Strengthening the Global Aid Architecture for Reproductive, Maternal, Newborn and Child Health: Options for Action

Key findings from report commissioned by

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The Partnership for Maternal, Newborn & Child Health

Prepared by

SEEK development

C. SCHRADE | STRATEGIC AND ORGANIZATIONAL CONSULTANTS

UCSF GLOBAL HEALTH SCIENCES

THE GLOBAL HEALTH GROUP

From evidence to action

The remit of this study was threefold

1. Assess alignment between:
   - **burden** of maternal and child mortality
   - **funding allocations**, and
   - **organization of global aid architecture for MDGs 4 and 5**

2. Consider **extent to which recent commitments effectively address weaknesses in aid architecture**

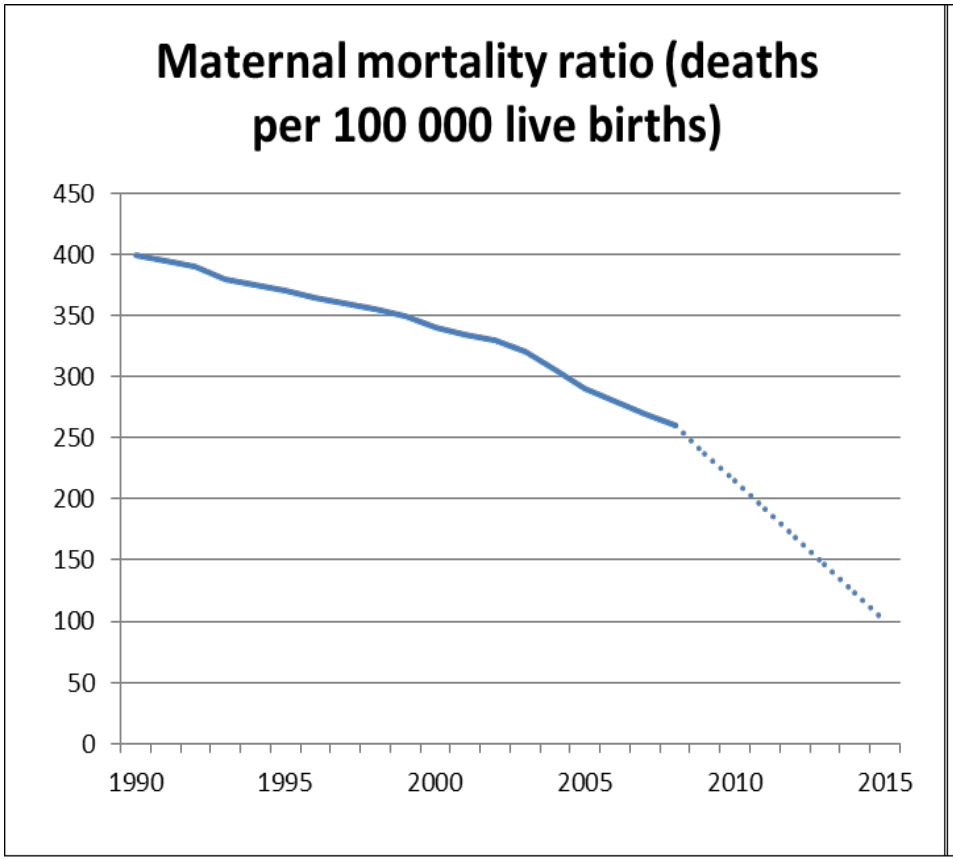
3. Set out **possible cost-effective options and recommendations to strengthen aid architecture** for MDGs 4 and 5

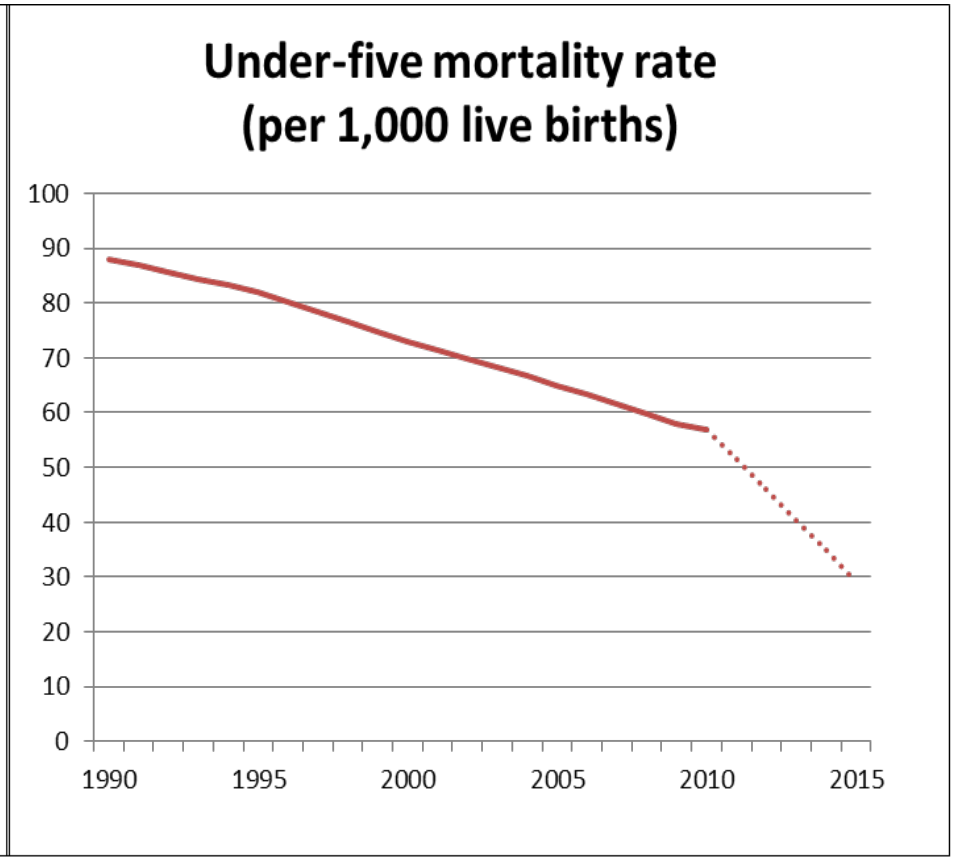
Methodology

- In-depth **literature review**
- 55 **key informant interviews** with broad range of stakeholders
- Analysis of OECD-DAC, IHME and Countdown **financing data**
- **Cost-Impact modeling** of options based on WHO data*
- Data limitations

