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Assessing public and private sector contributions in reproductive health financing and utilization for six sub-Saharan African countries

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Abstract: *The present study provides evidence to support enhanced attention to reproductive health and comprehensive measures to increase access to quality reproductive health services. We compare and contrast the financing and utilization of reproductive health services in six sub-Saharan African countries using data from National Health Accounts and Demographic and Health Surveys. Spending on reproductive health in 2006 ranged from US$4 per woman of reproductive age in Ethiopia to US$17 in Uganda. These are below the necessary level for assuring adequate services given that an internationally recommended spending level for family planning alone was US$16 for 2006. Moreover, reproductive health spending shows signs of decline in tandem with insufficient improvement in service utilization. Public providers played a predominant role in antenatal and delivery care for institutional births, but home deliveries with unqualified attendants dominated. The private sector was a major supplier of condoms, oral pills and IUDs. Private clinics, pharmacies and drug vendors were important sources of STI treatment. The findings highlight the need to commit greatly increased funding for reproductive health services as well as more policy attention to the contribution of public, private and informal providers and the role of collaboration among them to expand access to services for under-served populations.* ©2011 Reproductive Health Matters. All rights reserved.

Keywords: family planning services, antenatal care, delivery care, STI services, health financing, National Health Accounts, Demographic and Health Surveys, Africa

REPRODUCTIVE health (RH) may no longer be the "missing" Millennium Development Goal (MDG), but it remains a neglected one.[1] After being left out of the 2000 formulation of the MDGs, universal access to RH was added in as a sub-component of MDG 5 on maternal health in 2005 (MDG-5b). However, this acceptance of the importance of RH has not translated into sufficient investments for achieving the stated goal of universal access. Indeed, targets for RH funding set long before the MDGs at the International Conference on Population and Development in 1994 have not been met.[2] From 2000 to 2007, donor assistance for family planning (FP) decreased drastically from current US$518 million to current US$462 million, or from 30% to 5% of total population assistance (which includes FP; basic RH services consisting of maternal health, abortion, information, education, and communication about RH, among other services; sexually transmitted infections (STIs), HIV/AIDS, and basic

research, data, and population and development policy analysis). Funding for basic RH services other than FP and STIs was also reduced from 30% to 17% of the total population assistance.[3]

Low funding for RH is a cause for concern, given that RH service utilization in the vast majority of the developing world is well below desired levels. Worldwide, 21.6 million unsafe abortions took place in 2008, a nearly 2 million increase from the estimated 19.7 million in 2003.[4] Approximately 5 million women are estimated to be hospitalized each year for the treatment of complications from unsafe abortions.[5] In sub–Saharan Africa, only 17% of married women of reproductive age use modern contraception, and 39% of pregnancies in the region are unintended.[6] Furthermore, inequalities in access to RH services within countries across different socio-economic groups remain stark.[7] Ultimately, the mismatch between funding and the need for effective and equitable delivery of RH services threatens progress towards achieving universal access to RH by 2015.

Using data on financing and utilization of RH services in six sub–Saharan African countries, this paper provides evidence to make a strong case for the global health community to strengthen its financial and political commitment to ensuring universal access to RH. While the utilization data are drawn from the Demographic and Health Surveys (DHS), the health financing data are drawn from the RH Subaccount (RHS) of the National Health Accounts (NHA) framework. Combining financing and utilization data in these six countries allows us to gain insight into key constraints in the region, which can serve as a valuable addition to the global picture reviewed above. In particular, our analysis highlights the link between recent levels and trends in RH funding and utilization in the six countries studied. In examining the key stakeholders in financing and delivering RH services, we pay special attention to the role of the private sector in RH service provision, which we argue may be leveraged to improve access to quality RH services for underserved populations.

Methodology

Six countries were selected for the analysis based on the availability of NHA RHS data: Ethiopia, Kenya, Malawi, Rwanda, Tanzania, and Uganda.

Table 1. Countries and years of data used for the analysis

	National Health Account RH Subaccount	Demographic & Health Survey
Ethiopia	2006	2005
Kenya	2006	2003
Malawi	2004	2004
Rwanda	2002, 2006	2000, 2005
Tanzania	2002, 2006	1999, 2004
Uganda	2006	2006

As the NHA RHS is relatively new, estimates have been completed in only a few countries. Of the six countries, Rwanda and Tanzania have RHS estimates for 2002 and 2006, facilitating an examination of changes over this period. DHS data were selected to match the timing of the RHS as closely as possible. DHS data were downloaded from Measure DHS's website;[8] NHA data were obtained from country reports.[9–15] As shown in Table 1, in most cases, the timing of NHA and DHS follow each other closely. The study covers the years 1999–2006.

National Health Accounts and Reproductive Health Subaccounts

NHA is an internationally accepted tool used to estimate a country's total spending on health activities.[16] By comprehensively tracking the flow of funds through a country's health system, it provides information on the distribution of health spending across major financing sources, key stakeholders who manage health spending, the providers of services, and the type of services utilized. With the support from the World Health Organization, World Bank, US Agency for International Development and other major international organizations, NHA estimations have been conducted in more than 100 countries over the past 20 years.

The NHA subaccounts are designed to provide more detailed information about priority health areas such as RH, HIV/AIDS, tuberculosis, malaria, and child health. The RHS estimates total spending on RH services, which includes broadly FP, maternal health, and sexual health (including STIs). In the case of RH interventions that overlap with other subaccount areas, such as HIV/AIDS