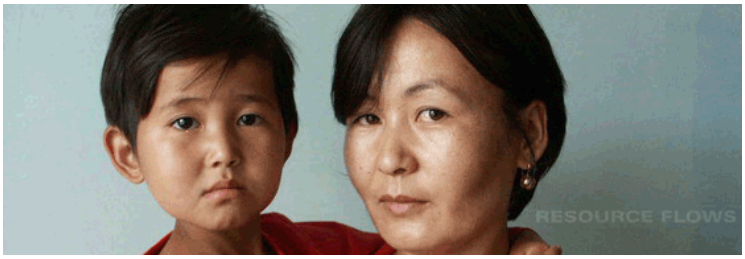


UNFPA/NIDI Resource Flows Newsletter, March 2012

The purpose of the UNFPA/NIDI Resource Flows Newsletter is to inform donor and developing country governments, public and private organisations, research institutes, universities and civil society about resource tracking for population and AIDS activities in general and the role of the Resource Flows (RF) project in particular.

The role of the Resource Flows project in the field of resource tracking initiatives for health

Over the years, numerous commitments have been made for additional expenditures on health. Most of these commitments have been based upon international agreements made during global events such as the 1994 International Conference on Population and Development and the 2010 UN Summit on the Millennium Development Goals (see box 1).. A major outcome produced at the previous summit entailed the dedication of stakeholders in raising an additional 40 billion dollars for improving maternal and child health.

In order to ensure such promises are actualized, resource tracking has proven to be an essential tool in improving transparency, tracking progress towards health goals, and creating the necessary information needed for the improvement of financial strategies and health policies.

Currently, several resource tracking initiatives are striving to hold organizations, donor countries, and developing countries accountable by closely monitoring their commitments. One such initiative is the Resource Flows (RF) project, a collaboration between the United Nations Population Fund (UNFPA) and the Netherlands Interdisciplinary Demographic Institute (NIDI). RF was established to track the commitments made during the 1994 International Conference on Population and Development (ICPD) in Cairo.

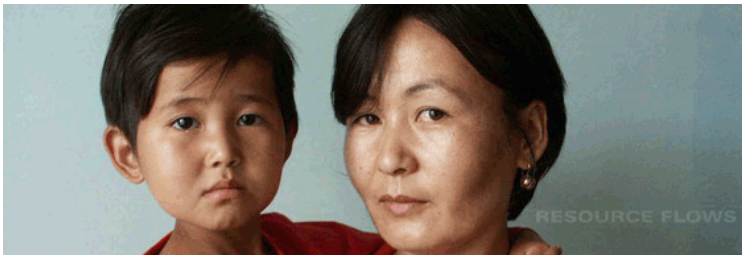
This Newsletter explores the role of the RF project in the field of tracking initiatives and its stance amidst others. It summarizes a larger RF report (Resource Flows, 2011) that builds on two previous reports; the RAND Corporation (2005)[4] and the the Center for Global Development (2007) [5]. While both provide extensive overviews of the tracking initiatives in the field of health, the RF report solely focuses on tracking reproductive health and family planning initiatives.

Further information on other initiatives was collected by exploring websites, reports, publications and methodology documents The focus was to identify the exiting gaps and overlap between the various initiatives, while also collecting missing information. Although we discussed important quality issues related to tracking resources, we averted from comparing initiatives based on data quality. Comparisons between figures are also hampered due to a wide variety in methods used.

This Newsletter firstly provides some background on the importance of resource tracking and data related issues. Second, the history, aims, and the methodology of the RF project are discussed. Subsequently, we look at other organizations active in the field of resource tracking in connection to reproductive health and family planning, and how these relate to each other and to the RF project, and compare them using several criteria. Finally, concluding remarks will pertain to the existing overlap and gaps found beween the initiatives, and to specifics on the RF project.

