

Countdown 2015
EUROPE
Campaigning for universal access
to reproductive health

Strategic Options for Greater European Investment in Reproductive Health Supplies

Produced by **Roger Drew**
for Countdown 2015 Europe
on behalf of Interact Worldwide

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interact
worldwide

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EXECUTIVE SUMMARY

Countdown 2015 Europe is a partnership of NGOs concerned with ensuring the following commitments to sexual and reproductive health (SRH) are fulfilled:

- In 1994, the International Conference on Population and Development (ICPD) adopted an ambitious 20-year Programme of Action focused on individuals' needs and rights. It was built on the cornerstones of gender equality, eliminating violence against women and ensuring women's ability to control their own fertility.
- In 2000, the world committed itself to a set of eight ambitious development goals to be achieved by 2015, the Millennium Development Goals, which focused on a set of barriers to overcome extreme poverty.
- At the World Summit in 2005, global leaders resolved to add universal access to reproductive health by 2015 to the MDG targets. In 2006, this commitment was endorsed by Ministers of Health of African Union member states.
- In 2006 the United Nations General Assembly committed to adopted the goal of universal access to comprehensive HIV and AIDS prevention programmes, treatment, care and support by 2010.
- In October 2007, the United Nations General Assembly adopted a set of indicators for tracking progress on universal access to reproductive health by 2015 including addressing contraceptive prevalence and the unmet need for family planning.

None of these targets will be met, unless urgent action is taken to ensure the sustained availability of reproductive health supplies. Reproductive health supplies (RHS) are not just condoms and other contraceptives. According to UNFPA, they refer to 'all the essential equipment, commodities and medicines required for sexual and reproductive health, maternal and neonatal health and for effective responses to HIV and AIDS'. An inter-agency list of essential medicines for reproductive health has been produced. Currently, there is evidence of massive gaps between the need for and the availability of these supplies:

- In 2003, a total of 137 million women, who did not want to have another child in the next two years, were not using contraception, that is, their need for contraception was unmet

- In 2005, UNFPA's Thematic Trust Fund for Reproductive Health Commodity Security responded to requests from over 51 countries and disbursed over US$30m for emergency supplies to avoid imminent stockouts

Different estimates have been made of the funds needed to bridge these gaps. In 2005, WHO estimated that an additional US$6.1b would be needed by 2015 to improve maternal health as envisaged in MDG5. However, these figures did not include existing amounts being spent or a full range of family planning and reproductive health services. The estimated cost of achieving the ICPD Programme of Action is currently being revised as original costing did not fully account for the scale up of SRH services requires for the response to the HIV and AIDS pandemic. UNAIDS recently provided two scenarios for funding scale-up towards universal access to HIV prevention, treatment, care and support. In order to achieve universal access by 2010 would require US$42.2b in 2010 and US$54b in 2015. To undertake a slower phased scale-up towards universal access would require US$28.4b by 2010 and US$49.5b by 2015.

Thus, the best available estimates indicate that, to achieve universal access to reproductive health and comprehensive HIV and AIDS services, US$29.8b will be needed by 2010 rising to US$35.8b by 2015. Given the limit of domestic resources available in developing countries for health responses international donors need to provide one third of these funds, that is, US$9.9b by 2010 and US$11.9b by 2015.

Although, since 2001, donor funding for sexual and reproductive health has risen dramatically, this is mostly due to the response to HIV and AIDS. Funding for basic reproductive health services has

changed little over that time and funding for family planning services has declined. Nevertheless, some donor countries, e.g. Sweden, the Netherlands and Denmark have performed extremely well. Not only have they met the target of providing 0.7% of their Gross National Income (GNI) as Official Development Assistance (ODA), they have also committed a significant proportion of this ODA to SRH.

For example, in 2004, the Netherlands provided more than 10% of its overall ODA to sexual and reproductive health. Other donors, such as the UK, have massively increased their financial commitment to sexual and reproductive health, including particularly the response to HIV and AIDS. Others, e.g. France and Germany, could do more. The European Commission's performance has been disappointing. The little support that was being given has declined. This is not in keeping with the commitments of the Cotonou Agreement and the European Consensus on Development.

The environment in which aid is provided is increasingly complex with a shift away from specific SRH projects/programmes towards sectoral and general budget support. In addition, there has been a growth of funds available through Global Health Partnerships, such as the Global Fund to Fight AIDS, TB and Malaria. Development aid needs to be provided more effectively. The Paris Declaration on Aid Effectiveness provides principles for doing this. This involves priorities and budgets being set and owned nationally, and donors aligning their efforts around these.

Increasingly, decisions about resources for reproductive health, in general, and reproductive health supplies, in particular, will be made nationally, e.g. in national health plans and expenditure frameworks in developing countries. For this reason, programmes, such as UNFPA's Global Programme for Enhancing Reproductive Health Commodity Security, focused on facilitating national efforts to prioritise and mainstream reproductive health supply security in health plans and expenditure frameworks, are of critical importance.

RECOMMENDATIONS

1. **FULL FUNDING** - Best available estimates indicate that the funding needed to achieve universal access to reproductive health and comprehensive HIV and AIDS services is US$29.8b in 2010 rising to US$35.8b in 2015. Countdown 2015 Europe calls on donor governments to take urgent action to provide one third of these resources and meet targets of US$9.9b in 2010 and US$11.9b by 2015.

2. **INCREASE ODA** – To achieve universal access to reproductive health, including the call of parliamentarians from G8, European and African countries for 10% of ODA to go to sexual and reproductive health, Countdown 2015 Europe calls on donor governments to provide 0.7% of their Gross National Income as ODA.

3. **ENSURE COMMODITY SECURITY** – To date, there has been little focus on ensuring that RHS are prioritised and mainstreamed in national health plans and expenditure frameworks. UNFPA, the Reproductive Health Supplies Coalition and others are focused on enhancing reproductive health commodity security. Countdown 2015 Europe calls upon donor governments to ensure their bilateral and multilateral channels similarly prioritise expenditure on reproductive health supplies.

4. **ADDITIONALITY** – Countdown 2015 Europe welcomes the increased levels of funding for sexual and reproductive health and reproductive health supplies which have been made available within the response to HIV and AIDS. We urge donors to ensure that funds for HIV and AIDS are not being provided at the expense of addressing universal access to reproductive health.

5. **SRH-HIV and AIDS INTEGRATION** – Countdown 2015 Europe calls on European donors to increase effective use of resources through appropriately integrated and linked responses to sexual and reproductive health and HIV and AIDS. Such responses need to be aligned within national frameworks. Investments in SRH need to mainstream HIV and AIDS, and investments in HIV and AIDS should be appraised for appropriate inclusion of SRH.

6. **HEALTH SYSTEMS AND HEALTH WORKFORCE** – Universal access to reproductive health requires strong health systems. Countdown 2015 Europe calls on donor governments to ensure that aid instruments, including the International Health Partnership, are used to provide long-term, sustainable investment in health systems strengthening, particularly for significant investment in human resources for reproductive health.

7. **EDUCATION SECTOR RESPONSE TO SRH** – Most of the focus on barriers to access of RH supplies currently centres on lack of commodities but an equal or perhaps larger barrier to access is in terms of demand. Countdown 2015 Europe calls on donors to fund comprehensive evidence–based sexuality education to help educate the public on SRH and create demand for the provision of RH supplies.

8. **NATIONAL PRIORITIES** – The Paris Declaration on Aid Effectiveness outlines the need for increased national ownership of development efforts and alignment of donor efforts around national plans. Countdown 2015 Europe calls on donors to; consider effects on SRH when assessing the effectiveness of aid, including general and sectoral budget support; work with government to ensure that national plans include robust SRH indicators; ensure RHS budget lines are implemented; and annual reviews indicate expenditure against these goals.

9. **EUROPEAN COMMISSION** – Countdown 2015 Europe is extremely concerned that the European Commission's support for sexual and reproductive health is declining, contrary to commitments made in the European Consensus on Development. Urgent measures are needed to ensure that funds for reproductive health are prioritised in country and thematic programmes.

10. **GLOBAL FUND** – Resources provided for the response to HIV and AIDS by the Global Fund have been significant and increasingly recipients seek to leverage benefits to SRH and wider health services. Countdown 2015 Europe calls on the Global Fund to be explicit in its support for SRH-HIV and AIDS integration, beginning by approving a Round 8 Call for Proposals that outlines the funding opportunities for SRH programming and reproductive health supplies.

INTRODUCTION

Countdown 2015 Europe is the label under which ten European NGOs will work together with their partners to increase European investment in reproductive health supplies[1]. Countdown 2015 Europe is funded by a grant from the Bill and Melinda Gates Foundation through the International Planned Parenthood Federation European Network. The members of the Steering Committee are:

- Deutsche Stiftung Weltbevölkerung (German Foundation for World Population), Germany
- Equilibres & Populations, France
- European Parliamentary Forum, Brussels
- Interact Worldwide, United Kingdom
- IPPF European Network, Brussels
- Marie Stopes International, Brussels
- The Swedish Association for Sexuality Education, Sweden
- Sex & Samfund (Danish Family Planning Association), Denmark
- Vaestoliitto (Family Federation of Finland), Finland
- World Population Foundation, Netherlands

This document is the inception publication of a Countdown 2015 Europe project, Europe Champions Reproductive Health Worldwide II: Tackling the Supply Challenge (IPPF EN et al., 2007c). This project aims to increase financial support as well as improve European coordination and coherence on reproductive health supplies in order to narrow the gaps between the needs, demand and availability of the necessary supplies and secure reproductive health as an essential step toward achieving the MDGs.

