

Countdown Working Group on Financing

Annex 2

Tracking domestic expenditures for MNCH Work plan and proposed budget January 2009 to April 2010 *Revised proposal for the Countdown (Draft 27 October 2008)*

Requesting Organization: Department of Child and Adolescent Health (CAH),
Department of Health Systems Financing (HSF)
Department of Making Pregnancy Safer (MPS)
Department of Reproductive Health (RHR)
World Health Organization
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Total funds requested: US\$ 409,060

Time period: 1 January 2009 - 30th April 2010 (16 months)

Overall objective

The overall objective is to support the collection of data on national health expenditures going to maternal, reproductive, newborn, and child health programs ((here referred to as MNCH). We propose to support the development of a methodology and the institutionalization of a process whereby countries are given assistance to gather expenditure data.

Background

Countries have pledged to scale-up the coverage of health services to reach the Millennium Development Goals (MDGs). MDGs 4 and 5 refer to reducing child and maternal mortality, and imply improving access to reproductive health. Scaling up the delivery of interventions across the MNCH continuum of care in order to reach every woman and child in need will require additional investments in commodities, equipment, and human resources as well as strengthening of the operational health system.

National policy makers often lack information to assess the amount of resources devoted to priority health areas. They need information on budget expenditures in order to assess how resources are distributed within the health sector, and to determine the funding gap between the resources currently available and those additional investments required to achieve national targets. Such information provides the evidence necessary to make informed decisions, to allocate resources between competing needs, to help set strategic priorities and to ensure sustainable funding for MNCH programmes and strategies.

Efforts are already ongoing to track country level investments in areas related to MDG 6 for HIV/AIDS, TB and malaria. Similar initiatives exist for health expenditure tracking on non-communicable diseases. This work plan outlines the suggested steps to initiate a similar process for tracking government expenditures for child and maternal health. The findings will allow stakeholders, including civil society, to assess the financial accountability of national governments (and their contributing development partners) for MDGs 4 and 5.

Objectives

The general objective is to enable the assessment of spending patterns on MNCH across space and time, in order to develop the following indicators:¹

- Expenditures on child health as % of total government health expenditures
- Government Expenditures on child health per capita / child under five
- Expenditures on reproductive health as % of total government health expenditures
- Government Expenditures on reproductive health per capita
- Expenditures on maternal health as % of total government health expenditures
- Government Expenditures on maternal health per capita / pregnant woman
- Proportion (%) of Government Health Budget going to Child Health
- Proportion (%) of Government Health Budget going to Reproductive Health
- Proportion (%) of Government Health Budget going to Maternal Health

The availability of such data will enable program managers to inform and influence policy discussions and budgeting processes at national level. The perspective will be public sector finances, i.e., government funds going towards MNCH investments. The estimates will exclude donor funds except for instances where these are managed by the public sector.

This methodology is intended to be complementary to the assessment of ODA for MNCH and also complementary to the domestic expenditure tracking processes as currently carried out for other disease programs.

This area of work has two additional objectives:

- To strengthen capacity at country level to monitor inputs into the programme cycle, in particular financial such, and to evaluate programme implementation using an input-output-outcome conceptual approach.
- To support the institutionalization of data collection related to domestic expenditures on MNCH, in order to provide data on an annual basis.

A fourth and final objective is related to monitoring the efficiency of current spending in relation to achieving mortality reduction goals. Indicators have been developed as per the *Guide for producing Child Health Subaccounts within the National Health Accounts Framework* (forthcoming, WHO). This assessment will also look into ways of using proxy indicators for obtaining information on measures related to efficiency, such as:

- Public provider care expenditures as a % of total care expenditures
- Preventive care as a % of total care expenditures

Expected Outputs

- Methodology developed for tracking MNCH expenditures (related to the amount and when possible also to efficiency) using limited data inputs.
- By January 2010, quality controlled data on government MNCH expenditures in priority Countdown countries (at least from the African region).
- By March 2010, summary report available including description of the methodology and process, for a) 2010 report of the Countdown to 2015, b) Lancet special issue and c) Countdown conference in 2010.

¹ It may not be feasible to provide separate indicators for reproductive and maternal health, in which case this will be presented as a joint indicator.

- Institutionalization of expenditure monitoring and reporting for MNCH within MOH programs.
- Institutionalization of expenditure monitoring for MNCH within WHO.
- Capacity built within MOH related to monitoring financial inputs into the program cycle.
- Over time, data collected from an increasing number of countries, allowing for assessment of trends.

