NSI The North-South Institute

Policy Brief

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The Muskoka Initiative and Global Health Financing

In 2010, Canada led donor countries in launching the G-8 Muskoka Initiative for Maternal, Newborn and Child Health (MNCH). The $2.85 billion 5 year commitment (2010-2015) was undertaken at the highest level with the strong support of the Prime Minister.

The funding commitment entails $1.1 billion in new and additional spending, over and above $1.75 billion in continued baseline funding.

The key finding from our analysis, based on data from the start of the commitment to 2013, is that Canada is well on track to meet its financial commitment. This is salutary, especially given the impact of fiscal austerity on the aid budget and other significant changes such as the amalgamation of the former aid agency with the department of foreign affairs during this period. These changes have not deterred Canada's commitment to global health. Canada emerges as a leader in global health financing and health is the most important sector in Canadian aid.

Replicating official claims regarding the status of the initiative, however, proved relatively difficult. While a lot of useful information has been made available, this tends to be fragmented (across sources, data and format types). This presents an opportunity to further enhance data transparency, access to information and ultimately accountability to both taxpayers and our development partners.

Most analyses of health financing to date have focused either exclusively on Canada, or more generally on global health financing. Placing Canada in a global perspective is a gap this report seeks to respond to. This report aims to provide a more complete picture of the MNCH initiative by leveraging open data from a range of sources. The report also explores health financing from a developing country perspective, taking Canada's 10 priority Muskoka-MNCH countries as a sample.

A limitation of this analysis is that it focuses primarily on financial data analysis, as opposed to a wider analysis of health outcomes and program results.

This policy brief offers a preliminary data analysis of Canada's Muskoka MNCH health financing initiative, placing the same in the wider context of global health financing. The analysis sheds light on the following questions:

Where is Canada with respect to its financing commitment?

Where does Muskoka-MNCH funding go? And who are the key partners?

Which subsectors, within health, are the focus of the initiative?

How does Canada compare with other donors active in global health financing?

How does donor health spending compare with other sources, such as domestic financing in developing countries?

About Muskoka-MNCH

The Muskoka-MNCH initiative came about as a result of a concerted effort by global health experts and health advocates during the mid-2000s to raise awareness of key maternal and child health concerns across the developing world. Canada, which hosted the 2010 G-8 summit, took a leadership role in both committing financing and galvanizing other donors around maternal and child health.

G-8 countries committed to mobilizing $5 billion of additional funding over the five years starting in 2010 towards MNCH, in addition to $4.1 billion that G-8 members already contributed annually. In total the Initiative was anticipated to mobilize significantly more than the $10 billion over the period 2010-2015. With commitments by other governments (Netherlands, New Zealand, Norway, Republic of Korea and Switzerland), and by foundations (the Bill and Melinda Gates Foundation and UN Foundation), the total amount (including Canada's $2.85 billion) committed at Muksoka reached US$7.3 billion (Integrated Implementation Framework).

Access to information and accountability, have been top priorities for the global MNCH agenda since Muskoka. The Commission on Information and Accountability for Women's and Children's Health (COIA) was set up in December 2010, soon after the Muskoka summit. Here again Canada has played a leadership role. Prime Minister Stephen Harper co-chaired the Commission along with President Kikwete of Tanzania. The Commission played a key role in setting an ambitious but realistic accountability framework. Its recommendations covered three main areas: *investing in the generation of better information for better results* (ranging from investment in health information systems, to tracking 11 common indicators at a disaggregated level for monitoring). *Better tracking of financial resources going towards MNCH* (ranging from aggregate resource indicators on total health expenditure to compacts between governments and development partners to increased capacity to review health spending and relate the same to human rights, gender and other equity goals). *Better oversight of results and resources* (at the national level, through increased information sharing on commitments, improvements to the OECD-DAC Creditor Reporting System and establishment of an independent expert review group at the global level) (WHO 2010).

Our analysis and approach

This analysis focuses primarily on financial tracking, as opposed to a wider analysis of health outcomes and indicators. In many ways it reflects the level of progress made in the areas noted above, but also reflects some of the limitations and opportunities. A fuller analysis would take into account health outcomes and results data, and would go well beyond an operational or programming perspective. It would need to account for a host of factors that make attribution of results to particular expenditures very challenging, especially over a relatively short period of time as far as (mostly) slow moving health indicators are concerned.

NSI's analysis was motivated by the fact Muskoka-MNCH is the largest individual element in Canadian aid spending. While we found a lot of very useful "open data" was available that helped shed light on the projects and activities within the initiative, this was often fragmented across sources, data types (CSV, XML, HTML tables etc.) and formats (see Figure 1). NSI's work on leveraging open data to enhance development effectiveness is aimed in part at building tools and solutions that help make open data less technical and more accessible. One of the ways NSI does this is through interactive data visualizations on the Canadian International Development Platform (CIDP). The analysis here will also be available through the platform (www.cidpnsi.ca), via interactive visualizations and as raw data (in machine readable formats).

Figure 1: Databases and Sources

Muskoka-MNCH Tracker Data	
Main Source	**Specific Database or Datasets**
Department of Foreign Affairs Trade and Development (Canada) (DFATD), via the departmental Open Data Portal	MNCH Project Browser Projects Browser Historical Projects Data Set International Aid Transparency Initiative (IATI) standard Statistical Report on International Assistance List of Muskoka-MNCH Unique Project IDs Direct data from DFATD
Institute for Health Metrics and Evaluation (U Washington)	Financing Global Health 2013
Organization for Economic Cooperation and Development - Development Assistance Committee (OECD-DAC)	Creditor Reporting System (CRS)
World Bank	World Development Indicators Database Health Stats Database
World Health Organization (WHO)	Global Health Expenditures Database (GHED) Global Health Expenditures Atlas 2011

See references section for further details.

Another motivation behind this analysis is simplifying the relatively complicated nature of the Muskoka-MNCH financial commitment. The Canadian contribution is broken down into $1.1 billion in *new* funding, in *addition* to $1.75 billion in continued baseline funding. Baseline funding is tracked through the OECD-DAC CRS database according to a predetermined formula agreed by the G-8 donor countries (G8 2010). When we began our analysis there was no publically available source that linked this legacy data with the new and additional $1.1 billion (which was shared to a large extent but not completely through the DFATD MNCH Project Browser). Furthermore, expectations around transparency, accountability and data access have increased since the start of the initiative due to substantial progress made by Canada (or more particularly former CIDA) by: (a) publishing more project level data through the open data portal (2011), (b) committing and publishing to the IATI standard (since 2012), and (c) raising Canada's global profile as a transparent aid donor as indicated by the 2013 Aid Transparency Index (Bhushan and Bond 2013).

The technical work in terms of joining and combining databases and datasets, conducting analytics and building visual interfaces was done through a series of coding events (also called 'hackathons' or data dives). Proofs of concept and preliminary findings were discussed at the Random Hacks of Kindness (Ottawa) data dive in December 2013 and at the Open Data Development Challenge (Montreal) in January 2014 (Bhushan 2013, 2014, 2014a; ODDC 2014).

The main databases and sources used are specified in Figure 1 (further details are available on request). Canadian sources were accessed through the DFATD open data portal between December 2013 and April 2014 (with the exception of project identifiers and legacy financial data sought directly from the department).[1] OECD-DAC data was used to situate Canada amongst other DAC donors. The Institute for Health Metrics and Evaluation and World Health Organization health expenditure data sources, are used to situate Canadian and other donor health spending within the

[1] IATI data could have been an option but does not (yet) contain MNCH identifiers. This it is not an issue of Canada not providing the data via this channel, but more a limitation of the global standard, and an area for future enhancement.

