

Development Co-operation Directorate  
Development Assistance Committee

## DAC Working Party on Development Finance Statistics

### POLICY BRIEF: RECOMMENDATIONS TO THE OECD DAC TO IMPROVE THE TRACKING OF SRMNCAH ODA

Formal meeting of the Working Party on Development Finance Statistics (WP-STAT)  
22-23 November 2018, OECD Boulogne

This document, prepared by the Joint Countdown to 2030 and Partnership for Maternal, Newborn & Child Health Technical Working Group for the Tracking of Financing for Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health (SRMNCAH), is presented FOR DISCUSSION under item 8 of the draft annotated agenda DCD/DAC/STAT/A(2018)3/REV1.

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JT03439973



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## Policy Brief: Recommendations to the OECD DAC to Improve the Tracking of SRMNCAH ODA

### Introduction: Purpose and scope of this paper

This paper was developed by the Joint Countdown to 2030 and Partnership for Maternal, Newborn & Child Health Technical Working Group for the Tracking of Financing for Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health (SRMNCAH). It makes recommendations to the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) on the tracking of financing for SRMNCAH.

More specifically, the paper provides recommendations to the DAC member countries. DAC members are part of the Working Party on Development Finance Statistics. The next Working Party meeting will take place in November 2018. The recommendations below are intended to inform the November meeting and to support dialogue on greater transparency, better estimates, more effective aid, and ultimately better health outcomes.

The Working Group strongly recommends that DAC members report on their RMNCH ODA. The availability of accurate, complete and timely data on donor spending for RMNCH is critical to ensuring accountability, continued effort by donors, and the identification of funding gaps.

At the 2010 G8 Muskoka summit, a new methodology was introduced to track funding for maternal, newborn and child health. For many years, the “Muskoka method” was used by donors to report on their spending for RMNCH and significantly contributed to financial accountability. However, in recent years the use of the method eroded and weakened financial accountability for RMNCH. Following the Muskoka summit and based on recommendations by the [WHO Commission on Information and Accountability for Women’s and Children’s Health](#), a more robust policy marker system was developed and implemented in the OECD/DAC Creditor Reporting System. However, uptake for the marker by a few major contributors has been slow, leading to weakened financial accountability for RMNCH.

More generally, effective tracking of financial contributions to RMNCH requires high quality, timely data from a comprehensive group of donors. While the quality and comprehensiveness of data in the CRS has improved, further improvements are required to facilitate the tracking of ODA for SRMNCAH at a more granular level and over time, in order to promote accountability.

## **Recommendations to the OECD DAC Working Party on Development Finance Statistics**

We make **six recommendations** to the members of the DAC Working Party on Development Finance Statistics and its Secretariat:

- 1. DAC members should report on their RMNCH spending using the RMNCH policy marker to the maximum extent possible. The DAC Secretariat should update definitions and coverage in consultation with DAC Members, as required.**

The RMNCH policy marker is a tag that donors can use in their annual reporting to denote that their aid is being directed to RMNCH, without relying solely on estimates and imputations (like in the Muskoka method, see below). The use of the policy marker would also support the other recommendations in this brief, namely to better track commitments, improve the quality of financial donor data, and, tracking RMNCH in large UHC programs and non-traditional sectors like humanitarian assistance. The marker could be used in its original 5-code system (4=100%, 3=75%, 2=50%, 1=25%, 0=0% supporting RMNCH), or by mirroring the policy marker 3-code structure (2=100%, 1=50%, 0=0%).<sup>1</sup> We also strongly encourage use of the policy marker by multilateral organizations and partnerships, especially those making large contributions to RMNCH, as well as private institutions, such as the Bill & Melinda Gates Foundation.

We recommend full implementation of the RMNCH marker by 2020, ideally by 2019, and suggest annual reviews of its implementation.

- 2. Until donors fully adopt the RMNCH marker, the Muskoka 2 method should be used to estimate disbursements for RMNCH globally, for recipient countries, and for those donors for which the RMNCH policy marker has not yet been implemented. When the RMNCH marker is fully adopted, the continued use of Muskoka2 should be reviewed.**

With input from the Working Group, LSHTM developed an updated Muskoka method (Muskoka2), which allows tracking of RMNCH financing. Like the original Muskoka method, Muskoka2 relies exclusively on required reporting fields in the CRS (donor, recipient, purpose code, disbursement value). It is therefore an approach which can be used with immediate effect to estimate the value of individual donors' contributions to RMNCH – including DAC members, non-DAC bilaterals, multilaterals, and private donors that report their disbursements to the OECD. Muskoka2 generates global and recipient-specific estimates from 2002 onwards.

