

# Donor Commitments and Disbursements for Sexual and Reproductive Health Aid in Kenya, Tanzania, Uganda and Zambia

Denis Kibira et al | 2021 | [Download PDF](#)

*Citation: Kibira D, Asiimwe C, Muwonge M, van den Ham HA, Reed T, Leufkens HG and Mantel-Teeuwisse AK (2021) Donor Commitments and Disbursements for Sexual and Reproductive Health Aid in Kenya, Tanzania, Uganda and Zambia. Front. Public Health 9:645499. doi: 10.3389/fpubh.2021.645499*

**Background:** Sexual and Reproductive Health and Rights (SRHR) investments are critical to people's well-being. However, despite the demonstrated returns on investments, underfunding of SRHR still persists. The objective of this study was to characterize donor commitments and disbursements to SRH aid in four sub-Saharan countries of Kenya, Tanzania, Uganda and Zambia and to compare trends in donor aids with SRH outcome and impact indicators for each of these countries.

**Methods:** The study is a secondary analysis of data from the Organization for Economic Co-operation and Development's Assistance creditor reporting system and SRH indicator data from the Global Health Observatory and country demographic health surveys for a 16-year period (2002–2017). We downloaded and compared commitments to disbursements of all donors for population policies, programs and reproductive health for the four African countries. SRH indicators were stratified into health facility level process/outcome indicators (modern contraceptive prevalence rate, unmet need for family planning, antenatal care coverage and skilled birth attendance) and health impact level indicators (maternal mortality ratio, newborn mortality rate, infant mortality rate and under five mortality rate).

**Results:** Donor commitments for SRH aid grew on average by 20% while disbursements grew by 21% annually between 2002 and 2017. The overall disbursement rate was 93%. Development Assistance Cooperation (DAC) countries donated the largest proportion (79%) of aid. Kenya took 33% of total aid, followed by Tanzania 26%, Uganda 23% and then Zambia (18%). There was improvement in all SRH outcome and impact indicators, but not enough to meet targets.

**Conclusion:** Donor aid to SRH grew over time and in the same period indicators improved, but improvement remained slow. Unpredictability and insufficiency of aid may be disruptive to recipient country planning. Donors and low- and middle-income countries should increase funding in order to meet global SRHR targets.

# Background

Universal access to sexual and reproductive health and rights (SRHR) is necessary for the achievement of people's social, economic and environmental dimensions of sustainable development (1). The attainment of SRHR has not been realized as highlighted by an estimated annual death of more than 350,000 women and 5.6 million children worldwide from preventable complications related to pregnancy and childbirth (2). Developing countries are affected disproportionately with 99% of the deaths from complications related to pregnancy and childbirth which could be mostly prevented by proper healthcare and services (3). Developing countries have the highest maternal, newborn and under-five mortality rates in the world (4). About 80 per cent of under-five deaths occur in two regions, that is sub-Saharan Africa and Southern Asia (2). [Table 1](#) shows SRH indicators for some of the most affected sub-Saharan countries namely Kenya, Tanzania, Uganda and Zambia.

SRHR is one of the inequities that the Millennium Development Goals (MDGs) sought to address (9). Building on the MDGs, the Sustainable Development Goals (SDGs), agreed by 193 world leaders in 2015, are a 17-point plan to end poverty, combat climate change and fight injustice and inequality. SDG 3 aims to ensure healthy lives and promote well-being for all at all ages (10).

SDG 3 sets targets by 2030 which include: reduce the global maternal mortality ratio to <70 per 100,000 live births; end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to as low as 12 per 1,000 live births and under-five mortality to as low as 25 per 1,000 live births; ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs.