* Data kindly provided by WHO's Department of Health Systems Financing

Progress is impressive, yet insufficient to meet MDGs 4 and 5





* Dotted lines show the accelerated rate of decline that would be needed to reach MDGs 4 and 5.

Source: WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990-2008; UNICEF: Levels and trends in child mortality 2011.

Six countries account for half of all maternal and child deaths

	Number of Maternal Deaths 2008	Number of Child Deaths 2009
INDIA	63,000	1,696,000
NIGERIA	50,000	861,000
DRC	19,000	465,000
AFGHANISTAN	18,000	191,000
PAKISTAN	14,000	423,000
ETHIOPIA	14,000	271,000
TOTAL	**178,000**	**3,907,000**

6 countries account for 50% of maternal deaths and for 51% of child deaths worldwide.

- Mortality highly concentrated in SSA and Southern Asia
- Progress slowest in Sub-Saharan Africa
- Increases in MMR in SSA strongly linked to high HIV prevalence

Source: WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990-2008; UNICEF: Levels and trends in child mortality 2011.

Three major coverage gaps along the continuum of care account for a significant degree of burden

1. Care during birth and the early neonatal period

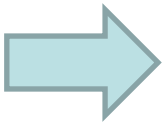
- Highest risk period for mother/baby
- Low coverage with key interventions; weak infrastructure and health worker crisis

2. Prevention and treatment of childhood pneumonia and diarrhea

- Only 27% of children with pneumonia and 42% with diarrhea receive appropriate treatment; coverage with preventive interventions also low

3. Family planning

- Contraceptive prevalence rate remains low - 31% in Countdown countries, 22% in SSA

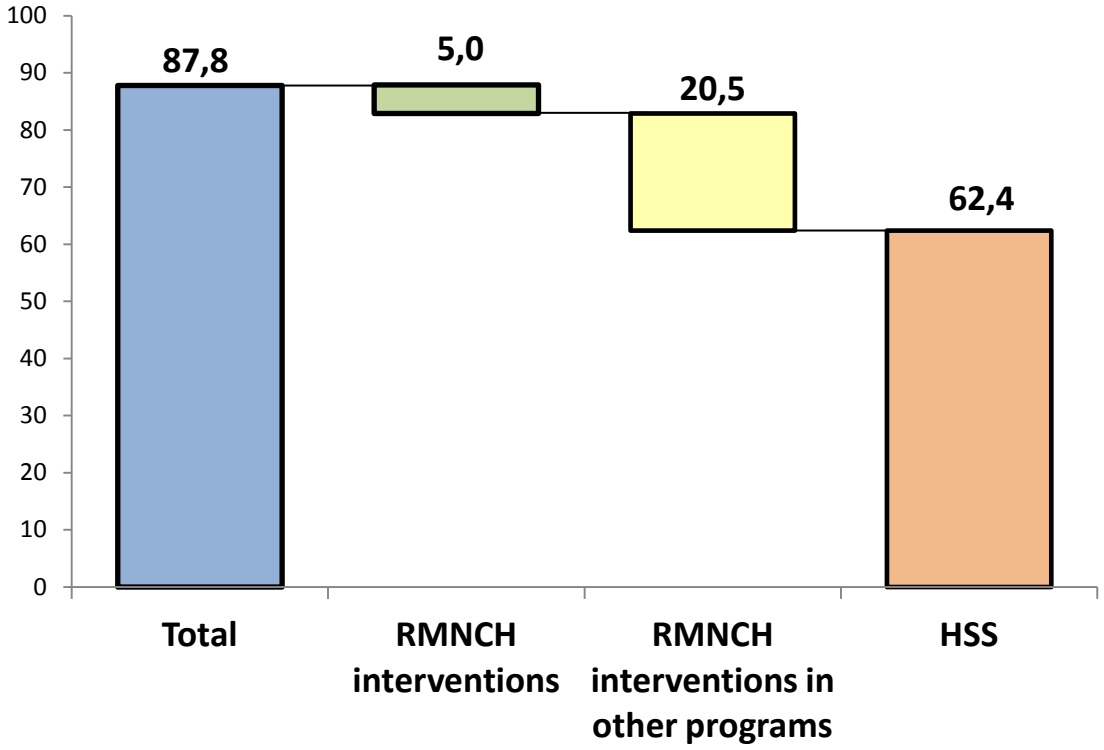


Levels of financing have been inadequate for closing these gaps

Source: Countdown to 2015 Decade Report

Total additional funding needs to reach MDGs 4 and 5 estimated at $88 billion by the Global Strategy

Breakdown of additional funding requirements (2011-2015)
in US$ billion



Note: Numbers do not add up due to rounding
Source: Global Strategy 2010.