Background

In 2005, the RAND Corporation conducted an assessment of the current developments in global health resource tracking. RAND examined various initiatives active in the field of resource tracking for health, and explored possibilities for setting up a global system for tracking health resources [4]. A similar assessment was conducted a few years later by the Center for Global Development (2007), investigating how to make health resource tracking more effective [5]. Both reports produced a clear overview of the developments in tracking resources and data-related issues in the health field. Before discussing these issues, we will first present a few more general thoughts on health resource tracking.



Box 1: The ICPD and the MDGs

The International Conference on Population and Development (ICPD) was held in 1994. One of the conclusions of this conference was that population and development are closely related, and that empowerment of women and increased access to education and health are essential for development. The conference was concluded with a Programme of Action for the next 20 years. Important goals pertain to gender equality, providing universal access to education and reproductive health, and reducing child and maternal mortality [1].

The 1994 ICPD Programme of Action is closely interlinked with the Millennium Development Goals (MDG), adopted in 2000. During the UN summit on the MDGs in 2000 world leaders agreed to take action to reduce poverty, hunger and disease in the developing world by 2015 [2]. To achieve this goal, eight Millennium Development Goals were adopted [3]:

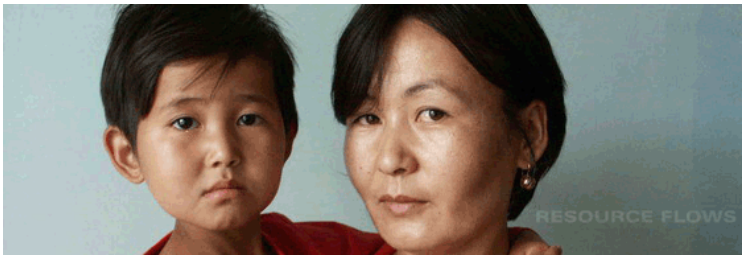
MDG 1: Eradicate extreme poverty and hunger
MDG 2: Achieve universal primary education
MDG 3: Promote gender equality and empower women
MDG 4: Reduce child mortality
MDG 5: Improve maternal health
MDG 6: Combat HIV/AIDS, malaria and other diseases
MDG 7: Ensure environmental sustainability
MDG 8: Develop a global partnership for development

Resource tracking follows funding flows for all aspects of the health system, including financial sources, recipients of these finances, goods, and services and the target population benefitting from these goods or services [4]. Initially, health resource tracking commenced with national surveys among several developed countries in the 1950s. Subsequently, similar surveys were also conducted in developing countries [6]. The first initiatives to systematically collect indicators on health financing came from the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO) [7]. The OECD was also the initiator of the System of Health Accounts, a method to collect country-specific health indicators in a more standardized way. In collaboration with the WHO and World Bank this framework was adapted and manuals were developed on how to obtain these Health Accounts [7]. In more recent years, resource tracking has increasingly been used for advocacy by showing that more money for health is needed and to hold donors accountable to their commitments. Conversely, donors also use these data to see where their money is going, and how to spend it more effectively [6].

Health resourse data are used for several purposes:

- By indicating how funding is spent and for which purposes, one can evaluate whether commitments are met and whether money is spent efficiently. It also shows whether funding is generated in a fair manner, i.e. the balance between funding generated by public, private and external sources. This is essential information to determining the sustainability of health systems. [6],
- By showing the gap between how much money is spent and how much is actually needed, additional funding can be raised. In this way, resource tracking can be used as a strong advocacy tool [6]. Looking at specific health topics makes it possible to identify areas that are underfunded [5],
- Preventing duplication of funding, thus making new funding more effective,
- Better information on health spending in relation to health outcomes will lead to better financing strategies and more relevant health policies. By complementing financial data with information on epidemiologic and demographic trends and health care utilization, it becomes possible to see how health funding relates to health outcomes and helps achieve health goals [5].

The various health-tracking initiatives all use different sources and methods to collect the data, which leads to a diverse range of available data. The reports by the RAND Corporation [4] and the Center for Global Development [5] provide a clear overview of the required criteria for producing data on health financing. Ideally, resources should be tracked for the complete health system, which includes funding from donor countries (including non-DAC countries), domestic funding from the public sectors in developing countries, private health expenditures, and out-of-pocket health expenditures made by individuals and households. Most of the initiatives in the field of research tracking focus on health funding from donor countries and a limited number of multilateral organizations [5] [6]. But other multilateral organizations, NGOs and private organizations should also be tracked more comprehensively.



