African Health Economics and Policy Association

Association Africaine d'Economie et de Politique de la Santé

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EVIDENCE BRIEF

FUNDING STRATEGIES, GAPS, AND SUSTAINABLE RESOURCE MOBILIZATION FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS IN GHANA

August 2023

EcASARH PROJECT

INTRODUCTION

It has been almost 30 years since the world's first largest gathering of 179 governments ratified a global action plan to commit to addressing issues of population and development, including sexual and reproductive health rights of adolescents. Many positive changes have occurred since then, but there is a long way to go, especially in resource-limited settings like Ghana, where donor aid remains integral to health financing. A potential decline in external funding for health due to donor fatigue, for instance, poses an imminent threat to financing adolescent sexual and reproductive health (ASRH) interventions and reverses gains made over the last three decades. The gap in funding is much larger for African countries that require a substantial sum to become resilient to post-COVID-19 shocks.

HOW EVIDENCE WAS OBTAINED

Evidence in this brief was obtained through a qualitative study in Ghana and a review of relevant published reports and other documents. The qualitative study involved interviewing key informants selected from different stakeholder institutions between December 2022 and January 2023. The review highlights the situational challenges regarding ASRH and the potential implications of limited or no actions.

Implications of underfunding ASRH interventions in Ghana

In 2016, Africa registered 450,660 births among adolescents aged 10-14. Between regions, the proportion of registered births among the same adolescent age group were 58% for Africa compared to 28% for Asia and 14% for Latin America. These numbers may be higher if unregistered births and those between 15 and 19 years are considered. Adolescents account for about a third of maternal deaths in sub-Saharan Africa. Substance use by adolescents is also increasing in Africa. Today, 3 in 10 adolescents are likely to drink alcohol, and up to 10% and 4% may have experienced smoking cigarettes and used marijuana, respectively.

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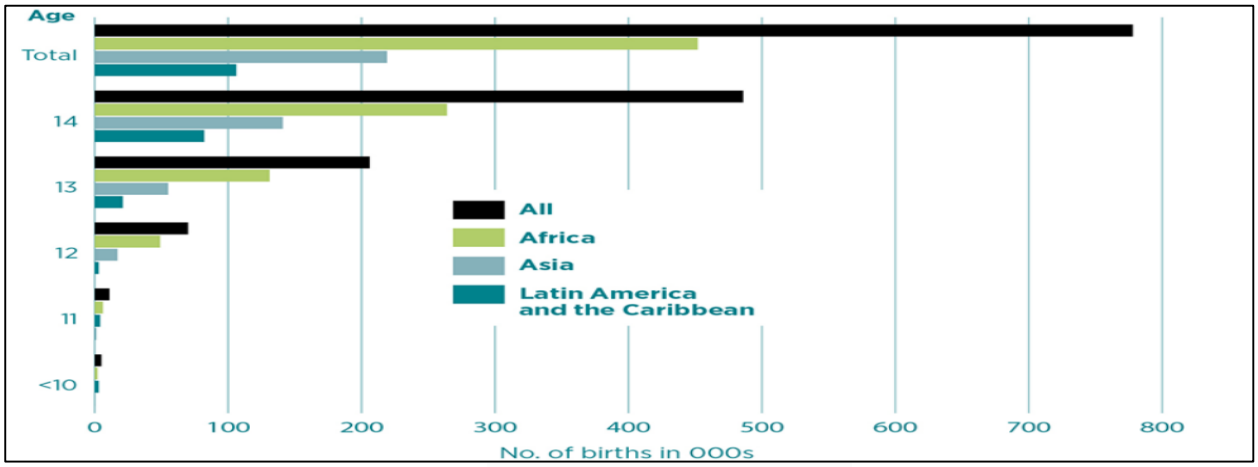
Figure 1. Registered births among younger adolescents 10-14 years old, 2016



Source. Woog and Kågesten 2017.