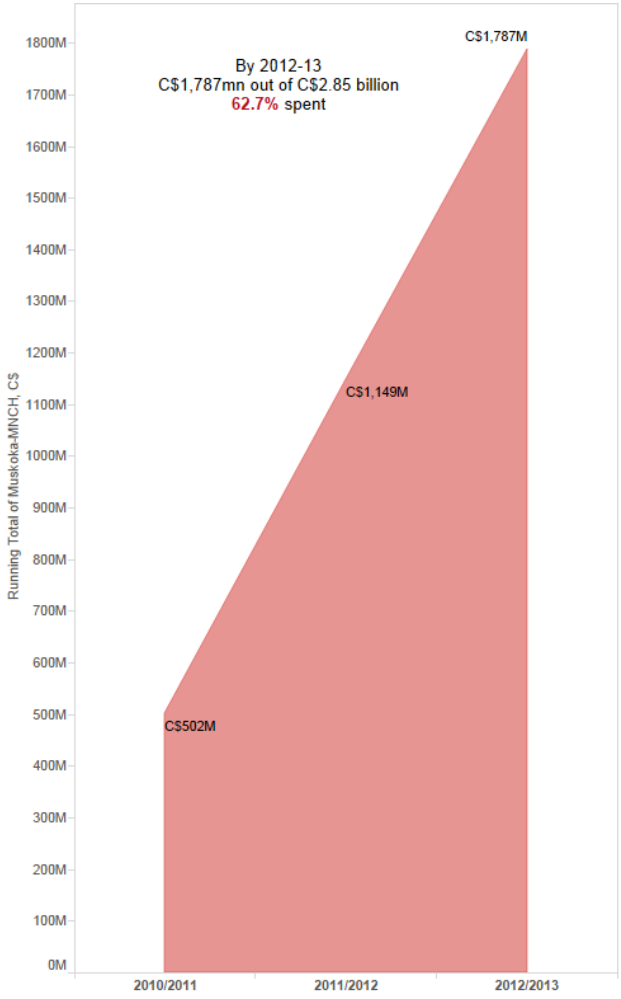
wider context of global health spending, which includes domestically mobilized resources in developing countries that are spent on health, and contributions from the private sector, foundations, other non-profits and philanthropies (IHME 2014, WHO 2011, 2011a, WHO-GHED).

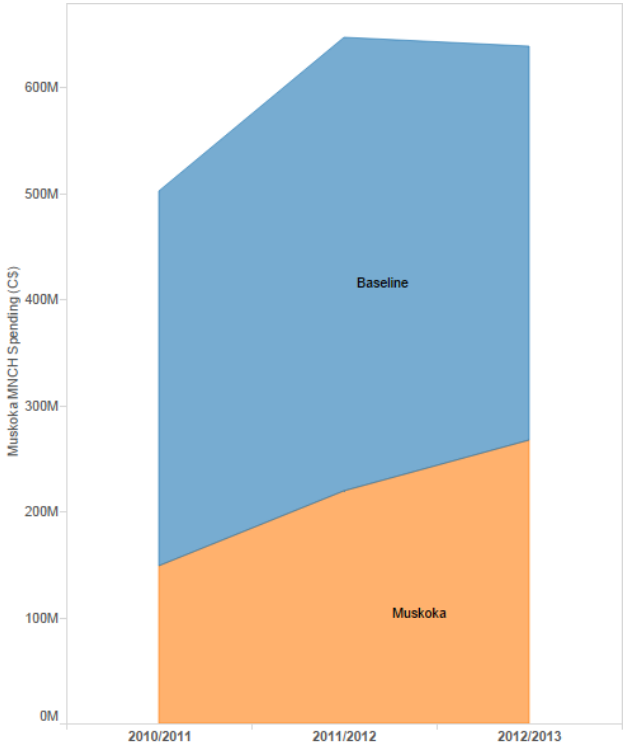
Where is Canada with respect to its financing commitment?

The data in Figure 2 below tracks spending on the overall $2.85 billion 5 year Canadian commitment and breaks it down into “baseline” and “Muskoka” funding. The graph on the left (red) indicates cumulative totals. The data go up to 2012-13. Up to that point, as can be seen, $1.787 billion out of $2.85 billion had been spent or 62.7%.[2] Given the initiative was in year 3 out of 5, we can conclude that spending was well on track. The data also shows most of this spending is related to ongoing baseline funding. By 2012-13, baseline spending totaled $1.15 billion while Muskoka spending[3] totaled $635 million.

[2] It should be emphasized our data only goes up to 2012-13. The recent publically quoted figure in the Canadian media, around 80%, which includes preliminary spending in the 2013-14 fiscal cycle, is not covered by this analysis. However, 80% expenditure by May 2014 is consistent with trends in the data discussed here.
[3] Muskoka spending in this case refers to the new and additional $1.1 billion.

Figure 2: Muskoka-MNCH Overall Spending, 2010-11 to 2012-13





Type	2010/2011	2011/2012	2012/2013	Grand Total
Baseline	C$353M	C$428M	C$372M	C$1,153M
Muskoka	C$149M	C$219M	C$267M	C$635M
Grand Total	C$502M	C$647M	C$639M	C$1,787M

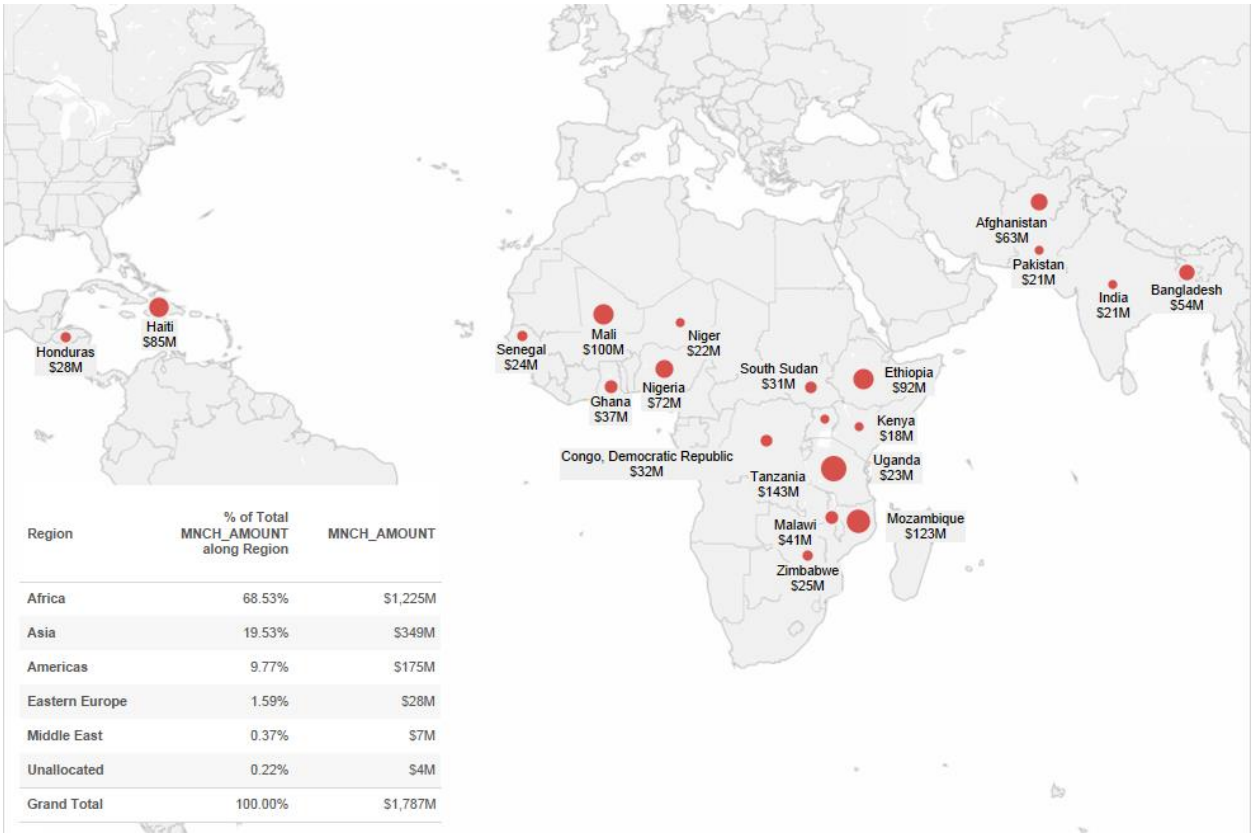
Source: author calculations based on data from DFTAD sources (see Figure 1).

Where does Muskoka-MNCH funding go? And who are the key partners?

Figure 3 below maps Muskoka-MNCH funding that is allocable by country. Not all funding is allocable by country, for instance a substantial amount is at the regional level and not specified by country (and so cannot be mapped). Figure 3 maps the Top 20 Muskoka-MNCH recipient countries for Canada. The data spans the start of the initiative to 2012-13 (as above).

The largest recipients by country are primarily in Africa, led by Tanzania ($143mn), Mozambique ($123mn), Mali ($100mn), Ethiopia ($92mn) and Haiti ($85mn) which is the largest non-African recipient (all data is up to 2012-13). As Figure 3 also shows, the vast majority of Muskoka-MNCH spending at the regional level is in Africa which accounts for 68.5%, followed by Asia 19.5% and the Americas at 9.7%.