This report provides baseline evidence, analytic rationale, recommendations and strategic options for consideration by European donors, other policy makers and colleagues in development. It is divided into three main sections: evidence of gaps in reproductive health supplies; resources needed to fill those gaps; options for greater investment. Recommendations to policy makers are fully stated in the Executive Summary and briefly reviewed at the conclusion of the document.

EVIDENCE ON GLOBAL REPRODUCTIVE HEALTH SUPPLIES GAPS

This section considers the evidence of gaps in the global provision of reproductive health supplies. This includes unmet contraceptive need, low utilisation of poorly-supplied health facilities and requests for emergency supplies to avoid stock outs. It then considers gaps in capacity and the causes and consequences of supply gaps.

Evidence of Gaps in Supply

Most recent estimates are that 137 million women globally have unmet need for contraception (Sonfield, 2006), that is they do not want another birth in the next two years but are not using contraception. 64 million were using traditional family planning methods[2]. As a result, more than a quarter (29%) of women in developing countries had unmet need for modern contraception. This is particularly severe in sub-Saharan Africa where almost half (46%) of women at risk of unintended pregnancy are using no method of family planning and almost two thirds (63%) are not using modern methods of contraception (Singh et al., 2004; UNFPA, 2004).

Lack of health facilities, equipment, health personnel and medicines all contribute to reduced/delayed utilisation of health services and reduced quality of those services. In the case of maternal health services, these factors have been identified as major causes to delays in receiving emergency obstetric

[1] The terms reproductive health supplies and reproductive health commodities are used interchangeably in the literature on this topic. The former term is used in this document except where directly quoting from other documents or referring to names or organizations / programmes.
[2] Such as periodic abstinence and withdrawal as well as breastfeeding infertility

care[3]. These delays are major contributors to maternal deaths (World Bank, 2002).

The importance of reproductive health supplies is recognised in some countries, e.g. Uganda, where the most commonly used injectable contraceptive, Depo-Provera, is one of six indicator drugs for monitoring stock outs. However, information on stock outs remains poor because of missing stock cards, incomplete reporting and calculation errors (Chattoe-Brown and Bitunda, 2006). Nevertheless, stockouts of reproductive health supplies at clinic level are reported to be common (PAI, 2004 and see Box 1).

Box 1:
Gaps in Reproductive Health Supplies: An Example from Northern Uganda

A recent study in Northern Uganda (Krause, 2007) concluded that there was a significant gap in the coverage of health facilities and a dearth of qualified health care workers. Stock outs of essential reproductive health materials and supplies were both reported and directly observed in some health facilities. Female condoms were not available and some drugs had passed their expiry dates. Conversely, where supplies were available, uptake of reproductive health services increased. Overall, the study concluded that 'family planning services were very weak and women were desperate to access birth control.'

Many countries are making emergency requests for support to obtain reproductive health supplies. For example, in 2002, UNFPA assisted 33 countries with reproductive health supplies to a value of US$1.5m (UNFPA, 2002). In 2005, UNFPA's Thematic Trust Fund for RHCS responded to requests from over 51 countries for emergency response activities. This led to disbursements of over US$30 million to directly address shortfalls. UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (RHCS) has one of its three themes focused on funding for emergency responses (UNFPA, 2006a).

Gaps in Capacity

UNFPA's Global Programme on RHCS identifies two elements of the gap in supplies. First, there is the gap in availability of supplies themselves. Second is the gap in capacities to deliver reproductive health services, in general, and these supplies, in particular. Historic efforts have focused largely on the first gap but a sustainable solution will require the capacity gap to be addressed also. The need for capacity development currently significantly exceeds 'commodity gaps' and therefore demand higher priority in national programmes (UNFPA, 2006a). Thus, the main focus of the Global Programme on RHCS is now on facilitating national efforts to prioritise and mainstream reproductive health supply security into national health policy and budget framework. Currently, this approach is being applied in six[4] 'proof of concept' countries with plans to add more[5].

This approach fits well with Sector Wide Approaches, with the Paris Declaration on Aid Effectiveness and current aid architecture all increasingly focusing on country-led approaches and use of new aid instruments.

In response to the fact that shortages of essential reproductive health commodities are growing, the Reproductive Health Supplies Coalition (RHSC) was founded to provide global leadership in making essential reproductive heath available to developing and transitional countries. The RHSC comprises a forum of Multilateral organisations, Bilateral donors, private foundations and NGOs in which to develop collaborative strategies and exchange technical information. The three working groups: Systems Strengthening, Market Development Approaches and Resource Mobilization and Awareness are working to provide countries with increased resources and technical capacity to scale up RH commodities.

[3] All five major causes of maternal mortality; haemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour can be treated at a well-staffed, well-equipped health facility. Expanding access to emergency obstetric care requires that all women and newborns with complications have rapid access to well-functioning facilities, whether a mobile health unit, district hospital or upgraded maternity centre.

[4] Burkina Faso, Ethiopia, Ghana, Mongolia, Mozambique, and Nicaragua
[5] Including Yemen

Causes and Consequences of Supply Gaps

Causes of shortages in reproductive health supplies are varied and include a rising number of people of reproductive age, increasing demand for contraceptives, increases in transmission of HIV and inadequate management capacity (IPPF, 2007a).

These gaps in supplies have serious consequences. They contribute to maternal mortality, hinder the implementation of effective SRH programmes and undermine progress towards international commitments, such as the Millennium Development Goals (MDGs) and those made at the International Conference on Population and Development (ICPD) (Singh et al., 2004; Supply Initiative, 2004a and 2005; UNFPA, 2005a; IPPF, 2007a).

RESOURCE NEEDS ESTIMATES FOR SEXUAL AND REPRODUCTIVE HEALTH, INCLUDING RH SUPPLIES

This section considers resource needs estimates for sexual and reproductive health in three specific areas - achieving universal access to reproductive health; improving maternal health and achieving the SRH components of universal access to HIV prevention, treatment, care and support. It then considers issues relating to costs of RH supplies specifically before concluding with discussion of how identified costs can be met.

The Cost of Achieving Universal Access to Reproductive Health

The 1994 International Conference on Population and Development (ICPD) adopted a 20-year Programme of Action focused on individuals' needs and rights and built on the cornerstones of gender equality, eliminating violence against women and ensuring women's ability to control their own fertility. At the World Summit in 2005, world leaders resolved to achieve universal access to reproductive health by 2015 and committed to integrate the goal of access to reproductive health into national strategies to attain the MDGs (UNFPA, 2005c). This was adopted by the UN General Assembly in 2006 (ELDIS, 2007). The meaning of universal access to reproductive health and what is needed to achieve this has been explored by a number of authors (e.g. Fathalla et al., 2006, ELDIS, 2007). In October 2007, the UN General Assembly adopted a revised set of indicators for monitoring progress on the MDGs, which include a more explicit focus[6] on reproductive health (UN General Assembly, 2007).

Following the production of resource estimates for reproductive health and population for the International Conference on Population and Development held in Cairo in 1994, a great deal of work has been done on this topic (e.g. Fraser et al., 2002; Singh et al., 2003; UNAIDS, 2005; WHO, 2005; Bernstein and Vlassoff, 2006, Ethelston and Leahy, 2006; Millennium Project, 2006). Results from this work are summarised in Table 1.

Estimated needs are now considered to be higher than when the original ICPD estimates were made. Reasons for this include more explicit figures for system costs; improved data on costs of emergency obstetric care and other maternal health interventions; an expanded list of HIV prevention interventions; better methods for collecting health and population policy data needs; and better approximations of the costs for scaling up to universal coverage of services (Bernstein and Vlassoff, 2006).

[6] This included achieving universal access to reproductive health by 2015 as an indicator. It also included contraceptive prevalence as an indicator for the target on maternal mortality and indicators on adolescent birth rate, antenatal care coverage and unmet need for family planning for the target on universal access to reproductive health.

Table 1: Estimated Annual Cost for Achieving the ICPD Programme of Action (US$b)

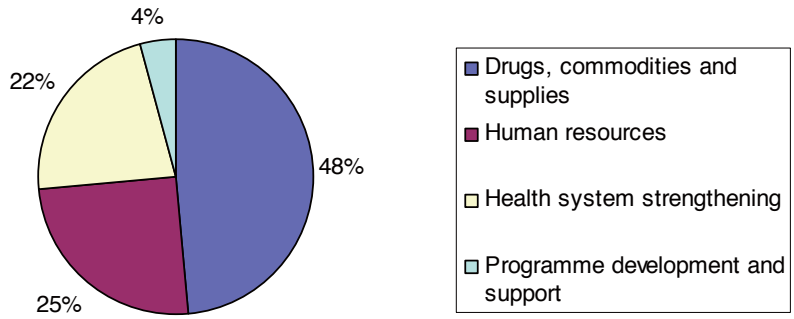
Components of RH/Population Package	2000	2005	2010	2015
Basic RH services (including family planning)		13.9	19.4	24.4
Sexually transmitted diseases and HIV/AIDS activities		4.1	9.7	11.1
Basic research data and population and development policy analysis		0.3	0.8	0.4
Total		**18.2**	**29.8**	**35.8**
Original ICPD figures[7,8]	17.0	18.5	20.5	21.7
Cost of RH supplies[9]	1.84	2.34	2.88	3.43
Drugs and medical supplies	1.01	1.27	1.56	1.84
Contraceptives	0.75	0.84	0.92	0.99
Condoms[10]	0.08	0.22	0.40	0.60

Data Source: Bernstein and Vlassoff, 2006 except where stated in footnotes

The Cost of Achieving MDG 5: Improving Maternal Health

A key element of achieving MDG 5 is improving the coverage of maternal and newborn care. The additional cost of doing this in 75 countries was estimated at US$1b in 2006, rising to US$6.1b in 2015. The total additional cost for the period 2006 to 2015 would be US$39b. Of this, almost half (48%) would be for drugs, commodities and supplies, a quarter (25%) for human resources, 22% for health system strengthening and 4% for programme development and support (see Figure 1; WHO, 2005).