RMNCH funding historically was not prioritized relative to other areas

- **Absolute funding levels increased** from $1.85 to $4.1 billion between 2003 and 2008; over half of it came through bilateral channels
- However, **RMNCH share of total health ODA remained constant**; funding for family planning decreased, from 8.2% in 2000 to 2.6% in 2009
- **Funding for HIV/AIDS grew much more rapidly** (from $0.2 billion to $6.2 billion between 1990 and 2008)
- **Child health expenditures** accounted for more than **two-thirds of all donor disbursements** to RMNCH
- Support **not highly targeted** to countries with the highest mortality rates and predictability low
- Funding for MDG 5 showed a **relatively high degree of fragmentation**

Source: Countdown 2010; IHME 2010; MDGs Progress Chart 2011.

Features that have contributed to poor alignment between RMNCH financing flows and needs

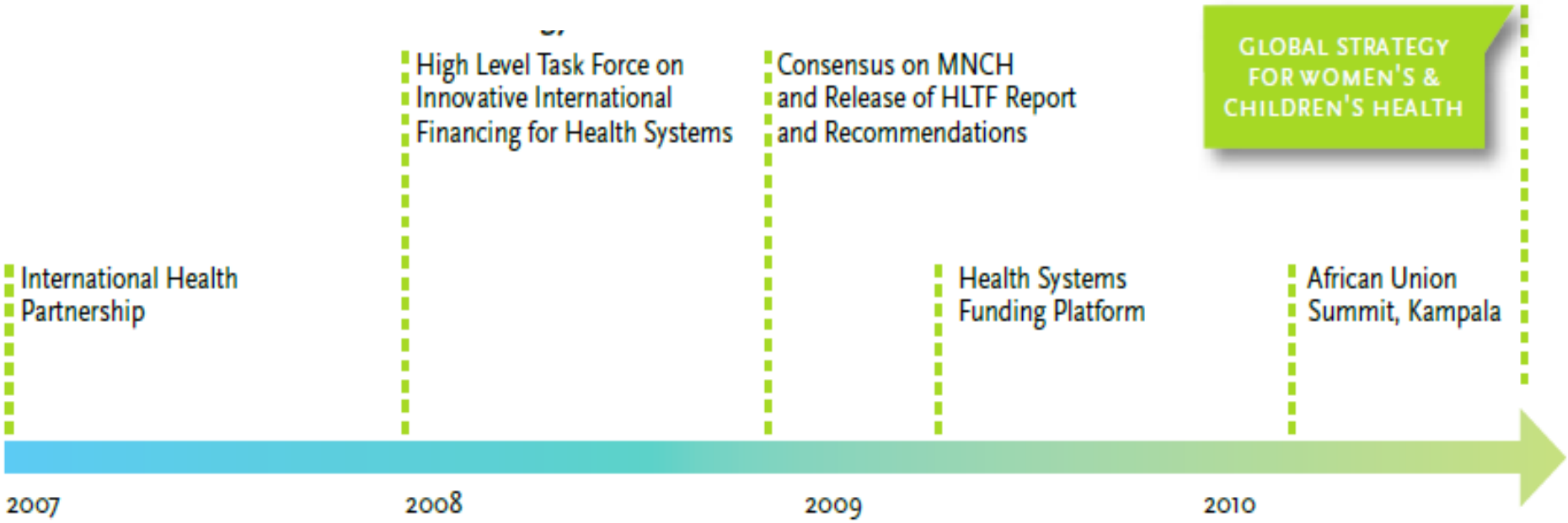
1. Lack of **a focused, coordinated approach to mobilizing and channeling resources** for RMNCH

2. **Few donors prioritized RMNCH and associated HSS in their bilateral funding** until very recently; family planning and reproductive health programs suffered particularly

3. Lack of **global tracking of RMNCH funding flows and results**

4. No clear **consensus on how best to strengthen and measure the success of health systems** to scale up RMNCH interventions

Recent efforts culminating in the Global Strategy have aimed at addressing these issues in the aid architecture



Achievements

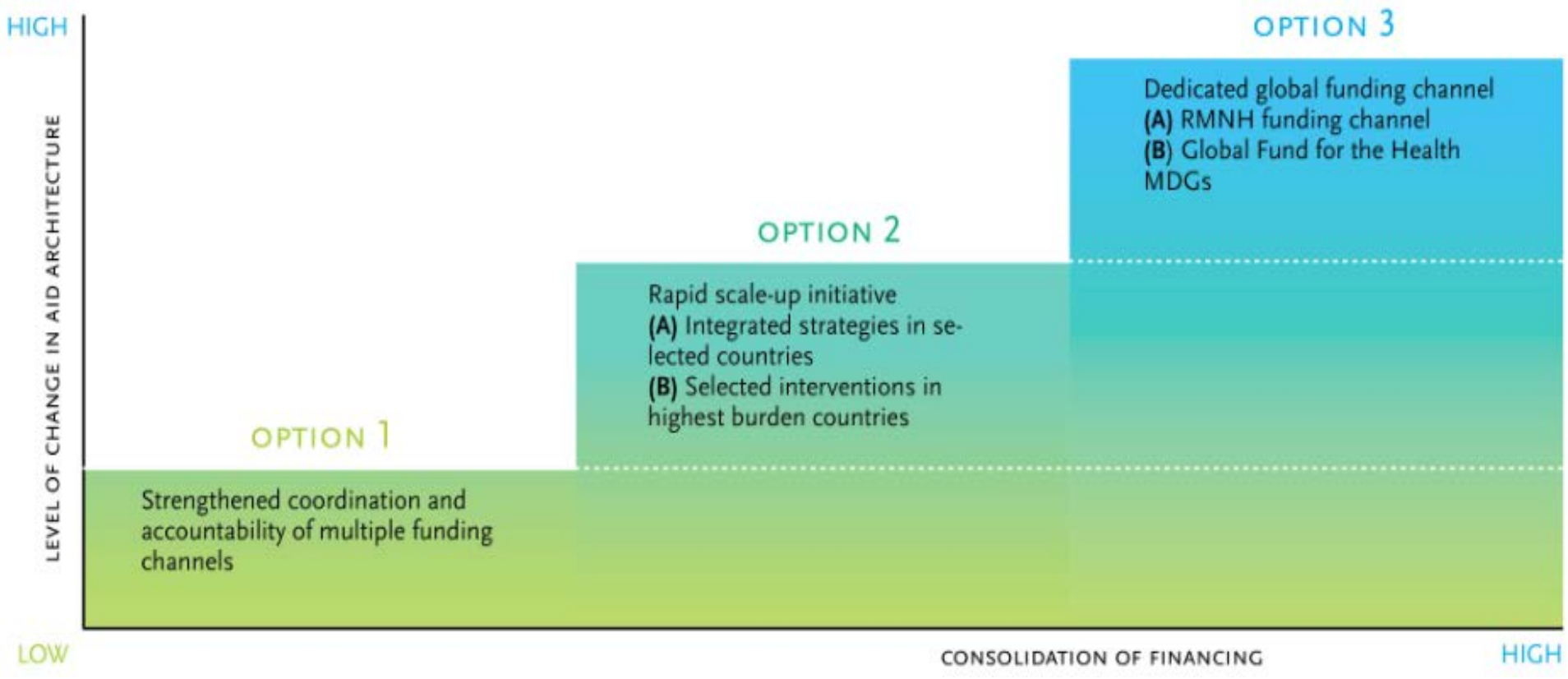
- ✓ Placed women and children on top of political agenda
- ✓ $43 billion in financial commitments from donors and recipient countries
- ✓ Additional service and policy commitments by a range of actors
- ✓ Commission on Information and Accountability

