DFID HEALTH RESOURCE CENTRE

Proposal appraisal: UNFPA financing for sexual and reproductive health supplies and capacity building

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ABBREVIATIONS

CMB	Commodity Management Branch
CMS	Central medical stores
CPR	Contraceptive prevalence rate
DFID	Department for International Development
GF	Global Fund to Fight AIDS, TB and malaria
GPRHCS	Global Programme on Reproductive Health Commodity Security
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HRU	Humanitarian Response Unit
ICPD	International Conference on Population and Development
KfW	German Development Bank
LAC	Latin America and Caribbean
LTAs	Long term agreements
MDGs	Millennium Developments Goals
MoH	Ministry of Health
MTSP	Medium Term Strategic Plan
NGOs	Non-governmental organisations
PPS	Procurements Services Section
PRSPs	Poverty Reduction Strategy Papers
RH	Reproductive health
RHCS	Reproductive health commodity security
SRH	Sexual and reproductive Health
SSA	Sub-Saharan Africa
SWAps	Sector Wide Approaches
TPP	Third party procurement
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation

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1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.1. Economic appraisal

The economics of SRH
Poor sexual and reproductive health (SRH) is one of the world's main causes of disease and ill health, far beyond e.g. HIV/AIDS. Improving it will also be a means to meet six of the MDGs, as well as making an impact on poverty, population stabilization (and hence the environment) and gender imbalances. There is a strong economic case for investing in low cost SRH commodities, given that they are public/merit goods (i.e. benefiting others beyond the end user) and that they are more cost effective than most alternative health interventions (see Annex 2). It costs an estimated $34 to avert a DALY[1] through contraception in Sub-Saharan Africa (SSA), making it ten times more cost effective than ART treatment against HIV/AIDS, for example, and more effective in health improvement than infrastructure investments such as improved water and sanitation. Over time, family planning programmes in individual countries have tended to produce economic returns of several times the amount expended.

Demand side of commodities market
Past rises in the prevalence of contraceptive use have come to a halt, and unmet need for contraception ($841m in 2005, or $1.333bn with HIV prevention) far outstrips donor-funded supply ($213m). Moreover, unmet need (sometimes referred to as the 'condom gap') is expected to expand rapidly while donor funding has stagnated in recent years, and also excludes any need for spending on capacity building. SSA suffers the greatest proportionate unmet need, and receives the bulk of donor funding. The private sector is large and under-researched, though it plays a minor role in those countries most in need.

Supply side of commodities market
UNFPA is the lead procurement agency for SRH commodities (mainly contraceptives), spending $72m in 2006, with $32m of this on behalf of third parties who select UNFPA as a superior purchaser. UNFPA currently depends on this volatile third party income stream to fund much of its purchasing function, which is problematic. Its own procurement is generally directed by a Board-established allocation mechanism, or towards SSA, when it enjoys discretion. Condom prices have come down, with strong generic competition. Cheaper generic supply could be available for some other products, but will require help from UNFPA through prequalification in order to overcome quality problems.

Procurement is beset by a number of problems, including donor funding delays and unpredictability and imprecise forecasting of requirements, but there have been improvements in these over the last few years, and further initiatives are underway. There are more challenging issues further down the supply chain, mostly related to lack of human and information capacity and especially prevalent in fragile states, though also evident in stable countries (which contain the bulk of population). Increasingly, these are the main causes of gaps and shortfalls, and they will require well-considered capacity development to overcome.

Efficiency and effectiveness of funding via UNFPA compared to alternatives
UNFPA's Global Programme on Reproductive Health Commodity Security (GPRHCS) envisages both increased funding towards current unmet needs and also a related series of incentives and assistance to help national governments develop effective long term capacity to address such needs in future. The concept is sound and is targeted directly at some of the main obstacles to improved SRH. But it relies on UNFPA working hard to develop and implement its plans, to learn quickly from proof of concept experiences and to be able to scale up. There is certainly risk that

[1] DALYs – disability adjusted life years - are a standard measure for comparisons between health interventions – see Annex 2.

some funds will be used inefficiently, especially since several new tasks are being attempted, but there is also an important opportunity to make a major advance towards universal SRH.

The GPRHCS offers important advantages over two short/medium term alternative means of addressing SRH (downstream) supply problems that were considered. A focus on fragile states exclusively would miss a key opportunity to modify SRH commodity provision in stable states, which are often equally needy and are those most amenable to reform and to developing government ownership. The GPRHCS also has a fragile states funding stream, which could be expanded if necessary. Use of a separate trust fund to implement the policy would further complicate the aid architecture and there would be disadvantages (likely to outweigh potential benefits) in involving the World Bank as administrator of the fund. While the GPRHCS proposal is the most promising in theory, however, much depends on UNFPA's ability to convey and apply the GPRHCS's incentive properties, to fine-tune its strategy and on a range of its institutional capabilities.

Should DFID decide to contribute to the GPRHCS, there are a number of factors to consider related to the timing and amount of contribution. These include how for any given amount of funds, lengthening the period of contribution will be likely to strengthen the Programme's incentives and allow for better institutional learning. A smaller annual contribution will be likely to reduce the number of countries able to benefit from the GPRHCS, rather than scaling back the scope of the Programme within countries. If the UK does decide to contribute, the proposed amount should be proportionate to those of donors such as the Netherlands and Spain, taking the greater size of the UK economy into account.

1.2 Institutional Appraisal and Report Recommendations

Is UNFPA the right agency through which to channel funds for procurement of commodities?

UNFPA is the right agency through which to channel funds for procurement of commodities, in the short to medium term, because:

- Its advantages outweigh those of the other two possible options
- It has a recognised international mandate to advocate for better RH and the systems in support of this.
- It has considerable technical expertise in procurement

The GPRHCS is an initiative of UNFPA's Commodity Management Branch (CMB) with twin objectives. Its goals are substantially to increase funding for SRH commodities in developing countries, and to develop in-country capacity to confront problems of SRH commodity insecurity, so that over time this activity becomes country-led (and funded) wherever possible. UNFPA is seeking multi-year core budget funding, over a suggested five year planned initial operating period for GPRHCS.

A key feature of GPRHCS is its three funding modalities, according to country context. In Streams 1 and 2, the programme will support capacity building as well as commodity procurement (40:60). Stream 1 qualification implies the capacity (and government commitment to budget at least part of the funds) to take over most of UNFPA's SRH commodity procurement responsibilities. Stream 3 includes those countries where there are urgent SRH commodity shortfalls (including fragile states). The GPRHCS Programme is currently being piloted in five 'Proof of Concept' Stream 1 countries: Ethiopia, Burkina Faso, Mozambique, Mongolia and Nicaragua.

The GPRHCS represents an important step forward in UNFPA's approach to commodity security:

- It demonstrates a broader understanding of the problem of commodity security and a commitment to addressing systemic and political barriers.
- It makes a commitment to greater working in partnership at both international and national level and clearly states that the purpose of the programme is to become a shared vehicle for change not just a single agency .
- It makes a commitment to promote national ownership of the problem of commodity security.
- The programme is a bold and ambitious approach to addressing a complex and intransigent problem.
- It has good international buy-in by key partners in the Reproductive Health Supplies Coalition, as well as several like-minded bilaterals.

Does UNFPA have the capacity to deliver the programme?

UNFPA does ***potentially*** have the capacity to deliver the programme:

- It has an MTSP which has RHCS embedded in it and provides a strategic framework for delivery of the Programme.
- Senior management at UNFPA have made a clear commitment to the Programme.
- It is undergoing various organisational developments which will give it better capacity to work effectively at field level, such as a more developed performance management system, and regionalisation to promote better technical support for country offices.
- It has an enthusiastic and committed staff at HQ in CMB and PSS who have substantial experience of some aspects of delivery of the Programme and a good track record in implementing relevant programmes such the older RHCS Thematic Trust Fund.
- It has developed effective relationships at international level, especially through the Supplies Coalition whose members are supporters of the Programme.
- It has a Programme document which presents lots of ideas for capacity development throughout the organisation and recognises the importance of ongoing lesson learning, regional support and tools to help Country Offices address differences in skills and experiences and local circumstances.
- It has useful experiences from the Proof of Concept countries on which to draw in developing internal capacity building tools, and staff from these offices are keen to share their knowledge with the rest of the organisation.
- It is developing an innovative approach to programme monitoring through the 'dashboard' which aims to measure the progress of processes as well as outputs in a way which will be shared by all participating country offices.
- The Programme represents an approach which is coherent with UN reform.
- The Programme can be funded through core-funds with soft earmarking.

However UNFPA still has some challenges to face in developing the capacity to implement the programme. These should be the priority for the next year:

- It needs to further develop the logframe and appropriate indicators that can be used to monitor the programme as a whole.
- It needs to devote resources, time and energy to developing and rolling out the capacity building activities described in the GPRHCS Programme document to equip Country Offices to implement the Programme.
- HQ needs to do more thinking on how it is actually going to manage and support the implementation of the programme once funds become available to many more countries. It also needs to give more consideration to how countries are going to be selected, given that there may well still be more demand than money even with additional funding.
- It needs to formalise its thinking on various strategies such as how to increase SRH globally and lever more funds, how it might consolidate its experience and expertise in advocacy and apply this through the GPRHCS, how it might reduce funding and

procurement functions for low income states, and how it might work more effectively towards a country led approach.
- It needs to consider how parts of the organisation outside CMB such as Procurement Services Section and Humanitarian Response Unit can be more engaged with the Programme.
- CMB should consider whether it should be less explicit about the funding possibly available for Streams 1 and 2 because there may be issues of absorptive capacity and loss of focus if too much money is available per country. There need to be more flexible and sensitive allocations than "$5m for good countries, $1m for less good ones";
- They should consider a strategy beyond the current 5 year timeframe after which, for example some capacity may immediately need to be rebuilt if trained staff have left.

Over the course of the first 1-2 years of the Programme UNFPA also needs to give special attention to:
- Stepping up its engagement with the Supplies Coalition to use it more effectively as a platform for advocating for higher levels of SRH funding; UNFPA should also seek more opportunities for leadership
- Ensuring that the transition period whilst regional teams are relocated and reorganised, does not undermine the Programme at a critical time.
- Whilst it still has funds to spend, UNFPA should be more forthcoming in taking part in joint funding strategies at country level for wider health programmes through such mechanisms as pooling. This could increase local credibility, promote the sense of shared ownership of the RH agenda, and as evidence from one of the Proof of Concept countries shows, help lever more funds for commodities. We recommend that UNFPA develop an explicit policy re the pooling of donor funds, e.g. under what conditions UNFPA might refuse to join a pool. If these conditions were met, it would then be incumbent upon UNFPA to join a pool.
- Similarly UNFPA needs to consider when and how it will contribute to other wider national systems development initiatives such as the improvement of procurement processes. In countries attempting to integrate procurement and distribution systems for all health commodities UNFPA should commit to contributing to building these wider systems alongside other development partners**.**

UNFPA may also consider the further development of procurement services, including:
- A more upstream strategic role for PSS;
- Phasing down/out PSS's dependence on third party income to meet its core operational costs by other funding in conjunction with the Supplies Coalition and / or donors;
- Increased support for pre-qualification efforts, sufficient that this becomes a sustainable and institutionalised policy.
- CMB should also work with PSS to consider a more a more explicit policy for the GPRHCS on the circumstances and the process by which procurement responsibility may be handed over to countries.
- Ensuring that its guidance on capacity building means that countries undertake activities that are additional because of the programme, not just an extension of 'business as usual'.
- Ensuring that clear and concrete time bound milestones for evolving support are built into agreements with governments. These milestones should focus on progress in monitoring, systems development, nationally led coordination and funding commitments which are realised.

Considerations if DFID were to fund the Programme

It is recommended that if DFID were to make a financial commitment to the programme it should be dependent on reaching agreed milestones at the end year 1.

Suggested milestones are:

- Completion of the RHCS orientation tools and guidelines as described in section 5.1.2 and further detailed in Annex 2 of the GPRHCS.
- Development of the RHCS Integrated Capacity Development Strategy as described in section 5.1.3 of the GPRHCS.
- Establishment of the Lesson Learning Mechanism outlined in section 5.5 of the GPRHCS and an initial programme lesson learning programme developed.
- Development of a coherent monitoring framework for the programme as a whole. While good work is in progress for developing indicators for country level use, this should include indicators that will show how internal capacity has been built. There should also be provision to monitor the wider impact of the programme on the poor in terms of improvements in SRH.

We also recommend that DFID:

- use a soft earmarking approach for this type of allocation. The commitment to RHCS in the MTSP does not translate into appropriate core funding for this strategy due to a disconnection between the MTSP and the core funding resource allocation mechanism. Meanwhile DFID should maintain dialogue with UNFPA and engage with the wider UN reform agenda to seek a long term solution to the resource allocation problem. The existing Trust Fund should remain as it is.
- DFID should encourage UNFPA to establish what is spent on RHCS as a whole, from all funds.

Other wider points to which DFID should give attention are:

- Continued working with UNFPA and other Supply Coalition members to support their attempt to establish useful elements of the 'McKinsey proposal' (i.e. an effective pledge and volume guarantee function) without having to create a new institutional body. UNFPA has the mandate to and should be able to fulfil the necessary functions, including expanded procurement, on behalf of Coalition members. One of the reasons UNFPA would be good for this role is its ability to make recommendations to governments on commodity usage. It is noted that the current Terms of Reference include UNFPA's potential role. DFID's ARH Team is contributing programme funds to the test of concept phase in 2007/08.
- Encouraging the improvement of systems for tracking spending on SRH supplies through broad funding mechanisms (SWAps, PRSPs, etc).
- Promoting access to RH supplies as a key indicator for SWAps, MDGs, PRSPs, and GF programmes.

2. INTRODUCTION

These economic and institutional appraisals were carried out by consultants from HLSP through the DFID Health Resource Centre. The brief was to inform the process by which DFID is to consider the allocation of additional funding to UNFPA in support of the Global Programme on Reproductive Health Commodity Security (GPRHCS). Terms of Reference are at Annex 1 and a summary of the programme is in Annex 3.

The Economic Appraisal reviews the case for funding SRH and SRH supplies (see also Annex 2), looks at the economics of demand and considers the role of UNFPA and other participants on the supply side. Two other options for funding instead of the GPRHCS are briefly reviewed and compared to the GPRHCS proposal. The Institutional Appraisal then considers UNFPA's capacity to deliver the Programme, its progress in addressing the strategies outlined in section A of the ToRs and then other areas including the GPRHCS in the context of the Draft Medium Term Strategic Plan. Annex 4 considers a number of other current policy initiatives which have some bearing on UNFPA's proposed policy: the SRH commodity finance reforms proposed by McKinsey, the possible Market Development Project and the Medicines Transparency project.

The approach of the consultants was to review available literature and then make a visit to UNFPA HQ in New York to meet with a wide range of staff engaged with the programme. A subsequent visit was made to PSS in Copenhagen by one of the consultants. The terms of reference proposed a visit to one of the country offices which has embarked on the Programme but the consultants thought a more representative overview could be gained by telephone interviews with a larger number, namely Tanzania, Ethiopia, Vietnam and Burkina Faso. A list of staff and others interviewed and documents consulted are at Annex 5.

3. ECONOMIC APPRAISAL

3.1 The economics of SRH commodities: a summary

Poor SRH is one of the world's main causes of disease. The annual toll within developing countries includes more than half a million maternal deaths following unintended and unwanted pregnancies (e.g. via deaths in childbirth, unsafe abortions), around 4 million perinatal deaths and over 8 million nonfatal morbidities[2]. The poorest are disproportionately affected.

Use of contraceptives, the key SRH commodity, on the other hand, is highly efficacious. It can prevent 25-30% of maternal deaths[3], for example. And condoms also remain the only means of preventing sexual transmission of STIs, including HIV.

Improving SRH will also be a means to meet six of the MDGs, including the Improvement of maternal health – the MDG toward which countries have made least progress (in Africa, little or none), as well as a number of other international commitments.

Beyond the association with its own heavy burden of disease, SRH is also closely linked to poverty. The poor are more likely to suffer from bad SRH due to their lower levels of education, inability to meet health care costs and other associated risks such as poor sanitation, malnutrition, adolescence and rural isolation. Research shows that SRH care is the most inequitably distributed of all health services[4].