Figure 3: Top 20 Muskoka-MNCH Recipient Countries



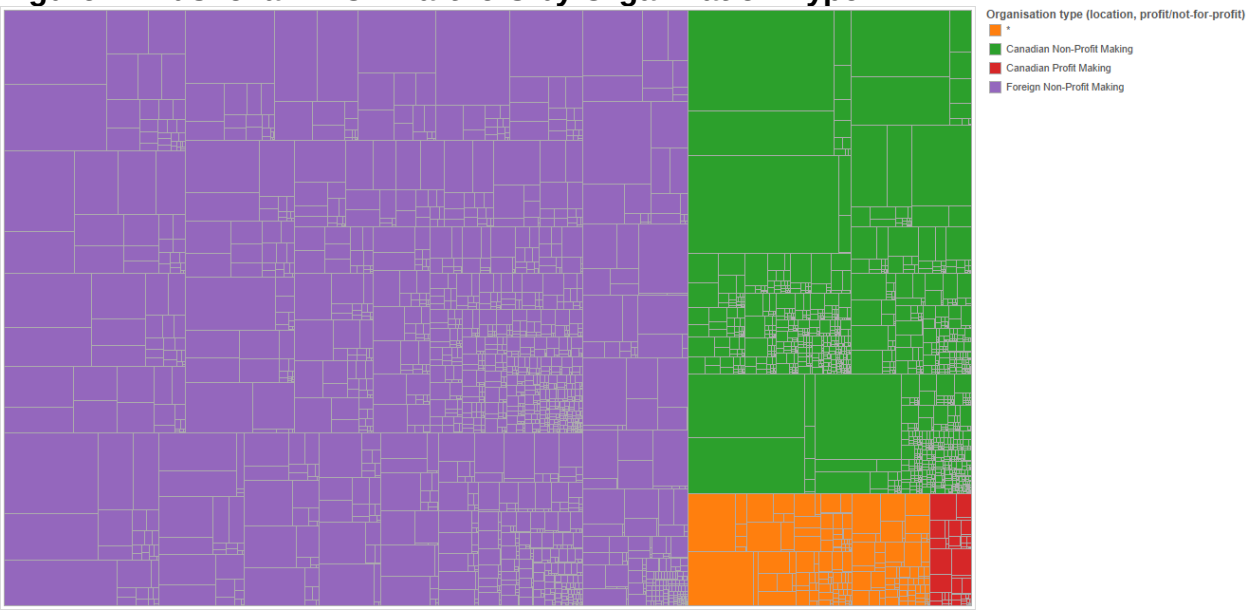
Region	% of Total MNCH_AMOUNT along Region	MNCH_AMOUNT
Africa	68.53%	$1,225M
Asia	19.53%	$349M
Americas	9.77%	$175M
Eastern Europe	1.59%	$28M
Middle East	0.37%	$7M
Unallocated	0.22%	$4M
Grand Total	100.00%	$1,787M

Source: author calculations based on data from DFTAD sources (see Figure 1).

To get a sense of which partners Canada's Muskoka-MNCH spending is channeled through multiple databases need to be accessed. In order to analyze spending by partner organizations and organization types, information from the known list of 686 Muskoka-MNCH unique projects IDs is connected with other DFATD data sources from the open data portal. This process invariable entails some tradeoffs. Adequate data from other sources is found for only 455 out of 686 total project IDs. In other words of the $1.787 billion in Muskoka-MNCH spending we are only able to track $1.186 billion, or 66.4%, at this level of detail, and even within this there are some limitations.[4]

Figure 4 provides a tiled graphic which shows each individual transaction (squares are sized to reflect the size of the transaction) and the type of organizational partner they were channeled through. The data cover the above mentioned $1.186 billion in Muskoka-MNCH spending (not the full $1.78 billion). The vast majority in purple represents financing channeled through foreign non-profit making organizations, which include multilateral partners, UN agencies and others. These account for $838 million or about 47% of the total Muskoka-MNCH spending. The next largest type (green) is Canadian non-profits, accounting for $282 million or about 16%. Canadian for-profits make up a very small share (red). As mentioned earlier, a large share (yellow and not included below) comprises transactions for which we do not have sufficient data at this level (accounting in total for $657 million).

Figure 4: Muskoka-MNCH Partners by Organization Type



Source: author calculations based on data from DFTAD sources (see Figure 1).

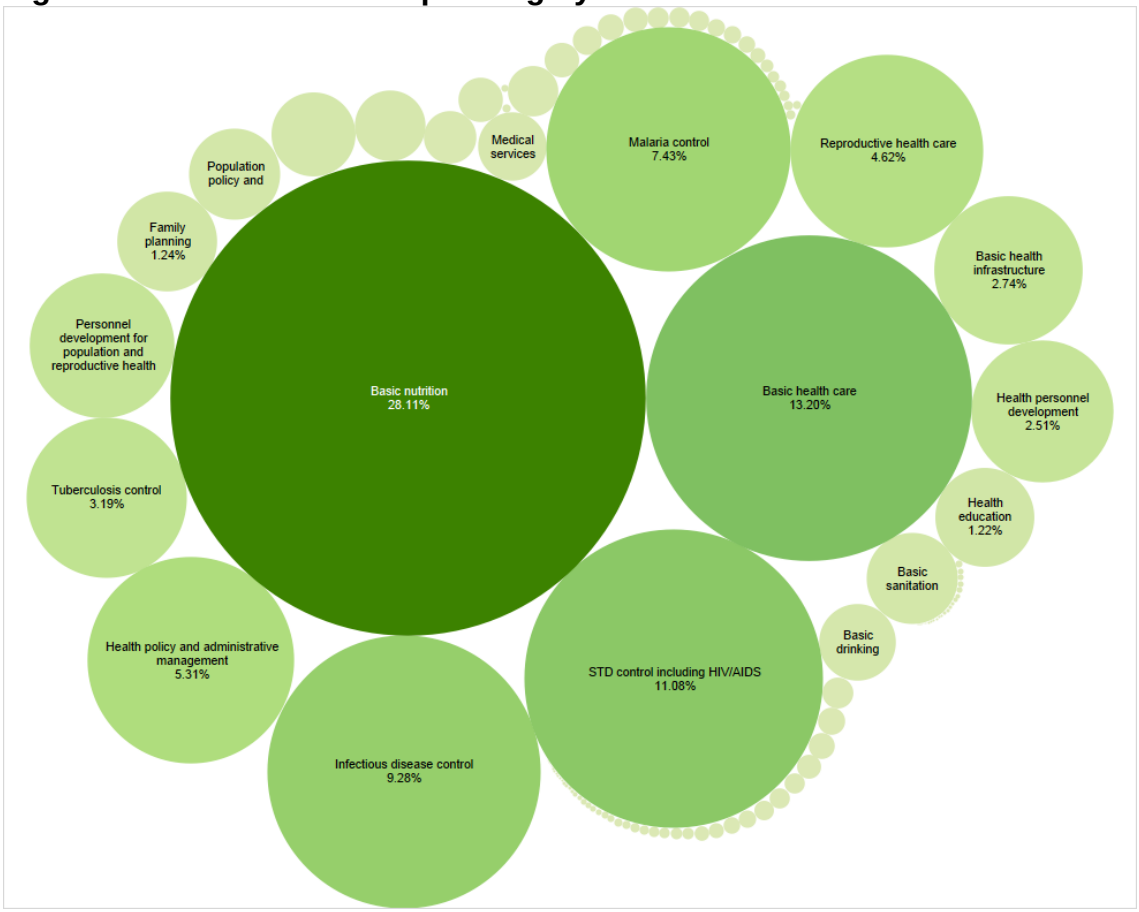
[4] The 231 unique project IDs for which we do not have enough data account for about $601mn of the expenditure. However data was unavailable for another $56mn worth of expenditure due to errors in database connections, which may be a result of our own limitations, but only represents a small share overall. This aspect of the analysis remains a work in progress.

The same data indicates organizations and agencies part of the UN system (WHO, WFP, UNDP and UNICEF being the most important) are the largest single channel for Canadian Muskoka-MNCH spending and account for around 36%; followed by international financial institutions (including the World Bank and regional development banks) which account for 23%; and international and Canadian NGOs which account for 22%.

Subsectors within health that are the focus of the initiative

There are several subsectors within health spending. The largest among these for Canada's Muskoka-MNCH spending has been basic nutrition, which accounts for 28.1%, followed by basic health care (13.2%), STD control and HIV AIDS (11%), infections disease control (9.2%) and malaria control (7.4%). This data is presented as a bubble graph in Figure 5, where the bubbles are sized and colored to reflect the amount of spending going to the particular subsector. Standard OECD-DAC CRS sector codes are used.

