

Financing for maternal, newborn and child health



Monitoring financial resource flows for maternal, newborn and child health is a central part of the *Countdown*—determining the funding gap between resources currently available and the actual investments required to reach national and MDG targets and holding governments and the international community to account for investing adequately in the health of women and children. Policy-makers need financial information to make informed decisions on how to best allocate resources among competing needs, set priorities and ensure sustainable funding for programmes. This section presents an update on the financing gap and patterns in ODA; work on compiling data on national contributions is under way and will be reported in 2011.

Closing the gap: what resources are needed to scale up coverage of maternal, newborn and child interventions?

Preliminary estimates show that if current funding trends continue during 2008–2015, the 68 *Countdown* countries will face a roughly \$60 billion funding gap relative to the costs of implementing a full package of maternal, newborn and child health *Countdown* interventions (figure 20). If public commitments by both aid donors and governments are met (assuming a linear increase to 15% of gross national product by 2015 for African countries committed to reaching the Abuja target and 10%–12% for all other *Countdown* countries), the gap remains \$22 billion. This analysis shows that more funding is needed for countries to be able to provide universal coverage of essential maternal, newborn and child health services.

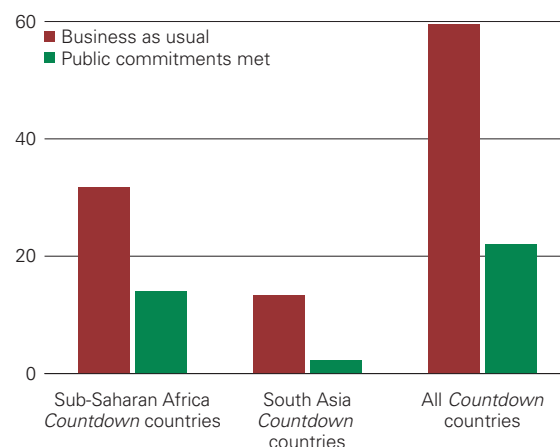
Official development assistance to maternal, newborn and child health shows promising trends

Total ODA for maternal, newborn and child health in 2007 was \$4.1 billion, up 16% from

FIGURE 20

What resources are needed to close the funding gap for maternal, newborn and child health in *Countdown* countries?

Financing gap in maternal, newborn and child health, by region, 2015 (\$ billions)



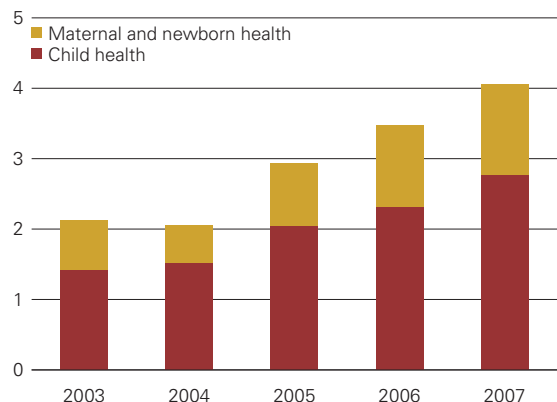
Source: Greco and others 2010.

2006 and nearly double the \$2.1 billion in 2003 (figure 21). Although these trends show improved commitment, ODA for maternal, newborn and child health accounted for only 31% of all ODA for health in 2007. ODA flows for maternal, newborn and child health are important to track, but national resources are a much larger share of funding for maternal, newborn and child health. Even for very low-income *Countdown* countries such as Ethiopia and Malawi, national sources account for half or more of total spending on reproductive and child health. Tracking government and nongovernment spending at the country level is essential for policy-makers to follow progress in making adequate resources available for women and children. Estimates of domestic expenditure on maternal, newborn and child health, including family planning, will be available in 2011 for a subset of *Countdown* countries.

FIGURE 21

Official development assistance for maternal and newborn health and for child health has been increasing

Official development assistance to child health and to maternal and newborn health, *Countdown* countries, 2007 (2005 \$ billions)



Source: Pitt and others 2010.

Trends in official development assistance by purpose

There are important differences in levels and trends for ODA to child health, maternal and newborn health, and family planning, which is included in *Countdown* for the first time in this update. Following significant declines in the 1990s, ODA for family planning continued to decline in real terms concurrent with increases in ODA for maternal, newborn and child health (figure 22). This may indicate replacement, with funds targeted to family planning being reallocated to maternal, newborn and child health—especially given that some interventions are delivered in the same service settings. Accurate donor reporting, including correct attribution of funds to specific service areas, is a problem with available data. Better-resourced maternal and child health services result in improvements in maternal, newborn and child survival and other health benefits similar to those that result from strengthened family planning services in many cases. In-depth analyses of these questions are under way and will be reported in 2011.