Figure 1: Breakdown of Additional Costs of Scaling Up Maternal and Neonatal Health Services in 75 Countries



Data Source: WHO, 2005

These figures are significantly lower than those for providing universal access to reproductive health/implementation of the ICPD Programme of Action. There are two main reasons for this. First, these figures are for additional costs to scale up to meet MDG5 targets, not the total cost required for baseline through target figure. Second, they do not include the costs of a full range of contraceptive needs, only post-partum family planning.

[7] Figures for 2000 and 2005 from Euromapping Project, 2007
[8] Figures for 2010 and 2015 from UNFPA, 2005b; UNFPA, 2006a
[9] UNFPA, 2005a
[10] The figures for condoms are lower than in UNFPA, 2005d of US$0.42b in 2000, US$0.49b in 2005 and US$0.55b in 2010.

The Cost of Achieving the SRH Components of Universal Access to HIV Prevention, Treatment, Care and Support

In 2005, UNAIDS estimated that the global resource requirements for an effective response to HIV and AIDS would be US$14.9b in 2006, US$18.1b in 2007 and US$22.1b in 2008 (UNAIDS, 2005b). Estimates were released in September 2007 on the costs of providing universal access to HIV prevention, treatment, care and support (UNAIDS, 2007b). These vary according to two scenarios. The first, universal access by 2010, would require US$42.2b by 2010 and US$54b by 2015. The second, a phased scale-up to universal access, would require US$28.4b by 2010 and US$49.5b by 2015.

There is clearly an overlap between resource needs for universal access to comprehensive services for HIV and AIDS and universal access to reproductive health. However, there are a number of challenges in how these costings inter-relate. Not all interventions included in UNAIDS' method relate directly to access to reproductive health, as described in the ICPD Programme of Action, e.g. antiretroviral therapy. There have been attempts to try to quantify the proportion of spending on particular HIV prevention interventions that should be included in methods for costing providing universal access to reproductive health (Bernstein and Vlassoff, 2006). The estimated cost of providing the SRH elements of universal access to HIV prevention[11] is shown in Table 2. In 2010, US$9b would be needed for the SRH elements of HIV prevention to achieve universal access by that date, whereas US$6.5b would be needed to achieve a phased scale-up.
Although this is a possible approach for calculating resource needs, it will be difficult to track spending in this way. If total spending on HIV and AIDS continues to be counted as contributing to improving access to reproductive health, in general, and the ICPD Programme of Action, in particular, there is a risk of creating a false impression of the level of resources available (see Figure 2, p14). However, attempts to disaggregate reproductive health and HIV/AIDS spending risks creating the impression that these issues are separate and unlinked (Fathalla et al., 2006).

Concerns have been raised about funding which have contributed to SRH and HIV/AIDS as separate and unlinked service areas. This has been part of the rationale for calls for stronger linkages between reproductive health programmes and responses to HIV and AIDS (Druce et al., 2006).

The Cost of RH Supplies

UNFPA has produced detailed estimates of the costs of providing sufficient RH supplies to implement the ICPD Programme of Action (UNFPA, 2005a; see Table 1, p9). These were estimated to be US$1.84b by 2000, US$2.34b by 2005, US$2.88b by 2010 and US$3.43b by 2015. The proportion needed for drugs and medical supplies would remain constant at 55%. The proportion needed for contraceptives was predicted to fall from 41% by 2000 to 29% by 2015 while the proportion needed for condoms for HIV prevention was predicted to rise from 4% to 18% over the same period[12].

How Can These Costs Be Met?

ICPD envisaged that two thirds of the money required would come from developing countries and one third from donors (Euromapping Project, 2007). This would have meant that the amount required from donors would have been US$5.7b by 2000, US$6.2b by 2005, US$6.8b by 2010 and US$7.2b by 2015 (UNFPA, 2005b). Using the same proportions and revised figures (see Table 1, p9) the new donor targets would be US$9.9b by 2010 and US$11.9b by 2015.

Actual figures for 2000 (Singh et al., 2004) indicate that developing countries were financing around three quarters of the cost of sexual and reproductive health services indicating that, at that time, developing countries had made more progress ICPD targets than donors had in terms of providing their proportion of financing.

There is evidence, however (Fathalla et al., 2006) that 42% of all expenditure on sexual and

[11] The summary paper contains figures for HIV prevention only. It is unclear if other figures are available for other parts of the response to HIV and AIDS which might be considered to have relevance to SRH.
[12] These figures need to be considered when seeking to interpret findings such as those presented in Figure 3.

reproductive health services is actually out of pocket expenditure. Whilst it is recognised that market mechanisms are extremely important in extending access and overall distributive capacity, where such very high proportions of services and commodities are only available on a paid for basis, there is serious concern about equity of access amongst the poor and marginalised.

Table 3 shows the split of funds from different donor sources for 2004 with estimates for 2005/6.More than 80% of donor funding came from developed countries in 2004 and this proportion was expected to rise (UNFPA, 2005b).

Table 2: Estimated SRH Elements of Costs of Achieving Universal Access to HIV Prevention 2010: Two Scenarios (US$m)

HIV Prevention Activity	Scenario 1: Universal Access by 2010	Scenario 2: Phased Scale-up to Universal Access	Multiplier for SRH (%)	SRH cost Scenario 1	SRH cost Scenario 2
Communication for social and behavioural change	386	257	70[13]	270	180
Community mobilisation	135	69	80	108	55
Voluntary Counselling and Testing	1349	939	90	1214	845
Youth in school	145	108	80	116	86
Youth out of school	633	269	80	506	215
Programs focused on sex workers and clients	1542	1420	90	1388	1278
Programs focused on men who have sex with men	1183	1183	90	1065	1065
Harm reduction for injecting drug users	3181	3181	20	636	636
Workplace	835	382	20	167	76
Programs focused on prisoners	261	261	Not included[14]	N/A	N/A
Other vulnerable populations	209	252[15]	100	209	252
Condom provision	900	561	100	900	561
Management of sexually-transmitted infections	2001	893	100	2001	893
Prevention of mother to child transmission	662	662	50	331	331
Male circumcision	157	105	Not included	N/A	N/A
Blood safety	359	359	10%	36	36
Post-exposure prophylaxis	4	4	20%	1	1
Safe medical injections	859	859	0%	0	0
Universal precautions	277	123	25%	69	31
TOTAL	**15078**	**11885**		**9017**	**6541**

Data Source: Scenario data from UNAIDS, 2007b; Multipliers for SRH from Bernstein and Vlassoff, 2006

[13] Referred to as 'mass media'
[14] Multiplier table does not have this category – rather it has prevention programs for people living with HIV.
[15] It is unclear why the figure for scenario 2 is higher than for scenario 1

Table 3: Sources of Donor Funding for Sexual and Reproductive Health Services

	2004	2005 (est)	2006 (est)
Total (US$b)	**5.6**	**6.9**	**7.8**
Developed countries	80%	84%	86%
UN System	1%	1%	1%
Foundations/NGOs	8%	7%	6%
Development Bank Grants	4%	3%	3%
Development Bank Loans	6%	5%	5%

Data Source: UNFPA, 2005b

PERFORMANCE OF EUROPEAN COUNTRIES ON FINANCING SEXUAL AND REPRODUCTIVE HEALTH AND REPRODUCTIVE HEALTH SUPPLIES

This section focuses on the performance of a number of European countries[16] and the European Commission in financing sexual and reproductive health overall and on supplies. First, it considers these issues in general. It then considers a number of specific issues, including actions and financial provision by the selected European countries and the European Commission, and pledges to UNFPA's Global Programme to Enhance Reproductive Health Commodities Security.

