



Countdown 2015

EUROPE

**Campaigning for universal access
to reproductive health**

The Role of **Reproductive Health** and **Reproductive Health Supplies** in Strengthening Health Systems

Produced by Joyce Haarbrink
for Countdown 2015 Europe
on behalf of IPPF EN

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About Countdown 2015 Europe

Countdown 2015 Europe brings together a group of 18 leading European non-governmental organisations experienced in advocacy for reproductive health in development aid. As civil society organisations, we work in 15 European countries in a concerted effort to achieve increased support from European donors for reproductive health supplies (RHS). We aim to improve European coordination and coherence to narrow the gaps between the needs, demand and availability of essential supplies. Building greater political and financial commitment in Europe is key to securing universal access to reproductive health, which is an essential step in achieving the Millennium Development Goals.

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ACRONYMS AND ABBREVIATIONS

ACP	African, Caribbean and Pacific
CCM	Country Coordinating Mechanism
CSP	Country Strategy Paper
DAC	Development Assistance Committee
EDF	European Development Fund
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GFATM	The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GNP	Gross National Product
ICPD	International Conference on Population and Development
IFFIm	International Financing Facility for Immunisation
IHP+	International Health Partnership and Related Initiatives
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
MDG	Millennium Development Goal
NGO	Non-governmental organization
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PMTCT	Prevention of mother-to-child HIV transmission
PoA	Programme of Action
PRSP	Poverty Reduction Strategy Paper
RHS	Reproductive health supplies
RHSC	Reproductive Health Supplies Coalition
RSP	Regional Strategy Paper
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
WHO	World Health Organization

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EXECUTIVE SUMMARY

The signing of the International Conference on Population and Development Programme of Action (ICPD PoA) in 1994¹ by 179 governments was an important step towards improving health and well-being in countries worldwide. Yet 15 years later, more than half a million women in the developing world die annually from pregnancy complications, more than 200 million have an unmet need for family planning and 340 million new cases of sexually transmitted infections (STIs) are diagnosed each year, with one-third occurring among young people. While in the past many donors earmarked funding for Sexual and Reproductive Health (SRH) programmes, funding for SRH has dropped dramatically in the last few years as donors are moving increasingly towards supporting the health sector in general. SRH and Reproductive Health Supplies (RHS) security is part and parcel of a sound health system and can benefit from this move by claiming its rightful position in health system reform and health system strengthening policies and programmes.

The adoption of the Paris Declaration on Aid Effectiveness and the Accra Agenda of Action prioritised the partner countries' ownership of development aid, thereby confirming that they are responsible for their own policies regarding health. The adoption of an additional target 5B on achieving universal access to reproductive health by 2015 under MDG 5 on maternal health (2005), together with the adoption by the African Health Ministers of the *Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and reproductive Health and Rights 2007-2010* (2006)² should have contributed to achieving clear progress on reproductive health, particularly in Sub-Saharan Africa. However, the above figures show that this is not the case.

Sexual and reproductive health services and strong health systems

Both donors and partner countries have identified weak health systems as a serious constraint in achieving the proposed health targets. Health system strengthening has therefore become an important target for donor funding through both bilateral and multilateral channels. Sexual and reproductive health is an indicator of good health overall and should therefore be included in any effort to strengthen health systems. The major components of SRH, such as the provision of contraceptives (family planning), maternal and newborn health, prevention of unsafe abortion, management of SRH and STIs and the promotion of SRH, contribute to the promotion of health in general. Moreover, the strong focus of SRH on prevention and sexuality education and information can contribute to the prevention of morbidity and mortality. This is achieved not only through health education, but also through timely referrals for treatment of other conditions, such as STIs and HIV. Integrated health services can benefit SRH by ensuring that medical facilities are accessible and nearby when complications arise, for example, during and after childbirth. Moreover, primary health care integration with SRH and bi-directional SRH-HIV service integration can also bring a reduction in costs through the sharing of health facilities, personnel and procurement systems.

Women and girls and vulnerable groups, such as people living in extreme poverty, young people, lesbian, gay, bi-sexual and transgender people, people living with HIV and AIDS, and refugees, whose SRH needs are often ignored, are the main targets for SRH

care. However, rising costs of health care, the taboo around the status and behaviours of vulnerable groups and the inaccessibility of certain rural areas denies them access to proper SRH care. Strengthening health systems must increase access to every aspect of care, including access to a consistent and sustainable supply of reproductive health commodities, not only in urban or regional centres but also in remote rural areas. Hence, comprehensive health policies (including SRH and RHS policies) need to be developed and adequate funding needs to be allocated for implementation.

Policy commitments have not translated into action

In this respect the role of EU donors is important. While the EU has developed strong language on the need to support SRH and RHS security in its development cooperation activities, implementation is often hampered by lack of prioritization by EC and EU Member States' Delegations and national governments. Moreover, many ministries of health do not have the capacity to develop and implement a strong health policy, and ministries of finance often lack the political will to allocate sufficient funding to SRH and RHS security. As long as the principle of 'country ownership' of health policies is limited to 'government ownership', it will continue to exclude civil society, particularly those with the weakest political voice such as women, girls and vulnerable groups.

While donors can influence the choice of focal areas in the policy dialogue with partner governments, research has shown that the EC and Member States often fail to emphasize the inclusion of SRH and RHS security in their political discussions with partner governments. Thus, very few developing countries have adopted health as a focal area for development aid, resulting in a serious lack of donor funding. With donors' increasingly moving towards general and/or sectoral budget support, advocacy needs to be stepped up to ensure that partner countries integrate comprehensive SRH and RHS policies into their health strategies or implement the existing policies.

International health initiatives fail to address sexual and reproductive health

International health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI and UNITAID are beginning to play a major role in supporting the health sector in developing countries, as donors increasingly channel their funding for health through these organizations. While some of these initiatives, such as the Global Fund, include support for SRH and RHS in their disease-specific programmes on HIV and AIDS, international health initiatives seldom include SRH and RHS in recently developed programmes for health system strengthening. And even though gender awareness has been stated as a priority in international health initiatives, it has not yet led to the recognition of the importance of SRH and RHS in achieving development goals, especially those related to reducing infant and child mortality and the spread of HIV.

International health initiatives, therefore, would do well to include SRH and RHS security programmes in their activities and guidelines and should advocate for partner countries to include them in their health system strengthening policies and project and programme proposals.

¹ <http://www.unfpa.org/icpd/icpd-programme.cfm>

² African Union, Sp/MIN/CAMH/5(I)

INTRODUCTION

This report will look at the importance of reproductive health (-RH) and reproductive health supplies (RHS) within basic health care and health system strengthening (HSS) and will present recommendations on how to ensure that they are included in the implementation of national health policies and health system strengthening.

It will examine the role of European Union (EU) donors in supporting RH and RHS in the broader context of support to health system strengthening, not only through bilateral aid (e.g. in the form of budget support) but also through their contributions to global health organizations such as The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI) and global health initiatives such as UNITAID and the International Financing Facility for Immunisation (IFFIm).

It will also consider donor coordinating mechanisms such as the International Health Partnership and Related Initiatives (IHP+) and the EU Code of Conduct on the Division of Labour, which were developed in line with the Paris Declaration and the Accra Agenda for Action on Aid Effectiveness.

Living up to International Commitments on Reproductive Health and Supplies

The Universal Declaration of Human Rights³ states clearly that everyone has the right to life, liberty and security of person (Art. 3). In 1994 the **International Conference on Population and Development (ICPD)** recognized the need to prioritize women's reproductive health and adopted a **Programme of Action (PoA)** identifying universal access to reproductive health as an important development goal. In 1999 the 21st Special Session of the United Nations General Assembly adopted the 'Key Actions of the Further Implementation of the Programme of Action of the International Conference on Population and Development', embedding and even prioritising SRH in the broader context of health sector reform, including the strengthening of basic health systems (Art. 52a). It also called for increased training on reproductive health for health workers and urged donors to continue and even increase their funding for reproductive health interventions.⁴

In 2000 the Millennium Declaration set out the eight **Millennium Development Goals (MDGs)**, three of which are related to health (MDGs 4, 5 and 6);⁵ yet, in spite of the ICPD PoA and the Key Actions adopted earlier, it was only in 2005 that '**Universal Access to Reproductive Health**' was included as an additional target 5B for MDG5 (see Box 1). In 2007 the United Nations General Assembly adopted a set of indicators to track progress towards achieving universal access to reproductive health by 2015, which included the contraceptive prevalence and the unmet need for family planning.

Box 1 - MDG 5: Improve Maternal Health

Targets:	Indicators to monitor progress
5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1: Maternal mortality ratio
	5.2: Proportion of births attended by skilled health personnel
5B: Achieve, by 2015, universal access to reproductive health	5.3: Contraceptive prevalence rate
	5.4: Adolescent birth rate
	5.5: Antenatal care coverage (at least one visit and at least four visits)
	5.6: Unmet need for family planning

Source: Official List of MDG Indicators

Reproductive Health Supplies (RHS)⁶, identified by United Nations Population Fund (UNFPA) as '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', are crucial in ensuring good reproductive health. If women, and men, have no access to family planning commodities, to medicines to ensure healthy pregnancies and safe births, or to drugs and condoms to prevent HIV infections or mother-to-child transmissions of HIV, they are much less able to decide on the number and spacing of their children and go safely through their pregnancies and deliver healthy babies.

As the biggest donor of development funding, the European Union (EU), i.e. the European Commission and the EU Member States, has an important role to play in supporting recipient countries in the implementation of sound policies on health and particularly on SRH. In the past some EU donor countries strongly supported reproductive health, as was shown, for instance, by the Commission's additional contribution in 2002 of € 32 million for a three-year period to fill the 'decency gap' left by the USA's decision to cut its funding for UNFPA and IPPF⁷. However, recognising that weak health systems and insufficient funding for the health sector in general cause serious constraints on the delivery of health, including SRH, donors are increasingly moving towards channelling their financial support through the national budget (i.e. offering general and/or sectoral budget support). By empowering the national governments to decide on their health spending, it will be up to those governments to engender the political will to ensure that sufficient funding is allocated to SRH and RHS in line with the various international commitments on supporting SRH, including through health system strengthening.

³ See also art. 2.1 and 25.2 of the Declaration of Human Rights (1948), <http://www.un.org/en/documents/udhr/>

⁴ See also Article 14.1 of the ICPD PoA and Article 92 of the Key Actions

⁵ MDG4 on reducing child mortality, MDG5 on improving maternal health, MDG6 on combating HIV/AIDS, Malaria and other diseases

⁶ For the purpose of this paper the words reproductive health 'supplies' and reproductive health 'commodities' are considered to be interchangeable, denoting the products and drugs necessary for family planning and good reproductive health.

⁷ See also http://europa-eu-un.org/articles/fr/article_1521_fr.htm

SECTION I: REPRODUCTIVE HEALTH, REPRODUCTIVE HEALTH SUPPLIES AND HEALTH SYSTEMS IN THE SOUTH

When analysing the implementation of the international commitments on SRH and RHS on the ground, it is clear that both donor and recipient country governments need to strengthen their efforts to put their words into action. Some 536,000 women die annually in childbirth worldwide, of which 66,500 as the result of unsafe abortions, 204 million women have an unmet need for family planning services, and some 100 million young people are among the 340 million new cases of sexually transmitted infections (STIs) each year.⁸ Moreover, worldwide the availability of RHS falls short of current demands. Various reasons have been mentioned for the shortage of RHS in developing countries, but the main ones are the lack of financial resources, weak health systems and a lack of coordination and harmonization, both at the global and national level, to combat resource shortfalls and make effective use of those resources that are available.⁹ But, most importantly, there seems to be a lack of political will to ensure that SRH and a sustained supply of RHS are kept high on the political agenda.

The ICPD PoA, adopted in 1994, defines reproductive health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes’ (Art.7.2). It implies that people should have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. This requires systems to be in place that facilitate universal access to safe, affordable and acceptable methods of family planning of their choice and to appropriate health care services which enable women to go safely through pregnancy and childbirth. While the signatories of the ICPD PoA include many representatives from the developing world, progress towards achieving the PoA targets is slow.

In 2005 the Millennium Project Group published a report which identified SRH services as essential for achieving all MDGs by 2015 (see Box 2), even though reproductive health had not been included in the MDGs adopted in 2000. Although remedied in 2005 by the UN General Assembly’s adoption of an additional target ‘to achieve universal access to reproductive health by 2015’ as target 5B under MDG5 on maternal health, the *Millennium Development Goals Report 2008*¹⁰ indicates that maternal mortality remains high and MDG5 is the least likely to be reached by 2015, particularly in sub-Saharan Africa. In 2005 a woman’s risk of dying from pregnancy-related causes was 1 in 22 in that region, compared to 1 in 7,300 in developed countries – indicating that, although at the global level maternal mortality decreased to less than 1%, in sub-Saharan Africa there was no real progress. In 2006 nearly 61% of births were attended by skilled health personnel in the developing world as a whole, but in sub-Saharan Africa the rate was 47% and in Southern Asia only 40%. In almost all developing regions adolescent fertility fell between 1990 and 2000 but stagnated after 2000, with a very high adolescent fertility rate in sub-Saharan Africa. Although overall the unmet need for family planning has dropped, nearly one in four married women in sub-Saharan Africa has an unmet

need for family planning, and the provision of contraceptives has not kept pace with the increased demand for methods to delay or limit births, especially among young women. In order to address above stated problems, a closer look at the realities on the ground in countries in the South is needed. Also, the increased attention of international donors health systems strengthening (HSS) should go hand in hand with a sufficient focus on SRH and RHS for HSS to be effective.

Box 2 - Sexual and reproductive health essential for reaching all MDGs:

Goal 1: *Eradicate extreme poverty and hunger.*

Smaller families and longer birth intervals allow families to invest more in each child’s nutrition and health. In addition, the voluntary reduction of birth rates may enable faster social and economic development.

Goal 2: *Achieve universal primary education.*

Families with fewer children, and children spaced further apart, can afford to invest more in a child’s education. In addition, girls who have access to contraceptives are less likely to drop out of school as a result of pregnancy.

Goal 3: *Promote gender equality and empower women.*

Women who can plan the timing and number of their births have greater opportunities for work, education and social participation outside the home.

Goal 4: *Reduce child mortality.*

Prenatal care and the ability to avoid high-risk births (due to pregnancy at a very young age or too closely spaced together) help prevent infant and child deaths.

Goal 5: *Improve maternal health.*

Preventing unplanned and high-risk pregnancies and providing care in pregnancy, childbirth and the post-partum period save women’s lives.

Goal 6: *Combat HIV/AIDS, malaria and other diseases.*

SRH care includes preventing and treating STIs, including HIV and AIDS.

Goal 7: *Ensure environmental sustainability.*

Providing SRH services, and avoiding unwanted births, decreases the population burden on the environment, particularly in rural areas.

