Notes:

1. This document is a technical submission of the Working Group on Accountability for Resources for the consideration of the Commission.

2. This document was open for consultation prior to the final meeting of the Commission. Incorporation of input as a result of the consultation was at the discretion of the Working Group Chair.

3. The final version of this document will be presented to the Commission during the second and final meeting of the Commission. Further to that meeting, the final document will be made available on the Commission website.
Executive Summary & Key Recommendations

1. Tracking financial resources provides critical information that helps increase the accountability of governments to their citizens. It shows whether countries have spent funds according to the priority areas budgeted in national health plans, supports more informed policy-making, and enables money spent to be associated with results achieved. Resource tracking also helps to show whether development partners have provided external financial support in line with their commitments.

2. The Commission on Information and Accountability for Women’s and Children’s Health was established on the foundation that every woman and every child has the right to health. Its objective is to propose a framework to help countries monitor where resources go, how they are spent and with what results. The Commission is supported by two Working Groups, focusing on accountability for results and resources. The Working Groups are linked through an accountability framework which revolves around three interrelated actions – monitoring health outcomes and resources for health, reviewing progress, and remedying to ultimately improve health results. While the immediate scope of the Commission relates to women’s and children’s health, the framework is relevant to health more broadly and thus serves as a critical starting point for strengthened accountability for the whole health system.

3. To ensure accountability for resources to health, more information is needed on how much is spent, where, on what, and who is benefitting. This presents three main challenges: a lack of capacity to produce, monitor, analyse and use data in national processes; a lack of transparency in data production and availability; and a lack of use of information to take remedial action.

4. The Working Group on Accountability for Resources proposes to the Commission six main recommendations to address these problems. They are listed below according to financing flows at the country and global levels, and according to the three dimensions of accountability – monitor, review, remedy.
Accountability for Resources at the Country Level

**Recommendation 1:** Governments should monitor financial resources directed to health, and specifically to women’s and children’s health, defined here as reproductive, maternal, newborn and child health (RMNCH) services. To ensure this can happen, each year an additional 10 low income countries should receive development partner support to strengthen capacity for resource tracking, meaning that all low income countries would have strengthened capacity by the end of four years. Countries should by 2015:

- 1a: have developed compacts with all development partners wishing to work in a country to ensure they report on externally funded expenditures on health following an agreed template. Regional and international organizations provide fora that can empower countries to take this step and encourage all development partners to participate.
- 1b: be tracking the following two aggregate indicators: (i) total health expenditure by source, per capita and (ii) total RMNCH expenditure by source, per capita.
- 1c: make this information available nationally, regionally, and internationally to the World Health Organization (WHO) for inclusion in its health expenditure database.*

5. The long-term objective is that governments should annually report on total health expenditure by all financing sources (i.e. entities that provide funds including the government, private entities – e.g. firms and individual households, and development partners) and for specific health priorities or population groups. The Working Group recognises that countries are starting with different capacity levels to track resources and will need to progressively expand their reporting of health expenditures over time, if necessary starting initially with annual tracking of total government health expenditure and external assistance, and providing more detailed reporting on private sources as their capacity increases. Compacts or binding agreements between governments and all development partners should be agreed to ensure that all partners provide governments with their budget and expenditure reports and in a standard format, thus providing a clear picture on external health financing and linkages with national health priorities. Monitoring such agreements via scorecards will further help to ensure compliance.

6. To enable countries to respond to this recommendation, capacity needs to be strengthened to track resources to health, organise data into established accounting frameworks, and analyse

* [http://www.who.int/nha/country/en/]
and use information in national policy and accountability processes. Capacity is least in low income countries, and development partners should commit to strengthen capacity in an additional 10 low income countries each year, prioritising those with the greatest burden of women’s and children’s health. This support should be coordinated by the key institutions involved (World Bank, World Health Organization (WHO), Organisation for Economic Co-operation and Development (OECD), Bill and Melinda Gates Foundation, and bilateral agencies). This shorter-term support should be undertaken within the framework of longer term efforts to strengthen underlying public expenditure management systems (PEMs), and capitalise on Information and Communication Technology (ICT) opportunities that help capture and process data, link information systems, increase the timeliness of information produced, and store data for institutional memory.

**Recommendation 2:** Governments should at intervals (annually when capacity permits) **review** health spending, and within that RMNCH spending, and relate spending to:
- 2a: commitments budgeted in national health plans and by development partners,
- 2b: goals of equity and human rights, by disaggregating health expenditure by socio-economic status and other demographic or geographic variables, and
- 2c: results achieved, as an indication of whether expenditures are providing value for money.

7. Reviewing resource flows is the second element in ensuring accountability for how resources are distributed and used. Initially countries with less capacity may be able to undertake reviews only every two to three years, or may decide to focus the review just on annual government health expenditures.

8. Firstly, countries should review spending against priorities budgeted in national (and, where appropriate, lower level) health plans. Ideally, this entails an annual analysis of total health expenditure and its distribution across priority diseases (e.g. HIV/AIDS) and population groups (e.g. women and children). Countries should also review country-level data on external resources that have been received and compare it to similar information provided by development partners to the Creditor Reporting System managed by the OECD. Connecting global-level information to national-level information is critical to understand the amount and nature of external resources available for use at country level.
9. Secondly, countries should review whether investments are equitably distributed and directed to communities of concern. This entails disaggregating indicators by socio-economic status and other demographic or geographic variables to reveal inequities of financial burden and use of services among population groups. Such analyses can inform assessments of whether governments are meeting their commitments to ensuring the right to health*.

10. Thirdly, countries should compare overall public spending on health to results achieved (e.g. DPT3 coverage, assisted deliveries, percent of children receiving Vitamin A supplementation) as very rough proxy measures of value for money.

**Recommendation 3:** All countries should ensure they have in place by 2015 an accountability mechanism that uses the information on resources spent in national review processes in order to increase accountability, acknowledge success and remedy performance. Regional bodies can play an important role in helping empower countries to enforce mutual accountability with development partners.

11. A number of review models already exist in countries (e.g. parliamentary reviews, annual health sector reviews, national health assemblies, civil society processes, memoranda of understanding, codes of conduct, etc.). All countries should assess the most appropriate review model, and adapt and strengthen it with the goal of having in place by 2015 a sustainable accountability mechanism for spending on health. The challenge is to move beyond simple monitoring to critical review (including technical review of data quality) and to implementation of remedial actions that will improve results. To ensure effective accountability, mechanisms should include policy, technical, academic, and civil society constituencies.

12. Regional bodies such as the African Union and other regional level entities of the United Nations (UN) and WHO are also particularly important to ensuring mutual accountability. There are precedents in global health and development where regional networks facilitate both national and global accountability processes. Such bodies can further empower countries by providing fora for voicing their concerns, amplifying their voices and putting pressure on partners at the global level.

13. Information on resources spent on health should be publicly available within countries and at regional and international levels in a user-friendly format. Transparency in information availability and common data standards can drive community, national, regional and global efforts to increase accountability. ICT can facilitate such availability and accessibility including to those outside of governments (e.g. civil society, implementers, academia, citizens, and media).

**Accountability for Resources at the Global Level**

**Recommendation 4:** To improve ability to monitor resources at the global level, all development partners, including emerging donors and private foundations, should provide more timely, complete and consistent information on resources to health to the Creditor Reporting System of the OECD. The target is to ensure that all major development partners report to the OECD by 2015.

14. Development partners currently report project-level aid flows to the Creditor Reporting System (CRS), an internationally accepted database maintained by the Development Assistance Committee (DAC) of the OECD. While the CRS captures around 90% of development assistance to health, it misses out growing sources of development aid from those donors that are not members of the DAC and from some private foundations, although complete reporting is now available from the Gates Foundation, which is by far the largest private funder. These partners are playing a greater role in development, and with this comes responsibility to maintain levels of transparency similar to those required of DAC members, by reporting details of their development assistance to the CRS.