Source: Global Strategy 2010; PMNCH 2011.

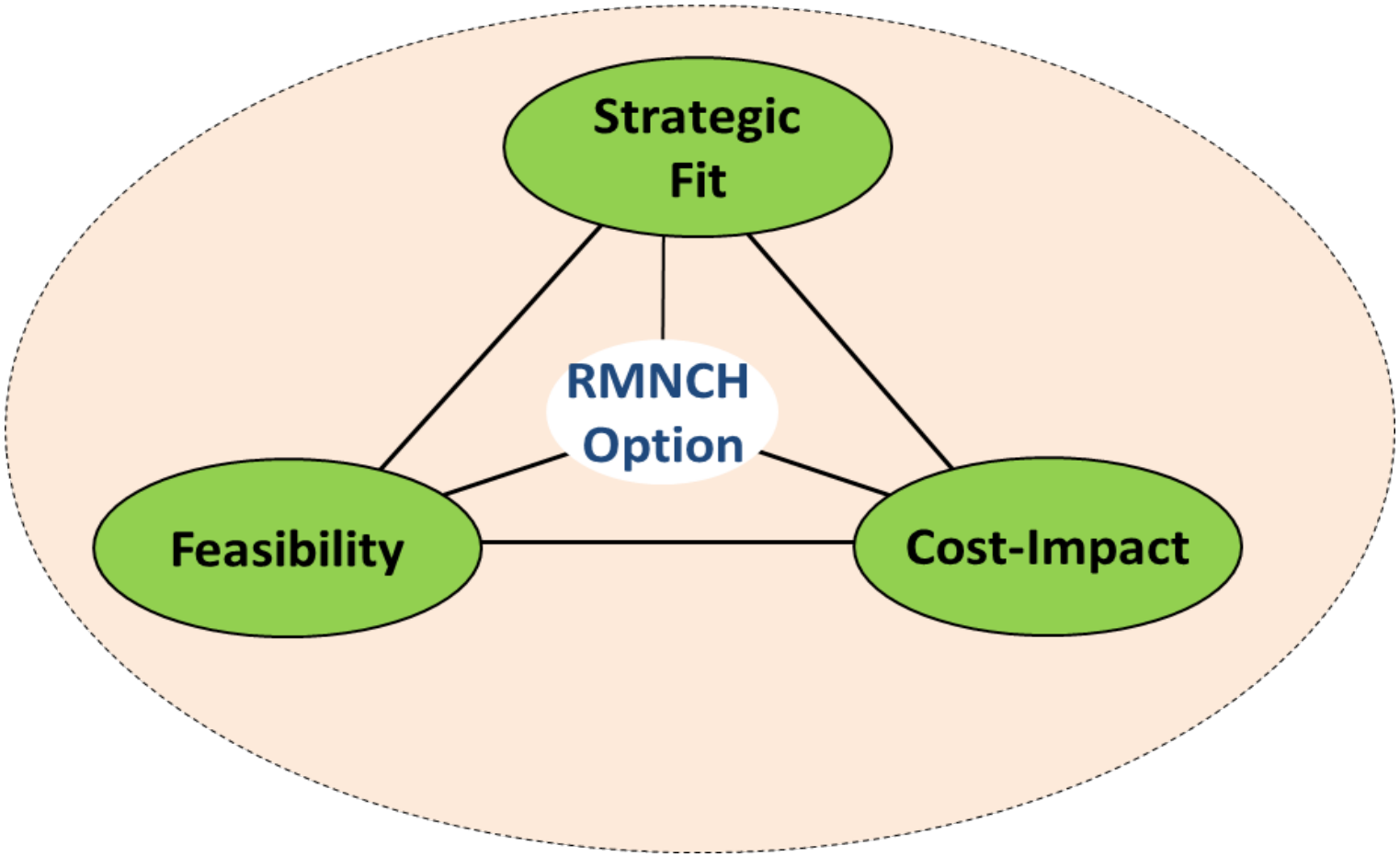
Despite critical importance of recent efforts, the global aid architecture still does not fully meet countries' needs