Goal 8: *Develop a global partnership for development.*

Affordable prices for drugs to treat HIV and AIDS and a secure supply of contraceptives would greatly advance reproductive health programmes in all developing countries.

Source: Millennium Project: Report to the UN Secretary-General. *Investing in Development. A Practical Plan to Achieve the Millennium Development Goals, 2005*

⁸ See *Mapping European Development Aid and Population Assistance*. Euromapping 2008.

⁹ See also the *Reproductive Health Supplies Coalition: What is the problem?* at http://www.rhsupplies.org/about_rh_supplies/what_is_the_problem/lack_of_coordination.html

¹⁰ Published by the United Nations in 2008.

1.1 Reproductive health and reproductive health supplies in the South

When looking at the realities on the ground, African Health Ministers recognise the importance of investing in SRH and RHS in their countries. During the Special Session of the African Union in September 2006, the Conference of Ministers of Health adopted the 'Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010',¹¹ to promote universal access to comprehensive SRH services in Africa. It clearly links STIs, HIV and AIDS, and sexual and reproductive health and rights (SRHR) programmes and services as a means to maximize the effectiveness of resource utilization, and recognizes family planning as an essential part of the attainment of the health MDGs. Special attention is given to the SRH needs of adolescents and youth. Quality and affordable services to promote safe motherhood, child survival and maternal, newborn and child health and combating unsafe abortion are seen as key strategies to attain the objectives of the ICPD PoA and the health MDGs in Africa.

In addition, the signatories committed to address RHS and ensure sufficient funding for the implementation of the Maputo Plan of Action from their own national resources. It was estimated that US\$ 3.5 billion would be required for 2007 to implement the Plan of Action and a total of US\$ 16 billion through to 2010.

The adoption of this Plan of Action shows the political will of African health ministers to make progress towards achieving universal access to reproductive health. However, although national policies and programmes have been developed, often by the national Ministries of Health, implementation requires the political will of the whole government. In some countries, such as Uganda, the political leader can be in favour of increasing the population and, therefore, does not support family planning but will promote safe motherhood and the fight against STIs, which includes the provision of RHS except contraceptives (see also Box 6 below). In others, traditional beliefs favouring high fertility, the role of religious leaders and the lack of male involvement¹² can lead to a similar result. Funding constraints also play an important role. However, it should be recognized that good SRH contributes to poverty eradication, as can be seen above (Box 1). The reproductive health status in developing countries can only be improved if governments increase their efforts in supporting reproductive health interventions, not only by developing national policies on reproductive health but also by implementing them and allocating sufficient funding. SRH, linking SRH-HIV/AIDS, and RHS need specific attention.

1.1.1 Reproductive health

Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems (ICPD PoA, Art. 7.2). It aims to ensure that men and women can freely decide on the timing and spacing of wanted and healthy pregnancies.

To meet these aims, a comprehensive policy on reproductive health is needed. Although many developing countries are aware that women, particularly in rural areas,¹³ have a huge need for reproductive health care, there is a preference to integrate it in their policy on combating HIV and AIDS and to focus primarily on maternal and child health, without integrating extensive family planning mechanisms and comprehensive sexuality education.

If SRH care is to be supported through donor aid, recipient countries need to make sure that it is included as a policy area within the Country Strategy Papers (CSPs) and National Indicative Programmes (NIPs), which are used as the basis for EU development cooperation programmes with development partners, and in Poverty Reduction Strategy Papers (PRSPs) where these are used by other donors.

Box 3 Reproductive Health

Reproductive health should meet the needs for:

- family planning counselling, information, education, communication and services;
- education and services for prenatal care, safe delivery and postnatal care, especially breastfeeding and infants' and women's health care;
- prevention and appropriate treatment of infertility;
- prevention of unsafe abortion and the management of complications;
- treatment of reproductive tract infections, STIs and other reproductive health conditions;
- information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood;
- active discouragement of harmful practices, e.g. female genital mutilation.

1.1.2 Links between reproductive health and the response to HIV and AIDS

In 2004 the HIV/AIDS and reproductive health communities agreed that an effective response to HIV and AIDS required a link with reproductive health interventions. This resulted in the adoption of the 'Glion Call to Action on Family Planning and HIV/AIDS in Women and Children'¹⁴ and the 'New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health'.¹⁵ The Glion Call to Action focuses primarily on the link between family planning and the prevention of mother-to-child HIV transmission (PMTCT). By promoting full access to modern contraceptive methods, including male and female condoms, primary HIV infections can be prevented, while women living with HIV can prevent unintended pregnancies. Education, information and counselling for HIV-infected pregnant women and Voluntary Counselling and Testing (VCT) programmes during pregnancy, birth and postnatal care are seen as crucial elements to achieve PMTCT.

¹¹ African Union, Sp/MIN/CAMH/5(I)

¹² See also *Repositioning Family Planning: guidelines for Advocacy Action*, published by WHO and USAID, 2008.

¹³ Cf *Rural Women's Health in Asia: Health Status and Barriers to Access*. Prepared by Michelle Rogers, Asian-Pacific Resource and research Centre for Women (ARROW), www.asianruralwomen.net/themes/health.doc

¹⁴ Adopted in May 2004. See also http://www.unfpa.org/upload/lib_pub_file/333_filename_glion_cal_to_action.pdf

¹⁵ Adopted in June 2004. See also: http://web.unfpa.org/upload/lib_pub_file/321_filename_New%20York%20Call%20to%20Commitment.pdf

Box 4 - MDG6: Combat HIV/AIDS, Malaria and other diseases

Target 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Indicators

- 18. HIV prevalence among pregnant women aged 15-24 years
- 19. Condom use rate of the contraceptive prevalence rate
- 19a. Condom use at last high-risk sex
- 19b. Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
- 19c. Contraceptive prevalence rate
- 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

Source: Millennium Project, 2005

The New York Call to Commitment focuses more on a comprehensive approach to the links between the two issues, with particular attention on young people. Since the adoption of these two documents more attention has been given to these bi-directional links (i.e. between HIV/AIDS prevention and SRH). An overview of research published in 2008 showed that the reviewed studies reported an increase in access to and uptake of these integrated services.¹⁶ It is interesting to note that the study reported as inhibiting factors for successful linkage: lack of commitment from stakeholders; non-sustainable funding; understaffed clinics; inadequate infrastructure, equipment and commodities; cultural and literacy issues; women not sufficiently empowered to make SRH decisions; and poor programme management, among others. In short: weak health systems and lack of education, information and communication, particularly for women.

Moreover, in the reports *Universal Access to HIV/AIDS, TB and Malaria Services by 2010: Update on HIV/AIDS in Africa*¹⁷ and *Report of the AU Commission Chairperson on Health-Related Activities (2007-2009)*¹⁸, published for the 4th Session of the African Union Conference of Ministers of Health from 4-8 May 2009, both HIV/AIDS and reproductive health are discussed, but no mention is made of the links between them – this in spite of the fact that the Africa Health Strategy: 2007-2015, adopted during the 3rd Session of the African Union Conference of Ministers of Health in 2007¹⁹, recommended integrating related and complementary programmes to improve the cost-effectiveness of the health system and overcome the problems of a vertical (i.e. disease-specific) and fragmented approach (Art. 38). So, although SRH and HIV/AIDS prevention are closely linked, policymakers are still very hesitant to adopt a bi-directional health approach linking both issues.

1.1.3 Reproductive health supplies

“No one should die for want of a three-cent condom.”

Dr. Peter Piot, former Executive Director, UNAIDS

Linking HIV and AIDS programmes with reproductive health programmes is not only about linking health care programmes, it is also about dual use of commodities. Male and female condoms not only prevent unwanted pregnancies, they are also an effective method to prevent HIV infection (‘dual protection’). However, it is important to remember that RHS include more than just condoms. As previously stated, UNFPA defines RHS as ‘*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*’. For instance, RHS include hormonal contraceptives, intra-uterine devices, barrier methods, implants, creams and jellies for family planning; pharmaceuticals to ensure safe deliveries and neonatal health; and kits for health care providers needed for emergency deliveries, professional midwifery and blood transfusions; antibiotics and diagnostic tests to address reproductive tract infections; and medicines to treat HIV and drugs to prevent mother-to-child transmission (PMTCT).

Box 5 Contraceptive Security

Contraceptives security means that the end user receives:

- The right product, i.e. that a wide range of products are available
- in the right quantities
- and the right conditions
- at the right time
- for the right cost (including the cost of contraception and indirect costs such as health care services, transportation, loss of income etc.)

Source: *Contraception at a Crossroads*. IPPF 2008

Reports regularly flag up a massive gap between the need for and the availability of these supplies, particularly in developing countries, where stock-outs²⁰ of different commodities are not uncommon. This is in spite of the fact that it is clear that regular shortages of RHS are seriously undermining progress towards achieving both the MDGs and the ICPD PoA.²¹

In 2005 UNFPA calculated that the number of contraceptive users in the developing world would rise from 571 million in 2000 to 731 million by 2015.²² The number of deliveries would rise from 123 million to 127 million over the same period, while the incidence of STIs would rise from 316 million to 405 million. This means that the demand for all kinds of RHS will rise accordingly (see Figure 1).

16 See also *Sexual and reproductive Health and HIV. Linkages: Evidence Review and Recommendations*, published jointly by WHO, UNFPA, IPPF, UNAIDS, UCSF in 2008.

17 See African Union CAMH/EXP/10(IV), published for the meeting of experts 4-6 May 2009.

18 See African Union CAMH/EXP/2(IV), published for the meeting of experts 4-6 May 2009.

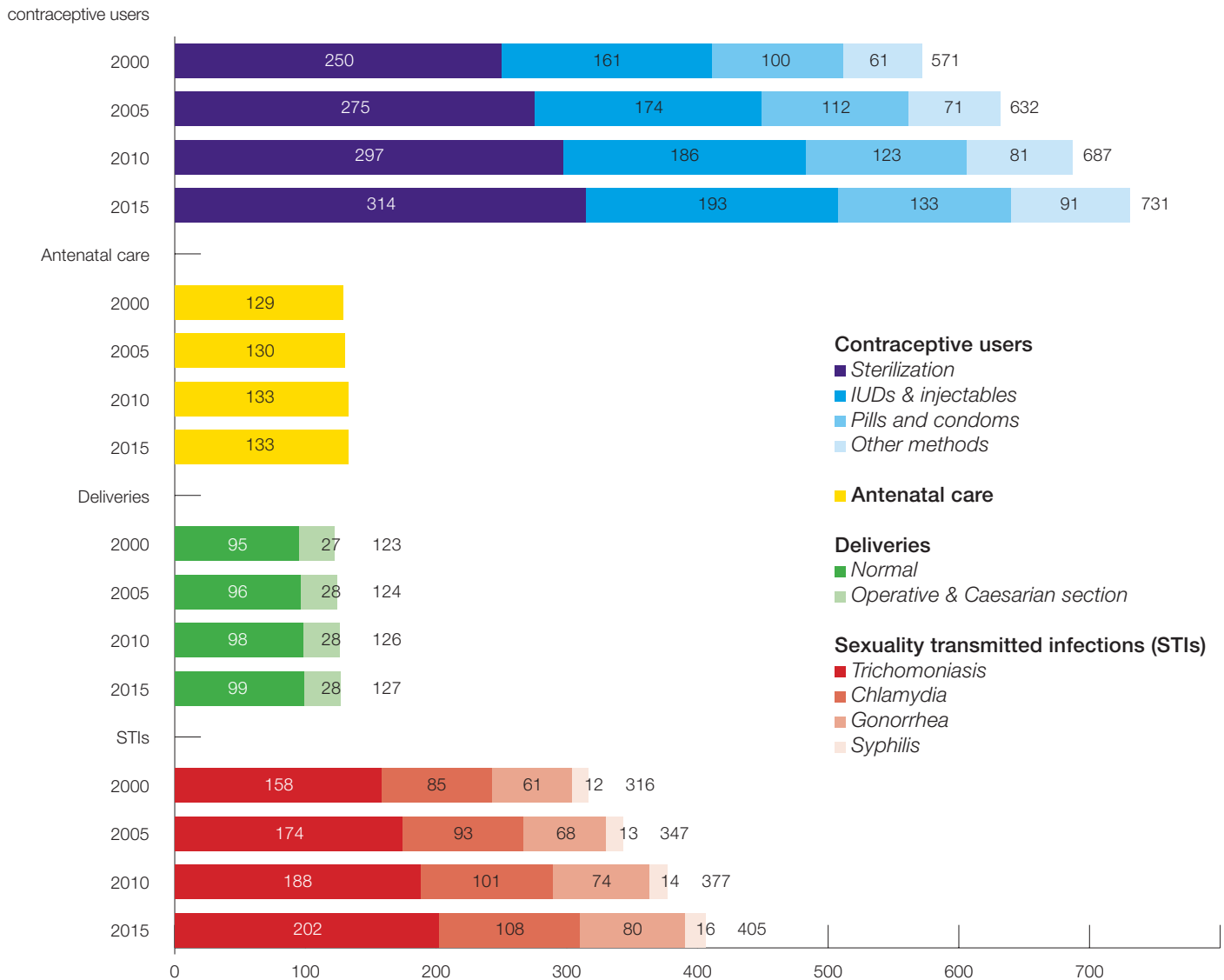
19 See CAMH/MIN/5(III), published by the African Union, 2007.

20 ‘Stock-out’ refers to the situation where supplies have run out and no safety/buffer stock has been built up to ensure sustained supplies.

21 See also pp. 101 and ff. in *Public choices, private decisions: sexual and reproductive health and the Millennium Development Goals*. By Bernstein, S. and Hansen, C.J., published by UN Development Programme, New York, USA, 2006.

22 See *Achieving the ICPD Goals: Reproductive Health Commodity Requirements 2000-2015*, published by UNFPA, 2005.

Figure 1. ICPD Reproductive Health Commodity Requirements



Source: *Achieving the ICPD Goals: Reproductive Health Commodity Requirements 2000-2015*

UNFPA also calculated the total financial requirements for commodities for each five-year period for all regions: for the period 2001–2005 US\$ 10.7 billion was needed, for 2006–2010 it will be US\$ 13.3 billion, and for 2011–2015 US\$ 16.0 billion. It is clear that this will need a strong increase in overall funding for reproductive health. UNFPA recognized that it would not be feasible for most developing countries to achieve 100% coverage by 2015 but felt that a target of 95% should be achievable by that time. However, so far many developing countries still face regular stock-outs of various RHS, and it is uncertain that they will achieve the proposed target by 2015.