Current fertility levels imply a further 50% increase in the world's population by 2050. Unchecked, this will make all of the MDGs harder to achieve, as well as negatively affecting the environment in a number of ways. High population-growth countries are also associated with increased levels of civil conflict.

A further important link is that between SRH and gender equality. A woman's ability to plan her family is fundamental to her potential empowerment and equality. Conversely, for teenage girls, early pregnancy often brings an end to their education (undermining progress towards the education target within MDG 3). In SSA, between 8 and 25% of girls who fail to complete school do so for this reason[5].

From an economic perspective, there is a strong case for donor funding of low cost SRH commodities, which are 'public goods' with a good return in terms of DALYs. The following table is extracted from Annex 2 of this report, and gives an indication of the cost-benefit advantages of investment in SRH commodities compared to other health interventions:

Table: *Cost effectiveness of comparative health interventions and health-relevant policies*

Health intervention	Cost (US$ 2001) per DALY averted
Expanded immunization against TB, DPT, polio, measles	7
Insecticide-treated bed nets (malaria)	5 -17*
Family planning	**30 - 60**
Integrated management of childhood illness	39*

[2] Campbell White, A, T Merrick and A Yazbeck Reproductive *Health: The Missing Millennium Development Goal*. Washington, DC. World Bank.
[3] Singh, S., et al. 2004. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. Washington, DC and New York: The Alan Guttmacher Institute and UNFPA. LSHTM estimate up to 40%.
[4] Gwatkin D 2002. "Overcoming the Inverse Care Law" Leverhulme Lecture, London School of Tropical Medicine, September. Gwatkin D, A Wagstaff, and A Yazbeck 2005. *Reaching the Poor with Health, Nutrition, and Population Services.* Washington, DC: International Bank for Reconstruction and Development. Note: to a small extent this may be mitigated by the fact that wealthier couples typically want smaller families than do poorer couples.
[5] UNFPA State of World Population 2002.

HIV/AIDS: condom promotion and distribution	52 -112*
Childhood TB vaccination	55 - 82
DOTS for infectious or latent TB	84 - 551
Construction and promotion of basic sanitation	141
Improved comprehensive emergency obstetric care	151*
Anti-retroviral therapy against HIV/AIDS	350 -1,494*
Advertising ban and restriction on alcohol sales	367 - 441
Dengue vector control	1,992 – 3,139
Improved water and sanitation (where infrastructure currently exists)	1,974 - 6,396
Cholera or rotavirus immunisation	2,478 – 2,945
Hepatitis B vaccination	23,520
Treatment of Kaposi's sarcoma (HIV/AIDS)	34,968 – 69,930

* SSA figures only. Data is drawn from various sections of Levine R, Langer A, Birdsall N, 2006. *Disease control in Developing Countries (2nd edition)*, World Bank, Washington, DC. The basic model is from AGI (Alan Guttmacher Institute, Futures Group International, Population Action International, Population Reference Bureau, and Population Council, 2000. *The Potential Impact of Increased Family Planning Funding on the Lives of Women and their Families.* Washington, DC: AGI.

Family planning programmes in individual countries have produced savings of up to 31 times the amount expended, typically through savings in maternal and child health costs and other public services (again, see Annex 2 for more detail).

3.2 Analysis of demand for SRH commodities

3.2.1 Current contraceptive usage

About 632m women, or their partners were estimated to have used contraceptives in developing countries in 2005. At standard prices[6], the cost of these commodities would have been $841m. Overall, usage has grown from a prevalence rate of modern contraceptive methods (CPR) of around 10% in developing countries in 1965 to 53% today[7], although recent years have seen only marginal increases.

While the fastest increasing region, Sub-Saharan Africa (SSA) still represents only a small fraction of demand – around 5% of total developing country usage in 2005, at 36m[8]. Among the 41 SSA countries, only 17 countries had a CPR of modern methods above 10%[9]. In several (e.g. Kenya, Nigeria), there has been either no increase or a decline in their CPR over recent years. Thus, SSA is a priority region for SRH.

While demand in the developing countries is large in terms of volume, it is weak in economic terms. In 2002, despite accounting for 84% of the world's women, developing countries accounted for only 8.5% of sales, i.e. $0.75 per capita[10]. This influences the behaviour of manufacturers (see section 3.2.2).

[6] i.e. what UNFPA generally pays for commodities? Actual per unit costs may have been higher, while programme (e.g. distribution and system) costs will be additional to this. One UNFPA estimate was that programme costs amounted to a minimum of four times the cost of the commodities themselves.
[7] UNFPA 2007 *State of World Population 2007.* New York.
[8] This contrasts with China and India, which had 331m between them. Source: UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.
[9] UNFPA 2007 *State of World Population 2007.* New York.
[10] This contrasts with $42.20 per capita by the 16% of women in developed countries. Source: Hall, P. 2005. *What has been achieved, what have been the constraints and what are the future priorities for pharmaceutical product-related R&D relevant to the reproductive needs of developing countries?* Commission on Intellectual Property Rights, Innovation and Public Health, Morges, Switzerland.

Globally, in 2004 the CPR is comprised of 24% sterilization[11]; IUDs 14%; oral pills 7%; condoms 5%; injectables and implants 3%; others 1%[12]. However, in the same year, donor-supported contraceptives were comprised: condoms 38%; injectables 31%; oral pills 25%; all others 5%[13]. Within SSA, condoms accounted for 65% of donor-supported spending. Globally, condoms' share of donor funds has been stable over recent years, at around a third. Growth in use of mifepristone (for medical abortion) has been limited, due both to policy and its relatively high price.

Where demand is lacking, surveys show that price is a barrier to contraception use in less than 2% of women with unmet need[14], perhaps understandably given how the costs of childbearing dwarf those of contraception. Lack of knowledge, health concerns and social disapproval are far more important barriers. This indicates the greater efficiency of investment in inputs that address these problems, including investment in improving quality levels and access to a variety of contraceptive methods, increasing accurate knowledge and effective influence of social norms[15].

Factors outside of the health sector are also important. An important example is female education. Girls who complete their secondary education are between 3 and 13 times less likely to become mothers early in life, tending to have fewer and healthier children.

3.2.2 Public and private sector funding

Total donor support was $213m in 2005[16]. Donor support has been relatively stable in absolute terms over recent years (i.e. steadily declining as a proportion of need – see Figure 1, below). To an extent this is related to a shift in donor funding from family planning to HIV/AIDS-related activities[17]. SSA receives the largest share of donor support (54% in 2005), followed by Asia (32%), and Latin America/Caribbean (10%)[18]. An unpredictable element of donor funding is that for emergency situations[19]. Public sector funders are discussed in section 3.3 on SRH commodity supply, below.

Private provision is also important, but it is little researched. One study, cited by UNFPA, found that in the 90 countries that depend on donor support, more than half of oral contraceptives and two thirds of condoms were provided privately[20]. Another recent study, commissioned by DFID, found that in four countries, social marketing organisations provided between 47% and 88% of condoms and 38% and 74% of oral pills (though much of this was funded by USAID, KfW and DFID)[21]. Faith-based organisations, NGOs and commercial traders also play an important role in some settings.

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[11] Note: several donor reports (including many by UNFPA) ignore expenditure on sterilisation, so figures should be compared with care.

[12] Hall P, 2006. *Op. Cit.*

[13] Excludes World Bank financing. Source: UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.

[14] Mathneny, G, 2004. "Family Planning Programs: Getting the Most for the Money" *International Family Planning Perspectives* 30(3): 134-8.

[15] In this respect, the GPRHCS's commitment to information, education and communication (IEC) and to behaviour change and communication (BCC) – see Annex 3 – is welcome, if largely untested as regards its effectiveness.

[16] UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.

[17] Whereas the ratio of the two was 6-1 in favour of family planning in 1995, it had reversed to 4-1 in favour of HIV/AIDS in 2004. Source: UNFPA, 2005. *Financial Resource Flows for Population Activities in 2004,* New York. Note this is despite SRH accounting for a far greater share of the burden of disease (see Annex 2).

[18] This is equivalent to $0.16 per capita, compared to $0.01-0.04 per capita in the other regions. Source: UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.

[19] These are not accounted for separately, but can easily add $5m to support annually.

[20] UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.

[21] Druce, N, 2006. *Reproductive Health Commodity Security- Countries Case Study Synthesis: Cambodia, Nigeria, Uganda and Zambia,* DFID, London. It is worth noting that the same study found social marketing preferred to the public sector because it the service was friendlier, more accessible and presented fewer associated costs, including transport.

However, it is also true that donor funding/procurement is the primary source of contraceptive supplies in countries with critical need. For example, a recent report based on JSI data, found that in those countries classed as most in need, donor support account for around 70% of total contraceptive spending, compared to around 20% in those developing countries least in need[22]. Another issue to be borne in mind is that even within a very needy country, donor/publicly-funded services cannot be assumed to be targeted to the poorest population groups. Though there is a lack of data for SRH commodities specifically, the benefit incidence of many RH services is known not to be pro-poor[23]. Table 1 below shows the main recipients of donor support for SRH commodities[24], although it should be noted that the top ten countries vary by year, depending on funding and procurement cycles.

***Table 1**: Leading recipient countries for donor funding of SRH commodities, 2005*

Country	Amount of donor funding, $m	Share of total donor funding
Ethiopia	18.5	8.7%
Nigeria	16.3	7.7%
Bangladesh	12.5	5.9%
Kenya	10.8	5.1%
Egypt	8.4	3.9%

Source: This includes HIV/AIDS prevention as well as RH. Source: UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.

3.2.3 Current unmet need

There is significant and growing unmet need for contraception. UNFPA estimates that were about 200m women in 2005 who would like to limit or space the number of children that they are having but are not using contraceptives. As Figure 1 shows, it is estimated that it would cost an additional $600m to meet the contraceptive cost of current unmet reproductive need, with a further $500m required to purchase commodities required for protection against HIV/AIDS[25]. Programme costs would add significantly to this.

This unmet need averages a disproportionately high 27% of the female population of reproductive age across Africa[26]. The unmet need is also concentrated among the poor. While fertility in the richest quintile has declined in the last decade, in the poorest quintile it has either stagnated or risen[27]. Unmet need is also not where donations are always concentrated[28].

[22] Group 1 (most in need) countries included Cameroon, Mali and Rwanda and exhibited CPR of 13%, unmet need of 27%. Group 3 (least in need countries) included Brazil, Indonesia and Jordan, while their CPR was 52% and unmet need 14%. Source: Presentation by Mercer Management Consulting *Contraceptive Availability Study: Discussion with DFID.* 12 May, 2005.

[23] For example, a study of facility-based deliveries and ante-natal care in Vietnam found that the richest quintile benefited from more than twice the public subsidies as did the poorest. See Knowles, J. 2000 "Benefit Incidence Analysis of Safe Motherhood Services in Vietnam", Paper delivered at WBI Core Course. World Bank Institute, Washington, DC.

[24] This list is relatively dynamic. For example, neither Ethiopia nor Kenya featured in the top five recipients in the previous year.

[25] UNFPA, 2006. *Op. Cit.* The estimate is comprised of 137m without contraception and 64m using unreliable traditional methods.

[26] J Baudouy (2006), World Bank "Bringing population dynamics and sexual and reproductive health into development policy debates" Paper presented at DFID workshop on "Demography, reproductive health and sustainable economic growth in Africa", Paris, March, 2006.

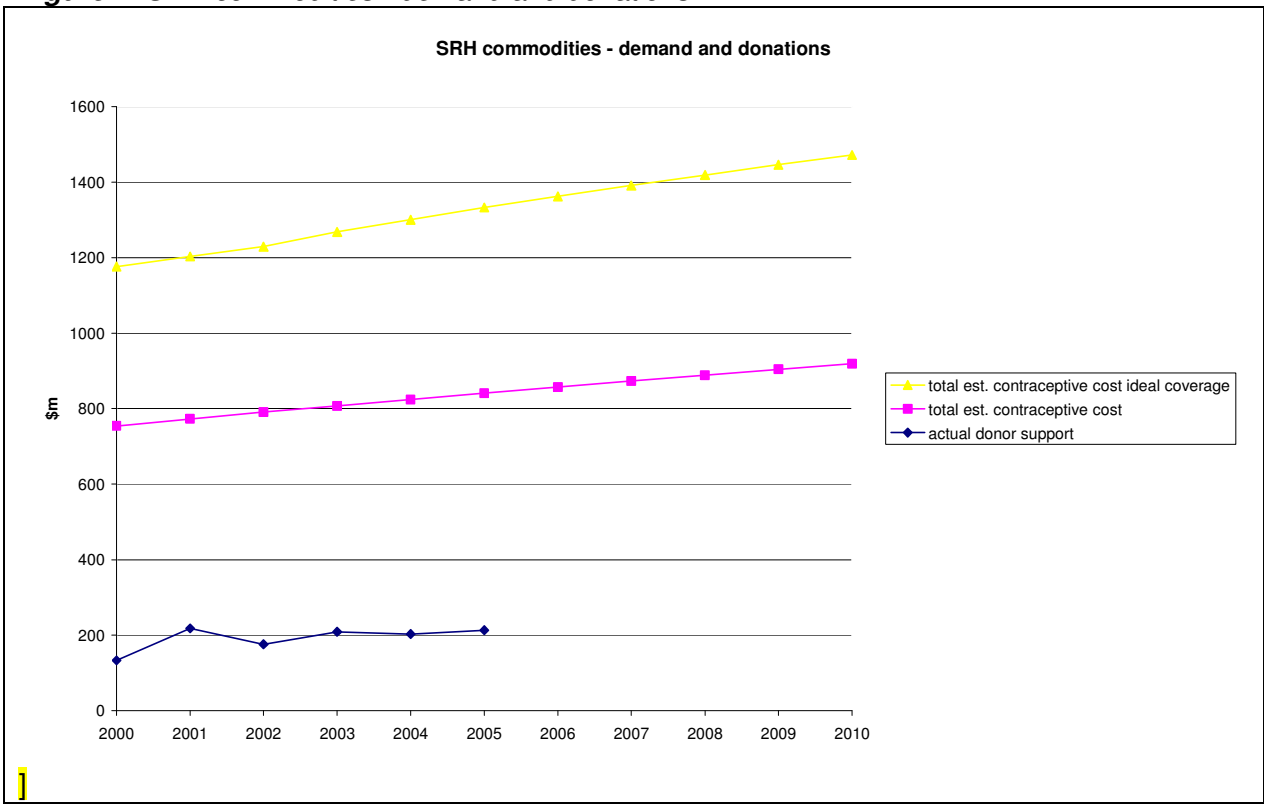
[27] Evidence submitted by MSI to All Party Group on Population, Development and Reproductive Health, 2007, *Return of the Population Growth Factor: It's Impact upon the millennium development goals.* London

[28] E.g. a Population Action International study of 41 countries showed that in 2003-4, six of the ten countries receiving the lowest values of donated RH supplies per capita all had unmet needs ratios of above 20%. http://www.populationaction.org/Publications/Research_Commentaries/Are_Contraceptives_Going_Where_Most_Needed/March_2006_Research_Commentary.pdf

3.2.4 Future demand growth

As Figure 1 shows, unmet need is expected to increase significantly over the next decade. The factors driving this growing demand include the fact that over the next 10-15 years, the largest ever generation of young people (15-24) will enter their reproductive years, boosting the number of reproductive age women by 23%[29]; the spread of HIV/AIDS; and the effects of decades of successful family panning and SRH programmes, as well as greater female access to education, which all work to increase knowledge and demand. The total number of contraceptive users is expected to rise 28% to 731m[30], with SSA as the fastest rising region[31].

***Figure 1**: SRH commodities - demand and donations*



Condoms are forecast to be particularly prominent in the increased level of demand (hence unmet contraceptive need sometimes being referred as "the condom gap"), with total demand expected to reach more than 12bn condoms worldwide by 2015[32].

Given this increased demand, the annual cost of meeting unmet contraceptive need is forecast to rise a further $200m[33] by 2015, to close to $1.5bn (still excluding programme costs). It should also be noted that these forecasts include countries such as India and China that have decreasing dependence upon donor support. Excluding them could reduce the cost by $370m[34].