Figure 5: Muskoka-MNCH Spending by Health Subsectors



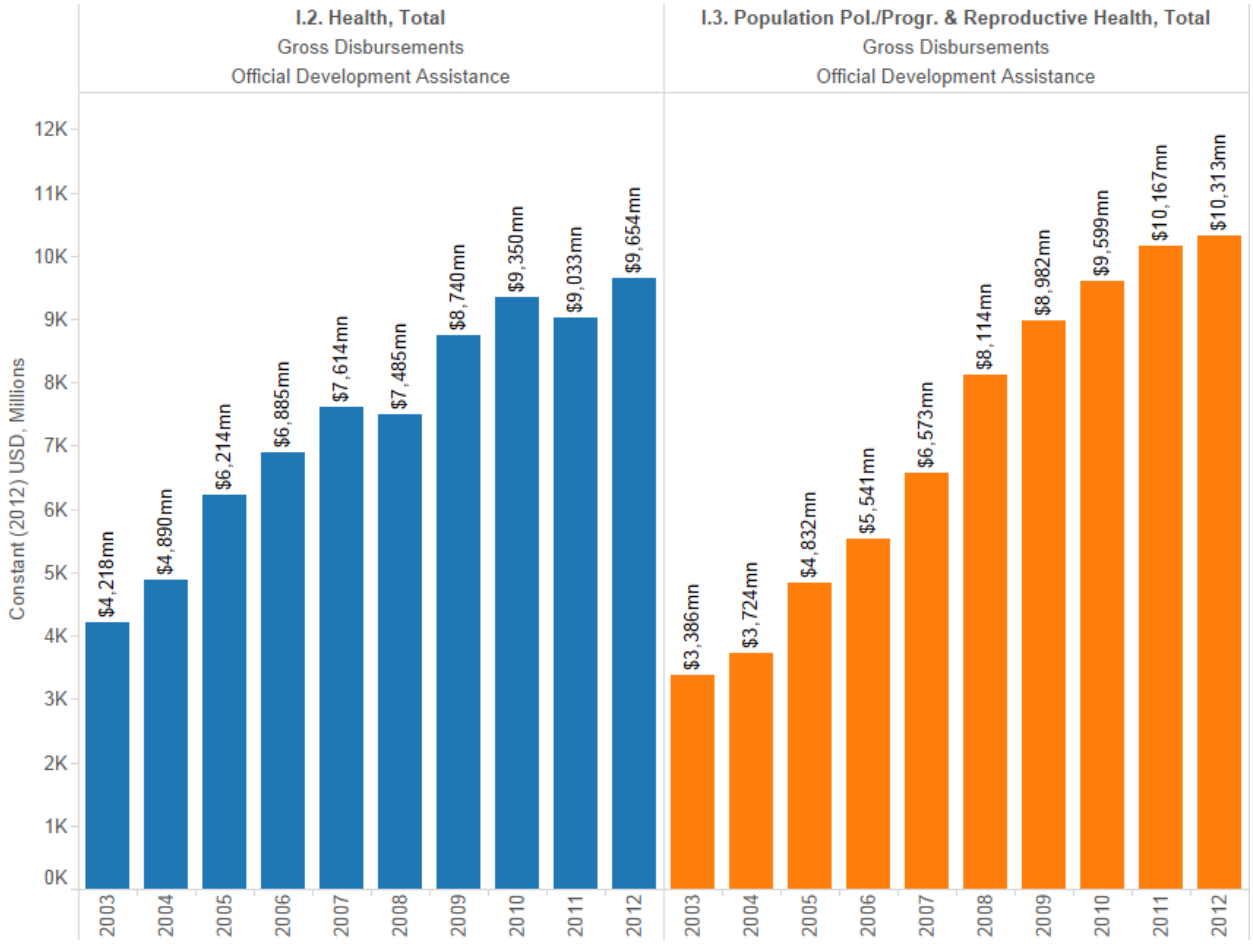
Source: author calculations based on data from DFTAD sources (see Figure 1).

How does Canada compare with other donors active in global health financing?

Canada is one of several donors active in global health. Placing Canada's contribution in a global perspective is an important gap this analysis aims to fill. Doing so requires working with internationally comparable data. In this regard there are two main approaches and associated data sources.

The first is to focus on OECD-DAC CRS data. This is the most comprehensive source of project level (i.e. disaggregated) foreign aid data. However an analysis, specifically of global health financing, is made complicated by the fact that the "Health" sector coding within the DAC (code 120) is only one component of what counts as MNCH spending globally. Select elements, such as "Population and Reproductive Health" (code 130) and "Water and Sanitation" (code 140) are also included in global MNCH spending but only up to specified percentage shares (G8 2010). Nevertheless, the DAC CRS "Health" code provides a comparative perspective on where Canada stands relative to other DAC donors. The DAC CRS's main "Health" codes (120) cover the bulk of Canada's health financing as they include basic health care, nutrition and disease control, which comprise the largest share of Canadian health aid. For comparison we also discuss global health aid with the inclusion of Population and Reproductive Health (which has not been a major focus of Canadian health sector aid).

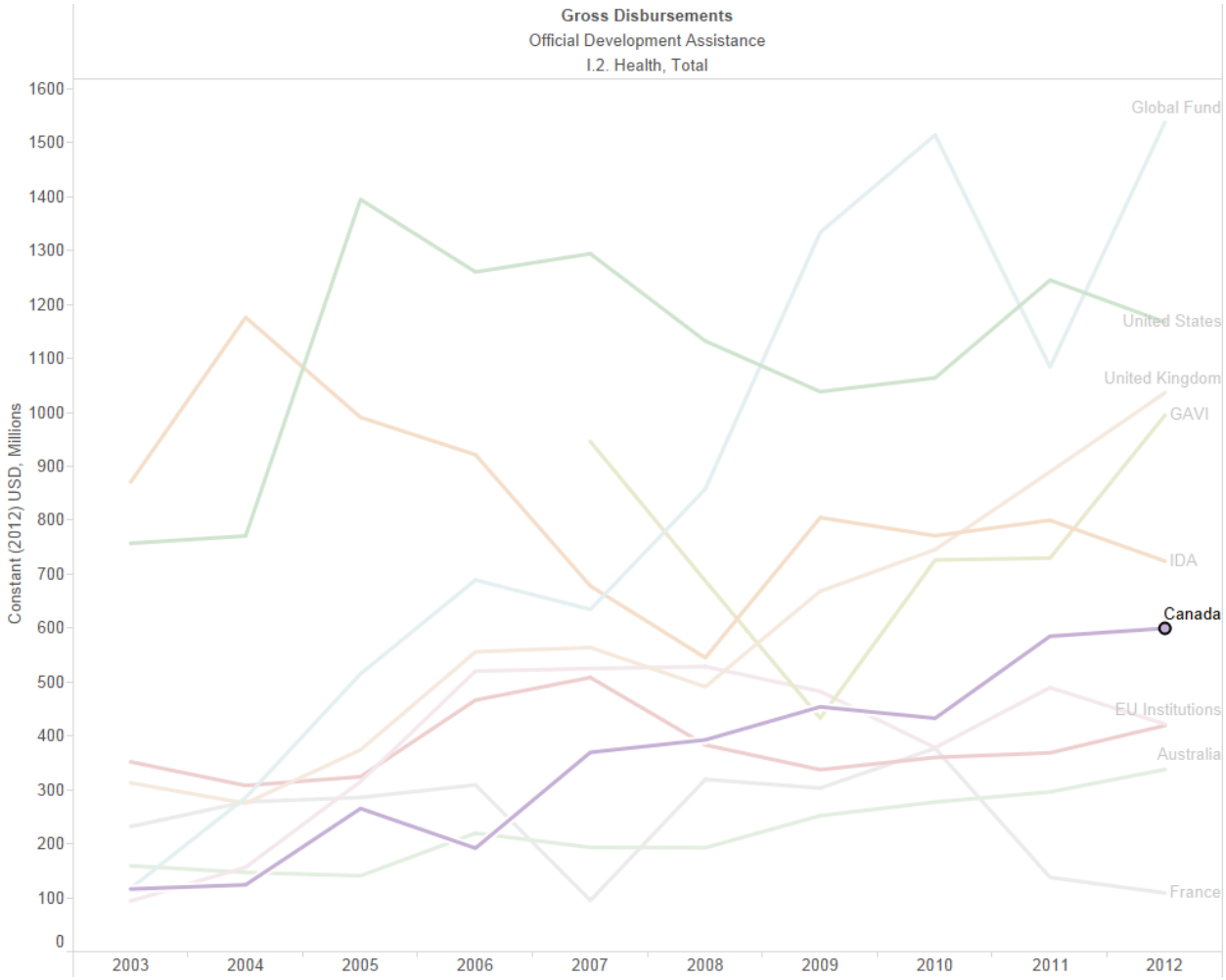
Figure 6: Foreign Aid to Health Sectors in the OECD-DAC CRS



Source: OECD-DAC CRS.

