Methodology for Calculating Baselines and Commitments:
G8 Member Spending on Maternal, Newborn and Child Health

Context: To date, there has been no agreed methodology for tracking donor support to maternal, newborn and child health (MNCH), as the international standard for tracking donor support is to track the purpose or outcome of aid dollars, rather than flow to beneficiary groups (e.g. women of reproductive health and children). In addition, spending in a broad range of areas contributes to improved maternal and child health, including for health systems strengthening, infectious diseases, improved water and sanitation, and others.

In the lead-up to the Muskoka Summit, the G8 Health Working Group proposed the following methodology to capture G8 baseline spending in MNCH.

Year/Currency: This data is reported in current US dollars. The G8 used 2008 disbursements as the baseline, given this is the most recently available data reported to the OECD through the Development Assistance Committee (DAC) Creditor Reporting System (CRS) codes.

As noted in the 2010 G8 Muskoka Accountability Report, a commitment amount (as opposed to disbursement amount) is measured when the funds for a specific project are allocated and includes the entire project budget, which may be disbursed over a number of years. A disbursement takes place when the funds are actually spent against a committed budget amount. While over time, measuring Official Development Assistance (ODA) on a commitment basis or on a disbursement basis will eventually even out, commitments tend to fluctuate as disbursements are profiled over several years. For example, a G8 member may make a significant commitment for a single project in one year. If measured on a commitment basis, the full project amount will be counted in one year, whereas the actual spending will take place over several years. In order to eliminate the fluctuations that occur when making commitments, it is recommended that G8 members report on a disbursement basis.

Multilateral contributions: Multilateral agencies and initiatives analyzed their 2009 spending, as the most recent data available, to identify MNCH-related activities, and supplied an imputed percentage to the G8 members (see below). G8 members applied these imputed percentages to their multilateral core contributions in order to identify the portion of their multilateral disbursements relevant to MNCH in their baseline year. These imputed percentages are also relevant to identifying future commitments to multilateral initiatives and funds. Contributions by G8 members of the European Union through the European Commission are not attributed back to individual countries – but instead are contained within the Commission baseline. This approach decreases the baselines for G8 members of the European Union.

Multilateral agency/initiative	**Imputed percentage**
GAVI	100%
Global Fund to Fight AIDS, TB and Malaria	46%
Regional Development Banks	AfDF – 3%
	AsDF – 2%
	IDB Special Fund – 1%
UNFPA	67%
UNICEF	55%

World Bank	5%
World Food Programme	15%
World Health Organization	22%

*We requested and accept a recommended imputed percentage of 100% for the Global Polio Eradication Initiative. Spending on polio is tracked largely through DAC CRS codes for bilateral spending.

Bilateral contributions: The G8 Health Working Group recommended that the following imputed percentages be applied to bilateral expenditures through MNCH-related OECD-DAC CRS codes. This methodology was developed in consultation with and support from the OECD, the World Bank (WB) and the Countdown to 2015.

DAC CRS Code		**Imputed Percentages**
12110	Health policy and administrative management	40%
12181	Medical education/training	40%
12191	Medical services	40%
12220	Basic health care	40%
12230	Basic health infrastructure	40%
12240	Basic nutrition	100%
12250	Infectious disease control	40%
12261	Health education	40%
12262	Malaria control	88.5%
12263	Tuberculosis control	18.5%
12281	Health personnel development	40%
13010	Population policy and administrative management	40%
13020	Reproductive health care	100%
13030	Family planning	100%
13040	STD control including HIV/AIDS	46.1%
13081	Personnel development for population and reproductive health	100%
14030	Basic drinking water supply and basic sanitation	15%
14031	Basic drinking water supply	15%

14032	Basic sanitation	15%
51010	General budget support	4%

Rationale for using select OECD-DAC CRS Codes: The G8 Health Working Group focussed on OECD-DAC CRS codes describing activities the primary purpose of which is to protect or to improve health. Medical research (DAC code 12182) was however removed from the list because it was extremely difficult to estimate the proportion of currently funded health research targeting major causes of maternal and child death, and because their proportion is likely much smaller than their demographic weight. Basic drinking water supply and sanitation (CRS codes 14030 to 14032) are included as the primary purpose of these activities is to protect health.

*Demographic focus***:** An analysis was undertaken to determine the population segment targeted by an activity in order to assign an imputed percentage.

1) Activities targeted entirely or mostly at women of reproductive age and/or children under five (imputed percentage: 100%)

When activities described by a DAC code were targeted entirely or almost entirely at women of reproductive age and/or children under five, an imputed percentage of 100% was applied. While some DAC codes could include activities that extend beyond improving MNCH (e.g., reproductive health (13020) could include the treatment of infertility), we assumed that in the context of developing countries such activities represented a negligible proportion of ODA-funded initiatives. The DAC codes falling into this category are:

12240	Basic nutrition
13020	Reproductive health care
13030	Family planning
13081	Personnel development for population and reproductive health

2) Activities targeting the general population (imputed percentage: 40%)

For activities that targeted the entire population, demographic data was used to determine the percentage of the population represented by women of reproductive age and children under five. According to an analysis of UN population data[1] global estimates, these two groups represent approximately:

- Women of reproductive age (including those who are pregnant) – 25% of the population;
- Children under five – 15% of the population.

