UNFPA
UNAIDS
NIDI

The Programme of action adopted at the 1994 international Conference on Population and Development (ICPD) in Cairo outlines specific funding targets to be met to achieve the ICPD population and development objectives. The declaration of Commitment on HIV/AIDS adopted at the 2001 United Nations General Assembly Special Sessions (UNGASS) on HIV/AIDS urges the international community to supplement the efforts of developing countries through increased international development assistance, particularly for those countries most affected by HIV/AIDS. The project on 'Financial Resource Flows for Population and AIDS Activities' aims at monitoring expenditures and future commitments for population and AIDS programmes in response to the ICPD and the UNGASS on HIV/AIDS.

The 'Resource Flows' Project is a joint collaboration between the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Netherlands Interdisciplinary Demographic Institute (NIDI).

Resource Flows NIDI P.O. Box 11650 2502 AR The Hague The Netherlands

Tel +31 (0)70 356 52 29 Fax +31 (0)70 356 52 99 E-Mail resflows@nidi.nl

www.resourceflows.org www.unfpa.org www.unaids.org

UNFPA/UNAIDS/NIDI Resource Flows Newsletter. October 2006

The purpose of the UNFPA/UNAIDS/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.

Financial Resource Flows for Population and AIDS Activities in 2004

International Donor Assistance for Population and AIDS Activities

International donor assistance for population and AIDS activities continues to increase. Data for 2004 point to an almost 20% increase in assistance from the previous year. Together with developing bank loans, donor assistance stood at USD 5.6 billion in 2004, up from almost USD 4.7 in 2003 (see Table 1). This represents almost 92% of the USD 6.1 billion target agreed upon in Cairo as the international community's share in financing the Programme of Action of the International Conference on Population and Development (ICPD) by the year 2005.

If the trend towards increased donor assistance continues, it is highly probable that the target for 2005 will be reached. However, it should be noted that the Cairo targets were fixed over ten years ago, with cost estimates based on experiences as of 1993. Since that time, the population and health situation in the world has changed dramatically. The HIV/AIDS crisis is far worse than expected and infant, child and maternal mortality remain unacceptably high in many parts of the world.

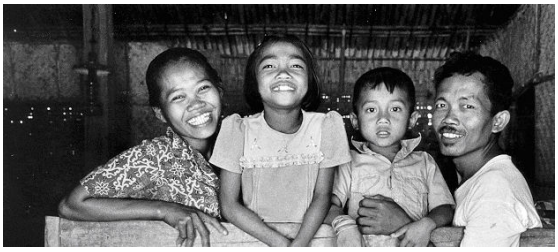
In addition, since that time, health-care costs have skyrocketed. Furthermore, the value of the dollar nowadays is far lower than it was in 1993. As a result, the ICPD target of USD 6.1 billion in 2005 for donor assistance will not be sufficient to meet current developing country needs in the area of population and AIDS.

Table 1: International population assistance, by major donor category, 2003–2004 (in millions US$)

Donor category	2003	2004
Developed countries	3,738	4,537
United Nations system	43	61
Foundations/NGOs	380	434
Development Bank grants	28	227
Total US$	*4,189*	*5,258*
Development Bank loans	501	361
Grand Total US$	4,689	5,620

Source: UNFPA (2005), *Financial Resource Flows for Population Activities in 2003,* and UNFPA, *Financial Resource Flows for Population Activities in 2004*, forthcoming.
Note: Totals may not add up due to rounding.

UNFPA
UNAIDS
NIDI



UNFPA/UNAIDS/NIDI Resource Flows Newsletter. October 2006

Distribution of International Donor Assistance

The Resource Flows project monitors expenditures for population and AIDS activities by the following four ICPD costed population categories:

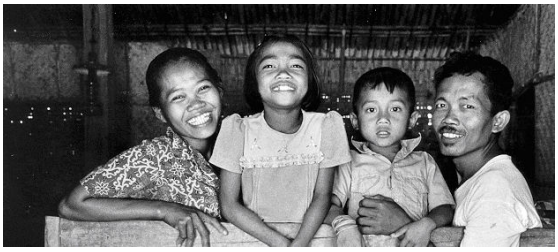
- family planning services,
- basic reproductive health services,
- STD/HIV/AIDS activities, and
- basic research, data and population and development policy analysis.

