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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.

Mapping of reproductive health financing in developing countries: a way forward to achieve Millennium Development Goals

Since the early 1990s there have been continuous efforts to increase access to reproductive health (RH) services globally through several international initiatives. In September 2000, the countries of the world adopted the Millennium Declaration, a collective commitment to accelerate progress on human development, setting out eight Millennium Development Goals (MDGs), which they pledged to achieve by 2015. There are two RH-related MDG targets. First, MDG5A set at reducing maternal mortality by three-quarters between 1990 and 2015. Second, MDG5B aims at achieving universal access to reproductive health by 2015. Indicators used to measure progress in achieving MDG5B include contraceptive prevalence rates, adolescent fertility rates, antenatal care coverage and unmet need for family planning. It has been widely acknowledged that these goals can only be reached if there are significant improvements in reproductive health, especially in the poorest developing countries. Most families in this part of the world still have more children than they want. Women especially suffer from the lack of means to control their fertility, and many die young from causes related to maternal health. It is well evidenced that: i) poor reproductive health accounts for an estimated one third of the global burden of illness and early deaths among women of reproductive age (UNDP, 2006); ii) about 220 million women in developing countries still have an unmet need for family planning (Singh and Darroch, 2012); iii) about 47,000 maternal deaths annually (13 per cent of all maternal deaths) are due to unsafe abortions. Moreover, an estimated 21.6 million unsafe abortions took place worldwide and almost all in developing countries (WHO, 2011). Half way to 2015, a number of countries have been identified as not being on track to meet the RH-related MDGs.

More importantly, stagnant levels of funding have not kept pace with growing needs in developing countries, fueled by growing numbers of women of reproductive age and high levels of unmet need for family planning. National and international organizations are examining how efforts to achieve the MDGs and related targets can be made more effective. One way is to improve understanding and management of competing financial resources for health. Decision-makers need to know whether their country has adequate resources to achieve its RH related health goals. If there is a funding gap, can external resources fill it? And where are the resources going? In particular, what resources are earmarked for reproductive health?

Context of producing RH sub-account/country report

Looking at the challenges and need, the United Nation Population Fund (UNFPA) in collaboration with the Netherlands Interdisciplinary Demographic Institute (NIDI), endeavour to strengthen the institutionalization of country-owned systems to produce periodic reports that compare the need for sexual and reproductive health (SRH) funding at country level with the allocation of resources (domestic and external); actual expenditure and distribution of resources; as well as projected availability of resources (domestic and external) in the years ahead. Initially, an attempt was made to produce this report in two countries i.e. Bangladesh and Kenya, with a specific focus on the similarities and differences in their health system to manage funds for reproductive health. The assumption is that sexual and reproductive health and family planning related policy making, budgeting and planning by governments and other stakeholders at country level would benefit tremendously if quality periodic reports that compare the health sector funding needs with the allocation of resources (domestic and external), actual expenditure and distribution of resources as well as projected availability of resources (domestic and external) are made available on a

regular basis. These reports would respond to critical questions relating to the match between SRH policy priorities and actual expenditures, the predictability of funding for different SRH components, the availability of funds across the different levels of the health system, the equity and efficiency of health financing, etc.). The results of this report will also enable developed nations to identify priority areas in RH services, and decide how best to extend their support to address the key RH challenges.

Often, governments do not have the technical instruments they need to plan budgets that would allow them to achieve their RH goals. Civil society also lacks adequate information about where money is going, and is thus unable to lobby successfully for national and international funds to fill the gaps. The challenge is, therefore, to obtain information that will lead to more effective use of the resources available. Considerable value would be added if resource monitoring were done in a comprehensive and consistent way, with standard definitions that allow for internationally comparable time trends. Policymakers will require, on a regular basis, comprehensive data on the flows of RH funds in order to adjust policy to reflect the needs of the country and the current distribution of funding. RH subaccounts help to make more effective resource allocations in order to achieve better health outcomes. Information from Reproductive Health Accounts could help stakeholders in the following areas:

- Help to allocate resources more effectively and efficiently
- Inform planners and policy makers to address neglected priorities in RH
- Address gaps in financial resource needs for RH services
- Monitor the progress of programmes in a broader perspective

Empirical evidence from the Bangladesh country report

Bangladesh is a signatory of both the ICPD Programme of Action and the MDGs and the government set an ambitious agenda for improving RH services to achieve the targets by 2015. For the uniform distribution of resources, policymakers need to understand what is already being spent on RH and who is financing RH care, how much each financing source is spending and for what kind of services. This study is primarily based on a desk review that involves a thorough review of the available information from a variety of sources that includes, National Health Accounts, Demographic Health Surveys, published reports of various ministries, research studies on RH expenditures, etc. The core objective is to see the operational aspects of the health system to track RH funding at both micro and macro level. Also a critical analysis is done to see whether the existing financial status could sufficiently address the key RH challenges. Key results from the report are as follows:

Table 1. Millennium Development Goals (MGD 5: Improve Maternal Health), Bangladesh

Goals, Targets and Indicators	Base year 1990/1991	Current Status	Target 2015
Target 5 A : Reduce MMR by three quarters, between 1990 an 2015			
5.1 Maternal mortality rate, per 100,000 live births	574	194 (2010)	144
5.2 Proportion of births attended by skilled health personnel %	5.0	31.7 (2011)	50
Target 5 B : Achieve by 2015, universal access to RH			
5.3 Contraceptive Prevalence rate %	39.7	61.2 (2011)	-
5.5 a Antenatal care coverage (at least one visit)%	27.5	54.6 (2011)	100
5.5 b Antenatal coverage (at least four visits)%	5.5	25.5 (2011)	100
5.6 Unmet need for family planning %	19.4	11.7 (2011)	7.6

Source: Bangladesh Maternal Mortality and Health Care Survey (BMMS), 2010; Bangladesh Demographic Health Survey (BDHS), 2011

Current reproductive health status vs. MDG targets

Bangladesh is committed to achieve the MDGs set by the nation and is making continuous efforts in this direction. Table 1 gives an overview of MDG 5 in terms of base year values, current status and target for 2015.

Maternal mortality rate (MMR) declined from 574 in 1990 to 194 in 2010. Less than one-fourth of deliveries occur in health facilities, about half of them in public sector and the remaining half in private and NGO facilities (BDHS 2011). Nearly 32 percent of deliveries are attended by medically trained health professionals. Although 55% of women receive antenatal care (ANC) from a medically trained provider, only 26% complete the WHO-recommended minimum of four or more ANC visits (BDHS 2011). At the same time, the unmet need for contraception is significant and it has experienced an increasing trend over a couple of years (Figure 1).

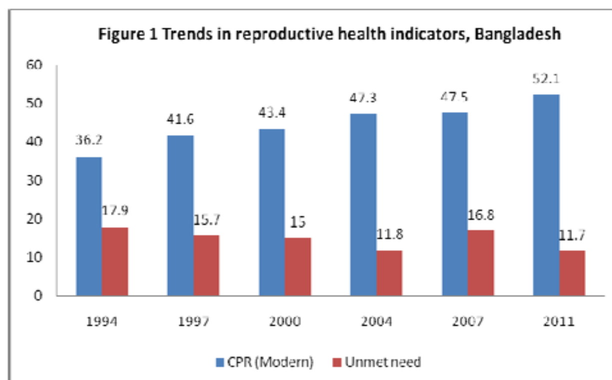

Figure 1 Trends in reproductive health indicators, Bangladesh

Flow of RH funds

Financing for reproductive health in Bangladesh is a combination of different methods, which include households, government revenue, donors and community financing through NGOs (Osman 2008). The Ministry of Health and Family Welfare (MOHFW) operates as a financial intermediary of the Government of Bangladesh (GOB) obtaining funds from the Ministry of Finance (MOF) and allocating and disbursing them to its reproductive healthcare providing units. It also provides regular annual transfers or grants-in-aid to NGOs operating in this sector (Figure 2). As in other government ministries in Bangladesh, MOHFW expenditures are funded from and classified under two GOB budget categories: (a) Revenue Budget, and (b) Development Budget or the Annual Development Programme (ADP). The Revenue Budget is financed by the GOB by its tax and non-tax revenues including borrowing from the domestic market and self-financing by public (or GOB owned) autonomous corporations. The ADP is primarily financed by GOB revenue surpluses. ADP also relies on development partner assistance in the form of development grants and loans. The MOHFW recurrent expenditures (termed revenue expenditures) are funded through the Revenue Budget.

