2022). While the model has been broadly a success in reducing OOPs, poorer households that don't qualify for the subsidised premiums still face trouble in accessing the insurance scheme (Lenhardt 2023.) Furthermore, NDCs are a growing concern in Rwanda, similarly to other countries in Africa, and their coverage in the insurance is limited according to our interviewee.
- Tanzania also made efforts towards SHP and introduced a public-private partnership (PPP) in the health (Nuhu et al. 2020; Verbrugge et al. 2018) sector to improve the delivery of health services. Yet, PPPs should not be seen as a silver bullet, and require adequate capacities to be negotiated and implemented to ensure 4AQ health services (Oxfam 2014).

Source: From the authors.

In regards to the service coverage, especially relating to SRHR, the African Union has signalled high-level commitments to gender equality (AU 2023), setting ambitious milestones for universal access to reproductive health. In 2016, the African Union (AU) approved the revised Maputo Plan of Action (MPoA) (AUC 2016) titled "Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa," building upon the initial 2007-2015 plan and aligning with the strategic objectives of the African Union's Agenda 2063. Both African and European governments have committed to the implementation of the Programme of Action established during the 1994 International Conference on Population and Development, with

these commitments reaffirmed at the Nairobi Summit in 2019 (EU n.a.-a) (box 2). Yet, the topic is delicate for both European and African stakeholders, and there has been strong political pushback on advancing SRHR, particularly their 'rights' - component. The political commitments also have not necessarily materialised into adequate financing. While there is only very limited data on African countries' domestic spending on SRHR priorities, the existing literature points to significant underfunding in many African countries. PAI has estimated in its project that family planning allocation and expenditure data from Benin, Burkina Faso, Côte d'Ivoire, Malawi, Tanzania, Uganda and Zambia for the four fiscal years tracked show no consistent increase in family planning investment over time (PAI 2022). An increasing number of donors - such as United Nations Population Fund (UNFPA) - have come up with approaches to ease the controversies around the topic and address culturally and politically sensitive issues by trying to create a more enabling environment for promoting SRHR (UNFPA 2023). Creating an enabling environment to address SRHR challenges is also featured in the EU's Gender Action Plan III (GAP III).

Box 2: Good practices on SRHR financing

There are some encouraging examples of countries integrating SRHR services into their health coverage plans. For instance, South Africa - a country with one of the longest-running modern family planning programmes in Sub-Saharan Africa - the provision of SRH services has been supported by a set of progressive policies, including providing free of charge modern contraceptives through primary health care (Kriel et al. 2023). While the significant issues remain in terms of equitable access to health services and quality of care, the government has committed to improving access to SRH services by committing to the goals set out by FP2030 (Kriel et al. 2023). In Ghana, in the last two decades, sexual and reproductive health (SRH) services have been increasingly integrated into national health insurance programs due to persistent advocacy by civil society organisations, but challenges persist regarding service comprehensiveness, with issues like abortion costs potentially deterring safe access.

In Kenya, the government launched its Universal Health Coverage Policy in 2020. Kenya's Reproductive Health Policy 2022-2032, although lacking explicit references to sexual health or rights and having service gaps, supports the realisation of universal health coverage. It links to other important policies and there is room to gradually increase service coverage (Hagos et al. 2023). However, previous research has indicated that in the past SRH agenda has been largely driven by donors in Kenya, with few champions in the national administration, and thus the level of political prioritisation of the topic has remained low (Onono et al. 2019). The financing to family planning and SRH services in Kenya is largely reliant on donor funding. A memorandum of understanding (MoU) created between the Ministry of Health and major development partners in 2019 outlined a plan for Kenya increasing its domestic spending on health, with donors' financing decreasing accordingly. Yet, the government has struggled to keep up with that commitment, which has reportedly hit hardest on family planning, HIV, malaria and TB programmes - those most reliant on donor funding. Further the government announced budget cuts to family planning for fiscal year (FY) 2023/2024 (Saya 2023).

Indeed, political economic factors can both open and close doors to promote SRHR. Political elites have an interest in staying in power and are guided by their own cultural and religious beliefs, which in the case of Kenya, contributed to them shying away from controversial topics like SRHR (Onono et al. 2019). In Tanzania, on the other hand, the change of government has brought opportunities. The change of the leadership from President Magufuli to Suluhu Hassan has opened up some avenues to work on this sensitive topic.

Source: From the authors.

Key insights

- African health financing relies on several actors, from governments to financial institutions for development, development partners and OOP expenses. However, funding coming from inefficient/unequitable (OOP) or unsustainable (donor funding) accounts for close to three quarters of health financing.
- While domestic health financing focuses on increasing domestic resource mobilisation - through taxation and/or social health insurance contributions, it is critical to ensure that income collection and spending is progressive rather than regressive. In this regard, healthcare financing through public sector tends to be more progressive than financing through health insurance schemes (Barasa et al. 2021).
- Financing from different actors and focusing on specific areas of health systems in a way that contributes to UHC does not seem well coordinated, resulting in inefficiencies and the increase of transaction costs - sometimes due to the duplication of structures.
- Financing should not rely solely on market mechanisms or disproportionately burden the poor through user fees or uniform insurance premiums. Even in resource-constrained situations, the government must ensure the fulfilment of the fundamental elements of the right to health and allocate the "maximum available resources" for the progressive realisation of economic, social, and cultural rights. (OHCHR n.a.).
- UHC is a clear policy priority in most African countries, and is reflected at the continental level through the AU. However, health is competing with other key priorities that also emerged following the polycrisis (health, climate, geopolitical and debt crises). As a result, concrete progress on UHC has stagnated over the past few years - though service coverage has improved, financial coverage has stagnated, inducing increasing OOP expenses.
- While service coverage has improved, those relating to SRHR suffer from limited funding and are often perceived as politically sensitive both within the EU and Africa. Given the importance of SRHR for primary health care, further efforts will be needed to foster effective SRHR services.

3.2. Health spending

While more health financing is needed to address the current funding gap, it is equally important to look at how current resources are utilised and optimised. Public PFM plays a key role in ensuring that resources i) are properly allocated and adequate; ii) flow in time where they are needed and iii) are properly utilised and accounted for (Welham et al. 2017).

Public sector funding for health services in developing countries is too often "inadequate, inefficient, inequitable, unreliable and poorly accounted for" (UNICEF 2023:8) undermining UHC. Several factors undermine PFM in the African region (Barroy et al. 2019):

- Budget formulation is affected by the lack of priority settings, inadequate costing techniques, inappropriate health budget structures (inputs instead of programme-based), fragmentation of multiple sources of funds, schemes, and funding flows, lack of influence in government budget negotiations.
- Budget execution is affected by institutional factors (high centralisation of power), under-spending of health budget (reports show that in a sample of 26 African countries, 50% had an average of more than 15% under-spending of their health budget allocations yearly between 2008 and 2016), weaknesses in the cash management systems (liquidity issues), lack of flexibility of input-based budget design and transfer of funds to the local level.
- Budget monitoring and accountability is affected by multiple (and fragmented) funding flows challenging monitoring and reporting systems and the absence of performance-oriented accountability consolidated with financial information.

Some countries have started implementing some reforms and technical solutions to address these issues aforementioned, sometimes with the support of donors.

Box 3: Examples of some of the good practices relating to health spending

Budget formulation

- Budgeting on a multi-year basis, through mid-term expenditure frameworks (MTEF) improves predictability of resources dedicated to the health sector. More than MTEF, a number of African nations including Kenya have implemented Annual Operations Plans (AOPs) that link financial inputs and operational outputs thus establishing a clearer connection between plans and budgets in the health sector. Mechanisms to facilitate and institutionalise a dialogue and coordination between Ministries of finance and health are also conducive to better health budget formulation (as in the case of Cote d'Ivoire).

Budget execution

- Several African countries (Burundi, DRC, Senegal, Zambia, Uganda etc.) have introduced performance-based financing (PBF) or results-based financing (RBF) mostly at primary care level, in the context of strategic purchasing reforms. While results vary depending on the context, studies show that PBF helped improve budget execution including disbursement at

the local level, by providing funds to health facilities against a set of requirements and performance indicators (while these funds were often managed at the subnational level). Direct facility financing such as Tanzania's Direct Health Facility Financing is another example illustrating this approach.

Budget monitoring and accountability

- Countries such as Burkina Faso and South Africa have introduced performance frameworks as part of their budget structure reforms, delivering positive results in streamlining both financial and technical accountability.

Importantly, effective resource pooling is crucial for optimising the allocation and utilisation of resources in health systems, reducing fragmentation, and sharing financial risks across the population. For instance, in Tanzania, health mutuals are structured around districts and each district constitutes a pool, that is, 169 separate pools. Rwanda pooled all its 30 health mutuals together in 2015, when establishing a public fund for health insurance, which significantly reduced fragmentation (Ly et al. 2022).