Donor Funding for Sexual and Reproductive Health

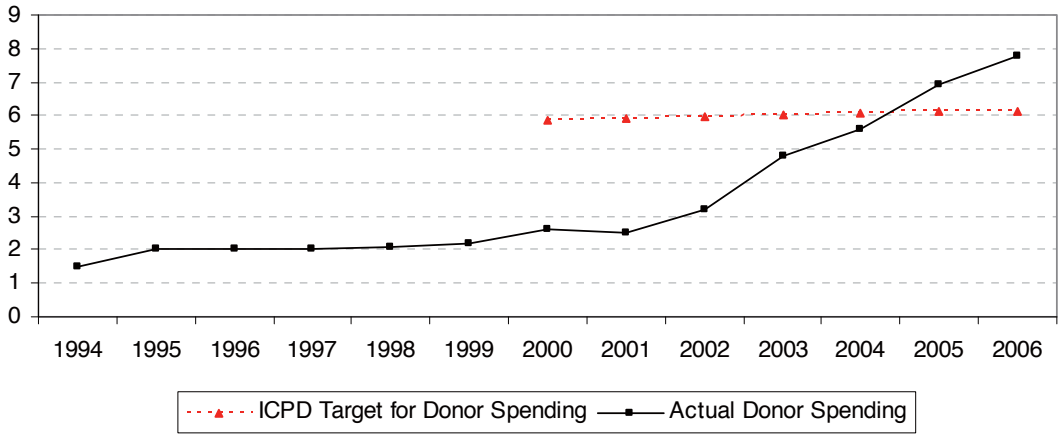
The amount of funding available for sexual and reproductive health is affected by the amount of funding available as official development assistance (ODA) overall. This issue is not considered in detail in this document[17]. However brief notes are included here:

- The countries of the European Union provide two thirds of ODA overall
- Although levels of ODA provided by Development Assistance Committee (DAC) member countries rose steadily to 2005…
- …this was due in large part to debt relief and fell in 2006
- The biggest European donors overall are France, Germany and the UK
- The biggest per capita donors are Denmark, Luxembourg, the Netherlands, Norway and Sweden, all of whom have met the target of providing 0.7% of their gross national income (GNI) as ODA

There are challenges in tracking spending on sexual and reproductive health services (Fathalla et al., 2006). Budgets and expenditure reports may not disaggregate spending on sexual and reproductive health within overall health spending. Issues of how to deal with spending on HIV and AIDS have been discussed earlier (see p11). Figures for donor spending (see Figure 2).on sexual and reproductive health services show this lagging behind ICPD targets until 2004 but exceeding them after this date (UNFPA, 2005b).

[16] Denmark, Finland, France, Germany, Netherlands, Sweden and the UK
[17] For more detail, see Euromapping, 2007

Figure 2: Donor Spending on Sexual and Reproductive Health Services: 1994-2006: Comparison to ICPD Targets (from UNFPA, 2005b)



Data Source: UNFPA, 2005b

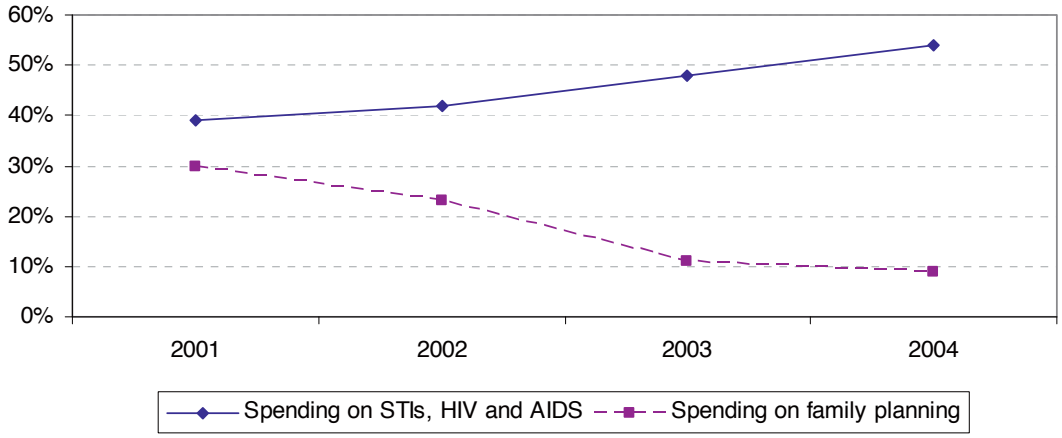
However, almost all of this increase is due to increased funding for responses to HIV and AIDS[18], and masks reducing levels of funding for aspects of services including for family planning[19]. From 2001-04, the percentage of donor spending on SRH services going to HIV and AIDS rose from 39% to 54%, while the percentage spent on family planning fell from 30% to 9% over the same period (UNFPA, 2005b; Euromapping Project, 2007; see Figure 3, p15).

Figure 4 shows a similar picture for individual European donors for projected spend in 2006 (UNFPA, 2005b). The percentage of SRH funds to be spent by individual European donor countries on HIV/AIDS ranged from 65-97%[20]. Overall, donor countries were projected to spend US$6.6b on SRH in 2006, of which 82% would be for HIV/AIDS, 7% for basic reproductive health services, 3% on research and 2% on family planning. As a result, in 2006:

- The largest donor supporting family planning in 2006 was the US (61%). Significant European donors were the UK (21%) and Germany (13%)
- The largest supporter of basic reproductive health services was the US (34%). Other significant funders included the UK (17%) and the Netherlands (10%)
- Almost all research funding for sexual and reproductive health from donors was to from the US (95%)

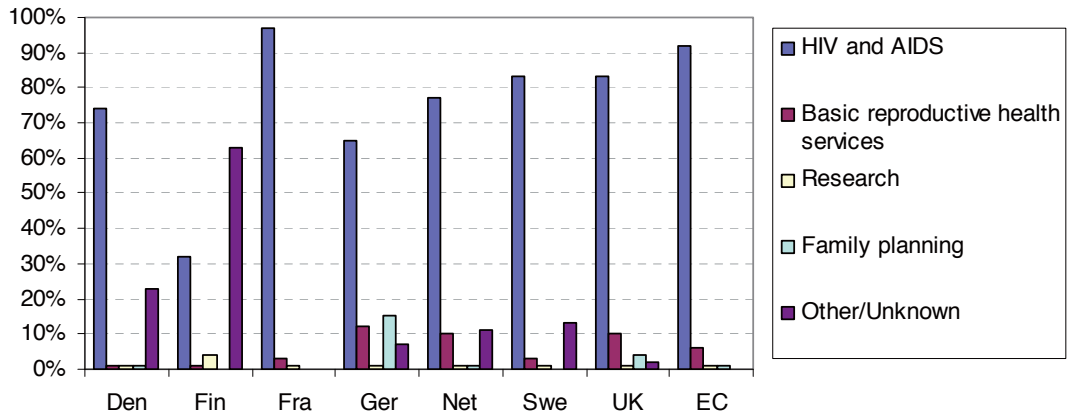
[18] Including provision of condoms and PMTCT within antenatal services
[19] Including contraceptives
[20] Excluding Finland. Although their projected spend on HIV/AIDS was only 32% of total spending on SRH, this was because almost two thirds (63%) could not be allocated.

Figure 3: Donor Spending on Sexual and Reproductive Health Services: 2001-2004: Percentage Spent on Particular Activity Types



Data Sources: UNFPA, 2005b and Euromapping Project 2007

Figure 4: Projected Donor Spending on Sexual and Reproductive Health Services: 2006: Percentage on Particular Activity Types by Selected Donor Countries and the European Commission



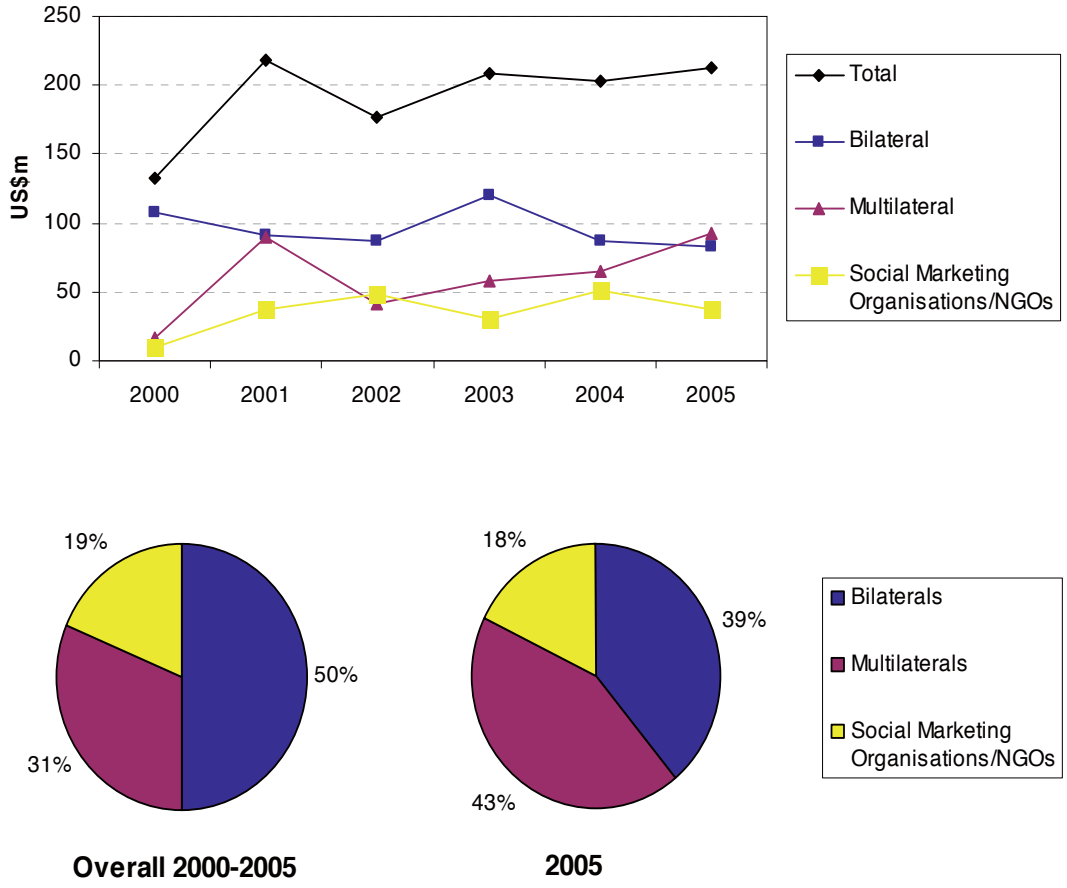
Data Source: UNFPA, 2005b

Funding for Reproductive Health Supplies

In 2005, donors provided a total of US$213m for the purchase of condoms and contraceptives (UNFPA, 2005d) compared to an estimated need of at least US$1.06b[21] (see Table 1, p8). This had risen from US$133m in 2000 and US$203m in 2004. Of this total, 43% was provided through multilateral organisations[22], 39% directly by bilaterals[23] and 19% by social marketing organisations/NGOs[24]. The proportion going through multilaterals increased in 2005 as compared to the entire period 2000-2005, while the proportion going directly through bilaterals fell during the same period (see Figure 5).