**Recommendation 5:** To strengthen review processes:

- 5a: development partners should urgently discuss within the DAC enhancements to the CRS which would permit improved analysis of the purposes of development assistance for health, such that multiple purposes (e.g. maternal health and AIDS) can be reflected, and should provide the necessary financial support to enable CRS improvements to be implemented. In the meantime, development partners should agree on a simple method to define and identify development assistance spent on RMNCH, to be implemented in 2011.
- 5b: development partners, governments and other actors\(^*\) should urgently clarify their financial commitments to the Global Strategy for Women’s and Children’s Health to enable these commitments to be tracked at global and country levels.
- 5c: development partners should publicly report their development assistance to health against the aid effectiveness indicators developed through the Paris Declaration.

15. Expenditure by development partners on RMNCH cannot easily be obtained from the CRS, because the coding system does not flag expenditures by all types of intended beneficiaries. Discussion should take place urgently in the relevant DAC committees on whether such flags can be developed and implemented, and what resources would be required for reporting. In the short term, a rough estimation of development partner expenditure on RMNCH can be obtained by methods such as that developed by the G8\(^†\), and should be implemented in 2011. Development partner reporting on financial resources devoted to the health of women and children is a vital complement to the recommendation to countries to report on their own spending on RMNCH, and helps ensure mutual accountability.

16. Reviewing resource flows at the global level should address whether development partners and governments have kept their promises and spent their aid in line with their commitments to the Global Strategy for Women’s and Children’s Health. As a first step, this means clarifying what was initially promised to ensure that funds are transparent, results-oriented, additional (avoiding double-counting), conditional (e.g. on fiscal transparency), and kept (the ‘TRACK’ principles\(^‡\)). Resource flows should also be reviewed to understand the quality of the assistance provided, including how much reaches a country and can be programmed at the country level. Appropriate aid effectiveness indicators have been developed and further elaborated with respect to the health sector (through the Paris Declaration and the IHP+ Results scorecard process\(^§\)). These should be used and made publicly available to assess the quality of assistance to health.

Recommendation 6: The Working Group endorses existing initiatives that make use of the data in the Creditor Reporting System in remedy processes and that leverage the role of regional and international, non-governmental and philanthropic organisations, civil society, the business community, and health care professional associations.

\(\text{*}\) international, non-governmental and philanthropic organisations, civil society, the business community, and health care professional associations.
\(\text{‡}\) http://www.one.org/c/international/policybrief/3298/
\(\text{§}\) http://network.human-scale.net/docs/DOC-2697
international bodies (e.g. African Union, UN General Assembly, G20, G8) to hold development partners to account for their stated financial commitments to the health of women and children, and for the quality of their development assistance to health.

17. Several initiatives exist that draw on the data in the Creditor Reporting System to review information on external resources (e.g. those undertaken by the G8, the Partnership for Maternal, Newborn and Child Health, the Countdown to 2015, and academic studies). In addition, regional and international bodies exist as high-level platforms to encourage accountability. The Working Group calls for continued scrutiny, challenge and debate on financial commitments and expenditures, building on existing mechanisms. The Working Group on Accountability for Results has proposed an international Independent Review Group to ensure accountability for results. The Working Group on Accountability for Resources has not been able to reach consensus on the level of priority to be attached to such a mechanism with respect to tracking resources. It recognises value in such a mechanism, particularly as an opportunity to ‘name and shame’ when commitments are not kept, as a platform for taking practical action to ensure accountability, and as a means to increase participation from multiple constituencies in accountability processes. However, some members were concerned about the introduction of an additional international body, in particular questioning: its added value when data on resources are publically available and used for accountability purposes by several groups; its ability to evaluate the quality of expenditure data which can be adequately checked only within countries; and whether, given limited resources, these should not rather be focused on supporting greater country capacity to produce good quality data rather than on a new international mechanism.

18. Recognising that the quality, and not just the quantity, of development assistance to health is crucial to better results, the Working Group endorses efforts to track the effectiveness of aid to health such as the regular high-level fora on aid effectiveness organised by the OECD which bring together development partners, governments and civil society to review progress in implementing the Paris Declaration and Accra Agenda, and the IHP+ Results process which has adapted the indicators for the Paris Declaration to the health sector and is using these to hold development partners to account.

19. The implementation of these recommendations would ensure that information on resource flows for women and children’s health is produced, reviewed and acted on, and that the
underlying problems of capacity, transparency and use are addressed. The Working Group urges the Commission to take forward these recommendations.
Working Group on Accountability for Resources
Draft Final Report

Section 1: Overview

1. “Every woman should have access to the basic health services she needs, and every child has the right to a healthy future” (Ban Ki-moon)\(^1\). Part of ensuring this right to health depends on the accountability of governments to their citizens in using scarce funds in a way that delivers priority health interventions to populations most in need. Tracking financial resources provides critical information to increase accountability. It shows whether countries have spent funds according to the priority areas budgeted in national health plans, and enables money spent to be associated with results achieved. Resource tracking also helps to show whether development partners have provided development assistance in line with their commitments.

2. The global community has come together to support improving women’s and children’s health. The still unacceptably high rate of preventable maternal and child morbidity and mortality represents a challenge to the global health community and to basic human rights. In response, political commitments have been made at the international and regional levels\(^*\) and stakeholders committed an estimated USD 40 billion in resources to a Global Strategy to save the lives of 16 million women and children by 2015\(^2\). The increased attention and resources to women’s and children’s health underlines the importance of effective accountability mechanisms to ensure that support is indeed forthcoming and improves the health of women and children.

3. The Commission on Information and Accountability for Women’s and Children’s Health was established at the request of the UN Secretary-General to ensure proper reporting, oversight, and accountability on women’s and children’s health\(^3\). The Commission will propose a framework to help countries monitor where resources go, how they are spent and with what results. While the immediate scope of work relates to women’s and children’s health, the

framework is relevant to health more broadly and thus serves as a critical starting point for strengthened accountability for the whole health system.

4. The Commission is supported by two technical Working Groups that focus on accountability for results and resources. The two groups are linked through an accountability framework which revolves around three interrelated actions – monitoring health outcomes and resources for health, reviewing progress, and remedying to ultimately improve health results. In the context of financial resources, monitoring means tracking how much is spent on women’s and children’s health, where, on what, and for whom. Reviewing progress means analysing whether expenditures have been made against agreed priorities or commitments. Finally, a crucial dimension of accountability is remedy or the taking of action that ensures commitments are kept and resources are re-allocated to have maximum health benefit.

5. The work of the Commission and of the Working Groups is founded on the fundamental human right to the highest attainable standard of health. In addition to this cornerstone, the Working Group on Accountability for Resources was guided by four underlying principles, namely country focus, national leadership, long-term perspective, and harmonisation. First, the framework adopts a country focus, recognising that the needs of in-country decision-makers are the priority. Any proposed framework should first and foremost improve the country generation and use of data for improving health results. Second, the Working Group placed national leadership and ownership of results at the forefront. This calls for national decision-making over financial resources and requires strengthening national capacity to produce, monitor, analyse and use financial data. Third, the Working Group recognised that short term actions need to be guided by a long term vision of the framework needed for monitoring resource use across the whole health system, building on what exists rather than creating new mechanisms. Fourth, given this goal, it is critical to harmonise and strengthen existing tools and mechanisms for tracking resources, in order to maximise use and minimise reporting burdens.