To meet the above targets and improve health status, adequate health financing is essential (11). However, low- and middle-income countries (LMICs), in which resources are limited, also have inadequate health expenditure by governments (12). For example, in financial year 2009/10, the Kenyan government allocated about US\$12.20 per person (equivalent to 5.4 % of the domestic budget) to health, and in Uganda the domestic budget was about US\$11.20 per person equivalent to 7.4 % of the budget (13). This is against a backdrop of US\$ 34 per person recommended by the WHO Commission on Macroeconomics and Health for governments to spend per year to provide a set of essential interventions (14). The limited spending on health by LMIC governments has meant that outside support is required (15). The magnitude of external funding on health as a percentage of total health expenditure has been significant, varying from 11 to 60% in over 28 sub-Saharan countries (16).

The United Nations (UN) Secretary-General's *Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030* aims to catalyze the SDGs by mobilizing stakeholders including governments, donors/development partners, civil society, academia, healthcare providers and communities to scale up and prioritize high-impact interventions for strengthening health systems, integrating efforts across diseases and sectors as well as promoting human rights, gender equality and poverty reduction (9). In low-income

countries, where much development assistance for health (DAH) is targeted, it made up 34.6% of total health spending in 2016 (17). DAH was estimated to total \$37.6 billion in 2016, up 0.1% from 2015. However, after a decade of rapid growth from 2000 to 2010 (11.4% increase annually), DAH grew at only 1.8% annually between 2010 and 2016. SRHR is one of the priority areas financed by DAH from wealthier nations and international agencies (18).

In order to improve accountability for DAH, there has been increased efforts in resource tracking (19, 20). Studies have tracked trends and magnitude of donor funding to different areas of SRH that is reproductive, maternal, newborn, and child health (21), and sought to verify whether donor resources are better targeted to countries with the highest need (21). However, there is need to further explore what determines donor aid to recipient countries, priorities funded by donors within recipient countries, donor aid predictability (including whether donors disburse what they commit), how the donor aid is used by recipient countries, its effectiveness, and how donor aid influences funding of priorities by recipient countries (22).

This study sought to characterize donor predictability by examining their commitments and disbursements for SRH aid in four of the most affected countries in sub-Saharan Africa. The study therefore described the types of donors, the value and trends of their commitment and disbursement for SRH aid and matched the aid to changes in SRH indicators across the four countries in order to add to the body of knowledge on DAH accountability.

## Methods

### Data Sources and Definitions

The study is a secondary analysis of data on donor aid commitments and disbursements for SRH from the Organization for Economic Co-operation and Development's Assistance creditor reporting system (OECD CRS) for a 16-year period (2002-2017).

The OECD CRS is a database to which donors of official development assistance (ODA), other official flows and private grants report their commitment and disbursement activities as described at <http://www.oecd.org/dac/stats/methodology.html>. The CRS is a publicly accessible web-based database on aid activities, developed and maintained by the Development Assistance Committee (DAC) of the OECD (18). OECD DAC commitments and disbursements are tracked at both the aggregate level and at the level of particular aid programmes (22).

ODA refers to grants or loans from members of the OECD DAC (a group of 30 nations including most of the West European and North American countries, the European Union, Australia, New Zealand, Japan, and Korea), non-DAC bilateral donors (mostly Eastern European and Middle Eastern countries for example Croatia, Bulgaria, Turkey, Israel, United Arab Emirates, Kuwait), multilateral institutions (for example International Monetary Fund, regional development banks), global health initiatives (for example Global Fund to Fight Tuberculosis, AIDS and Malaria, Global Alliance for Vaccines and Immunization) and

private philanthropists (for example Bill and Melinda Gates Foundation, Metlife Foundation, United Postcode Lotteries) with promotion of economic development and welfare as the main objective (22). In addition to financial flows, technical co-operation is included in aid (22).

Commitments refer to a firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organization (22). Recipients are defined by the CRS as all “developing countries” eligible to receive ODA. These include all “least developed countries” as defined by the United Nations and all LMICs defined by the World Bank, except any members of the G8, or members or agreed future members of the European Union (23).

Disbursements refer to the release of funds to or the purchase of goods or services for a recipient; by extension, the amount thus spent. Disbursements record the actual international transfer of financial resources, or of goods or services valued at the cost to the donor. In the case of activities carried out in donor countries, such as training, administration or public awareness programmes, disbursement is taken to have occurred when the funds have been transferred to the service provider or the recipient.