Key insights

- African health financing should be seen from a comprehensive perspective, i.e. one that encompasses not only the financing of health systems but its spending - i.e. once provided, how are resources utilised and contributing to UHC? The matter is indeed not only about fostering investments in health, but making sure that these are coherent, efficient and effective in achieving policy priorities.
- PFM plays a key role in this context. Evidence shows that, despite years of policy reforms, PFM remains challenged by several issues at each step of the budgeting cycle - from the formulation to the execution and monitoring and accountability.

3.3. Role of CSOs in advancing health priorities in Africa

Civil Society Organisations play several roles in improving health outcomes in Africa. They can serve as advocates for improved healthcare, as implementers of health initiatives, and watchdogs of government health expenditure and governance and of health services on the ground, that can deter malpractice and corruption , as well as raise the alarm whenever problems arise.

Recognising health as a human right compels states to ensure 4AQ healthcare. But realising this commitment requires organised citizens (the rights-holders) to provide push and pull on their authorities (the duty-bearers). Communities are increasingly engaging in regulatory processes, a critical step in regions where healthcare infrastructure may be sparse and training limited. Participatory frameworks inclusive of patients, communities, and civil society can improve health outcomes on the ground (Wale et al 2023). CSOs are crucial in enhancing

the reach of health systems to remote populations and in upskilling frontline health workers, as seen in documented examples from India (Jayaraman and Fernandez 2023).

The African Union has a history of work on the inclusion of civil society, with several prominent mechanisms to that effect, such as the Livingstone formula in the area of peace and security (Aeby 2021). At the time of writing, the AU had tasked its organ United Nations Economic and Social Council (ECOSOC) with the mission of overhauling the Union's engagement with CSOs through a unified consultative status. While the objective of the initiative is to promote inclusiveness, it is important to highlight that there is some reluctance from AU Member States to leave space to engage in culturally sensitive areas to gain access. Without prejudice to possible outcomes of the process, it remains that SRHR and LGBTQI issues are controversial in some AU Member States.

In the meantime, the African Medicines Agency Treaty Alliance (AMATA) was set up as a multi-stakeholder alliance advocating for the ratification and implementation of a dedicated Treaty under the auspices of the African Union, and seeking to provide meaningful engagement with communities and patients. The alliance has a Steering Committee including representatives of patient groups and CSOs, alongside industry associations, researchers, youth and advocacy groups (IAPO 2023).

Yet the limited space for civil society advocacy in many countries constrains their effectiveness in this diversity of roles – and especially when it comes to holding duty-bearers to account. According to CIVICUS' annual monitor 2023, civic space rating changed in 25 countries over the past year – in 15 of them for the worse – and civil society is under severe attack in 117 of 197 countries and territories examined (Civicus 2023). Despite the shrinking civic space in many countries, CSOs have successfully led legal challenges to enforce health rights, as illustrated by following examples:

- In Uganda, the CSOs Ahaki and Center for Health, Human Rights and Development (CEHURD) have led litigation to enable better access to SRHR services. Ahaki also trains legal practitioners (Ahaki 2023) CEHURD has also taken numerous cases to court to enable better access to health services in Uganda and East Africa (CEHURD n.a.).
- In Namibia, The Southern Africa Litigation Centre (SALC) supported Namibia Women's Health Network and the Legal Assistance Centre to challenge the coerced sterilisation of three HIV-positive women at public hospitals in Namibia. The court case began in 2009, and was won in 2014 (Chingore-Munazvo 2014).
- In South Africa, Section27 has carried out several litigation cases over the years to promote access to health and SRHR, for instance on COVID-19 Vaccines (Section27 2022).

International Non-governmental Organisations (INGOs) such as Transparency International have been instrumental in promoting mechanisms that increase the role of local civil society in the framework of international support. For instance, bilateral relations have been complemented by three-way 'integrity pacts' linking partners and local stakeholders for the delivery of a programme, with clear monitoring roles for the local civil society. The EU has introduced this mechanism as a pilot on its territory but the methodology is now being

extended to international development support, with promising possible applications to the health sector (EC n.a.-b, interview).

Key insights
• 'Civil society' refers to a wide diversity of actors that play many important roles across the health policy chain. • From a rights perspective, CSOs are instrumental in ensuring that duty-bearers deliver – this can involve taking them to court or assisting them in service delivery. • Civic space is constrained and shifting in Africa as elsewhere, which forces civil society and its sponsors to adapt and establish new partnership modalities.

4. State of play of European ODA on health financing

4.1. High-level overview of EU health policy commitments

The EU has made significant policy commitments[1] and expressed a broad range of priorities as it comes to global health and supporting health in African countries, with universal health coverage being at the heart of the EU's policy and action. While the Global Gateway identifies investments in health (soft) infrastructures as a key priority (reflecting the focus on human development in the NDICI-GE regulation), the EU's Global Health Strategy (GHS) and its list of actions[2] place the focus of EU's action on strengthening health systems and achieving UHC, strengthening (access to) primary health care and tackling the root causes of ill health.

The GHS also recognises social health protection as a key determinant of health, with the ambition to "strengthen social protection systems through bilateral country programmes, particularly by supporting the creation of minimum social protection rules that include equitable access to essential healthcare." In practice, this translates into the implementation of a regional Team Europe Initiative (TEI) on social protection in sub-Saharan Africa. Likewise, to ensure that no one is left behind, the strategy places a specific emphasis on SRHR (box 3), referring to the Team Europe Initiative on SRHR. However, it is to date unclear how synergies and complementarities between TEIs on health and TEI on social protection are ensured as well as coherence with international actors and key initiatives on social protection (E.g. ILO). According to our interviewees, the TEI on social protection does not have a direct focus on social health protection, and thus far the cooperation with health focussed TEIs has been limited. This is, however, a clear area where potential synergies could be sought both between

[1] Health is a longstanding priority to the EU and it is part of the 20% spending target for human development under NDICI-GE regulation.

[2] Team Europe Initiatives, together with support to global initiatives and programming on country-level are the main actions listed in the strategy. While there is no comprehensive overview available to date on the implementation of GHS and the TEIs, the interviewees have pointed out that MAV+ is the TEI with most progress. Some also point, that the TEI on SRHR (discussed in the box 4) is advancing with multiple actions linked to it, but its progress is not widely reported beyond the immediate stakeholders.

the TEIs but also in broader context with the main global initiatives on social protection, such as The Global Accelerator on Jobs and Social Protection for Just Transitions.

Box 4: SRHR as EU priority

Sexual and reproductive health and rights are a key policy commitment to the EU's external action. The EU has had SRHR as a longstanding priority over the years (Bossuyt et al. 2019) and it is also featured in the NDICI regulation. The latest key strategic documents for the EU where SRHR is not only mentioned, but also taking an important role are the EU's GAP III (EC 2020), EU youth Action plan (YAP) (EC 2022a) and the EU's GHS (EU 2022). GAP III outlines the EU's commitment to creating an enabling environment for safeguarding the sexual and reproductive health and rights of women and girls, which includes increasing access to related services, addressing issues like female genital mutilation (FGM), expanding services in humanitarian contexts, and promoting HIV/AIDS prevention. In the GHS, the EU also commits itself to promoting universal access to SRHR.

Both GAP III and GHS provide good opportunities for strengthening the EU's work on SRHR acknowledging its fundamental role in global health and UHC. In January 2024 the Council also adopted Conclusions for the GHS, which emphasise that EU and its MS must play a leading role in global health. However, in the case of the GAP III, the strategy was never endorsed by the Council Conclusions due to objections of some member states. Instead, the presidency issued presidency conclusions. Furthermore, the evaluation of GAP III notes that in the EU delegations, promoting SRHR, for instance, in policy dialogues, has proven difficult due to its politically sensitive nature in African countries. SRHR is also not a topic widely selected to be pursued in country-level implementation plans (CLIPs), which would essentially bring in GAP III principles to country-level and connect them with MIPs (EC 2023a).

Furthermore, EU and 10 member states have joined their forces under the regional TEI on SRHR, which broadly aims at strengthening the implementation of continental and regional SRHR frameworks and commitments, improved affordability, acceptability and availability of SRH products as well as strengthening advocacy and accountability on SRHR. According to previous ECDPM research, the TEI sets a framework to allow better coordination of the policy dialogue between the EU and the African stakeholders and has moved towards long-term strategic planning beyond the political commitment made by the African regional actors. It builds on commitments made by AU under Maputo protocol and aims at increasing coherence and alignment between the EU and member states, and AU's priorities (Sabourin and Jones 2023).

Source: From the authors.

