Bridging the gap

Fiscal justice in sexual and reproductive health and rights in Africa

Introduction

Christian Aid has previously highlighted the importance of gender-sensitive reproductive health to achieving wider development goals.[1] The African Union's Sexual and Reproductive Health and Rights Continental Policy Framework[2] is a progressive regional instrument which sets out challenges and commitments for progressing sexual and reproductive health and rights (SRHR). However, much remains to be done at national level to implement current policies and ensure best practices. This briefing shares the main findings of Christian Aid's research in Kenya, Malawi, Nigeria and Sierra Leone to explore the barriers to women and girls' access to SRHR. It builds on Christian Aid's past work to make the case for fiscal justice in achieving women and girls' rights and access to services.

Main findings

- Public financing is the most reliable, sustainable and equitable way to increase access to SRHR for marginalised women and girls.
- Public financing of SRHR is increasingly important as donor priorities shift, but weak financing policies mean universal health coverage and especially SRHR remain under-resourced, resulting in high out-of-pocket spending.
- A limited role for citizens and health and technical personnel in decision making contributes to lack of allocation to, and transparency of, SRHR budgets.
- Retrogressive gender norms suppress demand for and uptake of SRH services and mean funding and accountability for delivering SRHR are deprioritised.
- There is potential to progressively improve domestic resource mobilisation (DRM) to address gaps in health and SRHR financing.

What needs to change

- **Public financial management and monitoring should be improved** for better prioritisation, planning and accountability in SRHR, including through improved data to inform provision, access and uptake of services and more transparent and gender-responsive budgeting.

- **Domestic resource mobilisation for SRHR should be enhanced** through progressive tax policies, action to end illicit financial flows and abusive tax practices, reallocation of resources where appropriate to create fiscal space for SRHR, and promoting civic responsibility towards taxation.

- **Citizens' participation in decision making should be improved through** increased access to information about, and improved means for engaging in, the prioritisation, planning, budgeting and implementation of SRHR.

- **Levels of education and awareness around SRHR and related issues should be enhanced** among traditional, religious and community leaders, women and men and girls and boys, especially in relation to harmful practices, gender rights, relevant policies and laws, and SRHR information, services and commodities,

- **Law enforcement should be better informed and strengthened** to support better responses, especially in relation to gender-based violence; and laws that restrict access to SRHR services should be reviewed.

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Rationale

In the communities where we work, we see the link between poverty and power imbalances create barriers to accessing essential sexual and reproductive health (SRH) products, services and information, and to participation in policy and resource allocation. These barriers contribute to high levels of disease and death and limit the choices available to women and girls. Our work in Africa focuses on improving health outcomes – particularly SRHR[3] – for marginalised communities. As levels of healthcare spending by governments are a critical factor in improving health indices[4] (alongside better use of funds), we continue to advocate for improved DRM and public health financing.[5]

Huge deficits remain in policy implementation, demand creation and service provision to enable access to SRHR for women and girls in Africa. Since Covid-19, these can be expected to have worsened.[6] This is due to the refocusing of healthcare resources to the pandemic response, movement restrictions and other measures put in place to address the pandemic. The need for more and better financing of SRHR to improve health outcomes is therefore urgent but not new – it was recognised in the Programme of Action adopted at the International Conference on Population and Development in 1994.[7] Alongside the Beijing Platform for Action (which also stressed the role of macroeconomic policy for gender equality[8]) this now guides delivery of Sustainable Development Goal (SDG) target 5.6 on universal access to SRHR, which recognises how central SRHR is to gender equality.

In 2001, African Union countries adopted the second Abuja Declaration,[9] pledging to allocate at least 15% of their annual budgets to health, and calling on donor countries to fulfil their 0.7% of GNI as official development assistance (ODA) target to help address shortages in funds for improving health in low-income settings. While aid continues to play a part in health service delivery, a more sustainable and reliable way to increase health financing is through domestic taxation. As well as raising valuable revenue, this can help strengthen the compact between citizens and government, improving accountability.

'Fiscal justice' encompasses actions governments can take to ensure fiscal policy is coherent with commitments to human rights and the 2030 Agenda for Sustainable Development (Agenda 2030), including universal health coverage, reduced inequality and the 'leave no-one behind' principles. It includes progressive taxation to raise public financing and redistribute wealth, avoiding regressive approaches such as indirect taxes which tend to place an unfair tax burden on women and people living in poverty. It also means public spending that helps to realise human rights and progress development goals, prioritising the needs of people who are most marginalised. SDG indicator 10.4.2 on the redistributive impact of fiscal policy[10] now provides a tool for assessing the effectiveness of fiscal policy in addressing income inequality. However, transparency and social accountability in implementation, and approaches such as gender-responsive budgeting,[11] are also key to ensuring responsiveness to diverse needs.