[21] UNFPA, 2005d has a higher figure for need of US$1.33b
[22] Particularly UNFPA
[23] Germany, Canada, the UK, Japan and the US
[24] DKT, IPPF, MSI, PSI

Figure 5: Support for Contraceptive and Condom Supplies by Donor/Agency Type: 2000-2005



Data Source: UNFPA, 2005d

Focus Governments – Actions and Financing

This section covers the actions and financing of sexual and reproductive health in developing countries by European donors that are the focus of Countdown 2015 Europe. Table 4 presents summary financial data (Euromapping, 2007; UNFPA, 2005b) Euromapping reviewed funding trends by considering total grants to the international NGO IPPF, the Global Fund and UN agencies UNAIDS, UNFPA and UNIFEM as contributing to SRH. This poses the risk of overestimation as most donors would attribute only a percentage of grants towards SRH e.g. Sweden counts 58% of the Global Fund grant to HIV and AIDS.

All countries increased their total funding for sexual and reproductive health services by at least 29% between 2002 and 2004[25]. Four countries[26] more than doubled their financing. Although two countries[27] reduced the percentage of their ODA being spent on SRH from 2002 to 2004, three[28] more than doubled this percentage. In 2004, the Netherlands provided more than 10% of its ODA and more than US$25 per person on SRH activities in developing countries. The Netherlands was also the largest EU contributor to selected international organisations with a focus on SRH and/or HIV/AIDS in 2003. In 2005, the UK was the largest contributor.

[25] Although as previously noted and shown in Figure 4, the majority of this increase is for responses to HIV and AIDS
[26] France, the Netherlands, Sweden and the UK
[27] Finland and Germany
[28] The Netherlands, Sweden and the UK

Table 4: Support for Sexual and Reproductive Health in Developing Countries: Summary Financial Data for Selected European Donors – focus countries of Countdown 2015 Europe

	Total funding for SRH (US$m)		% of ODA on SRH		Funding for SRH per capita (US$)	% of funds[29] from EU countries[30] to international organisations for SRH and/or HIV and AIDS [31]		SRH funding through RH orgs per capita (US$)
	2002	2004	2002	2004	2004	2003	2005	2004
Denmark	70	90	4.0	4.4	18	7	7	12
Finland	20	27	5.3	4.2	5	3	3	5
France	85	206	1.5	2.4	3	9	N/A	3
Germany	105	142	2.0	1.9	2	8	13	0.7
Netherlands	160	442	4.9	10.5	27	23	17	13
Sweden	60	197	3.1	7.2	22	7	15	16
UK	160	661	3.4	8.4	11	12	18	2
EC	180	159	2.8	1.8	N/A	N/A	N/A	N/A

Data Sources: UNFPA, 2005b and Euromapping Project 2007

Grading donor countries on their performance on SRH financing[32] and policies[33] (Leahy, 2007) shows another perspective. Current grades and historic grades, from 2004, are shown in Table 5. More details of scores for selected European donors are shown in Table 6.

In general, the focus countries of Countdown 2015 Europe are among the better performing donors relating to sexual and reproductive health in developing countries. Among them are some strong performers, such as Denmark, the Netherlands, Sweden and, more recently, the UK. Others, such as France are improving. Germany has provided strong support to the provision of family planning supplies (see Figure 4). In general, countries have appropriate policies. Some examples of these are featured in Box 2. Some areas for improvement are:

- Finland and the UK could increase their proportion of GNI provided as ODA
- France and Germany could increase their proportion of GNI provided as ODA **and** the proportion of their ODA spent on SRH

[29] In 2003, this was US$781m and in 2005 US$1,600m
[30] And Switzerland and Norway
[31] UNFPA, IPPF, UNIFEM, the Global Fund, UNAIDS and IPM
[32] Using three scores of up to 20 each for % of GNI provided as ODA; % of ODA spent on SRH activities and degree to which donor has met its 'fair share' of ICPD commitments
[33] Using an eight-point score in five policy areas – reproductive health; gender; existence of policy restrictions; support to UNFPA/IPPF and degree of tied aid

Table 6: SRH Financing and Policy Scores: Current Detailed Scores for Focus Countries (see Leahy, 2007) [34]

				Financial Scores (max 20)			Policy Scores (max 8)				
Country	Current Grade	2004 Grade	Total Score	ODA as % of GNI	SRH spend as % of ODA	ICPD 'fair share' performance	Reproductive Health	Gender	Policy Restrictions	Support to UNFPA/ IPPF	Use of untied aid
Denmark	A	A	93	18	*15	*15	8	8	8	8	7
Finland	B	A	79	7	18	18	4	8	8	8	7
France	B	C	63	8	6	17	4	8	8	4	8
Germany	B	B	68	6	8	15	8	8	8	8	7
Netherlands	A	A	95	16	20	20	8	8	8	8	7
Sweden	A	A	95	16	19	20	8	8	8	8	8
UK	A	B	87	7	20	20	8	8	8	8	8

Data Source: Leahy, 2007 with correction, personal correspondence Sex&Samfund

Scores assigned to countries on a scale of "A" to "F" (or full marks of 100% to Failure) according to their performance as donors, based on the following indicators:

- The generosity of each donor's overall development aid program in relation to the size of that country's economy;
- The proportion of development assistance funds allocated to reproductive health and population programs;
- The distance each donor has to go to reach its "fair share" of the ICPD spending goal for 2005 from 2002 spending levels; and
- The extent to which a country's policies foster the maximum level of impact in addressing the goals of the ICPD Programme of Action based on their official reproductive health and population policies, gender policies, percentage of "tied" aid, and contributions to key United Nations and non-governmental organizations

[34] Colour coding is based on the same as for grading – dark green for A (>80%); light green for B (60-80%); amber for C (40-60%) and red for D (<40%)

Table 5: SRH Financing and Policy Scores: Current and 2004 (see Leahy, 2007) (Focus countries of Countdown 2015 Europe underlined and bold)

A Grade		B Grade		C Grade		D Grade	
	2004		2004		2004		2004
Denmark	A	Australia	C	Spain	D	Austria	D
Luxembourg	A	Belgium	B	Portugal	D	Greece	-
Netherlands	A	Canada	B	USA	C	Italy	D
Norway	A	**Finland**	A				
Sweden	A	**France**	B				
UK	B	**Germany**	B				
		Ireland	C				
		Japan	B				
		New Zealand	B				
		Switzerland	B				

Data Source: Leahy, 2007

In relation to funding contraceptive and condom supplies, donors provided US$213m in 2005, of which 39% was provided directly by bilateral donors (see Figure 5, p15). The largest part of this (80%) was provided by the US. Significant European donors funding contraceptives and condoms bilaterally were Germany (16%) and the UK (4%) (UNFPA, 2005d). Other European donors funded contraceptive and condom supplies through their funding of UNFPA[35], which accounted for 43% of all such funding in 2005 (see Table 8).

The European Union and European Commission – Actions and Financing

This section focuses mainly on the European Commission and its actions and financing for SRH activities in developing countries. However, it starts with a brief review of the contribution of the European Union and its member states as a whole.