4.2. European health financing

a) Health financing from EU institutions

Overall, the EU has committed to spend 20% of its ODA on human development, including health, education and social protection. In the last years it has also been able to meet and exceed the target, in 2022, the EU committed EUR 7.9 billion to human development, which was 32.4% of its total ODA (EC 2023c). However, within the human development spending, in 2022

health received only a small fragment. According to the Annual report by the EC, the commitments in 2022 to health and population policies/ programmed and reproductive health were in total EUR 379 million which is small when compared to other human development priorities. For instance, EUR 1.4 billion was committed to education in 2022. At least part of this is likely explained with the yearly fluctuation of commitments, as in 2021 the EU committed to health in total EUR 2.2 billion (EC 2022b).

In 2021, EU Institutions' ODA disbursement to health and reproductive policies / programmes in Africa was EUR 447 million, of which 76 % went to project-type interventions and 22 % to budget support. The majority of sectoral budget support to health was dedicated to health policy and administrative management, whereas projects were the main way to address COVID-19.

Table 1: EU Institutions bilateral ODA to health in 2021 in Africa, the main sub sectors

Sub-sector	EUR, million	% of total
COVID-19 control	206	46%
Health policy and administrative management	109	24%
Basic health care	69	16%
Basic nutrition	31	7%
Population policy and administrative management	12	3%
Others	19	4%
Total	**447**	**100%**

Source: From the authors.[3]

Overall, 5% of the operations name SDG 3 (health and well-being) as the main one they are contributing to and in 22.1% of the budget support operations SDG 3 is either a primary or significant objective (BS trends and results; see EC, DG INTPA and DG NEAR 2022). The estimates of the EU's spending commonly are low. For instance, according to DSW, SRHR received only 1.76% of the total ODA spending of EU Institutions in 2021, which is a slight increase of 1.36 % of the previous year, but remains lower than in 2019. (DSW and EPF 2023). It thus points to low prioritisation of SRHR in the EU's international spending, which can arguably also be due to low prioritisation of SRHR topics by partner countries, leading to fewer opportunities to support SRHR.

a) EU Institutions' funds channelled to and through multilateral system and global health initiatives

The EU is a significant contributor to multilateral organisations like WHO, and global health initiatives such as the Global Fund, and Gavi (see table 3 for examples). Particularly in the domain of health, the EU is counting on a multilateral system. In 2021, the share of global health

[3] Based on data by OECD DAC, 2021, disbursement, constant prices converted from $ to EUR by ECDPM.

-focussed ODA going to (as core contributions) or through (as earmarked contributions) multilateral system was 53%, which is a high share given that from the EU's total ODA, only 21% (USD 5.2 billion) went to and/or through multilaterals (OECD 2023; Donor tracker 2023a).

While this funding is not earmarked to any African country as such, the interviewees pointed out that this global level funding will also have impacts in African partner countries. When looking at the ODA particularly earmarked for Africa - regionally or for African countries - according to OECD in 2021, 11% were channelled through multilateral organisations, with UNFPA and United Nations Children's Fund (UNICEF) being the leading partners (OECD n.a.).[4] Beyond the EU Commission, the EIB has also supported GAVI since 2021, and has had 2 operations with Gavi (Guarantee facility 1 and 2, EUR 322 millions of EIB finance in total) and it has also funded COVAX.

Table 2: Contributions of EU and member states to Global fund, WHO and GAVI, vis-a-vis selected international actors

	Global fund	WHO	GAVI
EU member states	7 813	1 485	5 221
EU commission	1 482	562	1 331
US	14 180	1 311	4 870
UK	2 966	433	2 709
China	18	164	120
Russia	no information	57	10

Source: The Global Fund n.a.; GAVI n.a., WHO 2023e.[5]

The EU has made a strong political commitment to support and strengthen WHO. A key component of the GHS is to bolster an effective and adaptable multilateral system with the WHO at its core, aiming to enhance the global health framework. Our interviewees also brought up the key role that WHO could have in coordination on global health financing and bringing leaders together. More broadly, well-resourced multilateral organisations - including WHO but also beyond - could in theory make significant influence in reducing fragmentation around health financing, if a larger share of financial flows would go through them. While interviews highlight the important role that the WHO should and must play, including by bringing leaders of the world to discuss health, they also recognise that the WHO is significantly and consistently

[4] The percentages are based on OECD-DAC CRS data. It looks at ODA allocations to Africa (earmarked at country level and regional ODA) in two main sectors: Health (120) Population policies /Programmes and Reproductive Health (130), and by channel used, which according to OECD classification can be Public Sector; NGOs & Civil Society; Public-Private Partnerships (PPP); Multilateral Organisations; Teaching institutions, research institutes or think-tanks; Private Sector Institutions; Other.

[5] Data from Global fund includes two latest replenishments 2020-2022 and 2023-2025; data from WHO includes the latest biennium 2022-2023; data from GAVI includes 2021-2025, total pledges made through 31 December 2022. Data expressed in USD million. Due to timelines, data is not directly comparable between organisations.

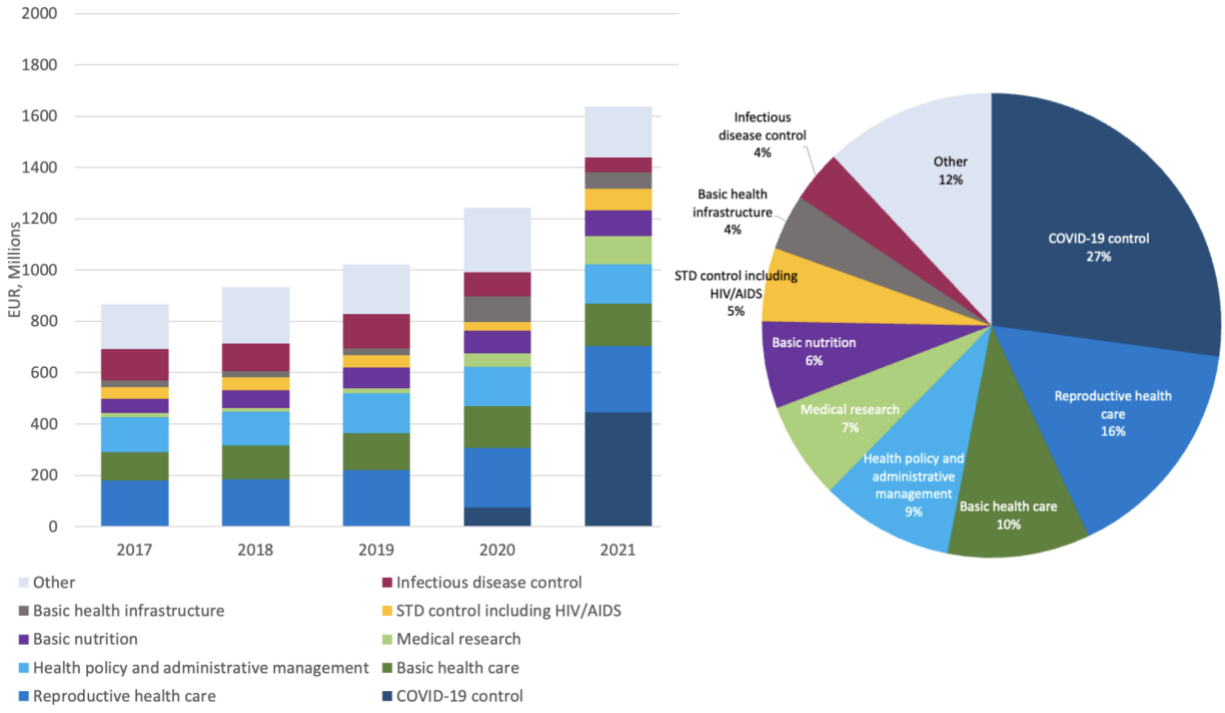
underfunded, which poses challenges in its ability to fulfil its mandate. The EU has partnered up with WHO in the context of The Universal Health Coverage Partnership, which enables targeted technical support in 119 countries. Upon the launch of the GHS, the EU also pledged to invest €125 million to reinforce the partnership, with a focus on strengthening health systems (WHO 2022d). Given the global dimension of health, as experienced during COVID-19 and beyond, working at the multilateral level under the leadership of WHO with the support and contributions of countries seems even more important. Other multilateral organisations, including UNICEF and UNFPA, have also a significant role in their own domains, and are key implementing partners to the EU.