[29] The number of reproductive age women is expected to rise from 1.26bn in 2000 to 1.55bn in 2015. Source: United Nations Population Division. 2005. *World Population Prospects: The 2004 Revision.* New York.
[30] UNFPA, 2006. *Achieving the ICPD Goals: RH Commodity Requirements 2000-2015.* New York
[31] An increase of 118% is forecast. Source: UNFPA, 2006. *Op. Cit.*
[32] UNFPA, 2004. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2002.* New York: UNFPA
[33] Calculated at standard costs – i.e. the (low) prices achieved by UNFPA.
[34] This includes HIV/AIDS prevention as well as RH. Source: UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.

But on the other hand, it should also be recalled that the estimates of SRH commodity shortfalls do not include the substantial costs associated with capacity building (see section 3.4.1).

At present the prospects for correcting for this under-funding are poor[35]. The consequences may be devastating, as the following calculation example by UNFPA shows. For every shortfall of $1m in contraceptive supply funding it estimates there are likely to be an additional 360,000 unwanted pregnancies; 150,000 additional induced abortions; 800 additional maternal deaths; and 11,000 additional infant deaths[36].

3.3. Analysis of supply of RH commodities

3.3.1 UNFPA procurement activity

Via its Procurement Services Section (PSS), UNFPA procured $74m of contraceptives in 2006[37], out of a total programme budget for the organisation of $246m[38]; It is the world's largest public sector procurer of contraceptives. Table 2 provides details, with injectables, oral pills and condoms each accounting for almost a third of procurement – though condoms play a more important role in SSA.

***Table 2**: UNFPA contraceptive procurement, 2006*

Contraceptive procured	Expenditure	%age of spend
Injectables	$25.8m	35%
Oral pills	$22.4m	30%
Condoms (m and fm)	$22.1m	30%
Implants	$3.3m	5%
IUDs	$0.6m	1%
Spermicides	$0.1m	0%

Source: UNFPA PSS

Of the $74m spent on contraceptives, just under $2m was purchased at country level and $32m was procured on behalf of third parties (TPP), such as country governments, donors and NGOs.

Table 3 gives a breakdown of the main TPP clients during 2006. TPP transactions are controversial within PSS for a combination of three reasons. First, they absorb staff time which would otherwise go to UNFPA procurement activities, including tasks such as finding new supply sources, quality assurance and long term strategic planning. Secondly, PSS is dependent on TPP transactions, because only a third of its own costs are covered by core funding. Finally, TPP represents a highly volatile income stream (see Table 4). While it is indeed more efficient for UNFPA to procure the commodities than it would be if the TPP clients were to do so themselves (given UNFPA's superior buying power and procurement expertise), the destabilizing effect on UNFPA-PSS's activity has some detriment. This might become even more acute if PSS takes on a major responsibility for capacity building in-country as part of GPRHCS.

[35] Especially since USAID recently announced a significant reduction in its SRH budget.
[36] Quoted in UNFPA brochure *Securing the Supplies that People Rely on* published October 2004.
[37] UNFPA's total programme activities were $246m in 2006. Contraceptive expenditure has been relatively constant over time, e.g. $58m in 2002.
[38] The largest contributors to UNFPA in 2006 were Netherlands ($69m); Sweden ($55m); Norway ($39m); and the UK ($34m). Source: UNFPA, 2007 Annual *Financial Statements for the year ended 31 December, 2006 (Un-audited).* Unpublished version.

***Table 3**: Key third party procurement clients, 2006*

Client	Funds made available, $m	Programme spending, $m
Pakistan Govt.	15.0	8.1
CIDA – Bangladesh	9.6	9.1
World Bank / Global Fund	7.2	0.6
NGOs	3.8	2.7
DFID – Pakistan	3.1	2.6
DFID – Zimbabwe	1.4	1.3
UN agencies	1.0	1.2

Source: UNFPA, 2007 Annual *Financial Statements for the year ended 31 December, 2006 (Un-audited).* Unpublished version.

***Table 4:** Third party procurement 2001-6*

2001	2002	2003	2004	2005	2006
$88m	$7m	$11m	$41m	$35m	$33m[39]

Source: Interview with David Smith, PSS-UNFPA

A buffer stock of around $5m of commodities is also maintained for emergencies, and is administered by UNFPA's Emergency Response section.

Almost $21m of UNFPA-procured commodities in 2006 were financed via the Thematic Trust Fund on RH Commodity Security (see Institutional Assessment), a reduction on 2005's figure. As with other expenditure, efforts are made to target this to those areas most in need, though in this case UNFPA has greater discretion[40]. Where spending has gone on middle income countries, it tends to be due to emergency or changing political situations[41]. The following table describes how this discretionary procurement was geographically distributed.

***Table 5:** RH Commodity Spending via the Thematic Trust Fund*

Region	2006 spend, $m	%	2005 spend, $m	%
SSA	14.7	71	19.1	59
Asia Pacific	2.7	13	8.4	26
Arab, Europe, Central Asia	1.6	8	3.0	9
LAC	1.6	8	1.9	6
Total	20.7		34.7	

Source: UNFPA, 2007. *Thematic Trust Fund on RH Commodity Security, Progress Report 2006.* New York.

Procurement by UNFPA and by other public sector organizations is subject to common problems. There are mismatches between deliveries (which can need substantial lead times from purchase orders) and in-country requirements, often due to unreliable forecasting (discussed below). There are also delays and unexpected variations of amount in funding from donors. All of these contribute to incidence of gaps and shortfalls across all types of country.

To an extent the problems with donor funding are being addressed by proposed reforms to the financing system (see Annex 4). UNFPA has also made significant progress in reducing purchase order lead times[42], tracking deliveries[43], and through investing in logistics software for

[39] Note: this $33m figure comes from a separate (UNFPA) source from that supplied in the text ($32m), and may have been calculated using a different methodology.
[40] With non-Trust Fund programme spending, distribution between countries is influenced by a resource allocation mechanism, established by UNFPA's Board. Supplies may then flow to these states.
[41] E.g. certain Latin American countries where responsibility has been decentralized to state governments, which are lacking in resources.
[42] E.g. average overall delivery time reduced from 295 days in 2004 to less than 88 days in 2007.

use in-country (more below). Also, UNFPA has extended the length of its supply contracts[44], which gives manufacturers more incentive to invest in capacity, thus implying lower long term prices. To date, suppliers[45] still see UNFPA as unable to forecast volumes accurately – though they level this complaint at all public sector clients, and it is probably an unavoidable consequence of poor demand forecasting by recipient countries, on which UNFPA's forecasts must be based. Suppliers tend to rate UNFPA as one of the best organised public sector agencies with which they deal, having improved over recent years. The high volume of TPP business suggests other procurement agencies concur with this view.

Apart from UNFPA, the other major procurement agencies are: USAID, the leading bilateral funder ($66m in 2005); PSI the leading NGO/social marketing source ($29m); BMZ/KfW ($13m); and DFID ($4m)[46]. UNFPA has been increasing its role, up from $17m of support in 2000 to $92m in 2005.

3.3.2 Current manufacturers

***Table 6**: Leading UNFPA contraceptive suppliers 2006*

Vendor	Amount, $m	Av. order, $000	Vendor based	No. orders
Pfizer	17.1	348	US	49
Schering	7.9	138	Germany	57
Organon	6.8	190	Netherlands	36
Wyeth	6.2	221	Canada	28
Famy Care	5.6	350	India	16
Utd Med-Health	5.3	329	US	16
Female Health Co.	4.6	81	UK	57

Source: UNFPA PSS

There is regular change in the leading suppliers[47], suggesting a successful competitive tendering process. However, among contraceptive suppliers, distinction should be drawn between manufacturers of male condoms and suppliers of other products. Generic suppliers now dominate male condom procurement, with five of the top six UNFPA suppliers being based in developing countries[48]. Female condoms are an unusual case, with a US company holding a monopoly[49].

But to date there has been scant use of generic suppliers of hormonal products by UNFPA[50] or indeed any of the major public/NGO/social marketing purchasers. There are a large and increasing number of generic manufacturers of, e.g. injectables and oral contraceptives. But the majority of these suppliers lack the investment and technical support necessary to take them to

[43] Many interviewed suppliers said that UNFPA was the only procurement agency with an effective tracking system.
[44] E.g. for male condoms from typically a year to typically three years. UNFPA contracts tend to specify price, but leave volumes open. Source: interviews with suppliers.
[45] Source: supplier interviews, UNFPA-PSS interviews.
[46] 2005 figures used because 2006 data not yet available for several donors. Note: PSI and other NGOs/social marketers are in many cases funded by other donors.
[47] E.g. Only four of the 12 leading suppliers in 2006 were among the 12 leading suppliers of 2002.
[48] In 2006, UNFPA purchased $19m worth of contraceptives from developing countries: India, Pakistan and Peru were the main national sources.
[49] Female Health Company has monopoly over female condoms, selling 13.5m in 2005 (8.6m in SSA). Source: UNFPA, 2006. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention, 2005.* New York.
[50] While only an indication, of the nine leading suppliers of pills, injectables and implants, only one was not an established OECD pharmaceutical manufacturer. Developing country-based generic manufacturers have made headway in IUD supply, however. Source: UNFPA, PSS and interviews.

WHO prequalification standard[51], for which UNFPA-PSS carries out contraceptive approvals – i.e. product quality is too low. While UNFPA PSS, with WHO, has recently expanded prequalification activities[52], and there are hopes that a small number of generic manufacturers will soon prequalify[53], it is hindered by a lack of resources from doing this thoroughly. Resources are needed for both regular inspections and to advise manufacturers on what they must do to reach the necessary standard. Without this, the prequalification system, and the downward pressure on prices and upward pressure on quality which it provides, is in danger of petering out.

The other problem which discourages investment by generic suppliers is uncertainty about order volumes[54]. Something of a 'chicken and egg' problem exists, as procurement agencies await lower prices in order to commit to larger orders, and suppliers await the orders in order to justify investment[55] which would produce lower prices.

The key current area of R&D is Microbicides, likely to be important but not yet close to launch. The mark two version of the female condom represents a recent innovative success[56], and the product is likely to grow in importance, given the feminization of HIV/AIDS and increased attention to gender empowerment. There remains controversy within the development community over the private retention of intellectual property rights with mirena (a levonorgestrel - releasing IUD), developed partly with public funds[57]. This is overshadowed by the extent of political controversy which hangs over safe abortion products, such as mifepristone[58]. UNFPA has significant influence over the development of demand for products through its advocacy role and strong reputation among recipient country governments.

The price of male condoms has been declining over recent years[59], as new generic suppliers have entered the market, but is unlikely to decline much further in the medium term[60]. Given the current thinner supply market, there is likely to be more scope for price reductions with hormonal commodities, such as oral pills and injectables, if greater competition can be generated from generic suppliers. Coupled with pre-qualification/US or European registration requirements for all international public sector procurement (as proposed by Supplies Coalition members), this should also ratchet up quality standards.

[51] See, for example, the recent assessment of manufacturing quality for DMPA and oral levonorgestrel, Hall, P et al., "A study of the capability of manufacturers of generic hormonal contraceptives in lower- and middle-income countries", in *Contraception* 75 (2007) 311-317.

[52] As of July 2007, this had involved the development of a prequalification profile, 9 IUD factories being inspected and 32 condom factories being inspected. Source: Interview with David Smith, Head of PSS.

[53] One estimate was 4-5 oral pill and injectable suppliers within the next 1-2 years.

[54] McKinsey, admittedly toward the more bullish end of the spectrum, believes that guaranteeing order volumes could cut 10-50% from public sector costs, with UNFPA a prime beneficiary. For more detail see Annex [A]. Source: See Reproductive Health Supplies Coalition: Systems Strengthening Working Group, 2006. *Reproductive Health Financial Mechanism Analysis*. Unpublished.

[55] Such investment is in greater manufacturing capacity, but also in promotional activities. The Mark two female condoms is a current example of this situation. Source: industry interviews.

[56] Costs reduced by 25% for volumes below 10m. Source: Hall, P. 2005. *Op. Cit.* The suppliers themselves claimed they would reduce their price from 60c/unit with current 20m volume to 20c/unit if 200m volume achieved.

[57] This product's development was aided by the Population Council, a US-based public-sector group. However, the private partner firm was bought by Schering, who did not share the view of previous Population Council private partners of aiming for maximum accessibility through a low price. Mirena is now marketed at a price (around $40) out of reach of most women in developing countries. Source: Hall, P. 2005. *Op. Cit* and industry interviews.

[58] Over 20m illegal abortions are carried out annually (Hall, P. 2005. Op. Cit.), with significant associated mortality and morbidity, and in many countries where abortion is legal there is much unmet need. Although the US, the donor with the strongest objection to offering safe abortion products even to countries where it is legal, has already cut off funding from UNFPA, the UN agency still generally steers clear of any involvement with abortion issues.

[59] In 2002, UNFPA paid an average of $3.93/gross, whereas during 2006 it paid between $2.80 and $3.25/gross. Sources: UNFPA-PSS. Most procurement agencies pay a similar price to UNFPA, though USAID pays a higher price due to its obligation to buy from US vendors.

[60] Several interviewees believed prices were as low as was compatible with required quality levels. UNFPA already achieves preferential prices due to large volumes, good supplier relationships (not enjoyed by all donors), and because suppliers are able to trade off of their status as 'UNFPA-approved', when dealing with other clients.

3.3.3 Problems further down the supply chain

The supply chain for SRH commodities is a complex one, with many stages: manufacturers – procurement agents – MoH/CMS – in-country distribution – district service provision – end users. Stockouts are frequent in some countries' service delivery points, especially in SSA[61]. It is not always clear what factor is the root cause, often because problems are due to complex interactions between factors.

Every supply chain stage has its own issues. With manufacturers, supply must be assured for an acceptable price-quality combination, innovation must be incentivised, and low-cost suppliers encouraged to make all of the necessary investments (see above). Procurement agents face problems of coordination, forecasting, a challenging funding environment and (in some cases) insufficient volume orders. As improvements are being made to these upper supply chain elements, attention is shifting to recipient countries.

At the central government level, countries also wrestle with forecasting - not just of demand, but of unpredictable donor supplies, which serves to undermine the development of long term forecasting capacity. Management of their own supply chains is also often a challenge, as are unhappily frequent economic and political shocks and crises. For their distribution systems, product security and product expiry are often leading problems. At the district level, financing and marketing are often challenges. While the end user often finds her (or his) own preferences ignored by all other market participants. This last fact is important, because it means that commodity distribution programmes may not be organised in the way that maximises their effect on health outcomes (see section 3.2.1 on the implications of survey data for programme organisation)[62].

These issues tend to be more acute in fragile states[63] or resource poor environments (where rates of unmet SRH need are generally high); less severe in stable and middle income countries (though these are where the bulk of poor populations reside, and in some cases need is also high). In poor countries, the dominance of the public sector means that its problems will dominate the national situation. In middle income countries, the private sector will be more likely to step in wherever the local population has disposable income. In all environments, public engagement with the private sector could potentially elicit greater efficiency and effectiveness[64], but little currently takes place[65]. Some more stable and/or middle income countries may allow shortfalls to occur through lack of prioritization of SRH. While the vertical family planning services common 25 years ago have been largely integrated with general primary care provision, this integration has often not led to equality at the level of policy-making and resource allocation. SRH remains sidelined within MoHs in many countries. This is one of the key problems that will be targeted by the GPRHCS programme (see section 3.4.1 and Annex 3).

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[61] E.g. A 2003 survey of service delivery points lacking pills, injectables or condoms found 76% of those in Nigeria fell into this category, as did 70% in Uganda, 63% in Mali, 61% in Ethiopia. Source: JSI/DELIVER, 2003. *Overview: Monitoring and evaluation strategies for DELIVER*. Washington, DC.

[62] UNFPA's recognition of the need to approach populations as segmented markets is helpful in this respect, as it implies tailoring different approaches to meet the profiles (and hence different obstacles to contraceptive use) of separate segments.

[63] While there are a number of differing definitions of 'fragile state', this report uses DFID's "poor countries unable or unwilling to use domestic and international resources effectively for the purpose of poverty reduction" – see http://www.cgdev.org/content/publications/detail/13893

[64] This can range in scope from coordination with commercial distributors (of contraceptives and/or other products) to the distribution of condoms via traditional healers.

[65] A rare, commendable exception has been UNFPA's Total Market Initiative carried out in seven (middle income) countries in 2006, jointly with IPPF.

[67] Two potentially useful, user-friendly packages, designed to help programme managers determine the type,quantity and timing of products to acquire. However, these do present the danger of verticality when not developed through system-wide, pooled policy-making. The RH Supply Coalition is attempting to review and rationalise the wide range of software currently used.