6. The purpose of this report from the Working Group on Accountability for Resources is to propose institutional arrangements to monitor financial resources (including methods and indicators), to review spending against commitments in national budgets and by development partners, and to implement actions to improve accountability. This report further highlights ways in which ICT could facilitate the production, analysis, and transparency of financial data.
and thereby further drive accountability for financial resources. The report was informed by current work and existing literature and was further refined through consultations and country and regional experiences. The Working Group identified a clear need for more information on spending on women’s and children’s health. There are three main challenges in this regard: a lack of **capacity** to produce, analyse and monitor; a lack of **transparency** in data production and availability; and a lack of **use** of information by review mechanisms that can ensure that information is employed to take remedial action. The Working Group on Accountability for Resources proposes six key recommendations to the Commission. These are described and justified below according to financing flows at the country and global levels, and according to the three dimensions of accountability – monitor, review, remedy.

**Section 2: Accountability for Resources at the Country Level**

**Summary of recommendations:**

Governments should **monitor** financial resources directed to health, and specifically to reproductive, maternal, newborn and child health (RMNCH). To ensure this can happen, each year an additional 10 low income countries should receive development partner support to strengthen capacity for resource tracking, meaning that all low income countries would have strengthened capacity by the end of four years. Countries should by 2015:

- have developed compacts with all development partners wishing to work in a country to ensure they report on externally funded expenditures on health following an agreed template. Regional and international organizations provide fora that can empower countries to take this step and encourage all development partners to participate.
- be tracking the following two aggregate indicators: (i) total health expenditure by source, per capita and (ii) total RMNCH expenditure by source, per capita.
- make this information available nationally, regionally, and internationally to the World Health Organization (WHO) for inclusion in its health expenditure database.

Governments should at intervals (annually when capacity permits) **review** health spending, and within that RMNCH spending, and relate spending to (a) commitments budgeted in national health plans and by development partners, (b) goals of equity and human rights, by disaggregating health

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* Following established methods or, if not feasible, by following a ‘rapid’ approach using various estimation methods (see Box 1)

† [http://www.who.int/nha/country/en/](http://www.who.int/nha/country/en/)
expenditure by socio-economic status and other demographic or geographic variables, and (c) results achieved, as an indication of whether expenditures are providing value for money.

All countries should ensure they have in place by 2015 an accountability mechanism that uses the information on resources spent at country-level in national review processes in order to increase accountability, acknowledge success and remedy performance. Regional bodies can play an important role in helping empower countries to enforce mutual accountability with development partners.

7. The foundation for the accountability framework is centred at the country level. Governments are accountable to their citizens and are responsible for ensuring that scarce funds are spent in a way that delivers priority health interventions to populations most in need, such as women and children. To do this requires timely, reliable and complete information on the sources and uses of financial resources. Such information can show whether governments have efficiently spent funds according to the priority areas budgeted in their national health plans, underpins informed policy-making and enables money spent to be associated with results achieved, thus helping to ensure ‘more money for health, and more health for the money’.

8. Accountability for resources at the country level requires monitoring data, reviewing this against national priorities, and implementing action to acknowledge success or remedy lack of progress. However, all of these actions firstly depend on reliable data. Countries particularly face challenges of lack of capacity to produce financial information and lack of transparency in development assistance flows within countries.

Monitor

9. Monitoring resource flows can produce a comprehensive picture of health financing in a country and a clear understanding of the role of different actors in the health system. It provides critical information regarding how much is spent, where, on what, and on whom. Frameworks and methods are available to monitor financial flows (Box 1).

Box 1: Frameworks and Methods
Frameworks and methods to track resources to health already exist, namely National Health Accounts (NHAs) and OECD’s ‘System of Health Accounts (SHA), and are being further developed including to cater better for countries with less well developed information systems*. Internationally accepted frameworks organise the amount and flow of financial resources across actors within a country’s health system and are

* http://www.oecd.org/pages/0,3417,en_40045874_40037351_1_1_1_1_1,00.html
essentially a standard set of tables that classify health expenditure information into a ‘sources and users’ matrix which answers the two questions of ‘where does the money come from?’ and ‘where does the money go to?’ Health expenditure information obtained from various primary and secondary data sources is categorised across four dimensions: financing sources (public, private, development partners), financing agents (e.g. government, social security funds, private insurers, households), health providers (e.g. hospitals, nursing facilities, retailers), and functions (e.g. purchase of preventive or curative health services or goods such as medicines). The use of standard methods is critical for maintaining consistencies in international accounting and benchmarking performance across countries.

‘Sub-accounts’ produce similar information but for specific sub-sectors of health, such as reproductive, maternal, newborn and child health services. Child health expenditure and reproductive health expenditure are respectively estimated in a child health sub-account and a reproductive health sub-account (which includes maternal health expenditures).

Ideally, sub-accounts are undertaken as part of an overall effort to track resources in the health sector. If this is not feasible, a variety of relevant data (e.g. secondary data on utilisation patterns, household survey data on out-of-pocket expenditure by demographic group, demographic data) can be used in a ‘rapid’ approach to estimate the share of health expenditure which benefits women and children.

10. The Working Group recommends that by 2015, all countries should track resources to reproductive, maternal, newborn and child health (RMNCH) by using existing methods (Box 1) to annually monitor the following two sets of indicators:

- Total health expenditure by source per capita of the total population, in International dollars
- Total RMNCH expenditure by source per capita of children under five and women between the ages of 15 and 49, in International dollars.

These should be reported to WHO, whose existing health expenditure database should be expanded to include these indicators and adapted to be more user-friendly, to encourage downloading data and wider use of the information.

11. The first indicator underlines the need for countries to understand spending to health in general. The second focuses attention on spending to improve the health of women and children, defined as reproductive, maternal, newborn and child health (RMNCH) services.

Both sets of indicators can be expressed in other currency units (national, US dollars) and can be expressed also disaggregated by major source of funds:

- Government funds (Government health expenditure, per capita)
- External resources (External resources for health, per capita)
- Individual households (Out-of-pocket expenditure, per capita)

* Entities that provide funds including the government, private entities (e.g. firms and individual households) and development partners
The basic information needed to generate these indicators can be used to derive other indicators of spending patterns (e.g. total RMNCH expenditures as a percentage of total health expenditure, proportion of RMNCH expenditure financed by the government) and help assess how well governments are providing financial protection for women and children.

12. However, monitoring expenditures on health and, more specifically on women’s and children’s health (i.e. RMNCH expenditures), is currently not done on a systematic basis and often remains a one-time exercise led by consultants working for external partners. A recent assessment of 130 countries who have produced expenditure estimates found that only a third have adequate capacity to do so on a consistent basis. Furthermore, the lower a country’s income and the greater the health need, the less likely it is to regularly produce or use estimates (Figure 1). Production of sub-accounts relating to reproductive and child health is even less widespread. For example, child health sub-accounts have been conducted in only seven countries.

![Figure 1: Country capacity for producing national health accounts](image)

13. Reasons for difficulties in obtaining information are numerous (Table 1), and relate both to weak underlying information systems and lack of willingness to share information between development agencies, NGOs and governments. In addition, capacity for resource tracking is constrained by shortages of skilled staff to undertake core monitoring activities, including

*Indicators for consistent production: public data collection annually, private data collection every five years and estimated annually; Indicators for consistent use: NHA data are integrated with health information systems, reported in government documents and publicly available on websites; Indicators for adequate capacity to routinely produce: production mandated by law/regulation, identified ‘institutional’ home, earmarked budget for NHA activities (World Bank 2010).
coordinating across government agencies and non-state actors, conducting quality checks of data and preparing reports.