Global health initiatives (GHIs) are key actors in the health sphere, both in Africa and beyond. For instance, Gavi and Global Fund have significant roles in supporting health systems in African countries. In that sense GHIs are in a significant role in 4AQ healthcare and achieving UHC. However, several interviews pointed out issues they saw for instance in disease specific interventions some GHIs focus on, which increase fragmentation of health systems and services in partner countries and undermines more systemic approaches to health, including in terms of tackling NCDs - a growing concern in many African countries. Furthermore, interviewees brought up concerns over the value of money compared to financing health priorities through other actors, as well as potentially more negative perceptions in partner countries, when money flows to large international initiatives and not to national and local actors. According to some interviewees, there is thus room to increase efficiency of the GHIs and tackle governance to reduce fragmentation and a more holistic view on health systems going beyond disease specific interventions.

a) EU Member States health financing

Given the Team Europe approach, it is important to also look at European health financing at Member States level. The figures by OECD DAC data also show a general trend of growing disbursements to health sectors by member states since 2012, that was particularly spurred by the COVID-19 pandemic in 2020. In 2021, EU Member States health financing amounted to over EUR 1.6 billion. However, it is still an open question to what extent this spending will be sustained under the pressure of other priorities, including the war in Ukraine, the food and the climate crisis, the digital transition etc. As expected, COVID-19 has been a major driver for health financing in 2021, with over a quarter of ODA being dedicated to that priority. Beyond that, the European funders focus on reproductive healthcare, basic health and health policy, which together have since 2017 represented over half of the EU member states' ODA to health, as shown in the figure 2 below.

Figure 2: EU member states' ODA spending by health sub-sector between 2017 and 2021 and EU member states' ODA allocation by health subsector in 2021 for Africa



Source: From the authors.[6]

Overall, bilateral health financing in terms of disbursements of the EU and its member states (including ODA and other official flows) to Africa has remained modest despite the pandemic. In fact, it does not challenge the dominant position of the US, which provided USD 8.2 billion on bilateral health ODA in 2021, including USD 6.1 billion in Africa, 43% of which is channelled through multilateral organisations and initiatives such as GAVI and the Global Fund (CRS 2022; Donor tracker 2023b). The issues targeted revolved around population policies and programmes and reproductive health and more specifically, to tackle STDs, including HIV and AIDS. However, our interviewee pointed out that health financing from European actors is highly valued in many partner countries compared to funding from the US. While smaller in size, it has historically taken a stronger focus on health systems strengthening and taking a longer time horizon instead of going for "short-term results" and vertical disease specific interventions. European donors are also generally seen to pay more attention to aid effectiveness principles compared to the US. (Steurs 2019). This notion is in line with previous ECDPM research, pointing to high appreciation of the EU's cooperation in human development sectors (Sergejeff et al. 2023). Yet, in recent years some European donors have increasingly moved towards the US-like approaches emphasising value for money and quick results that are attributable to individual interventions and easily communicated to the public (Steurs 2019).

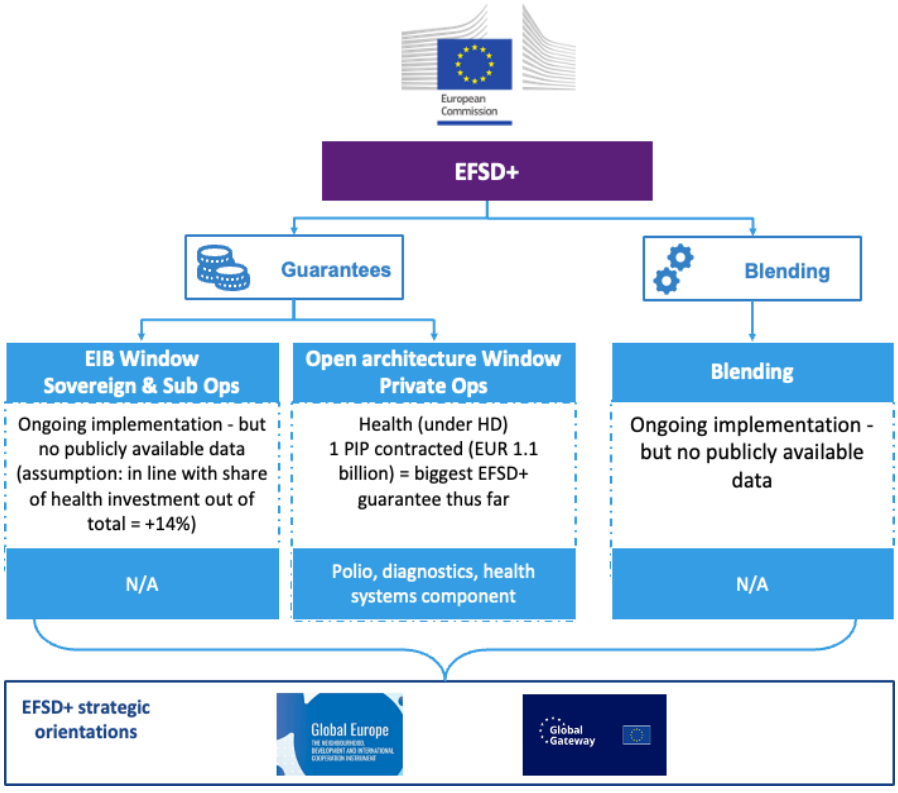
[6] Based on data by OECD CRS data, graph produced by ECDPM. Data expressed as EUR million, constant 2021 prices, converted from $ to EUR by ECDPM.

While it is not straightforward to estimate the impact of European financing on domestic financing for health in partner countries, there are examples of European financing working well to promote HSS in them. For example, in Ethiopia pooling contributions from European donors and beyond under MDG/SDG fund contributed significantly to the harmonisation of health financing in the country. While this was not a strictly European initiative, all European donors contributed to the fund (Steurs 2019).

a) Development finance

With its ability to catalyse public and private finance, development finance has become a key instrument including in the EU development landscape. The EU has been at the forefront of this gradual shift from grants to blending and guarantees, as reflected by the i) increasing amount of ODA channelled through private sector instruments; ii) the increasing role of DFIs and PDBs as development actors; and iii) the development of the European Fund for Sustainable Development (EFSD) and EFSD+ (Bilal and Karaki 2022). The main tool of the EU to foster development finance, and the investments in health in partner countries is the EFSD+, born in the broader context and serving the objectives of NDICI-GE, which dedicates one of the investment windows to human development (including health), reflecting the priorities of the Global Gateway. While this translated into concrete investments in health (infrastructure), the share of blending and guarantees allocated to health remains limited to about 10% (figure 3).

Figure 3: EFSD+ investments in the health sector

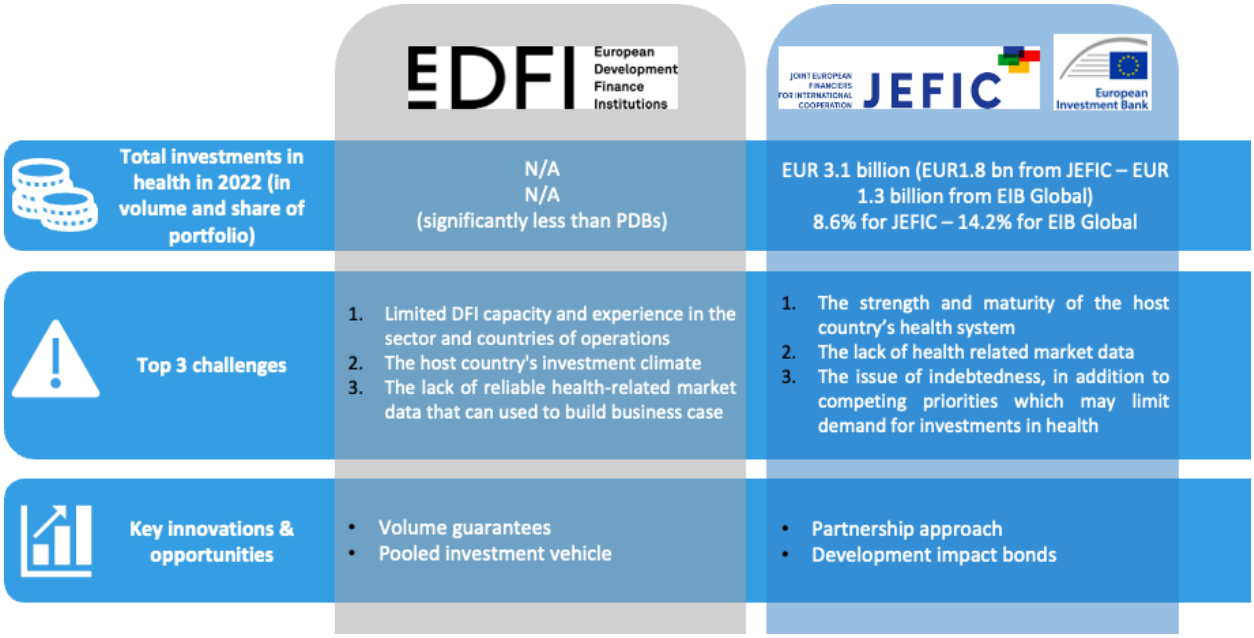


Source: From the authors.

In a context in which the EFSD+ is perceived to focus more traditional sectors (infrastructures and private sector development) where development additionality is sometimes questioned, there is a merit in considering how investments in social sectors including health could provide a way to strengthen its development focus, in line with the objectives set in the NDICI-GE regulation.