Some places have already seen a degree of supply chain improvement through better use of information technology, either as developed in-country or through use of UNFPA's 'Country Commodity Manager (CCM)' and 'Channel' logistics management software[67], which should improve forecasting. A serious contributing factor to all in-country supply chain problems is high turnover among trained public sector staff, due to their poor working conditions relative to alternatives in the private sector, work abroad and international organizations. Unfortunately (for governments), the better-trained public sector staff are, the more external job opportunities they are likely to enjoy. This issue needs to be considered in the development of UNFPA's GPRHCS, which implicitly depends on one-off capacity building investment.

A further issue concerns UNFPA in particular. UNFPA's reputation (mandate) as donor of last resort gives governments and other donors and incentive to shift their funds elsewhere when funding is tight, in the knowledge that UNFPA will cover gaps and shortfalls. The sometimes marginal position of SRH within policymaking[68] can contribute to such funding shifts. For UNFPA, these unprogrammed calls upon its resources reduce its ability to develop the capacities and systems to prevent these shortages in the first place. The GPRCS policy is an attempt to break this cycle.

3.3.4 Data insufficiency

Lack of data is a problem at all levels, even if it is not always acknowledged. The lack of reliable information for forecasting and logistics has already been noted above. It should also be borne in mind that (for political reasons); UNFPA published no data on the use of medical abortion, though this is an activity with significant SRH repercussions. The UNFPA's GPRHCS does seek to address problems of data sufficiency through its capacity building role, however, as does its 'Channel' software development.

End users are also regularly ignored, and not only (as mentioned above) as regards their preferences. There were 1.553bn women of reproductive age (15-49) in the world in 2000, but the UN only collects data on those who are married or in union (1.047bn), and far less is known about the 0.506bn unmarried women, living mainly in the developing world.

Finally, in the context of pooled funding, support for SRH is often not identified or monitored separately once aid takes the form of budget support or SWAps. This can sometimes force the unenviable choice between pursuing it through separate vertical programmes, and allowing SRH to drop off the health policy agenda altogether. This is an area that the GPRCS does not yet seem to address fully, which may reduce the scope of potential advances.

3.4 Assessment of the likely effectiveness and efficiency (in reaching the programme's objectives) of channelling funds through UNFPA as opposed to other options explored by PRD and UNCD

3.4.1 The GPRHCS

UNFPA's Global Programme on Reproductive Health Commodity Security (GPRHCS) invites donors to contribute to an attempt to address some of the main problems in achieving a reliable and increased supply of contraceptives in developing countries. It is described in more detail in Annex 3.

The GPRHCS does indeed speak to the main problems in SRH commodity provision. First, it promotes expanded donor funding, which as section 3.2 above shows, is of great and increasing need. As such it will act to counterbalance the relative neglect of SRH by other global health

[68] See Druce, N. 2006 *Reproductive Health Commodity Security Country Case Studies Synthesis: Cambodia, Nigeria, Uganda and Zambia Final Report.* DFID Health Resource Centre, London.

initiatives – at least over the short/medium term. If substantial multi-year funding were established, this would also reduce the short-term, volatile and sometimes uncoordinated nature of donor SRH commodity funding at international and country level. This would act to improve national forecasting and planning capabilities.

Perhaps more importantly, the GPRHCS also looks for a means to solve some of the supply chain problems outlined in section 3.3.3, above, over the longer term. This is proposed to be achieved through building country level capacity (primarily with governments, but also necessarily with UNFPA country offices, and with other partners), related to a wide range of interlocking areas, including policy formulation; planning; training; logistics; IT; and communication. The programme concentrates on the lower (in-country) part of the supply chain, which seems warranted as other initiatives are underway along the upper reaches of the chain, including those introduced via the RH Supply Coalition (see section 3.3.1 above and Annex 4 below). While the GPRHCS is directed at product- and, to an extent, service-related problems, by seeking to enhance SRH's position in the policy agenda, it could also lay important foundations for addressing behaviour-related problems[69]. UNFPA support for policy formulation could additionally involve marshalling the types of arguments (e.g. cost benefit studies – see Annex 2) which are likely to persuade ministries of finance to take SRH seriously – another key factor in achieving effective policy change.

As such, as the discussion of the economics of SRH shows (see Annex 2) the programme's objectives are well aligned with the goals of the ICPD and with achievement of the MDGs.

An incentive structure is built into the GPRHCS, which seeks to address the problem of low SRH prioritisation through offering greater resources to those governments seen to be engaging with SRH issues most seriously. These incentives do have the potential to modify governments' behaviour, though only insofar as those incentives are understood and credible, and insofar as UNFPA does indeed provide the required technical assistance to help governments achieve lasting capacity improvement. As is further explored in the Institutional Assessment within this report, it seems that many elements for this are already incorporated within the GPRHCS planning documents. It is to be hoped that additional elements (such as a strategy to interact with pooled funding arrangements where appropriate, the analysis and use of lessons learned from pilot countries, the further development of a monitoring and support network for capacity building at global/regional headquarters and of a clearer policy regarding the circumstances in which governments should finance and/or procure commodities) will soon follow.

If the incentives are effective and appropriate technical assistance is provided by UNFPA, then country ownership and prioritisation of SRH could indeed be engendered, making longer lasting positive change feasible – though it is certainly not guaranteed. Transfer of responsibility to national governments would, over time, also reduce the verticality of SRH procurement and logistics arrangements.

At the same time, organising the programme through a single institution (UNFPA) presents the potential for greater efficiency and effectiveness that can come through economies of scale, scope and organisational learning. This too, however, rests on UNFPA's institutional capabilities (on which, more below), including its ability to learn and scale up from proof of concept countries, as yet undemonstrated. Using an existing institution means that aid architecture will not be further complicated.

[69] Survey evidence suggests that ignorance and social norms are substantial barriers to contraceptive use (see section 3.2.1).

Initial results via the Thematic Trust Fund that has already been established have been encouraging, with progress evident, at least in terms of institutional form[70]. But this data is only preliminary, probably representing the 'easy hits' and enjoying close attention from UNFPA headquarters in a way that a scaled-up version could not. UNFPA is likely to be on as steep a learning curve as are the countries in which it seeks to build new capacities. To an extent, funding of the GPRHCS will inevitably represent a step into the unknown.

An example is that while there are incentives for governments to make many important changes to SRH commodity policy and operations, there is no precise funding 'exit strategy' yet, no definite plan for how UNFPA would finally pass financial responsibility to a government that had made the appropriate policy changes to achieve and maintain Stream 1 status, but whose finance ministry, say, was unwilling to allow the health ministry to meet SRH commodity costs. Thus, there is a risk that in some country settings, increased funds may be expended without achieving the desired goal. Yet it is hard to see how all risk of this sort can be eliminated, without foregoing the opportunity to make major advances.

Two short/medium-term alternatives to the GPRHCS have been considered by DFID. The first was a multi-year core budget commitment to UNFPA for the 20 or so countries considered to be 'fragile states'; the second was multi-year funding through a trust fund (probably World Bank-hosted) to procure commodities and 'contract' UNFPA for capacity building.

3.4.2 Comparison with other options: (1) the Fragile State focus

The first of these options would build upon an earlier contribution by DFID of £5m to UNFPA specifically for RHCS in fragile states[71]. Such funding would be directed to populations with pressing SRH needs[72]. It would also be in keeping with the UN's comparative advantage in fragile states and humanitarian situations[73].

However, one of the challenges of the fragile state environment is that governments there face so many fundamental problems that building the capacity to undertake their own procurement and provision of SRH commodities is still a very distant prospect, local partners are lacking and absorptive capacity is often limited. The prospects of transfer to longer term ownership and procurement financing by government will be slim.

Moreover, such funding would not address poor capacity and systems in stable states, where the bulk of developing country populations live. It is in more stable (also often highly needy) countries that there is the potential for governments to take responsibility for SRH, and so for long-term rather than temporary solutions to unmet SRH need. Neglect of SRH does not always correlate with the overall strength of the state, with some governments that have proved themselves capable in other fields have addressed SRH as weakly as have many fragile states. A concentration of funding in fragile states would not allow UNFPA to shift its modus operandi, from procurement to helping build a lasting solution to SRH need. . It should also be noted that more of the world's poor live in stable countries than do in fragile states.

So, while fragile states will need continued funding and attention (probably for longer than any other countries), concentrating substantial new funds there would miss the opportunity to make the most substantial potential long term progress in SRH in developing countries.

[70] The RHCS Thematic Trust Fund Report for 2006 reports, for example, that by the end of the year 81 countries had established budget lines for SRH; that 77 had established RHCS coordination committees; and that 116 countries included contraceptives in their Essential Drugs Lists.

[71] UNFPA reported in July 2007 that seven countries had been supplied so far, using almost £2m of the funds.

[72] E.g. women and children account for 80% of refugees and internally displaced persons. Source: UNFPA, 2006. *Women are the Fabric: Reproductive Health for Communities in Crisis*. New York. However, it should also be noted that UNFPA's under-funded Humanitarian Response Unit, arguably responding to more dire need, receives no money from the Fragile States initiative.

[73] This is visible in UNFPA's acting on behalf of a wide range of agencies and NGOs in crisis situations.

The GPRHCS also has a stream of funding (Stream 3, see Annex 3), dedicated to meeting the needs of fragile states. Were it considered desirable in the future, funding via this stream could be expanded within the GPRHCS. Thus, funding via the GPRHCS would allow assistance to those suffering from a lack of SRH commodities in both fragile and stable states, whereas a concentration on fragile states alone would exclude the majority stable state population from assistance.

3.4.3 Comparison with other options: (2) a dedicated Trust Fund administered by the World Bank

The second option would address the full range of countries, and would also be in keeping with DFID's policy of reducing the transfer of large funds through UN agencies, whose role in the longer term is not a financing one. It would also bring something of a fresh approach to the issue, involving an institution with a number of advantages: global reach; experience in dealing with finance ministries; health sector expertise; and with experience of successful capacity building in other areas, including financial management and fiduciary oversight.

However, here too, there would be a number of disadvantages. Firstly, this would create a new financing mechanism at a time when it is recognised that the complication of aid architecture has a significant cost. It would also run counter to the views of other, like-minded donors, while UNFPA has a clear international mandate for SRH supply security.

Moreover, while the World Bank does possess a number of capabilities, there are also some doubts about it being an ideal candidate for such a major role in the SRH field. The Bank has not the significant and dedicated expertise in SRH procurement that UNFPA-PSS has[74], nor indeed of SRH commodity demand forecasting – both key functions. It also has mixed experience in championing SRH[75], especially contentious aspects such as emergency contraception and safe abortion. Also, while a trust fund might prove useful in smoothing the flow of donor resources, UNFPA is seeking to accomplish precisely this, through its attempt to secure multi-year core funding for the GPRHCS.

Given these obstacles, and with no other obvious institutional candidates, if the UNFPA is itself institutionally capable, then it would be a preferable vehicle for the proposed funding.

3.4.4 UNFPA's capacity

With the two alternatives considered presenting serious limits to their effectiveness and efficiency, the GPRHCS option would appear the only way forward, provided UNFPA is capable of implementing the policy. There are a number of aspects to this where questions must be raised however. These include the specification of the GPRHCS; definitions of capacity building; planning of how responsibilities will be effectively and permanently transferred from UNFPA to governments; the GPRHCS's incentives for governments, and for UNFPA; monitoring arrangements; UNFPA's own absorptive capacity; development of UNFPA's future role; provision for addressing longer term issues, such human resource leakage; interaction with other relevant policies beyond SRH, such as regarding pooled funding.

These issues are all discussed in more detail in the sections of this report that relate to UNFPA's institutional capacity, below.

[74] There is some criticism of the Bank's approach to quality assurance of SRH commodity suppliers, demonstrated in recent tenders in which it was involved, for example. Source: project interviews.

[75] The (unfortunate) fact that SRH often operates with some degree of separation from central health sector policymaking and operation also means that World Bank health sector experience is often limited when it comes to SRH operational issues. Against this, the Bank is well placed to apply additional pressure to lift SRH up the health policy agenda, and has done so in some countries.

4. INSTITUTIONAL APPRAISAL AND REPORT RECOMMENDATIONS

This section addresses UNFPA's institutional capacity to deliver the programme objectives, reviews progress on the specific issues raised by DFID in section A of the ToRs and then considers other programme issues.

4.1 UNFPA's institutional capacity to deliver the programme objectives

4.1.2 Capacity at HQ

The role of UNFPA HQ is primarily as a facilitator of the Programme: the GPRHCS document states that its role at global level is to facilitate the GP through needs assessment tools, supply side coordination and a focus on access issues. Capacity at HQ has been just about sufficient to develop the Programme and make it available to a handful of countries. However it is questionable whether with current staffing levels they will be able to undertake the necessary facilitation activities in preparation for the full roll out of the programme or whether they would be able to cope with an influx of applications in the event of new funding and support them once approved.

The GPRHCS document is full of good ideas about how the Country Offices can be supported but these now need to be implemented. HQ has to rely on leadership from the field to implement the programme appropriately in line with local circumstances so offices have to be equipped to take on that role. The GPRHCS effectively outlines a strategy for internal capacity building but this should be rolled out as a matter of urgency and should cover HQ's response to Programme demands. A good start has been made with the 'dashboard' developed to help monitoring progress in countries and comparing them with each other which in itself could be a platform for capacity building (see section 4.3.3).

It will be particularly important in the next year that CMB:

- Considers how countries are going to be selected, given that there may well still be more demand than money even with additional funding.
- Completes the RHCS orientation tools and guidelines as described in section 5.1.2 and Annex 2 of the GPRHCS.
- Develops the RHCS Integrated Capacity Development Strategy as described in section 5.1.3 of the GPRHCS.
- Comes up with ways of sharing experiences from country to country through the proposed Lesson Learning Mechanism.
- Formalises its response to the strategies noted by DFID (see section 4.2)
- Finishes developing a coherent monitoring framework for the programme as a whole so that overall programme progress can be monitored.

There is also a need to work more closely with PSS and the Humanitarian Response Unit (HRU) in order to ensure that their contribution to the Programme can be maximised.

There is strong senior management buy in and support to the programme in both the Technical Support Division and the Regional Divisions with whom we met (Africa and Asia). In particular senior staff welcome the opportunity to address underlying problems of commodity security and work more upstream.

Recommendation:
UNFPA should address internal capacity building issues as a top priority over the next year. DFID should consider making any long term funding contingent on this.

CMB should ensure that it is working closely with all relevant areas of the organisation in development and delivery of the GPRHCS. For example PSS and HRU could participate in the RHCS Operational Working Group and the Commodity Working Group. In addition to the three

procurement officers to be based in Copenhagen but who will be part of the Global Programme Management Team, it may also be worth considering having a GP financed staff member in HRU.

4.1.3 Capacity of country offices

A significant challenge for UNFPA will be the country office led implementation of the Programme. Country office buy in is most likely to be an issue not in terms of whether offices want to participate, but whether they wish and are able to participate in the right way. The programme has had a relatively easy start: the 'proof of concept countries' have been limited in number (5), the staff already have many of the necessary skills to work effectively in this area and they have had an opening for the capacity building element of the programme as governments have been receptive to the GP approach. This has also been a manageable number for CMB in New York to support. As a result the programme in these countries has moved swiftly and generated lots of experiences which can help with roll out in other countries.

The challenge now will be to open the doors to other countries where the environment is riskier:

- Relationships with the government may be more difficult
- The political environment may be less conducive to policy and budgetary commitments to RH.
- Relationships with partners may be more difficult
- UNFPA staff capacity may be less

Key areas where capacity challenges at country level are likely to be greatest and present the most risk to the Programme are:

- Moving to closer working with other partners so that the GPRHCS is a truly shared programme particularly where this entails aid modalities which are new to those local UNFPA staff.
- Advocating for greater resources for commodities within a wider health programme environment by using GPRHCS as a lever.
- Helping to develop better systems to deliver commodities and avoiding carrying out independent initiatives that do not take account of wider plans.
- Working with governments to move them away from reliance on UNFPA funding and procurement.

Recommendation:

UNFPA is well aware of these challenges but as discussed in section 4.1.2 needs to formalise its strategies for supporting country offices in dealing with them.