WHO and the United Nations Interagency Working Group set 17 population-based indicators to provide an overview of the global and national SRH situation (24). We divided these indicators into health facility level process/outcome indicators and health impact level indicators. Of the process/outcome indicators, we selected indicators that are routinely collected using country demographic health surveys conducted between 2002 and 2018. These include modern contraceptive prevalence rate (mCPR), unmet need for family planning (FP), antenatal care coverage (ANC) and percent of births attended by skilled health personnel. For impact we selected the mortality indicators, maternal mortality rate (MMR) and neonatal mortality rate (NMR), and added infant mortality rate (IMR) and under five mortality rate (U5MR).

## **Data Collection**

We downloaded ODA data on commitments and disbursements for all donors for population policies, programs and reproductive health for four sub-Saharan African countries; Kenya, Tanzania, Uganda and Zambia from the OECD CRS for a 16-year period (2002 to 2017) on 22nd September, 2019.

OECD-CRS database has eight parameters: donors, sectors, ODA flow, channels, amount type, flow type, type of aid, and unit of aid in US million dollars. We selected data for all 110 donors reporting onto the system to the four recipient countries. Under sectors we selected code 130 with data on population policies/ programs and reproductive health and took into consideration all its subgroups which included population policy and administrative management, family planning, sexually transmitted diseases control and personnel development. We used total ODA and we considered all the different channels of fund flows including the public sector, non-government organizations (NGOs) and civil society, public-private partnerships, multilateral organizations, teaching institutions, research institutions

or think tanks. On amount type, we chose constant prices in US dollars (USD) which is the amount that is adjusted for the effects of inflation. Under flow types, we considered both commitments and disbursements. We selected all types of aid including budget support, core contribution and pooled programmes, project-type interventions and technical assistance. The selected data was then exported into Microsoft Excel spreadsheet.

We collected data on the SRH indicators from the Global Health Observatory (GHO) and DHS surveys accessed from DHS StatCompiler on 22nd September, 2019. The Global Health Observatory derives this data from the United Nations Inter Agency Group (UN IAG) for Child Mortality Estimates: Levels and Trends in Child Mortality, Report 2017 (Available from: <http://www.childmortality.org>). Data on the MMR was derived from the World Bank Database available at <http://data.worldbank.org/indicators/sh.sta.mmrt>. We selected the four countries (Kenya, Tanzania, Uganda and Zambia) and filtered available data which was for the period (2002-2017) that was then exported into Microsoft Excel.

## Data Analysis

We studied trends for donor commitments and disbursements of SRH aid for the period 2002-2017 to the four countries. We examined variations in: the commitments and disbursements over time by total value; the commitments and disbursements over time by different types of donors (we considered DAC countries, multilateral organizations, UN agencies and the World Bank which contributed 83.4% of funding to the four countries); and examined the commitments and disbursements over time to each of the four countries and by type of donors to each of the countries.

In a descriptive manner, we compared the time series data on donor aid disbursements to SRH indicators in each of the four countries.

## Results

### Total Donor Commitments for SRH Aid to the Countries

Total donor commitments for SRH to the four countries (Kenya, Tanzania, Uganda and Zambia) grew annually by 20% on average between 2002 and 2017 from USD 319.14 million to 1,635.05 million. There was an increase in commitments between 2002 and 2008 but thereafter there were fluctuations. The total amount of commitments equalled USD 21,678 million over the 16-year period. Kenya received the largest donor commitments totalling USD 7,571.24 million (35%) over the sixteen-year period, followed by Tanzania at 24% amounting to USD 5,296.66 million, Uganda at 22% amounting to USD 4,837.67 million and then Zambia being the lowest at 18% amounting to USD 3,972.04 million. Despite the general growth in commitments, there were year on year fluctuations over the period with a general decline in 2010. [Figure 1](#) shows trends in donor commitments to the four countries.