Most importantly, domestic funding should be included as this remains the largest funding source whilst having limited information available. Additional information is also needed on public health expenditures within developing countries, likely also pertaining to lower regional and local levels [4]. To increase capacity-building, such data are preferably collected by developing countries themselves.

Data on health funding should be collected from primary sources in a manner which allows for country comparisons. National data should be complemented by primary data on private expenditures, including data on private organizations, firms and households, by using periodic surveys.

To be used optimally in policy making, it is important for financial data to be as complete and detailed as possible [1]. Data have to be disaggregated into specific health sectors, such as maternal health, and health oriented training, education and capacity-building [4]. Furthermore, to adequately respond to policy issues data need to be up-to-date and accurate [5].

An article by Schäferhoff et al. (2010) [8] specifically looked at resource tracking for Maternal, Newborn and Child Health (MNCH). They state that data on financing MNCH is not only hard to collect, but also that definitions and methodology to be used are debated. The WHO, for example, looks at how expensive it is to scale-up health systems to reach universal coverage, while the World Bank looks at how much it costs to overcome constraints in the health system. Both methods give a different estimate of the funding gap between the amount spent on MNCH and what is actually needed. To improve the availability and quality of data on MNCH financing, they recommend that data for MNCH should become available in a timelier manner. Timely data are needed to track commitments and to be more responsive to current policy issues. Donor countries should also improve data quality to make tracking of MNCH possible. It is suggested to include specific keywords for MNCH in the project description used for the OECD-CRS database, and to use allocation factors to estimate amounts spent on MNCH from integrated health funding [8].

RF project: Background

The project on Financial Resource Flows for Population and AIDS activities (in short, the Resource Flows (RF) project) was set up after the 1994 International Conference on Population and Development (ICPD) in Cairo. In the ICPD Programme of Action, funding commitments were accorded on how to reach the population and development targets set within the four main areas of population activities: family planning services; basic reproductive health services; sexually transmitted infections and HIV/AIDS; basic research, data, and population and development policy analysis. Additionally, in 2001 the United National General Assembly Special Session (UNGASS) called for increased development assistance for HIV/AIDS. The RF project monitors progress towards the commitments made during these meetings.

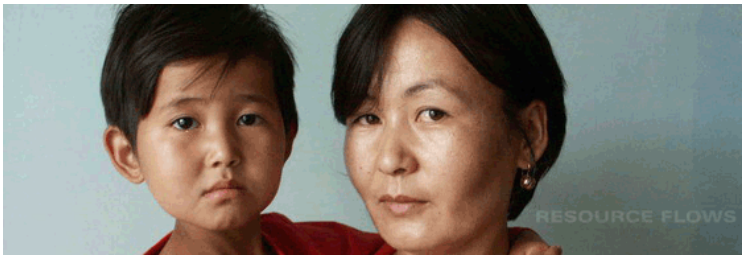
As mentioned, the project was started as a collaboration between the United Nations Population Fund (UNFPA) and the Netherlands Interdisciplinary Demographic Institute (NIDI) in 1997. The Joint United Nations Programme on HIV/AIDS (UNAIDS) participated in the project from 1999 to 2007. Capacity-building is one of the aims of the project, and to that end collaboration with institutes in developing countries has been set up [7]. Since 2005, the Indian Institute of Health Management Research (IIHMR, Jaipur, India) joined the project to work on data collection from developing countries specifically. Additionally, the African Population and Health Research Center (APHRC, Nairobi, Kenya) joined in 2011 as a representative of the African region.

RF project: Data

The core of the RF project consists of two surveys: one survey for donor countries and organizations, and the second targeting governments and organizations within developing countries and countries in transition. Both surveys are disseminated annually, and collect financial data for population activities at the project level.