RHS face a range of challenges in-country. There is a trend within developing countries towards the decentralization of health care. Regions are increasingly becoming responsible for

the management of health care but in many cases still depend on the central government for the final procurement of RHS. A central monitoring system for RHS is seldom in place, and where forecasts are being made for future needs these are often based on past usage without taking into account increasing demands – for instance, due to a growing number of adolescents with reproductive health needs.²³ As a result, procurement is often ad hoc, short-term and only addresses immediate needs. In addition, the scale of the procurement is relatively small, resulting in higher prices as the procurer cannot benefit from price reductions by buying in bulk. Funding flows from both donors and national governments tend to be volatile and are often unpredictable, creating serious problems for the procurement of RHS as suppliers want to have a guarantee that the supplies will be paid for.²⁴

23 See also *Strategic Options for Greater European Investment in Reproductive Health Supplies*, produced by Roger Drew for Countdown 2015 Europe on behalf of Interact Worldwide, 2008.

24 See also: *Reproductive Health Financial Mechanism analysis. Business Plan July 2006 for the Reproductive Health Supplies Coalition: System Strengthening Working Group*, an analytical support provided by McKinsey & Company, at http://www.rhsupplies.org/fileadmin/user_upload/McKinseyRHFinancialMechanismAnalysisBusinessPlanJuly_2006.pdf

As donors are increasingly moving away from providing earmarked funding for reproductive health and RHS (see below), national governments have to step in to fund the sustained procurement of RHS. This requires setting up a national system to monitor RHS. Governments need to develop a strategy that identifies available stocks of supplies, calculates future needs, manages the dissemination of supplies to every corner of the country, and put in place the necessary funding. The specialized Ministries of Health are best placed to take the lead in developing such a structure, with the Ministry of Finance contributing the necessary funding and other line ministries such as the Ministry of Transport and the Ministry of Trade contributing by ensuring effective transportation and support in procuring the necessary products at reasonable prices. Project RMA,²⁵ a partnership initiative between Population Action International (PAI), the International Planned Parenthood Federation (IPPF) and the German Foundation for World Population (DSW), has identified four key points that are essential to guarantee that a government has the capacity to ensure a sustained supply of RHS at all levels:

- RHS need to feature on the national essential drug list;
- an RHS coordination committee needs to be in place, including representatives from the different stakeholder groups;
- a government budget line for RHS should be in place; and
- RHS should be integrated into the financing mechanisms.

To enable the government to meet the demand for commodities, it will need to ensure that RHS are included on the national essential drug list, based on the Interagency List of Essential Medicines for Reproductive Health developed by the World Health Organization (WHO) in 2006.²⁶

Although the selection of essential medicines for the national essential medicine list depends on the country-specific health situation, joint research by WHO, UNFPA and Path found that of the 111 medicines for safe motherhood/ maternal health on the Interagency List an average of 75 (i.e. 68%) were found on national lists; of the nine family planning medicines only an average of three (i.e. 33%) were included; of the 22 medicines listed for STIs and reproductive tract infections only 12 (i.e. 55%) were found on national lists; while of the 27 medicines for HIV and AIDS only five (i.e. 18%) figured on national lists.²⁸ This is in line with findings in some research documents stating that national essential medicines lists, particularly in Africa, are seldom including more than one contraceptive and are selective in including injectables, intra-uterine devices or other modern medicines in their national lists. Very few national essential drugs lists include emergency contraception, even though it contributes to the reduction of (unsafe) abortions.²⁹

Moreover, even if a medicine is to be found on the national list, there is no guarantee that funding will be allocated to its procurement, albeit that the chance of funding is enhanced by the inclusion in the list. One of the reasons quoted for the low priority of contraceptives on the essential medicine list is that they are seldom seen as therapeutic, even though estimates indicate that preventing unwanted pregnancies could avert the loss of 4.5 million disability-adjusted life years (DALYs) each year.³⁰

Box 6 List Essential Medicines for RH

Outline of the Interagency List of Essential Medicines for Reproductive Health ²⁷	
Maternal and Neonatal Health	Anaesthetics, general
	Anaesthetics, local
	Analgesics
	Antianemia
	Antibacterial
	Antimalarials
	Antituberculosis
	Anthelmintics
	Anticonvulsants
	Antihypertensives
	Diuretics
	IV Fluids
	Plasma substitutes
	Anticoagulants
	Antidiabetics
	Immunologicals and vaccines
	Dermatologicals
	Disinfectants and antiseptics
	Oxytocics
Tocolytics	
Sedatives	
Antiallergics and medicines used in anaphylaxis	
Medicines used in emergencies	
Steroids	
Family Planning	Oral hormonal contraceptives
	Injectable hormonal contraceptives
	IUD
	Barrier methods
Reproductive Tract Infections/ Sexually Transmitted Diseases	Various medicines
HIV Medicines (Antiretrovirals, Mother-to-Child Transmission, and Opportunistic Infections)	Various medicines
	Non-nucleoside reverse transcriptase inhibitors
	Protease inhibitors
	Medicines used in opportunistic infections

source: WHO

25 See also http://www.rhsupplies.org/working_groups/resource_mobilization_and_awareness/project_rma.html

26 See also: http://www.who.int/reproductive-health/publications/essential_medicines/essential_medicines.pdf

27 Ibid.

28 See also *Essential Medicines for Reproductive Health: Guiding Principles for Their Inclusion on National Medicines Lists*, published by WHO, UNFPA and Path, March 2006.

29 See also p. 23 in *Contraception at a crossroads*, published by IPPF, 2008.

30 Ibid. p.10.

1.2 RH and RHS as important components of health systems and Health system strengthening in the South

When adopting the Maputo Plan of Action, African leaders not only committed to addressing the SRHR challenges faced by Africa but also called for the strengthening of the health sector component by increasing resource allocation to health. It recognized that SRH ‘...must be built into and on an effective health system and sufficient financial and human resources...’ if SRH interventions are to be implemented effectively (Art. 7).

WHO defines a health system as a system ‘...consisting of all organizations, people and actions whose primary intent is to promote, restore and maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities’.³¹ A health system, covering all aspects from basic health to highly specialized health care, does not limit itself to the publicly owned health facilities but also includes exterior actors such as women carers, private providers, behaviour change programmes, health insurance organizations and contributions to health by other sectors such as education, infrastructure or trade.

Box 7 Six building blocks health system

The six building blocks in a health system identified by WHO:

1. **health services** that deliver effective, safe, quality personal and non-personal health interventions;
2. the **health workforce**, consisting of a sufficient number and mix of staff;
3. a **health information system** that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status;
4. **equitable access** to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness;
5. a **sound health financing system** which raises adequate and sustained funding for health;
6. **leadership and governance** to ensure that strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives and accountability.

Source: WHO

WHO distinguishes six building blocks in a health system (see Box 7), all related to providing health services and ensuring sound health care for the treatment of diseases. While health system strengthening aims to improve these building blocks and manage their interaction in such a way that they achieve better health outcomes and facilitate universal access to health goods and services, the exterior actors should not be excluded, particularly in view of the important role they play in ensuring good SRH for all. A focus on enhancing diagnostics and prevention interventions (of unwanted pregnancies, but also of STIs, including HIV) as well as sexuality education and health promotion for both men and women are essential within a comprehensive health system, as they contribute to alleviating

the pressure on an over-burdened health system by preventing ill-health. Links with the education sector are, therefore, crucial. Moreover, health system strengthening should involve women in particular, not only because they are often the health carers but also because it is their SRH that is at risk if SRH and RHS are not addressed through health system strengthening.

Good SRH is a basic human right, for women and girls in particular, and as such should be included in any discussion on public health reform, even though these discussions often take a narrow, disease-oriented approach.³² The five major components of SRH – maternal and newborn health, family planning, prevention of unsafe abortion, management of reproductive tract infections and STIs, and promotion of sexual health – aim to serve the needs of the whole population, including adolescents. If reproductive health care is integrated in the entire health system, it can strengthen the provision and efficacy of health care, as it not only focuses on the curative aspects of women’s health but also on preventing ill-health, thereby diminishing the risk of complications due to untreated health issues. At the same time SRH care can benefit from an integration into the health system, as it would allow for comprehensive referral systems, close monitoring of individual clients, not only in relation to their reproductive health but also linked to other diseases such as malaria or tuberculosis, which can seriously endanger the life of the mother and (unborn) child. Moreover, integrated health services not only promote a more efficient health service delivery but also offer indispensable opportunities to provide information and education on family planning and promote voluntary HIV testing and counselling. Integrated health services will also address the issue of stigma linked to HIV and AIDS or unwanted pregnancies, as clients can go to the health centre instead of a specialized clinic.³³ Lastly, integrating health services will also be cost-effective through the sharing of health facilities, combined procurement systems and, in some cases, health personnel.

Although at present there is a tendency among national decision-makers – and donors – to favour health system strengthening and including reproductive health care as one of the health services to be delivered within the health system framework, there is a danger that the human rights aspect might lose out in favour of the narrow, disease/ill-health approach. Women, girls and vulnerable groups, such as people living with HIV and AIDS, are among those with the greatest need but have the least access to SRH care and supplies, especially in rural areas where health centres are sparse. It will, therefore, be crucial to ensure that SRH and RHS are supported by additional activities, especially in health system strengthening policies, and funding to ensure that these groups are guaranteed access to reproductive health care through, for instance, outreach programmes.

While it is clear that comprehensive and integrated health services can be more efficient than separate services for selected health problems and can lead to an increase in uptake and coverage of preventive programmes, it requires capable, knowledgeable and dedicated staff to provide the services.³⁴ However, the current

31 See also *Everybody’s Business. Strengthening Health Systems to Improve Health Outcomes. WHO’s Framework for Action*, published by the World Health Organization, 2007.

32 Cf. *Health Sector Reform and Reproductive Health. Report of a technical consultation*, published by UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, 2005.

33 Cf. *Integrating sexual and reproductive health-care services*. Policy brief 2 in the series: *Implementing the Global Health Strategy*, published by the WHO, <http://www.who.int/reproductive-health/publications/policybrief2.pdf>

crisis in availability of sufficient human resources for health, particularly in rural areas, is due to a variety of factors. Low training capacity, poor retention due to inadequate compensation linked to constricted fiscal space in the public sector,³⁵ and a lack of incentives, particularly in areas overburdened by disease and rural areas, are aggravated by the existing brain drain of health workers who migrate or take up opportunities outside the public sector. This results in weak and poorly staffed health systems and poses serious challenges for health system strengthening policies. Prevention of diseases promoted by integrating SRH in health policies, therefore, becomes even more important as a

means to lessen the burden of ill-health on overstretched health systems.

So, if donors and national governments are to honour their commitments to support SRH, they need to ensure that it not only receives its rightful place within the health sector reforms but that it also receives additional funding to allow it to fulfill its human rights obligation to ensure good SRH to every woman and girl, independent of their social and economic status. For this it will be essential to include the voice of women and girls in the political dialogue on health sector reforms, including health system strengthening.

SECTION II: FUNDING, FUNDING MECHANISMS AND EUROPEAN UNION POLICIES

By adopting the 'Monterey Consensus on Financing for Development' during the International Conference on Financing for Development in 2002, the signatory Heads of State and Government expressed their concern that dramatic shortfalls in resources seriously endangered the achievement of the MDGs by 2015. They acknowledged that developed countries needed to substantially increase their Official Development Assistance (ODA) to achieve the target of 0.7% of Gross National Product (GNP) as ODA to developing countries (Art. 42) and that other resources would also need to be developed (Art. 41). While capacity-building and good governance were seen as essential for sustainable development (Art. 19), so were investments in basic and social infrastructure, social services and social protection, including education and health, benefiting women and children in particular, together with the poorest and most disadvantaged communities, especially in rural areas (Art. 16).

The 2008 Doha Follow-up International Conference on Financing for Development to Review the Implementation of the Monterey Consensus reaffirmed the Monterey Consensus. In addition to the commitments adopted in the Consensus certain aspects were highlighted as a result of recent developments such as the Paris Declaration and the Accra Agenda for Action. Each country has primary responsibility for its own economic and social development, which emphasizes the importance of national policies, domestic resources and sound development strategies (Art. 2 in the Doha

Declaration on Financing for Development).³⁶ In relation to health the Doha Declaration stresses the need to increase the mobilization of resources to provide universal access to social services (Art. 13); to ensure that social security services are in place that also protect the most vulnerable (Art. 12); and underscores the need to develop human resources by supporting training, to exchange expertise and to build capacity (Art. 53). ODA, seen as a complement to other sources of financing for development, can play a catalytic role in assisting developing countries, not only in removing constraints to sustained, inclusive and equitable growth but also in improving health and education (Art. 41).

The Doha Declaration, therefore, identifies both national governments in developing countries and donors as important actors in development cooperation. The constraints on developing a strong health system are aggravated for SRH and RHS by the fact that they are not always considered strictly health issues, because religious mandates and cultural norms strongly influence sexual behaviour. This complicates management of SRH interventions, resulting in poor performance by developing countries in achieving the goals of both the ICPD PoA and the health MDGs, and particularly MDG5. So, if developing countries have difficulties in developing and implementing policies on SRH, RHS and health system strengthening, how can donors, and EU donors in particular, support developing countries in addressing the needs of women and men for reproductive health?

2.1 European Commission and European Union Member States' policies

In the report by the African Union entitled *Health Financing in Africa: Challenges and Opportunities for Expanding Access to Quality Health Care*³⁷ the rapporteur stated that countries at all income levels are heavily dependent on donor support, as donors are major funders for health in Africa (par. 13). As the world's biggest donor of development aid, the EU, consisting of the European Commission and the EU Member States, can play a major role in ensuring that SRH and RHS issues receive the adequate support.

In November 2004 the Council of the EU adopted Council Conclusions on Cairo/ICPD+10.³⁸ In those Conclusions the Council reaffirmed that the implementation of the ICPD PoA is key to poverty reduction and fundamental to achieving the MDGs (Art. 3). The ICPD agenda should, therefore, be included in PRSPs and the Country and Regional Strategy Papers (CSPs and RSPs), while EU action at country level will also need to focus on ensuring that efficient and well-trained human resources are

34 See also Chapter 3 in *The World Health Report 2008: Primary Health Care – Now More Than Ever*, published by WHO, 2008. ISBN 978 92 4 156373 4.

35 The lack of fiscal space is a result of policies of international financing institutions such as the World Bank and the IMF. In particular, the IMF's deficit reduction and inflation reduction targets have been critiqued for keeping public spending at unreasonably low levels, effectively placing wage caps on public servant's salaries, including those of public health personnel.

36 See also <http://daccessdds.un.org/doc/UNDOC/LTD/N08/630/55/PDF/N0863055.pdf?OpenElement>

37 African Union CAMH/EXP/13a(V), drafted for the 4th Session of the African Union Conference of Ministers of Health in Addis Ababa, Ethiopia, 4–8 May 2009.