DFIs and PDBs are also active outside of the EFSD+ when it comes to financing health. PDBs and especially the EIB are the main financiers of health amongst financial institutions for development while European DFIs investments are more limited (figure 4).

Figure 4: European DFIs and PDBs investments in health in 2022



Source: From the authors.

The relatively low maturity of the health sector in most African countries, the current polycrisis (debt crisis, climate crisis, inflation etc.) makes the health sector a challenging sector to invest in for DFIs and PDBs (and explains why budget support in the form of grants still plays a key role in health financing). This is where blending and guarantees can play a key role, as a means to incentivise investments in the health sector, by tackling issues relating to the lack of a pipeline of bankable projects, de-risking investments even in the riskiest part of the health value chain, creating a demonstration effect, and maximising investments' development additionality.

Last, beyond European led initiatives, European actors contribute or are part of multilateral endeavours, aiming to facilitate investments in health. This includes the recently established Health Impact Investment Platform for Stronger Primary Health Care, and Health Systems Resilience, led by the WHO in collaboration with MDBs including inter alia the EIB and AfDB. This platform aims to make available over EUR 1.5 billion in financing through a combination of concessional loans and grants for primary healthcare, thereby reducing financing

fragmentation, investing in the more challenging contexts and streamlining and leveraging other donor funds.

Beyond this initiative, most EU Member States are shareholders of the World Bank Group (and contributors to the International Development Association (IDA)), which is a key actor financing health and who has launched a number of relevant initiatives including the Pandemic Fund, whose first investments will take place in 2023. Yet, it is not clear the extent to which the EU Member States, as shareholders, use the World Bank differently (and in a coordinated manner) than the EIB or their bilateral financial institutions for development. While the focus of this paper is on European and African financing to health, multilateral organisations and banks - especially the World Bank Group) also have a role in financing health priorities in Africa (box 5).

Box 5: The financing of World Bank and IDA to UHC in Africa

The World Bank, through the International Bank for Reconstruction and Development (IBRD) and the IDA provide significant investments in the health sector in Africa. IBRD commitments (which differs from actual disbursement) in 2022 and 2023 amounted to USD 6.3 billion and USD 3.1 billion respectively (WB 2023a), while the IDA window, which supports the world's poorest countries, committed USD 4.3 billion and USD 2,7 billion in 2022 and 2023 respectively. When looking at the share of health financing out of the total volume, it remains around 10%. As for its private sector arm, the IFC, investment commitments in 2023 stood at USD 505 million, which accounts for a 3% of the total annual investment volume (IFC 2023). These results - especially when looking at the share of investments out of total investment volumes, are broadly in line with what can be observed in the case of European financial institutions for development. Importantly, when it comes to health investments, the World Bank has played a key role as the biggest financier under the global COVID-19 health response with USD14.3 billion committed to nearly 100 countries, including 32 countries impacted by fragility, conflict and violence (WB 2023a). Another key initiative of the World Bank includes the establishment of the Global Financing Facility (GFF) together with other partners in 2015. The aim of GFF is to support maternal, child and adolescent healthcare is already having an impact. (GFF n.a.). The WB Group and IDA also support women and reproductive, maternal and child healthcare, for instance through the Sahel Women's Empowerment and Demographic Dividend (SWEDD) (WB 2023) project and numerous country level interventions. More recently, the World Bank also works through African institutions, and for instance provided USD 100 million to Africa CDC to strengthen continental health preparedness (WB 2022).

Source: From the authors.

Key insights

- European health financing has increased in the past few years, although there may be a COVID-19 bias explaining the rise of health financing in 2021. However, the EU's and member states' health financing in Africa is dwarfed compared to other international actors, with the US and Global fund being the biggest actors in terms of bilateral health ODA in Africa.
- European health financing is done through various channels and actors: by EU institutions, its member states, European financial institutions for development, and multilateral fora. Though Team Europe provides a concrete entry point for a more coordinated and less fragmented approach, most financing actors tend to operate in silos.
- From the point of view of the EU and its member states, using different channels of funding can serve several different purposes, and include both opportunities and challenges depending on the context.
  - Channelling funds through the public sector and working with the government may enhance the EU's visibility as a partner and provide better opportunities for policy dialogue (whilst supporting countries local ownership). However, in the context of autocratic consolidation or severe governance issues, such as rampant corruption, channelling funds through the civil society may be a better option.
  - Using DFIs and PDBs to leverage limited public resources and attract public and private finance to invest in health at scale and for greater impacts, through the use of financial instruments. However, it remains challenging for these institutions to invest in specific segments - vulnerable groups including the poorest, in fragile and least developed country (LDC) contexts and more broadly in any nascent markets - even when provided with guarantees of investment subsidies in the case of blending.
  - By providing parts of health services, CSOs can create bottom-up demand for UHC and SRHR. Channelling funds to and through CSOs - particularly local CSOs - can help the EU to gain better access to local and underserved communities and CSOs expertise and networks. However, the absorbing capacity of funding varies according to the organisation and its size, which creates complications (and fragmentation) particularly for funding small grassroot organisations (Sergejeff et al. 2023).
  - Channelling funds via multilateral organisations and /or global health initiatives can be an effective way to advance global objectives. In the eyes of the donors, multilateral organisations are reputable, with long track records, networks and experience in specific policy areas. However, allocating funds to multilateral organisations may include bureaucratic barriers, loss of visibility, and sometimes less transparency (Biscaye n.a.).

4.3. The role of CSOs in promoting better European health financing

In the European development policy context, CSOs have major roles to play – similarly to African policy contexts outlined above – in advocacy and holding the EU accountable for its policy commitments, as well as delivery of programmes. When it comes to high profile policy making, the European Institutions have a track record of consultations with civil society, for instance in the lead up to the adoption of the GHS and around the Global Health Summit. Civil society networks – both thematic on health and more generalist – also have developed a record of keeping track and engaging with these developments, both directly and through public advocacy.

It is in that context that a coalition of health CSOs recently stressed that the EU's funding mechanisms are problematic in the area of health, with a reliance on yearly grants that reduce the predictability of work, and that multiannual funding should be more systematic, while adding that there is an important role for public-funded CSOs that may be lost with calls for them to diversify their sources of funding through engaging the private sector (Richer 2023). In addition, EU funding to CSOs is increasingly project-based - whereby CSOs are considered in their quality of implementing partners, which has two downsides: i) CSOs working in the health sector risk substituting potential actions from the local governments; and ii) there is less funding available for supporting their core activities and role in influencing health governance. A coalition of civil society organisations – including health specialists – has called on the EU institutions to come up with an integrated civil society support strategy, in order to address these issues (EU4health 2022).

Similar concerns were echoed in the context of EU programming by CONCORD, the European Confederation of NGOs working on sustainable development and international cooperation. CONCORD highlighted that CSOs' inputs provided as part of formal consultations processes were not sufficiently reflected throughout the programme implementation cycle, and thus questioning the role of CSOs in the implementation of the NDICI-GE (CONCORD 2023).

Importantly, CSOs also engage with European and bilateral financial institutions for development. For instance, the EIB organises annually a CSO lunch seminar, allowing dialogue and exchange, and often consult CSOs on the environmental, climate and social matters (e.g. EIB gender strategy). Similarly, the EC organises a Policy Forum on Global Health, that offers CSOs opportunities to get their voice heard. At the global level, there are also several platforms for CSOs to engage for instance in the context of multilateral initiatives.

Box 6: Global health engagement platforms

A number of developments at the international level can improve the ability of both European and African civil society actors to advocate for stronger international action on health. Some examples include:

- Gavi's CSO constituency was launched in 2010 and is now made up of a reported 450 CSOs ranging from INGOs to national and grassroots organisations, as well as technical associations and agencies. The initiative now also supports national CSO platforms for immunisation and health.
- The Future of Global Health Initiatives process brings together a group of global, regional and national health stakeholders - from governments and national and international funding partners to civil society, health organisations and academics - in a time-limited consultation and research process until 2023, to consider how GHIs can be optimised to best support national health priorities and countries' progress towards UHC (FGHI n.a.).
- UHC2030 is the only multi-stakeholder platform that brings together private sector, civil society, international organisations, academia and governmental organisations to accelerate progress towards UHC (UHC2030 n.a.).
- The WHO recently launched its civil society commission (WHO 2023f – list of 120 participating CSOs), also with a view at making decisions more inclusive of priorities from civil society and from the Global South. An interviewee pointed to the fact that the WHO, as an inter-governmental organisation, is not well-equipped at this point for consulting wider CSO circles and ensuring that their inputs are included. But in 2022, the WHO initiated the formulation of a treaty addressing pandemic prevention, preparedness, and response – a process that was reportedly influenced by civil society advocacy. Civil society efforts seek to ensure that perspectives from the global south are amplified in these discussions, to address the pronounced disparities unveiled by the pandemic (Civicus 2023). However, the momentum generated by COVID-19 is reportedly dissipating fast, which narrows the opportunity for such a treaty to be developed in an inclusive manner.