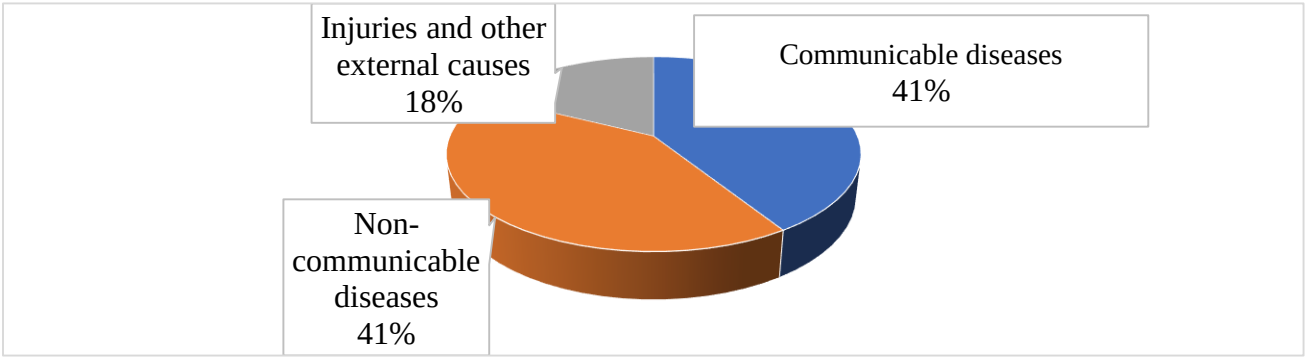
INSIGHTS FROM GHANA

What are the concerns regarding ASRH in Ghana?

Adolescents aged 10-24 account for over 30% of Ghana's population, and up to 40% of those under 20 years are sexually active. More than 15% of female adolescents get pregnant each year before their fifteenth birthday. Most pregnant adolescents become anaemic due to multiple nutrient deficiencies, with 12% dying annually from pregnancy-related complications alone. More concerning is the rising impact of non-communicable diseases, which used to be a disease for older adults. Non-communicable diseases are now prevalent among younger adolescents, exacerbated by poor care during pregnancy. A review of adolescent autopsy reports in a teaching hospital in Ghana shows that non-communicable diseases account for up to 41% of deaths (Figure 2). Addressing these problems requires sustainable funding of priority interventions, among addressing other social determining factors. In this evidence brief, we share stakeholders' experiences of the funding strategies for ASRH interventions, the funding gap, and the way forward.

Figure 2. An autopsy confirmed causes of death among Ghanaian adolescents 10-19 years old.

Who are



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those providing ASRH interventions in Ghana?

There are five categories of institutions providing direct and indirect ASRH interventions in Ghana as listed below with examples.

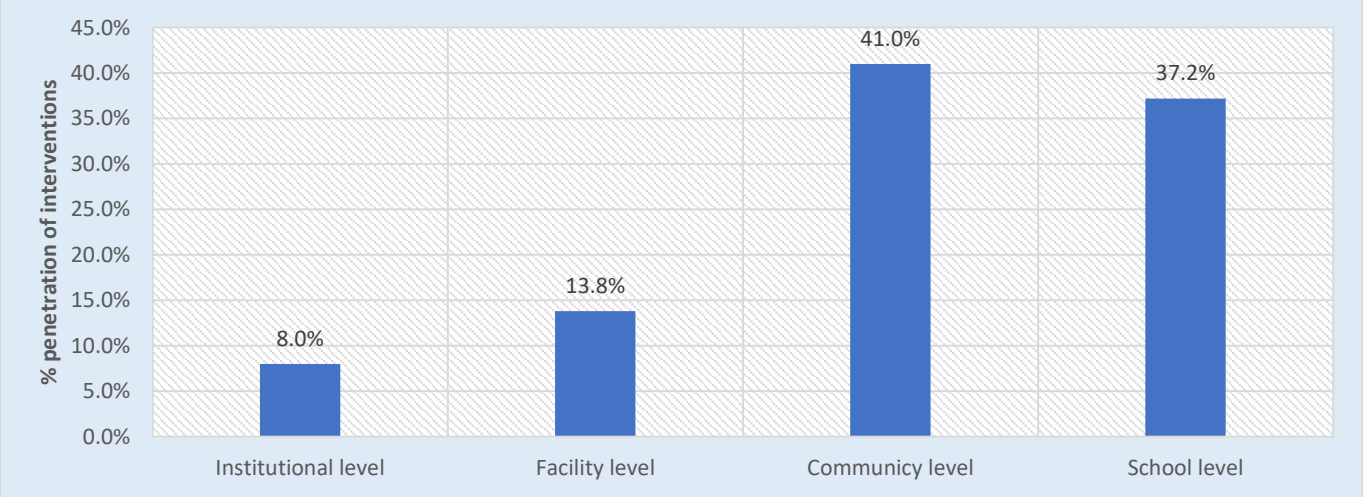
- State-owned institutions like the Ministry of Health, Ghana Health Service, Ministry of Children, Women, and Social Protection, National Youth Authority, and Ghana Education Service.
- Private-owned institutions, for example, DKT International Ghana and Marie Stopes International Ghana
- Non-governmental Organisations, including Alliance for Reproductive Health Rights, Plan International Ghana, and Planned Parenthood Association of Ghana
- Development Partner institutions like UNFPA, UNICEF and WHO provide funding, technical support and capacity-building