In recent years, there has been a pronounced shift towards funding for STD/HIV/AIDS at the expense of other population activities. In fact, the largest and increasing proportion of total population assistance is increasingly going to fund STD/HIV/AIDS activities. When the project first began to monitor expenditures by the four ICPD population categories in 1995, funding for STD/HIV/AIDS accounted for 9% of total population assistance; by 2004, it accounted for 54%. Consistent with the ICPD call for integration of services, funding for basic reproductive health services increased slightly, with fluctuations, from 18% in 1995 to 25% in 2004, while explicit funding for family planning services decreased significantly, with fluctuations, from 55% to 9% during the same period. Funding for basic research activities decreased with fluctuations since 1995, from 18% to 12% in 2004.

It is interesting to note that the adopted ICPD targets in 2005 called for 8% of total population assistance for STD/HIV/AIDS prevention activities, 62% for family planning services, 29% for basic reproductive health services and 1% for basic research, data and population and development policy analysis.

Given the increased emphasis on addressing the global AIDS pandemic, including the Millennium Development Goal of combating HIV/AIDS, malaria and other diseases and the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the United States President's Emergency Plan for AIDS Relief (PEPFAR), the shift towards funding for STD/HIV/AIDS is expected to continue. This funding is for prevention activities as well as treatment and care, especially substantial amounts of funding for anti-retroviral therapy. Since the Cairo financial targets include funding levels for prevention activities only, the achievement of the targets can be attributed in part to funding for anti-retroviral therapy. The accounting systems of many organizations make it extremely difficult to report on expenditures for prevention only.

There are fears that the larger share of funding that goes to AIDS activities might distract the attention for the necessary funding for the other three elements of the ICPD costed population package. This is especially evident in the case of funding for family planning, where absolute dollar amounts are lower than they were in 1995. If not reversed, the trend towards less funding for family planning will have serious implications for countries' ability to address unmet need for such services and could undermine efforts to prevent unintended pregnancies and reduce maternal and infant mortality.



Developments in Mobilization of Resources for Population and AIDS Activities

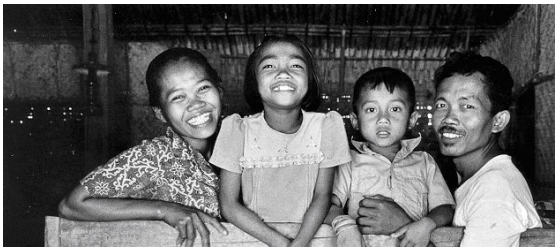
Considering the information on the past decade it can be said that there are a number of significant developments in the area of mobilization of resources for population and AIDS activities:

- There is a pronounced shift towards funding for STD/HIV/AIDS activities at the expense of other population activities
- A relatively small number of donors play a major role in population and AIDS assistance
- Current needs and costs are much higher than the original 1993 cost estimates
- The majority of global domestic resources are mobilized by a small number of developing countries and most countries cannot generate sufficient resources to fund their own population and AIDS programmes
- Out-of-pocket spending by consumers plays an important role in mobilizing domestic expenditures for population and AIDS
- Population and reproductive health are central to development and the achievement of the Millennium Development Goals (MDGs).

What do Households invest in Sexual/Reproductive Health and AIDS? The Case of Karnataka, India

Over the last year, NIDI in collaboration with the Centre for Multi-Disciplinary Development Research (CMDR, Dharwad, India), implemented a Reproductive Health sub-Account in the state of Karnataka, India. The accounting exercise included a household survey to assess the share of out-of-pocket expenditures (OOPE) in the total spending on sexual/reproductive health, including HIV/AIDS. Previous research indicated that these private payments are by far the largest source of funding of health services and goods in India. Estimates of the 2001-2002 India National Health Accounts suggest that households incurred no less than 98% of expenditures on overall health care activities. A study in Rajasthan found a corresponding estimate of 71% for the specific area of reproductive and child health.