4.1.4 Relocation of regional teams to their geographical areas and reorganisation of the Country Support Teams.

This has only recently been decided so details are not agreed but the intention is to bring better technical support to the country offices by relocating the regional teams currently based in New York and amalgamating them with the Country Support Teams. These CSTs represented a good idea but one that has not worked as effectively as hoped. This new initiative has the potential to build greater capacity in RHCS nearer to the field in a way which is more accessible and relevant for the country offices. However it will also present some risks, of which UNFPA HQ is aware:

- Those remaining in HQ may find it harder to keep in touch with developments in the field
- Regional teams could turn into local empires rather than keeping focussed on country level activities.
- During the period of transition less support may be available to Country Offices.

Recommendation:

UNFPA should give special attention to the decentralisation process to ensure that the GPRHCS implementation is fully supported throughout the transition period and subsequently.

4.1.5 Procurement[76]

Some senior management staff in UNFPA see the GPRHCS as providing an opportunity for the organisation to work more upstream in procurement so that it could be more involved in actively building capacity in country to enable procurement responsibility to be transferred. It could also be engaged in market and product development, supporting the expansion of product ranges, facilitating the introduction of more generics, and improving prices and quality available to countries.

An internal UNFPA draft paper entitled the "Strategic direction of procurement"[77] suggests that the GPRHCS should enable:

- Countries to build the capacity of their national procurement system;
- Broadening supplier-bases, so that countries can buy from UNFPA's pre qualified and audited manufacturers;
- Collaborating with WHO and other partners on the development of standards in RH commodities;
- Providing Long-Term Agreements (LTAs) that leverage procurement volume and the UNFPA brand, for RH Commodities;
- Developing RH Testing and Inspection Capacity, including LTAs;
- Developing in-country RH procurement training and support;
- Developing logistics management, warehousing, distribution systems and expertise in country.

There is some debate about how a more strategic role could be achieved. At the moment much time and energy is spent on third party procurement and the income from this has become essential to the functioning of PSS. It funds nearly 2/3rds of the procurement staff but also makes great demands on their time and is an unpredictable source of income as levels vary considerably from year to year. Such strategic work that PSS is able to do is funded from third party income but this is not ideal and makes that strategic work something that gets done in the margins of day to day business for both financial and work load reasons.

One way to resolve this might be to increase the levels of TPP and market this is as a service to countries and donors so that income from it could become more predictable and create a sufficient margin for more strategic work. There is clearly a demand for TPP among national governments (see table 3 in section 3.3.1) not only because UNFPA is perceived as getting better prices but because it is regarded in many places as a trusted and reliable agent. Also where another donor is funding the commodities a government may see it as more straightforward to agree for the donor to commission UNFPA as procurement agency.

UNFPA PSS and CMB both appreciate this problem, but there needs to be more thinking within the organisation as a whole about how this can be addressed, especially if PSS is to take a more central place within the GPRHCS and ultimately redefine UNFPA's approach to procurement. The Supplies Coalition should be engaged in the debate as it is on its members' behalf that TPP is sometimes carried out. There is a risk that the Programme will be implemented without this fundamental reappraisal of PSS's role and function unless there is strong leadership from UNFPA senior management to address this issue. PSS could become more preoccupied with day to day procurement for the GPRHCS as funds increase and not take on the wider strategic role that will enable better country capacity development or market development activities

Recommendations:

CMB and PSS need to establish PSS's role in the implementation of the GPRHCS.

[76] See also section 3.3.1, above, for discussion of UNFPA's procurement function.

[77] Strategic direction of procurement", D. Smith, Draft 19 May 2006

Senior management needs to make a commitment to UNFPA procurement moving upstream, and agree how this may be achieved.

DFID may wish to consider allowing specific funding to PSS as part of the GPRHCS contribution (beyond the three posts already allowed for).

Ideally PSS staff should all be core-funded. Then TPP will not be so disruptive and could be hived off as a separate activity.

4.2 Progress on Programme strategies (See section A in the terms of reference)

The GRHCS document has been finalised. UNFPA has continued to develop its thinking on implementing a programme which potentially has much greater levels of funding but this has yet to be formalised into an implementation plan, so development of the strategies below is still in process. More work will be done when the first 'proof of concept' Global Programme countries have progressed further and lessons can be learned from their experience.

Meanwhile it has been strongly recommended to UNFPA that they formulate a plan to develop these strategies. There is clearly considerable thinking going on within the organisation but the ideas need to be documented, articulated round UNFPA and driven forward as a concerted programme of work, as discussed in the previous section. The focus needs to be on supporting country offices to implement the programme and address these issues themselves as it is at country level that many of the key programme activities will take place especially in the area of national capacity building.

Recommendation
UNFPA should formulate a plan to develop these strategies based on lesson learning from the proof of concept countries

4.2.1 A vision for increasing SRH commodity security globally through:

- *An organisational advocacy strategy for encouraging governments to take up their responsibilities.*
  UNFPA staff were enthused by the challenge of getting government to take more leadership both in policy and financing and believe that the ability of UNFPA to fund capacity building activities and some commodities will act as a lever to help achieve this. Over the last few years the debate in UNFPA especially at HQ has become more in tune with DFID thinking about how this leadership can be encouraged. For example there is a greater appreciation for the need to get RH issues and commodity security reflected in national strategies and plans such as the PRSP and health sector strategy. In particular UNFPA is concerned to ensure that there is a government budget line for commodities and allocations made and disbursed against it; this is used as one of the Programme monitoring indicators. Experiences in the implementation of the Thematic Trust Fund have been encouraging as discussed in section 4.4.1. UNFPA has been successful in urging governments to establish budget lines, set up RHCS coordination committees and include contraceptives on essential drug lists.

  Substantial capacity building of national governments (and local civil society) will be essential to encouraging them to take up their responsibilities. Hesitancy by governments to take a stronger role comes in part because they know they cannot carry out forecasting, procurement and distribution to the standard required to ensure continuity of supply. UNFPA's scope to support long term capacity building through the GPRHCS has the potential to address this problem and therefore the Programme could give significant 'added value' to UNFPA's advocacy work in country. Without the capacity building

element of the Programme there is a risk that funds spent on supplies will offer a short term solution at best and not tackle underlying problems. UNFPA will have to be aware however of the risk that capacity building can still lead to dependence unless it is done well; the Agency will need to have clear exit strategies and timebound plans firmly negotiated with government, and ensure that governments fulfil their obligations so UNFPA does not find itself more deeply embroiled in national procurement problems. Also, the problem of staff turnover must be addressed, or the capacity that is built will steadily leak away.

UNFPA should also give thought to how it may contribute to capacity building in shared procurement, delivery and forecasting systems. As countries are encouraged to move away from vertical programming towards more integrated approaches it is appropriate for UNFPA to support wider initiatives to improve systems even when the use of these systems for SRH commodities may not yet be feasible. The Agency should give thought to investment in systems improvements which may have long term gain.

Recommendation:
UNFPA should continue to develop its thinking in this area and ensure that the lessons learned from recent and current experiences in both Proof of Concept countries and the Thematic Trust Fund on RHCS are captured and disseminated.

UNFPA needs to consider when and how it will contribute to other wider national systems development initiatives such as the improvement of procurement processes, and socioeconomic analysis and planning [this is how to ensure the poor benefit]. In countries attempting to integrate procurement and distribution systems for all health commodities UNFPA should commit to contributing to building these wider systems alongside other development partners.

- *A market development plan for increasing global availability of new products.*
  There are elements of a market development plan in the minds of some UNFPA staff. For example the UNFPA Procurements Services Section is keen to improve availability of new products in the areas of female condoms for example, and to generate wider availability of generics across several existing products. The prequalification initiative being undertaken with WHO is expected to play a major part in achieving this and UNFPA is working closely with them on it. Again however these have not been formalised into a written plan that has staffing and funding and support from the top of the office. Part of the problem is lack of capacity in the procurement team to develop and implement these ideas, as discussed above in section 4.1.5.

  Some activity on the demand side is underway: a couple of the Proof of Concept countries interviewed have initiatives at national level although it is not clear that these are beyond what UNFPA may have been doing anyway. Centrally UNFPA is working with the Coalition through the Market Development Approaches Working Group (chaired by a UNFPA staff member) and there is discussion of a fund to support market development activities. The Working Group is also engaging with the manufacturers to consider innovative public private partnerships to improve supply. As a Coalition member, UNFPA has also funded some work, such as market segmentation studies and potential for developing new non subsidised markets for generic products in middle and lower middle income countries with IPPF ICON and PSI.

Recommendations:
UNFPA should further increase its support for pre-qualification efforts, so that this becomes a sustainable and institutionalised policy[78] (an investment which should exert downward pressure on SRH commodity prices, as well as helping maintain quality, as generic manufacturers are encouraged to invest).

UNFPA should consolidate its thinking on demand side activities and particularly focus on potential work to address the private sector.

- *A plan for leveraging funds from other donors at both country and international level.* Again UNFPA staff are very conscious of the need to do this leveraging and have various ideas about how it may be achieved but these are not written up into a plan that pulls everyone together and helps them do it. UNFPA is clearly active in the Coalition, taking the lead on some working groups and being active members of others as well as supporting other work undertaken by the Coalition but there may be greater potential for UNFPA to take a more central role in particular in the development and application of the proposed pledge and minimum volume guarantees (see annex 4). Similarly if UNFPA is to do less third party procurement and more advocacy to encourage other funding, the Coalition will be an essential forum.

  The country offices we spoke to talked about various ways they were trying to encourage other partners particularly through promoting joint ownership of national action plans. We have some concerns that UNFPA is not yet pooling funds as much as it should given the context in some countries and the fact that it still has some programme funds to allocate for implementation. It should address this issue; the willingness to pool could be seen as a barometer for UNFPA's understanding of the current aid environment and how to engage with it. This may not be appropriate long term if UNFPA is no longer to fund in the future but participation now can be a valuable step to influencing later, and promoting a common agenda; also from the point of view of a government wanting coherent participation amongst its partners it is one thing for UNFPA not to pool when it does not have money, but another when it *could* do so but is seemingly not prepared to.

  The example from Tanzania is a positive one: UNFPA participation in the pool since 04/05, their better relationship with other donors and their clear commitment to supporting the development of government ownership and systems has encouraged both the basket fund and the government to make allocations to contraceptives from budgets from 05/06 onwards, and to spend even more when necessary. At HQ as well the debate has moved on considerably over the last 3 – 4 years and there are stronger messages from the top of the office. The GPRHCS has the potential to bring important field experiences to the fore and share them round other country offices if an explicit plan to do so is formulated.

  Recommendations:
  UNFPA should examine its role in the Coalition to identify more opportunities for leadership and engagement.

  UNFPA should consider a clearer policy on pooling that sets conditions when it might refuse to join a pool. If these conditions were met, it would then be incumbent upon UNFPA to join a pool so that the contribution of at least some funds becomes the norm rather than the exception.

[78] PSS has estimated that $490,000 would be required to undertake the necessary inspections of condom and IUD manufacturing facilities in 2008. It is not yet clear what if any funds will be forthcoming.

4.2.2 A strategy for withdrawing from financing and procuring SRH commodities in low income stable states over the medium term

As a UN organisation the term 'withdrawing' is problematic for UNFPA, and they are considering alterative wording to this strategy. They will however talk in terms of support 'evolving' according to countries' needs either because their requirements for commodities or capacity building may change or because they shift category, for example from A to B which affects their core funding (see footnote in section 4.2.4 which explains core funding allocations). Whilst UNFPA therefore will not stick to a predetermined timetable which takes no account of changes in local circumstances they will however continue to negotiate how that support will evolve with the aim of refocusing away from commodity support and capacity building. The key issue here is the extent to which they are agreeing milestones with governments for changing levels of commodity support and how they are working to achieve these. At this stage milestones do not seem to be agreed, but this in part reflects the lack of long term funding for the Programme.

Various people in UNFPA agree that some of their work approaches provide disincentives for government to fund their own commodities; for example some recognise that a relationship with an RH Division in an MoH which led that division to rely heavily on UNFPA for technical and commodity support could not only provide a disincentive for that RHD to lobby for government resources for commodities but could also take capacity away from their ability to do so. It is also recognised in the organisation that being an emergency provider provides a safety net which whilst necessary is also problematic; UNFPA has been criticised for stepping in too soon, but the impression we gained is that this decision is not taken lightly or without considerable consultation within the organisation, and that UNFPA has declined to give support on occasion. The problem of possible contradictory incentives brought about by TPP is also recognised.

Within the GPRHCS there is the potential for UNFPA to address these issues more specifically and strategically with governments. The funding for capacity building, coupled with that for commodities that UNFPA will be able to act as a strong motivator for government to negotiate milestones and should give UNFPA more scope for being explicit about disincentives and over reliance on emergency funding. Without the GPRHCS there is a risk that reliance on short term measures and emergency support will continue even in countries where capacity could be much greater. However in the context of the GPRHCS UNFPA will still need to focus on holding to its agreements with governments and be prepared to be tougher than it has been in the past. Backing from donors at Board and country level will be essential to encouraging UNFPA to stand firm where governments are failing to meet their targets. Through the GPRHCS the Fund will be exposing itself to potential criticism and there is a risk that it will not be strong enough to withstand this.

Recommendations:

UNFPA needs to ensure that clear and concrete time bound milestones for evolving support are built into agreements with governments. These milestones should focus on progress in monitoring, systems development, nationally led coordination and funding commitments which are realised.

UNFPA needs to pay particular attention to the problem of incentives *for governments* when working with Country Offices and undertaking capacity building with them, to ensure that staff understand what is expected of them and how to achieve it.

UNFPA needs to maintain dialogue with its donors at Board and Country level on challenges and risks to reducing funding in some countries and be open about national pressures and circumstances which may compromise the Programme.

4.2.3 A strategy to ensure a country led approach

The points above cover some of the issues that need to be addressed to support the country led approach and support national systems: redefining UNFPA's strategic role in supporting national procurement, greater preparedness to pool funds to promote a shared agenda, and encouraging government partners to be less reliant on parallel funded activities. More could still be done by UNFPA to work more closely with other partners in support of country led plans, but we gained the impression that approaches and understanding at least at HQ and in some of the country offices have moved forward. Again however there needs to be more structured lesson learning based on field experiences. A more explicit policy with regard to pooling could also support this as discussed in section 4.2.1.

UNFPA should also consider whether in countries which develop good capacity for procurement but have an acceptable problem with funds whether it should hand over procurement responsibility to government and allow it to use GPRHCS funds. This would necessitate close working with PSS to establish a policy and criteria for this to happen.

Recommendation:

Internal capacity building and advocacy activities over the next year should specifically address how to promote a country led approach.

UNFPA should consider a more a more explicit policy for the GPRHCS on the circumstances and the process by which procurement responsibility may be handed over to countries.

4.2.4 A strategy to enable core funding of the programme

UNFPA proposes that any DFID funding is paid into the UNFPA core budget with a directive from DFID that this is for the GPRHCS. The money will be allocated to the GPRHCS Thematic Trust Fund and DFID would receive reports for this pooled money as a whole i.e. not specifically for its own expenditure. Effectively this is soft earmarking and UNFPA is prepared to do this immediately.

We had extensive discussions with several parts of the organisation about simply allocating it to core funds. This could be done (although senior staff were generally very unhappy with the idea), but the funding will then be subject to the UNFPA allocation process which is set by the Board. Unfortunately there seems to be a disconnection between the resource allocation process and the MTSP. This allocation process is based primarily on the needs of the countries for UNFPA assistance as shown by a set of indicators which measure how far counties are from attaining the targets of ICPD+5, rather than solely on what UNFPA is trying to achieve within a given period i.e. the MTSP[79]. There is some flexibility to determine the split between HQ,

[79] The Review of the system for the allocation of UNFPA resources to country programmes explains: "The current system is based on a set of eight indicators and their thresholds: proportion of births attended by skilled health personnel; contraceptive prevalence rate for modern methods; proportion of population aged 15-24 years living with HIV/AIDS; adolescent fertility rate; under-five mortality rate; maternal mortality ratio; literacy rate among 15-24 year-old females; and age dependency ratio of females. Countries are classified into A, B and C groups based on the threshold levels they have attained for the eight indicators. Group O consists of other countries for which detailed data are not available and/or those countries that have received limited or temporary assistance.
Under the current system, the groups of countries are defined as follows: any country that meets the threshold levels of 0-4 indicators and has an annual gross national income (GNI) per capita of less than $900 is included in Group A. All least developed countries (LDCs) are automatically included in Group A. Countries that have met the threshold levels for 5-7 indicators or countries that have met the threshold levels for 0-4 indicators but whose per capita income is more than or equal to $900 are categorized as Group B countries. Countries that have met the threshold levels of all eight indicators are categorized as Group C countries. In addition, the system includes other countries (Group O) that receive limited assistance from UNFPA". From The Review of the system for the allocation of UNFPA resources to country programmes July 2007.
See: http://www.unfpa.org/exbrd/2007/secondsession/dpfpa_2007_18.doc

regional and country level programmes such that this year there has been a greater proportion allocated to country level, but funding inputs are not closely tied to outputs or outcomes. There is however efforts to link the two more closely by sharing selected indicators as proposed in a recent review (see previous footnote for source). The term 'core funding' is in some ways a misnomer because it is the trust funds and other flexible contributions from donors at various levels that enable UNFPA to direct itself towards carrying out the specific outcomes of its strategic plan.