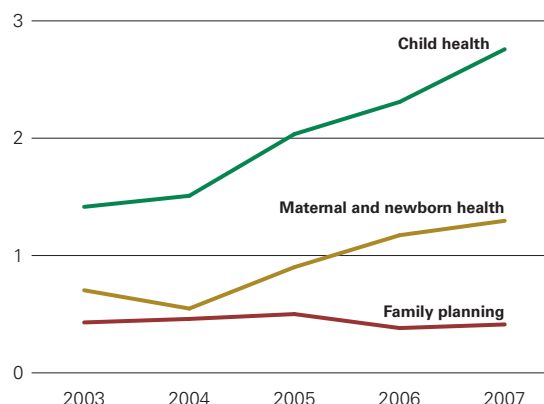
Is official development assistance targeted to countries in greatest need?

ODA flows are rarely well targeted to either the poorest countries or the countries with the greatest burden of mortality. Table 2 shows

FIGURE 22

Have increases in official development assistance for maternal, newborn and child health substituted for declines (in real terms) in official development assistance for family planning?

Official development assistance, *Countdown* countries, 2003–2007 (2005 \$ billions)



Source: Greco and others 2010; UNFPA Donor Support, March 2010, (http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/2008_donor_support_report.pdf).

TABLE 2

Official development assistance is not always going where it is most needed

Official development assistance to *Countdown* countries, by income group and under-five mortality rate, 2007

GDP per capita (\$)	ODA for maternal, newborn and child health per capita (\$)
Less than 500	0.02–6.40
500–1,000	0.24–6.90
More than 1,000	0.04–28.40

Under-five mortality rate (per 1,000)	ODA for child health per child under age 5 (\$)
More than 200	4.0–28.7
150–200	4.5–225.7
100–149	2.7–18.9
Less than 100	0.3–12.9

Source: Greco and others 2010.

the distribution of ODA by country income group and under-five mortality level. The wide and overlapping range of ODA for maternal, newborn and child health per capita by country income group and of ODA to child health per child by under-five mortality level indicates the weak link between ODA levels and these two measures of need.

Action now for Millennium Development Goals 4 and 5



The majority of maternal, newborn and child deaths are preventable. Commitments to action are needed by governments and the international community to:

- Make every mother and child count, by registering and counting every birth and death.
- Ensure that every woman, newborn and child has access to essential health services, by overcoming financial barriers.
- Improve equity, by making services available to poor, remote and vulnerable populations.
- Ensure adequate numbers of skilled health workers in every district, by prioritizing training, distribution and retention.

Specific actions for governments and leaders

All countries should:

- Identify inequities in coverage—by geographic area, ethnic group, income and the like—and initiate actions to provide universal coverage of essential interventions and packages.
- Identify gaps in coverage and quality of care along the continuum of care.
- Initiate actions to improve the delivery of essential interventions and packages.
- Increase resource allocations for reproductive, maternal, newborn and child health services, ensuring that interventions and programmes are sufficiently funded.

Parliamentarians should:

- Participate in national and local reviews of health MDG data to monitor progress
- Advocate for greater budgetary resources for maternal, newborn and child health and hold governments to account for meeting promised commitments.
- Review legislative frameworks to be sure evidence based policies for women's and children's health are adopted.

Countries on track to achieving their MDG4 and MDG5 targets should:

- Continue to improve coverage and maintain declines in child, newborn and maternal mortality.
- Ensure that all underserved populations are reached.
- Document and share experiences to show how effective policy changes, programme approaches and investments have helped improve maternal, newborn and child health.

Countries making progress towards achieving Millennium Development Goals 4 and 5 should:

- Identify high coverage interventions and document the approaches and investments that supported those achievements.
- Identify low coverage, but high impact, interventions in order to determine how best to provide additional attention and investment.
- Identify and overcome health system constraints and social determinants hindering high coverage.
- Broaden focus to reach underserved populations.

Countries not making progress in reaching Millennium Development Goals 4 and 5 should:

- Identify resource, health system and broader contextual constraints to high coverage.
- Develop national investment and implementation plans for scale-up of interventions proven to reduce maternal, newborn and child mortality.
- Learn from successful local programmes and global research findings
- Adopt and implement evidence-based policies.
- Utilize international expertise and resources.
- Focus on scaling up using innovative strategies.

Countries that have not adopted internationally recommended policies should:

- Review those policies in relation to their own policies and conditions.
- Act on policies that will contribute to improving reproductive, maternal, newborn and child health.

Specific actions for the international community

- Increase and better target donor funding for reproductive, maternal, newborn, and child health through innovative mechanisms and ensure that funding is predictable, consistent and responsive to national needs and plans.
- Support country efforts to improve data collection and analysis by strengthening health information and vital registration systems as well as by undertaking additional surveys to

measure mortality, coverage and financial flows.

- Invest in implementation research to identify effective strategies for delivering proven interventions and quantify their impact.
- Maximize financial and technical support for large-scale implementation of priority strategies and interventions.
- Encourage the development and use of mechanisms for holding key actors accountable for fulfilling their commitments.