Figure 6 shows Overseas Development Assistance (ODA) from all donors to the two main health sectors. ODA to global health increased from around $4.2 billion a year in 2003 to $9.6 billion a year by 2012. Adding population and reproductive health indicates an increasing trend, from $7.6 billion a year in 2003 to nearly $20 billion a year by 2012. Clearly, aid to global health, including reproductive and population health has grown rapidly, and now accounts for around 14% of all global aid (on a gross disbursement basis, in constant 2012 US$).

Figure 7: Canada and other OECD-DAC Health ODA Providers



Source: OECD-DAC CRS. Only CRS code 120 (i.e. the main Health code 1.2 total) is included above.

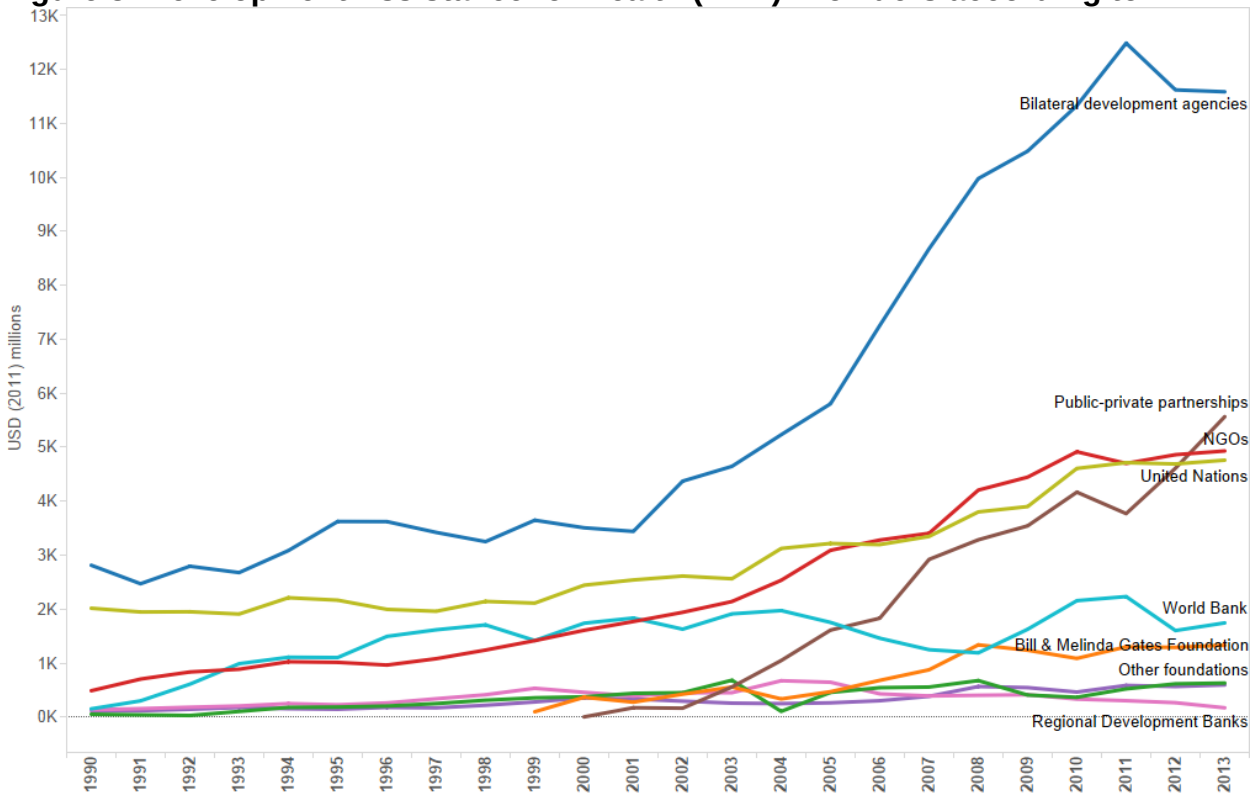
Figure 7 provides a trend comparison of the top 10 OECD-DAC health donors (code 120 only), with Canada highlighted. These 10 donors account for the majority of health aid (76% in 2012). Canada ranks 6th, behind the Global Fund, United States, United Kingdom, the Global Alliance for Vaccines and Immunization or GAVI and the World Bank's International Development Association. Canada's health aid according to the OECD-DAC increased from around $115 million a year in 2003 to $600 million by 2012. Canada's share of overall health aid increased from 2.7% in 2003 to 6.2% by 2012.[5] Canada's health ODA has not only increased in absolute terms but also as a share of overall health ODA from donor countries.[6]

[5] OECD DAC data differs from Canadian data cited earlier for a few reasons: a) it is reported here with a substantial lag, b) while the Canadian data is on a fiscal year basis DAC data is on calendar year and c) the data are in US$ (constant, 2012) whereas Canadian data are in current Canadian dollars.

[6] It should also be noted that when ODA to population and reproductive health are included Canada is a far smaller donor as most of this assistance is provided by the US, the Global Fund and UK.

An alternative approach in terms of situating Canadian health aid in a global perspective is to use the Institute on Health Metrics and Evaluation's (IHME) "development assistance for health" (or DAH) methodology. The DAH accounting is far more comprehensive and encompassing than OECD-DAC data which are self-reported by donor agencies.[7] A further advantage of the DAH method is that the data include contributions from non-official agents (such as private corporations, philanthropies, foundations and others), which are key players in global health finance.

Figure 8: Development Assistance for Health (DAH) Providers according to IHME

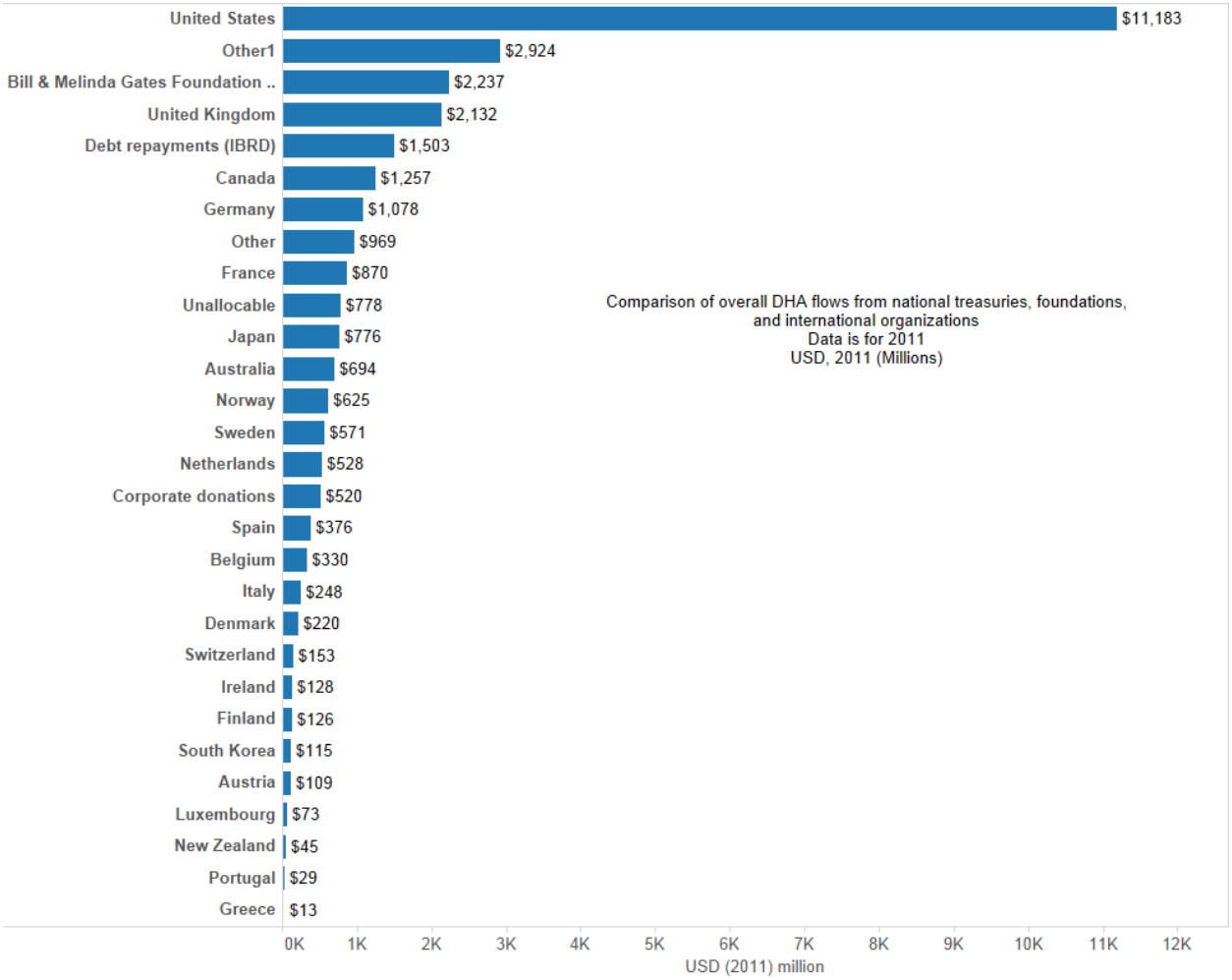


Source: IHME 2014.