The donor questionnaires are sent to countries that are member of OECDs Development Assistance Committee, multilateral organizations, foundations, NGOs, and development banks. Each year, about 130 key organizations are selected, representing the majority of expenditures on population activities [7].

These organizations are asked to provide both aggregated and specific (at project level) data, a method used to avoid double-counting and obtain detailed information. The RF project not only looks at project expenditures, but also tries to track general expenditures, i.e. unearmarked funding given to multilateral organizations. Since this kind of funding is beneficial for several health sectors, it is much harder to track.



To gain insight into the current financial flows within developing countries, a 'domestic questionnaire' was developed and sent to developing country governments and national NGOs with the help of the local UNFPA country office. A representative of this country office is also asked to fill in a questionnaire providing an overview of the country's total financial flows, including funding from donors, national governments, and private funding by residents. Since UNAIDS already collects data on domestic spending on HIV/AIDS via the National AIDS Spending Assessment (NASA), the domestic questionnaires ask about population activities excluding HIV/AIDS. The NASA is a survey on financial flows for AIDS within developing countries, and in order to avoid collecting the data twice, domestic spending on HIV/AIDS is collected directly from UNAIDS.

The current sample consists of about 105 countries, partly selected on the basis of population size, data availability and geographical balance.

Both the donor and domestic questionnaires ask about spending on four areas of population activities distinguished by the 1994 ICPD Programme of Action:

- Family planning services,
- Basic reproductive health services,
- Sexually transmitted infections (STDs) and HIV/AIDS,
- Basic research, data, and population and development policy analysis.

Basic reproductive health services and STDS/HIV/AIDS are further divided into subcategories to record information in even greater detail, and to respond more closely to the information needed for the Millennium Development Goals (MDGs).

In both surveys, special sections are included with questions about future expenditures referring to the next two years. If such estimates are impossible, respondents are requested to indicate whether expenditures are expected to increase, decrease, or stay the same in the next two years, which allows for up-to-date information.

Where does RF stand when compared with other initiatives?

When the Resource Flows project started in 1997, it was still one of the few initiatives collecting data on health financing, especially in the field of reproductive health and family planning. By now, there are several other initiatives active in the field of health resource tracking.

Specifically, the growing attention towards improving women's and children's health (MDG 4 and 5) has recently led to a number of new initiatives tracking funds for MNCH.

In order to understand the RF project's role amidst other initiatives, it is important to assess the scope of the activities in detail. In other words: what exactly is the niche of RF, and to what extent is this comparable to other initiatives' interests and data? To answer these questions, a summary of several important issues presented in the larger 2011 RF report will be provided.

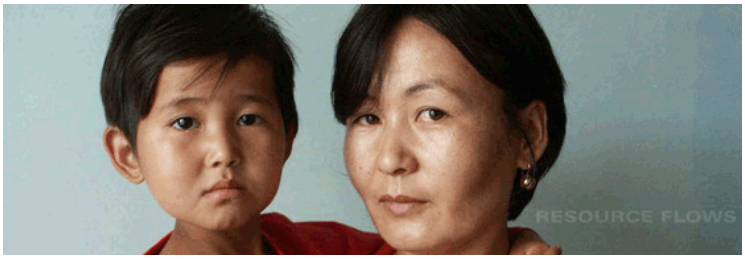
There is a wide scope of initiatives, ranging from large international organizations such as the OECD, WHO, Pan-American Health Organization (PAHO), and World Bank which collect data on a large range of topics including health resource tracking, to smaller organizations such as RF, which are mainly interested in reproductive health topics and the funds involved, including: G8 Muskoka [12], Partnership for Maternal, Newborn and Child Health (PMNCH), Countdown 2015, and Global Strategy. Other initiatives, such as AidData, Kaiser Family Foundation (KFF), Institute for Health Metrics and Evaluation (IHME) and USAID amongst others, also focus on RF issues to a certain extent.

Naturally, all these initiatives have their own way of collecting and processing the data. The following section will elaborate on the data collection process, the frequency of data dissemination, data coverage (i.e. identifying donors which fund reproductive health), data collection responsibilities (i.e. to what extent is data collection outsourced to domestic stakeholders), details of streams and funds, which health topics are covered, the type of output, and disbursements vs. commitments.