At the global level, international cooperation to support fiscal and policy space for countries to address inequalities, such as support for improved DRM and action to tackle illicit financial flows, is provided for in SDG targets 16.4, 17.1 and the Addis Tax Initiative.[12] However, necessary normative and systemic reforms were not adequately addressed at the 2015 International Conference on Financing for Development.[13] While the Addis Ababa Action Agenda supports a renewed focus on public finance for services,[14] international financial institutions continue to set a policy agenda that prioritises reducing the tax burden on companies alongside cuts in public spending on health and related areas, which shifts the burden of health costs onto people living in poverty.[15] There is ample evidence of the impacts of structural adjustment programmes on the fiscal parameters set for health policy making and thus on access to maternal and child health

services for vulnerable populations, issues which are particularly acute in African countries.[16]

Research design and methods

Our research was conducted in 2019/20 and brought together fiscal justice and SRHR advocates in Kenya, Malawi, Nigeria and Sierra Leone to examine financing for health, focusing on SRHR, as one of the best ways to advocate for the rights of vulnerable people. Detailed findings were documented in a global review[17] and four national reviews.

Aims and objectives

We aimed to enhance our understanding of the political, socio-economic and contextual factors that influence and impede positive outcomes for women and girls in SRHR, to establish the root causes behind these challenges, and to inform action to increase public financing for comprehensive SRH services. The starting point was the hypothesis that:

'public financing represents the most reliable, sustainable and equitable way of increasing access to comprehensive SRHR services for the poorest, most vulnerable and marginalised populations. It is the only reliable means of ensuring that all communities have more control over the type, quality and accessibility of SRHR'.

The initiative supported our wider programmes and advocacy objectives including to:

- Build the capacities of civil society organisations (CSOs) to analyse and influence macroeconomic policies (especially from a gender perspective) to support the effective realisation of SRHR.
- Use evidence to build the understanding of national-level decision makers about the links between progressive fiscal policy and realising SRHR – particularly as part of the SDG process.
- Increase national-level commitments to public financing for comprehensive SRH services for women and girls.
- Heighten public pressure on decision makers at the national, regional and global level to increase public funding for SRH services through DRM including progressive taxation.

The research comprised 1) a desk-based review of literature, policies and guidelines on global SRHR and universal health coverage; 2) a political economy analysis using a variety of data-gathering tools to reach out to civil society, government agencies, donors, communities, and health sector agents and practitioners; 3) a desk-based review, using a political economy analysis approach, of country-level policies, standards, spending and literature; 4) producing a final global report highlighting the points of convergence between the four national reviews.

We conducted a robust gender and power analysis in each country to explore how women and girls are included and excluded, and how different forms of male privilege operate. A stakeholder analysis provided an opportunity to rethink agency and power in the contexts of SRHR and fiscal justice. This was firstly by examining what's needed to enable women and girls to overcome barriers to claiming their rights and accessing services. And secondly by considering how to engage the 'high influence but low interest' actors such as community elders and leaders, traditional authorities and religious leaders who, because of their status, have the power to shape public opinions and practices.

Summary of findings

The research outputs situate fiscal justice and SRHR within an understanding of the prevailing local political and economic processes. Some of the main findings are summarised below.

The importance of SRHR is recognised by governments but there are significant deficits in public provision and high levels of out-of-pocket spending.

Domestic policies in all four countries[18] recognise the importance of financing universal health coverage, committing to uphold relevant

international human rights frameworks and thus, to optimising the available resources for progressing SRHR. They also reflect relevant global goals and targets, for which all have committed to principles of leave no-one behind and gender equality.

However, efforts to improve the quality of services have been undermined by institutional weaknesses at all levels and there are serious gaps and inadequacies in provision. In all four countries these were found to be particularly acute in rural areas, where lack of health facilities and staff, transport fees and poor road networks mean women and girls have to endure difficult and lengthy journeys, even during labour, to access services.