Educational and research institutions also contribute through data and evidence generation to support the implementation of ASRH interventions.

At what level are the ASRH interventions delivered?

About 41% of all ASRH interventions in Ghana are community-based, while 37% are school-based. From Figure 3, out-of-school adolescents may be less targeted compared to those in school who may also benefit from community-based interventions.

Figure 3. Levels at which ASRH interventions are delivered.



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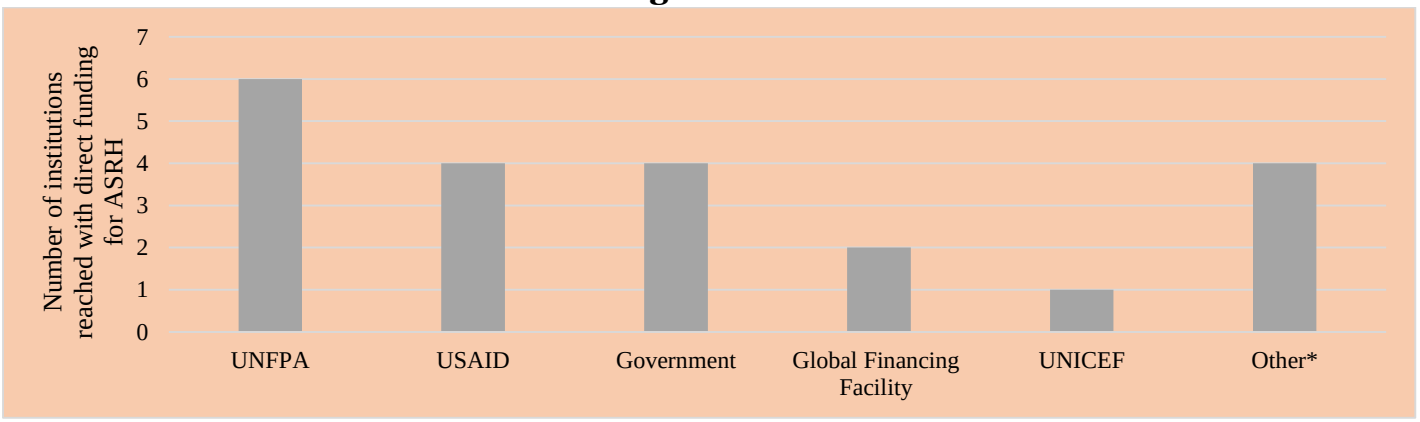
Where do local institutions receive funding for ASRH interventions in Ghana?

Currently, Ghana does not have dedicated funding specifically for priority ASRH interventions. Elsewhere, we described the top seven priority ASRH interventions in Ghana, of which the first five include adolescent club formation, empowerment through sex education, institutional capacity building to provide ASRH services, e-health service provision, and safety-net programs.