Source: From the authors.

Beyond the policy level, CSOs are sometimes involved at the operational level (consultation to get inputs on the local knowledge, or involvement as part of the monitoring of sensitive environmental or social issues). However, the engagement of CSOs by financial institutions for development is very targeted and often needs-based, and does not necessarily leave space for constructive dialogues and concrete changes in the ways actors operate. Likewise, CSOs are not involved in the EFSD+ governance processes.

Key insights

- The European policy making context is characterised by strongly structured civil society networks and institutionalised engagement processes for civil society to play a role.
- When it comes to practical funding decisions and implementation, civil society reports that it is less substantially engaged.
- The EU has a strong role to play in fostering civil society, but its reliance on a managerial funding approach with short project timelines is reported to be a limiting factor.

5. Challenges and opportunities linked to health financing

5.1. Provide more or at least maintain the current volume of health financing

While there are indications that compared to the Multiannual Financial Framework (MFF) 2014-2020, EU Institutions have increased investments in health financing,[7] particularly spurred by COVID-19, there is a risk, confirmed by interviewees, that the political traction to support health sectors in partner countries is (and will be) waning in the post-COVID-19 world. This risk is even more pronounced given the accumulation of crises that followed the COVID-19 pandemic including climate disasters, debt crises, the impact of the war in Ukraine, inflation etc. More crises mean more pressing needs, and shifts in political priorities, which translate into more or less attention to pre-existing issues. Therefore, going forward, one of the key challenges will be if not to increase, at least to maintain the current volume of health financing.

a) The EU and its Member States should use strategically the mid-term review and evaluation of NDICI-GE to maintain or increase health financing in Africa

At the European level, several moments will be key opportunities (or threat) to increase health financing. First, the mid-term review of the NDICI-GE will provide space for strategic discussions amongst EU Member States on whether or not, the current prioritisation of policy objectives (and underlying investments) are fit to deliver on the ambition of the EU. While health financing has been increasing in comparison to the previous MFF, it accounts for a minor share of the total budget. In a context where some EU Member States are concerned that ODA is not focused enough on social sectors - which are challenging to finance other than through grants - EU Member States could push for increasing the share of resources going to health (in the broader frame of human development), for the second part of the MFF (2025-2027 period). Beyond this rationale, health can also be used by the EU to advance its geopolitical influence in partner countries - serving the objectives of the Global Gateway. Previous ECDPM research has indicated that stakeholders in partner countries highly value the EU's support to human

[7] Mapping of EU and European actors' investments in health in Africa (Sergejeff et al. 2023, unpublished).

development sectors (Sergejeff et al. 2023). It is thus a key part of the added value of the EU's international engagement and its geopolitical value should not be overlooked. Second, the EFSD+ Strategic Orientations could be revisited, in the context of the mid-term review and evaluation, by the EFSD+ Strategic or Operational Board to dedicate a higher share of guarantees and blending to human development. This should be tested ex-ante with DFIs and PDBs, to ensure that there is a strong public and private sector demand and pipeline in partner countries. Third, the election for the new Commission will also have an impact on the extent to which the EU wants to further position itself on health issues, as a global health actor. Independently of the results, EU Member States will have to exert their influence through governance settings, to ensure that health remains a key priority and area of investments of the EU. That has been the case with the Spanish Presidency building on the work done under the Swedish presidency, and with the upcoming Belgian presidency, health will remain high on the EU agenda in the first part of 2024. However, the presidencies of Hungary and Poland may be less conducive to such a process.

b) EU Member States should leverage shareholder position to stimulate health development finance for 4AQ health care

Beyond EU processes, EU Member States could use their position as shareholders of bilateral DFIs and PDBs, and of multilateral development banks (the EIB, European Bank for reconstruction and Development and World Bank) to push and empower their DFIs and PDBs to invest more in the health sector. They could do so by providing them with a mandate and investment targets in health (Swedfund has for instance a mandate to invest in health). They also need to support them in this endeavour - this could be done by providing additional support in the form of guarantees, blending and technical assistance. Importantly, in doing so, they should ensure that EU and African priorities are well reflected - particular attention should be paid to UHC, SHP and primary healthcare (through which SRHR services could be fostered). This can be done by e.g. partnering with regional and local development banks, as done by the EIB and KfW with Afrexim Bank. PDBs potential to facilitate debt-for-health swaps (and other innovative financing mechanisms such as the systematic inclusion of pandemic disaster clause, the use of health/development bonds etc.) should also be investigated, as a means to foster liquidity to address the health financing gap. Last, several AU member states have a public development bank, where they could mobilise by channelling additional funds, which can be leveraged to attract additional public and private investments for health.

c) EU Member States should explore the potential of SDRs rechannelling for health

Last, beyond the European level, European Member States could also rechannel their SDRs to partner countries, and earmark them for health financing. This could be through the IMF RST provided that its scope (in terms of sectoral focus and absorption capacity) is increased. Alternative options should be explored and notably the possibility to use MDBs such as the EIB, which is a SDRs prescribed holder, to rechannel SDRs in health through the so-called hybrid capital proposal. This would allow attracting additional investments, as MDBs would be able to raise three to four dollars for each SDRs-dollar equivalent. This cannot be achieved through the use of IMF mechanisms, and yet most relevant in an era characterised by limited fiscal space and growing health financing needs). The IMF recently approved the hybrid capital

proposal, providing additional confidence in the relevance, feasibility and sustainability of the model.

d) African Member States should boost domestic resource mobilisation for health

Enhancing DRM is a top priority for many African countries as a means to enhance fiscal space for investments in health and the SDGs, and ensure the foundation of sustainable, equitable and effective country-owned health systems once donor funding comes to an end (GHAI 2023). This is challenging because i) national revenue systems are underdeveloped and sometimes ineffective, resulting in a low government revenue-to-GDP ratio; ii) the current fiscal environment (where fiscal tools use has already been expanded to mitigate the effect of economic disruptions following the polycrisis (Plant and Moore 2021). In addition, the political environment/will largely determine the extent to which DRM for health will be pursued as an option, and implemented.

Several non-mutually exclusive avenues could be pursued including with the support of the EU who has supported the DRM agenda notably through budget support (EU 2020). Importantly, income collection and spending should be progressive and not regressive (so as to ensure that no one is left behind) (AU 2016):

- **The use of levy**: An opportunity to support domestic revenue mobilisation to health is exploring different avenues to fund national insurance policies. African countries have adopted various ways to fund their health insurance policies. For instance, in Ghana (NHIS 2023), the national health insurance scheme is funded from multiple sources, including national insurance levy which is 2.5% levy on goods and services collected under the Value Added Tax (VAT). The Zimbabwe AIDS Levy and Zimbabwe National AIDS 'Trust Fund' is another example illustrating the relevance of levy. However, the use of levy should be carefully thought out, as it can have regressive effects, if not well designed.
- **The use of additional taxes**: some countries have also explored sugar taxes or alcohol as in the case of Botswana, or a mobile phone tax in the case of Gabon, as a way to finance their health systems. Other initiatives concern taxing the informal private sector - as currently done in Zimbabwe through fixed monthly presumptive tax rates or tax on turnover in South Africa, Kenya, Zambia and Tanzania. Yet, the design of these taxes should be progressive in order to avoid any negative externalities on the most vulnerable groups. A key consideration is also on tax reforms that address the informal sector - a major factor for many African economies. Tax policies for informal sector should remain progressive and distinguish clearly between those who are earning too little to meet VAT or income tax thresholds and those 'hiding' in the informal economy to evade taxes (ActionAid 2018)
- **Social health insurance contributions**: Tunisia introduced a mandatory payroll contribution rate of 6.75% of earnings for the Tunisian National Health Insurance Fund, allowing for the expansion of health insurance to 71% of the population. While their effect on achieving UHC varies depending on the context, private (or voluntary) healthcare insurance programmes can drive inequalities through so-called adverse selection problems.

- **Integrity**: Other reform measures include anti-corruption to reduce leakage of funds, limiting opportunities to engage in tax avoidance or evasion, and curtailing illicit financial outflows that disproportionately affect Africa and its ability to mobilise domestic resources through taxation. While curbing illicit flows is proving to be a challenge, promising initiatives include the Stolen Asset Recovery Assistance (StAR) initiative of the World Bank and UN, whereby ill-gotten gains have been reinjected into state budgets in service of developmental objectives – in one prominent case, to the extent of ca USD 0.5 billion to Nigeria, a substantial part of which was subsequently allocated to health programmes (Hussman 2020, Miyandazi and Ronceray 2018).