These weaknesses are reflected in health indicators. In Nigeria for example, maternal mortality stands at 810 deaths per 100,000 live births; 43% of women do not receive skilled prenatal care; 61% still deliver outside health facilities; 57% do not have access to skilled birth assistance; and only 34% have their family planning aligned with modern methods. Also, 36% of women and girls over the age of 15 years are subjected to physical, sexual or emotional violence by a current or former intimate partner. Only about 29% of these women and girls participate in making their own informed decisions on sexual relations, contraceptive use and reproductive healthcare.[19]

Out-of-pocket spending on health services remains high across Africa with significant impacts on health and levels of poverty.[20] Among the countries studied, Malawi has relatively low out-of-pocket spending both per person and as a percentage of health expenditure, although the latter has risen from 8% in 2014 to 11% in 2018.

It is notable that all four countries display very low levels of public health expenditure per person (which as a percentage of GDP ranges from 1% for Nigeria to 2% for Sierra Leone and Kenya and 3% for Malawi[21]). Although the quality of health expenditure is equally important, these figures fall well below the recommended average of $86 per person public spending for delivering a set of essential health interventions.[22]

	Out of pocket (OOP) spending per person ($, 2018)	OOP spending as a % of current health expenditure in 2018	Domestic general government health spending per person ($, 2018)
Malawi	4	11	10
Kenya	21	24	37
Sierra Leone	38	45	8
Nigeria	64	77	12

Source: World Health Organization Global Health Expenditure Database

In Sierra Leone, we found that very high rates of poverty coupled with high inflation make it difficult for many people to access adequate and quality health services.[23] In Nigeria, we found very low levels of public spending leave the burden of financing healthcare predominantly on households. Kenya has made efforts to reduce out-of-pocket spending through a National Health Insurance Fund. But uptake remains significantly low at only 16% of the population to date.[24]

Public financing of SRHR is increasingly important as donor priorities shift, but weak financing policies mean health and SRHR remain under-resourced.

The extent to which our focus countries rely on donor funding for health services varies. In Kenya, the government is the largest financier of health, whereas Sierra Leone continues to receive significant external funding, including for the Free Health Care Initiative which aims to reduce out-of-pocket payments on health for pregnant and lactating mothers and children under 5 years.[25] However, across all four countries, increasing needs and shifting donor priorities are likely to mean governments must become the largest financer of health, yet none of the countries studied are achieving the Abuja Declaration target of an annual health spend of 15% of total budget. Malawi is the only country that has surpassed it (between 2007 and 2011) but recently its

allocation has been less than 10%. Kenya's spending stands at about 8.5% of budget, despite increases in recent years. Nigeria's highest budget allocation to health was in 2002 (6%), now down to 4% in 2020. Sierra Leone has fluctuated between 7% (2017) and 11% (2020).[26] In the past two decades, a downward trend in government spending on health as a share of total government spending has been identified in about half of African countries, accompanied in many cases by growth in total health expenditure driven to a large extent by out-of-pocket spending by households.[27]

Insufficient public budget allocations to health are leading to health budget deficits where donor funding fails to fill the gaps. Sierra Leone's National Health Sector Strategic Plan (2017-2021) cites lack of attention to fiscal space and available resources as an issue in implementing the previous strategic plan.[28] For the current period, it needed $1.4 billion to finance all the components, but up to 2020 the total budget allocation to the health sector had been $291 million, leaving a gap of $1.1 billion.[29]

Although it was often difficult to identify SRHR budget allocations, there is evidence that SRHR is deprioritised, possibly in expectation of donor funding. Again, in Sierra Leone, just 6% of the total health budget was found to be allocated to SRHR.[30] The Reproductive, Maternal, Newborn, Child and Adolescent Health Framework (2017-2021) required a budget of $545 million, of which $487 million (89%) was to come from donors with the government of Sierra Leone planning to contribute US$44 million in the five-year period. Of the $545 million, just $98 million was for SRH, and only $23 million of this had been allocated up to 2020 (less than $7 million contributed by donors) leaving a gap of $75 million.

A limited role for citizens and health and technical personnel in decision making contributes to lack of allocation to, and transparency of, SRHR budgets.

Decision making on budget allocations was found to be largely influenced by political and private interests and religious social norms at both subnational and national levels.[31] Even where there is increased revenue therefore, there are barriers to this being effectively and efficiently allocated in a gender-transformative way.