38 Council of the European Union, Doc. 15157/04 of 24 November 2004.

in place to help deliver SRH care and services (Art. 4), including the link with the response to HIV and AIDS. It pointed out that so far donors had only provided 50% of the funding they had pledged at the ICPD, and invited the European Commission and EU Member States to make additional funding available through geographic and thematic instruments and other multi-sector and multilateral financing modalities (Art. 6).

In 2006 the EU – represented by the three European institutions: the Council, the Commission and the European Parliament – adopted the European Consensus on Development,³⁹ setting out the framework for development cooperation to be adhered to by the European Commission and the EU Member States. It identifies poverty eradication and the achievement of the MDGs as the key objectives of EU development cooperation. In line with the 2004 Council Conclusions it recognizes that investing in health, including SRH, contributes to combating poverty (Art. 11 and 12).

2.1.1 The European Commission

While the European Consensus does not specifically call on the Member States to invest in reproductive health, it clearly commits the European Commission to support SRH when it indicates that *'The Community will support the full implementation of strategies to promote sexual and reproductive health and rights.'* The Community (i.e. the European Commission) will also address the human resources for health crisis, support health system strengthening and make medicines more affordable for poor people (Art. 94).

This is reiterated in the Regulation establishing a Financial Instrument for Development Cooperation (DCI)⁴⁰ adopted in December 2006, which states that geographic programmes can include actions aimed at increasing access to and provision of health services in developing countries in line with the MDGs and the commitments in the ICPD PoA (Art. 5.2b(i)). It also aims to support health system strengthening, with a special focus on addressing the human resource crisis in the health sector and enhancing capacities in the areas of public health, research and development (Art. 5.2b(ii) and (iii)). Although these policies offer an entry point for including support for SRH and RHS, according to the principles of ownership and alignment in the Paris Declaration and the Accra Agenda for Action on Aid Effectiveness, this support can only be included in the European Commission's country support activities if the recipient country has requested it. It will, therefore, have to be raised in the preparatory dialogues for the development of, for instance, CSPs and the discussion on the Mid-term Review of the CSPs in 2009/2010.

While the geographic coverage of DCI is limited to Asia and Latin America, the Cotonou Agreement and its accompanying financial instrument, the European Development Fund (EDF), cover the African, Caribbean and Pacific (ACP) countries. The

Cotonou Agreement, signed in 2000, was revised in 2005. The amendments proposed concerned, among others, the inclusion of a reference to the MDGs – including the health MDGs – in the preamble of the Agreement, and to the protection of women's SRHR in the context of the fight against HIV and AIDS (Art. 25).⁴¹ However, here too the inclusion of activities in relation to SRH and RHS will depend on the political dialogue between the European Commission, as implementer of the Cotonou Agreement and the EDF, and the recipient countries in preparation of the CSPs and their Mid-term Review.

In the past few years the European Commission has worked towards a decentralization of its development cooperation towards its delegations in developing countries. Dialogues and negotiations on the development, implementation and monitoring of the CSPs is mainly in the hands of the delegations, with a form of supervision from the Commission's headquarters in Brussels. Over time, guidelines for the development and programming of CSPs were developed for each sector and published in the form of Programming Fiches. In 2006 the Programming Fiche for the inclusion of the response to HIV and AIDS⁴² was published, setting out how the HIV and AIDS situation in a given country is to be analysed, how to include the response to HIV and AIDS as a development objective in itself, and how to ensure the fight against HIV and AIDS as a cross-cutting issue. The link with SRHR and the promotion of gender equality and equity is seen as an important line to be followed, together with health system strengthening and the need to address the human resources for health crisis.

In November 2008 a Programming Fiche on Health⁴³ was developed, focusing on the three health MDGs. It calls for the prioritization of Health, HIV and AIDS and Population (HAP) in the European Commission's bilateral aid. It is important to note that the guiding principles in the Fiche include a strong gender dimension in the design and provision of health care, the need for a decentralized and participatory management, and the necessity to prioritize SRHR (based on the ICPD PoA and the revised MDG5 targets). It shows that the EU is very aware of the importance of supporting health, and reproductive health in particular, through development cooperation activities.

However, as far as the geographic programmes – based on the CSPs – are concerned, health, particularly reproductive health, is seldom identified as a focal area for European Commission support. Initial research on (draft) CSPs done in 2007 showed that of the 61 draft ACP CSPs analysed only two included support for health as a focal sector,⁴⁴ while none of the 15 draft CSPs for Latin America included health as a focal point, although five included some references to support for health. In Asia five of the 15 draft CSPs examined included health as a focal sector.⁴⁵ Some of the CSPs in ACP countries and Asia included references to health, but SRH or RHS were seldom included.⁴⁶

39 2006/C46/01 in the Official Journal of the European Union.

40 Regulation (EC) No. 1905/2006 of the European Parliament and of the Council of 18 December 2006, establishing a Financial Instrument for Development Cooperation in the Official Journal of the European Union, L 378/46, of 27 December 2006.

41 See also http://ec.europa.eu/development/center/repository/Cotonou_EN_2006_en.pdf

42 http://ec.europa.eu/development/center/repository/F44_HIV_AIDS_fin_en.pdf

43 http://ec.europa.eu/development/center/repository/F34_healthaidspopulation_fin_en.pdf

44 See also p. 38 in *Health Warning. Why Europe must act now to rescue the health Millennium Development Goals*, published by Action for Global Health, July 2007.

45 See also *An Unhealthy Prognosis? The EC's development funding for health*, published by Action for Global Health, May 2007.

46 Cf also p. 24 in *Funding for Reproductive Health Supplies: An Analysis of Official Development Assistance from European Donors*, published by Countdown 2015 Europe, June 2008.

While CSPs are strategy papers developed for the European Commission and EU Members States, other donors, particularly the World Bank and the International Monetary Fund (IMF), tend to adhere to PRSPs. In this context it is interesting to note that WHO's study, *PRSPs: Their Significance for Health: second synthesis report*,⁴⁷ published in 2004, reports that reproductive health is included in all 21 PRSPs analysed, closely linked to support for maternal health. However, it points out that only one PRSP included monitoring indicators to reflect pro-poor targeting of maternal and reproductive health activities and only five PRSPs provided disaggregated data. It raises the question of whether reproductive health in the broadest sense is targeted and whether any meaningful activities have been implemented. This leads to the conclusion that here too programmatic priorities might theoretically be in place, but implementation is lagging far behind.

In addition to geographic programmes the EU also works with thematic programmes which aim to cover those countries in Asia, Latin America, ACP countries and European near-neighbourhood countries where the sectors covered by the thematic programmes are not addressed through geographic programming. For health, SRH and RHS the multi-annual thematic programme 'Investing in People',⁴⁸ developed for the period 2007–2013, is the most important, as it has 'Good health for all' as one of its sub-headings. 'Good Health for all' focuses on four different, albeit linked, areas: the crisis in human resources in health care; the poverty-related diseases, including HIV and AIDS; SRHR; and ensuring a balanced approach between prevention, treatment and care. The European Commission clearly states that the programme will primarily be implemented through global partnerships and targeted support aimed primarily at public/private partnerships and global initiatives. It is, however, important to note that in the Annual Action Programme for Investing in People for 2007 'Good Health for all' has as its sole action the annual contribution to the GFATM,⁴⁹ with a contribution of € 62 million. For 2008 the Annual Action Plan identified support to the GFATM,⁵⁰ to UNIFEM (support for the project 'Supporting Gender equality in the context of HIV/AIDS'), to GAVI and to WHO. The Commission had also originally proposed to allocate funding to RHS for emergencies in 2008; however, it decided that this should be postponed to 2009.⁵¹ The earmarked funds have been used to support UNFPA's work on RHS with AccessRH, which aims at facilitating the procurement of RHS at a cheaper rate and ensuring a sustained supply, as an important component. In addition, the European Commission launched a call for proposals aimed at building the advocacy capacity of civil society organizations in developing countries in 2008. Another one will be launched for 2009–2010.

The European Commission also implements the 'European Programme for Action (PfA) to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007–2011)',⁵² which includes a strong focus on the link between the response to HIV and AIDS and SRH. It points out that it is crucial to reinforce the political and policy dialogue with the recipient countries, as they have the lead in developing strategies to fight the three communicable diseases. These dialogues will need to include

children's and women's rights and SRHR. The EU commits to ensuring that health is being treated as an exceptional case in public-sector reform programmes which needs an increase in public spending and flexibility in creating fiscal space to allow for increased activities in the health sector. Complementary health care activities such as improving local or regional health services, reinforcing human resources for health and building new health infrastructures – for example, hospital wards – are needed if access to medical care coverage is to be guaranteed. The EU also commits to supporting countries to develop sound and efficient procurement policies and practices for pharmaceutical products and commodities such as condoms. In its support to the education sector the European Commission will promote the inclusion of life skills education and safe schools for children – especially girls – to protect them against rape, pregnancy and STIs, including HIV. It will use partnerships and specific support to help finance, for instance, the targeted distribution of free contraceptives, linked to increased investment in health promotion and building capacity for social marketing, and it will help to provide free access to voluntary counselling and testing and to antiretroviral drugs for HIV-positive pregnant women. The programme recognizes that health systems are weak due to a lack of trained health providers to scale up the provision of prevention, treatment and care services and, therefore, commits to supporting a set of innovative responses to the human resource crisis. These commitments to support SRH and RHS activities are very strong, but once again implementation depends on the agreements reached with the recipient countries. To allow for strong, comprehensive health commitments, both parties need to be convinced of the importance of including SRH and RHS in their national policies and budgeting.

In line with its commitment to help address the human resources crisis, the EU adopted 'A European Programme for Action to tackle the critical shortage of health workers in developing countries (2007–2013)'⁵³ in 2006. By supporting the development of comprehensive and inclusive national strategies to increase the capacity and performance of the health workforce, it aims to help recipient countries to strengthen their national health systems. Member States and the European Commission are invited to include the strengthening of social governance in their discussions with partner countries, while the EU also commits to conducting dialogues not only with governments but also with international financing institutions on possibilities for increasing fiscal space for investment in the social sector. By offering technical support and training, the EU hopes to increase a country's capacity, while it will also encourage governmental and non-governmental services to reach out to community-based care and support, particularly as part of national human resource strategies. While this is a very welcome initiative, it does not reflect the strong language on SRH found in the documents mentioned earlier. SRH requires health staff that are not only qualified to offer health care but equipped with good communication skills to provide education and information on SRH, including family planning, as prevention of ill-health is the first step in the delivery of a sound public health system.

47 Published by WHO, 2004. See also <http://www.who.int/hdp/en/prsp.pdf>

48 See also http://ec.europa.eu/development/icenter/repository/how_we_do_strategy_paper_en.pdf

49 See also *Annual Action Programme in respect of the programming document Investing in people for the Development Cooperation Instrument for 2007*.

50 WHO produced an internal review of GFATM Rounds 1–7 (2002–2007) which demonstrated some support for SRH and RHS in funded proposals. GFATM introduced policy guidance to support country demand for funding for SRH/HIV integration in May 2008 and funded a number of proposals that include this approach in Round 8 (2008).

51 See also *Summary concerning the 2008 Annual Action programme covered by the "Strategy Paper 2007–2013" for the Thematic Programme "Investing in People" under the Development Cooperation Instrument*.

52 COM(2005)179 final.

53 http://eur-lex.europa.eu/LexUriServ/site/en/com/2006/com2006_0870en01.pdf

The EU thus has the basic policies in place to support health system strengthening, including support for SRH and RHS. However, as the Court of Auditors wrote in its special report No. 10/2008: *EC Development Assistance to Health Services in Sub-Saharan Africa*, the Commission is relatively absent from the health sector. This has contributed to a serious shortfall in support to sub-Saharan African countries to achieve a minimum level of health services and make progress towards achieving the health MDGs.⁵⁴ Moreover, the Court of Auditors found that the European Commission delegations lacked sufficient staff with the health expertise needed to support partner countries, while the headquarters lacked sufficient expertise to provide adequate back-up to the delegations in sub-Saharan Africa.⁵⁵

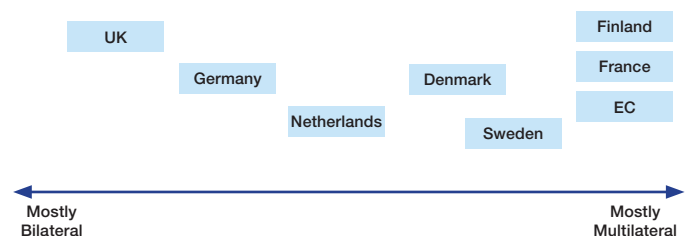
2.1.2 EU Member States' policies

While the European Commission implements development policies at the EU level – often seen as multilateral aid because it is developed in cooperation with the EU Member States through the Council and where possible the European Parliament – EU Member States also develop and implement bilateral development assistance policies. European donor support for reproductive health has been strong over the last decade, with the UK, Netherlands, Sweden, Norway, Ireland, Belgium, Spain and Finland significantly increasing their spending on reproductive health activities from 2004–2006. Nevertheless, the incremental funding destined to population assistance during the past decade has been mainly channelled to combat HIV and AIDS and STIs. Simultaneously, however, relative and absolute funding for all other components of reproductive health assistance such as family planning services, basic reproductive health services and basic research stabilized or decreased. For family planning, in particular, the consequences have been detrimental, with a budget shrinking from 55% of the resource flows for population activities to only 5% over the same period. Moreover, in 2007 for the first time since the MDGs were adopted in 2000, disbursements for health from the EU-15 countries and the European Commission decreased by US\$ 124 million – more than for all Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) countries combined. Donor support for reproductive health has tended to waver, with, for instance, Italy and Switzerland reducing their reproductive health spending in 2006, and, apart from Spain and the UK, all other donors either maintaining or reducing their health spending in 2007.⁵⁶

In general there is a tendency for donors to balance support for vertical (i.e. disease-specific) health interventions towards support for horizontal approaches (i.e. covering the health sector as a whole) such as health system strengthening and tackling the human resource crisis. EU Member States take different approaches to support for health through development aid. Countries such as Portugal,⁵⁷ Italy,⁵⁸ Luxembourg⁵⁹ and France⁶⁰ focus on (primary) health care and addressing the human resource crisis. Others such as Belgium⁶¹, the Netherlands⁶², Denmark⁶³, Ireland⁶⁴, Finland⁶⁵, Sweden⁶⁶, Spain⁶⁷ and the UK⁶⁸ not only focus on support for disease-specific financing and support health systems strengthening and efforts to addressing the human resource crisis but also include funding for reproductive health. In addition the Netherlands, Sweden and the UK contribute to the procurement of RHS.⁶⁹ This is also reflected in the overview of the reproductive health-related ODA breakdowns for some of the countries mentioned (see Annex 1).