However, improved fiscal conditions do not automatically mean increased domestic resources to health. Indeed, the country's health financing and its prioritisation in the budget is influenced by a variety and at times conflicting interests. Often efforts to take steps towards UHC are highly political (McDonnell et al. 2019). For instance, in Ghana, the establishment of the NHIS benefitted from high-level political support as well as popularity amongst the citizens. Gaining the support from development partners, including the EU, was also crucial for the success. (Novignon et al. 2021). Beyond supporting country-led initiatives - as in the case of Ghana - donors can support prioritisation of the health sector in budgets for instance including health in political and policy dialogues more strongly.

5.2. Deliver better financing for health

In addition to the questions on 'more financing', another key consideration is how to deliver 'better financing' for sustainable impact. This second avenue may provide more entry points that can be addressed in the short-term.

a) African member States should keep improving PFM practices

African countries often need to further strengthen PFM for health, in a way that delivers on UHC and social health protection. Several non-mutually exclusive avenues can be pursued in this context:

- **Budget formulation:** Multi-year/programmatic budgeting (case of South Africa) or the use of AOPs - linking financial inputs and operational outputs performance monitoring frameworks as in the case of South Africa).
- **Budget execution:** strategic purchasing or flexible financing models (PBF or RBF) in Rwanda/Senegal or Direct facility financing in Uganda/Tanzania.
- **Budget monitoring and accountability:** digitalisation of health.

At the same time, it is important to recognise that PFM is not only a technical exercise - it is highly political, explaining why the support to PFM in the past decades did not necessarily lead to significant impact. In fact, an evaluation focusing on EU budget support for PFM recommends the EU to take better account of political economy factors when carrying out PFM reforms, as well as reinforcing policy and political dialogue notably on strategic topics including revenue mobilisation, sources of financing and fiscal space. Better accounting for

the winners and losers of PFM reforms, and their ability to support or block this process is key to developing reforms that are not only desirable but feasible.

In addition, an indirect way to support budget allocations to health could be to explore gender sensitive budgeting in the context of PFM reforms. In 2021, 18% of new EU actions around PFM reforms included a gender budgeting component. The target is 20% by 2025 (EC 2022b). Introducing gender-responsive budgeting in the health sector could be a crucial way to address broader gender inequalities in the health sector in terms of access but also pay attention to the specific needs of girls and women. It could also be a way to increase finance allocations to SRHR, which is a key component to UHC, but a politically sensitive area. However, in practice gender responsive budgeting is not an easy exercise, that does not necessarily benefit from much political traction. Some other common challenges for partner countries include a lack of guidance, coordination, and expertise in gender analysis and data (Curristine et al. 2022).

b) The EU and its Member States should better reflect and respond to, local needs and priorities - whilst thinking and acting politically

Lack of effective Africa - EU coordination - including in the health sector - undermines the relevance of EU interventions and their impact on the ground, limiting the space for African ownership (Karaki and Ahairwe 2022). While the Team Europe approach allows Europeans to speak with one voice, it takes time to align and African actors who often come late in the process, leaving limited time/margin of manoeuvre for the AU and its member states to react. At the continental, particular attention should be paid to the AU and Africa CDC and building on Africa's New Public Health Order (Veron et al. 2022). At national and local level, fostering local ownership is crucial, which is also well recognised in the GHS. In practice, fostering domestic health system investment and ownership in partner countries requires a nuanced understanding of political factors influencing system strengthening, including issues like capacity gaps and corruption hindering reforms (Veron et al. 2022).

In addition to better integrating local needs and priorities, paying attention to political economy dynamics at the central and local levels, and the narratives used at partner countries around health systems is crucial in order to achieve UHC, and ensure sustainable financing to health sectors. Sustained political level in all levels of government as well as in all relevant line ministries - including the ministry of finance - is important to ensure broad support to UHC reforms (Novignon et al. 2021). Prioritisation of certain sectors is first and foremost the matter of national politics and interests, and the examples from Rwanda and Ghana, for instance, illustrate the importance of domestic political drive in attaining UHC. However, UHC has also benefited from some level of 'donor-driven' push, which has also raised concerns of government buy-in (Gautier and Ridde 2017).

Regardless, political context plays an important role in defining the success of the country's path towards UHC. Opportunities for donors to support UHC can open for instance after a leadership change in the country. For instance, in Zambia, the change of leadership opened a door for some donors for considerations to re-enter the health sector, as the government

made strong commitments in tackling the rampant corruption in the sector. Reacting to emerging opportunities to improve relations with the government, the EU has also resumed budget support to the country in education and health sectors (EC 2023b). In Tanzania the change of the political leadership after the passing of President Magufuli, and stepping in of the new President Ms. Samia Suluhu Hassan, has opened up avenues to support SRHR (see e.g Burke 2022). In the donor community, this has encouraged some actors to work increasingly on the topic. As mentioned above, SRHR is a highly sensitive, even controversial topic in many African countries, which may form a barrier to supporting it and hamper the potential social gains. According to past ECDPM research, one way to help convince decision makers for the support to SRHR is macroeconomic arguments that highlights the potential of economic gains, e.g. in terms of preventing unintended early pregnancies (Sergejeff et al. 2023).

c) The EU and its Member States should foster a more coordinated and integrated approach

Coordination between different interventions (between European actors, between European and African actors, across policy areas and geographical scope - regional, national and local) also remains a challenge, yet this is a crucial factor in determining the impact and sustainability of support interventions. In fact, a fragmented approach negatively impacts PFM for health, and thus the achievement of UHC and social health protection policies.

At the European level, TEIs bring together the EU institutions, member states and their development agencies as well as the European DFIs, which brings in an opportunity to leverage their resources, expertise and knowledge in health, and ensure a certain degree of coherence, complementarity and synergies between different interventions. All in all, that could in principle also contribute to a strengthened European Financial Architecture for Development (Karaki and Bilal 2023) and lead to more innovative approaches - especially when it comes to financing more challenging sub-sectors and fragile countries. For instance, the partnership between the Bill and Melinda Gates Foundation, EIB and EC for polio eradication can bring in innovative solutions to eradicate diseases through strengthening local manufacturing thus contributing to more resilient health systems. In doing so, it also helps incentivise the EIB to invest in "new" health sub-sectors.

In this regard, further efforts should build on the EDFI-JEFIC-PN statement of intent, to foster collaborations between these actors in health in a way that scale up investments and achieve greater impacts - especially on UHC, SHP and SRHR. Though there is progress in terms of coherence through TEIs, it is important that more will need to be done to shift from an addition of projects to a coherent, synergetic and programmatic approach.

European actors should not only focus on working as a team amongst themselves, but also working as a team with African stakeholders and make significant and explicit efforts to involve them in the implementation of the TEIs. This is also key to strengthening the EU as a global health actor, and to ensure local ownership and the sustainability of health interventions. More efforts should be geared to exploring ways to better involve formally and informally African counterparts - and not limit this dialogue necessarily to government institutions. For instance,

more efforts should be paid to analyse the potential for partnership between European financial institutions for development and African regional and national development banks in the health sector.

d) The EU and its Member States should make a more efficient of their resources and target health financing more strategically, towards 4AQ health care

We have indicated some challenges and opportunities for different funding modalities (grants, technical assistance, financial instruments) in the previous sections, which already indicates that choosing a right mix of modalities is a challenging endeavour that needs to rely on careful analysis of the given economic and political context and needs. On the one hand, the factors that determine which modality should be chosen, should reflect the sector of intervention, political context of the country, and the relevant governance issues, economic and fiscal context (e.g. debt burden), and the resources and actors involved. On the other hand, factors like visibility of the action, geopolitical influence, economic interests and other strategic dimensions will also dictate the type of modality mix. The point should be for the EU to be coherent - serving its more geostrategic and political interests should not come at the expense of achieving development impact at scale in partner countries. Importantly, the mix of modalities will evolve over time as e.g. markets mature, as progress is achieved towards UHC and social health protection etc.

One key question on the more strategic health financing is on the area of interventions. Some experts consider that efforts should be put into leaving partner countries serving the core services of health systems, whilst external interventions can provide punctual support more at the periphery - the point being that such support does not become a substitute for governments. As part of these core services, particular attention should go to supporting primary health care as the core of UHC. By financing primary health care, countries can make significant steps in advancing towards UHC with a relatively small cost by investing in public primary healthcare centres especially in underserved areas (Hanson et al. 2022). If not possible through domestic resources, donor financing should provide financial support at least in the short to mid-term, and coupled this with support to DRM to enable the partner country to later take charge over primary health care facilities (Karamagi et al. 2023; Ndolo and De Jong 2022).