Data sources

The OECD is still the leading source of data on health financing. OECDs Creditor Reporting System (CRS) database shows health financing on a project level, presenting information on receiving countries and purpose. Data are collected directly from DAC countries and several multilateral organizations. Data are also available for a few non-DAC members, who provide their data on a voluntary basis [14]. The CRS database is a much-used source for most of the other initiatives.

Some of the other initiatives conduct analyses on original CRS data (KFF) [12,13], while most others reclassify the codes or allocate specific amounts for maternal and child health (Aiddata, Countdown 2015, IHME, RF).



Because the OECD aggregates data to broad health subsectors, whereby only one subsector can be chosen, their categorization does not give detailed information on the precise project aims. Some organizations collect additional financial data from project documents and financial reports (e.g. AidData, Countdown 2015 and IHME) [9] [17] [25], or from other existing sources like IMF or WHO (like IHME) [25]. Only a few initiatives, such as AidData, IHME, and RF, contact donors directly.

The National Health Accounts (NHAs), initiated by the WHO (and the PAHO), and based on the System of Health Accounts (SHA) developed by the OECD [26], are the main source for domestic data. Also the World Bank is involved in the NHA coordination, and show results in their database. Most initiatives considering domestic expenditures use NHAs as a main source, while IHME uses WHO data (mainly based on NHAs) and IMF data. The RF project collects its own data on domestic funding via a survey sent to developing country governments and NGOs, accompanied by a survey on the national budget showing aggregated flows of donor, public and (if available) private spending. Some initiatives also include non-financial indicators to show progress made in improving maternal and child health. These indicators come from a wide range of sources such as the World Bank, UNICEF, WHO and national surveys like the Demographic Health Survey (DHS) [17]).

Organizations included

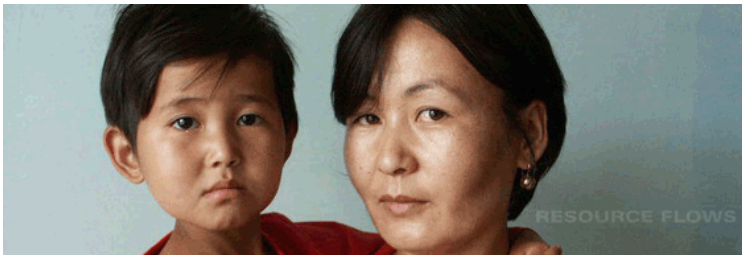
The OECD databases include data from their member organizations, including 23 donor countries (DAC countries), the European Commission, multilateral organizations (mainly UN agencies), development banks, and recently the Bill and Melinda Gates Foundation. No data are collected from other foundations or NGOs. Information on non-DAC countries remains limited, but some non-DAC donors provide data on a voluntary basis [14]. As the OECD CRS database is the main source, most initiatives include the same organizations as the ones included by the OECD. Also the larger initiatives like WHO, PAHO and the World Bank make use, next to their own data-collecting work, of data gathered by or in cooperation with the OECD. Only a few organizations include funding from additional NGOs and foundations. The PMNCH monitors commitments made by the partner organizations (including NGOs) [16], partly through the network of the Countdown 2015 initiative.

The Global Strategy also involves commitments made by NGOs, health professionals and academics that agreed to contribute funding to maternal and child health [21]. Their commitments are tracked to hold them to their promises. Both the IHME and the RF project track funding from a large group of foundations and NGOs. The IHME only tracks foundations and NGOs that are based in the United States (US) (due to data availability), while the RF project also collects data on NGOs and foundations beyond this country. Organizations working on NHAs track domestic funding by collecting data from several actors in the field of health. This includes not only governmental expenditures and donor funding, but also health financing by institutional health providers, private national agencies, individuals and households [27]. The RF project collects domestic funding from governments and from local NGOs and foundations. If available, information on private spending is also collected, but only on an aggregated level. Therefore detailed figures for expenditures by individuals and households as collected by the NHAs are not available.