The increased commitment to RHCS in the MTSP could be taken as an indicator that more activity will be done on it and therefore more core funded activity will support it; moreover the intention to allocate a larger proportion of core funds to country offices could also afford greater support to RHCS. However the wide demands on core funding and the way funds are allocated are such that the impact on commodity security will be less than if the funds are channelled solely into the TTF. For example they will not necessarily go where most needed for that specific objective, or where the commitment by government to address RHCS is strongest which would undermine the incentive element of the programme; the resource allocation formula is not sensitive enough to take these into account. There is some room for adjustment after allocations have been made but this is not significant.

This resource allocation process has recently been reviewed. However our understanding is that for core funds to be allocated more sensitively and more in line with the MTSP and the objectives of specific programmes such as the GPRHCS there would need to be a revision of the fundamental process - and this would be a highly political issue. Whilst the problem presumably would need to be addressed as part of UN reform, any allocation by DFID may not be the lever to solve the problem and if embarked upon would not generate greater commodity security at least in the short term.

In the interim it *may* be possible for DFID to establish what is spent on RHCS in total by requesting a breakdown from UNFPA which covers both core funding and the TTF. The financial systems may be able to deliver this information.

Recommendation:
We recommend using the soft earmarking approach suggested above for any allocation, but maintaining dialogue with UNFPA and engaging with the wider UN reform agenda to seek a long term solution to the resource allocation problem. Meanwhile the existing Trust Fund should remain as it is.

DFID should encourage UNFPA to establish what is spent on RHCS as a whole, from all funds. However, this should be part of obtaining information about spending on other programme or strategic priorities, to ensure an overall picture.

4.2.5 A plan to explore how the procurement of health commodities by the UN can be rationalised.

There are already initiatives underway to improve procurement in the UN such we do not believe that any more action is necessary within the specific remit of the GPRHCS. UNFPA is an active player in current initiatives in the context of UN reform which affect procurement. For example Thoraya Obaid is the Chair of the Higher Level Committee on Management. In addition UNFPA staff are active in the Inter-Agency Procurement Working Group which was brought together by this Committee (based on a previous networking group) to carry out consultation on procurement in the context of one UN at country level, and to review procurement rules. There is already a degree of rationalisation on which to build in that there is a lead agency arrangement whereby

UNFPA leads on RH commodities and UNICEF on ARVs for example, but this needs to be brought down to country level more effectively where some agencies overstep the bounds and procure outside their remit unless caught and constrained. UN reform is expected to address this problem, among others.

4.3 Other issues:

4.3.1 The Global Programme in the context of the draft Medium Term Strategic Plan

Supplies security and the GPRHCS are adequately embedded in the Medium Term Strategic Plan:

- "Focus area 2: Reproductive Health and rights" makes specific mention of "lack of access to affordable commodities as a major obstacle to universal access of reproductive health and HIV prevention" under lessons learned.
- The MTSP recognises that ensuring a reliable supply of commodities is a key component of health systems strengthening which should be undertaken by UNFPA. In addition national budgets and plans should support this.
- It highlights the GPRHCS and makes reference to UNFPA working with partnership with the RHCS coalition in the context of the programme.
- It addresses the need for wider changes to promote commodity security and the UNFPA role in facilitating these changes especially in the areas of increasing demand through such strategies as behaviour change communication and community mobilization, enabling communities and individuals to claim and exercise their reproductive rights, and encouraging service providers to understand their duties to respect, promote, protect and fulfil reproductive rights.
- In emergency situations it recognises the importance of implementing the Minimum Initial Service Package including the supply of RH commodities.

Importantly the MTSP highlights national capacity development as the central thrust of UNFPA's work at country level, including developing systems for improved performance in the area of RH commodity quality, coverage and effectiveness

4.3.2 The MTSP as a strategic context for achieving commodity security

The MTSP also creates a strategic context in which commodity security could be more effectively developed:

- Advocacy is emphasised: the document stresses a strategic engagement in advocacy globally, regionally and at country level.
- It undertakes to focus on more effective dialogue to promote increased allocations or national and international financial resources for population and RH related programmes.
- UNFPA aims to strengthen knowledge-sharing and internal capacity building to better respond to the changing development environment.

It presents a better system for performance management. Through the Performance Assessment and Development system the strategic objectives of the organisation will cascade down through staff and office work programmes. This will be coupled with more systematic and organisation wide feedback on performance through the 'balanced scorecard' which will eventually be expanded to cover programme as well as management outputs. In addition the management results framework in the MTSP identifies nine management outputs for which UNFPA will be accountable which address better results based management at all levels; in particular the focus on capacity building of staff, more effective partnerships, and becoming more field focussed will support the approach in the Global Programme. This performance management system should help promote country office buy in to both the programme and the means by which it is to be implemented.

There is emphasis on working within more upstream aid modalities, including the pooling of funds where possible. UNFPA is still rather slow to move forward in this area (though ahead of possibly most of the other ExCom agencies) and still has some way to go in understanding at HQ about the need to pool funds in order to promote a shared agenda of RH and to lever other funds. However they are working on it, some field offices are engaging much better with the wider aid management environment and really leading the way in the organisation and spurring it to move forward, and there has been considerable progress in thinking over the last 3 – 4 years, such that UNFPA now has some success stories e.g. Tanzania from which to learn.

4.3.3 Performance assessment framework of the MTSP

With regard to the performance assessment framework the picture is mixed. The internal performance management processes as outlined in the MTSP and discussed in section 4.3.2 will help with the effective delivery of the GPRHCS. Some of the Management Results Framework Indicators could very broadly, and at a very high level, suggest appropriate implementation of the Programme e.g.:

Output 4: Effective partnerships that protect and advance the ICPD agenda to be maintained and expanded.
Indicator: Percentage of stakeholders assessing UNFPA as a trusted partner.

Output 9: UNFPA will have become a stronger field focussed organisation.
Indicator: Percentage of partner survey respondents considering UNFPA country level presence as adequate for effective and quality programme delivery.

However in terms of monitoring commodities security there are no indicators in the MTSP which directly show progress in achieving greater levels of security. Unmet need for family planning, demand for family planning, adolescent fertility rate and CPR come nearest but these could all change independently of changes in commodity security. Other indicators which may point to better system performance and availability are 'proportion of service delivery points offering at least 3 modern methods of contraception' and 'condom use at last high risk sex' although again these are not particularly sensitive to RHCS. Similarly the indicator which aims to measure the 'proportion of countries with national development plans that allocate resources for an essential sexual and reproductive health package' will not show whether those resources were actually disbursed as planned. It should be noted that many of these indicators are new and that baselines will not be immediately available for all of them.

All the regional programmes documents except the one for the Arab States, place achieving RHCS as central to their RH Programmes (Africa through the Maputo Plan of Action). Monitoring however is less consistent. For example both Africa and Asia regional programmes have included improved RHCS as a specific, though differently worded output and the indicators are also different.

For Asia:

Output: Enhanced regional capacity to forecast, plan, manage and budget for securing essential RH commodities
Indicator: Number of countries with in-country capacity to forecast contraceptive requirements with a functioning MIS.
Comment: The indicator implies a limited definition of security, and in itself needs indicators; e.g. what is the measure of 'functioning'? How accurate do forecasts have to be?

For Africa

Output: Strengthened capacity of regional, sub-regional and national partners in RH Commodity Security.

Indicator: Proportion of countries with: situation analysis in past 3 years, multi-year national RHCS plan, RHCS included in list of essential drugs, RHCS budget line, and national mechanism to monitor RH stocks and flows including stock-outs.

Comment: The indicator is more comprehensive but needs a measure of how successful the improved systems and inputs are, e.g. number of stock outs.

Variations between the regional programme indicators would be less of a problem if the GPRHCS currently provided a comprehensive means of monitoring commodity security as discussed in the next section.

4.3.4 Monitoring of GPRHCS

With regard to the monitoring of GPRHCS at programme level there is a logframe which aims to encapsulate the complexity of the programme and measure processes such as capacity enhancement as well as more concrete things like whether commodity needs have been met. However it is not designed to monitor the entire programme. The Programme proposes that 'The Indicative Logframe is intended to facilitate the development of national Logical Frameworks but is not prescriptive. All or some of the Objectively Verifiable Indicators detailed below may be retained or adapted. Equally other indicators may be developed.'

The Dashboard system currently being developed by CMB will be the main tool for monitoring RHCS capacity building processes and results in country and its development should inform the development of indicators and the possible revisiting of the logframe. The Dashboard is a questionnaire which COs will complete at regular intervals which will monitor progress on such issues as the development of national action plans, coordination, partnership, and country office capacity. The scores generated will be openly available to other country offices and will enable self comparison across the Programme. The tool is intended to develop as the Programme rolls out with new indicators being added as appropriate. The idea is a new and interesting one with considerable challenges for implementation not least how to agree indicators amongst stakeholders so that different countries and situations can be monitored in the same way and how the indicators are weighted to show progression across time. The plan is to field test the questionnaire in 10 pilot countries by mid August, present it to partners during the coalition meeting in October and get input from stakeholders, carry out necessary revisions, and then roll it out by the end of the year.

The Dashboard however focuses primarily on Stream 1 and 2. The Programme therefore still needs some common indicators to measure overall progress of the Programme in:

- The level of provision of commodities funded, how these changed over time within each country and across countries, and whether these were planned or emergency,
- The overall impact on commodity security: for example whether countries moved from needing emergency assistance to only needing planned support, whether the programme has had an impact on overall availability of commodities.

Some of the indicators in the current logframe could be used to monitor overall programme performance but a logframe for the programme as a whole needs to be developed.

Ideally this logframe should also give some indication of the impact of the Programme as a whole on issues such as how access for the poor is improved. Given that a key problem of current SRH services is that they are often not very pro-poor (see section 3.1), and the poor are

disproportionately affected by bad SRH, the Programme should seek to demonstrate how additional funding from DFID and other donors can counteract this situation.

Recommendation:
UNFPA in the course of developing the Dashboard should also develop a set of indicators and a logframe that show Programme progress across all three streams.

These should monitor progress in implementing the programme (e.g. whether the capacity development tools have been created), changes in capacity in those countries where the programme operates and most importantly the status of commodity security in and across countries. Ideally the last indicator should be in the MTSP, but in its absence this monitoring should take place at programme level.

4.3.5 UNFPA's financial and fiduciary risk management arrangements.
In some areas there is little financial or fiduciary risk in the GPRHCS:

- The proposal for allocating the DFID funds to the GPRHCS Thematic Trust Fund via core funding (see section 4.2.4 above) would result in a management arrangement similar to the one in existence for the Thematic Trust Fund on RHCS which is currently acceptable to DFID. There will be pooling of funds and reporting against this pool.

- Expenditure on GPRHCS activities in country will be managed alongside other UNFPA funds where there are adequate checks in place.

- Procurement using GPRHCS money will be done by UNFPA which is rigorously controlled according to UN standards.

A possible concern that funds for capacity building will be diverted to emergency commodity procurement does not seem likely to be a serious risk. The Chief of CMB is regularly asked for funds for emergency procurement but has the backup of the senior management in his process for prioritising requests and does not meet them all not simply because of a lack of funds. The enthusiasm in the organisation for funding for capacity building and the expectation that this will help lessen emergencies we anticipate will protect capacity building finances

There are some possible areas of fiduciary risk. There are questions as to whether: too much money has been allocated for capacity building and that the absorptive capacity for some country offices and governments will not be sufficient. Whilst keeping the figures in the GPRHCS as rules of thumbs to work out how far funds could go, it may be more appropriate to not specify the amount of funding available but take each case on its merit.

Recommendation:
UNFPA should consider this suggestion along with whether the capacity building/commodity funding ratio should be maintained, or again decided on each case**.**

All the activities that might be undertaken in the name of capacity building for RHCS should actually be funded by the GPRHCS. In the countries we spoke to the range of activities was huge and some fitted more obviously into the Programme than others from an outsiders view although they were no doubt valued by the recipients. The first Programme output of "integrated approaches to RHCS improved at all levels in country" is a bit of catch all.

Recommendation:
More guidance is needed to ensure that the programme is not supporting 'business as usual' but is guaranteeing additionality.

We recommend elsewhere in 4.2.1 in the report that UNFPA open up the option of pooling GPRHCS funds at country level where there is a national plan for capacity building as well as some form of pooled or basket funding. It is potentially damaging to national capacity to maintain parallel funding arrangements in this environment and better joint ownership could be achieved by working with other development partners in this way. Where UNFPA chooses to do this there will be fiduciary risks which it should anticipate in advance and consider how it will manage them in conjunction with other partners. Moreover in many of these cases DFID should not be concerned about the risk to contribution to the GPRHCS as they will already have joined the pool and in some cases moved to sector or general budget support already.

4.3.6 UNFPA and other donors.

To the extent that we were able to gauge in the course of this appraisal, UNFPA is an important player in the Supplies Coalition and the Coalition has played a valuable role in the development of the GPRHCS (and aims to continue to be so), especially in the selection of 'proof of concept' countries. The idea that it is a shared programme for all partners in commodity security seems to have meaning at the level of international coordination.

The development of the pledge and minimum volume guarantees as proposed in the McKinsey report (see Annex 4) has been a complex and difficult topic for all parties concerned, including UNFPA, but it has worked closely with donors on the development of the ToRs for the proof of concept exercise, it will be part of the test and can be expected to be central to any implementation of the guarantees.

At country level the picture is more mixed, depending as it does on the capacity of the country office and the representative in particular to work out the shared ownership idea in an environment where some UNFPA offices have been more accustomed to working bilaterally with government. From the conversations we had with field offices there is clearly good working locally with partners on specific commodity security plans but in some places there needs to be greater coordination beyond that relatively small group in order to build wider ownership of the RG agenda and therefore the CS one too. As discussed in section 4.1.3 this is an area where capacity building led by HQ and supported by the regions should help the country offices.

Recommendation:

UNFPA, in the course of capacity building should give special attention to helping local offices develop shared ownership. This should be back up messages from the Coalition to demonstrate shared ownership at international level

4.3.7 Coherence with UN reform

At this stage in the UN reform process there does not appear to be a contradiction with the approach of the GPRHCS. Experiences in some countries where both UN reform and the GPRHCS have been piloted have been positive in that no loss of focus has been reported. Again however both sets of countries were chosen with swift gains in mind, it is early days for both the programme and UN reform, and challenges lie ahead where the local environment is more difficult.

In those countries interviewed in the course of this appraisal where UN reform was not yet underway the UNDAF process already requires some joint working and UNFPA was positive about the potential for joint working on underlying capacity problems regarding such issues as procurement; even UNFPA procurement is likely to benefit where there is better local coordination and less risk of encroachment by other agencies. In One UN countries it is expected that there will be one plan and it will be important that the GPRHCS is part of this if appropriate; if it is not included the people interviewed thought it likely that implementation of the programme could continue but were unsure how much of a focus or priority it would be. UNFPA will need to monitor UN reform as it develops in practice to see how this will play out in practice.