Table 1: Problems in obtaining resource tracking data on health

<table>
<thead>
<tr>
<th>Expenditure source</th>
<th>Examples of problems in tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government expenditure</td>
<td>Weak public expenditure management systems[^1^]. Health expenditure of government agencies outside the Ministry of Health, and of decentralised agencies, often not clearly identified in financial accounts. Too many ad hoc requests for tracking expenditure in different areas which overburden limited capacity for resource tracking. Lack of use of computerised accounting systems.</td>
</tr>
<tr>
<td>External assistance</td>
<td>Expenditure off budget not disclosed to governments. Difficulties in getting actual expenditure (as opposed to commitments) from development partners. Difficulties in getting information on purpose of spending (e.g. on RMNCH).</td>
</tr>
<tr>
<td>Out-of-pocket payments</td>
<td>Household surveys done only intermittently. Non standardisation of questions on utilisation and payments.</td>
</tr>
<tr>
<td>Private firms; NGOs</td>
<td>Difficulty in obtaining and disaggregating health-related expenditures from organisations outside of government.</td>
</tr>
</tbody>
</table>

14. A particular problem for governments is obtaining accurate and timely data on both the volume and purpose of external assistance expenditures within a country. Rwanda provides an excellent example of requiring development partners to report on their expenditures (Box 2).

**Box 2: Obtaining information on development assistance**

The Ministry of Health (MoH) in Rwanda has led efforts to harmonise health resource tracking across all development partners in order to foster better planning and coordination across the sector. In one tool, developed by the MoH[^1^], information on budgeted and realised expenditures is collected from all international donors, implementing partners, and the government. The tool, known as the Joint Annual Work Plan, originally consisted of a standard excel spreadsheet in which development partners self-reported financial data relating to the health sector. It has since then been replicated for use in Kenya in the HIV sector and is under discussion for adaptation in several other countries (i.e. South Africa, Zambia and Ethiopia). In Rwanda, this tool has now been transformed into an innovative online interface[^1^], the Health Resource Tracker, with increased capabilities for data analysis useful for decision-making. Over a 4-6 week period, data is collected every year on the source of funds, use of funds by the district and facility level, and cost categories including technical assistance and overhead costs. Information can further be analysed through a system of ‘tagging’ expenditures to specific health programmes/interventions and/or to specific beneficiary groups. Resources are linked to results, as each item is associated with a specific national objective. The Ministry has been effective in requiring development partners to supply information such that lack of transparency is not tolerated. The success of health resource tracking in Rwanda has been tied to strong government leadership and close coordination with development partners.

[^1^]: With the support of the Clinton Health Access Initiative
[^2^]: With support of the USAID’s Health Systems 20/20 programme and Abt. Associates
15. The Working Group accepts that countries are starting with different capacity levels to track resources and will therefore progressively expand their reporting of health expenditures over time. It therefore recommends that:

- The initial priority should be to track total government health expenditure and external assistance to health annually, and at intervals (e.g. every two to three years) to estimate private expenditures for health.
- As part of country compacts, all development partners operating within a country should be required to report annually and in a coordinated manner on both the volume and purpose (including RMNCH) of their health expenditures, as well as their three-year forward plans, in a standard format to the relevant government ministry.
- Regional bodies (e.g. the African Union) and/or international organizations (e.g. UN, WHO) provide fora that can empower countries to ensure development partners collaborate in reporting expenditures.
- Development partners should support capacity strengthening in resource tracking in an additional 10 low income countries each year, prioritising those countries with the highest burden of maternal and child mortality.
- Countries should provide more detailed and frequent reporting as their ability to do so increases.
- Current initiatives between WHO, OECD and the European Commission to revise resource tracking frameworks and include lighter and more rapid methodologies should continue, and should include data capture systems to standardise data collection.
- A ‘rapid’ method (see Box 1) for estimating expenditures on RMNCH should be further developed by WHO and OECD, for use by countries with limited capacity.

16. Capacity strengthening is critical if countries are to be able to produce the above indicators. Capacity building for resource tracking should be undertaken within the framework of longer term efforts to strengthen national public expenditure management (PEM) systems. Such systems often face shortcomings related to weak budget formulation, weak accounting and auditing practices, and poor data generation. The actual information systems needed to support PEM are relatively modest but are a prerequisite for tracking resources for accountability. They include budgetary and financial practices as well as standard computer equipment and off-the-shelf software (e.g. basic spreadsheet programmes such as Excel). Systems should be able to capture and process data, generate automatic reports and store data.
for institutional memory. They should be ‘interoperable’ or capable of linking across systems found at different levels of the government and between local entities as well as with the central government and with development partners.

17. A small team of skilled staff needs to exist within countries to manage core monitoring activities. Ideally, these individuals should have experience of working with various government agencies and other health actors. They should be knowledgeable of national and local data sources, accounting practices, estimation methods and trend analyses. In countries without experience in tracking health expenditures, some technical assistance and training will initially be needed. Regional bodies have proven to be particularly useful for peer-to-peer training workshops and for sharing best practices and lessons learned.21

18. Each year an additional 10 countries should be supported by development partners to strengthen capacity related to resource tracking building on ongoing initiatives. A global plan already exists to build capacity to track resources over the 2011-2020 period in order to ensure the regular production and use of health expenditure data. It has estimated needed country-level investments to initially scale-up national capacity range from USD 75,000 to USD 300,000 per year and per country depending on national contexts, current capacity levels, previous experience in resource tracking, and external technical assistance. While a significant amount, there are potential cost-savings to these investments: when resource tracking is done regularly and locally, production costs have been estimated to be lowered by 66%. Moreover, regular monitoring will demonstrate the value of investments and encourage ongoing support, as has been the case in some countries (Box 3). Capacity building to strengthen public financial management, which complements specific support to resource tracking capacity, is currently being undertaken as part of a process led by the World Bank.

Box 3: Experience in the Philippines, Thailand & Tanzania

The Philippines and Thailand are two countries that regularly track financial resources to health with estimates of health expenditures now spanning more than a decade. Both have an established institutional ‘home’ for conducting such activities in government agencies and thus benefit from a lead organisation to ensure its regular production, build technical capacity and ensure relationships with national statistical agencies and other partners. Factors that have supported sustainable production and use of data from resource tracking include strong national demand for evidence-based decision making, a law mandating data

collection, a comprehensive approach including capacity-building and use in research and policy-making, and stable domestic funding for core activities. The common challenge faced by the Philippines and Thailand relate to the turnover or loss of staff in partner agencies, although this is balanced by the stability of an established core team in both countries.

Tracking financial resources to health in Tanzania is an important priority of the government and is particularly used to inform national decision-making for more equitable use of funds across socio-economic groups. It has benefited from support from the Ministry of Health and the government has notably endorsed a plan to institutionalise the tracking of resources which will further address specific constraints related to capacity (e.g. weak and fragmented underlying systems, poor quality data, and shortages of skilled staff).

19. Recently, there has been an international effort by WHO, OECD and the European Commission to move towards a single global standard for producing health expenditure accounts through the development of a revised SHA framework*. This global standard provides a consistent methodology for producing reliable comparable indicators on health spending. Building on the methodological work of the NHA Producer Guide, the framework further develops the health care financing framework to allow for a systematic assessment of how finances are mobilised, managed and used. The new global standard would allow for improved resource tracking of both domestic financing and external aid and mapping to information on aid flows reported through the OECD CRS data. Plans for lighter and more rapid methodologies for capacity constrained countries are important, and should include data capture systems to standardize the annual collection of data. Pending the development of these approaches, a ‘rapid’ method for estimating RMNCH expenditures can be used (Box 1).

20. Exploitation of ICT for resource tracking is still confined to basic systems but offers great potential for innovative approaches to support accountability and transparency, allowing for an audit trail of administrative and financial transactions (Box 4).

**Box 4: Examples of innovative ICT systems to support tracking of resources**

**Development Loop†**: a prototype, simple, easy-to-use, app that tells the real story of foreign assistance by enabling users to add and edit their own project information at a sub-national level, and to view and share this information with others in both online and offline environments. Users can view their own projects alongside those of other organizations or important indicators, such poverty rates or maternal mortality. It can also be linked to beneficiary feedback.