Frequency of data dissemination

Most initiatives provide annual data, where highlights are often presented in annual reports. The WHO, OECD, and World Bank continuously attempt to enlarge the scope of their databases by adding more indicators as well as providing longer and up-to-date time series. But, for detailed health resource tracking time horizons are normally short. RF seems to be a favorable exception, since the project collects data on project level from 1997 onwards.

Depending on the scope of the data collection and the moment updates become available, initiatives work continually on the dissemination of new data, or may concentrate on online updating once a year. Some data can only be updated after new surveys have been conducted, which may only take place once every two years or even less frequently. To overcome the lag in time between collecting the data and final publication, some organizations estimate future funding based on projections, which allows for an improved understanding of current issues. Both the RF project and IHME use projections to estimate expenditures for the upcoming two years [25]. Countdown 2015 includes a large time span and makes projections up until 2015 [17].



Data coverage

When looking at donor funding, all tracking initiatives include funding from the DAC countries. The CRS database only includes those developing countries that are identified by the OECD as eligible for Official Development Assistance (ODA) [14].

Most of the other initiatives also use this classification for the developing countries included. Some organizations focus on specific groups of developing countries, based on their characteristics. The PMNHC and Countdown 2015, for example, focus on 68 high-priority countries (countries with high maternal and child mortality rates [17]), while the priority countries for the Global Strategy include the 49 lowest-income countries [22].

USAID also has a particular focus on a selection (about 50) of specific developing countries. PAHO collects data specifically for countries in Latin America. The WHO collects data on their 193 Member states, both developed and developing countries. Since the IHME also uses WHO data for part of their analysis, they include the same countries. However, because of data uncertainties, the data are aggregated into regional figures [24]. The World Bank includes data on the highest number of countries (209 countries).

Responsibility for data collection

Though accountability has been recognized as very important for resource tracking, many initiatives do not prioritize this. Most initiatives collect data directly from the OECD or other sources provided by developed countries. The amounts going to developing countries are then calculated based on these data. Hence, some initiatives like AidData, KFF and IHME do not gather data directly from domestic sources. Initiatives by the PMNCH do state accountability as very important in resource tracking. Countdown 2015 tries to encourage countries to collect the required data themselves, and become in that way more responsible for their own data collection [20]. The Global Strategy prefers data collected solely on the basis of national tracking systems [23].

The NHAs are coordinated by the WHO, but produced by the countries themselves (e.g. by a ministry) [27]. However, funds for producing NHAs still come from large organizations like the WHO or the World Bank. The availability of a NHA per country varies widely, as there are only very few countries where NHAs are produced on a regular basis. As mentioned, the RF project tracks domestic resource flows with the help of local UNFPA country offices. Data collection for developing countries is done by partner institutes in India and Kenya.

Details on funding and its flows

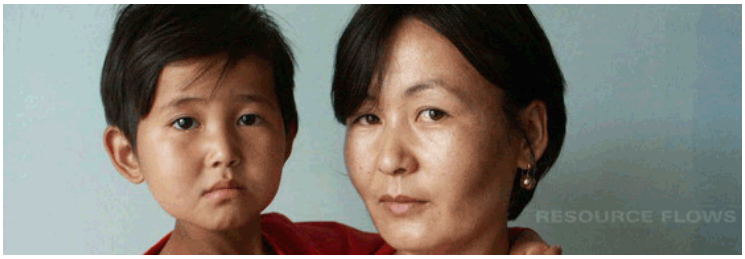
The CRS database (OECD) is a good source for data on health resources as it contains data on the project level. This is an advantage compared to the DAC database, which only has aggregate flows, as the CRS database provides users with ample information on e.g. receiving countries and project aims. However, their categorization includes only large subsectors of health, and does not give information on specific aspects like maternal health. Another disadvantage is that, to avoid double-counting, only one sector code can be assigned to each project [15]. When the project is beneficial to multiple sectors, the code of the sector receiving most funding is chosen.