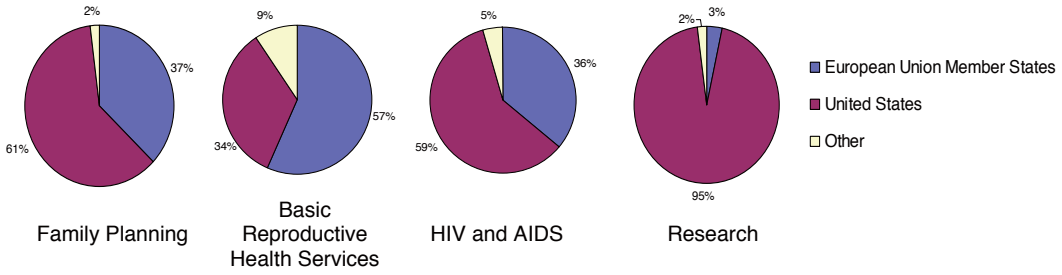
The European Union's development policy, e.g. as stated in the European Consensus (Council of the EU, 2005), the Joint EU-Africa Strategy[36] (Europa, 2007 and the Cotonou Agreement (ACP and the European Community, 2000 and 2005), includes strong commitments to the ICPD Programme of Action. The European Parliament has been active, e.g. through its Development Committee, in urging the Commission to focus more on poverty in its aid plans, including on health and education sectors. There have also been initiatives within the European Parliament to ensure that budget reports and instruments contain specific reference to reproductive health but unfortunately the Parliament rejected proposals to earmark the increase in funding for SRH for the 2008 budget

In May 2007, the European Union proposed a voluntary code of conduct on complementarity and division of labour in development policy with the intention of making aid more effective as envisaged by the Paris Declaration. However, there is a risk that certain parts of this code, e.g. limiting the involvement of bilateral agencies to three sectors in-country could be taken by some donors to justify their non-engagement with issues of reproductive health or by others to justify their withdrawal from this sector (Council of the EU, 2007).

According to UNFPA figures (UNFPA, 2005b), just over one third (38%) of the expected funds for SRH activities under the ICPD Programme of Action for 2006 were expected to come from EU member states. This proportion was similar for family planning programmes (38%) and responses to HIV and AIDS (36%). It was much higher for basic reproductive health programmes (57%) and very much lower for research (3%). These figures also reflect the funding priorities and practice of other major funders of SRH activities, particularly the US (see Figure 6).

[35] And to a lesser extent through funding of NGOs, such as IPPF
[36] Due to be adopted at the second EU-Africa Summit scheduled to be held in Lisbon in December 2007

Figure 6: Share of Different Types of SRH Funding: EU, US and Other Donors: 2006



Data Source: UNFPA, 2005b

Applying a set of financing and policy scores (Leahy, 2007; see Table 5, p17) show the diversity of performance among EU states. Five (Denmark, Luxembourg, Netherlands, Sweden and the UK) of the six[37] best performing donors are EU member states, but so are the three poorest performers (Austria, Greece and Italy).

From 1994 to 2001 (covering the Financial Perspectives 1993-1999 and 2000-2006), the European Commission provided 655.4m as population assistance (Particip GmbH, 2004). Of this, 43% was for responses to HIV and AIDS, 27% for reproductive health, 13% for family planning, 10% for safe motherhood and 6% for population policy and management. Figures in Table 4, show that between 2002 and 2004, the European Commission reduced both funding for SRH activities and the proportion of ODA spent on SRH interventions. There are concerns that this reduced level of funding indicates a reduced policy focus on SRH by the European Commission (see Box 3).

Advocates consider the European Commission to be inconsistent in its support to SRH[38]. The total amount of money for SRH during the last financial perspective
(2003-2006[39]) was 70.1 m. The EC has pledged that it will make the same amount of money available for the period 2007-2013, although the current Financial Perspective spans 7 years while the money allocated in the previous Financial Perspective to SRH only covered three years.

Figures for 2006 show that the proportion of the EC's SRH funding of HIV and AIDS had increased significantly to over 90%. 2006 marks the end of the 2000-2006 financial perspectives and therefore the funds leftover must be spent. It is worth noting that the increase is in great part due to the fact that for accounting purposes, the EC must spend the money rather than political will to increase funding.
(see Figure 4).

In addition, in 2007, the European Commission's entire health envelope within 'Investing in People' was allocated to the Global Fund (Action for Global Health, 2007). One of the underlying principles of the Global Fund is to make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis and malaria. Donor contributions to the Global Fund should be in addition to, not a replacement of, existing funding. Using the entire available health budget to meet the Commission's commitments to the Global Fund is not in keeping with that principle.

[37] The other is Norway
[38] personal correspondence MSI
[39] The SRH budget line was only introduced in 2003 – following a report on SRH by the former President of the EPWG.

Box 2: Has the European Commission Reduced its Policy Focus on SRH?

Evidence of ongoing policy commitment includes strong reference to SRH in recent EC policy documents, e.g. on gender equality and women empowerment (EC, 2007).

Evidence of reduced policy commitment includes:

- Prioritisation by Commissioner Louis Michel of issues of trade, infrastructure and regional integration
- The absence of a specific budget line for sexual and reproductive health in the new thematic funding programme 'Investing in People'
- The absence of a focus on reproductive health in the Commission's country programmes. Of the Commission's 106 country strategy papers, 38 (36%) refer to support for health, 13 (12%) to HIV/AIDS and 42 (40%) to gender (Euromapping Project, 2007).

Funding to International Organisations

From 2003 to 2005, the countries of the European Union increased their funding to a number of organisations who have a focus on or benefit to reproductive health from US$871m to US$1,600m. Organisations[40] received an increase in funding from EU countries of between 25-70%. (see Table 7; Euromapping Project, 2007). The seven donor countries and the European Commission that are the focus of Countdown 2015 are important funders of organisations working on reproductive health. In 2006, they provided between 38%-63% of these organisations' funds (see Table 8).

Table 7: Funding to Organisations Working on Reproductive Health from Countries of the EU: 2003 and 2005 (US$m)

	2003	2005	% increase
Global Fund to Fight AIDS, TB and Malaria	385	656	70%
United Nations Population Fund (UNFPA)	235	293	25%
Joint United Nations Programme on HIV and AIDS (UNAIDS)	89	130	46%
International Planned Parenthood Federation (IPPF)	42	47	11.9%
United Nations Development Fund for Women (UNIFEM)	23	35	52%
International Partnership for Microbicides (IPM)	7	11	57%

Data Sources: Euromapping Project, 2007, IPPF (individual correspondence)

UNFPA's Global Programme to Enhance Reproductive Health Commodity Security provides a structure for moving beyond ad hoc responses to stockouts towards more predictable, planned and sustainable country-driven approaches for securing essential supplies and ensuring their use. Budgeted at US$150m per year, it provides three funding streams to build capacity, enhance systems and avoid stockouts (UNFPA, 2006a). To date, UNFPA has US$39m available for this fund. Sources of these funds are shown in Table 9.

[40] Euromapping reviewed funding trends by considering total grants to these organisations posing risk of overestimation as most donors would attribute differential percentages of grants to these agencies as contributing towards SRH.

Table 8: Funding Trends to Organisations Working on Reproductive Health from Focus Donors (US$m – all figures 2006)

	Global Fund[41]	UNFPA[42]		UNAIDS[43]		IPPF[44]	UNIFEM[45]
		Rank	Amount	Rank[46]	Amount		
Denmark	24	6	31	6	8	8.4	1.9
Finland	4	8	17	10	9	0.9	1.5
France	293	16	2	14	3	0.0	0.0
Germany	88	7	20	13	2	4.6	1.5
Netherlands	77	1	75	2	38	5.4	0.2
Sweden	82	2	55	5	34	15.6	11.1
UK	120	4	38	4	29	14.4	8.0
EC	117	N/A	N/A	22	0.4	3.6	0.0
% of total funding	40%	63%		53%		49%[47]	38%

Data Source: Euromapping Project, 2007

Table 9: Sources of Funds for Global Programme to Enhance Reproductive Health Commodity Security (US$m)(Focus countries of Countdown 2015 Europe underlined and bold)

Donor	Amount
European Commission	10.6
UK	9.8
Netherlands	6.0
Canada	4.0
Sweden	3.7
Finland	1.9
Spain	1.5
Ireland	0.7
UN Foundation	0.4

Data Source: UNFPA, 2006a

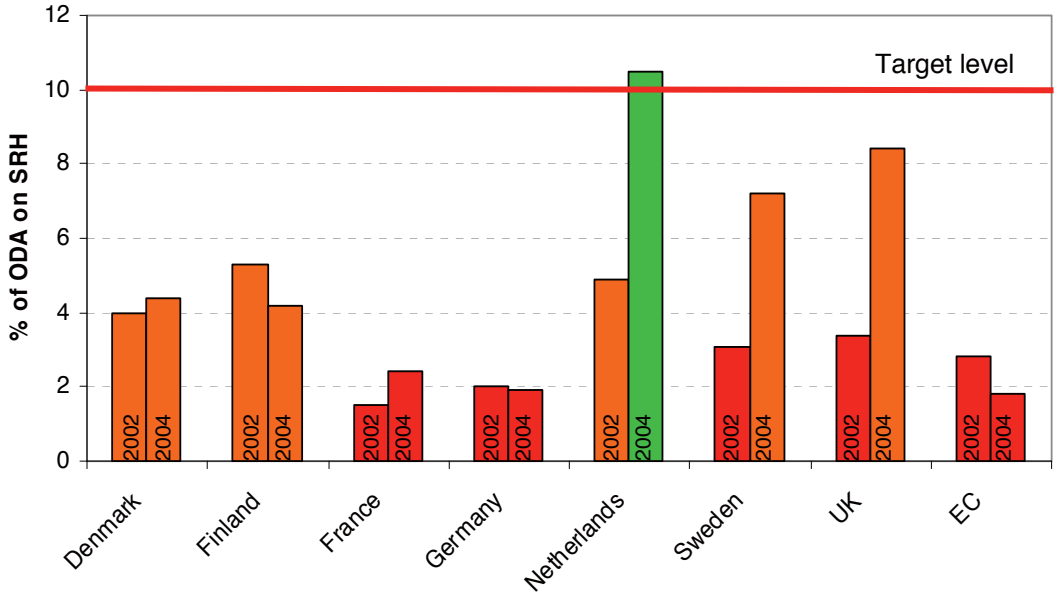
OPTIONS FOR MAKING PROGRESS TOWARDS GREATER INVESTMENT IN REPRODUCTIVE HEALTH SUPPLIES

Financial Targets

International Parliamentary Conferences on the implementation of the ICPD Programme of Action (Ottawa, 2002; Strasbourg, 2004; Bangkok,2006 – UNFPA, 2007b) and European and African Parliamentarian conferences in advance of G8 summits (Edinburgh, 2005; Berlin, 2007) have called on donor countries to allocate at least 10 per cent of development assistance and national development budgets to reproductive health. Only the Netherlands had met this target as of 2004, although both Sweden and the UK had made substantial progress towards it (see Figure 7).