- Lack of strong **implementation architecture** for the Global Strategy
- Limited guidance on how additional resources will be **channeled** and how they can be **accessed** by countries
- No clear mechanism for **financing of high quality, jointly assessed national strategies** with strong RMNCH components
- **Fragmentation of financing** remains problematic
- No joint approach to ensure **improved targeting** of aid

Potential options for strengthening the aid architecture build on each other



Assessment framework for RMNCH architectural options



Option 1: Strengthen, fully leverage and improve accountability of existing mechanisms to finance RMNCH

Features

- Strengthen IHP+, H4+ and related **implementation/ support mechanisms** for Global Strategy
- Clarify **division of labor** and fully leverage **existing funding mandates** of multilateral financers
- Improve **coordination and transparency of bilateral funding**
- Explore greater role for UNFPA and UNICEF in **financing and/or procuring RMNCH commodities**

Strategic Fit

- Expanded World Bank role fits with latest strategy
- Global Fund and GAVI able to exploit financing mandates around RMNCH
- Unclear if IHP + could play stronger coordinating role (or who else in its absence)

Cost-Impact

- Modest cost to strengthen existing mechanisms; nonetheless, high overall investment levels required
- Could have substantial benefits for the health of women and children (impact hard to quantify)
- Not clear yet that will bring urgency, new resources, and strong leadership required to be a "game changer"

Feasibility

- Political support likely
- Unclear if stakeholders will make the changes to their operating/financing practices required for success

Option 2A: Targeted scale up integrated national health strategies in selected countries, in addition to Option 1

Features

- Embraces/ builds on Option 1
- Adds strategic initiative, focused on five high burden LICs with jointly assessed, national health plans
- Tests idea that access to pooled donor funding for RMNCH-related elements of these plans would enable rapid scale up
- Requires dedicated pool of funding, potentially hosted at World Bank
- Potential link to IDA funding to create leverage

High strategic fit with World Bank as agency to host funding pool (focus on RMNCH/HSS; lead partner within IHP +; HSFP)

Cost-Impact

- Moderate implementation costs (~$475-590 million) for initial 5 countries
- Impact in 5 countries could be significant

Feasibility

- High in initial 5 countries, but not necessarily in others
- Rigorous evaluation framework required to understand impact/value for money

Option 2B: Targeted scale up of selected interventions in limited number of highest burden countries, in addition to Option 1

Features

- Embraces/ builds on Option 1
- Adds strategic initiative to scale up selected high impact, low coverage interventions in LICs with highest mortality rates
- SBA, IMCI, Family planning
- Given synergies with current investments, initiative could (but does not have to) be hosted by the Global Fund
- Funding would be separate from/additional to the Global Fund's core mandate funding

High strategic fit with Global Fund existing investments and funding approach (but other mechanisms also possible)

Cost-Impact

- Initial implementation cost in 12 LICs comparable to 2A (~$520-650 million)
- Expected impact somewhat higher than in Option 2A and focused on countries without much donor attention

Feasibility

- Straightforward to implement (if applications outside Round system possible)
- Political support? - rapid implementation of Global Fund internal reforms required

Option 3A: Dedicated global funding channel for RMNH

Features

- Create a dedicated global financing channel for RMNH only
- Child health to be covered through existing financing arrangements - GAVI, UNICEF, GF, bilateral
- Hosting arrangements could include the World Bank, the Global Fund or UNFPA

Strategic Fit

- Strong fit with some aspects of Global Fund portfolio/approach, but changes to financing model, core structures, and Secretariat required
- Potentially stronger fit with World Bank as host

Cost-Impact

- High start-up costs; ongoing operational costs benefit from synergies with existing portfolio
- High program/HSS costs: ~$3.4-4.2 billion
- Impact on MDG 5 could be significant

Feasibility

- Low at this point in time, given operational constraints and lack of sufficient political support by donors

Option 3B: Creation of a Global Fund for the Health MDGs

Features

- Creation of a fully integrated global funding channel for *all* health MDGs
- Most likely through expansion of the Global Fund's mandate
- Other arrangements also thinkable, although rarely mentioned

Strategic Fit

- Strong in some aspects of Global Fund's current financing approach; significant changes required in others

Cost-Impact

- High start-up costs; medium-term efficiencies; very high program/HSS costs (~$7-9 billion in addition to MDG 6)
- Impact could be very high (up to 2.7 million deaths and 4.6 million unwanted births averted); initial scale up expected to be slow; aid effectiveness and accountability benefits likely

Feasibility

- Currently very low given current economic climate and ongoing reform efforts at the Global Fund