IHME data are generally consistent with OECD-DAC trends and confirm the finding that DAH reached a historic high in 2013 at $31.3 billion. This figure is understandably higher because, as was mentioned, the IHME methodology is more comprehensive. The latest IHME data reveal interesting trends. Bilateral development agencies remain the largest providers of DAH, but shifts in sources of financing are visible, as funding from many bilateral donors and development banks has declined, while funding from the GAVI Alliance, the Global Fund, non-governmental organizations, and select donors (such as the UK) has increased substantially. DAH for different health issues is tracked up to 2011, revealing that the greatest increase in funding was for MNCH (IHME 2014).

[7] To develop DAH estimates, IHME collects data from organizations that provided funding for health projects in developing countries from 1990 through 2013. These data include annual reports, publicly available budgets, tax returns, and other information obtained through correspondence. Conversations with global health partners allow IHME to validate these data (IHME 2014).

Figure 9: Development Health Aid from Various Sources in 2011



Source: IHME 2014.

Figure 9, also based on the IHME's DAH method and database, provides a comparison of overall flows from all sources. Here data is provided on the basis of national treasuries (as opposed to focusing only on donor agencies in developing countries) and thus provides a more complete picture of the scale of DAH flows from national donors, foundations and international institutions. DAH flows on national treasury basis are far higher than flows from bilateral donor agencies alone. For instance DAH from Canada, from the bilateral agency only, in 2011 was around $663 million, consistent with the OECD-DAC approach. However DAH from Canada on a national treasury basis (which includes other financing sources such as Finance Canada) was estimated at around $1.25 billion. In 2011, the latest year for which this data is available, Canada ranked the 5th largest DAH provider, behind the US, Bill and Melinda Gates Foundation, UK and the World Bank. At $1.25 billion in 2011, Canada's share of total DAH is around 4%.

How does donor health spending compare with other sources, such as domestic financing in developing countries; and health spending overall?

Donor funding is a key source of global health finance. However, it is only one component. A far larger share is made up of financing that developing countries mobilize domestically, through taxes, social security contributions or through the domestic private sector.

Total global health expenditure has been estimated at $6.5 trillion in 2012 (WHO 2011, WHO GHED).[8] We can use the above discussed IHME global development assistance on health (DAH) method to get a sense of the share of total global health expenditure that is made up by donor spending on health. Using this approach, donor spending only accounts for about 0.5% of total global health spending (IHME 2014, WHO 2011, WHO 2011a, WHO GHED).[9] This ratio is of course very different when we net out the amount rich countries spend on their own health systems and if we focus on donor health spending in poorer regions. According to the WHO, the share of funds spent on health in Africa that is provided by donors is around 11% (WHO 2011).

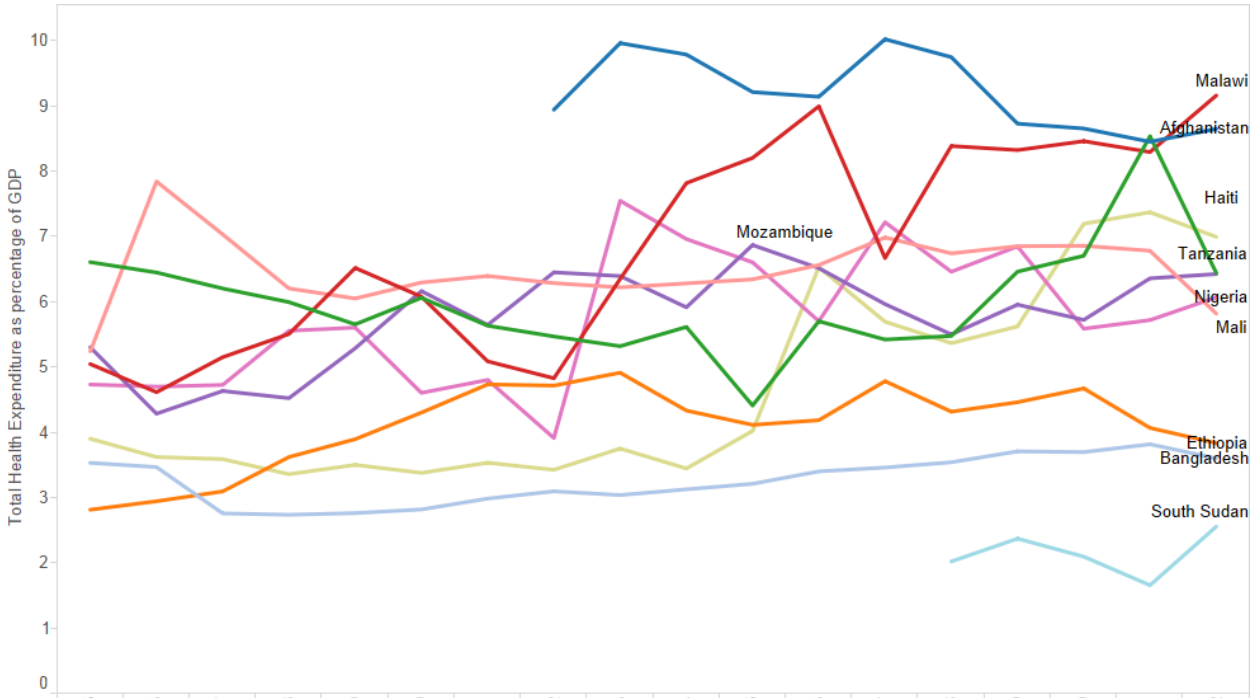
Clearly, while donor spending is large and, as discussed, growing, donors only make up a small share of overall health financing. This fact is often ignored but is critical from an accountability standpoint as the attribution of health outcomes and results to specific spending can be very challenging. It would be helpful for instance if donors and other development partners framed their expectations, as well as their contributions towards complex outcomes in a more nuanced manner than is often the case in the way donor results data is presented currently.[10]

[8] The data however correspond to 2010. Our estimate, based on WHO GHED for the most recent year available (2012) is around $5.5 trillion.
[9] The $6.5 trillion figure of course is mostly made up of health spending in rich countries, and is not strictly comparable to donor spending in developing countries alone. See the next section for an examination of select countries.
[10] See for instance the results fields in DFATD open data sources, including the browser. See also summary results here http://mnch.international.gc.ca/brochure-depliant-en.html#Afghanistan

Health financing from a developing country perspective

The above discussion helps put donor contributions to global health financing in a more realistic perspective. This section discusses health financing from a developing country perspective, taking Canada's 10 priority MNCH countries as a sample. The data are from the WHO's GHED database.[11]

Figure 10: Total Health Expenditure (%GDP), in Canada's 10 Priority MNCH Countries