Procurement is likely to benefit from economies of scale and scope provided it is adequately resourced

ANNEX 1 TERMS OF REFERENCE

Proposal appraisal: UNFPA financing for sexual and reproductive health supplies and capacity building

Background: DFID recognises the need for SRH supplies, given high levels of unmet need in low income countries, and the impact of fertility control on the MDGs and on population stabilisation and climate change. Depending on the outcome of the Comprehensive Spending Review in late summer/autumn 2007, DFID is considering the allocation of additional funding to UNFPA. PRD and UNCD have agreed that UNFPA is the most appropriate channel for scaling up supplies financing, given unsuitability of other options examined.
The UNFPA proposal must ensure alignment with UN reform processes and the inclusion of appropriate targets and monitoring arrangements embedded within UNFPA's new medium term strategic plan (2008-2011). See note A for important components recommended by DFID for UNFPA to consider and include in their proposal. DFID documentation required for the submission is: a two page project rationale (cf a PCN), that forms the basis of the agreement/MOU with UNFPA; an economic and institutional appraisal of UNFPA's proposal; and a monitoring framework (that is embedded in UNFPA's MTSP).

Purpose and approach: To inform the decision making process, PRD and UNCD has agreed to commission two external consultants to develop the institutional and economic appraisals. Consultants will need to work in close liaison with the ARH team in PRD, and UNCD, and with UNFPA itself. Visits to UNFPA in New York and possibly to a couple of UNFPA country offices may be necessary. UNFPA has already developed a detailed proposal for the Global Programme for RHCS, which should be reviewed, along with other documentation and studies.

Outputs:

1. Economic appraisal, to include:
- Summary of the economic case for SRH supplies (health, poverty reduction and population stabilisation benefits, and benefit of investment versus other health investments)
- Analysis of current and projected markets, role of public versus private sector funding, reasons for gaps and shortfalls at country level in different contexts (fragile states, stable low income countries and middle income countries) (NB new data collection should not be necessary: several studies commissioned by DFID, Gates and UNFPA, as well as existing data sets are available)
- Assessment of the likely effectiveness and efficiency (in reaching the programme's objectives) of channelling funds through UNFPA as opposed to other options explored by PRD and UNCD

2. Institutional appraisal, to include:
- Assessment of the degree to which UNFPA has taken into account and incorporated DFID's suggestions (at Note A) into its revised programme approach, and likely effectiveness of the extent to which proposed strategies will be successful
- Review of the draft Medium Term Strategic Plan to ensure that supplies security is embedded as UNFPA core business, and that the performance assessment framework covers DFID reporting requirements
- Assessment of UNFPA's financial and fiduciary risk management arrangements. This should include potential linkages between its financing and procurement functions and the proposed mechanisms to be piloted by the Reproductive Health Supplies Coalition to smooth funding flows and get better value for money (pledge and minimum volume guarantees)
- Exploring the longer term feasibility of channelling the additional funds to UNFPA's core budget, including the best options for managing the transition period, and roles for soft earmarking, the existing trust fund etc

- Assessment of UNFPA's institutional capacity to deliver the programme objectives, and risks that need to be addressed at country and HQ levels: including the structuring and likely effectiveness of performance management arrangements and other incentives for progressively shifting the financing of supplies to country governments.

Inputs and timeline: Two consultants will be commissioned through the DFID Health Resource Centre to undertake the work, which should be completed in draft by mid August.
Up to ten desk based days will be allocated for each appraisal, with a further 15 days for travel by one or both consultants as necessary to UNFPA New York and/or country offices (i.e. 35 days total). The budget will include expenses to cover two visits to New York, and a visit to one country office in sub Saharan Africa. The work will be managed by Nel Druce, who is a consultant adviser with DFID's AIDS and Reproductive Health team, and Julie Jones, ARH team, DFID.

Note A:
PRD and UNCD are recommending that UNFPA further consider and address the following issues in the proposal. These points have been shared with UNFPA.
- Vision for increasing SRH commodity security globally, including: an organisational advocacy strategy for encouraging governments to take up their responsibilities; a market development plan for increasing global availability of new products; and a plan for leveraging funds from other donors at both country and international level (e.g. GFATM, UNITAID, World Bank, bilateral), through fora such as the Reproductive Health Supplies Coalition (which includes UNFPA).
- In consultation with other international partners, for UNFPA to develop a strategy for withdrawing from financing and procuring SRH commodities in low income stable states over the medium term (5 years), together with addressing both government and UNFPA incentive structures to build capacity and transfer procurement and other functions to government
- A strategy to ensure that at country level all activities and funding related to SRH commodity security will be done in a way that supports the country led approach and supports national systems, in accordance with the country context and policy environment (fragile states, low income countries, others incl. MICS).
- Institutional issues and arrangements - to include UNFPA's organisational and strategic response to SRH supplies, inclusion in MTSP, processes for country office buy-in, relationships with other donors and implementers, including the RHSC
- a strategy to enable DFID (and other donors) to move progressively towards greater unearmarked long term financing, which in the short term may require that the money for commodities needs to be as "core as possible", for example by being soft earmarked core funds in support of SRH commodities.
- All activities in line with UNFPA's UN reform processes and plans, and include working with others in both pilot and non-pilot countries.
- A plan to explore how the procurement of health commodities by the UN can be rationalised

ANNEX 2 THE ECONOMICS OF SRH COMMODITIES

Poor sexual and reproductive health (SRH) contributes a fifth of the global disease burden in women (their leading cause of death and ill health) and more than 13% in men. By comparison, HIV/AIDS is estimated to cause only around 6%. When men and women are combined SRH is the second highest cause of ill health, after communicable diseases[80].

The annual toll within developing countries includes more than half a million maternal deaths following unintended and unwanted pregnancies (e.g. via deaths in childbirth, unsafe abortions), around 4 million perinatal deaths and over 8 million nonfatal morbidities[81]. The poorest are disproportionately affected. In Sub-Saharan Africa (SSA), poor reproductive health (RH) accounts for nearly two thirds of disability-adjusted life years lost among women of reproductive age. In the poorest African countries one in six women are likely to die as a consequence of pregnancy.

The same lack of RH commodities (i.e. condoms) also contributes to the spread of sexually transmitted infections (STIs). In 2001, the WHO found there to be some 340m curable STI cases globally, with 69m in SSA and a further 151m in South and Southeast Asia. Most of the 14,000 new HIV infections every day are via preventable sexual transmission.

The good news is that SRH is an area in which preventive care is both simple and potentially economically efficient to provide.

ICPD and MDGs

SRH has important implications for attainment of the 1994 International Programme of Action (ICPD) Programme of Action, the Beijing (World Conference on Women) Platform of Action and the Millennium Declaration's MDGs, all of which are mutually reinforcing. Several of these commitments assert RH as a basic human right.

While universal SRH care was not made into an explicit MDG, despite its consideration, SRH will play a major role in determining whether the following MDGs are met:

- MDG 1: Eradicate poverty and hunger
- MDG 3: Promote gender equality and empower women
- MDG 4: Reduce child mortality
- MDG 5: Improve maternal health – the MDG toward which countries have made least progress (in Africa, little or none).
- MDG 6: Combat HIV/AIDS, malaria and other diseases
- MDG 7: Ensure environmental sustainability

Given SRH's key role in achieving so many MDGs, the UN has now approved a new target for consideration under MDG 5 calling for "universal access to reproductive and sexual health services through the primary healthcare system by 2015". This echoes the central ICPD commitment: to make RH care universally available "as soon as possible and no later than 2015". International parliamentarians have supported this emphasis with their own commitment[82] that 10% of development aid be targeted for population and reproductive health (including some HIV/AIDS prevention).

[80] WHO's Commission on Intellectual Property, Innovation and Public Health

[81] Campbell White, A, T Merrick and A Yazbeck Reproductive *Health: The Missing Millennium Development Goal*. Washington, DC. World Bank.

[82] At Ottawa in 2002, Strasbourg in 2004 and Bangkok in 2006.

The effect of SRH commodities upon health outcomes

The Commission on Macroeconomics and Health (CMH) stated that "Investments in reproductive health, including family planning and access to contraceptives, are crucial accompaniments of investments in disease control."

Use of contraceptives can prevent 25-30% of maternal deaths[83], both through pregnancy- and childbirth-related diseases and through (mainly illegal and hence unsafe) abortions. High fertility, i.e. many, closely-spaced children, is also strongly correlated with child mortality. A child born 18 or fewer months after the birth of the previous sibling will have three times the chance of dying than one born after a 36 month interval[84]. Where family planning services have been extended, the effect upon health outcomes has often been dramatic[85]. Condoms also remain the only means of preventing sexual transmission of STIs, including HIV.

Products for safe abortion should also be considered as SRH commodities, as they share most of the economic effects of non-condom contraceptives. The only barriers to their use in countries where abortion is legal[86] are those of policy.

SRH commodities fall under the economic category of public, or merit goods[87]. This is because their consumption benefits not only the person who consumes them, but also society more generally. For example, condom use will prevent others being infected with STIs, and population stabilisation will benefit a country's economic, social and physical environment (see below), in addition to any individual benefits. This quality is the reason that public goods are often ones for which consumption are not left to the market and to consumer sovereignty[88].

Links with poverty

Poverty is the first of several problems which exist with SRH as mutually causal relationships, i.e. poverty leads to poor SRH, while low levels of SRH cause further poverty.

The poor are more likely to suffer from bad SRH due to their lower levels of education, inability to meet health care costs and other associated risks such as poor sanitation, malnutrition, adolescence and rural isolation. Research shows that SRH care is the most inequitably distributed of all health services[89]. In Ethiopia, for example, the richest income quintile is 25 times as likely to have their births attended by skilled personnel as are the poorest quintile[90].

Poor SRH produces poverty via both direct microeconomic effects and through broader societal macro effects. The former effect begins with heavy financial and social burdens on afflicted families. High out of pocket service costs can push families into poverty and deepen impoverishment. This is compounded by lost wages, or time that would otherwise have been spent earning. And in the poorest settings, women, who are most susceptible to SRH, do most

[83] Singh, S., et al. 2004. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. Washington, DC and New York: The Alan Guttmacher Institute and UNFPA. LSHTM estimate up to 40%.

[84] DFID's written evidence to Hearings of the All Party Group on Population, Development and Reproductive Health, 2006. In individual studies, birth-spacing was credited with reducing child mortality by close to 20% in India, and 10% in Nigeria.

[85] E.g. Improved access to comprehensive reproductive health services in Mauritius helped reduce maternal mortality by roughly three quarters between 1990 and 2000.

[86] e.g. India, Nepal, Cambodia.

[87] This is true of many, but not all health interventions.

[88] This approach could function as a justification for state intervention against social traditions that, for example, deny rural women access to SRH commodities and decision-making.

[89] Gwatkin D 2002. "Overcoming the Inverse Care Law" Leverhulme Lecture, London School of Tropical Medicine, September. Gwatkin D, A Wagstaff, and A Yazbeck 2005. *Reaching the Poor with Health, Nutrition, and Population Services.* Washington, DC: International Bank for Reconstruction and Development. Note: to a small extent this may be mitigated by the fact that wealthier couples typically want smaller families than do poorer couples.

[90] World Bank, 2004, *Round II Country Reports on Health, Nutrition, and Population Conditions Among the Poor and the Better-Off in 56 Countries.*

work.[91] SRH diseases also tend to afflict and kill people in their most economically productive years.

At the societal level, the CMH found that: "Investments in reproductive health…is likely to translate into…greater investments in the health and education of each child." A number of studies support this, through finding that smaller family size contributes to economic growth[92]. With the exception of a few oil-rich states, no country has risen from poverty while still maintaining high average fertility. Lower birth rates are generally a necessary, but not sufficient condition for a developing country to escape from poverty.

DFID has recognized the link between poverty and SRH, recently stating that "Sustained high fertility rates and rapid population growth could for some countries pose obstacles to poverty reduction as serious as that from HIV and AIDS"[93].

Link with population stabilization

Another policy area not explicitly referred to by the MDGs, but affecting all of them (as the common denominator), is the level of population. UK parliamentarians recently concluded "The evidence is overwhelming. The MDGs are difficult or impossible to achieve with current levels of population growth in the least developed countries and regions."[94] Those growth levels mean that a further 50% increase in the world's population is expected by 2050. The CMH has clearly linked SRH with reduced fertility and reduced population growth.

Population stabilisation will be of especial importance for achieving MDG 7 (Ensure environmental sustainability). One element of this is water scarcity, a situation in which 750m people currently live, with numbers expected to rise to 2.6-3.2bn by 2025. Other environmental aspects are forest decline (of which Africa has the fastest rate of any continent) and fisheries decline.

The Stern Review concluded that population stabilisation is necessary to fight climate change, the effects of which are expected to fall disproportionately on poorer populations.

Given falling cropland per capita, lowing population growth is also essential in reducing outbreaks of famine and achieving food security, as recognised by the Food and Agricultural Organisation (FAO). No coincidence that the most fertile countries tend to face food insecurity (e.g. Niger, Haiti, Ethiopia).

Recent research additionally highlights how demographic transition (a population's shift from high to low rates of death) is associated with continuous declines in the vulnerability of countries to civil conflicts[95]. A high proportion of young adults (15-29 years olds, the so-called 'youth bulge') conversely relates to greater levels of conflict.

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[91] This is often hard to calculate since so much female work is not formally recorded. But data is reported in Campbell White, A, T Merrick and A Yazbeck *Reproductive Health: The Missing Millennium Development Goal*. Washington, DC. World Bank, which describes how Ugandan women were found to do 75% of agricultural work, cf only 15% of manufacturing, 32% of services.

[92] The most oft-quoted example of this is East Asia, which in 1950 had health, economic, fertility and literacy statistics similar to present day SSA. By 1965 each of the countries which 20 years later were classed as Asian 'tiger' economies (South Korea, Taiwan, Thailand, Singapore, Indonesia, Malaysia and the former Hong Kong territory) had well-resourced family planning programmes. This led to three key developments: more moderate growth in the number of school-age children (allowing more educational investment per child); household and government savings increased; and the dependency ratio slowed. More recently, Ireland, Chile, Vietnam and China have also benefited significantly economically from declining fertility.

[93] DFID's written evidence to Hearings of the All Party Group on Population, Development and Reproductive Health, 2006.

[94] All Party Group on Population, Development and Reproductive Health, 2007, *Return of the Population Growth Factor: It's Impact upon the millennium development goals*

[95] For example, see

It is also suggested that countries with high HIV prevalence and uneven population growth rates across ethnic groups are also more vulnerable to violent conflict, though conclusive data is harder to come by for these situations.

Provision of SRH services and supplies can have a significant effect, having helped reduce fertility by 43% in developing countries during 1965-90[96]. However, both such provision and declines in fertility levels have declined more recently.

Link with gender equality

A further important link is that between SRH and gender equality. A woman's ability to plan her family is fundamental to her potential empowerment and equality. Conversely, for teenage girls, early pregnancy often brings an end to their education (undermining progress towards the education target within MDG 3). In SSA, between 8 and 25% of girls who fail to complete school do so for this reason[97].

High levels of gender inequality are associated with high maternal mortality. Social norms can augment economic conditions as barriers to contraceptive availability. SRH is also useful to support women's share of paid employment (another target within MDG 3).

SRH commodity and programme cost issues

Among contraceptives[98], IUD is generally viewed as the most efficient, costing around 25c (after a significant initial cost) and lasting around five years – but it doesn't protect against STIs. Neither do oral contraceptives, at around 20c/month, though with a lower up-front cost. STI protection is conferred by condoms, for which a couple's average annual usage is likely to cost $3-5, again without any large initial cost. The female condom, at around 60c each, is more expensive, but offers the additional benefit of potential female control over usage.

Social marketing programmes tend to incur lower costs than community-based distribution (though not in SSA, where they are less developed), and both tend to enjoy lower costs than clinic-based distribution[99]. Costs tend steadily to decline as family planning campaigns become better established.

Comparison with other health investments

The studies that exist demonstrate clearly that SRH commodities are a relatively cost-effective health intervention[100]. Cost benefit analysis is complex in health, and SRH provides at least as many conceptual issues as do other health interventions[101], but several decades of studies and increasing numbers of meta-analyses offer an increasingly reliable dataset.

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http://www.populationaction.org/Publications/Reports/The_Security_Demographic/Summary.shtml

[96] Leete, R and M Schoch. 2003. "Population and Poverty: Satisfying Unmet Need as the Route to Sustainable Development." *Population and Development Strategies Series* . New York; UNFPA

[97] UNFPA State of World Population 2002.

[98] This analysis follows UNFPA practice and excludes voluntary sterilisation, which is often the most efficient of all contraceptive methods.