Conclusions

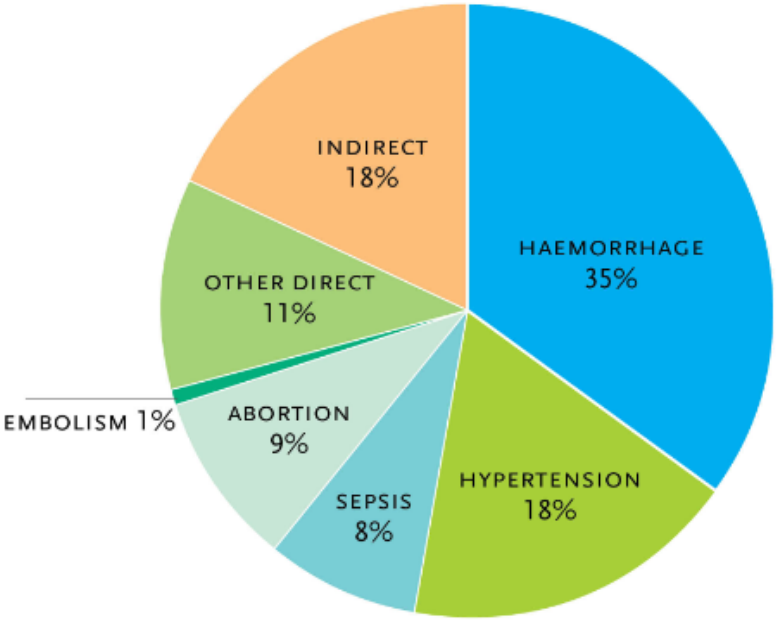
- **Option 1** should be implemented, but is it enough on its own?
- **Option 2** proposes a **pragmatic, strategically focused approach** to achieve rapid impact in selected countries at limited cost:
  - **blends Option 1 with one (or combination) of two rapid scale-up initiatives** (Options 2A/2B)
  - captures opportunities for increased **efficiency and accountability** while **testing innovative approaches** with high potential for impact
- **Options 3** appears not feasible at current point in time
- Gathering **structured input from key stakeholders to further develop and refine the options** could be useful next step

THANK YOU

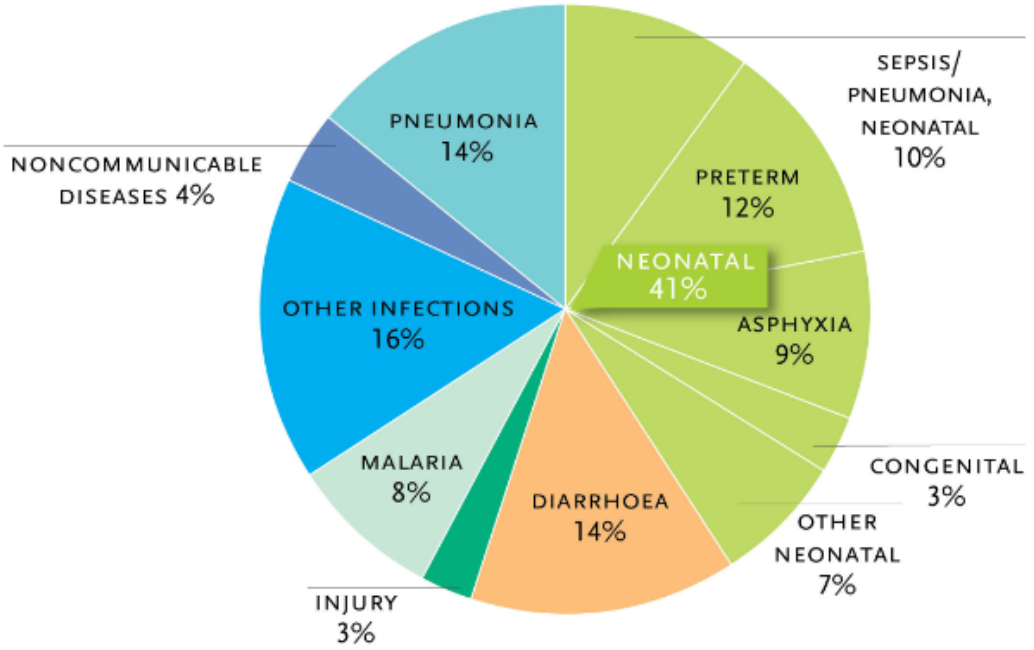
Backup

Most maternal and neonatal deaths occur during childbirth or the early postnatal period