Unlike the policy marker, however, it does not allow donors to indicate on a project-by-project basis how much of their funding was directed towards RMNCH. While it thus does not have the precision the project-level, it helps to complete the data and arrive at global and recipient country estimates over time.

Key differences between the original Muskoka method and Muskoka II include that there is no standard coefficient for funding to AIDS, TB, and malaria but that the share of funding contributing to RMNCH reflects the disease burden in recipients countries (the higher the burden for women of reproductive age and children in a country, the higher the share counting to RMNCH); three multilateral organisations with

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<sup>1</sup> There is an ongoing discussion on the scoring system.

an RMNCH-specific mandate (GAVI, UNFPA, UNICEF) are dealt with differently to all other donors, and have organisation-specific proportions of all funding that are considered to benefit RMNCH; the inclusion of funding to the humanitarian sector; the inclusion of funding from private foundations reporting to the CRS; and finally estimates were generated to allow the breakdown of RMNCH funding into the three subcomponents “R”, “MN”, “CH” (see Annex 1 for further details).

Once the RMNCH marker is fully adopted by donors, the need for a continued use of Muskoka2 should be reviewed.

### **3. Significantly improve the quality of financial donor data**

DAC members should continue to make substantial improvements to the quality of their submitted financial data. Donors (i.e. the DAC members) should make much better use of the project (aid activity) description field to provide precise, complete, and coherent descriptions. While some donors provide admirable detail in their reporting, others provide only a few words or use the same standardized paragraph for all records in a purpose code or sector. This greatly limits the usefulness of the data and the validity of more granular analyses. Ideally, donors would provide breakdowns of their disbursements by main activities or focus area. Donors could also report more detail on characteristics of intended beneficiaries, including age and sex; this would help to assess contributions to adolescent health, child health etc.

Donors could also include weblinks to supplementary data as part of the project descriptions, in addition to the basic descriptive text. A range of key global health donors have valuable data on their websites (e.g. USG’s PEPFAR’s expenditure database; the International Aid Transparency Initiative;), which provide more detailed information about their financing and activities.

Data quality could also be improved with further engagement with data users; for example, to develop quality metrics for donor reporting or to support donor reporting officers. Sector subject matter experts are at the heart of ensuring consistent and reliable reporting. Health experts need to be involved in creating reporting guidelines and to ensure follow up with program divisions. Without the engagement of health experts and policy advisors, program and statistical analysts alone will find it difficult to instil rigor in the project coding and reporting.

To avoid (at times politically motivated) underreporting on project activities, the DAC Secretariat should also consider providing guidelines to define what kind of information donors need to provide in the project description.

### **4. Enable better tracking of SRMNCAH/UHC investments outside health sector code reporting**

Important ODA investments in health occur outside the health sector. Humanitarian aid projects, for example, often include significant support for SRMNCAH and universal health coverage (UHC) more broadly (e.g. significant funding for disease outbreak response; medical services/supplies). However, it is difficult to track these investments as project descriptions for other sectors are often even weaker than for health projects (covered by codes 120/130).

To facilitate identification and assessment of health funding outside the health sector, DAC members should agree on ways to track these investments. There are various ways of doing it. The proposed Muskoka II method already includes coefficients for the humanitarian sector, but it could be expanded to include additional standard coefficients for other sectors; the policy marker could be extended to also cover additional investments. This could automatically be coded for all projects in the health and population sectors (120/130) and allow donors to indicate any health content in other sectors, notably education, social services, and humanitarian aid. In addition, more explicit guidance and support to other health sector codes on the writing of project descriptions, use of key terms, or even changes to the purpose code structure, such as inclusion of a humanitarian health purpose code within the humanitarian sector could be considered.

There is a related ongoing effort in the DAC, which recently introduced a “SDG Focus Field” in the Creditor Reporting System (CRS) database.<sup>2</sup> This focus field could potentially be leveraged to improve reporting outside the health sector codes. One challenge is that the focus field is not mutually exclusive and designed to track spending (it is qualitative in nature), not supported by all donors, which limits its usefulness. In addition, the OECD is also exploring the use of machine learning to classify projects, which appears an exciting initiative, but will depend on the quality of donors’ project descriptions.