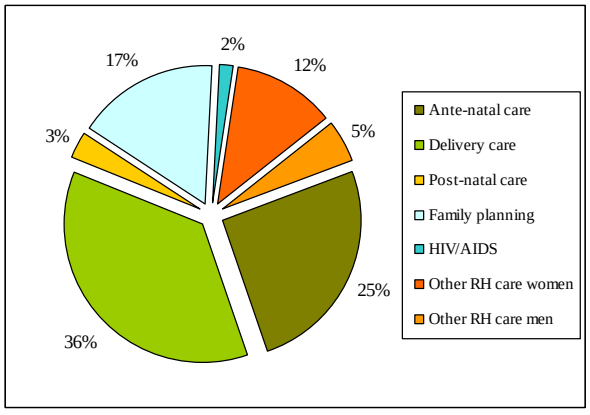
The Karnataka survey will not only reveal the share of household expenditure within total sexual/reproductive health expenditure in Karnataka, but it also gives an indication of the corresponding financial burden impressed on households. In addition, it highlights the specific areas within the reproductive health realm – e.g. ante-natal care or family planning – that embody most costs for households and the types of expenditures – e.g. costs for treatment or drugs.



Household Expenditure within the Sexual/Reproductive Health Realm: the Intervention Area

Provisional results of the survey show that household expenditure on sexual/reproductive health is largely for women: only 6% of all costs were incurred by men. As shown in Figure 1, delivery care represents the largest share of household expenditure on sexual/reproductive health (36%), followed by ante-natal care (25%).

Figure 1: Household expenditure by sexual/reproductive health intervention area



Family planning services accounted for 17% of household costs. Sterilisation – overwhelmingly female sterilisation – signified the major spending on childbearing regulation (29% of all costs related to family planning), whereas other means combined made up only 10% of all family planning related costs. A surprisingly large share (33%) was spent on services related to infertility. Equally surprising is the large share spent on pregnancy testing (28%).

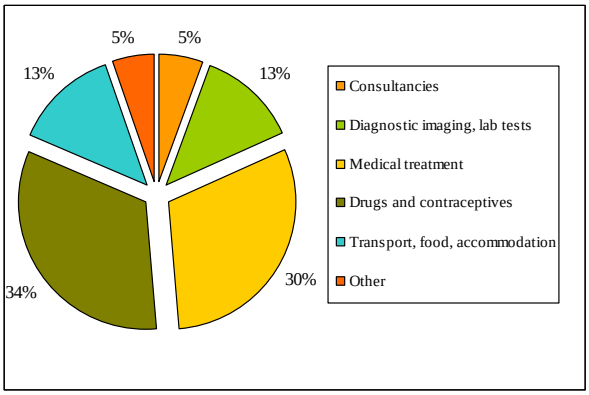
Costs for post-natal care and HIV/AIDS-related activities (mainly treatment of infections and HIV testing during pregnancy) were only minor expenditure categories.

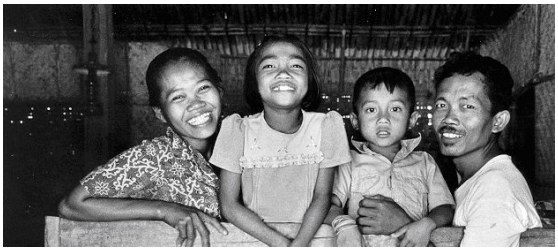
In the category 'Other reproductive health care for women', costs related to reproductive tract infections and cancers in the reproductive organs comprised the largest expenses (respectively 49 and 38%). Sexually transmitted and other reproductive tract infections accounted for almost all costs for 'Other reproductive health care for men'.