GLOBAL CAUSES OF MATERNAL DEATHS, 1997–2007



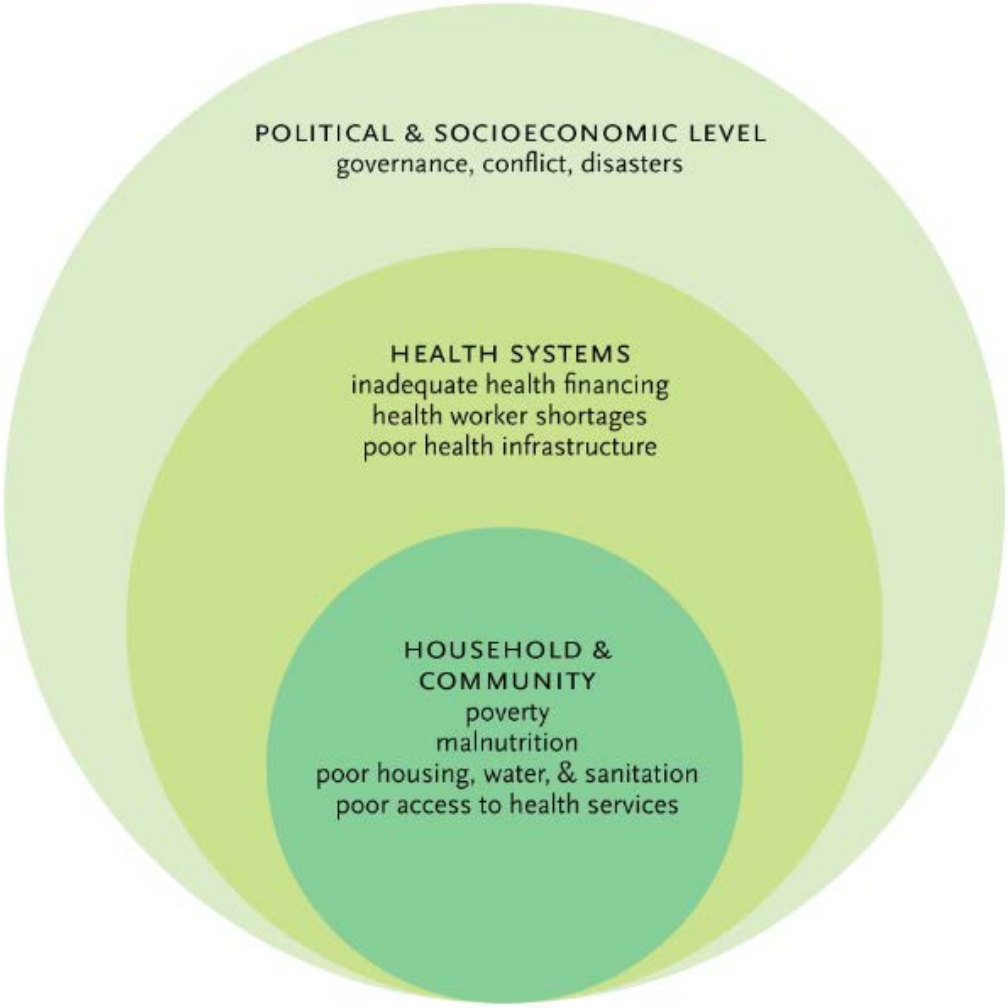
GLOBAL CAUSES OF DEATH AMONG CHILDREN AGES 0–59 MONTHS, 2008



Undernutrition contributes to one-third of child deaths.

Source: Countdown to 2015 Decade Report, 2010.

Underlying social and structural determinants at country level hinder progress towards MDGs 4 and 5



Country Spotlight: Liberia's mortality trap

EXTREMELY HIGH MMR, TFR, IMR, AND CMR

Political/socioeconomic: Recent civil conflict
Health systems: Fewer than 3 doctors per 100,000 population
Household and community: Ranks 165th out of 172 countries on the Human Development Index

Source: Countdown to 2015 Decade Report, 2010.

Domestic investments by Countdown countries alone will be insufficient to accelerate progress on RMNCH

- In 2008, 68 Countdown countries allocated **$58.5 billion** in domestic RMNCH financing
- **Lowest income countries**
  - Contributed $3.4 billion of this amount
  - Are expected to spend $2.4 billion on top of current funding levels on RMNCH between 2011 and 2015
  - Will continue to rely on external donor financing
- **Middle-income countries** could mobilize sufficient domestic resources to finance their own RMNCH needs (an estimated additional $59 billion between 2011 and 2015)
- IHME study suggests that health ODA provided to LICs in SSA is associated with these countries reducing their domestic spending on health

Source: Global Strategy 2010; IHME 2010

Three major coverage gaps along the continuum of care account for a high degree of burden

Coverage gap	Financing gap
Care during birth and the early neonatal period • Highest risk mortality period for mother/baby • Low coverage with interventions, e.g. in 68 Countdown countries, only 54% of women are attended by an SBA[8]	• Global Campaign for the Health MDGs estimates additional program/HSS costs of scaling up quality facility birth care in 51 countries at $2.4 billion in 2009, rising to $7.0 billion in 2015 (total of $33 billion would be required for 2009-2015)[20] • Over 50% would be for HSS (e.g. functioning health facilities, trained personnel) • Additional program costs for postnatal care are estimated at $216 million in 2009, and at $552 million in 2015[20]
Prevention and treatment of childhood pneumonia and diarrhea • In Countdown countries, only 27% of children with pneumonia and 42% with diarrhea receive appropriate treatment • Treatments can be safely delivered by CHWs[18] • Coverage with diarrhea prevention (e.g., hand-washing, rotavirus vaccination) is very low[19]	• Global Strategy estimates the additional program costs to scale up IMCI in 49 countries at $0.3 billion in 2011, rising to $2.7 billion in 2015 (excludes costs for malaria treatment)
Family planning • Contraceptive prevalence rate is only 31% in Countdown countries (rate in SSA is 22%)[8] • About 1 in 4 women have an unmet need for family planning	• Global Strategy estimates cost of scaling up comprehensive family planning in 49 lowest-income countries at an additional $1 billion per year from 2011-2015