Given the absence of dedicated national funding for ASRH interventions, most priority interventions depend on grants from development partners. For instance, between 2019 and 2023, up to six institutions reported receiving direct funding from UNPFA in the form of aid or project grant for priority ASRH interventions, followed by USAID (4 institutions), the government of Ghana (4 institutions), and Global Financing Facility (2 institutions). Other sources included UNICEF, DANIDA, and philanthropic gestures. Also commendable is that some private service providers offered support using their internally generated funds (IGF) (Figure 4).

Figure 4. The number of ASRH institutions in Ghana funded by different funding agencies



Source. Stakeholder interviews, 2023.

What is the magnitude of funding received for ASRH interventions?

An estimated 41% of direct funding received by stakeholder institutions for ASRH interventions in Ghana over the last five years came from the UNFPA, followed by 23% from the Global Financing Facility (GFF), 13% from the government of Ghana, 8% from UNICEF, and the remaining 23% from other sources including the USAID, DANIDA, French Embassy, Philanthropic donations and IGF support from the private sector (Figure 5). Most of the funding received from the GFF went into institutional capacity building to drive efficiency and performance toward universal health coverage.

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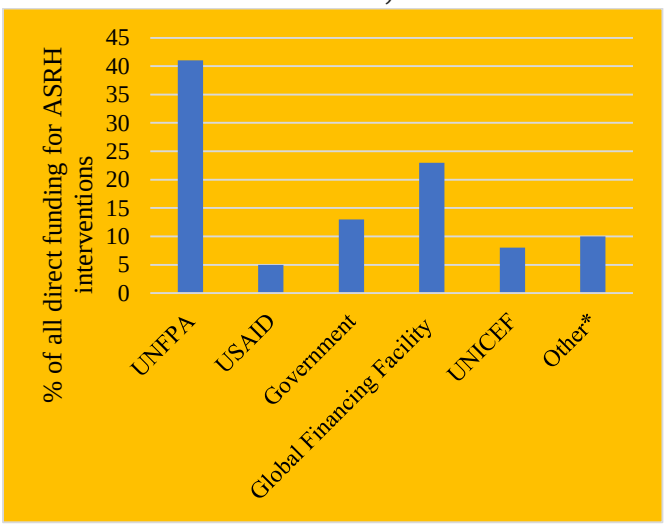
Figure 5. Percentage distribution of received direct funding for ASRH interventions in Ghana, 2018-2022.



*Includes DANIDA, French Government, internally generated funds, and philanthropy.

How can ASRH interventions be funded sustainably?

Stakeholders recommended conventional and non-conventional sources of funding ASRH interventions. Conventional funding sources included tax-based, policy-based, need-based, and performance-based financing approaches. Regarding tax-based financing, the removal of taxes on sanitary pads, widening tax handles for more revenue, and allocation of 1% out of the 5% mineral royalties, according to stakeholders, was enough to set the country on a path of progress to addressing ASRH issues. Alternatively, need-based approaches involve exemption tactics where those who cannot afford care receive it for free. Performance-based financing requires the government to sustain funding for effective ASRH interventions. Most importantly, a policy-based approach requires a long-term national plan devoid of political gymnastics. Unconventional approaches involve direct assistance through multiple domestic fundraising events and donations of supplies from the private sector to a dedicated ASRH account like Ghana experienced during COVID-19. As this evidence brief sets the tone for policy discussions, future research is needed to show which adolescent groups benefit the most from ASRH-funded interventions in Ghana. This is important to identify those left behind and to bridge the equity gap regarding access to ASRH interventions.

Stakeholders' perspectives on the funding gap for ASRH interventions.

For the complimentarity of interventions, a minimum of US$45.00 per adolescent, equivalent to US$450 million annually, is required to implement the top five out of seven priority ASRH interventions in Ghana.

For public sector service providers, less than 40% of budgeted ASRH interventions receive central government funding. Disbursement is often delayed and affects the timely implementation. Since the funding received by local NGOs funds specific school and community-based interventions, most adolescents do not benefit.

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