Besides offering bilateral development assistance the EU Member States also allocate funding for reproductive health, RHS and health in general to various multilateral organizations, international health initiatives and non-governmental networks. While contributions to UNFPA and IPPF mandate a very clear focus on SRH, support to UNICEF, WHO and UNAIDS need not be earmarked specifically for SRH or RHS, which means that it is difficult to track donor funding for SRH and RHS through these organizations.

Figure 2: Balance between bilateral and multilateral contributions of some EU Member States and the European Commission⁷⁰



Data Sources: UNFPA, 2005b and Euromapping Project 2007

54 P. 17 in *EC Development Assistance to Health Services in Sub-Saharan Africa*, European Court of Auditors report No. 10/2008.

55 Ibid Pp. 19 and 20.

56 See *Mapping European Development Aid and Population Assistance: Euromapping 2009*, published jointly by EuroNGOs, DSW, EPF with support from the European Union, 2009.

57 See *A Strategic Vision for Portuguese Development Cooperation*, published by the Instituto Português de Apoio ao Desenvolvimento and the Ministério dos Negócios Estrangeiros, 2006.

58 See *Relazione Previsionale e Programmatica sulle Attività di Cooperazione allo Sviluppo nell' Anno 2008*, which specifies that Italy will offer training, materials, hospitals and doctors as part of its development assistance in Africa (p.6)

59 See also *Rapport Annual 2007. La Cooperation Luxembourgeoise au Développement*.

60 See also *Memorandum de la France sur les Politiques et Programmes en Matière d'aide Publique au Développement*, published jointly by the Ministry for Foreign and European Affairs, Ministry for Economy, Industry and Employment and the Ministry for Immigration, National Identity and Development in Solidarity, December 2007.

61 See also *Beleidsnota: Het recht op gezondheid en gezondheidszorg*, published by DG D0.1 of the Belgian Ministry of Federal Public Service Foreign Affairs, Foreign Trade and Development Cooperation, November 2008.

62 See also *Memorie van Toelichting 2008*, Tweede Kamer, vergaderjaar 2008–2009, 31 700 hoofdstuk V.

63 See also *A World for All*, Denmark's Development Policy for the period 2008–2012.

64 See also *Improving Health to Reduce Poverty: Ireland's Response*, Briefing Paper published by Irish Aid, 2006.

65 See also *Finnish Development Policy Guidelines for the Health Sector*, published by the Ministry for Foreign Affairs of Finland, 2006.

66 See also *Global Challenges – Our responsibility. Communication on Sweden's policy for Global Development*, published by the Regeringskansliet, Government Offices of Sweden, 2008.

67 See also *The Master Plan for Spanish Cooperation 2005–2008*, published by the Spanish Ministry of Foreign Affairs and Cooperation, November 2005.

68 See also *Working together for better health*, published by DFID, 2007.

69 See p. 48 in *Global Challenges – Our responsibility. Communication on Sweden's policy for Global Development*, published by the Regeringskansliet, Government Offices of Sweden, 2008.

Although the above analysis indicates that both the EU Member States and the Commission have adopted policies on support for health system strengthening, reproductive health and, in some cases, RHS, the funding does not seem to materialize in significant changes for the people who need them. No region in the developing world has achieved the annual decline in maternal mortality of 5.5% needed to achieve MDG5 by 2015. Globally maternal mortality showed an average decline of 0.4% each year, making a total of only 5.4% for the whole period 1990–2005. In sub-Saharan Africa there was hardly any improvement during that period. In 2008 the gaps in universal coverage in four intervention areas – family planning, maternal and neonatal care, immunization, and the treatment of sick children – is estimated at 43% across 54 selected countries in Asia, Latin America and Africa, with a peak of more than 70% in Chad and Ethiopia. The gap in coverage between the poorest and the richest quintiles of the population, with the wealthiest

being three times more likely to receive care than the poorest, particularly in relation to family planning and maternal and neonatal care, is not being addressed in many countries.⁷¹ The Working Group on Constraints and Costs within the Taskforce for Innovative International Financing for Health Systems identified insufficient funding, poor use of resources, unbalanced funding of different services and fragmented funding flows as serious impediments to achieving the health-related MDGs.⁷² This means that although EU donors include support for the health sector and, in some EU donor countries, for reproductive health and RHS in their development policies, this has not contributed significantly to bridging the gaps. Much more money will be needed from both domestic and external resources and a better use of these resources is required if progress towards the achievement of the health-related MDGs is to be greatly increased.

2.2 European Commission and European Union Member States' funding and funding mechanisms

When it comes to funding the above mentioned policy commitments the EU confirms in the *European Consensus on Development* that it aims to reach the target of 0.7% of Gross National Income (GNI) by 2015, with an intermediate target of 0.56% by 2010 (Art. 23).⁷³ Development assistance can be provided through different modalities ranging from project aid – for example, humanitarian aid or support through non-governmental organizations (NGOs) – through sector programme support to general and sectoral budget support, depending on what suits the recipient country's situation best. However, it does call on the Member States and the European Commission to use general or sectoral budget support where circumstances permit (Art. 26) as the preferred aid modality, thereby eliminating opportunities for donors to earmark funding for, for instance, SRH.

The move by EU donors from specific project and programme support towards budget support is in fact in line with the principles of the Paris Declaration on Aid Effectiveness, adopted in 2005, and its follow-up, the Accra Agenda for Action, agreed in 2008. The adopted principles for aid effectiveness of ownership, alignment, harmonization, managing for results, and mutual accountability imply that the recipient governments play an important role in deciding the terms of development cooperation. By developing national policies, for instance, on health or SRH, they determine how the budget will be spent. While the principles of managing for results and mutual accountability should allow donors to develop monitoring and evaluating indicators, through extensive dialogue with the recipient country, the national government is ultimately responsible for how the donor allocations to the national budget are spent. Yet, ownership raises the question of whose ownership? Is it only of the

Box 8. General Budget Support in Zambia, 2007

Total general budget support: US\$ 143.6 million	
Donors (in US\$ millions):	
UK	49.5
EC	36.8
Norway	19.0
Sweden	14.2
Netherlands	10.7
Finland	6.7
Germany	6.7
Total:	143.6
<i>Source: 5th National Development Plan of Zambia</i>	
Assessment:	
67% of the targets set have been achieved	
Underachievement was identified in rural infrastructure and agricultural reforms	
For social equity 82% of the targets were met	
Access to schools and health centres improved (cf HIV and AIDS).	
Performance assessment indicators for Health:	
Percentage of institutional deliveries (i.e. births)	
Percentage of fully immunised children under the age of one in the 20 worst performing districts	
Utilisation rate of public health facilities	
Percentage of Ministry of Health grant releases to the district level.	
Performance assessment indicators for HIV and AIDS:	
Percentage of clients tested for HIV and receiving results	
Percentage of HIV-positive eligible clients accessing antiretrovirals	
Percentage of HIV-positive pregnant women receiving a complete course of antiretrovirals (PMTCT).	

Source: <http://www.netherlandsembassy.org.zm/en/development-cooperation/general-budget-support.html>

70 *Strategic Options for Greater European Investment in Reproductive Health Supplies*, produced by Roger Drew for Countdown 2015 Europe on behalf of Interact Worldwide, October 2008.

71 See also *World Health Statistics 2008*, published by WHO, 2008.

72 See also *First report to Taskforce*, 13 March 2009.

73 It specifies, however, that Member States are to aim at 0.51% of GNI by 2010 and 0.7% by 2015, while those Member States that joined the EU after 2002 are expected to have reached 0.17% of GNI by 2010 and 0.33% by 2015.

government or of the country as a whole, including civil society? Both the Commission and the EU Member States insist that civil society needs to be included in the development, implementation and monitoring of development policies, including those on health.⁷⁴ It is only by offering all levels of society a voice that the needs of the poorest people, of the most vulnerable and of the most needy can be addressed. Donors and recipient governments alike have to ensure that this voice is heard and listened to whether during policy negotiations, funding allocations or evaluation activities.

2.2.1 General and sectoral budget support

General and sectoral budget support are seen as financing mechanisms that support recipient countries' national policies. Both forms of budget support imply a transfer of resources to the national treasury, with the recipient country respecting agreed conditions of payment; they are usually foreseen to cover a period of three years (see Annex 2 for more detailed information). While general budget support contributes to the overall national budget, sectoral budget support is allocated to support the budget for a specific sector such as, for instance, health. Policy dialogues are held between the donor and recipient countries to establish the criteria and performance indicators for budget support, based on the national development policies. If SRH and RHS are to be funded through budget support, donors and recipient countries need to make sure that they are included in the national health policy and the national budgetlines and that there are clear performance indicators to assess progress made towards achieving the adopted targets.

As both forms of budget support go through the national treasury, the Ministry of Finance will be involved in the joint policy dialogues between the partner countries and EU Member States, together with the respective line ministries. An essential criterion for effective budget support for the health sector is that it is chosen as one of the limited (usually two) focal areas for development aid. While, as stated above, health system strengthening in the widest sense is an important objective for development cooperation, it is up to the Ministry of Health to ensure that there is a clear health policy in place which includes a strong SRH and RHS component. In addition, it needs to convince the Ministry of Finance to write the necessary funding into the budget (as will be explained below). This latter aspect proves particularly difficult, since health has to compete with many other development aspects, such as trade, infrastructure or debt relief, which are usually more appealing to the Minister of Finance.⁷⁵ Moreover, these discussions become even more difficult when the health policy specifically includes support for SRH, as this is in some countries still a controversial issue due to cultural constraints and the standpoints of religious leaders worldwide.

However, so far the donor community and the recipient countries have not prioritized health in general nor SRH specifically.

The European Court of Auditors' report on *EC Development Assistance to Health Services in Sub-Saharan Africa*⁷⁶ pointed out that the European Commission's contribution to the health sector in sub-Saharan Africa had decreased from 5.1% under the 8th EDF, to 3.6% under the 9th and 3.5% under the 10th.⁷⁷ While it is difficult to identify specific funding for health, let alone for SRH, through general budget support, research done by the IMF in 2007 indicated that countries in sub-Saharan Africa on average spent up to 70% of the budget support they received through, among others the EDF, on reducing their budget deficits, resulting in the decrease in funding for health through the 9th EDF. This seems in contradiction with the commitment of, for instance, the African partner countries to spend 15% of their national resources on health (Abudja Declaration), as it is only on their request that the EDF can support the health sector (as explained above).

Although sectoral budget support has the potential to increase support to the health sector, the Auditors' report found that in practice only two sub-Saharan African countries, Mozambique and Zambia, had health as a focal sector (see Box 8 as an example) and received health sector budget support under the 9th EDF. As one of the reasons for this situation the report stated that the eligibility criteria to receive health sector budget support required the existence of a well-defined health sector policy, which did not exist in many of the sub-Saharan countries.⁷⁸ It raises the question whether the European Commission delegations in the respective partner countries should not have offered technical expertise during the political dialogues to ensure that a sound health sector policy would be put in place. However, the European Court of Auditors pointed out that in fact the Commission and the delegations lacked the necessary number of health specialists to support partner countries; consequently, it recommended that the Commission should ensure that sufficient health expertise is in place, particularly in the delegations, to adequately implement EU health sector policies and interventions and play an effective role in health sector dialogues with partner countries.⁷⁹ Another issue that the European Court of Auditors identified as a challenge to the effective use of budget support for the health sector was the use of health performance indicators. Some health indicators were such that the partner country did not have any control over them, data were often unreliable, and when it was found that targets were not met and money was left unspent, the funding would be made available to other sectors or programmes, leaving the health sector underfunded.

So, although general and sectoral budget support could be used as an effective aid modality, the current procedures show that there are various constraints to their effectiveness as tools to promote a sound national health system accessible to all. It is, therefore, important that there are other tools for donor support to health, not only where a partner country does not qualify for budget support (cf. the eligibility criteria) but also in those countries where health, including SRH, is not a focal area. These can be in the form of pooled or basket funding or project support.

74 See art. 4.3 in the European Consensus on Development, 2006/C46/01 in the Official Journal of the European Union.

75 In this context it is interesting to note that the IMF, World Bank and African Development Fund (AfDF) developed the *Multilateral Debt Relief Initiative (MDRI)* as part of the Initiative for Heavily Indebted Poor Countries (HIPC Initiative) to boost Social Spending through the financial resources freed up through debt relief. However, in its 2008 report it found that education and health, including maternal health and reproductive health, were not benefitting from this initiative. See also <http://siteresources.worldbank.org/INTDEBTDEPT/ProgressReports/21899739/HIPCProgressReport20080912.pdf>

76 *EC Development Assistance to Health Services in Sub-Saharan Africa, together with the Commission's replies. Special report No. 10/2008*, published by the European Court of Auditors in 2008.

77 Ibid. par. 11.

78 Ibid. par. 32.

79 Ibid. par. 75.

2.2.2 Pooled/basket funding, programme funding, and Sector Wide Approaches

A pool/basket fund – not to be confused with sectoral budget support (which supports a whole sector through the national budget) – is a fund that receives contributions from different external agencies, and in certain cases from governments, to finance a set of budget lines or activities agreed as eligible in support to a sector programme, such as health.⁸⁰ They contribute to a reduction in transaction costs for the government and can be seen as an important form of donor coordination, as they are often supported by several donors and managed by a management team consisting of donor and partner country representatives. However, pooled funding can also lead to a decrease in ownership by the partner country, as the financial resources are usually not integrated into the national budget. This can lead to an undermining of existing government systems.⁸¹ Pooled funding can cover broader health issues but also more targeted ones such as RHS.

Programme funding, also called Sector Policy Support Programmes (SPSPs), is another financing modality used by the European Commission to support sector policy programmes. The funding is earmarked to support certain activities in sector programmes.⁸² For reproductive health it could, for instance, support training of midwives or contribute to putting in place a comprehensive supply chain for RHS. These procedures differ from normal project funding and implementation in that even though targeted at specific issues, they have to adhere to the national sector policy programme agreed upon with the partner country, implying that the results need to contribute to the improvement of the sector as a whole. However, this could offer an entry point for earmarking funding for SRH in the context of health system strengthening.

To define which mix of aid modalities would contribute most to the improvement of the health sector, donors often refer to SWAs (Sector-Wide Approaches). This is a tool to ensure government ownership, as it includes the development of a single national sector policy (addressing both the private and public sectors), the need for extensive policy dialogues, the existence of a common and realistic expenditure programme, common monitoring arrangements and coordinated procedures for funding and procurement.⁸³ It is clear that the government in the partner countries, and the Ministry of Health in particular, has an important role to play in ensuring that a comprehensive health policy/strategy is in place that also includes reproductive health and RHS if women's rights to good health and the achievement of MDG target 5B on reproductive health are to be achieved. The Minister of Finance, as the main negotiator for donor support, has to be convinced of the importance of including the health policy/strategy in its political dialogue with donors and in the public finance system to ensure sufficient financial resources for implementation.