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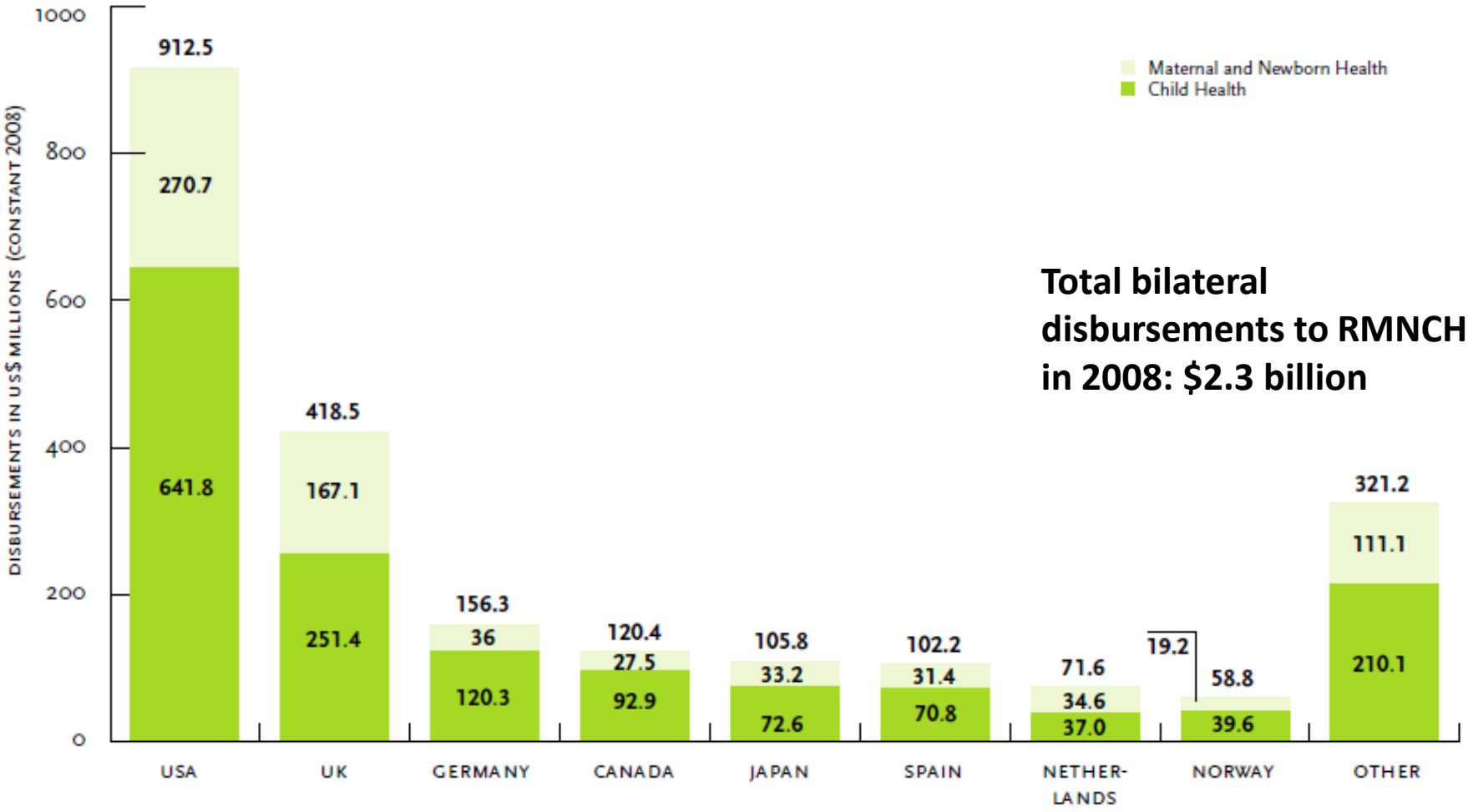
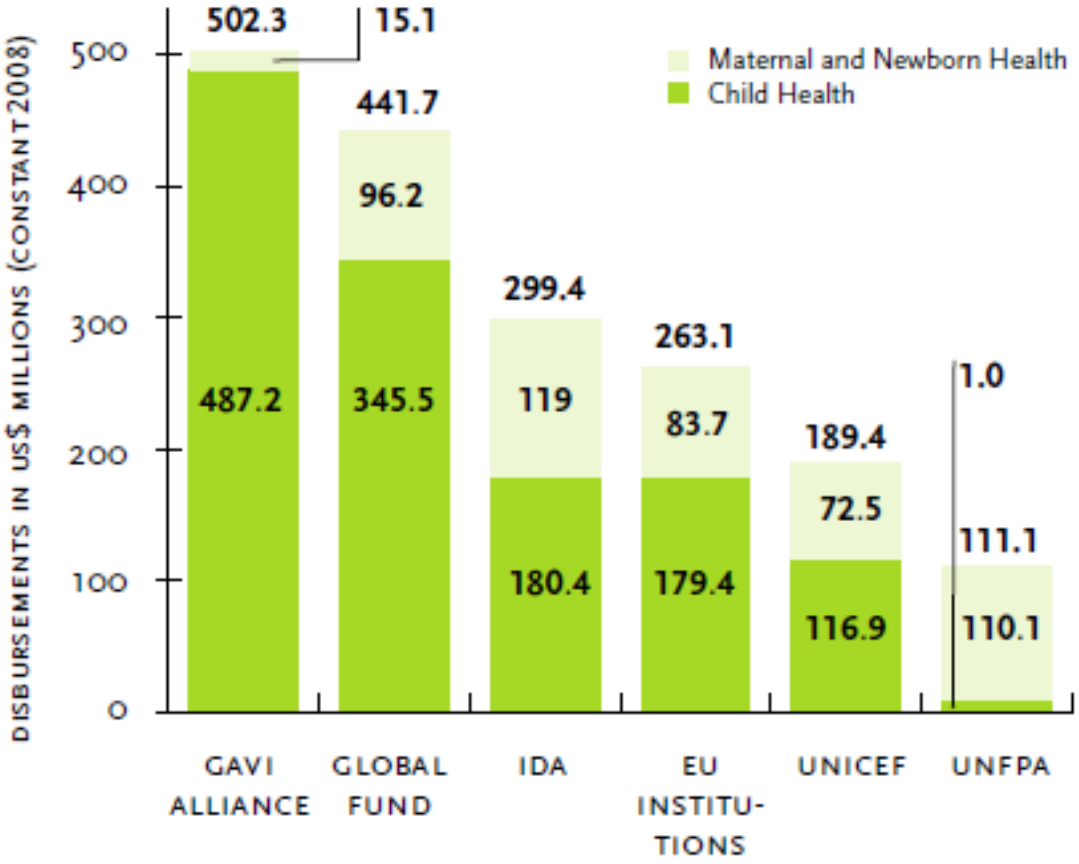
Bilateral funding for RMNCH is concentrated on a few key donors



Total bilateral disbursements to RMNCH in 2008: $2.3 billion

Pre-pregnancy activities such as family planning are not included. Source: Pitt et al. (2010).

Financing partnerships have become the largest providers of multilateral aid to RMNCH, with a strong focus on child health



Total multilateral disbursements to RMNCH in 2008: $1.8 billion

Pre-pregnancy activities such as family planning are not included. UNITAID and regional development banks are not included.
Source: Pitt et al. (2010).