Mapping of Reproductive Health Financing: Methodological Challenges

Jalandhar Pradhan¹,², Estelle Monique Sidze³, Anoop Khanna⁴, Erik Beekink⁵

Abstract

Comprehensive data on financial resources in reproductive health sector is critical for planners and policy makers, particularly in developing countries. Low level of funding for reproductive health is a cause of concern, given that RH service utilization in the vast majority of the developing world is well below the desired levels. Though there is an urgent need to track the domestic and international financial resource flows for reproductive health, the instruments through which financial resources are tracked in developing countries are limited. In this paper we examined the methodological and conceptual challenges of monitoring financial resources for family planning and reproductive health services at the international and national level. Results suggest that the Creditor Reporting System (CRS), which is the best possible data source to track donors contribution fails to give the complete picture of the Official Development Assistance (ODA) for reproductive health. At the national level Reproductive Health sub-accounts (RHA) suffers from country specific challenges related to definitional and boundary issues of RH activities. Lastly, weak link between data production by the RHA and its application by the stakeholders and lack of political will act as decelerate factor for the institutionalization of RHA at the country level.

Key words: reproductive, health, financing, flows, accounts, institutionalization

Introduction

It is well evidenced that poor reproductive health accounts for an estimated one third of the global burden of illness and early deaths among women of reproductive age (UNDP, 2006). About 201 million married women in developing countries still have an unmet need for modern contraceptives and around 70,000 maternal deaths annually (13 per cent) occur due to unsafe abortions (Hill et al, 2007). Moreover, 97% of the unsafe abortions occurred in developing countries (David et al, 2006). It has been widely acknowledged that the RH related Millennium Development Goals⁶ can only be achieved if there are significant improvements in Reproductive Health (RH), especially in the poorest developing countries. Most families in this part of the world still have more children than they want. Women especially suffer from the lack of means to control their fertility, and many die young from causes related to maternal health.

Since early 1990’s there have been continuous efforts to increase access to Reproductive Health (RH) globally through greater resource mobilization. Recent studies show that the funding for

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reproductive health programmes has consistently fallen short of the financial targets agreed during the International Conference on Population and Development (ICPD) in 1994 (Schrade et al, 2011; Senanayake and Hamm, 2004; Berstein et al, 2008; UNFPA, 2004). From 2000 to 2009, donor assistance for family planning (FP) decreased drastically from 30% to 5% of total population assistance (which includes FP; basic RH services consisting of maternal health, abortion, information, education, and communication about RH, among other services; sexually transmitted infections (STIs), HIV/AIDS, and basic research, data and population and development policy analysis). Funding for basic RH services other than FP and STIs was also reduced from 29% to 23% of the total population assistance (UNFPA, 2012).

A number of organizations- including bilateral assistance agencies, multilateral and research organizations and governments of developing countries- are putting their efforts to track the flow of health resources to and/or within developing countries. Some of the data collection efforts have been ongoing for several years and facilitate for trend analysis of financial flows for Reproductive Health. However, there are significant gap in the data and to have a comprehensive picture of country owned health system to track financial resources. Currently, the available resource data constitute a patchwork of information at different level of aggregation and of varying quality that falls short in meeting the needs of many diverse objectives of country health system. Second, most of these data collection focus extremely either on the external flows (health resources provided to developing countries) or on domestic flows (country level resources expanded on health) (Eiseman and Fossum, 2005). Finally, the instruments through which financial resources are tracked in developing countries are limited (Singh et al, 2004; Berstein et al, 2008).

It is well evidenced that planner and policy makers in developed and developing world are less likely to have an accurate, up-to-date and detailed data on the health resource devoted to developing countries. Since accurate and updated data are not available, policy makers fail to make their decisions regarding health resource mobilization and allocation, strategic planning, priority setting, monitoring and evaluation, advocacy and general policy making.

Objectives

From the background of such varied contexts, the objectives of this paper are threefold: First, review the existing instruments to map financial flows for reproductive health; second, assess the conceptual and methodological challenges with the existing health system to track financial resources at both international and national levels; third, examine the possibilities to institutionalize the process to get periodic data on reproductive health financing.