The KFF uses the original CRS data to track funding on health, using four health sectors identified in the CRS database: health; population policies and reproductive health; social mitigation of HIV/AIDS; and water supply/sanitation [13]. This is one option, but several initiatives, including RF, choose to reclassify the projects making their aims more specific. AidData tries to overcome such limits by reclassifying the CRS projects based on activity codes, by using keywords in the project title or description. Their activity codes are much more detailed, and multiple activity codes can be assigned, showing all health sectors that benefit from the project [9]. Countdown 2015 and the IHME also reclassify their projects into wider subcategories using a keyword search on the CRS project data [18][19]] [25].

For data on developing countries, mainly aggregated flows are tracked. The WHO, World Bank and USAID all give indicators of resource tracking, but with little detail. The WHO provides more detailed information via the NHA country reports, but these details are not stored collectively in one single place / database. Still, NHAs remain useful for other organizations as it includes details on domestic spending, and private spending. The latter is rather rare, and includes out-of-pocket expenditures by both individuals and households.

Health topics

As was already indicated, there is a wide variety in health topics covered by the various initiatives. The OECD data includes a limited number of health sectors, 26 main sectors, each with subsectors [14].



The KFF uses the same classification, but most other organizations reclassify the CRS codes. The RF project, for example, uses the original CRS codes, but via percentages as allocation factors estimates are made about the amount going to the four ICPD categories. This classification into four ICPD categories is also employed in the RF survey.

AidData, Countdown 2015 and IHME reclassify the codes based on a keyword search, which enables them to also include topics like child health (AidData)[9], MNCH (Countdown 2015 [17]; IHME) and non-communicable diseases (IHME)[24] next to regular topics like HIV/AIDS, malaria and tuberculosis, already included in the CRS categories. Other initiatives, like the WHO and World Bank, include different indicators that give more information on a country's context (e.g. population numbers and GDP) and health status (e.g. mortality rates, risk factors and coverage of services). Yet other organizations look more specifically at the link between health financing and related health outcomes and health needs. This kind of analysis is mainly done by Countdown 2015 and the IHME [17] [24].

Data output

Most initiatives collect data mainly for publishing reports, tracking commitments, or policy making. The majority of organizations publish annual reports, while Countdown 2015 produces biennial reports complemented by research articles. AidData consists of an online database that can be used by policy makers and researchers, and its team produces additional papers and reports on development financing [10]. The OECD's main purpose is data collection, although they also publish reports on various development issues, including annual statistical reports on aid flows. Some initiatives present downloadable databases on health indicators like the WHO, World Bank and OECD do, although these provide more information on the country's health status than on health resource tracking.

Commitments vs. disbursements

Financial data can be collected in the form of commitments and disbursements. Commitments are "firm written obligations by a government or official agency, backed by the appropriation or availability of the necessary funds, to provide resources of a specified amount under specified financial terms and conditions and for specified purposes for the benefit of the recipient country" [13].

Disbursements can be described as: "the placement of resources at the disposal of a recipient country or agency, or in the case of internal development-related expenditures, the outlay of funds by the official sector" [13].

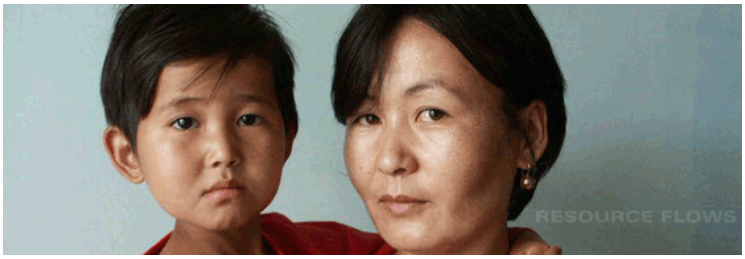
Commitments thus refer to the promise of funding, while disbursements are the amounts actually spent. Both ways of measuring funding have advantages and disadvantages, and which of the two is used depends on the specific initiative. The OECD collects information on both commitments and disbursements, but the CRS database does not have complete information on either of them for all years. The completeness of the CRS database is measured using the 'coverage ratio', i.e. checking the project data to figures of total funding. Despite detecting incomplete coverage, improvements have been made in recent years. The coverage ratio also varies for commitments and disbursements wherein commitments have a better coverage.