Trends in RH expenditure

The analysis of expenditure in Bangladesh specifically on RH indicates that about US$ 194 million has been spent during 2007 and according to the needs assessment and costing done by the Government of Bangladesh, US$ 234 million will be required in 2012, which will increase to US$ 319 million by 2015. The major challenge that was encountered was the fact that most of the RH budget and projections could not be broken down by service elements like FP, maternal and infant care, management of sexually transmitted infections and management of other SRH problems. So, an effort is required to address the possibilities give a projected figures for specific categories of RH spending.

Who pays for reproductive health services?

In Bangladesh, historically, supply side financing of health care services has been the backbone strategy for improving the access of poor households to essential health-care services. The financing of health in Bangladesh is dominated by two main methods: taxation/development partner funding and out-of-pocket payments. The first mostly finances the public provider system while the second is used mainly to finance pharmaceutical products and diagnostic tests. Social and private insurance and official user fees currently form a very small proportion of total finance. More than two-thirds of the total expenditure on health is privately financed through out-of-pocket payments. Of the remaining one-third, about 65 per cent is financed by MOHFW, which includes donor support channeled through the government system. Community financing mechanisms and risk pooling systems are nearly non-existent except on a limited scale from NGO-innovated activities.

Figure 2: Flows of Funds to the Health System of Bangladesh

Funding Sources
Financing Intermediaries
Providers
Public Sector Financing
Ministry of Finance
MOHFW Revenue Budget
Foreign Development Partners
MOHFW Development Budget
Other Ministries
Corporations
Corporations Health Offices
Local Government
Local Govt. Health Offices
Private Sector Financing
Non-Govt. Development Partners
Non Profit Institutions and NGOs
Community Health Insurance
Firms
Households
Private Insurance

Medical College Hospitals
District Hospitals
Thana Health Complex
Community Clinics
Specialized Hospitals
Other Ministry Facilities
Local Government Facilities
Corporation Facilities
Education, Research and Training
NGO Facilities
Private Modern Qualified Providers
Private Modern Unqualified Providers
Private Traditional Providers
Drug Retail Outlets

Key providers of RH services

In Bangladesh, facility based services in the public sector, which are more decentralized, are provided at three levels: i) primary health care facilities at the upazila and lower level (e.g. Upazila Health Complexes (UHC), Union Health and Family Welfare Centers (UHFWC) and community clinics); ii) secondary level facilities including district hospitals and maternal and child welfare centers (MCWC); and iii) tertiary level facilities including specialized and teaching health institutions, most of which are in the capital and other large cities. Different types of institutions, both government and non-government, have varying roles in providing emergency management of obstetric care (OmOC) to the people. UHC and private clinics/hospitals have a major role in providing antenatal care services, delivery and postnatal care services. However, more than half of the caesarean sections are conducted at private clinics/hospitals. Medical colleges and district hospitals have a greater role in the management of complications.

Table 2. Expenditures on RP and FP by Facility Provider (in Percentages), Bangladesh

Provider	Percent Expenditures
General Hospitals	23.15
Specialty Hospitals	0.03
Family Planning Centres	48.11
Outpatient Care Centres	21.32
Providers of Home Care Services	4.68
Provision and Administration of Public Health Programmes	2.58
General Govt Administration of Health	0.14

Source: National Health Accounts, Round III 1997-2007. Health Economics Unit, Ministry of Health and Family Welfare, Government of Bangladesh.

Table 2 presents data for public expenditures on RH and FP. Nearly 48 percent of expenditures are incurred through family planning centres, which are key providers for reproductive health services in Bangladesh. General hospitals and outpatient care centres are providers for 23 percent and 21 percent of expenditures, respectively.