Methodology

Comparison with National Health Accounts (NHA)

The method proposed here is not intended to replace more detailed methods such as the NHA sub-accounts for child health and reproductive health respectively. Rather the intention is to provide a rough method for quickly determining the resource allocation towards MNCH, as part of the Monitoring work of the Countdown to 2015. The method proposed will require less funding than NHA sub-accounts and ensure an annual reporting process (see Table 1 below). Meanwhile it is encouraged that sub-accounts are implemented whenever there is policy interest and funds available.

Table 1. Comparing the proposed method with that of NHA sub-accounts

NHA sub-accounts	Proposed data collection process
Resource intensive, requires national team inputs for at least one month.	Less resource-intensive, data collection followed up by long distance support
Produced by 2-3 countries per year per area	Produced by 30-70 countries per year per area (*)
Tracks financial flows from all sources	Tracks financial flows from government only
Provides detailed breakdown of spending	Provides an indicative rough overview of spending
Intended to be implemented every 4-5 years depending on policy relevance	To be implemented annually

(*) the number of countries producing data is expected to grow over time

Methodological approach

- The method will follow the logic and boundaries of the NHA sub-accounts.²
- The method proposed will build upon the approach under development by other programs such as TB and Malaria for government routine reporting on program expenditures.
- The approach will take into account data collected for immunization financing through the WHO/UNICEF Joint Reporting Forms.
- Efforts will be made to liaise with UNFPA in areas where data on reproductive health expenditures and budgets is collected from countries.
- The Questionnaire will request information on financial data for activities directly associated with MNCH. Some of these expenditures may be easily identified as specific to MNCH, such as vaccine related costs.
- Much of the resources for MNCH will be shared between MNCH and other programs, which means that a proportion of their spending will need to be allocated to MNCH. In order to support the production of rough expenditure estimates for MNCH, the methodology will request information on gross spending per service delivery level, and service utilization statistics. Based on the utilization patterns, a proportion of the total spending will then be allocated to child, maternal and reproductive healthy respectively.

² Note that additional work will be required to separate Reproductive health and Maternal Health expenditures as these are currently estimated jointly in the Reproductive health sub-accounts.

- With respect to budget data, we will request information on audited budgets as well as executed budgets (not yet audited) when available.

More details are provided in Annex 2.

Development of data collection materials

The initial phase of this work will involve the development of two separate questionnaires, one for Child Health and one for Reproductive health and MNH combined (RMNH). The reason for two separate questionnaires is as follows:

- The collection of data is expected to occur through the MOH national program manager for the respective program. There is considerable heterogeneity between countries regarding to what extent there is a separate program manager for child health, maternal and reproductive health/family planning. In general there is greater integration of reproductive and maternal health (RMH) programs while child health is often managed by separate programmes (e.g. nutrition, EPI, IMCI, malaria, HIV).
- Secondly, it is important that the data collection becomes part of routine monitoring of programmes. WHO/CAH and WHO/RHR both have an annual reporting system (WHO/MPS does not currently have a regular country reporting process in place). It is recommended to integrate the additional questions on expenditures into the existing data collection systems, in order to emphasize the need to consider expenditures as part of a holistic monitoring process which takes into account inputs, outputs and outcomes.

It is therefore proposed to develop two separate questionnaires, one for child health and the other for RMNH, with the longer term aim to integrate the processes.

Data collection process

As part of the generic global reporting processes, all countries will receive the questions on expenditures as an integrated component of the general M&E questionnaire. For WHO/CAH the Global Monitoring System survey is usually sent out to WHO country offices in November with a request for feedback to be provided by January the following year. For RHR the questionnaires are sent out each year in January with data expected by September, and reports are officially presented to stakeholders every 2 years. In order to allow for field testing the expenditure related questions prior to inserting them into the questionnaires, we propose to delay the sending out of the CAH and RHR questionnaires in 2008 until April/May.

It is expected that the data collection process will require technical support through emails and telephone. Managing the data collection process through the relevant WHO departments will ensure that data is regularly collected using existing annual reporting processes, and that the analysis of the data will be carried out in a coherent way across programs. While all countries will receive the survey instruments, it is proposed that technical support to expenditure tracking in the first phase of this project focus on countries in the African region.

Capacity building

Given that expenditure tracking is an area in which there is limited information available at country level and few national program managers have the required competency, there will be a need for capacity building and technical support in order to support countries in obtaining the data. It is envisioned that capacity building for national program managers will take place through workshops and learning-by-doing. Ideally the capacity building will focus on the importance of linking input indicators to outcomes, using financial data to improve programming, and building local capacity for gathering data related to the implementation of MNCH programs.