Malawi offers an example of what can be achieved when CSOs are able to participate in national budget cycles and particularly when they work together. A consortium of CSOs succeeded in advocating for increasing spending on contraception in 2014/15 and 2015/16, amounting to a total 17% increase of government funding for contraceptives[32] and in 2018/19 the Malawi Health Equity Network asked the government to increase funding to the health sector including SRHR.[33] However, the health lobby must compete with other interests which may be prioritised. It also faces a lack of transparency, with district-level health authorities often not kept fully informed on the allocation of resources to hospitals and primary health facilities; and reports that these in turn are frequently noncommittal in releasing information to CSOs during budget tracking exercises.[34]

Overall, our research found data gaps often made it difficult to identify and break down SRHR budget allocations and public spending. The most reliable data on SRH tended to relate to HIV and AIDS. Malawi does have a stand-alone SRHR budget line under health for family planning commodities. However, this excludes other items such as awareness campaigns and outreach clinics, resources channelled through integrated financing and personnel costs. Also, most of the funds for this budget line come from development partners, with the government allocation in 2018/19 at just 2%.[35]

Retrogressive gender norms suppress demand for and uptake of SRH services and mean funding and accountability for delivery of SRHR are deprioritised.

Visible and invisible power relations including patriarchy and norms about women's roles and

control over their bodies and fertility were found to influence decision making around gender and SRHR. One example of this was the delay in the enactment of the Gender and Equal Opportunity Bill in Nigeria because of deep-rooted religious and cultural resistance. Despite sustained advocacy efforts by CSOs and the Federal Ministry of Women Affairs and Social Development, it was vehemently rejected in 2016 by members of the Nigerian Senate on the grounds that it was not in line with the religious and cultural beliefs of most of the Nigerian population. This bill was reintroduced in 2019 by a female senator in the National Assembly and passed through first reading without any opposition, but it is yet to become law.

Women have the potential to be important agents for change, but customs, social norms and conditioning, as well as barriers to education and information, mitigate against their voice and agency in influencing SRHR provision and spending. Some aspects of providing SRH are seen as controversial because they contradict cultural, religious and individual beliefs, norms and values. In Malawi, these often oppose providing SRH services to people outside wedlock and particularly to young people. Malawi has one of the highest adolescent fertility rates in Southern Africa, and rates of child marriage that are among the highest in the world. Early teen pregnancies (29% in the 2015/16 Malawi Demographic and Health Survey)[36] contribute to girls dropping out of school at very high rates, with just 10% of these girls being readmitted to school after childbirth.

High rates of poverty and illiteracy, combined with power relations, norms and customs, also affect health-seeking behaviours and outcomes for the most vulnerable women and girls. In Malawi, barriers in access to education (including teenage pregnancies) have important implications for girls' futures and also for their health, as education is linked to use of contraception to avoid unwanted pregnancy, and to uptake of antenatal care, HIV counselling and testing, and antiretroviral treatment.[37] In Sierra Leone, early marriage and female sexual control by male spouses, including through violence and other practices, were found to prevent women controlling their own fertility. They were also found to determine how and by whom health-related decisions were made at household as well as community levels. The research concluded that increasing the availability of economic resources alone is inadequate unless accompanied by increased women's agency and influence over decisions that can have positive health impacts.

There is potential to progressively improve DRM to address gaps in health and SRHR financing. Tax revenues as a proportion of GDP remain quite low in all countries, although Malawi is just above the 16.5% average for Africa.[38] Sierra Leone's low tax effort was cited as a reason for low health budget allocations.[39]

	Tax revenues as % of GDP	SDG 10.4.2 (progressivity of fiscal policy)
Nigeria	6[a]	0.4
Sierra Leone	11	0.5
Kenya	15	0.8
Malawi	17	0.6

Sources: UNU-WIDER Government Revenue Dataset[40] for tax-to-GDP ratio and Oxfam's Commitment to Reduce Inequality Index.[41] Note a) for Nigeria the data refers to total revenue in 2017 as data for 2018 are not available. All other data are for 2018.