This is one of the reasons why some organizations, like KFF, include commitments instead of disbursements [11]. Still, most other initiatives base their analysis on disbursement data. Since this is the amount actually spent, it fluctuates much less than commitments. To overcome the problem of missing disbursement data when using the CRS database, IHME estimated disbursement data from commitments for several time series from 1990 up to 2002. Others provide the data for both commitments and disbursements (AidData and World Bank).

Conclusion

This Newsletter has shown that several initiatives are simultaneously active in the field of health resource tracking, even if a selection is made of initiatives relevant to population activities specifically. Some initiatives focus on several aspects of health, like the OECD, WHO, PAHO, World Bank, IHME, KFF and AidData, while others focus on specific subsectors, as for example maternal and child health (the Muskoka initiative, PHMNCH, Countdown 2015 and the Global Strategy).

As one of the initiators of resource tracking, OECD is still the leading data source on health financing. Some initiatives base their analytical work on the original CRS data, while others reclassify the codes using keywords, or by allocation factors to allow for more specific subsectors. Only a few initiatives collect information from additional NGOs and foundations.



For data on developing countries, the NHAs, mainly conducted by WHO are the main sources of information. The RF project also tracks domestic spending using questionnaires for national NGOs and governments, and overall national funding.

Data on health resources spending are not only of interest to donors and organizations in the developed world, but also to developing countries as these may help improve their health systems. Some initiatives, like the NHAs and Global Strategy, aim at setting up tracking systems that eventually allow countries to collect their own data. However, currently not yet many initiatives collect data from domestic sources, and they usually do not use local tracking systems.

In terms of RF's position amidst other initiatives, we mainly explored those involved in health resource tracking, covering reproductive health issues in particular, as these form part of the ICPD categories. It seems the RF project is unique in the sense that it is one of the first initiatives to collect data on population, producing longitudinal results on the ICPD goals. Additionally, it remains the only initiative which tracks the resources spent on ICPD goals, in which it longitudinally tracks both U.S and European NGOs, foundations, and other civil organizations, and additionally tracks primary data on domestic spending (also done by NHAs). An important limitation of the RF project is the lack of information on private domestic spending and out-of-pocket expenditures – both accounting for large sources of health financing in developing countries.

No less important, are similar initiatives such as PMNCH, Countdown 2015, IHME, and the Global Strategy which have emerged, tracking additional key information for achieving goals in the health field. Whilst Countdown 2015 aims to accelerate progress towards achieving the MDGs (in particular MNCH), the Global Strategy tries to unite actors to work in unison for improving women's and children's health through raising additional funding and developing integrated intervention packages. IHME tracks domestic governmental funding, general health funding, but also focuses on subtopics such as HIV/AIDS, MNCH, and others (similar to the RF project's focus). In addition, IHME is one of the few initiatives currently reporting on financing information by NGOs and foundation based in the U.S.

In the end, all initiatives should optimally strive to accelerate the achievements of the set (health) goals, and to make a valuable contribution in improving global health, working towards more transparent, effective, and accountable health financing systems is an invaluable step in this process.

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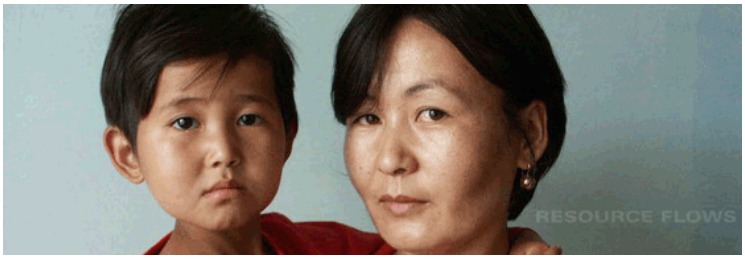

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