We propose to organize two workshops in the African region. For the other regions, sessions on expenditure monitoring will be piggybacked onto workshops on strategic planning, costing and

monitoring. In general economies of scale and scope will be achieved by linking the training on the expenditure monitoring tools to:

- (a) data collection and data analysis for the Countdown to 2015 process;
- (b) data collection and data analysis for CAH, IVB, MPS and RHR annual reporting mechanisms;
- (c) workshops on strategic planning and monitoring programs for CAH, IVB, MPS and RHR.

Human resource needs

- WHO staff to support the initial development and testing of the questionnaire as well as the development of capacity building materials.
- The number of countries for which data will be collected and compiled depends on the availability of technical support. Given the need to have data available by January 2010, there will be a need to have at least one full time staff person available to support the process for child health and MRH jointly from September/October 2009 -January 2010.

Work plan

Development Phase prior to the work plan for this proposal: October - December 2008

- A working group is established with representation by CAH, HSF, MPS and RHR departments. Other relevant departments (IVB, RBM, etc) are invited to contribute to this process as are external partners as needed.
- Draft questionnaires are developed for child health and Reproductive health + MNH.
- Boundaries between maternal and reproductive health spending are established.

Development Phase continued January- March 2009

- Draft questionnaires are piloted in 3 countries³ (preferably 1 in EMRO region, 1 in AFRO region, and 1 in WPRO region) with country support of 4 days per country (2 days Child Health, 2 days RMNH). The objective will be to assess the validity and feasibility of the proposed methodology.
- Outcomes of the pilot test assessment are compared with results available from sub-accounts for child and reproductive health or other expenditure data where available. This provides a quality check of the quick rough method vis-à-vis the more detailed approach.
- Draft questionnaires are further revised as needed and user instructions developed.
- Pilot test methodology (questionnaires) in 2 additional countries with long-distance support provided through email and telephone. The objective will be to assess the long-distance support process.
- Develop training module on expenditure assessment

Integration into existing reporting forms, dissemination and initial capacity building: April 2009

- Data collection process integrated into CAH Global Monitoring tool for child health (web-based).
- Data collection process integrated into reporting mechanisms for RHR and MPS.
- Data collection process for MNCH introduced at regional workshops for program managers when opportunities arise.

Capacity building and initial implementation Phase: November 2009-March 2010

- Training workshops (2 workshops May 2009 - September 2009)
- Database set up with country data
- Further refinement of the methodology over time.
- Technical support to data collection.
- Analysis of findings.
- Summary report produced.

³ Ideally these should be countries where one of the sub-accounts have been applied.

Final dissemination of results at Countdown conference (April 2010)

- Travel to conference and dissemination of methodology and findings

Annex 1: Budget table

PHASE and timeline		Cost components (US\$)		Incl 13% PSC
PHASE 1 - Development (January 2009 - April 2009)				
	Draft questionnaire for child health expenditures	no additional cost	0	
	Draft questionnaires for Maternal and Reproductive health expenditures	no additional cost	0	
	Develop methodology to separate MH and RH spending	no additional cost	0	
	Consultant APW (30 days) @ p3 rate	30 x US\$250	7500	
	Pilot test methodology (all 3 questionnaires) in 3 countries (country visit)	travel x 2 persons x 3 countries	30000	
	Pilot test methodology (all 3 questionnaires) in 2 additional countries (follow-up by email and phone)	no additional cost	0	
		Activity cost sub-total	37,500	42,375
PHASE 2 - Dissemination and initial capacity building: (May- July 2009)				
	Translate the questionnaire into French and Spanish	no additional cost	0	
	Develop training module on expenditure assessment	no additional cost	0	
	Data collection process integrated in RHR Global Monitoring tool	no additional cost	0	
	Data collection process integrated into CAH Global Monitoring tool for child health	no additional cost	0	
	Data collection process introduced at regional planning workshops (piggybacked)	no additional cost	0	
	Training workshops (2 workshops)	travel x 1 person x 2 countries	10,000	
	Training workshops (2 workshops) Participant support	travel x 3 persons x 10 countries x 2 workshops (3x10x2x3000)	180,000	
		Activity cost sub-total	190,000	214,700
	Staff cost	P3 ST 3 months (May July)	39,000	44,070
PHASE 3: Further capacity building and initial implementation Phase (August 2009 - January 2010)				
	Set up database with country data	no additional cost	0	
	Staff cost	P3 ST 6 months	78,000	88,140
PHASE 4: Analysis and reporting (February - April 2010)				
	Consultant APW (30 days) @ p3 rate	30 x US\$ 250	7500	
	Final dissemination of results at Countdown conference (April 2010)	Travel to conference, dissemination of methodology and findings	4000	
		Activity cost sub-total	11,500	12,995
PHASE 5: Second round implementation (May 2010 - April 2011)				
	CAH, MPS and RHR staff	no additional cost	0	
Other				
	Logistics / printing		1,000	
	miscellaneous	unexpected costs/Misc.	5,000	
		Sub-total	6,000	6,780
Grand total, including PSC (13%) in US\$				
				409,060

Annex 2. Categories of data to be used in the analysis

Note that the below list is intended to give an overview of the type of data which will be requested. The final methodology will be developed over the coming months and build upon the CH and RH NHA sub accounts.