Overall, there is scope for increasing tax revenues in a progressive manner, including by ending tax loss due to unnecessary tax incentives and illicit financial flows. International estimates suggest such flows amount to $416 billion for all developing countries,[42] of which the share of cross-border tax abuses amount to $3.9 billion for Nigeria, $236 million for Sierra Leone and $189 million for Malawi.[43]

Malawi could reconsider its approach to incentivising investment through tax breaks to companies.[44] Combined with revenues lost to illicit financial flows, this could go a long way towards bridging health funding gaps.[45] Sierra Leone could also end tax incentives, especially

those granted to extractive industries where they are often unnecessary for attracting investment.[46] In 2012 tax incentives, mainly to extractives and agricultural sectors, were found to amount to SLL 966.6 billion ($224 million), or 8.3% of GDP.[47] There is also scope for raising significant additional revenues by increasing corporate tax of extractive industries[48] or introducing a resource rent tax as proposed by the government in its Resources Revenue Bill in 2018.[49]

Tax revenues as a share of GDP in Nigeria were exceptionally low at 6.2% in 2017. Nigeria depends heavily on oil sector revenues[50] but could increase tax revenues by addressing unnecessary tax exemptions and illicit financial flows. According to the Federal Inland Revenue Service, Nigeria could also increase tax revenues by $15 billion annually by addressing poor performance. A revenue collection drive in Lagos State was able to increase revenues from NGN 20 billion ($52 million) in 2004 to NGN 170 billion ($446 million) in 2011 and NGN 244 billion ($640 million) in 2016. It has also been suggested that there is capacity to raise more revenue from personal income taxes.[51]

Conclusions and recomendations

The research findings support the case for increased public financing for SRHR as the best way to increase access to comprehensive SRHR services for the poorest and most marginalised women and girls. Public finance can provide more predictable resources and can also create opportunities to improve accountability and political will to prioritise SRHR and improve health service delivery. These opportunities are created through approaches that enable citizens to engage with and monitor government spending and other policies and behaviours that have an impact on demand for, delivery and prioritisation of SRHR. Fiscal justice, including progressive public financing, is central to implementation of national and regional policies and frameworks for SRHR.

We make the following recommendations.

For governments

- **Improve public financial management and monitoring** for better prioritisation, planning and accountability in implementation of SRHR, including through improved data to inform provision, access and uptake of services and more transparent and gender-responsive budgeting.
- **Allocate at least 15% of national budgets to building public health systems in line with Abuja commitments,** and reallocate appropriate resources for this purpose. Set transparent and gender-sensitive indicators to break down and track health budget allocations and prioritise spending on SRHR. Implement gender-responsive budgeting, with a focus on SRHR, at all levels.
- **Enhance DRM for SRHR** through progressive tax policies in line with Addis Tax Initiative commitments, action to end illicit financial flows and abusive tax practices, and action to promote civic responsibility towards taxation.
- **Improve citizens' participation in decision making by providing** increased access to information about – and improved means for engaging in – the prioritisation, planning and budgeting of SRHR and the implementation and monitoring of the effectiveness of service delivery. Address barriers to women's and girls' participation in decision making at all levels.
- **Enhance levels of education and awareness around SRHR and related issues** among traditional, religious and community leaders, women and men and girls and boys, especially in relation to harmful practices, gender rights, relevant policies and laws and SRHR information, services and commodities.
- **Better inform and strengthen law enforcement** to support better responses, especially in relation to gender-based violence; and review laws that restrict access to SRHR services.

For civil society organisations

- **Raise awareness and advocate for improved education about relevant rights, policies and laws – and about damaging social norms and practices**, particularly among marginalised women and adolescent girls, and to change behaviours including those of traditional leaders and men. Faith-based organisations have an important role in this.
- **Research and share information on health, demographic and ODA trends to support evidence-based advocacy** in relation to the need for increased public financing of SRHR, including by building partnerships for strategic collaboration across sectors and supporting South–South exchange of learning.
- **Advocate for progressive and gender-responsive tax and fiscal policies in health and related areas**; build CSO capacities for this and for engagement in fiscal decision making and monitoring.
- **Advocate for action to tackle corruption and illicit financial flows**, including by increasing public knowledge and discourse on these issues and their impacts on DRM.
- **Promote law enforcement and effectiveness in relation to SRHR and gender-based violence,** for example, by building skills to communicate with survivors and improving knowledge of protective legislation.

For all stakeholders

Agenda 2030, with its focus on delivering human rights, citizens' participation and improving the granularity of data for 'leave no-one behind' provides an important framework for action. Although indivisible, targets and indicators to help galvanise efforts in key areas include those for universal access to SRHR services (SDG targets 3.7 and 5.6), universal health coverage (SDG 3.8), health financing and health service strengthening (SDG 3.c), other targets under SDG 5 for gender equality and empowerment of women and girls, and SDG indicator 10.4.2 on progressivity of fiscal policy.