Assistance from Development Partners

Table 3 gives an overview of the share of population assistance by various donor categories in Bangladesh. Developed countries are the primary source of funds in the country, but the contribution is almost constant from the year 2006. The United Nations system is another major source of funding, whereas contributions from NGOs and foundations are considerably less. Development banks provided loans in 2000, and both loans and grants in 2005, but after that, funding from development banks ceased.

Donor Spending according to ICPD categories

Table 4 shows population assistance structure according to ICPD categories. There is a wide variation in the proportion of funding that is provided to reproductive health and other ICPD categories. The share of funding for research, data and policy analysis is extremely low. Donor spending on family planning decreased after 2003, and remained at a constant low level for the last four years. The share of spending on reproductive health increased substantially after 2005. The share of this component is around 35-67 % for the last five years.

Resource needs for achieving RH-related MDGs

Financing for reproductive health needs to be substantially increased in order to achieve the MDG targets for the country. The MDG needs assessment and costing study (2009) estimated promotional allocation of resources on different components of RH and FP services. According to the needs assessment and costing done by the Government of Bangladesh, 17,992 million BDT (US$ 234 million) will be required in 2012, which will increase to 24,584 million BDT (US$ 319 million) by 2015. It is estimated that to achieve the goal of reduction in maternal mortality, more than half of the resources will need to be allocated for obstetric complications and reproductive health problems.

Table 3. Population assistance to Bangladesh by donor category 2000-2010 (Millions of US$)

Donor category	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Developed countries	52.7	49.2	41.7	58.2	28.2	61.0	68.9	58.5	76.8	77.9	74.6
United Nations System	21.2	13.9	10.5	24.4	6.8	8.5	8.3	7.2	14.2	16.4	20.8
Foundations	0.2	1.5	1.6	0.1	0.1	0.1		0.1	0.0	3.0	3.2
NGOs	10.7	11.3	11.9	3.1	14.0	14.6	9.9	13.3	2.5	7.6	1.8
Development Banks Grants	-	-	-	-	-	10.0	-	-	-	-	-
Total	**84.7**	**75.9**	**65.7**	**85.8**	**49.0**	**94.3**	**87.1**	**79.1**	**93.4**	**104.9**	**100.4**
Development Banks Loans	40.0	-	-	-	-	72.0	-	-	-	-	-
Total Including Loans	**124.7**	**75.9**	**65.7**	**85.8**	**49.0**	**166.3**	**87.1**	**79.1**	**93.4**	**104.9**	**100.4**

Source: Resource Flows database, United Nation Population Fund (UNFPA)/Netherlands Interdisciplinary Demographic Institute (NIDI).

Table 4: Population assistance to Bangladesh by ICPD category 2000-2010 (Millions of US$)

ICPD Categories	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Family planning	31.3	37.3	29.2	42.3	19.6	36.2	19.6	8.2	9.5	11.8	12.2
Reproductive health	40.6	26.5	25.3	28.1	18.6	34.6	57.5	50.6	62.5	74.6	68.8
STD/HIV/AIDS	9.4	8.8	7.1	6.4	2.7	21.1	7.9	10.9	19.7	15.9	16.0
Research, data and policy analysis	3.4	3.3	4.2	8.9	8.2	2.3	2.0	9.4	1.7	2.6	3.4
Total	84.7	75.9	65.7	85.8	49.0	94.3	87.1	79.1	93.4	104.9	100.4

Source: Resource Flows database, United Nation Population Fund (UNFPA)/ Netherlands Interdisciplinary Demographic Institute (NIDI)

Evidence-based results for policy

The outcome of this report could help planners and policymakers to address critical dimensions of RH issues related to MDG5. Some of the key policy oriented findings are highlighted below:

- High maternal mortality rates are underpinned by the fact that about three-fourths of the deliveries take place at home and most of them are attended to by untrained providers. Although the government has established physical facilities at upazila and lower levels and arranged BCC write out and training of doctors, nurses and field staff to provide emergency obstetric care (EMOC) at these facilities, the utilization of these services is still quite low. Reproductive health outcomes and services in Bangladesh are inadequate, particularly for poor women, affected by both supply- and demand-side barriers.