**Social Development Network Budget Tracking Tool‡** aiming to ensure accountability from government and parliamentarians by providing information and a means for communities to ensure efficiency in service delivery. The tool is being currently used in Kenya to inform how much funding is allocated by the Constituency Development Fund to different

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* [http://www.oecd.org/pages/0,3417,en_40045874_40037351_1_1_1_1_1,00.html](http://www.oecd.org/pages/0,3417,en_40045874_40037351_1_1_1_1_1,00.html)
municipalities in different categories. Combined with mapping, the budget information can help constituents to track where their funds are actually being spent.

*Technology for Transparency Network: tracking Civic Engagement Technology Worldwide*: a research and mapping project that aims to improve understanding of the current state of online technology projects that increase transparency and accountability across the world.

**Review**

21. Reviewing resource flows ensures accountability for how resources are distributed and used for priority health programmes and/or priority groups such as women and children.

22. The Working Group recommends that governments should at intervals (annually when capacity permits) review health spending, and within that RMNCH spending, against commitments budgeted in national health plans and by development partners. Ideally, this entails a comprehensive analysis of total health expenditure and its distribution across priority diseases (e.g. HIV/AIDS) and population groups (e.g. women and children). Even with some overlap in expenditures between categories†, such analyses can provide policy-relevant information. Comparing the distribution of expenditures across age-groups and diseases can indicate whether health services to women and children are prioritised and, if not, provides information to advocate for mobilising resources or making policy changes. Initially, countries with less capacity may be able to undertake reviews only every two to three years, or may decide to focus the review just on annual government health expenditures.

23. Governments should review country-level data on external resources and compare it to similar information provided by development partners to the Creditor Reporting System, the global database of aid flows. Connecting global-level information to national-level information is critical to understand the amount and nature of external resources available for use at country level. This will reveal the degree of any mismatch, and reasons for it, between information known at country level on development assistance and that known at global level. It will also help country agencies identify and access development assistance resources committed to women’s and children’s health in their country. Furthermore, identifying the proportion of external resources provided off-budget‡ is a critical aid effectiveness indicator.

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† Some MNCH expenditures cross both child and maternal sub-accounts (e.g. preventive care of the newborn) or those of other diseases (e.g. malaria in the case of insecticide treated bednets)
‡ Financial resources not captured in the official public budget and whose expenditures cannot be controlled through the budget.
24. Governments should review whether investments are equitably distributed and directed to communities of concern such that all population groups can exercise their right to health and allowing for additional analyses of whether governments are meeting their commitments to the right to health*. Countries should work towards developing sufficient capacity to provide breakdowns of the recommended indicators by socio-economic status and other demographic or geographic variables (e.g. by lowest economic quintile, by place of residence) to reveal inequities of financial burden and use of services among population groups, particularly those that are disadvantaged or marginalized.

25. Governments should further compare expenditures with results achieved as a rough assessment of value for money. Coverage indicators such as DPT3 coverage, assisted deliveries and the percent of children receiving Vitamin A supplementation can be compared with health expenditures to provide proxy measures of value for money. For example, countries with relatively higher Vitamin A supplementation coverage relative to RMNCH expenditure per child can be thought to be achieving more health for the money.

26. Weak capacity to review data produced from tracking resources is often associated with a weak appreciation for their use in national policy and accountability processes. A culture of using data and evidence in decision-making takes time to develop28. Furthermore, the capacity strengthening efforts recommended in paragraph 18 should go beyond systems to include building the capacity of country staff to analyse national (and, where appropriate, sub-national) data. This could include training materials for analysing budgets in relation to expenditures and for analysing equitable resource allocation29 in order to demonstrate the relevance of resource tracking for national decision-making.

27. Other factors hindering countries’ ability to review data are that they are often out-of-date and of poor quality. 12-18 months30 are typically needed to produce, audit and publish expenditure estimates. A balance must be struck between the accuracy of data and its timeliness for decision-making. Opportunities in ICT can help address these issues through built-in functions that facilitate real-time and continuous information flows or functions that automate cross-checking or validation of data.

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**Remedy**

28. For accountability to be effective, it must move beyond monitoring and reviewing and include actions to both acknowledge success and remedy lack of progress (see examples in Box 5). The challenge is that information flows are not occurring to a sufficient extent between producers of data and a wide range of data users, including civil society, and review mechanisms do not fully draw on such information and nor are they regularly employed to take remedial action.

*Box 5: Using evidence from resource tracking*

Information produced from tracking resources have proven influential in health policy and accountability processes.

*Agenda setting & resource mobilisation:* In Rwanda, the Ministry of Health used data to lobby for an increase in government financing such that total government expenditure on health increased from 2.5 percent to 6.1 percent of total health expenditure between 1998 and 2002; similarly data showing a more than 50% decrease in reproductive health expenditure over 2001-6 was instrumental in lobbying for increased funding for reproductive, maternal and child health services and for raising it as a health priority within the national work plan.

*Resource allocation:* Breakdowns of public spending combined with data on health status revealed inequitable regional distributions in Mexico and informed the reallocation of funding to those most in need.

*Reform:* In Thailand, time-series data since 1993 and evidence of effective government investment in maternal and child health services supported the design of a universal coverage scheme in 2002.

*Performance benchmarking:* Lebanon’s higher expenditure on health relative to its neighbouring countries led to an eventual reform of its provider payment methods.

*Stewardship:* A 1999 resource tracking exercise in Tanzania revealed 23% of resources were provided externally and mostly ‘off-budget’. In response, the government advocated for development partners to channel funding into the pooled arrangements of Sector-Wide Approaches.

*Equity:* In Burkina Faso, data from national health accounts were used by Amnesty International in their campaign efforts calling for the removal of financial barriers to maternal health services.

*Accountability:* Parliamentary debates in India often reference health expenditure information and trends in spending by source or per capita.

29. The Working Group recommends that all countries should have in place by 2015 an accountability mechanism that uses the information on resources spent within countries in national review processes in order to increase accountability, acknowledge success and remedy performance. Information should flow freely in accordance with information sharing principles established by the government. Governments should make information on resources spent on health available on a public domain web site. Transparency in information can drive community, national, regional and global efforts to increase accountability, including using the WHO health expenditure database to make comparisons across countries. The

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*Financial resources not captured in the official public budget and whose expenditures cannot be controlled through the budget (Schick 2007, OECD Journal on Budgeting).*
greater availability of information will not only raise awareness of women’s and children’s health, but allow closer scrutiny of whether funds are being used responsibly and equitably, and can drive improvements in data quality.

30. ICT can greatly facilitate dissemination and sharing of information on health expenditures, including providing access to those outside of the government (e.g. civil society, parliamentarians, programme implementers, development partners, academia, citizens, and the media). Such transparency can enhance accountability and overall health system performance. However, capacity to act on such information must be strengthened. Users both inside and outside the government should be empowered through providing information on health determinants, equity issues, and budgetary constraints, and through guidance on advocacy techniques in order to better inform their arguments and increase their ability to call for changes in budgets or policies.

31. Country accountability mechanisms already exist to varying degrees (e.g. parliamentary reviews, annual health sector reviews, national health assemblies, civil society processes, memoranda of understanding, codes of conduct, etc.). Each has strengths and weaknesses (Box 6).

Box 6: Strengths and weakness of country review mechanisms

- Strong leadership, and an inclusive and multi-sectoral approach, have been exhibited by many National AIDS Commissions although they have also sometimes led to power-struggles and required technical assistance that can be disproportionate relative to their impact.
- Regular annual frequency and links with health measures/outcomes are strong points of health sector reviews, but they risk remaining a tool for development partners to monitor how funds are spent; reporting to a Head of State or Prime Minister could address this problem.
- The notion of binding agreements between governments and development partners is reflected in code of conducts, MoUs, and country compacts but these are not always upheld given there are often no concrete sanctions.
- The legitimacy held by parliaments and regional institutions and summits can provide a bridge between national and local accountability. Their oversight role can ensure policy and budget action, including advocating for increased domestic support for priority issues, however they can also fall short of their potential particularly as institutional set-up and capacities often vary.
- National assemblies are an innovative model for increasing public discussion on health policies but ensuring the full participation of stakeholders and monitoring the impact of policies passed remains a challenge.
- Civil society organizations are particularly good at linking accountability and advocacy. For example, the Africa Public Health Alliance mobilized communities behind the ‘15%+ Campaign’ to ensure accountability by African Heads of State to allocate at least 15% of domestic resources to the health sector. While they are...
particularly adept at movement at the local level, they face challenges regarding their legitimacy and ability to exert compliance\textsuperscript{46}.