In addition, when addressing questions around UHC, it is key to bring more nuances to analysis and interventions developed on the ground: for instance, some donors provide support to ensure that all women and children benefit from the UHC. While this is a laudable effort, it is worth considering the extent to which this is efficient for those women and children that could access and afford health services otherwise. To be efficient, efforts gearing towards UHC should subsidise only those that cannot access/afford health services. That being said, drawing the line between those who can and those who cannot access services without financial support is a highly complex and in many ways political process in practice. For instance, it depends on political considerations (how big of a segment of population should receive financial support and based on what grounds) as well as the available financial resources. In this context, different approaches and understanding between donors on UHC

and other health issues contribute to the fragmentation of health systems - an issue that should be taken up by TEIs at the national but also regional levels.

e) The EU and its Member States should use their collective weight to keep improving global health initiatives efficiency and effectiveness

While global health initiatives make a significant piece of the global health architecture, the interviewees also pointed to some issues in their governance and how particularly disease specific interventions may create fragmentation in the health services. As the key funders to GHIs, the EU and member states can also have an influence on their governance and work to ensure that they connect seamlessly with the health systems of partner countries, and are increasingly efficient in their governance to be able to reduce transaction costs and produce value for money.

f) African and European policy-makers should embrace CSOs as political actors with a role to play in SHP and SRHR

CSOs are pivotal in strengthening the European Union's approach to global health financing, notably by anchoring investments in local contexts, in partnerships between the EU, national governments, and indeed rights-holders through grassroots organisations that represent them. In other words, CSOs help ensure that funds are not only distributed in a way that reflects policy commitments (including to UHC and SHP) but are effectively tailored to meet the varied needs of local populations (including on sensitive issues like SRHR, where direct government support may not be possible). In one of many documented examples, in Senegal in 2014, a network of women's rights organisations engaged in targeted, local advocacy and secured from local authorities a substantial increase in funding for family planning; and in Malawi in subsequent years a similar effort led to increased use of contraceptives (USAID 2017). The influence of CSOs on local authorities should not be neglected, given the latter's role in designing a territorial health policy, and ensuring a multistakeholder approach to implement it.

However, several factors may undermine the involvement of CSOs in shaping health related policies and investments, and in monitoring the utilisation of resources and accountability of governments: i) the civic space around the world is shrinking; ii) the absence of more meaningful institutionalised type of approach with EU institutions and financial institutions for development; iii) the reduced amount of financing going to CSOs (though the fragmentation of CSOs is one aspect that can make funding less efficient), that often comes with high administrative and reporting requirements - often challenging for the smaller CSOs to address. Organisations working on sensitive topics such as SRHR are often the first to suffer from this double bind between restrictive civic space and insecure financing (Bossuyt and Ronceray 2020). Beyond the reduction of funding, the type of funding available also pushes CSOs to act as implementing partners, and does not support the role they could play within the health governance settings (EC 2012).

The EU and its member states have a role to play in critically examining their own funding modalities for civil society and ensuring that they respect local priorities and provide financial

security. Team Europe approaches offer the potential to review modalities since they often entail bringing together EU institutions and member states. Some member states have developed agile methods for supporting civil society and/or to consult and involve civil society in their own budgetary and decision-making processes. If prioritised in their design, this means that TEIs could help address the gaps identified by the EU4Health Civil Society Alliance and by CONCORD. Beyond financial support, the EU and its member states also have a role to play in ensuring that CSOs' role as governance actors is included in the policy and political dialogues with partner countries, and supporting the role of CSOs as key political and societal actors. The EU delegations and local representatives of Member States should play a key role in this context.

The EU should continue supporting international initiatives, which are increasingly factoring in the roles of organised civil society, and bringing them closer to decision making processes. This is for instance the case with *Gavi's CSO constituency* and of the WHO's recently launched civil society commission (WHO 2023f – *list of 120 participating CSO*), although an interviewee pointed to the fact that the WHO being an inter-governmental organisation, it is not well-equipped at this point for consulting wider CSO circles and ensuring that their inputs are included. That said, in 2022, the WHO initiated the formulation of a treaty addressing pandemic prevention, preparedness, and response – a process that was reportedly influenced by civil society advocacy. In addition, CSOs can also make statements in Intergovernmental Negotiating Body (INB) meetings as well as in the WHO decision making bodies. In addition, the AU and its member states could also support some key initiatives on the continent that are being implemented such as the Pandemic Action Network launched the African CSOs under the Resilience Action Network (RANA) - showing that CSOs are taking the lead on addressing pandemics and climate crises (Cullinan 2023), and even on sensitive issues such SRHR (see the African Cervical Health Alliance (ACHA) which has been launched to empower communities and increase access to prevention and control of cervical cancer in Africa by 2030 in line with global targets (Find 2023).

6. Conclusions

Reaching UHC is a joint commitment to both Africa and Europe, last reiterated in the high-level meeting on UHC at UNGA 78. Given the context of a high disease burden, and weak health systems in many African countries, advancing UHC is a key priority that can act as a catalyst for better human capital and economic growth. This paper offers a snapshot of both EU and African financing to UHC and health systems strengthening, paying particular attention to achieving UHC and supporting SRHR, a type of health services, and SHP, a mechanism to ensure its delivery.

The EU has demonstrated a clear added value as a global health actor (see figure 5), including in the context of promoting UHC and SRHR as well as SHP as key parts of it. They stem both from the EU's robust tradition of social welfare and comparatively strong health systems, as well as the size of its ODA and conveying power.

Figure 5: The EU's added value in global health

Consistent	While European countries and the EU are not the largest funders of health, their funding has been consistent (and growing) over time in their support of multilateral initiatives and organisations and key issues including UHC
Experienced	EU institutions have a long track record of supporting global health as an approach, although with sometimes some ambiguity of what that approach entails in practice from a European perspective
Influential	Key area of the EU's added value lies in its influence in multilateral settings. During the COVID-19 pandemic, the EU emerged as a leader in forming partnerships to address the crisis and filled the gap in global health diplomacy left by the US-China conflict.
Comprehensive	One source of the EU's added value remains its ability to pull together different actors that enable leveraging a wide mix of resources and financing modalities. Team Europe approach brings several opportunities for more effective support to health.

Source: From the authors.

The paper highlights that not only is it imperative for the EU and African actors to secure *the current or higher level of financing* to UHC and social protection, but also deliver *better financing* to those priorities. The choices of how to go about this can vary by contexts and objectives of given intervention: there is no one-size-fits-all solution. The table below provides a recap on key measures that can be undertaken by the EU and its MS to provide more and better health financing to Africa.

<table>
<tr><th>Recommendations for the EU and its Member States</th><th>Recommendations for the AU and its Member States</th></tr>
<tr><td colspan="2">Securing or increasing the volume of health financing</td></tr>
<tr><td>Use strategically the mid-term review and evaluation of NDICI-GE

Recognising the potential of support for health as a source of geopolitical clout, ensure that adequate ODA resources for health are secured.</td><td rowspan="2">Boost domestic resource mobilisation

Being a priority for many African nations, DRM could be strengthened, for instance, through tax reforms, the introduction of levies and taxes, social insurance contributions, and tackling illicit financial flow and corruption.

Any actions should be implemented in a way that is progressive to ensure that no one is left behind.</td></tr>
<tr><td>Leverage shareholder position to steer development finance for health

EU Member States can leverage their role in development banks to boost health sector investment, aligning with EU-African priorities and mobilising additional funds for 4AQ health care.</td></tr>
</table>

<table>
<tr><td>Explore the potential of SDRs rechanneling for health

EU member states have the option to redirect their SDRs to partner countries for health financing, for instance, through IMF RST expansion or MDBs like the EIB for greater investment attraction.</td><td></td></tr>
<tr><td colspan="2">On the quality of financing</td></tr>
<tr><td>Better reflecting and responding to local needs and priorities - whilst thinking and acting politically

The EU's support to UHC should align with the priorities and needs of African stakeholders and ensure local ownership. It is important to address political factors, capacity gaps, and corruption.</td><td rowspan="3">Improving PFM practices

Support African countries in PFM efforts, including in the context of:
i) budget formulation
ii) execution and
iii) monitoring

Given the political nature of these efforts and reforms, using a political economy analysis could help identify reforms that are not only desirable but feasible in practice.</td></tr>
<tr><td>Foster a more coordinated and integrated approach

Coordination is crucial and should be nurtured and strengthened both among the European actors but also between European and African stakeholders.</td></tr>
<tr><td>Be more strategic

Selecting funding modalities, whether grants, technical assistance, or financial instruments, is complex. It depends on the sector, political context, governance, economics, and actors involved, while considering visibility, geopolitics, and economic interests. The EU should balance strategic goals with development impact and adapt the mix as circumstances change.</td></tr>
<tr><td colspan="2">Embracing CSOs as political actors with a role to play in SHP and SRHR

Civil society, from local groups to global coalitions, plays a vital role in health initiatives. The EU and its member states should support it through consultation, partnership, and flexible funding to be part of the solution.</td></tr>
</table>

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This publication benefits from the structural support by ECDPM's institutional partners: Austria, Belgium, Denmark, Estonia, Finland, Ireland, Luxembourg, The Netherlands and Sweden.

ISSN1571-7577

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