Household Expenditure within the Sexual/Reproductive Health Realm: the Type of Cost

With respect to the types of expenditure, nearly two-thirds of all household expenditure within the reproductive health realm was used to pay for medical treatment, and drugs and contraceptive commodities (Figure 2).

Figure 2: Household expenditure within the sexual/reproductive health realm by type of cost





The category of drugs and contraceptives represents the greatest costs for households in ante-natal care, in 'other reproductive health care' for men and women, and in the smaller area of HIV/AIDS activities. 'Medical treatment' represents the largest financial burden for delivery and post-natal care, whereas 'other' costs figure most prominently in the area of family planning due to high expenditures on pregnancy testing. Costs related to diagnostic imaging and laboratory tests (13% of all expenses) are a significant category in ante-natal care and, to a lesser extent, in HIV/AIDS-related services.

Households also incur substantial expenses for transport to health facilities, accommodation and food during treatment (13% of all costs, of which 93% for transport). The share of transport costs in overall expenditure is similar for female and male patients. However, for men almost all costs are spent on transport of the patients themselves, whereas for women the costs are equally divided between transport of patients and their accompanying attendants.

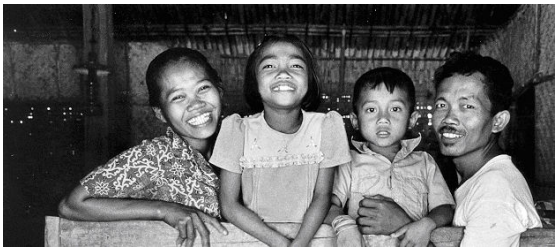
All together, the 2,502 surveyed households spent over 3 million Rupees on sexual/reproductive health services and goods in the year preceding the survey. This corresponds to Rs. 1,200 (USD 28) per household, which is around 4% of the average household income and consumption indices. A first rough estimation would indicate that all households together in Karnataka annually spend around Rs. 12 billion or USD 275 million on sexual/reproductive health, including HIV/AIDS.

The sample survey in Karnataka covered 2,502 households, of which 1,750 were located in rural areas and 752 in urban areas. Together, these households included nearly 14 thousand people. The head of the household and all (male and female) adults in the household have been interviewed.

Out-of-Pocket Expenditures on Sexual/ Reproductive Health and AIDS in urban Nepal

Studies have shown that household spending accounts for a substantial part of total financial resource flows on health world wide. Nepal is no exception (Hotchkiss *et. al.* 1998)[1]. These out-of-pocket expenditures on health – and specifically on sexual/reproductive health (RH) and HIV/AIDS – remain poorly visible in financial resource tracking efforts since they require specialized surveys. General income and expenditure surveys provide inadequate tools to measure these specific health expenses. To contribute to filling the gap, NIDI – in collaboration with the Center for Research on Environment, Health and Population Activities (CREHPA, Kathmandu) – conducted an out-of-

[1] Hotchkiss, D.R., J. Rous, K. Karmacharya, O. Sangraula (1998), Health expenditures in Nepal: Implications for health care financing reform. *Health Policy Planning* 13(4): 371-383.



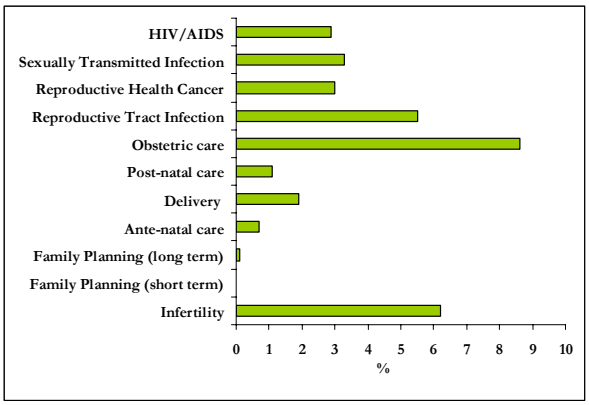
pocket expenditure study on sexual/reproductive health and HIV/AIDS in urban Nepal.
The study had two main objectives. First, the study aimed at assessing the financial burden of households and individuals for sexual/-reproductive health and HIV/AIDS in urban Nepal and examined levels of out-of-pocket expenditures on sexual/reproductive health and HIV/AIDS services and goods in relation to other household expenditures and wealth status. Second, research activities contributed to tracking financial resources in the health system in Nepal.