Active citizens can be empowered to do their own monitoring but they often lack direct links or incentives to actively demand greater responsiveness from the state.

32. Regional bodies such as the African Union and other regional level entities of the UN and WHO should be recognised as important fora to facilitate accountability at the national and global levels. For example, the African Union has led critical discussions on the commitment made by African Heads of State to allocate at least 15% of domestic resources to the health sector\textsuperscript{47}. Similarly, they have led a ‘Campaign for Accelerated Reduction of Maternal and Child Mortality in Africa’ (CARMMA) in relation to commitments to maternal, newborn and child health in 27 African countries. In addition, such bodies can further empower countries by providing fora for voicing their concerns, amplifying their voices and putting pressure on partners at the global level.

33. Accountability mechanisms are only likely to be effective if they are selected by countries rather than imposed from outside, and fit their specific circumstances. The Working Group therefore recommends that mechanisms should be nationally or locally selected, with perceived legitimacy, and be effective, transparent and inclusive of policy, technical, academic, and civil society constituencies. As the determinants of women’s and children’s health extend beyond the health sector (into education, water, sanitation, etc.), connections need to be made across a range of relevant agencies. Further, accountability, especially mutual accountability, has to be built around a system of relationships between actors in the health, development sector and the citizens and users of health care within a country\textsuperscript{48}.

Section 3: Accountability for Resources at the Global Level

**Summary recommendations:**

To improve ability to monitor resources at the global level, all development partners, including emerging donors and private foundations, should provide more timely, complete and consistent information on resources to health to the Creditor Reporting System of the OECD. The target is to ensure that all major development partners report to the OECD by 2015.
To strengthen review processes:

- development partners should urgently discuss with DAC the introduction of a modern structured relational database for the CRS which would permit improved analysis of the purposes of development assistance for health, such that multiple purposes (e.g. maternal health and AIDS) can be reflected, and should provide the necessary financial support to enable CRS improvements to be implemented. In the meantime, development partners should agree with OECD on a simple method to define and identify development assistance spent on RMNCH, to be implemented in 2011.

- development partners, governments and other actors* should urgently clarify their financial commitments to the Global Strategy for Women’s and Children’s Health to enable these commitments to be tracked at global and country levels.

- development partners should publicly report their development assistance to health against the aid effectiveness indicators developed through the Paris Declaration.

The Working Group endorses existing initiatives that make use of the data in the Creditor Reporting System in remedy processes and that leverage the role of regional and international bodies (e.g. African Union, UN General Assembly, G20, G8) to hold development partners to account for their stated financial commitments to the health of women and children, and for the quality of their development assistance to health.

34. While the foundation for our accountability framework is centred at the country level, resource tracking at the global level complements this, by monitoring the spending of development assistance agencies. This requires accountability arrangements that address specific challenges in the monitoring, reviewing and oversight of resources at the global level. These challenges include inadequate information on aid flows from both emerging donors, as well as many long-established donors, and a lack of information on where, and on what, aid money is spent. Almost 50% of development assistance to health is either unallocable by region or marked as global49. Better information on the purpose of development assistance flows, and where and on what they are spent, is critical for improved accountability.

* Including international, non-governmental and philanthropic organisations, civil society, the business community, and health care professional associations.
Monitor

35. The OECD Development Assistance Committee (DAC) is the main source of information on aid and other resource flows to developing countries, based principally on reporting by DAC members, multilateral organisations and other donors. The data are collected via two reporting systems: (1) the DAC aggregates on aid, other official flows and private flows, including a breakdown on type of aid extended, geographical distribution, sectoral breakdown and tying status of aid; and (2) the Creditor Reporting System (CRS) aid activity database, which contains detailed quantitative and descriptive data on individual aid projects and programmes. Both systems collect financial information on commitments (i.e. a firm obligation by a government to provide resources for the benefit of a recipient country) and disbursements (i.e. resources at the disposal of a recipient country or agency).

36. The Working Group recommends that all development partners, including emerging donors and private foundations, should provide more timely, complete and consistent information on resources to health to the CRS global aid database, and that all major development partners should report to the OECD by 2015.

37. The CRS, established in 1967, is an internationally accepted database on aid activities that draws on reports regularly submitted by the 24 members of the OECD DAC (including European Union institutions), one non-DAC bilateral member (United Arab Emirates), 23 multilateral agencies (including the Global Fund and GAVI), and one private foundation (the Bill and Melinda Gates Foundation). Reporting to the CRS has improved rapidly over the past decade, achieving complete coverage of DAC member commitment data for health activities in 2003 and of disbursement data in 2007. Information in the CRS is published online about a year after its reference year. The delay is due to the annual reporting cycle and time involved to collect data (with frequent late reporting by the statistical departments of donor agencies) and to check the quality of the data. The system captures at most 90% of development assistance to health but misses out important resource flows to health that are growing in volume (see below). Information in the CRS is used extensively at the global level by international policymakers, academics and civil society but has limitations for policy-relevant analysis.

* A large proportion of private aid flows to health is attributable to the Bill and Melinda Gates Foundation (BMGF). Official Development Assistance and private aid from BMGF together account for approximately 89% of DAH (IHME 2010).
38. Project descriptions in the CRS are critical both for countries wishing to use the CRS to understand development partner commitments and for any analysts wishing to track resources allocated to a particular purpose. Development partners should continue to improve these project descriptions in the information they supply to the CRS.

39. Aid provided by ‘emerging donors’ and private foundations are becoming increasingly important components of development assistance to health. It is estimated, for example, that Official Development Assistance (ODA) from the ‘BRIC’ countries (Brazil, Russia, India, China) – who do not report to the DAC – accounts for 3.3% of total ODA\textsuperscript{53}. More generally, development funding from emerging donors now amounts to 10% of bilateral ODA\textsuperscript{54}. Private foundations are another growing source of aid. Their contributions, together with donations from the corporate sector, rose by approximately 7.7% over the years 1998 to 2007\textsuperscript{55}. More specifically, the Bill and Melinda Gates Foundation represented 3.9% of development assistance to health in 2007. In 2009 the Gates Foundation disbursed USD 1.8 billion in grants to improve health in developing countries, making it the third largest international funder of health after the United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria\textsuperscript{56}.

40. As non-DAC bilateral donors and private foundations increase their aid spending, it will become increasingly important to track their contributions and integrate them into the system. In order to report to the CRS, emerging donors will need to increase their capacity in the collection, reporting and use of aid data, strengthening their PEM systems or adopting interim measures such as mandating a statistical agency or outside organisation to undertake data collection of their assistance to developing countries. Private foundations should also report to the CRS, clearly identifying both the sources and intermediaries of financial flows to avoid double counting. ICT that allows for decentralised automated data inputting and cross-checking of figures for validation could help both with this expansion of reporting requirements and with current reporting, and could reduce current time-lags.

41. There are complementary efforts in global health resource tracking. For example, AidData* maintains a database on development aid with several innovative features. In collaboration with the World Bank, it provides visual maps of projects that have been geocoded. This provides a useful tool for promoting geographical and sectoral coordination. In addition, it collects information on emerging donors, such as India, using non-governmental organisations

* http://www.aiddata.org
to track down aid projects in the budgets published by government departments. The International Aid Transparency Initiative (IATI) aims to provide more timely and transparent information\(^{57}\). It intends to collect aid information from non-governmental organisations and private foundations and to collect information on future aid flows. The goal is for information on aid flows to be updated on a monthly basis within two months of the end of each month and to regularly publish weblinks to existing documents of development partners.