In progressing these goals and targets, action is essential to improve the availability and quality of appropriately disaggregated data, to make the inequalities visible. This applies particularly to the need for a more holistic approach to gender data.[52] Citizens' groups, civil society and human rights organisations have an important role to play here in contributing to more inclusive data for improved decision making.[53]

We call on national and international champions of SRHR/universal health coverage to offer sustained and high-level political support for fiscal justice in fulfilment of SRHR.

End notes

[1] *Christian Aid's Policy on Family Planning*, Christian Aid, 2015, www.christianaid.org.uk/sites/default/files/2016-03/christian-aid-policy-on-family-planning-jun-2015.pdf
[2] *Sexual Reproductive Health and Rights Continental Policy Framework*, African Union Commission, 2006, https://au.int/sites/default/files/documents/30921-doc-srhr_english_0.pdf
[3] SRHR comprises four areas of health concerns that are not exclusive to women: sexual health, sexual rights, reproductive health and reproductive rights. It can include family planning, maternal and child health, gender-based violence, harmful practices and rights related to gender identity, sexual orientation and expression. A component of the right to health, SRHR is connected to other human rights, such as freedom from discrimination and access to education. The Convention on the Elimination of All Forms of Discrimination against Women guarantees women equal rights in deciding "freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".
[4] Public Spending on Health Care and Health Outcomes: A Cross-Country Comparison, Savas Cevik and Mehmet Taşar, *Journal of Business Economics and Finance*, 2013, 2, pp82-100.
[5] *Universal Health Coverage and Christian Aid's Role*. Briefing Paper, Christian Aid, 2020 (unpublished).
[6] *Gender and COVID-19. Advocacy brief*, World Health Organization, 2020, https://apps.who.int/iris/handle/10665/332080
[7] *Programme of Action. Adopted at the International Conference on Population and Development Cairo, 5–13 September 1994,* UN Population Fund, 2014, www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf
[8] *Macroeconomic policy and the Beijing+25 process*, Gender & Development Network, 2020, https://static1.squarespace.com/static/536c4ee8e4b0b60bc6ca7c74/t/5e2193b3ea165940538fe714/1579258810728/Macroeconomics+and+Beijing%2B25.pdf
[9] *The Abuja Declaration: Ten Years On,* World Health Organization, 2020, www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf
[10] The indicator measures the difference between the pre- and post-fiscal income inequality measured by the Gini coefficient, taking into account direct and indirect taxes, social insurance and old-age pension contributions, direct cash or near-cash transfers, and subsidies. See: *SDG Indicators. Metadata repository,* UN Department of Economic and Social Affairs, https://unstats.un.org/sdgs/metadata/?Text=&Goal=10&Target
[11] *Delivering for women and girls: the role of gender responsive budgeting.* Briefing paper, Christian Aid, 2016, www.christianaid.org.uk/sites/default/files/2017-08/delivering-women-girls-gender-responsive-budgeting-february-2016.pdf
[12] www.addistaxinitiative.net
[13] *Report of the Third International Conference on Financing for Development* (A/CONF.227/20), UN, 2015, www.undocs.org/A/CONF.227/20

[14] *Addis Ababa Action Agenda of the Third International Conference on Financing for Development*, UN, 2015, Article 22, https://sustainabledevelopment.un.org/content/documents/2051AAAA_Outcome.pdf
[15] *Financing Universal Health Coverage*, Partners in Health and Centre for Economic and Social Rights, 2020. https://www.cesr.org/sites/default/files/Brief10_HealthFinancing%20.pdf
[16] Structural adjustment programmes adversely affect vulnerable populations: a systematic-narrative review of their effect on child and maternal health, Michael Thomson, Alexander Kentikelenis and Thomas Stubbs, *Public Health Reviews*, 2017, 38, https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-017-0059-2
[17] *Bridging the Gap: The Importance of Fiscal Justice for Achieving Women and Girls' Sexual Reproductive Health and Rights*, Rachel Andras and Renee Katelburg, Christian Aid, 2020 (unpublished).
[18] **For Sierra Leone**: Reproductive, Maternal, Newborn, Child and Adolescent Health Framework (2017–2021); National strategy for the reduction of adolescent pregnancy and child marriage (2018–2022), https://sierraleone.unfpa.org/en/publications/national-strategy-reduction-adolescent-pregnancy-and-child-marriage-2018-2022
For Nigeria: National Reproductive Health Policy (2010); National Policy on Maternal and Child Health 1994); National Policy and Plan of Action on Elimination of Female Genital Mutilation in Nigeria (2002); National Policy on the Sexual and Reproductive Health and Rights of Persons with Disabilities with emphasis on Women and Girls (2018); Accelerated Reduction of Maternal and New-born Mortality in Nigeria: A Roadmap for Action (2019 – 2021); and National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria (2019–2023).
For Kenya: National Community Health Policy (2016–2020); Reproductive, Maternal, Newborn, Child and Adolescent Health Framework (2017–2021). National Strategy for the reduction of Adolescent Pregnancy and Child Marriage (2018–2022).
For Malawi: National Youth Friendly Health Services Strategy (2015–2020); National Strategy for Ending Child Marriages (2018–2023); Promoting Family Planning, Sexual, and Reproductive Health Rights (SRHR); National Sexual and Reproductive Health and Rights policy (2017–2022).
[19] *Maternal mortality,* World Health Organization, 2019, www.who.int/en/news-room/fact-sheets/detail/maternal-mortality
[20] *UHC in Africa: A Framework for Action*, World Bank, World Health Organization, JICA et al, 2016,