#### **5. Create better links between commitments and disbursements**

Donors should make greater efforts to link their commitments to actual disbursements. While disbursements are critical, a comparison of commitment and disbursement data could be useful to assess if donors meet their SRMNCAH commitments. In addition, commitment data could be used to assess short-term financing trends (especially if donors would provide anticipated disbursement schedules, which would help link disbursements and expenditures).

#### **6. Provide historical data to complete time series**

Donors that already report to the OECD DAC should complete disbursement data from 2002 – or at least 2006 – onwards. Many additional donors have begun reporting data to the OECD in the last decade and many more have improved the quality of their data. However, these improvements have not always been made retrospectively, which limits the tracking of SRMNCAH funding over time. This is also a challenge for numerous (albeit smaller) bilateral donors, including for example, Czech Republic, Denmark, Hungary, Iceland, Poland, Slovak Republic, Slovenia, as well as numerous multilaterals, including the World Health Organization (WHO). Other key examples include Gavi, The Vaccine Alliance, which does not report data prior to 2007, and the Bill & Melinda Gates Foundation, which does not report data prior to 2009. While completing the data series from 2002 onwards would require a time investment from the relevant donors, it would greatly expand the potential for more sophisticated analysis and fulfil donors’ obligations of transparency.

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<sup>2</sup> For more information, please refer to: [http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DCD/DAC/STAT\(2018\)41/REV1&docLanguage=En](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DCD/DAC/STAT(2018)41/REV1&docLanguage=En)

## **Annex 1: Aid for Reproductive, Maternal, Newborn and Child Health: Development of the Muskoka2 methodology**

### **Introduction**

Several methods currently exist for tracking aid for health, or different areas of health, including reproductive, maternal, newborn, and child health (RMNCH). The Muskoka method was developed by the G8 to estimate the amount of their own official development assistance (ODA) benefitting RMNCH. Muskoka is a very quick and simple algorithm-based method, which produces estimates of aid for RMNCH in total; However, it was not originally designed to produce estimates of aid from all donors or to facilitate granular analysis by RMNCH sub-area or by individual recipient country. By contrast, the Countdown to 2015 developed an approach to facilitate highly granular analyses of aid for RMNCH overall, as well as individually for reproductive health (RH), maternal and newborn health (MNH) and child health (CH), especially for the Countdown priority recipient countries. The Countdown approach involved detailed manual coding of donors' data by researchers and was labour-intensive, slow, and difficult to replicate. In an effort to harmonize and reduce the number of different estimates produced, the Partnership for Maternal Newborn & Child Health (PMNCH) and the Countdown to 2030 have engaged partners and are working together on a new, joint approach, Muskoka2, with the aim that it build on the strengths of both Muskoka and Countdown. Muskoka2 is intended as a method which is simple and quick to implement, yet which enables reliable granular analysis. Muskoka2 produces estimates of aid RMNCH globally, for individual donors, and for individual recipient countries and country groups, and also breaks these down further into separate estimates for RH, MNH, and CH.

### **The Muskoka2 method**

The development of Muskoka2 has been critically guided by a group of key stakeholders, who have participated in the Joint Countdown to 2030/PMNCH Financing Working Group. It has been an iterative process of development, consultation, and refinement. The consultative nature of the process has been fundamental in generating a method that is credible, comparable and comprehensive – the three criteria agreed at a stakeholder meeting in London in May, 2018.

Muskoka2 is an algorithm, implemented in Excel, which estimates the amount of ODA+3 benefitting reproductive, maternal, newborn and child health (RMNCH), reproductive health (RH)<sup>4</sup>, maternal and newborn health (MNH) and child health (CH). The method produces estimates for these respective health areas globally, by donor organisation, and also by recipient country. Muskoka2 uses disbursement data from the OECD Creditor Reporting System (CRS). In addition, it draws on data from the World Bank, WHO, and IHME for variables on population structure, government expenditure on health, and number and age structure of cases of malaria, HIV and tuberculosis. To examine the share of bilateral donors' core

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<sup>3</sup> Official development assistance (ODA) plus private grants – currently the Bill and Melinda Gates Foundation are the only private foundation that report their private grants to the OECD/CRS.