- Financial data for activities carried out by national programs for child, reproductive and maternal health. Data will be requested specifically for cost driving components, such as:
 - Staff working within the central program unit and at subnational level.
 - Routine program management and supervision activities
 - Training courses organized at province level
 - Training courses organized at district level
 - Development and printing guidelines, handbooks and training materials
 - Advocacy and social mobilization
 - Operational research
 - Surveys and monitoring work
- Information on expenditures on drugs and commodities for child, reproductive and maternal health services. Data will be requested specifically for cost driving components, such as:
 - Vaccines and injection materials and Vitamin A capsules
 - Pediatric formulations (syrups etc), Oral Rehydration Salts and zinc tablets
 - Incubators, pediatric NasoGastric tubes and other equipment for MNCH services.
 - Contraceptives
- For some drugs and commodities the methodology will assume that a proportion of the expenditures can be assumed allocated to MNCH. For example
 - ITNs
 - Antibiotics
- Expenditures associated with hiring, training and retaining community health workers if applicable.
- Data on expenditures for service delivery (from the executed budget) as available at the lowest level of desegregation (national/regional/district/type of facility, etc)
- Service utilization statistics on inpatient (IP) and outpatient (OP) visits for the latest year. The level of desegregation for IP and OP data should be the lowest level available to the central level administrative units. The level of desegregation should be the same for both types of visits (IP and OP), by diagnosis.
 - Number of total in-patient visits / in-patient days
 - Number of total out-patient visits
 - Number of under-5 in-patient visits / in-patient days
 - Number of under-5 out-patient visits
 - Number of institutional deliveries
 - Number of family planning visits
 - (etc)

Note that whenever health expenditures are not available separately for inpatient care and outpatient care, other methods are proposed to arrive at the relative distribution of costs. This includes using morbidity reports and utilization data for preventive care. When data is very sparse, a WHO regression model for deriving the relative distribution between inpatient and outpatient visits will be used.

- Data on the relative cost between Inpatient and outpatient visits for different types of services (when limited data is available, use WHO Regression model (Adam T et al.)
- NHA data.

Note: The questionnaire will include a description of how to collect the data. It will also include linkages to NHA resource persons in each country.

Annex 3: Financing indicators available in current WHO monitoring tools for MNCH

Reproductive Health financing indicators

Since 2 years back, WHO collects information on reproductive health performance and trends (implementation of Global Reproductive Health Strategy) in WHO Member States. Three indicators on financing were introduced in year 2007 as follows:

- % of Government budget allocated to health care
- % of Total Government Health Budget directed to Reproductive Health
- % of Government Health Expenditure directed to reproductive health care

Immunization financing indicators

Since 1998, the WHO and UNICEF Joint Reporting Form (JRF) mechanism has been collecting data on immunization financing indicators as part of a set of immunization indicators designed to measure system performance and trends in WHO Member States.

In 2005 two immunization financing indicators were analysed and key findings prepared for the WHO Vaccine Preventable Disease Monitoring System - Global Summary 2005. The first indicator reports whether or not a WHO Member State has a line item in its national budget for the purchasing of vaccines used in routine immunization. The second measures the percentage of all expenditures on routine vaccines which were financed by the government using internal public funds.

In early 2008 a revised analysis will include the full set of 6 immunization financing indicators available through the JRF mechanism.

- Is there a line item in the national budget for the purchase of vaccines used in routine immunization? (Yes-No)
- Is there a line item in the national budget for the purchase of injection supplies (such as syringes, needles and safety boxes) used in routine immunization? (Yes-No)
- What amount of government funds were spent on vaccines used in routine immunization? (US\$ or Local Currency)
- What percentage of all spending on vaccines was financed using government funds? (%)
- What amount of government funds were spent on routine immunization? (US\$ or Local Currency)
- What percentage of all spending on routine immunization was financed using government funds? (%)

The JRF is sent out to countries in February and results are submitted by April-May. Final analysis is completed around October each year.