http://documents1.worldbank.org/curated/en/735071472096342073/pdf/108008-v1-REVISED-PUBLIC-Main-report-TICAD-UHC-Framework-FINAL.pdf

[21] *NHA indicators,* WHO Global Health Expenditure Database, https://apps.who.int/nha/database/ViewData/Indicators/en

[22] *Spending targets for health: no magic number*, Matthew Jowett, Maria Petro Brunal, Gabriela Flores and Jonathan Cylus, World Health Organization, 2016, www.who.int/health_financing/documents/no-magic-number/en

[23] Sierra Leone National Reproductive Maternal, Newborn, Child and Adolescent Health Strategy 2017–2021, Ministry of Health and Sanitation, 2017, www.afro.who.int/publications/sierra-leone-national-reproductive-maternal-newborn-child-and-adolescent-health

[24] Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage, Edwine Barasa, Khama Rogo, Njeri Mwaura and Jane Chuma, *Health Systems and Reform*, 2018, 4(4), pp346-361, https://doi.org/10.1080/23288604.2018.1513267

[25] *National Health Sector Strategic Plan 2017–2021*, Ministry of Health and Sanitation, 2017, p52, https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/sierra_leone/sierra_leone_nhssp_2017-21_final_sept2017.pdf

[26] *The Abuja Declaration: 10 Years On,* World Health Organization, 2011, www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1

[27] *UHC in Africa: A Framework for Action*, World Bank, World Health Organization, JICA et al, 2016, http://documents1.worldbank.org/curated/en/735071472096342073/pdf/108008-v1-REVISED-PUBLIC-Main-report-TICAD-UHC-Framework-FINAL.pdf

[28] *National Health Sector Strategic Plan 2017–2021,* Ministry of Health and Sanitation, 2017, p72, https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/sierra_leone/sierra_leone_nhssp_2017-21_final_sept2017.pdf

[29] Unfortunately, the Health Sector Strategy does not provide a year-by-year breakdown of what is needed to finance the health sector. Thus, the study was not able to give a yearly breakdown of the financing gap.

[30] Total Sierra Leone expenditure for 2016 provided in Budget Profile 2017; spending on health based on expenditure reports of Ministry of Health and Sanitation, transfers to local councils, public investments and payroll expenditure. Reported in *National Health Sector Strategic Plan 2017–2021,* Ministry of Health and Sanitation, 2017, p52, https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/sierra_leone/sierra_leone_nhssp_2017-21_final_sept2017.pdf

[31] *Bridging the Gap: The Importance of Fiscal Justice for Achieving Women and Girls' Sexual Reproductive Health and Rights*, Rachel Andras and Renee Katelburg, Christian Aid, 2020 (unpublished).

[32] CSOs ensure that Malawi increases contraceptive budget line, funding is spent, Suzanna Dennis, PAI, 2016, https://pai.org/wp-content/uploads/2016/01/Malawi-Case-Study-Web-Friendly.pdf

[33] MHEN wants health budget hiked, Martha Chikoti, *Malawi 24*, 2018, https://malawi24.com/2018/03/23/mhen-wants-health-budget-hiked

[34] District health office' secrecy hampers budget tracking project, Tom Sangala, *The Times*, 2016, https://times.mw/district-health-office-secrecy-hampers-budget-tracking-project

[35] Interview with Deputy Director for Directorate of Reproductive Health in the Ministry of Health, 30 January 2020.