DAC countries committed the largest proportion (82%) equivalent to USD 18,444.25 million over the sixteen-year period (2002-2017) followed by multilateral institutions, UN agencies and then the World Bank as shown in [Annex 1](#).

DAC countries committed the highest amount (36% of their commitments) to a tune of USD 5,989.29 million to Kenya. Tanzania took the largest commitment of funds (USD 960.69 million, 30%) from multilateral donors. Uganda received the largest commitment of funds (USD 106.10 million, 30%) from UN agencies whereas the World Bank also committed most of its funds (USD 139.95 million, 46%) to Kenya. In contrast, Tanzania, Uganda and Zambia did not receive any commitments for SRH funds from the World Bank between 2005 and 2014. See table in [Annex 1](#) for details.

## **Total Donor Aid Disbursements to Countries**

The total disbursements to the four countries over the 16-year period were USD 19,852.92 million. The overall disbursement rate over the sixteen-year period was 93%. Disbursements grew over time rising from USD 181.27 million in 2002 to 1,999.51 million in 2013, but thereafter reduced to 1,455.43 million in 2015 and rising to 2,016.85 million in 2017 at an average annual growth rate of 21%. In contrast with the commitments, there was a steady increase in disbursements until 2013 and 2014 for Zambia and a drop in 2015 from where disbursements then started to rise slowly. Kenya received the largest donor disbursements totalling USD 6,457.52 million (33%) over the sixteen-year period, followed by Tanzania at 26% amounting to USD 5,258.61 million, Uganda at 23% amounting to USD 4,568.79 million and then Zambia being the lowest at 18% amounting to USD 3,567.99 million. Despite the general growth in disbursements, there was a general decline between 2013 and 2015 before picking up in 2016. Trends in donor aid disbursements to the four countries are shown in [Figure 1](#).

The highest donor disbursement over the sixteen-year period (2002–2017) was from DAC countries comprising 79% of the total and rising from USD 138.36 million in 2002 to USD 1,686.01 million in 2017. Multilateral funders followed the DAC countries contributing 17% of disbursements. United Nation agencies and the World Bank contributed 2% each. Trends in donor aid disbursements for SRH by donor type in the four countries are shown in [Annex 1](#).

Kenya was the biggest recipient from DAC countries getting 35% of funds worth USD 5,626.52 million over the period 2002–2017. Tanzania took the largest proportion (39%) of funds (USD 1,396.54 million) from multilateral donors; Uganda received the largest proportion 30% of funds worth USD 122.43 million from UN agencies whereas the World Bank also provided most (45%) of its funds (USD 146.05 million) to Kenya. This is detailed in table in [Annex 1](#).

## **Country Specific Donor aid Commitments and Disbursements**

[Figure 2](#) highlights the trends in the donor aid commitments and disbursements to each of the four countries. The trends show that the commitments and disbursements grew mostly in line overtime but peaks in commitments were not reflected in the disbursements. While Kenya received most aid, it also had most fluctuations between amounts committed and disbursed. For Kenya 86% of commitments were disbursed compared to 100% of commitments for Tanzania, 95% for Uganda and 91% for Zambia over the total study period.

## Comparison of Trends in Donor Disbursements to SRH Indicators

[Figure 3](#) shows SRH health facility level process/outcome indicators which showed improvement over the 16-year period across the four countries. ANC improved and remained very high, mCPR increased with most pronounced increase observed in Kenya, and unmet need for FP reduced mostly in Kenya. Tanzania was much slower in improvement in the indicators. Skilled birth attendance increase was most pronounced in Uganda and Zambia. Improvement in SRH impact indicators ([Figure 4](#)) were most pronounced for Kenya. U5MR and IMR dropped markedly across the four countries but reduction in NMR was slow. MMR dropped across the four countries with Kenya having the most pronounced improvement. The rise in donor aid disbursements between 2005 and 2017 aligned with improved SRH outcome and impact indicators but not enough to meet SDG targets. Impact indicators reduced majorly between 2002 and 2005 and slowed thereafter especially for under five mortality.