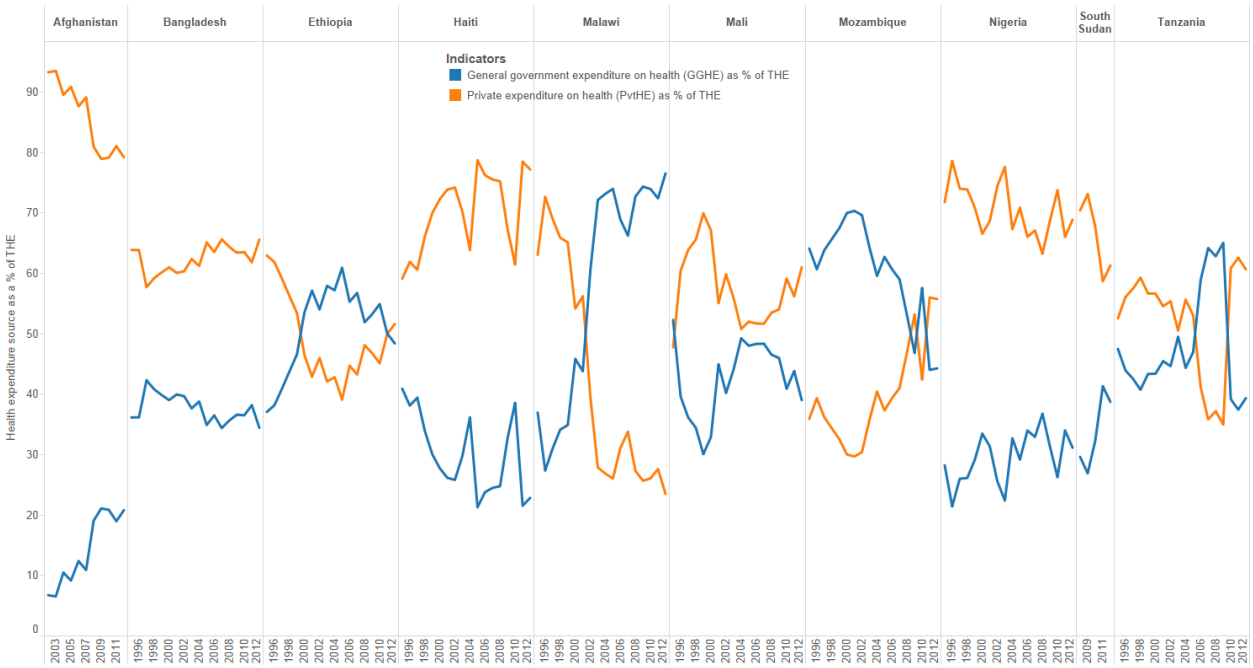
Countries	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Afghanistan								8.9%	10.0%	9.8%	9.2%	9.1%	10.0%	9.7%	8.7%	8.7%	8.4%	8.6%
Bangladesh	3.5%	3.5%	2.8%	2.7%	2.8%	2.8%	3.0%	3.1%	3.0%	3.1%	3.2%	3.4%	3.5%	3.5%	3.7%	3.7%	3.8%	3.6%
Ethiopia	2.8%	2.9%	3.1%	3.6%	3.9%	4.3%	4.7%	4.7%	4.9%	4.3%	4.1%	4.2%	4.8%	4.3%	4.5%	4.7%	4.1%	3.8%
Haiti	6.6%	6.4%	6.2%	6.0%	5.7%	6.1%	5.6%	5.5%	5.3%	5.6%	4.4%	5.7%	5.4%	5.5%	6.5%	6.7%	8.5%	6.4%
Malawi	5.0%	4.6%	5.1%	5.5%	6.5%	6.1%	5.1%	4.8%	6.3%	7.8%	8.2%	9.0%	6.7%	8.4%	8.3%	8.5%	8.3%	9.2%
Mali	5.2%	7.8%	7.0%	6.2%	6.0%	6.3%	6.4%	6.3%	6.2%	6.3%	6.3%	6.6%	7.0%	6.7%	6.8%	6.9%	6.8%	5.8%
Mozambique	5.3%	4.3%	4.6%	4.5%	5.3%	6.2%	5.6%	6.4%	6.4%	5.9%	6.9%	6.5%	6.0%	5.5%	6.0%	5.7%	6.4%	6.4%
Nigeria	4.7%	4.7%	4.7%	5.6%	5.6%	4.6%	4.8%	3.9%	7.5%	7.0%	6.6%	5.7%	7.2%	6.5%	6.8%	5.6%	5.7%	6.1%
South Sudan														2.0%	2.4%	2.1%	1.7%	2.6%
Tanzania	3.9%	3.6%	3.6%	3.4%	3.5%	3.4%	3.5%	3.4%	3.7%	3.4%	4.0%	6.5%	5.7%	5.4%	5.6%	7.2%	7.4%	7.0%

Source: WHO GHED.

[11] The database was accessed between March and May 2014.

As Figure 10 shows, there is wide variation in total health expenditure (as a share of GDP) even across Canada's 10 priority MNCH countries. In 2012, total health expenditure as (as a share of GDP) was highest in Malawi, followed by Afghanistan, Tanzania and Haiti. Health spending as a share of the overall economy has been rising steadily, or has been maintained at a relatively stable share over the period shown (1995-2012). However despite this, total health spending remains very low, and below the WHO minimum cut off of $44 per capita in most of these countries (WHO 2011).

Figure 11: Composition of Total Health Expenditure in Canada's 10 Priority MNCH Countries

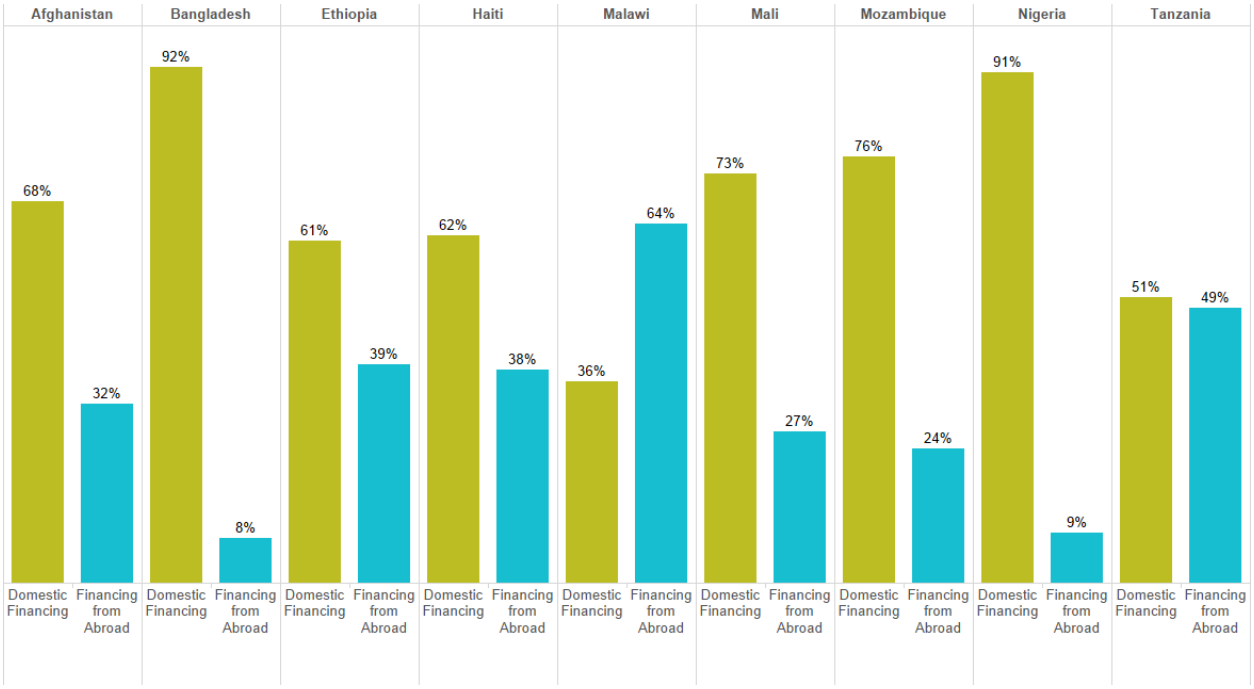


Source: WHO GHED.

Figure 11 provides further insight into the composition of total health expenditure, which is made up of general government expenditure on health and private expenditure on health. Again, there is substantial variation across Canada's 10 priority MNCH countries. Health expenditure is largely private in Afghanistan, Bangladesh, Haiti, Mali, Nigeria and South Sudan (where the yellow line is far higher). It tends to be more balanced between private and government expenditure in Ethiopia, Mozambique and Tanzania; whereas in Malawi government expenditure dominates the picture especially in recent years as health spending has grown.

Using Canada's 10 MNCH priority countries as a sample we can also look further into the health system's financing profile. In Figure 12 health system financing is disaggregated into domestic and foreign funding sources (the latter comprising all donors and foreign partners). The data is for 2010, the most recent year available (WHO 2011). The green bars represent domestic funding, while the blue bars represent foreign funding.

Figure 12: Who Funds Health Care: Domestic vs. Foreign Financing in Canada's 10 Priority MNCH Countries



Source: WHO 2011.

In most countries domestic financing dominates health funding. Domestic financing accounts for over 90% of total health financing in Bangladesh and Nigeria, it ranges between 60% and 76% in Afghanistan, Ethiopia, Haiti, Mali and Mozambique. In these countries foreign financing is substantial, but still lower than domestic sources. In Tanzania the two are nearly balanced, with foreign funding playing a major role, and in Malawi foreign funding accounts for 64% of total health financing, far larger than domestic sources.