- Affordability is a serious issue as far as poor women's access to reproductive health care is concerned; even public care has both directed and opportunity costs. In Bangladesh, two thirds of overall financing for reproductive health consists of household out-of-pocket payments. High out-of-pocket expenditure on reproductive health has grave consequences for equity and financial protection against the costs of illness. This implies the need for a strong commitment to increase and strengthen public sector financing and delivery of affordable reproductive health services. It appears that the health system would still require mobilizing funding from donors for many of the components, including drugs and contraceptives.

- NGOs and the private sector have been playing a critical role in the delivery of reproductive health services in Bangladesh. Since the public health system alone cannot fulfill the needs of reproductive health services, involvement of the private sector needs to be increased with greater accountability. Hence, from the funding perspective, performance-based payment mechanisms for private sector services would be essential for fostering public-private partnerships for maternal health service provision.

- There is a wide variation in the proportion of funding that is provided to reproductive health and other ICPD categories. The share of funding for research, data and policy analysis is extremely low.
  Donor spending on family planning decreased after 2003, and remained about 8-12% of total population assistance during 2007-2010. Therefore, development partners need to increase their support, ensuring that funds are additional and absorbable, and that they foster much-needed integration and rationalization of reproductive health services.

Challenges in the construction of reproductive health accounts

Secondary sources play a critical role in informing the construction of RHAs. For instance, data from public sources of RHA financing have largely been sourced from government audited accounts. One major concern with government sources has been the fact that government information is not disaggregated to the level (e.g. may not have line items on RH-specific services) desired in the sub-analysis tables.

For example, in Bangladesh, since data are not disaggregated by specific RH category, it is difficult to estimate National Health Accounts (NHA) matrices by specific providers and by functions.

Information collected from most providers that include NGOs could also not easily be broken by the respective functional classification as proposed by the WHO producer guide. With regard to data from private insurance, firms and employers, the NHA process especially the RHA suffers from lack of data from sources that have functional details required by health accounts.

The available data for estimating the role of households were not sufficient enough to estimate out- of-pocket spending (OOPE) on SRH. As a result, various research groups ended up using distributive variables like utilization statistics and unit costs to derive some estimates of the OOPE on SRH which was either highly underestimated or overestimated. A special Household Health Expenditure and Utilization Survey targeting RH services will therefore be required in the future to estimate a robust OOPE on SRH.

Institutionalization of reproductive health accounts

Ideally, institutionalization occurs when RHAs are conducted on an annual or regular basis and are supported both politically and financially by the national government. Use of RHA data on a recurrent basis for making RH policy decisions is essential for government ownership. The following key steps are therefore critical for the institutionalization agenda to be pushed forward:

- Expanding the NHA team to include the representation of key NGOs and development partners. This will ideally ensure these key players understand and appreciate why the RHA accounts are necessary and the kind of information required;
- Development of a standardized data collection tool that targets donors and NGOs. This can later be computerized so that expenditure information on RH is made available on a regular basis from NGOs.
- Institutionalization also requires an ongoing technical team to work on RHA and respond promptly to requests from policymakers and other stakeholders. Supporting the development of capacity for maintaining RHA accounts will substantially reduce the costs involved in generating routine estimates of resource flows of RH.

Recommendations

To have a comprehensive picture of RH financing in developing countries, the following steps should be undertaken at country level:

- A special household health expenditure and utilization survey targeting RH services required to estimate a robust OOPE on RH.
- A costing of RH services at the provider level is important. The costing will aim at generating unit costs of producing RH services by functional categories.
- A benefit incidence analysis that combines spending on RH with household utilization of RH services to generate data on who benefits from RH spending. Benefit Incidence Analysis is a tool that investigates the extent to which the financial benefits of public spending on social services accrue to different population groups (e.g. the poor, adolescents, older women etc).

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. *ICPD, Cairo, 1994*.

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