**Review**

42. Reviewing resource flows at the global level provides information to help hold development partners to account for the commitments they have made. A concrete opportunity is represented by the recent set of financial commitments that accompanied the launch of the Global Strategy for Women’s and Children’s Health in September 2010\(^{58}\). These financial commitments for maternal and child health, pledged by various constituencies including donors, governments in low-income countries, international, non-governmental and philanthropic organisations, civil society, the business community, and health care professional associations, amounted to an estimated USD 40 billion.

43. Development partners should urgently discuss within the DAC the introduction of enhancements to the CRS which would permit improved analysis of the purposes of development assistance for health, such that multiple purposes (e.g. maternal health and AIDS) can be reflected, and should provide the necessary financial support to facilitate the expanded reporting. In the meantime, development partners should agree on a simple method to define and identify development assistance spent on RMNCH, to be implemented in 2011.

44. The CRS has an established system of categorising aid projects according to what they do. Each aid flow is assigned a single purpose code, indicating its sector and sub-sector. The CRS is currently able to provide information on resource flows that in principle can be mapped reasonably easily to some of the health MDGs. There are purpose codes for HIV/AIDS, malaria and TB (MDG 6); for reproductive health and family planning (MDG 5); and for basic nutrition (MDG 1). However, there are practical challenges in tracking resources at the sub-sector level. Health-system oriented projects contribute to disease-specific goals and the same is true the other way round. The sum of aid flows in a disease-specific category, such as HIV/AIDS, thus captures aid flows that might be characterised as vertical projects. Not only is the true contribution of aid to specific sub-sectors under-estimated, donors who provide aid for disease
control in other ways will not be recognised when in fact their preferred aid modalities may be equally if not more effective.

45. Tracking aid flows to child health raises additional specific challenges for a system such as the CRS, for it essentially introduces a third dimension into the categorisation of aid to health. A demographic group, such as children under five years, cuts across both diseases and health system categories. A system in which aid flows are categorised under one purpose code only then becomes very difficult to maintain. For this reason, trying to develop a purpose code for child health will not provide a solution to the problem of tracking aid to RMNCH as long as the principle is maintained of discrete codes.

46. The CRS does not itself provide estimates of aid to RMNCH but has been used as the primary source of data for others to analyse. Two approaches have been developed by academic institutions\(^59\)\(^60\) and a third method has been adopted by the G8 to track financial commitments\(^*\) (see Annex 1). The most appropriate method depends on the objective of the exercise. If the intention is to get the most accurate estimate of aid to maternal and child health, or to understand the distribution of development assistance to health across the different sub-sectors, including maternal and child health, then the more academically rigorous methods are preferable. However, if the purpose of the exercise is to obtain a baseline estimate of ODA to RMNCH to support the tracking of donor pledges going forward in a way that is transparent, then the G8 method is the most appropriate approach of those currently available.

47. We have recommended above that development partners should urgently discuss within the DAC how the CRS can be improved and what investment this would require. In the meantime, development partners should agree on a simple method for defining and reporting on RMNCH expenditures in the CRS, such as the G8 method. These recommendations reflect the principle of mutual accountability, since not just governments but also development partners would be obligated to report on resources for RMNCH. It is the majority view of the Working Group that development partners should behave consistently in terms of what information they are willing to report themselves, and what information they are requesting from countries with more limited capacity to track resources.

48. Review is necessary not just of the volume of commitments but also of their quality. Development partners and governments alike have signed up to the Paris Declaration on Aid

Effectiveness and the Accra Agenda for Action\textsuperscript{61} where both have agreed to be more transparent on their use of aid funds. Critical indicators are shown in Box 6, and these have been adapted by the IHP+ Results process to apply to the health sector.

**Box 6: Aid effectiveness indicators**

Alignment (indicator 2): Aid flows are aligned on national priorities (percent of aid flows to the government sector that is reported on partners’ national budgets)

Target for 2010: Halve the proportion of aid flows to government sector not reported on government’s budget(s) (with at least 85% reported on budget).

Harmonisation (indicator 9): Use of common arrangements or procedures (percent of aid provided as programme-based approaches)

Target for 2010: 66% of aid flows are provided in the context of programme based approaches.

Mutual accountability (indicator 12): Number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness including those in this Declaration.

Target for 2010: All partner countries have mutual assessment reviews in place.

49. Development partners, governments and other actors should urgently clarify their financial commitments to the Global Strategy for Women’s and Children’s Health to enable these commitments to be tracked at global and country levels. Development partners should also publicly report their development assistance to health against the aid effectiveness indicators developed through the Paris Declaration and as adapted by the IHP+ Results scorecard process.

50. Tracking the USD 40 billion entails a number of significant challenges due to the nature of the commitments. As a pre-requisite, there needs to be greater clarity on the financial pledges in accordance with the ‘TRACK principles’ *(i.e. transparent, results-oriented, additional, conditional, and kept).* Commitments should be transparent, namely available and accessible with clarity on their calculation (e.g. time period, baseline, currency). Funds should be results-oriented or linked to desired outcomes set by countries. Information is also needed to judge the extent to which these commitments represent additional money. Because commitments have been made by various constituencies there is likely to be double-counting, most notably in the commitments of bilateral donors, multilateral agencies and non-governmental organisations. Commitments should also be clarified regarding any conditionalities (e.g. on fiscal transparency or on the programming of resources). Data on 2008 bilateral ODA showed that approximately only half (54%) was ‘Country Programmable Aid’ *(i.e. the portion of aid that each development partner can programme for each recipient country and for which recipient countries have a significant say)*\textsuperscript{62}. Finally, commitments should be monitored and reviewed to assess whether they have been kept.

\textsuperscript{61} http://www.one.org/c/international/policybrief/3298/
51. The Working Group notes that the Partnership for Maternal, Newborn and Child Health (PMNCH) is analyzing the financial, policy and service delivery commitments made in relation to the Global Strategy for Women’s and Children’s Health to ensure mutual accountability\(^3\). The Partnership will clarify the pledges made, review progress and conduct a gap analysis of the percentage going to women and children’s health, and report on progress and constraints in implementing them (e.g. amounts budgeted) including recommendations to remedy any constraints. This analysis will be available at the time of the UN General Assembly in September 2011. The Working Group also notes the existence of other applicable models to track financial commitments to international strategies. For example, accountability of financial pledges to the G8 Aquila Food Security Initiative is tracked through a process which collects information on commitments and disbursements identified as related development activities through the CRS and through ‘forward spending surveys’. This process is open to all who made pledges, irrespective of DAC membership\(^*\). The great attraction of the latter approach is its link to the CRS, supporting the principle that there should be one database where all information is collected, using the same reporting structure and identifying clearly the sources and intermediaries to avoid double-counting.

52. The potential for using data produced by resource tracking can be more fully exploited. Greater use of data could be encouraged through better visualisation of data through geo-coding and feedback loops between users of data and producers of data. Examples include AidData’s ‘Development Loop’\(^†\) (Box 3) which tracks data from sub-national aid projects and development indicators and visually displays them on maps. It additionally creates feedback loops that enable the social monitoring of development projects/programmes and facilitate mutual accountability. AidFlows\(^‡\) is another tool that employs visualisation techniques showing the connection between individual development partners and countries.