[41] From Global Fund, 2007a
[42] From UNFPA, 2007a
[43] From UNAIDS, 2007a
[44] From IPPF, 2007
[45] From UNIFEM, 2007
[46] This ranking is for financial contributions to UNAIDS for the period 1995-2006
[47] The seven countries featured provided 64% of all funds from individual donor countries to IPPF

Figure 7: SRH Funding from Selected European Countries and the EC for 2002 and 2004[48]



Data Sources: UNFPA, 2005b and Euromapping Project 2007

However, levels for this target depend on the amount of funding provided as ODA by different countries. This amount varies widely, with only five countries currently meeting the target of providing 0.7% of GNI as ODA (Table 6 p19). It is therefore essential for countries to meet this target also. Both targets could be incorporated into one, namely that countries should provide 0.07% of their GNI as ODA for SRH programmes.

Also, there have been calls for donors to spend 15% of their ODA and 0.1% of their GNI on health (Action for Global Health, 2007). Assuming that SRH spending is a sub-set of health spending, this would require two thirds of health spending to be focused on sexual and reproductive health[49]. Parliamentarians from G8, European and African countries have consistently called[50] for 10% of ODA to spent on SRH

Mechanisms for Enhancing Expenditure

This section is divided into two parts. The first examines issues relating to financing sexual and reproductive health at country level. The second explores issues related to donor financing.

A great deal has been written recently about new approaches to health financing (e.g. Braine, 2006), which form part of an overall process of health sector reform, and their effect on sexual and reproductive health services (Dmytraczenko et al., 2003). This section will briefly consider three elements of in-country financing of sexual and reproductive health – resource mobilisation, resource pooling and purchasing (WHO, 2006).

Sources of financial resources for sexual and reproductive health services include tax-based public funding, various types of insurance schemes, out-of-pocket financing and external aid[51]. In developing countries, the tax base is very small (WHO, 2006). National insurance schemes[52] seldom reach national coverage and risk bringing benefits mainly to richer people, particularly men (WHO, 2006; Standing, 2002). Community insurance might be better but experience shows that inequities still exist because

[48] Colour coding – red <4%; orange 4-10%; green >10%
[49] Defined as including sexual and reproductive health rights, maternal and neonatal health and responses to HIV and AIDS
[50] Edinburgh Declaration (2005), Berlin Appeal (2007)

[51] Considered later in this section
[52] Usually employment-based with or without public funding for those not in employment

premiums are high and exemption systems function poorly (McPake, undated). Schemes may not cover some sensitive services, e.g. family planning or some groups, e.g. unmarried adolescents (WHO, 2006). Out of pocket expenditure remains an important means of financing sexual and reproductive health services, accounting for more than 50% of financing in some countries, e.g. Bangladesh, Peru, Thailand and Uganda (McPake, undated).

Insurance schemes and newer aid instruments[53] are ways of pooling resources for health services, including those for reproductive health (WHO, 2006). Pooled approaches, in principle, should allow resources to be allocated more cost-effectively to areas where they will make maximum public health benefit. However, experience shows that there are often problems with such prioritisation in practice with resources focused on issues of lower public health priority and disproportionately benefiting richer people and urban areas (McPake, undated). Pooling of resources also creates challenges in tracking how they are expended on particular areas of health, e.g. SRH (see p26).

Discussions of purchasing of SRH services focus largely on the role of the private sector. This sector is heterogeneous, consisting of both for-profit and not-for-profit providers (Standing, 2002). This sector is currently providing a significant proportion of SRH services in many countries[54] and is the main recipient of out-of-pocket payments (McPake, undated). Some consider that more services could be provided through this sector, e.g. through social marketing. Non-profit providers may have a particular role in providing services in underserved areas (McPake, undated). However, concerns about increasing use of private providers include increasing inequities (WHO, 2006), poor quality of services, increasing inefficiencies and undermining the coherence and sustainability of the health system (Doherty, 2005).

Much of the discussion about donor financing, in general, and for SRH and HIV and AIDS in particular, has focused on the issue of aid effectiveness. Aid, which has been unpredictable in timing and magnitude, has had major negative impact on the delivery of reproductive health supplies (Reproductive Health Supplies Coalition, 2006). The Paris Declaration on Aid Effectiveness provides five principles for addressing this situation, namely alignment, harmonisation, ownership, results and mutual accountability. Many donor countries are now trying to deliver their aid in ways, which are consistent with those principles. This is seen, for example, in the recent establishment of an International Health Partnership and in the focus on country-led approaches and newer aid instruments, such as general and sectoral budget support. This shift has considerable implications for the funding of SRH (Standing, 2002, Vogel, 2006) and raises important questions for donors:

- To what extent should funding for SRH be provided through bilateral or multilateral channels? Donors currently answer this question very differently (see Figure 8, p26)

- How effective are Global Health Partnerships, such as the Global Fund to Fight AIDS, TB and Malaria in funding sexual and reproductive health (see p27). Concerns have been raised that increased levels of financing for HIV and AIDS may be negatively affecting financing for other SRH elements, e.g. family planning (see p14). This has been part of the rationale for calls for stronger linkages between reproductive health programmes and responses to HIV and AIDS (Druce et al., 2006).

- To what extent will new mechanisms for financing drug purchasing, e.g. UNITAID[55] have positive benefits for reproductive health supplies? Are specific mechanisms needed for reproductive health supplies, such as minimum volume or pledge guarantees[56] (Reproductive Health Supplies Coalition, 2006)?

- To what extent are new systems/initiatives needed, such as UNFPA's Global Programme for Enhancing Reproductive Health Commodity Security and The RHInterchange (Supply Initiative, undated, b)?

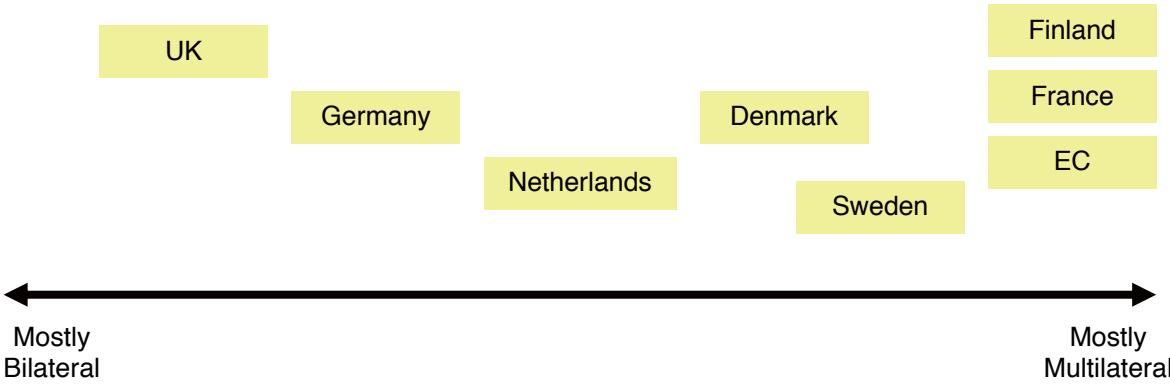
[53] Such as sectoral and general budget support (see p23)
[54] For example, Nicaragua – where social insurance was estimated to cover only 13% of the population (Carrazana, undated)
[55] See http://www.unitaid.eu/
[56] Pledge guarantee is a mechanism to advance money to a party based on projected financing flows from donors. Minimum volume guarantee is given to manufacturers to allow larger-scale production and reduction of unit costs.

- What mechanisms are needed to improve donor coordination on reproductive health supplies? How will the International Health Partnership address this?

There are a number of implications of this financing environment for sexual and reproductive health. First, it makes monitoring more complex. It is more difficult to track spending on sexual and reproductive health, in general, and RH supplies, in particular, when funding is provided as general or sectoral budget support rather than to specific SRH projects.

Mechanisms for doing this include public expenditure reviews, national health accounts and women's budgets. Each has its advantages and disadvantages (Standing, 2002). Second, advocacy on SRH issues is more complex and requires an understanding of the new aid architecture (Vogel, 2006). A shift to country-led approaches means that more advocacy/policy dialogue is needed at country level, e.g. for the inclusion of sexual and reproductive health in Poverty Reduction Strategies (PRSs) and Medium Term Expenditure Frameworks (MTEFs)[57]. This is a key focus of UNFPA's Global Programme for Enhancing Reproductive Health Commodity Security.