Conclusion



Countdown to 2015: Tracking Progress in Maternal, Newborn and Child Survival was founded on a commitment by academics, governments, international agencies, health care professional associations, donors and nongovernmental organizations to work together towards achieving Millennium Development Goals 4 and 5. By monitoring country progress in the 68 countries that account for more than 95% of all maternal and child deaths and by noting changes in both mortality and coverage of effective interventions, *Countdown* calls attention to what can be achieved and highlights where countries, interventions and health systems have stalled.

This third *Countdown* report documents changes since 2000, a decade of rapid progress for a few countries and continuing improvements for many others. Despite these positive signs, some

countries have shown little or no improvement in mortality rates and coverage levels or have yet to adopt the policies or evidence-based interventions that save lives. This report explores coverage determinants—including health systems and policies, financial flows and equity—that help explain these differences and acknowledges the importance of social determinants to maternal, newborn and child health and survival.

Countdown partners must work together now to increase their efforts and resources, focusing not just on one intervention or cause but on developing a functional continuum of basic services that save lives and improve health for millions of women, newborns and children. There is still time. This report shows that, by investing our attention and our financial resources, so much more is possible.



Notes



1. You and others 2009.
2. Jones and others 2003.
3. Black and others forthcoming.
4. Black and others forthcoming.
5. Gwatkin and others 2007.
6. Rutstein 2005.
7. WHO 1985.
8. Wall and others 2009.
9. Mwansa-Kambafwile and others 2010.
10. Lawn and others 2010.
11. WHO and UNICEF 2009.
12. UNICEF and WHO 2009.
13. UNICEF, Roll Back Malaria, and The Global Fund to Fight AIDS, Tuberculosis and Malaria 2009.
14. WHO 2006.
15. WHO 2009.
16. Phillips, Bawah, and Binka 2006; Wakabi 2008; Douthwaite and Ward 2005.
17. Dovo 2004.
18. Pereira and others 2007; Vaz and others 1999.
19. WHO 2010.
20. Xu and others 2005.
21. WHO 2005b.
22. WHO 2005a.
23. Gonzalez-Pier and others 2007.
24. Parry and Weiyuan 2008.
25. Kagumire 2009.
26. Franco and others 2008.
27. Nabyonga and others 2005.
28. SUZY Project, ICDDR,B 2009 (personal communication).
29. Shankar and others 2008.
30. AbouZahr and others 2007.
31. WHO Regional Office for South-East Asia 2009.
32. South Africa Every Death Counts Writing Group 2008.
33. WHO and UNICEF 2004a, 2004, 2009.
34. Dawson and others 2008.
35. Koblinsky and others 1999, 2006.
36. Boerma and others 2008.
37. UNICEF 2007.
38. UNICEF 2007.
39. Bishai and others 2002.

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Errata: Countdown 2010 Decade Report

Page ii

Under the subheading, "Additional writing team," Nancy Terreri's affiliation should read "(FCI/PMNCH)."

Under the heading, "Acknowledgements," the first line should read "UNICEF/Statistics and Monitoring Section for use of global databases, preparation of country profiles and review of report text."

Page 24

In figure 12, note that for each country the left bar shows the most recent year with data on coverage values and the right bar shows data for a previous year.

Page 25

The last sentence in the third paragraph should read, "Median coverage of care-seeking was only 48% for the 64 *Countdown* countries with data available, while the median coverage of children with suspected signs of pneumonia who actually received an antibiotic was 27% in 35 countries with data."

Page 32

In figure 17, the subtitle should read "Mean coverage index, poorest and richest wealth quintiles, selected *Countdown* countries, various years (%)," and the note should read "Mean coverage index is based on coverage rates of eight maternal, newborn and child health interventions: met need for family planning, at least one antenatal care visit, skilled attendant at birth, measles vaccination, DP T3 vaccination, BCG vaccination, oral rehydration and continued feeding, and care-seeking for pneumonia."

After the printed report was produced, an error was detected in the formula used to calculate the average coverage by wealth quintile. For most countries and wealth quintiles, the errors were very small. Errors greater than five percentage points in one or more wealth quintiles were noted in the following countries: Azerbaijan, Democratic Republic of Congo, Egypt, India, Mali, Nepal, Pakistan and Rwanda. The country profiles available on the *Countdown* website have been corrected (<http://www.countdown2015mnch.org>).

Page 33

In figure 19, the subtitle should read "Average coverage levels of selected reproductive, maternal, newborn and child interventions, poorest and richest wealth quintile, 38 *Countdown* countries with data."

Page 37

In figure 21, the subtitle should read “Official Development Assistance to child health and to maternal and newborn health, all countries, 2007 (2005 \$billions)

In figure 22, the subtitle should read “Official Development Assistance, all countries 2003-2007 (2005 \$ billions)

Data specific to *Countdown* countries will be presented in the 2011 *Countdown* report.