2.2.3 The MDG Contract

Although budget support is aimed at ensuring more long-term and predictable funding, the annual assessments and the fact that they are mainly scheduled for three-year periods, limits the scope of these objectives. If health systems are to be strengthened and the human resources for health crisis is to be addressed, longer-term financing is in fact needed. Recurring costs such as salaries for health personnel do not end after three years, while it takes more than three years to set up a sustainable health system that offers access and services to all. The Commission, therefore, developed an additional form of budget support called the MDG Contract,⁸⁴ which offers a six-year commitment to funding, consisting of a fixed base component of at least 70% of the total financial commitment and a variable performance component of up to 30%, divided into an MDG-based tranche of 15% and an annual performance tranche of 15% related to implementation. The eligible countries are those supported through the 10th EDF which have a positive three-year track record in the accountable use of budget support. The eligibility criteria and performance indicators for the MDG contract are similar to those applicable to allocating budget support, including the system of annual assessments. Although the system of MDG contracting can contribute to increased progress to the achievement of the MDGs, including the health MDGs, by ensuring longer-term and predictable funding, it has its limitations. So far MDG contracting is only available to ACP countries and only a few countries will qualify. Countries with weak health systems will not benefit, as they do not have a comprehensive health policy/strategy in place, increasing the gap between strong and weak performers.

2.2.4 Longer-term and predictable funding for RH?

While the different aid modalities discussed above are seen as contributing to longer-term predictable funding, allowing for a strong form of ownership and guaranteeing alignment with national policies, bringing different donors together, thereby facilitating increased mutual accountability, the impact so far has been limited, particularly in relation to health. This is also partly due to the inconsistency of the EU donors in the bilateral allocation of funding to health and reproductive health (also called 'population'). The contributions of funding to basic health and reproductive health respectively as reported to OECD DAC⁸⁵ are in general in line with the policies described above (Section 2.1.2), but some countries show large fluctuations in their contributions to, for instance, basic health and reproductive health (see Figures 3 and 4 for some examples). The European Commission is a very clear example, as it reported the allocation of US\$ 36.3 million in 2005, US\$ 41.6 million in 2006 and nothing in 2007. This is because the *EU Regulation on Reproductive and Sexual Health and Rights in developing countries (2003–2006)*⁸⁶ came to an end and with that the Commission's specific earmarking of funding for SRH. Another observation in analysing the figures reported to OECD DAC for 2005–2007 is that of the 16 donor

80 See also p. 23 in *Support to Sector Programmes. Covering the three financing modalities: Sector Budget Support, Pool Funding and EC project procedures*, published by the European Commission in the *Tools and methods Series, Guidelines no. 2*. Short version, July 2007.

81 Ibid p. 24.

82 Ibid.

83 See also *World Health Report 2000*, published by WHO, 2000.

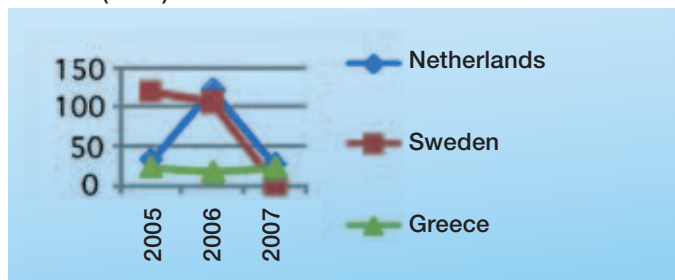
84 See also: *The "MDG Contract". An Approach for Longer Term and More Predictable General Budget Support*. European Commission, June 2008, http://ec.europa.eu/development/icenter/repository/MDG-Contract-Paper-0608_en.pdf

85 See for the OECD DAC Creditor Reporting System: <http://stats.oecd.org/WBOS/Index.aspx?DatasetCode=CRSNEW>, accessed on 12 August 2009. For comparison purposes the figures have all been recalculated into the equivalent value of 2009 US\$ as registered on 12 August 2009.

86 Regulation (EC) No 1567/2003 of the European Parliament and of the Council of 15 July 2003 on aid for policies and actions on reproductive and sexual health and rights in developing countries.

countries (including the European Commission) reporting to the OECD DAC 12 did not report on funding for Family Planning⁸⁷ (including the Commission), while in 2007 this had been reduced to eight,⁸⁸ albeit that the other eight countries reported contributions between US\$ 0.3 million and US\$ 1.3 million, which is low compared to, for instance, the UK's contribution of US\$ 533.1 million, Germany's US\$ 117.7 million and Sweden's US\$ 83.8 million reported to OECD DAC on STI control, including HIV and AIDS in 2007 (for more details see also Annex 1).

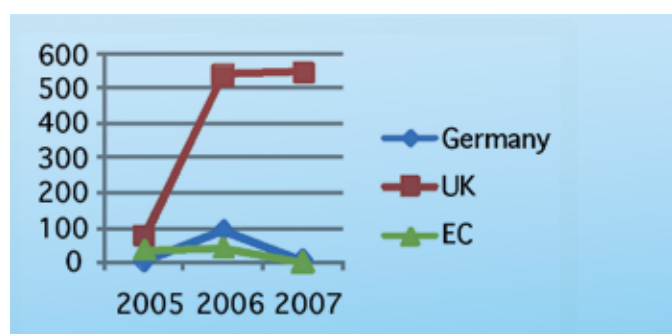
Figure 3. Fluctuations in basic health contributions in US\$ millions (2009)



In line with the principle in the Paris Declaration and, particularly, the Accra Agenda for Action, donors are increasingly joining forces in supporting development cooperation while simultaneously limiting the number of sectors for their donor interventions as a means to increase aid effectiveness. The

EU Code of Conduct on the Division of Labour, for instance, allows donors to either continue their activities on SRH, even taking the lead in those countries where they play an important role in supporting it, or withdraw from the sector in favour of supporting other sectors. Besides promoting the development of joint policies, the Code of Conduct also encourages joint funding either through basket funding or budget support. Although the Code is aimed at ensuring greater continuity, SRH stands to lose out as former strong supporters are moving more and more to supporting health system strengthening, leaving the support of SRH-specific issues to special focus organizations, such as IPPF or UNFPA. This is also apparent in the fact that donor countries are increasingly allocating their financial support to global health initiatives but balancing bilateral and multilateral aid.

Figure 4. Fluctuations in support for reproductive health care in US\$ millions (2009)



SECTION III: GLOBAL HEALTH INITIATIVES AND THEIR ROLE IN SUPPORTING REPRODUCTIVE HEALTH AND REPRODUCTIVE HEALTH SUPPLIES

As indicated above, many EU donors are also contributors to global health initiatives, not only as funders but also as either initiators (the European Commission in the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), UK in the International Finance Facility for Immunization (IFFIm), France in the development of UNITAID) and/or as members of their Boards. As such these donors can influence the policies developed by these initiatives, which means they have the means to promote the inclusion of SRH interventions should they so wish.

By bringing together public and private for-profit and not-for-profit sectors these global health initiatives aim to generate more funding for select health interventions. While they are successful in fundraising, they find that the disbursement of funds meets with serious constraints within the recipient countries due to weak health systems in the form of an inadequate infrastructure for service delivery, shortages of trained health workers, interruptions in procurement and delivery of health products, inadequate health management and financing systems, and poor governance.⁸⁹ This has led to the recognition that besides supporting disease-specific interventions, they will need to

invest in health system strengthening. Taking this line of thought further, it could be argued that health system strengthening needs to include investing in SRH and RHS, not only because of the mutual benefits of integrated health services discussed above (Section 1.1) but also in terms of disease prevention. For instance, pregnant women, women with anaemia or men and women suffering from STIs are particularly susceptible to catching various diseases and transmitting them to other sections of the population. By ensuring that the health care interventions funded by the respective global health initiatives include SRH provisions, they can promote good health for all.

The following section will look at the activities of some of the best-known global health initiatives such as the GFATM, GAVI, UNITAID and the Reproductive Health Supplies Coalition (RHSC), which also enjoy extensive support from a majority of EU donors. Although their focus differs, they all agree to invest more in health system strengthening and recently in additional financial support for reproductive health and, in some cases, SRH and RHS, except for the RHSC which is already fully focusing on these issues.

87 Code 13030 in the OECD DAC Creditor Reporting System.

88 Belgium, Denmark, Finland, Germany, Italy, Luxembourg, The Netherlands and Spain.

89 See also *Maximising positive Synergies between health systems and the Global Health Initiatives*, published by WHO, 2008.

3.1 The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria

Since its creation in 2002, the GFATM has become the main source of finance for programmes to fight HIV/AIDS, tuberculosis and malaria and has a mandate to ensure that increases in resources are used effectively in support of improving health services to save the lives of people living in developing and middle-income countries. Since its creation it has approved US\$ 15.6 billion for more than 572 programmes in 140 countries.⁹⁰ Although it focuses on the three diseases, the GFATM has become aware of the importance of health system strengthening and community system strengthening, and has taken initial steps to support it. In line with the Paris Declaration and the Accra Agenda for Action the GFATM has developed a model of country ownership, performance-based funding and inclusive partnerships by setting up Country Coordinating Mechanisms (CCMs), i.e. in-country groups which include the public sector, multilateral and bilateral agencies, the private sector, civil society actors and affected communities. CCMs submit proposals for funding to implement aspects of national health plans for the three main infectious diseases. While the GFATM in principle includes support for SRH in its activities, it depends on the CCMs to draw up sound proposals in line with national planning. This means that at the first instance it is up to the CCM to include SRH and RHS in its proposals. While it is encouraging to note that in its 2009 report *Scaling up for impact. Results report* the GFATM acknowledges that CCMs have increasingly been able to develop sound proposals, many of which have included a number of interventions in relation to SRH, the report does not give clear gender-disaggregated data and the interventions are mainly related to HIV/AIDS prevention and control, with the bulk of the money going to treatment rather than primary prevention.⁹¹

Since Round 7 (2007) and carrying on through Rounds 8 and 9 (2008 and 2009) GFATM has increased its funding of SRH. Technical assistance to CCMs pursuing integration of SRH and HIV was leveraged through the 'Mobilizing for RH/HIV Integration Initiative'⁹² during Rounds 8 and 9. The initiative partners pursued advocacy with the GFATM Secretariat and Board to question what the GFATM could do to promote the integration of SRH and RHS, given that the international consensus in 2004, the Glion Call for Action and the New York Call to Commitment (discussed in

Section 1.1) already called for such integration. The GFATM has persuaded country-level stakeholders at the national and global level to prioritize the integration of reproductive health and HIV strategies as a critical component of scaling up access to HIV and AIDS prevention, treatment and care, and a cost-effective use of limited resources. Support for SRH, and particularly for RHS, such as male and female condoms, can also have an important impact on the prevention of tuberculosis, while ensuring good SRH can help prevent malaria infections. While the GFATM proceeds to work with partners to accelerate country demand for integrated SRH and HIV programmes and services, including the provision of RHS, it should broaden their goals to integrate SRH and RHS through all its interventions, including those on health system strengthening, especially in view of the progressing feminization of HIV/AIDS.

The GFATM Board has adopted additional strategies to start responding more directly to gender inequities that impact access to health. It invited the GFATM Secretariat to develop a gender strategy,⁹³ adopted in November 2008 by the Board. The Gender Equality Strategy will help ensure that the vulnerabilities of women, girls and sexual minorities are included in the GFATM's efforts to fight the three diseases and strengthen both health and community systems. In 2009 this was complemented with the adoption of a Strategy in Relation to Sexual Orientation and Gender Identities.⁹⁴ Whether that means that more attention will be given to SRH and RHS besides those linked to the response to HIV and AIDS is unclear, but the Secretariat intends to include gender-sensitive criteria for grant eligibility, monitoring and evaluation and increase its own gender expertise by offering gender training to its staff and appointing a gender focal point.⁹⁵ However, although a positive, albeit late, first step, it will ultimately be up to the CCMs and the recipient country to ensure that SRH and RHS are included in the national health policies and in the country proposals to the GFATM. Especially in countries where it is less obvious for women and girls to participate in decision-making bodies and have their voice heard, a joint effort from donor and recipient countries is crucial to make the gender equality strategy meaningful to those people for whom it is intended.

3.2 the Global Alliance for Vaccines and Immunization (GAVI)

Focusing on the provision of vaccines and immunization, the GAVI was launched in 2000 and brings together the public and private sectors, both from developing countries and the donor community, including UN organizations. It focuses mainly on immunization and MDG4, on reducing child mortality, and only offers grants to countries with a GNI below US\$ 1,000 per capita in 2003.⁹⁶ Based on donor contributions it developed innovating funding mechanisms using funds committed in

advance by donors to guarantee the price of vaccines once they are developed (Advance Market Commitments) and longer-term (10–20 years) legally binding donor aid commitments as bonds for loans taken out on the financial markets (International Finance Facility for Immunisation (IFFIm)).⁹⁷

While GAVI focuses mainly on the development, procurement, supply and dissemination of vaccines, it has recognized that

90 See <http://theglobalfund.org/en/about/?lang=en>

91 See also p. 18 in *Scaling up for impact. Results report*. Published by the Global Fund, March 2009

92 Among its partners are: Friends of the Global Fund Africa, the Global AIDs Alliance, Interact Worldwide, the International HIV/AIDS Alliance, IPPF Africa Regional Office, and Population Action International. See also: http://www.interactworldwide.org/objs/233757337-mobilizing_integration_summary.pdf

93 See also *The Global Fund Annual report 2007*, published by the Global Fund to Fight AIDS, Tuberculosis and Malaria, 2007, <http://www.theglobalfund.org/documents/publications/annualreports/2007/AnnualReport2007.pdf>

94 See also http://www.theglobalfund.org/documents/board/19/GF-BM19-DecisionPoints_en.pdf

95 See also http://www.theglobalfund.org/documents/board/16/GF-BM16-13_ScalingUpGenderSensitiveResponse.pdf

96 See also <http://www.gavialliance.org/support/who/index.php>, which means that presently 72 countries qualify.

97 In August 2008 GAVI had approved US\$ 3.7 billion for various interventions, particularly in the poorest countries, for the period 2000–2015.