[99] Levine R, Langer A, Birdsall N, 2006. *Disease control in Developing Countries (2nd edition)*, World Bank, Washington, DC. Note: this is in terms of cost per couple-year of protection (CYP), but does not reflect how some distribution methods may do better at changing behaviour, and thus have a greater effect on health outcomes.

[100] They are also a unique health intervention in that they are generally used without direct reference to disease – i.e. to prevent conception, rather than to become healthier or prevent a risk to health – though their role in combating STIs is also of major importance. But the value of SRH commodities is such that the World Bank included them as one of only 11 health interventions in its influential 1993 recommended Basic Package, offering health care coverage for $12 per head.

[101] Issues include the fact that most of the literature on the global burden of disease uses a disease-based, rather than intervention-based framework; that studies mainly use average, rather marginal cost (which is more useful in comparing interventions; that most studies examine cost or effectiveness but not both; that family planning 'cost effectiveness' studies often use 'cost per couple-year of protection' (CYP), which is not linked to health outcomes; that there are substantial differences between settings that are compared; and that studies tend to limit their scope to a single generation, missing what are likely to be significant multigenerational effects.

As research typically looks at HIV/AIDS and other STIs separately from contraception, separate figures are given for the cost effectiveness of the use of SRH commodities for the two purposes. UNFPA's work is concerned primarily with family planning, with consequent differential targeting and promotion, but there are of course associated benefits for the fight against HIV/AIDS in any increase in condom use[102]. The figures for family planning below relate only to direct health benefits for women and children, through increasing birth intervals and decreasing adolescent pregnancies, and so should be seen as underestimates of the true health benefit obtained via SRH commodities (e.g. they exclude the benefits through reducing STIs, economic benefits for both individuals and countries and environmental benefits).

Table 8: *Cost effectiveness of comparative health interventions and health-relevant policies*

Health intervention	Cost (US$ 2001) per DALY averted
Expanded immunization against TB, DPT, polio, measles	7
Insecticide-treated bed nets (malaria)	5 -17*
Family planning	**30 - 60**
Integrated management of childhood illness	39*
HIV/AIDS: condom promotion and distribution	52 -112*
Childhood TB vaccination	55 - 82
DOTS for infectious or latent TB	84 - 551
Construction and promotion of basic sanitation	141
Improved comprehensive emergency obstetric care	151*
Anti-retroviral therapy against HIV/AIDS	350 -1,494*
Advertising ban and restriction on alcohol sales	367 - 441
Dengue vector control	1,992 – 3,139
Improved water and sanitation (where infrastructure currently exists)	1,974 - 6,396
Cholera or rotavirus immunisation	2,478 – 2,945
Hepatitis B vaccination	23,520
Treatment of Kaposi's sarcoma (HIV/AIDS)	34,968 – 69,930

* SSA figures only. Data is drawn from various sections of Levine R, Langer A, Birdsall N, 2006. *Disease control in Developing Countries (2nd edition)*, World Bank, Washington, DC. The basic model is from AGI (Alan Guttmacher Institute, Futures Group International, Population Action International, Population Reference Bureau, and Population Council, 2000. *The Potential Impact of Increased Family Planning Funding on the Lives of Women and their Families.* Washington, DC: AGI.

Cost effectiveness is measured in Table 8 as the cost of averting a Disability-Adjusted Life Year (DALY) from relevant diseases, amalgamating both deaths and non-fatal episodes[103]. Figures are sensitive to geographical setting, with those relating to SSA (and South Asia) generally lower than for elsewhere, due to lower costs for inputs such as human resources. Thus, the range of $30-60, covers $30 for South Asia; $34 for SSA; $49 for the Middle East and North Africa; $53 for Latin America and the Caribbean; and $60 for East Asia and the Pacific. In the case of SSA, this translates to a cost of $131 per birth averted; $1,367 per infant death averted and $10,231 per maternal death averted.

[102] While the table gives some indication of the benefits of prevention to cure, a more comprehensive estimate is that. Overall prophylaxis to prevent HIV are 28 times more cost effective than treatment, - Alan Guttmacher Institute and UNFPA. 2004. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care.* New York: AGI and UNFPA. Family Planning that is targeted at HIV-positive mothers is highly cost effective, at around $5/DALY – Stover, J. 2003"Costs and benefits of providing family planning services at PMTCT and VCT sites" Futures Group International, Washington, DC.

[103] DALYs are a standard measure for comparisons between health interventions, providing an alternative to the standard economic approach of seeking to place a monetary value on human lives. .

Individual country programme studies bring the cost-benefit ratio of RH investment into sharper relief. A Mexican study of family planning expenditure during 1972-1984, for example, found that nine times the amount expended was saved through lower expenditure on complications of unsafe abortion and provision of maternal and infant care alone. In a Thai study (launched in 1970 and projecting costs and benefits to 2010), the benefits outweighed the costs by 16 to one; in an Egyptian study (1992-2015), the figure was 31 to one. The long lengths of study period are necessary because benefits typically are strongest several years after the programme[104].

Table 9: *Cost effectiveness of country-level cost benefit studies of family planning services*

Location of programme	Dates over which costs and benefits estimated	Ratio of economic benefits to costs	Areas of savings
Mexico (IMSS social security programme - urban) [105]	1972-1984	9:1	Maternal and child health services only
Thailand[106]	1970-2010	16:1	Social services
Egypt[107]	1992-2015	31:1[108]	Food subsidies, education, water, sewage, housing and health care.
Vietnam[109]	1979-2010	7.6:1	Education costs, maternal child health, social security.
India (Tata Iron and Steel company, Jamshedpur)[110]	1956-1987	2.39:1	Corporate health care and education for dependents of employees.

Sources: see footnotes

[104] Vlassoff M, Singh S, Darroch JE, Carbone E, Bernstein, S (2004) "Assessing Costs and Benefits of Sexual and Reproductive Health Interventions", New York: Alan Guttmacher Institute

[105] Nortman D, Halvas J and Rabago A, A cost-benefit analysis of the Mexican Social Security Administration's family planning program, *Studies in Family Planning*, 1986, 17(1):1–6.

[106] Chao D and Allen K, A cost-benefit analysis of Thailand's family planning program, *Studies in Family Planning*, 1984, 10(3):75–81.

[107] Moreland SR, ed., Investing in Egypt's Future: The Costs and Benefits of Family Planning in Egypt, Cairo: National Population Council and RAPID IV, 1996

[108] NB The study used a 0% discount rate. If a 15% discount rate had been applied then the benefit ratio would be reduced to 25:1.

[109] Vietnam Center for Population Studies & Information and Futures Group International, *Vietnam's Population and Family Planning Investments and Savings (1979–2010)*, Hanoi, Vietnam: The National Committee for Population and Family Planning and Futures Group International, 1997

[110] Day JH, Parekh S and Wickstrom J, *Private Sector Family Planning in Jamshedpur, India: A Cost-Benefit Case Study*, Columbia, MD, USA: JSA Healthcare Corporation and USAID, 1990

ANNEX 3 SUMMARY OF THE GLOBAL PROGRAMME TO ENHANCE REPRODUCTIVE HEALTH COMMODITY SECURITY (GPRHCS)

The Global Programme to enhance Reproductive Health Commodity Security (GPRHCS) is an initiative of UNFPA's Commodity Management Branch (CMB) with twin objectives. The first goal is substantially to increase funding for SRH commodities in developing countries, something made necessary by the current and expected future funding shortfall (see section 3.2, above). The second aim is to develop in-country capacity to confront problems of SRH commodity insecurity, so that over time this activity becomes country-led (and funded) wherever possible. UNFPA is seeking multi-year core budget funding, over a suggested five year planned initial operating period for GPRHCS.

A key feature of GPRHCS is that it will operate in three different modalities, according to country context. In those countries where there are urgent SRH commodity shortfalls (categorised as Stream 3 and including fragile states), UNFPA will continue to meet commodity needs as at present. Around a third of funds are expected to be used for this Stream[111].

In other countries, where the situation is not that of an emergency, funds will be used for capacity building as well as commodity procurement, with an expected weighting of 40-60% for each purpose. However, importantly, there will be an incentive element to the programme, with possibly five times as much funds going to countries that show progress in developing competency in their approach to SRH (Stream 1) as to those that do not (Stream 2). Developing competency is taken to comprise these three features:

- *Integrated approaches to RHCS at all levels in country*. This includes, for example, incorporation of RHCS into national development frameworks, such as PRSPs, SWAps, UNDAFs; evidence of action to deal with cultural and physical barriers to RHCS; the establishment of an inclusive RHCS Coordinating Committee; and of an RHCS plan of action.
- *RHCS-related systems and capacity enhanced among national stakeholders*. This covers items such as a national budget line for RH commodities being created and funds being allocated; the relevant commodities being placed on the national essential drugs list; measures of reach of young and other target population groups.
- *RH commodity needs met consistently and reliably.* This will be measured by a range of indicators, which also include forecasting, logistics and quality of care.

In order to support these features, UNFPA commits to offering extensive technical assistance, where requested by countries, including in relation to:

- RH costing;
- commodity management needs projection;
- procurement;
- prequalification of medicines and RH commodities;
- information, education and communication (IEC);
- behaviour change and communication (BCC);
- HIV/AIDS prevention strategies and comprehensive condom programmes; and
- total market approaches that increase/ensure access for marginalised populations.

If a country meets the requirements to qualify for Stream 1 funds then it should develop the capacity (and at least initially, the funds) to take over most of UNFPA's SRH commodity procurement responsibilities, and this is indeed the intention. The plans for this final handover

[111] Details of this and other features are available in UNFPA, 2007. *Global Programme to Enhance Reproductive Health Commodity Security.* New York. In fact funding proportions may vary according to total donor funds that are made available.

are as yet unspecified. All GPRHCS activities are to be embedded in UNFPA's Medium Term Strategic Plan (MTSP) and also in country UN Development Assistance Frameworks (UNDAFs).

The GPRHCS Programme is currently being piloted in five 'Proof of Concept' Stream 1 countries: Ethiopia, Burkina Faso, Mozambique, Mongolia and Nicaragua. Lessons from these countries are expected to inform the development and implementation of the Programme elsewhere.

ANNEX 4 REFORMS WHICH MAY AFFECT SRH COMMODITIES PROCUREMENT

The following three current and proposed reforms all have potential relevance for UNFPA's GPRHCS policy, and should be borne in mind as the policy is further developed.

McKinsey's proposal for a new Supply Coalition financing mechanism
This proposal is intended to deal with three problems related to SRH commodities procurement: uncertainty regarding the timing of donor funds; uncertainty regarding the magnitude of such funds; and a perception that donor funds often arrive late in the fiscal year, with a requirement that they be spent rapidly. The management consultants, McKinsey propose a reform of the current system of procurement by Supply Coalition members, containing three key elements[112].

The first element is a 'Pledge Guarantee'. This would give a procurement agency (e.g. UNFPA) the credit to purchase commodities, based on a donor's pledge of funds, even if those funds became delayed. It would therefore allow the procurement agencies to smooth their purchases, unaffected by the volatility of actual donor disbursements.

The second element is a 'Minimum Volume Guarantee'. This would let procurement agencies aggregate their current and future orders to give manufacturers a guaranteed size of order. In this way, manufacturers will be encouraged to invest in additional capacity and costs (and hence prices) may be expected to fall.

McKinsey's proposal calls for a new institution to be established to administer these two Guarantees, with between five and nine separate functions, as well as a possible separate Board of Governors. McKinsey estimated that the cost of implementing both Guarantees (via their proposed new institution) would be a set up cost of around $30m, followed by annual costs of around $5m. Modelling by McKinsey suggested that implementing their proposals would save between $4.8m and $13.6m annually.

This is a relatively new approach to international public procurement, but something similar is already underway in the field of vaccines. With vaccine procurement through GAVI[113], a similar problem has been encountered of manufacturers requiring greater certainty regarding orders in order to make investments in capacity (and R&D). An Advanced Markets Commitment (AMC) has been established, which will act to an extent like McKinsey's Volume Guarantee. But it is only now about to be tested with the first vaccine, and has not yet been evaluated, though this is due shortly[114]. A mechanism has also been successfully established which will convert donor pledges into immediately available funds, which thus exhibits some elements of the Pledge Guarantee[115].

UNFPA's position (and apparently that of other Supply Coalition members) is that while the two Guarantees represent a useful approach to improving procurement, no new institutions are necessary and indeed the current Coalition body has a project to implement some version of the two Guarantees.

[112] See Reproductive Health Supplies Coalition: Systems Strengthening Working Group, 2006. *Reproductive Health Financial Mechanism Analysis.* Unpublished.
[113] GAVI is the international vaccine procurement organisation. See www.gavialliance.org for more details.
[114] The first candidate is Pneumococcal vaccine, but evaluation will be a challenge as no monitoring framework is yet in place.
[115] This is known as the International Finance Facility for Immunisation (IFFIm), though its main focus is to 'frontload' expenditure for use sooner not later, rather than merely to smooth out the flow. Again, see www.gavialliance.org for more details.

Medicines Transparency Alliance (MeTa)
MeTa brings together a number of international partners (including DFID, WHO and Health Action International). Its objective is to build capacity and improve transparency in developing countries as regards medicines, including policymaking, procurement and supply chain management. MeTa's methods include both technical and financial support to governments. But here too it is still early days: MeTa was only launched this year and four pilot country schemes have yet to be completed[116].

There are advantages to coordination between UNFPA's GPRHCS[117] and MeTa, as both will be engaging with issues such as building procurement capacity in some of the same countries. MeTA partners include DFID and WHO, and UNFPA and other Coalition members have participated in MeTA consultation.

Market Development Fund
Though the consultants have limited information about this, there is a proposal among development partners to establish a Market Development Fund for ambulatory care in developing countries, which would also include SRH within its ambit. The Fund would be aimed at improving access to needed supplies through the private sector. It would seek to encourage innovative and sustainable business models, and engagement of manufacturers and distributors.

Given the need for UNFPA to engage more closely with the private sector (especially SRH current or potential commodity distributors); it may be useful for UNFPA to involve itself with the Market Development Fund if and when it takes shape.

[116] See www.dfidhealthrc.org/MeTA/index.html for further details.
[117] UNFPA-PSS is aware of MeTa, though it is not clear whether other elements of UNFPA are yet.

ANNEX 5 PEOPLE MET AND DOCUMENTS CONSULTED

UNFPA, NY
Purnima Mane, Dep. Executive Director (Programme) and Asst. Secretary-General

Rogelio Fernandez-Castilla, Director of Technical Support Division (TSD)
Dr Hedia Belhadj, Dep. Director, TSD
Sam Bernstein, Senior Policy Adviser, TSD

Jagdish Upadhyay, Chief, Commodities Management Branch (CMB)
Benedict Light, Technical Adviser, CMB
Thidar Myint, Technical Specialist, CMB
Joseph Abraham, Systems Development Specialist, CMB
Kabir Ahmed, Technical Adviser, CMB
Daniele Landry, Technical Adviser, CMB

Mona Kaidbey, Dep. Director, Africa Division (AD)
Garry Conille, Technical Adviser on RHCS, AD

Sultan Aziz, Director, Asia Pacific Division (APD)
Neela Jayaratnam, Senior Programme Specialist, APD
Soyoltuya Bayaraa, Programme Specialist, APD

Pam DeLargy, Chief, Humanitarian Response Unit (HRU)

Purnima Mane, Dep. Exec. Director, Programme

Subhash Gupta, Director, Division of Management Services (DMS)
Rahul Bhalla, Chief, Finance Branch, DMS

Dia Timmermans, Senior Policy Adviser Aid Effectiveness, Reproductive Health Branch

Brendan O'Brian, Chief, Strategic Planning Office (SPO)
Dr Farah Usmani, Adviser, SPO

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Dr Kidane Ghebrekidan, RH Programme Officer, Ethiopia
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Akiko Takai, Programme Office, Vietnam

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David Smith, Chief, Procurement Services Section

GPRHCS Consultative Board
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Nel Druce – consultant for DFID

UK Mission to UN
Matthew Cannell

Suppliers
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PJ Reddy, CEO, Indus Medicare, India
Steven Croonyman, Pfizer, Belgium

External experts
Peter Hall, consultant, Switzerland
Dr Theo Pas, Sector Specialist Health, HIV/AIDS, Royal Netherlands Embassy, Ethiopia

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