Field work of the OOPE-project in Nepal was carried out at the beginning of 2006. A two-staged cluster sampling technique, covering nine urban areas in all three geo-ecological zones, resulted in 1669 respondents from 992 households: 664 married women (15-49 years), 530 married men (15-59 years), 244 unmarried women (13-24 years) and 231 unmarried men (15-24 years). Households with persons living with HIV/AIDS (PLWHA) were selected on purpose with help from PLWHA Organisations. Out of 211 PLWHAs identified by these organisations 167 were successfully interviewed. 137 disclosed their HIV status in the questionnaire.

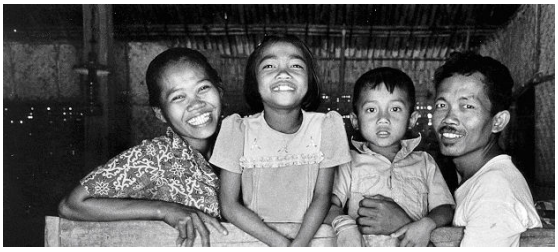
The financial burden

The financial burden of HIV/AIDS and sexual/ reproductive health intervention components is shown in Figure 3. Annual out-of-pocket expenditures are expressed as percentage of total annual household expenditure. Overall shares are 1.1% for sexual/reproductive health care and 2.9% for HIV/AIDS care. Households with one or more members having a maternal health problem requiring (emergency) obstetric services are worst off. Almost 9% of their total annual expenditure consists of payments for obstetric care, which is close to the 10% threshold that is somewhat arbitrarily defined by several authors as catastrophic payment.

Figure 3: *Annual Out-Of-Pocket Expenditure for HIV/AIDS and Sexual/Reproductive Services and Goods as Percentage of Annual Household Expenditure*



Surprisingly, out-of-pocket expenditures on infertility followed by reproductive tract infections are relative heavy burdens on total household expenditure. This is even more than for example households with a HIV infected person. The reason is that most services for HIV patients are offered free of charge, whereas this is not the case for infertility and reproductive tract infections. Similarly, most family planning services are without charge and thus its use hardly draws on the household budget.



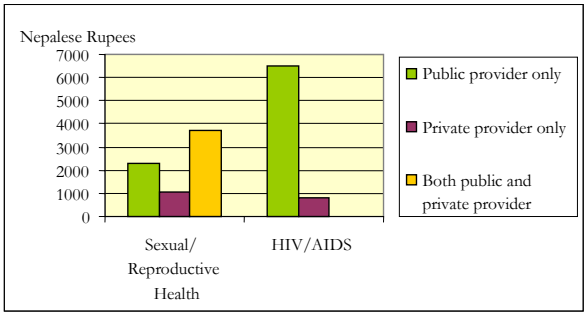
However, households that need to utilize a multitude of reproductive health and/or HIV/AIDS services due to multiple health problems of their members are expected to even pass the threshold for catastrophic payments. In rural settings the costs of transportation and accommodation of clients and their attendants are expected to seriously add to this.

Out-of-pocket spending on sexual/reproductive health care accounts for 13% of total health expenditure by the household. This is much more for households with HIV infected persons (34%). Spending on transportation by these households has a substantial impact on overall expenditure. Without the costs of transportation, out-of-pocket expenditure on HIV/AIDS care accounts for 20% of total health expenditure of the household. This would be 11% for sexual/reproductive health care.