See also <http://www.gavialliance.org/performance/commitments/index.php>

failing and weak health systems are a serious obstacle to ensuring the delivery of life-saving interventions through vaccination and immunization programmes and set aside US\$ 800 million for 2006–2010 to support health system strengthening.⁹⁸ With its strong focus on neonatal and child health it should not ignore the importance of a healthy and informed mother. Health system strengthening should, therefore, ensure that it includes a strong education and information component for young and/or future mothers on how to care for themselves before (e.g. family planning) and during pregnancy and for their children. In addition, funding for vaccines should include support for medicines found on the WHO's List of Essential Medicines for Reproductive Health,

3.3 UNITAID

UNITAID is a relatively new global health initiative, only launched in 2006. It was set up to respond to the need for additional, innovative funding resources for global health and development. In the period 2006–2008 UNITAID managed to mobilize US\$ 730 million, of which it has disbursed US\$ 450 million so far. The funding was mainly generated through the air tax mechanism, whereby air travellers contribute a small percentage of the price of the air ticket to the fund. While originally there were only five countries (Brazil, Chile, France, Norway and the UK) involved, the membership now consists of 29 countries and one foundation (the Bill and Melinda Gates Foundation), including a majority of the member countries from Africa.¹⁰⁰ By supporting its international partners such as UNICEF, UNAIDS and the William J. Clinton HIV/AIDS Initiative (CHAI) working on global health and health commodities procurement, it aims to contribute to the achievement of the MDGs, with a particular focus on MDGs 4, 5 (including Target 5B) and 6. UNITAID's working method is based

including for family planning, to ensure that newborns have the best start in life, as they will have been planned and will have a healthy mother. That GAVI has an increased interest in the need to increase women's access to GAVI's health interventions can be seen by the adoption of its Gender Policy (2008) to guarantee equal access to immunization coverage and health services.⁹⁹ Although the Gender Policy Implementation Plan 2009–2010 is mainly aimed at increasing gender awareness at GAVI's own institutional level, the gender-sensitive data it is to generate could offer an entry point to include SRH and RHS into its policies as a means to achieve not only MDG4 but ultimately all health MDGs.

on offering long-term funding commitments and purchasing high volumes of medicines and diagnostics. As a result, production is stimulated, while the purchase of bulk quantities of commodities helps bring the price down. In addition, UNITAID supports the development and production of more client-friendly and new medicines to address a client's needs better. The *Roadmap for the strategic collaboration between UNITAID and the Global Fund* agreed upon by the two organizations confirms that UNITAID's main focus lies on support for the three major infective diseases. Although SRH programmes are not directly supported, UNITAID does contribute to its partners' programmes on PMTCT. For instance, in 2007 it committed US\$ 21 million to support PMTCT programmes together with UNICEF.¹⁰¹ UNITAID recently changed its policy, so prevention supplies are now also eligible for funding as a result of advocacy by Countdown 2015 Europe. UNITAID has an excellent record of scaling up access to paediatric treatment and contributing to price reductions for antiretroviral therapy.

3.4 Reproductive health and reproductive health supplies partnerships

In addition to the, mainly indirect, support to SRH and RHS by the disease-specific global health initiatives discussed above, there are also SRH- and RHS-specific initiatives which aim to achieve MDGs 5 and 6 by 2015, such as the RHSC.

3.4.1 Reproductive Health Supplies Coalition and the Access RH and Pledge Guarantee initiatives

Although mainly a network of public and private organizations and NGOs dedicated to ensuring that all people in low- and middle-income countries can access and use affordable, high-quality supplies to ensure their better reproductive health, two of its initiatives – AccessRH and the Pledge Guarantee – merit a discussion in the context of this section. The RHSC focuses mainly on supporting efforts to provide contraceptives and other RHS in low- and middle- income countries. As it does not have extensive funding of its own, it relies on its partners to fund proposed activities and serves mainly as a forum bringing together expertise, catalysing

innovation and facilitating collaboration and harmonization.¹⁰³ While UNFPA has initiated the Global Programme to enhance Reproductive Health Commodity Security to ensure a more predictable, planned and sustainable country-driven approach for maintaining supply chains and prevent supply shortages, the RHSC also looked into developing mechanisms to ensure RHS. It decided to support two very recent initiatives: the AccessRH initiative, originally called the Minimum Volume Guarantee (MVG), which aims at facilitating the procurement of RHS at a cheaper rate and ensure a sustained supply, and the Pledge Guarantee initiative, which aims at allowing frontloading of funding by granting loans at a low interest rate based on donor pledges. While comparable to GAVI's Advance Market Commitments and IFFIm initiatives, they focus solely on SRH.

AccessRH grew out of the realization that there is a need to increase access to optimal pricing and delivery terms for quality RHS and to simplify the existing complex supply chain by creating an open procurement platform to be accessed across the

98 See also <http://www.gavialliance.org/vision/policies/hss/index.php>

99 See also http://www.gavialliance.org/resources/GAVI_Gender_Policy_Implementation_Plan.doc

100 See also <http://www.unitaid.eu/en/UNITAID-donors.html>

101 See also <http://www.unitaid.eu/images/NewWeb/hiv%20brochure.pdf>

102 See also http://www.rhsupplies.org/about_us.html

103 See also *Reproductive Health Supplies Coalition Strategic Plan (2007-2015)*, adopted in August 2007.

reproductive health community by purchasers in low-and middle-income countries.¹⁰⁴ While procurements agents (the purchasers of supplies, such as governments, NGOs or private companies) currently seldom have the possibility of projecting future needs for commodities, resulting in smaller purchases often at the last minute (emergency purchases), the AccessRH initiative will offer technical support in assessing future needs ('demand forecast'), bringing them together with others and negotiating favourable terms (put down in master contracts) with producers, based on the minimum bulk purchase it can guarantee through the accumulated needs assessment. It also aims to simplify the delivery system, thereby contributing to a more efficient and sustained supply of RHS at a lower price. It should be clear that such a platform would contribute to allowing lower pricing for the end-user if a sufficient number of purchasing agents took part in the initiative. In addition, the partners will have to develop the capacity to forecast reproductive health needs relatively accurately. The Pledge Guarantee was initiated as a response to the need for short-term credit to purchase RHS when funding is not immediately available for the timely procurement of essential

reproductive health products. The system is based on funds committed either by donors or by a Ministry of Finance to, for instance, the Ministry of Health, but not yet disbursed. These commitments function as the pledge for a loan from the initiative. However, in both cases a third party can act as guarantor to minimize the risk of default, which could impact on the purchase of the commodities and ultimately on the access of the end-user to a sustained supply of RHS. As the initiative is still very new, the original targets will be the reproductive health donors and the recipient government-funded procurements. At a later stage support for other commodities could be envisaged. Both initiatives are meant to support national governments to develop long-term planning for their reproductive health activities. As these are recent initiatives, they still have to prove their effectiveness towards increasing access to reproductive health services and RHS, particularly within the whole structure of the national health systems. However, as they are both aimed at enhancing RHS, ensuring a timely, cost-effective, efficient and sufficient delivery system for RHS, it merits the full support of all donors.

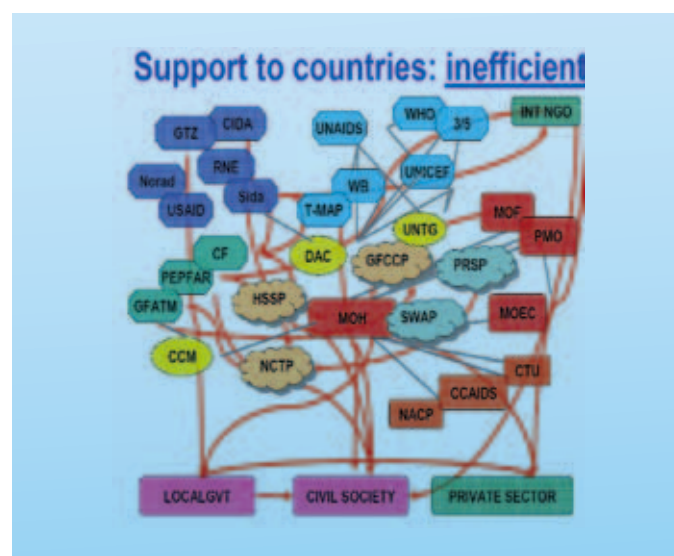
SECTION IV: COORDINATION MECHANISMS

Although it is acknowledged that aid for health has been increasing, specifically in support of the response to HIV and AIDS,¹⁰⁵ it will not be money alone that will solve the problem of poor health outcomes. Issues such as global governance and policy coherence, predictable and less volatile funding, health system strengthening, flexibility and responsiveness of aid in crisis situations, mutual accountability and a comprehensive and coherent approach to new and innovative financing mechanisms and health partnerships also need to be addressed if the health MDGs are to be achieved by 2015.

Over the years many health initiatives have been launched to address either vertical issues, such as the response to HIV/AIDS, malaria and other specific diseases, or horizontal ones, covering the health sector as a whole, resulting in the existence of some 140 global initiatives. This has resulted in a heavy burden for the recipient countries: having to draft individual proposals, monitoring the programmes and reporting to the respective donors (see Figure 5). In September 2007, global leaders decided to launch the Global Campaign for the Health Millennium Development Goals¹⁰⁶ to help accelerate progress towards achieving the health MDGs, and MDGs 4 and 5 in particular. Within the framework of the campaign various coordinating initiatives were developed, such as IHP+, involving not only donor governments but also international organizations, global health partnerships and recipient countries. In addition, world leaders set up the High Level Taskforce on Innovative International Financing for Health Systems in 2008 to make recommendations on the mix of innovative financing mechanisms needed to deliver

additional resources and promote international support for these recommendations to ensure that they are implemented. While they focus mainly on generating additional funding, they also aim to streamline fundraising by ensuring that fundraisers diversify and coordinate their activities.

Figure 5. Confusion of donors and policies a burden for the Ministry of Health (MoH).



Source: Mbewe, WHO

104 See also: Designing a Global Financing and Procurement Mechanism for Reproductive Health Supplies by Dalberg Global Development Advisors, June 2008.
105 See also pp. 8 and 23 in Mapping European Development Aid and Population Assistance. Euromapping 2008, published by EuroNGOs, DSW, EPF with support from Wallace Global Fund, 2008.
106 See also Global Campaign for Health: http://www.who.int/pmnch/topics/mdgs/norad_progress_report.pdf

4.1 The International Health Partnership and related initiatives

Launched in 2007 on the initiative of the UK, the Partnership currently includes the EU donor countries Finland, France, Germany, Italy, Norway, Portugal, Sweden, the Netherlands and the UK as its partners, together with international organizations¹⁰⁷ and developing country governments. The aim of the IHP+ is to get better health results by mobilising donor countries and other development partners, i.e. the international organizations and the recipient countries, around a single country-led national health strategy in line with the principles of the Paris Declaration and the Accra Agenda for Action. A key element of the IHP+ approach is the assessment of the strengths and weaknesses of national strategies for funding through a system of joint assessments. Based on country-level knowledge, national documents and independent reviews, the joint assessment is to form the primary basis for funding decisions by donors, while at the same time alleviating the burden on national institutions by conducting the assessment as a single harmonized process.

Based on the results of the joint assessments, the Ministries of Health and of Finance in the partner countries are supported in developing one costed, results-based national health plan in a harmonized and aligned way that will ensure predictable and long-term funding. To ensure a coherent approach, the partners in IHP+ promote the setting-up of 'country health sector teams' that lead the discussions with the ministries involved. The ultimate result is the 'country compact', a close-to-binding agreement that commits the development partners, both donors and recipients, to sustained and predictable funding and increased harmonization and alignment of aid in support of the costed and results-oriented national health plans and strategies aimed at tackling health system constraints.¹⁰⁸ How these will be linking up to existing CSPs and PRSPs has not been clarified so far. The development of country compacts was meant to include civil society and other development partners/stakeholders in the discussions, along the lines of the Sector-Wide Approach Secretariat model. To date few of these national negotiations have allowed for robust and transparent engagement by civil society. Once the national strategies have been developed, the in-country partners will have to identify country-specific financing mechanisms that mobilize both domestic and international resources for health system strengthening.

While the process is to be driven by the recipient country, the Partnership offers technical support in-country and develops high-quality guidance (based on best practice and evidence gathered and providing policy options) and tools to support decision-making at the country level. This is done within the Partnership

by the various interagency working groups and task forces. As mutual accountability, transparency and managing by results are key components of the IHP+ objectives, the Partnership will have to develop accountability mechanisms to gauge the performance of the development partners in implementing the national health plan and fulfilling their financing commitments. In January 2009, therefore, the Interagency Working Group presented a framework document setting out the general principles that are to guide a Joint Assessment process, together with a list of essential attributes of good national plans and strategies to form the basis of the Joint Assessment. The Working Group also drafted a Joint Assessment Tool to facilitate consistent and methodical assessments and monitoring. Ultimately these tools are also meant to feed into the new National Strategy Applications (NSA) system that is currently being developed by the GFATM.

While the main focus of IHP+ is health system strengthening and building a country's capacity to develop and implement a national health plan/strategy supported by donors in a harmonized and coherent way, SRH and RHS should also benefit as part of a comprehensive health system.

It is, therefore, of paramount importance to ensure that SRH and RHS are included in the discussions within the country health sector teams for these two issues to be included in the national health plan. For example, a study of the Ethiopia country compact based on the national Health Sector Development Plan (HSDP III) outlines Ethiopia's strategy for achieving the health MDGs and details actions to reduce maternal deaths and increase family planning coverage, but monitorable targets such as the contraceptive prevalence are only measured on a five-yearly basis and omit important information about RHS. In addition, the Joint Assessment indicators will need to include indicators covering both reproductive health, including access for all vulnerable groups, and RHS. It is, therefore, interesting to note that in the initial list of indicators for evaluation of IHP+ the coverage of maternal and child health, skilled birth attendance, PMTCT uptake and the coverage rates analysed by socio-economic groups and vulnerable groups are listed as outcomes, while child and maternal mortality rates are to be used to monitor impact.¹⁰⁹ However, this leaves out important elements of SRH such as family planning. Moreover, the proposed initial list of indicators includes service access and availability indicators for, for instance, facilities equipped, staff and supplies to deliver, for instance, antiretroviral therapy, but it does not refer to RHS, even though some of these are closely linked to ensuring maternal health.

4.2 The High Level Taskforce on Innovative International Financing for Health Systems

While the IHP+ is a partnership to promote donor harmonization and alignment and offer technical support, the High Level Taskforce on Innovative International Financing for Health Systems was established with short-term objectives to consider the financial constraints in strengthening health systems, defining

the funding gaps and proposing possible solutions by suggesting appropriate types of financing and of alternative fundraising modalities. It fits in with the demand for a more streamlined and harmonized approach to fundraising and coordinating the different initiatives already developed. It also aims to mobilize

107 WHO, the World Bank, GAVI, UNICEF, UNFPA, UNDP, UNAIDS, ILO, GFATM, GAVI, the Bill and Melinda Gates Foundation, and the AfDB.

108 See also *Scaling up for Better Health. Work Plan for the International Health Partnership and Related Initiatives (IHP+), for September 2007 to March 2009*, published by WHO and the World Bank, February 2008.