Existing studies to track RH financing

There are number of instruments through which financial flow for RH activities can be tracked at the national and international level. Table 1 provides a brief overview of the various databases available to track domestic and donor funding for reproductive health. The source of data could be divided into three categories: i) data on donor aid; ii) data on donor aid and country level expenditure; and iii) data on country level expenditure. The following table gives a brief overview about the databases and related challenges to track RH financing at the country level.
Table 1 Reproductive health resource data collection

<table>
<thead>
<tr>
<th>Type of collection</th>
<th>Name</th>
<th>Supporting organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data on donor aid</td>
<td>CRS (Creditor Reporting System)- Database on Aid Activities</td>
<td>Organization for Economic Co-operation and Development (OECD)/ Development Assistance Committee (DAC)</td>
</tr>
<tr>
<td>Data on donor aid and country level expenditure</td>
<td>Resource Flows Database</td>
<td>United Nations Population Fund (UNFPA)/ Netherlands Interdisciplinary Demographic Institute (NIDI)</td>
</tr>
<tr>
<td>Data on country level expenditure</td>
<td>OECD Health Data</td>
<td>OECD/ Directorate for Employment, Labour and Social Affairs (DELSA) Health Policy Unit</td>
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<tr>
<td>National Health Accounts</td>
<td>National Health Accounts</td>
<td>WHO</td>
</tr>
<tr>
<td>Reproductive Health Sub-Accounts</td>
<td>Health Accounts/ National Health Accounts</td>
<td>Pan American Health Organization (PAHO)</td>
</tr>
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<td></td>
<td>Reproductive Health Sub-accounts</td>
<td>Partners for Health Reformplus (PHRplus)/ Abt Associates</td>
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Conclusion and discussion

As reviewed above, several initiatives are simultaneously active in the field of reproductive health resources tracking. Some initiatives focus on several aspects of health, like the OECD, WHO, PAHO, World Bank, Institute for Health Metrics and Evaluation (IHME), Kaiser Family Foundations (KFF) and AidData, while others focus on a more specific sub-sectors e.g reproductive health, malaria, child health etc.

There are number of estimates that highlights financial resource needs for reproductive health programmes at national and sub national levels. Lack of understanding of these different estimates can lead to fragmented advocacy for financial prioritization of reproductive health. So, a well defined costing tool is necessary to predict the resource need for RH during forthcoming periods.

CRS database is still the leading source on health financing. The Resource Flows (RF) data base uses percentage figures to allocate part of the specific CRS to one of the ICPD categories, while other organizations focus more on maternal and child health, like the Muskoka initiative, Countdown 2015 and the Global Strategy. Moreover, the CRS purpose code for reproductive health is limited to assess donor disbursements for specific sub-sector of reproductive health- for example for sexual and gender based violence (SGBV). Also, the gap in data on international health funding by non-DAC government donors and private foundations and on funding that is channelled through and spent by NGOs and the private sector, need to be addressed. Better data on pattern and flow of global health financing would enable a more critical analysis of the performance of funders and global health actors in delivering appropriate and effective development assistance for health to LMICs (McCoy, et al, 2009).

In order to monitor the domestic financial flow for RH activities, the RHA (in the framework of NHA), is the best possible source to track national level spending on RH. However, producing RHA in the context of NHA suffers many challenges. First, use of RHA need to be enhanced.
Creating RHA is not enough, they need to be disseminated before national level planner and policy makers. Once they agree upon the findings of the RHA, the users of RHA will increase. Second, countries need to use the same methodology suggested in the WHO guideline (WHO, 2009a), in order to have better comparability. Third, there is a need to have an improved financial management and information system in recipient countries that are capable of providing a composite picture of health expenditure that integrate external and domestic funding for health.

Fourth, since special surveys to generate information on RH utilization are expensive, a module on RH utilization can be developed and “piggy backed” in other routine surveys like the DHS. This will however depend on the sample size since a survey targeting RH consuming population groups require a large sample size to generate the required RH indicators. Specific RH surveys are also subject to both sampling and non-sampling errors; so in health accounting they are best used in combination with other data; for example data from health facilities and other health service providers. This process of triangulation and integrating data sources increases the validity and reliability of the accounting process. Fifth, the development of RHA should be institutionalized in order to produce periodic report on financial flows for RH activities. Institutionalization of development of RHA, depends only on the technical and financial capacity of its institution. Hence, capacity-building is required not-only on how to develop RHA but also how to make use of data from RHA for national level health planning and programming.

Reference