Figure 8: The Extent to Which Selected Donors Fund SRH Services through Bilateral or Multilateral Channels[58]



Data Sources: UNFPA, 2005b and Euromapping Project 2007

The Potential of the International Health Partnership

A new international health partnership was launched recently by the UK,[59] which aims to improve coordination among donors, focus on strengthening health systems as a whole and develop and support countries' own health plans (DFID, 2007). The 'first wave' of countries in the partnership are Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal and Zambia.

The International Health Partnership could have benefits for sexual and reproductive health as potential big wins are refocusing health aid from treatment of specific disease to the development of health systems as a whole, reversing the tendency to fund certain diseases and providing a framework for harmonisation and alignment which will greatly reduce the transaction costs and distortions facing recipient countries. However, to have maximum benefit, it will need to:

- Include all major donors, e.g. the US and Japan, and be expanded beyond the 'first wave' of countries
- Demonstrate actual achievements, in terms of implementing the principles of the Paris Declaration on Aid Effectiveness
- Show that it is applicable in fragile states

[57] And in donor instruments, such as Country Strategy Papers/Country Assistance Plans

[58] Based on data presented in Table 4

[59] Signatories to the IHP agreement include Canada, France, Germany, Italy, The Netherlands, Norway, Portugal, The European Commission, African Development Bank, UNAIDS, UNFPA, UNICEF, World Bank, WHO, GAVI Alliance, Global Fund to Fight AIDS, TB and Malaria and the Bill and Melinda Gates Foundation

- Leverage large reallocations of health spending (Maxwell, 2007)

There is also need to see how it fits with other initiatives to improve aid effectiveness, such as the EU's code of conduct on complementarity and division of labour, adopted in May 2007. It remains to be seen at country level, how the Ministry of Health, Ministry of Finance and other key stakeholders will ensure that intervention-specific plans, importantly the recently defined national plans for scaling up towards universal access to HIV and AIDS services, are complementary to national planning process to builds on, not replace, existing progress. Additionally the approach should be harmonized with the plans for RHCS but at present only Ethiopia is both a focus country of the IHP and the UNFPA Global Programme on RHCS.

The Role of the Global Fund to Fight AIDS, TB and Malaria

To date, there has been very little emphasis on integration between SRH-HIV and AIDS in the Global Fund's policy documents, guidelines, proposals, progress and financial reports (Dickenson, 2006). Studies have shown a lack of support to sexual and reproductive health services from the Global Fund (see Box 5).

In a survey of 104 IPPF Member Associations, 18 reported that they were members of Country Coordinating Mechanisms (CCMs). Another 13 were involved in CCMs in some way. The main barrier to Member Association involvement in CCMs was lack of information. In some cases, there was misinformation, e.g. the belief that the Principal Recipient of Global Fund money cannot receive funds for its own activities. Over half (59%) of Member Associations had submitted a proposal for Global Fund monies and half of these had been successful but they reported long delays in receiving those funds (GTZ and IPPF, 2005).

Box 3: Effects of Global Fund Financing on Reproductive Health in Ethiopia and Malawi

A study showed that reproductive health players had not been actively involved in planning the proposal for the Global Fund and that activities financed by the Global Fund were not integrated with existing reproductive health and family planning services. Workload on staff had increased and there was shift of human resources towards activities financed by the Global Fund. Procurement and disbursement of pharmaceuticals had improved in Ethiopia but not in Malawi (Schott et al., 2005)

Global Fund financing might also impact SRH services indirectly through effects on the health system (UK Stop AIDS Campaign, 2007; PHRPlus, 2006). There is some evidence that the Global Fund has strengthened some health systems, e.g. through training and provision of equipment and infrastructures (Friends of Global Fight Against AIDS, TB and Malaria, 2007). The Global Fund's guidelines for Round 7 (Global Fund, 2007b) contained a strong focus on health systems strengthening, for example, including the requirements to assess the national health system, to identify strategic actions to strengthen health systems and to explain any possible adverse effects on health systems of planned actions. This has emboldened organisations to call for proposals to include ambitious human resource requirements in their proposals, as Malawi did in Round 5 (Asia Pacific Action Alliance, 2007).

In consultation with the Global Fund, in advance of Round 7, it was confirmed that proposals that establish linkages with SRH systems are acceptable to the Global Fund provided that a positive outcome can be demonstrated for one of the three diseases. Acceptable integrated services include, but are not limited to, financing and provision of family planning services and reproductive health supplies (Interact Worldwide, 2006). However, the Global Fund's guidelines have not made any specific mention of reproductive health services.

NGOs have produced guidelines on how sexual and reproductive health could be included in proposals to the Global Fund (Global AIDS Alliance et al., 2007a), including integrated treatment of STIs, integrated VCT, PMTCT, provision of ART, adolescent STI and HIV prevention programmes, integrated SRH services for vulnerable populations, and activities to combat gender-based violence. They also produced an Advocacy Action Plan (Global AIDS Alliance et al., 2007b) to provide countries with options on influencing Global Fund governance at national level and working on institutional reform at the Board and Secretariat. Currently there is a call for the Global Fund to be explicit in its support for SRH-HIV and AIDS integration, beginning by approving a Round 8 Call for Proposals that outlines the funding opportunities for SRH programming and reproductive health supplies.

Through this report's review of available evidence of donor support to improve sexual and reproductive health and enhance the availability of reproductive health supplies it is clear that the needs of the poor have not been compelling enough yet. Countdown 2015 Europe is committed to improve transparency in ODA for SRH and RHS and will continue to influence policy makers in each of our focus countries of the need to explicitly report multilateral and bilateral support to achieve universal access to reproductive health.

REVIEW OF RECOMMENDATIONS

FULL FUNDING - Countdown 2015 Europe calls on donor governments to take urgent action to provide one third of these resources and meet targets of US$9.9b in 2010 and US$11.9b in 2015.

INCREASE ODA – Countdown 2015 Europe calls on donor governments to provide 0.7% of their Gross National Income as ODA and 10% of ODA to go to sexual and reproductive health.

ADDITIONALITY – Countdown 2015 Europe urges donors to ensure that funds for HIV and AIDS are not being provided at the expense of addressing universal access to reproductive health.

ENSURE COMMODITY SECURITY –Countdown 2015 calls upon donor governments to ensure prioritisation through bilateral and multilateral efforts.

SRH-HIV/AIDS INTEGRATION – Countdown 2015 Europe calls on European donors to increase effective use of resources through appropriately integrated and linked responses to sexual and reproductive health, HIV and AIDS.

HEALTH SYSTEMS AND HEALTH WORKFORCE –Countdown 2015 Europe calls on donor governments to ensure that aid instruments provide long-term, sustainable investment in health systems strengthening, particularly for significant investment in human resources for reproductive health.

EDUCATION SECTOR RESPONSE TO SRH –. Countdown 2015 Europe calls on donors to fund comprehensive evidence–based sexuality education to help educate the public on SRH and create demand for the provision of RH supplies.

NATIONAL PRIORITY SETTING – Countdown 2015 Europe calls on donors to support the Paris Declaration on Aid Effectiveness principles, to engage in policy dialogue with national governments to ensure that the importance of reproductive health supplies is recognised and provide technical assistance to build capacity.

EUROPEAN COMMISSION – Countdown 2015 Europe calls on the European Commission to enact commitments of the European Consensus on Development and urgently ensure that funds for reproductive health are prioritised in country and thematic programmes.

GLOBAL FUND – Countdown 2015 Europe calls on the Global Fund to be explicit in its support for SRH-HIV/AIDS integration, beginning by approving a Round 8 Call for Proposals that outlines the funding opportunities for SRH programming and reproductive health supplies.

ABBREVIATIONS

ACP	Africa, Caribbean and the Pacific
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CCM	Country Coordinating Mechanism
DAC	Development Assistance Committee
DFID	Department For International Development (UK)
DKT	Social Marketing Organisation
DSW	Deutsche Stiftung Weltbevölkerung
E&P	Equilibres et Population
EC	European Commission
EPF	European Parliamentary Forum
EU	European Union
GAVI	The GAVI Alliance formerly Global Alliance for Vaccines and Immunisation
GNI	Gross National Income previously Gross National Product (GNP)
GTZ	German Development Agency
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPM	International Partnership on Microbicides
IPPF EN	International Planned Parenthood Federation (European Network)
MDG	Millennium Development Goals
MSI	Marie Stopes International
MTEF	Medium Term Expenditure Framework
NGO	Non Government Organisation
ODA	Official Development Assistance
PAI	Population Action International
PATH	Program for Appropriate Technology in Health
PMTCT	Prevention of Mother to Child Transmission
PRS	Poverty Reduction Strategy
PSI	Population Services International
RFSU	Swedish Association for Sexuality Education
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAP	Sector-Wide Approach
SWEF	Systemwide Effects of the Fund
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNF	United Nations Foundation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
US	United States of America
USAID	United States Agency for International Development
US$	United States Dollar
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WPF	World Population Foundation

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Author: **Roger Drew**

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Sophie Peresson (MSI),
Julia Schalk (RFSU),
Hilkka Vuorenmaa (Vaestoliitto)

interact worldwide

325 Highgate Studios | 53-79 Highgate Road | London NW5 1TL
T: +44 (0)20 7241 8500 F: +44 (0)20 7267 6788
E: info@interactworldwide.org
www.interactworldwide.org
Registered Charity No. 1001698 Company No. 2567545