<sup>4</sup> Within Muskoka2 we define RH as reproductive health activities for **non**-pregnant women

contributions to multilaterals that benefits RMNCH, it also draws on the OECD's separate data table, "Members' total use of the multilateral system".

Muskoka2 allocates a percentage of the value of each disbursement in the CRS data towards RMNCH, as well as towards RH, MNH and CH individually (which then add up to RMNCH in total). These can be summed to estimate ODA+ benefitting RMNCH or its components - RH, MNH or CH - in total, as well as by donor, by recipient country, and by the existing purpose code categories in the CRS (see Figure 1).

For all bilateral and private donors and most multilaterals, a purpose code-based approach is used. Purpose codes are assigned by donors when they enter their data into the CRS; they reflect the sector and specific purpose of the particular project they are funding, for example 'infectious disease control'. In Muskoka2 a specific percentage of funding in each purpose code is considered to benefit RMNCH. For most sectors and purpose codes, no funding is counted towards RMNCH. For 25 purpose codes in the health, population, water, and humanitarian sectors, as well as the general budget support purpose code, a non-zero proportion of disbursements is considered to benefit RMNCH.

For 16 of these 25 purpose codes, the exact same percentages of disbursements are counted towards RMNCH as in the original Muskoka1 methodology. Estimates of the proportion of funding with these purpose codes benefitting RH, MNH and CH individually were derived using the Countdown dataset (2003-2013). A further five of the 25 Muskoka2 purpose codes are from the humanitarian sector, which had been excluded from the Muskoka1 methodology. These percentages were also derived using the Countdown dataset (2003-2013) to estimate the proportion of funding within each humanitarian purpose code benefitting RMNCH, RH, MNH and CH. Finally, for four of the 25 Muskoka2 purpose codes – general budget support (51010), malaria (12262), HIV/AIDS (13040) and tuberculosis (12263) – the percentages of disbursements counted towards RMNCH estimates vary by recipient country and year. The approach follows the same logic as the original Muskoka1 approach, but attempts to use publicly available data to generate estimates that are more accurate, especially for individual recipient countries. For the three disease purpose codes, the percentages reflect the disease burden amongst women of reproductive age and children under five in a particular country. For general budget support, they reflect the proportion of government expenditure that is spent on health and the proportion of the country's population that is women of reproductive age and children under five.

Muskoka2 does not apply this purpose-code-based approach to three multilateral institutions – GAVI, UNFPA and UNICEF – with RMNCH-specific mandates, as doing so would underestimate their contributions. For these 3 institutions we developed institution-specific percentages, which are fixed percentages of all their disbursements that are considered to benefit RMNCH, RH, MNH and CH. These percentages were derived from the Countdown dataset (2003-2013).

### **Crediting bilateral donors for core contributions to multilateral institutions**

For estimates of funding from individual bilateral donors, we have also estimated the value of core contributions to multilateral institutions that benefitted RMNCH. Data from the OECD ("Members' Total Use of the Multilateral System" table) provided estimates of the amount of core contributions given by each bilateral donor to each multilateral institution. CRS data was used to calculate the proportion of disbursements from each multilateral that was considered to support RMNCH, as described above. These two values were then multiplied together to estimate bilateral donors' financial support for RMNCH

through core contributions to each multilateral organisation. These amounts are summed for each year and added on to individual bilateral donor estimates. Data from the OECD on members' total use of the multilateral system are only available from 2011 onwards, so the addition are only applied to bilateral estimates from 2011-2016 in our analysis.

This approach differs from the approach used in Muskoka1, where 10 multilaterals estimated the percentage of their funding spent on RMNCH activities in 2009. These percentages were then applied to bilateral core contributions to each of these multilaterals in all years, to calculate how much of bilateral core contributions were benefitting RMNCH. Bilateral donors were not credited for their core contributions to other multilaterals.

### **Using Muskoka2**

The Muskoka2 Excel template has been developed to ensure it is transparent and user-friendly for donors and other organisations to use to generate estimates. The template allows users to download and insert data directly from the OECD CRS, or for donors to input their own data using just a few variables (donor, recipient, purpose code, disbursement value) on each disbursement. The estimates are automatically generated once the data is inputted. While the template is designed to be easy to use, technical support can also be arranged through the Countdown to 2030/PMNCH Financing Working Group.

Figure 1: Flow diagram of Muskoka2 method