109 See also *M&E Proposal. Annual Monitoring and Evaluation of the IHP+. Technical Proposal*, published August 2008, <http://www.internationalhealthpartnership.net/pdf/IAWG/New%20Folder/Responsible%20Action%20IHP+%20M&E%20proposal.pdf>

support for its proposals among a wide range of stakeholders including the private sector, civil society, emerging economies, global initiatives and recipient countries. It has a mandate of 12 months. In 2009 it published its report *More money for Health, and more health for the Money*¹¹⁰ with some 10 recommendations towards innovative funding modalities such as the airline levy,

currency transaction tax, the IFFIm and De-tax. Importantly, the High Level Taskforce clearly includes reproductive health services in the list of services that should be included in the universal coverage of interventions.¹¹¹ This recognition needs to be strongly promoted through the advocacy which takes up the recommendations.

SECTION V: CONCLUSION AND RECOMMENDATIONS

As the internationally agreed deadline of 2015 for the achievement of the MDGs draws nearer, the chances of the health MDGs, and particularly of MDG5, being realized becomes increasingly slim. While the world's decision-makers have committed themselves to guarantee universal access to SRH by 2015, few concrete steps are being taken to achieve this in developing countries. The increased focus on the health sector in general, away from health-specific issues such as SRH and RHS, have left these sectors without sufficient funding, to the serious detriment of the SRH of both men and women. While a weak health system puts considerable constraints on the delivery of sound health services, health system strengthening should take a broad and comprehensive approach which includes not only the improvement of the health infrastructure, the health workforce and the medical aspects of health care but also the prevention of ill-health, and education and information services.

Good health services imply access to every form of health care whatever the health complaints. SRH is part and parcel of a person's life from early childhood to old age, as can be seen, for instance, from the consequences of female genital mutilation, lack of family planning, unattended pregnancies, and the development of complications due to untreated reproductive health problems. It is, therefore, important that SRH is integrated in a sound health system to facilitate easy referral for more serious reproductive health complications. In turn, health systems benefit from the prevention aspect offered by the inclusion of SRH within their services, by allowing early detection of diseases such as HIV, malaria, TB and others and by preventing serious health deterioration through a combination of bad reproductive health augmented by additional infections. Health system strengthening policies, therefore, need to include health promotion (including sexuality education, information and communication on SRH and related health issues) and disease prevention, treatment and care for SRH in a balanced way in every aspect of health system reforms. If this could be implemented, it would mean a major step towards the achievement of the ICPD PoA and MDG commitments.

Yet, many decision-makers are hesitant to allow SRH and RHS the place they deserve in the health aid agenda. While the European Commission and the EU Member States have adopted strong policy papers on the inclusion of SRH and RHS in their development policies, they lack the capacity or political will at country level to convince the recipient countries, through the political dialogues in preparation of CSPs and PRSPs, to include SRH and RHS in their national health policies. In line with the principles of the Paris Declaration and the Accra Agenda for Action the recipient countries are primarily responsible for the identification and inclusion of SRH and RHS as important

issues within their national health policies. As earmarked funding for development aid becomes more and more obsolete, to be replaced by general and/or sectoral budget support and core funding to international health initiatives, the local SRH community will have to step up its advocacy to make sure that the governments of the developing countries, and particularly the Ministries of Health and Finance, are convinced of the importance of including SRH and RHS in their health policies and health reform proposals and ensure sufficient funding through the national budget for the health sector. Only then can donor funding help alleviate the strain put on the health sector as a result of the consequences of bad SRH and a lack of a sustainable supply of RHS.

International health initiatives, such as the GFATM, GAVI or UNITAID, are starting to play a major role in supporting the health sector in developing countries, as donors increasingly channel their funding for health through these organizations and new fundraising mechanisms allow them to raise additional financial resources for their, often disease-specific, health activities. With the recognition that a weak health system puts a serious constraint on the achievement of their health objectives the organizations are now including health system strengthening in their health objectives. Yet, in spite of a growing focus on making programming more gender-sensitive, the international health initiatives have not seriously tackled the problems of SRH and RHS. If initiatives such as the GFATM, GAVI or UNITAID do not substantially fund SRH and RHS, any interventions to combat HIV and AIDS will be hindered and infant and child mortality rates will not go down. Women and girls and vulnerable groups such as the poorest people, young people in general, lesbian, gay, bisexual and transgender people, refugees and ethnic minorities – often the poorest of the poor – need full access to SRH services and RHS if they are to exercise their right to good (sexual and reproductive) health.

National and international donors and recipient country governments need to recognize that universal access to SRH services and RHS will have a very beneficial impact on a country's social and economic situation. This is shown by the fact that women in particular play an important role in the family, the community and the country as a whole, both as carers and providers. Particularly in view of the current economic and financial crisis decision-makers should not underestimate the important contribution women make to their country's survival. Their SRH, therefore, needs to be taken care of and their voices have to be heard, not only by governments but also by donors. Only then can progress be made to achieve the ICPD PoA objectives and the health MDGs by 2015.

What European policymakers can do: Recommendations

- **Increase funding** for sexual and reproductive health (SRH) and reproductive health supplies (RHS), through budget support or other funding mechanisms (e.g. programme/project support, pooled funding etc), and ensure funding is **consistent, predictable, and long-term** so recipient countries can plan and invest for the future.
- Ensure that SRH and RHS programmes and commitments are fully funded through a **mix of funding mechanisms**, including budget support and earmarked funding. This is particularly important where finance ministries do not include these issues in budget support agreements, in which case donors must take into account the specific SRH **needs of the poorest, most marginalized and vulnerable groups** and their access to services and supplies, which are rarely prioritized by governments or may be controversial in some cultures.
- Ensure that recipient-country governments include **SRH and RHS security in health policies and funding mechanisms**, implement existing policies and include SRH and gender **indicators** in monitoring and evaluation (M&E) strategies, in line with the Paris Declaration Principles on Managing for Results and Mutual Accountability.
- Support recipient countries to draft and implement **comprehensive health policies** which include all aspects of SRH – from the provision of contraceptives (family planning), through to maternal and medical SRH care. These should be stand-alone policies as well as priority elements in policies aimed at combating diseases, such as HIV and AIDS and malaria.
- Ensure that efforts to **strengthen health systems** in developing countries (including basic and specialist care, improvements in health infrastructure and workforce etc) **include SRH activities and programmes** at all levels – from prevention to highly specialized medical interventions, and with a focus on integrated services supported by effective referral mechanisms.
- Make sure that health systems strengthening leads to **improved access** to health services – including SRH care and RHS – **for the whole population**, with special consideration of the needs of women and girls and vulnerable groups, such as the poorest of the poor, young people, lesbian, gay, bi-sexual and transgender people, people living with HIV, and refugees, in both urban and remote rural areas (through outreach programmes).
- Work with recipient-country governments to create policies and support programmes aimed at behaviour change that enhances the social position of women; this should include **comprehensive sexuality education, information and communication** for men, women, girls and boys, through education and health systems as way to promote good SRH, thereby alleviating the burden of ill-health on an already struggling health system.
- Ensure that recipient countries' national budgets allocate **sufficient and transparent funding to SRH and RHS** as part of the health budget, preferably through separate budget lines, and that it reports accordingly for the budget discharge.

- Include a **wide variety of reproductive health medicines** on the national List of Essential Medicines for Health, particularly for family planning. This must be part of a sustainable supply chain mechanism that is supported by earmarked and predictable funding for RHS and monitored by a Reproductive Health Supply Committee, comprised of representatives of a range of stakeholder groups, including women.
- Create meaningful opportunities and platforms for the **participation of civil society** in health system reform policies, implementation and monitoring, particularly groups representing women, people living in extreme poverty, young people, marginalized and vulnerable communities. In this way, the Paris Declaration Principle of Ownership will lead to true country ownership, not just government ownership.
- Ensure that **international health initiatives**, such as the Global Fund, GAVI, UNITAID and others **expand funding for SRH and RHS security in their activities**, particularly in view of an increasing focus on gender and links between SRH and other diseases. This should also be included in support for health system strengthening.
- Ensure **aid is delivered in a coordinated, harmonized and efficient way**, in line with the principles outlined in the Paris Declaration, for example, through coordinating mechanisms such as the **EU's Division of Labour** and the **International Health Partnership and Related Initiatives (IHP+)**, without putting the onus of multiple implementation and reporting systems on national governments. Likewise, new funding initiatives such as GAVI's Advance Market Commitments and the AccessRH and the International Finance Facility (IFFIm) and the Pledge Guarantee should ensure that ultimately competition on the financial markets will not be detrimental to their respective objectives.
- Ensure that **EC Delegations' staff** includes **health and health policy experts**, who keep health issues on the political and funding agenda and can offer appropriate and effective **technical support** to recipient countries.

ANNEX I: European Union bilateral contributions to official development assistance, health and reproductive health as reported to OECD DAC

Bilateral Contributions to ODA, Health Care and Reproductive Health as reported to the OECD DAC in current 2009 US\$ millions (accessed 12 August 2009)

Purpose	Austria	Belgium	Denmark	Finland	France	Germany	Greece	Ireland	Italy	Luxembourg	Netherlands	Portugal	Spain	Sweden	UK	EC
ODA																
2005	1260	1578	1542	680	8414	9284	206	482	2711	219	3529	271	1926	2693	9868	11355
2006	1083	1545	1370	599	9442	9475	179	632	2515	198	10265	189	2685	3060	10453	12533
2007	1381	1586	1481	660	8223	9644	247	832	1439	252	4800	605	3778	2323	5711	13373
ODA % GNI																
2005	0.52	0.53	0.81	0.46	0.42	0.36	0.17	0.42	0.29	0.79	0.82	0.21	0.27	0.94	0.47	NA
2006	0.47	0.5	0.8	0.4	0.47	0.36	0.17	0.54	0.2	0.9	0.8	0.21	0.32	1.02	0.51	NA
2007	0.5	0.43	0.81	0.39	0.38	0.37	0.16	0.55	0.19	0.91	0.81	0.22	0.37	0.93	0.35	NA
Basic Health																
Basic Health care																
2005	6.6	28.8	8.7	1.7	5.5	23.6	24.4	28.7	37.3	6.2	33.6	0.3	30.1	120.6	9.1	399.3
2006	3.4	47.1	27.4	1.0	3.4	15.0	18.8	17.8	24.7	6.1	122.8	0.9	25.6	107.1	135.1	156.0
2007	2.7	57.9	1.2	12.7	24.2	29.9	23.8	17.0	21.0	6.1	27.6	1.2	31.6	2.2	126.1	194.2
Health Personnel Development																
2005	0.0	NA	NA	0.6	NA	3.6	NA	1.5	2.6	1.7	NA	0.1	5.4	0.2	0.5	NA
2006	0.0	1.1	0.9	6.8	NA	2.1	0.0	2.7	0.0	NA	0.0	0.0	4.1	3.9	0.1	NA
2007	0.2	3.7	NA	1.4	NA	2.8	0.1	0.7	0.9	0.4	0.7	NA	6.1	1.8	0.3	NA
Population/Reproductive Health																
Reproductive Health Care																
2005	0.9	1.1	1.6	4.3	NA	7.8	NA	0.1	0.8	2.7	35.4	NA	11.5	54.7	77.3	36.3
2006	0.6	0.5	NA	4.6	NA	94.7	NA	0.1	0.7	1.9	85.8	NA	18.0	8.7	539.5	41.6
2007	1.6	0.3	NA	7.9	NA	9.6	NA	0.2	0.5	6.4	30.6	NA	26.0	34.9	547.6	NA
Family Planning																
2005	NA	1.1	NA	NA	NA	18.3	NA	0.0	NA	NA	NA	NA	0.4	NA	0.9	NA
2006	NA	0.8	NA	NA	NA	12.5	NA	0.1	0.0	NA	8.4	NA	0.2	NA	NA	NA
2007	NA	0.8	1.3	0.6	NA	1.1	NA	0.0	1.0	0.6	0.3	NA	1.0	NA	NA	NA
Personnel Development: Population and RH																
2005	NA	0.2	NA	0.1	NA	0.3	NA	NA	NA	NA	NA	NA	0.6	NA	NA	NA
2006	NA	0.2	NA	NA	NA	1.2	NA	0.1	0.1	1.2	NA	NA	0.5	NA	NA	NA
2007	NA	0.2	NA	2.1	NA	0.8	NA	NA	NA	2.7	NA	NA	0.5	NA	NA	NA
STD control, including HIV/AIDS																
2005	0.6	17.4	12.2	0.9	5.2	48.1	0.5	20.7	9.4	3.8	80.6	0.1	16.2	80.8	362.9	15.1
2006	2.9	16.9	28.7	3.0	NA	117.0	7.9	70.0	3.3	5.4	88.6	0.0	21.7	29.1	226.6	46.4
2007	1.8	32.9	60.6	0.7	10.1	117.7	5.8	82.7	13.8	6.4	25.6	0.0	20.3	83.8	533.1	11.0

ANNEX II: General and sectoral budget support mechanisms

General and sectoral budget support are both seen as financing mechanisms that support recipient country's national policies. Budget support is perceived as a means to guarantee a more sustainable financing mechanism, allowing the recipient governments to plan ahead. In addition, they contribute to lower transaction costs for the partner government. What are the implications of general budget support on the one hand and sectoral budget support on the other? Both forms of budget support imply a transfer of resources to the national treasury, with the recipient country respecting agreed conditions of payment; they are usually foreseen to cover a period of three years. These conditions include the need to have a stability-oriented macro-economic framework in place or under implementation, together with a credible and relevant programme to improve the partner country's public financial management. Budget support should then be used in accordance with the public financial management system of the partner country. General budget support is meant as a contribution to the partner country's national budget, while sectoral budget support is aimed at supporting a specific sector such as, for instance, health. The policy dialogue between the donor and the partner country, to be conducted before agreeing on budget support programmes, focuses on the national (general) or sectoral objectives of the country's strategies and on the necessary results/outcome-based performance indicators, to be ultimately integrated in the Performance Assessment

Framework. These are then included in a Financial Agreement between the two partners, which is in fact the contract for the disbursement of budget support. Budget support is usually disbursed through a system of fixed and variable tranches. The amount of the fixed tranche is specified in advance in the Financial Agreement and will be disbursed in full once certain criteria, the so-called 'eligibility criteria', have been met. If these criteria have not been met, the fixed tranche will not be released, as partial disbursements are not foreseen for fixed tranches. The variable tranche, with a maximum value specified in advance in the Financial Agreement, is either disbursed in full or in part, depending on the performance achieved in relation to predefined indicators or targets to be achieved within the specific sector, provided that the eligibility criteria have also been met. Although budget support is seen as a longer-term and more predictable and aligned form of development aid, the fact that the fulfilment of the eligibility criteria needs to be reconfirmed on an annual basis could, in theory, jeopardize this predictability, albeit that the European Commission does allow a certain flexibility by including trends towards the fulfilment of the criteria as an indication of progress allowing for the continuation of budget support.

If health, SRH and RHS are to be supported in a partner country, the Financial Agreement has to include provisions for health and health performance indicators.



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