Therefore, DAC codes describing services targeted at or applicable to women of reproductive age and children under five were imputed a percentage of 40%. The DAC codes falling into this category are:

12110	Health policy and administrative management
12181	Medical education/training
12191	Medical services
12220	Basic health care

12230	Basic health infrastructure
12250	Infectious disease control
12261	Health education
12281	Health personnel development
13010	Population policy and administrative management

3) General Budget Support (imputed percentage: 4%)

To calculate the proportion of General Budget Support (GBS) for MNCH, we used 2007 data from the World Health Statistics Report to determine the average percentage of national budgets allocated to health in the 49 high-burden countries, which is approximately 10%. We then imputed to that "health share" a percentage of 40% based on the reasoning described above. The imputed MNCH percentage for General Budget Support (DAC code 51010) is therefore 4%.

4) Disease-specific DAC codes

Three DAC codes describe disease-specific control programs: 12262 (malaria control), 12263 (tuberculosis control) and 13040 (STD control including HIV/AIDS). In the context of official development assistance, virtually all the programs described by DAC code 13040 are HIV/AIDS prevention, treatment and care programs. We imputed to these DAC codes a percentage consistent with the proportion of death from the corresponding diseases (malaria, tuberculosis and AIDS) occurring in children, age 0 to 4 years, and women, age 15 to 44 years, based on WHO's Global Burden of Disease (2004 update).

12262	Malaria control	**89%**
12263	Tuberculosis control	**19%**
13040	STD control including HIV/AIDS	**46%**

5) Basic drinking water supply and sanitation (imputed percentage: 15%)

Water and sanitation are not part of the health sector as defined by DAC. However, basic drinking water supply and sanitation are activities whose primary purpose is to protect health, and, more specifically, to prevent gastro-intestinal infection and diarrhoea. Since diarrhoea is the second leading cause of under-five mortality, but not a major cause of maternal mortality (nor a leading cause of mortality in adults in general), we considered basic drinking water supply and sanitation as health programs targeting primarily under-five children and imputed a percentage of 15% based on the demographic weight of this population. This includes the following DAC codes:

14030	Basic drinking water supply and basic sanitation
14031	Basic drinking water supply
14032	Basic sanitation

Methodology for calculating G8 contributions To lives saved, support for access to family planning

The results identified in the Muskoka G8 Leaders' Statement are estimates. They are based on the findings and methodology of the Taskforce on Innovative International Financing for Health

Systems and adapted for the UN Secretary-General's Joint Action Plan (JAP) for Women's and Children's Health – "Investing in Our Common Future". The Taskforce estimated the additional financing needed on the basis of the interventions and health-system support required to accelerate achievement of the health Millennium Development Goals (MDGs) in the 49 lowest-income countries.

There is no fixed or agreed-upon path that countries must follow to scale up services, as countries are very diverse, and follow diverse paths. To account for the differences that exist, two analyses – "Scale Up One," based on the WHO-led normative approach, and "Scale Up Two," based on the World Bank and UNICEF-led Marginal Budgeting for Bottlenecks (MBB) approach – were undertaken to provide a range of costs and impacts, based on different assumptions with regards to speed and approach to the scale-up of services.

For the purposes of costing the achievement of the desired outcomes identified by the Taskforce and in the Joint Action Plan, the estimates were revised from a 2009-2015 timeframe to a 2011-2015 timeframe. As of June 2010, the Joint Action Plan Financing Working Group agreed to use the median estimates of the two approaches for the purposes of estimating the additional financing required in the 2011-2015 period. It is important to note that the methodology, the costing, the financial target, and the results estimates are all subject to change, and will not be finalized until the Joint Action Plan is agreed and launched in September 2010.

All actors — developing countries, OECD members including the G8, private foundations, the private sector, NGOs, global and regional funds, and the top 100 research foundations — must each play a role. If all partners respond as recommended in the Joint Action Plan, results which could emerge in the period 2011-2015 include:

(i) saving over 15 million additional lives of children under five years of age (child and infant deaths averted)

(ii) saving an additional 740,000 lives of mothers (maternal deaths averted)

(iii) enabling access to family planning for 141 million new users (towards unmet family planning need).

Accountability and Future Reporting

G8 members will work together with other organizations, such as the OECD-DAC, the World Bank, the WHO and the Countdown to 2015 to put in place an accountability mechanism that is rigorous and transparent. Details of this accountability mechanism and preliminary monitoring data will be made publicly available through the 2011 Accountability Report.

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1. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2008 Revision, **http://esa.un.org/unpp**

Source: http://g8.gc.ca/g8-summit/summit-documents/methodology-for-calculating-baselines-and-commitments-g8-member-spending-on-maternal-newborn-and-child-health/