[36] Teenage pregnancies on the rise—survey, Suzgo Khunga, *The Nation,* 2017, https://mwnation.com/teenage-pregnancies-on-the-rise-survey; Rate of teenage pregnancies increases by three percent in Malawi, Joel Chirwa, *Mana Online*, 2018; www.manaonline.gov.mw/index.php/national/health/item/7756-evangelical-association-of-malawi-bemoans-increased-teenagepregnancies

[37] Malawi Population and Housing Census (PHC) report, National Statistical Office, 2018; National Youth Friendly Health Services Strategy (2015–2020), National Statistical Office and ICF Macro, 2010; Demographic and Health Survey, Ministry of Health.

[38] *Revenue Statistics in Africa 2020*, African Tax Administration Forum, African Union Commission and OECD, 2020, www.oecd.org/tax/tax-policy/brochure-revenue-statistics-africa.pdf

[39] Interview with Ministry of Finance staff.

[40] *Government Revenue Dataset*, UN University World Institute for Development Economics Research, 2020, www.wider.unu.edu/project/government-revenue-dataset

[41] Oxfam's version of measuring progressive fiscal policy is one method to monitor progress towards SDG indicator 10.4.2 as no official monitoring has taken place yet by government bodies. *Fighting Inequality in the Time of Covid-19: Commitment to Reduce Inequality Index 2020*, Oxfam, 2020, https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621061/rr-fighting-inequality-covid-19-cri-index-081020-en.pdf

[42] *Trapped in Illicit Finance*, CBGA, Christian Aid, Fundación SES and Financial Transparency Coalition, 2019, www.christianaid.org.uk/sites/default/files/2019-09/trapped-in-illicit-finance-report-sep2019.pdf

[43] *Building back with justice: Dismantling inequalities after Covid-19*, Christian Aid, 2020, www.christianaid.org.uk/sites/default/files/2020-07/building-back-justice-covid19-report-Jul2020_0.pdf

[44] *The Malawi Growth and Development Strategy (MGDS) III (2017–2022)*, Government of Malawi, 2018, www.afidep.org/publication/malawi-growth-development-strategy-mgds-iii-2017-2022

[45] Health spending, illicit financial flows and tax incentives in Malawi, Bernadette O'Hare and Curtis, *Malawi Medical Journal*, 2014, 26 (4), pp133-137, www.ncbi.nlm.nih.gov/pmc/articles/PMC4325349

[46] *Building a Fair, Transparent and Inclusive Tax System in Sierra Leone. Sierra Leone Report*, Tax Justice Network, Budget Advocacy Network and National Advocacy Coalition on Extractives, 2010, p34, www.taxjustice.net/cms/upload/pdf/The_Sierra_Leone_report_final_version-1.pdf
[47] *Losing Out: Sierra Leone's massive revenue losses from tax incentives*, Budget Advocacy Network, 2014, https://curtisresearch.org/wp-content/uploads/Losing-Out.-Final-report.-April-2014.pdf
[48] For more information on fiscal revenue from extractive industries, see the *Ferdi database on mining taxation in Africa*: https://fiscalite-miniere.ferdi.fr/en
[49] *Mining Taxation in Africa: What Recent Evolution in 2018?* Summary Brief 21, Yannick Bouterige, Céline de Quatrebarbes and Bertrand Laporte, International Centre for Tax and Development, Institute of Development Studies, 2020, www.ictd.ac/publication/mining-taxation-africa-recent-evolution
[50] *African Tax Outlook 2019 edition*, African Tax Administration Forum, 2019, https://events.ataftax.org/index.php?page=documents&func=view&document_id=49
[51] *Taxation, Property Rights and the Social Contract in Lagos*, Tom Goodfellow and Olly Owen, 2018, http://eprints.whiterose.ac.uk/129579/1/ICTD%20Lagos.pdf
[52] See, for example, *Harnessing the Power of Data for Gender Equality: Introducing the 2019 EM2030 SDG Gender Index*, Equal Measures 2030, 2019, www.equalmeasures2030.org/products/global-report-2019
[53] *Inclusive Data Charter*, Global Partnership for Sustainable Development Data, www.data4sdgs.org/inclusivedatacharter