Contribution to financial resource tracking

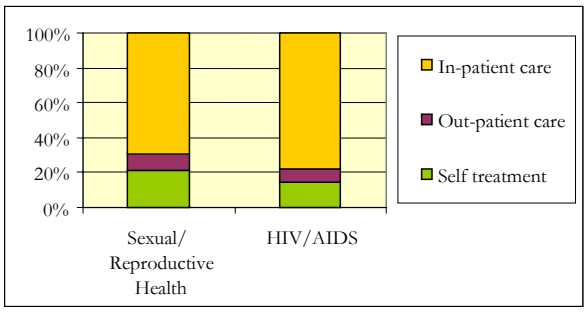
Results from specialized household expenditure surveys are a valuable direct input to resource tracking. Also, they have the potential to assess a level of detail usually not obtained from other sources, for example the costs of transportation or informal payments. Because surveys are subject to both sampling and non-sampling errors, in health accounting they are best used in combination with other data; for example data from health service providers, companies and funders. This process of triangulation and integrating data sources increases the validity and reliability of the accounting process.
This section shows survey results for overall out-of-pocket spending and by type of provider, type of care, type of expenditure and intervention area.

Figure 4: Annual Average Out-Of-Pocket Expenditure by Private and Public Provider (Nepalese rupees)



Total annual out-of-pocket expenditure for sexual/reproductive health and HIV/AIDS together for the survey population is NRs. 595,512 (8,362 USD), which is about NRs. 600 (8 USD) per household. Households that utilized any sexual/reproductive health service or commodity paid on average NRs. 1,720 (24 USD) per household. More than twice as much was paid by households that used any HIV/AIDS service or good (NRs. 3648; 51 USD). Because most HIV/AIDS services are offered by private non-profit facilities, the largest share of out-of-pocket payments for HIV/AIDS services is to public facilities. For sexual/reproductive health services the distribution is more even (Figure 4).

Figure 5: Out-Of-Pocket Expenditure by Type of Care



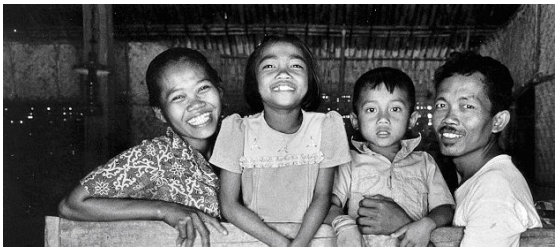
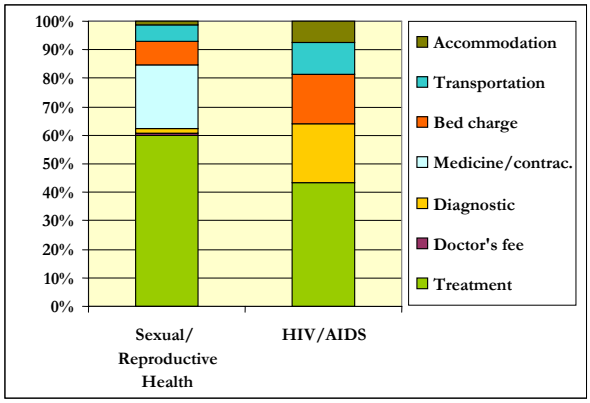


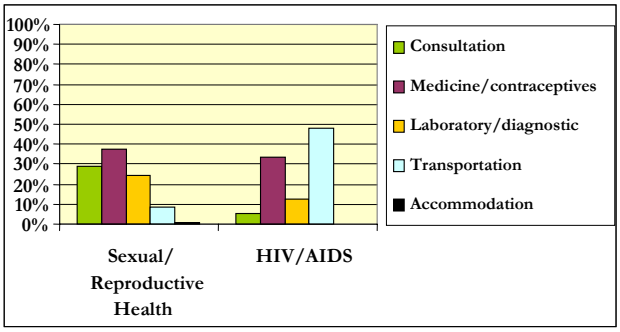
Figure 5 shows an almost similar distribution between sexual/reproductive health and HIV/AIDS by type of care. Not surprisingly, the largest share of out-of-pocket spending is on in-patient care. But still a substantial part of total expenditures is on self-treatment, which includes the purchase of non-prescribed drugs, traditional medicine and vitamins. Respondents did not report any costs related to home care.