Conclusions

The aim of this brief analysis has been to (a) present a comprehensive set of data on Canada's Muskoka-MNCH initiative and (b) situate the same in the wider context of global health financing. The following findings emerge from our analysis:

- Canada is on track with respect to its Muskoka-MNCH commitment; according to the data presented, by 2012-13 approx. $1.787 billion or 62.7% of the $2.85 billion committed had been spent. This includes $1.15 billion in baseline spending and $635 million in new and additional Muskoka spending.
- Africa is by far the largest recipient of Canada's Muskoka-MNCH spending. The largest recipients of the initiative are Tanzania, Mozambique, Mali, Ethiopia followed by Haiti.
- The majority of Muskoka-MNCH financing is channeled through foreign non-profits (47%) which include multilateral and UN agencies, followed by Canadian non-profits (16%). The largest multilateral and UN implementing partners include the WHO, WFP, World Bank, UNICEF and UNDP.
- Basic nutrition and health care are the main subsectors within Muskoka-MNCH spending.
- Canada is the 6th largest health donor according to OECD-DAC data and its share of overall health aid increased from around 2.7% in 2003 to 6.2% in 2012.
- These trends are confirmed by other sources and approaches such as the IHME's DAH method. According to this approach Canada is the 5th largest DAH provider, and accounts for around 4% of DAH.
- Total donor DAH increased to a historic high of $31.3 billion in 2013, with MNCH the fastest growing component. Raising the profile of MNCH within the global health agenda is one of the most important contributions donors, led by Canada, have made since the start of the Muskoka Initiative in 2010.
- It is important to remember however that foreign aid is only one component of the financing that goes into the health sector. Even in the poorest region where the bulk of donor health aid is focused, e.g. Africa, donor aid only makes up about 11% of total health expenditure.
- There is substantial variation across Canada's 10 priority MNCH countries in terms of health financing. In some countries private expenditure is far more important than government expenditure (e.g. Afghanistan, Bangladesh, Haiti and Nigeria) while in others government spending dominates (Malawi).
- In most of Canada's priority MNCH countries domestic financing for health makes up a greater share than foreign financing.

Recommendations

Going further in linking Canadian data: while there is wide range of useful open data available that helps shed light on Canada's Muskoka-MNCH initiative, much of this information is fragmented across data types, sources and documentation formats. The bulk of this analysis involved leveraging disparate strands of open data to make them more useable. More effort can be made to better link related data and present it in a more comprehensive and yet simpler manner, especially for non-technical users.[12] Data purveyors should keep in mind that the expectations surrounding transparency have increased. Canada has made substantial progress on aid transparency. In the Muskoka-MNCH agenda transparency and accountability was a key feature from the very beginning. These factors combine to heighten expectations. Meeting these expectations requires relatively little effort to put more and better linked official data in the public domain, in a timelier manner. For instance our analysis found that there was a proliferation of useful open data, but often with important differences between sources, not only in terms of the range of coverage, but also which fields are covered within each source. While the MNCH browser data encompasses new Muskoka projects (accounting for $1.1 billion of the $2.85 billion commitment) it does not include data on the rest $1.75 billion in baseline funding. While the data includes useful information such as project start and end dates, executing partners and agents, and the *overall budget* at the project level, the financial data is not possible to aggregate or analyze as it does not include *actual spending* that may have taken place to date within prescribed budgets. Yet (some) of this data is available from other open data sources. Joining the dots enables a more comprehensive analysis and representation of a fuller picture of Canada's efforts. In this regard some technical issues (such as a Muskoka-MNCH identifier in the IATI standard) merit further consideration.

Going further in linking transparency to fuller accountability and knowledge sharing: accountability does not end with data or access to better data. Data, especially financial data, are only a means to wider ends. Access to key information, as complete and timely as possible, is a prerequisite for transparency and accountability. Much more work is needed to assess the linkages between data transparency and fuller accountability and knowledge sharing within MNCH stakeholders. How does greater transparency and accountability translate into better programming, or wider sharing and discussion of what works and what doesn't in MNCH? These questions require going beyond financial data alone. More effort could be made for instance to get Canadian NGOs involved in MNCH programming to share their project level information in a common standard (such as IATI). After all the data presented here probably understates Canada's overall contribution to global MNCH and health as only official spending is adequately covered (private contributions made by Canadians through charitable and volunteer organizations are not available in a similar standardized format as none of the major Canadian NGOs involved in the Muskoka-MNCH initiative currently publishes IATI data). Motivating wider information sharing could go a long way towards fuller accountability.

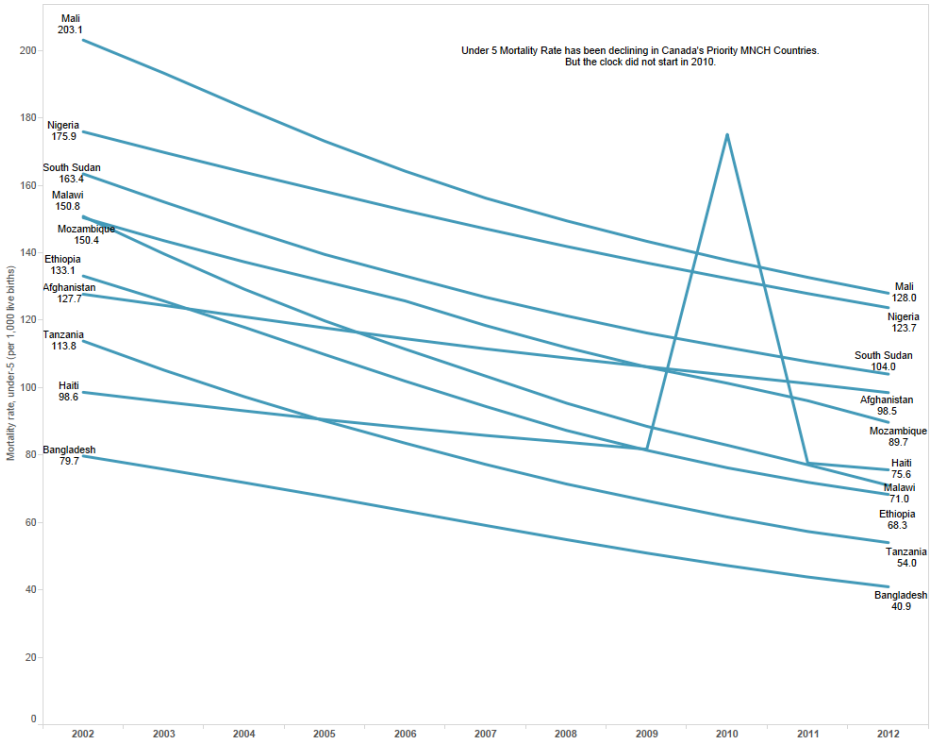
Framing results in a more nuanced and meaningful manner: donors need to be careful in the way they attribute results to particular project or programmatic spending. This is particularly the case in the health financing where causality can be difficult, aggregate level indicators are often slow moving compared to fiscal cycles, and attribution of outcomes to specific spending when there are a host of

[12] For technical users a recommendation would be to develop an Application Programmable Interface or API of all relevant open aid data related to health and MNCH. We attempted this at coding events with mixed results.

contextual and macro factors to account for, can be very problematic. As a basic step, more work is needed to rethink the way results are presented through various open data sources. Canada (DFATD) could undertake a simple analysis of how effective the results information shared via their open data portal is, by analyzing who is using it to what end, or by discussing the thinking behind the results information with implementing partners and agents and comparing the way results are captured in partner monitoring and evaluation systems.

Facilitating independent analysis of the quality of programming, and alignment with national and local priorities in partner countries: much of the data at the project level appears fairly granular. However it is not possible to address issues such as quality of programming or partnership, level of alignment with national and local priorities, in any systematic manner, without considerable effort. One step could be to undertake a pilot analysis on the ground in Canada's priority MNCH countries of the best way to capture some of these issues in a format that is possible to link back to programmatic and project data. A country level analysis may also help reveal the value and limitations of the data, as currently presented, from the perspective of partner organizations and host governments.

Figure 13: Under-5 Mortality Rate Declining Across Canada's 10 Priority MNCH Countries



Source: World Development Indicators database

Linking health outcomes and impacts data with macro (socioeconomic) data and financial information: there remains substantial potential to better link health data, socioeconomic data and financial data on MNCH. The COIA has established a set of common MNCH indicators. There is substantial academic literature on the factors affecting health outcomes and trends. Yet there is no single source that can help non-technical users assess, for instance, the overall impact of the $7.3 billion donors have spent on MNCH. As Figure 13 shows, taking one of the 11 COIA indicators as an example, progress is being made across Canada's 10 priority countries. For instance, the under-5 mortality rate has been more than halved over 10 years in countries like Tanzania and Malawi, both countries where donor involvement including Canadian support, has been a major contributor to health financing. However the clock clearly does not start in 2010. These are broad macro trends over long periods of time that are the result of a multitude of factors, donor involvement being just one among them. More innovation is needed in (a) better linking data, (b) leveraging new data streams including directly via partner organizations in developing countries, and (c) visualizing the same in an accessible yet meaningful manner. Doing so can have a powerful effect on generating greater public understanding and support, but also opening up new lines of inquiry.

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