Remedy

53. Several initiatives exist that draw on data in the CRS to review information on external resources devoted to women’s and children’s health and/or for accountability and advocacy purposes (e.g. those of the Partnership for Maternal, Newborn and Child Health, and the Countdown to 2015). The Working Group endorses existing initiatives that make use of the data in the CRS and agrees on the need for more use of resource tracking data in review and


\(^‡\) [http://www.aidflows.org](http://www.aidflows.org)
remedy mechanisms at the global level. The Working Group similarly supports initiatives to make the CRS data more accessible at regional and country levels, since this will increase transparency in the availability and use of development assistance within countries. The Working Group further endorses regional and international fora (e.g. African Union, UN General Assembly, G20, and G8) and encourages these to have spending on RMNCH as a standing agenda item. These high-level platforms should be further used to apply political pressure in order to hold development partners to account for their stated financial commitments to the health of women and children, and for the quality of their development assistance to health.

54. The Working Group further recognises that development partners should be held accountable for the quality, as well as the quantity, of development assistance to health, as both elements are crucial to the achievement of better health results. Improving the effectiveness of aid should increase its impact on development. The Working Group thus endorses ongoing efforts to track the effectiveness of aid to health and to ensure mutual accountability through regular high-level fora on aid effectiveness. The OECD notably brings together development partners, governments and civil society to regularly review progress in implementing the Paris Declaration and Accra Agenda, and the IHP+ Results process has adapted the indicators for the Paris Declaration to the health sector.

55. In the context of tracking resources to health, the Working Group had mixed views regarding the Independent Review Group proposed by the counterpart Working Group on Results. The Working Group on Resources recognises value in such a mechanism, particularly as an opportunity to ‘name and shame’ when commitments are not kept. It further sees as it as a platform for taking practical action to ensure accountability and encourages its goal of increasing participation from multiple constituencies in accountability processes.

56. However, some Working Group members had concerns over the introduction of an Independent Review Group, particularly questioning the added value of such a group when data on resources are publicly available via the CRS or the WHO expenditure database and are already used for accountability purposes by several groups. They also did not feel that an international expert group could evaluate the quality of expenditure data, which could be checked adequately only within countries. Finally, some members of the Working Group argued strongly that the top priority for investing scarce development partner resources should
be strengthening country capacity to produce good quality data on resource use, rather than financing an additional international mechanism.

57. The above views are expressed in the context of the Group’s remit for accountability for resources; they should not be viewed as reflecting on the task of accountability for results, since this was not within Working Group’s terms of reference.

Conclusion

58. The increased attention and resources to women’s and children’s health underlines the importance of effective accountability mechanisms to ensure that support is indeed forthcoming to improve the health of women and children. Tracking financial resources provides critical information that helps increase the accountability of governments to their citizens. It also helps ensure that financial resources are used in ways that increase access to services for women and children.

59. The principles guiding the accountability framework proposed in this report are country focus, national leadership, long-term perspective, and harmonisation of efforts. The three components of accountability - effective monitoring, critical review, legitimate action - require reasonably complete and credible data on the flow of resources at country and global levels, common reporting arrangements, and review mechanisms. Frameworks and methods are reasonably well established but their exploitation is limited by lack of capacity, transparency, and use of information.

60. The recommendations in this report have been designed to address these problems. Since resource tracking takes time and resources, a phased approach will be needed at country level where capacity has to be strengthened. Finally, resource tracking also takes political will – the Commission is thus requested to consider these recommendations and pursue the concrete actions put forward.
Annex 1: Methods for Tracking Development Assistance for MNCH

The OECD’s CRS does not in itself provide estimates of aid to maternal, newborn and child health but has been used as the primary source of data for others to undertake this task. Three approaches have been used to generate estimates of aid to MNCH by: the London School of Hygiene and Tropical Medicine [Lancet 2006]; the Institute for Health Metrics and Evaluation [IHME 2010]; and the G8 Health Working Group of the Muskoka Summit [Canada website]. The three methods are described below.

**LSHTM method.** This approach focuses on ODA. It draws mainly on data provided by the CRS but, where necessary, sources information directly from donor agencies that in previous years did not report to the OECD. The definition of expenditure on MNCH was determined by the activities on which the money is spent. These activities or boundaries were informed by National Health Accounts experts working on MNCH sub-accounts. ODA flowing through all aid modalities (i.e. general budget support, sector budget support, basket-funding and projects) is captured in the final estimates.

Each project in the CRS is manually reviewed and on the basis of the project description assigned to new categories developed specifically for the exercise. Allocation factors, informed by evidence from the literature, are then applied to projects in each category. For example, 48 percent of disbursements in primary health care projects are allocated to MNCH. Estimates are available annually for the period 2003-2008.

**IHME method.** This approach in principle focuses on DAH, although the analysis was limited to donors for which information on the recipient country or region was available. It uses project level data from the DAH database developed by researchers at IHME. The sources of data used to create this database are described elsewhere [IHME 2010]. Aid to MNCH and other sub-sectors in health is identified through keyword searches applied to the project description field of each project. The keywords include terms (in English and French) commonly used in the description of MNCH projects. As a result it is these words that effectively determine how expenditure on MNCH is defined. The disbursements of projects that are identified through the keyword search are included in the final estimates. Where a project is identified as belonging to both MNCH and other areas of health (e.g. HIV/AIDS), the disbursement amount is divided equally across the different areas. In terms of aid modalities, the nature of the keyword search strategy means only projects (targeting MNCH) are captured.

**G8 method.** In contrast to other two, this approach was developed with a very specific purpose in mind: to track the commitments made by G8 member countries at the Muskoka Summit in 2010. The objective of the exercise influenced the development of the method in two important ways. First, the method to track MNCH resources needed to be sufficiently simple and transparent such that bilateral donors themselves would know to what extent they are fulfilling their commitment. Second, the method needed to be able to trace MNCH spending via the core contributions of multilateral agencies back to the G8 member country. The approach focuses on the ODA contributions of G8 members. Allocation factors are applied to projects in each relevant CRS purpose code. The imputed percentages are based on demographic data, the burden of disease and other information. As with the IHME method, there is no explicit definition of MNCH expenditures but instead this is implied by the purpose codes of the included aid flows. All aid modalities are included. To impute G8 member spending via multilateral agencies, a percentage (provided by each multilateral) is applied to the core contributions of each bilateral donor.

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* As advised by the Countdown 2015 group, family planning activities were omitted from the definition of MNCH.
† These donors include the 23 DAC member countries, the EC, GFATM, GAVI, the World Bank, ADB, IDB, AfDB, and BMGF.
Table A2 gives a summary of each method. The most appropriate method depends on the objective of the exercise. The IHME method provides a full distributional breakdown of the purpose of all development assistance to health. The LSHTM method strives to provide the most accurate estimate possible of development aid to MNCH. Finally, the G8 method seeks to track donor commitments going forward in a way that is transparent.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>LSHTM</th>
<th>IHME</th>
<th>G8 Health Working Group</th>
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</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Academic research for use by global community</td>
<td>Academic research for use by global community</td>
<td>G8 agreed method to track member commitments</td>
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<tr>
<td><strong>Method</strong></td>
<td>Allocation factors applied to individual disbursements on the basis of project descriptions</td>
<td>Keyword search applied to project descriptions to identify MNCH disbursements</td>
<td>Allocation factors applied to CRS purpose codes</td>
</tr>
<tr>
<td><strong>Type of aid</strong></td>
<td>Official Development Assistance</td>
<td>Development Assistance to Health</td>
<td>Official Development Assistance of G8 members</td>
</tr>
<tr>
<td><strong>Aid modalities</strong></td>
<td>General budget support, sector support, basket-funding and projects</td>
<td>Projects (MNCH-specific)</td>
<td>General budget support, sector support, basket-funding and projects</td>
</tr>
<tr>
<td><strong>Years available</strong></td>
<td>2003-2008</td>
<td>1990-2008</td>
<td>2008</td>
</tr>
</tbody>
</table>
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**Working Group membership**

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<thead>
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</thead>
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