Figure 6: Out-Of-Pocket Expenditure for In-patient Services and Goods



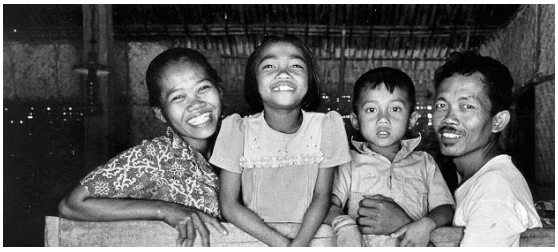
Out-of-pocket expenditure on in-patient reproductive health services is mainly determined by the costs of treatment and medicines. However, the composition is different for HIV/AIDS in-patient costs: expenditures on medicine are almost nil, and, next to treatment costs, one fifth of all payments are for transportation and accommodation of clients and their attendants, one fifth for bed charge and the last fifth for diagnostic and laboratory services (Figure 6). Both for in-patient as for out-patient services no informal out-of-pocket payments were recorded. This could be an artifact of the method used.

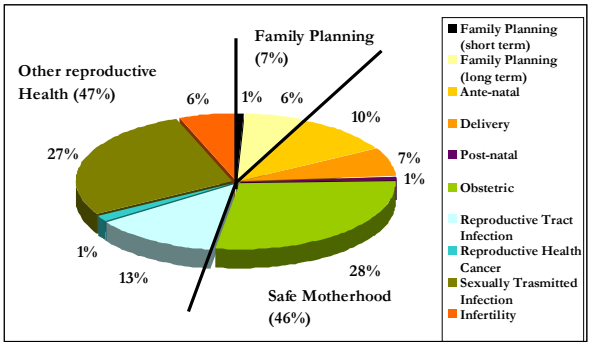
Figure 7: Out-Of-Pocket Expenditure for Out-patient Services and Goods



When studying the composition of out-patient expenditures for sexual/reproductive health and HIV/AIDS services, as shown in Figure 7, a considerable difference can be stated. Whereas average cost per household are almost similar (Rs. 1085 for sexual/reproductive health and Rs. 1292 for HIV/AIDS), households that used HIV/AIDS services spent less on consultation and laboratory fees, but relatively more on transportation of the patient and the accompanying persons. Almost half of all spending is on transportation.

Figure 8: Percentage distribution for Out-Of-Pocket Expenditure for Sexual/Reproductive Health Intervention Components





Lastly, the distribution of out-of-pocket expenditures among the intervention components of sexual/reproductive health is shown in Figure 8. Almost half of all out-of-pocket payments are on maternal health care, followed by expenditures on sexually transmitted infections and reproductive tract infections. Out-of-pocket expenditure on family planning services and goods is very modest. This is likely due to the low contraceptive prevalence rate in combination with the provision of free contraceptives and related services.

Conclusions

In urban Nepal, where health insurance coverage is very modest, out-of-pocket payments for sexual/reproductive health and HIV/AIDS services and goods may become catastrophic, especially when households are confronted with a multitude of health problems at the same time. Also, the financial burden on households becomes serious when private providers start charging fees for services that are presently offered for free, for example for HIV-infected persons; or when the costs of transportation become a large component of out-of-pocket expenditures, for example in rural settings.

Results from the present survey can be used as input into the triangulation process when embarking on a full scale reproductive health account and/or AIDS account in Nepal in the future.

The Resource Flows Newsletter is published three times per year. The next issue will be launched in late 2006. All newsletters will be posted on the Resource Flows website (www.resourceflows.org). If you have any comments or suggestions, please e-mail us at resflows@nidi.nl.