REPORT SUMMARY

FUNDING COMMON GROUND

COST ESTIMATES FOR INTERNATIONAL REPRODUCTIVE HEALTH

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HEALTHY FAMILIES HEALTHY PLANET

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INTRODUCTION AND PURPOSE OF THE REPORT

2010 is a pivotal time to build financial support for international reproductive health, including family planning and maternal health. Despite a global financial crisis, donors are mobilizing around the Millennium Development Goals (MDGs), especially around neglected MDG 5: Improve Maternal Health. There is a growing sense of urgency in the global public health community to prioritize the International Conference on Population and Development Programme of Action (ICPD POA) goal and MDG Target 5B of universal access to reproductive health, as well as MDG 5 as a whole, since progress has been lagging and the goal year of 2015 is looming for both. There is renewed support for these issues in the United States, which has historically been the largest single funder for family planning.

In the fifteen years since the ICPD, technical specialists and advocates have undertaken basic re-costings of the ICPD, and estimates for achieving elements of the ICPD POA as part of ongoing initiatives. Existing estimates target varying audiences (donors, governments, intergovernmental entities), meet different purposes (advocating to increase funding for family planning or maternal health, boosting support for contraceptives), and are used by different constituencies and coalitions (family planning, maternal and child health).

Harmonized data and messaging around funding requests and needs are vital components of robust advocacy, planning and budgeting. The proliferation of different and unique estimates has led to confusion regarding which numbers to use for what advocacy purposes, as well as inconsistent messaging across efforts.

While it is important to encourage the development of complex estimates, without guidance, disaggregated numbers over a series of years are difficult to translate into easy messaging for a policymaker audience, and can lead to poorly understood and underutilized estimates. Weak understanding of cost estimates undermines political and financial support for the ICPD and MDG goal of universal access to reproductive health. Without a clear understanding of funding needs, advocates have a hard time explaining differences and making qualitative judgments between estimates, and evaluating which to use in what context. This can lead to uncertainty and confusion when advocates communicate with policymakers, who are often presented with multiple financial "asks" for similar funding priorities. Cross-messaging undermines advocates' credibility with policymakers, and policymakers are likely to dismiss funding requests and base support on factors other than needs.[1]

The purposes of this report are to: (1) Enhance advocates' and policymakers' understanding of the reproductive health cost estimates currently in circulation; (2) Build their confidence in using estimates that reflect the needs they seek to address; and (3) Promote more consistent use of the same number for the same purpose, particularly among financial requests to policymakers. We aim to accomplish this goal by analyzing the most frequently cited estimates and presenting the range of estimates of funding needs.

1 Even with clear estimates of resource requirements, policymakers can base support on factors other than needs. However, a clear sense of funding needs helps to build a strong case for financial support to be based on actual needs.

COSTING REPRODUCTIVE HEALTH

In 1994 at the ICPD, the international community agreed to the following definition of reproductive health:

> "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the **right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice,** as well as other methods of their choice for regulation of fertility which are not against the law, and the **right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant**" (UNFPA 2004, para 7.2).

As the bolded phrases suggest, this agreed definition includes family planning and maternal health, and implies prenatal and newborn care. In line with this definition, the ICPD POA produced a "costed package" that was adopted by United Nations member states. The costed package includes: Family planning services and supplies; Basic reproductive health services, including maternal and newborn health; Prevention of sexually transmitted infections including HIV/AIDS;[2] and Basic research, data and population and development policy analysis (UNFPA 2004: para. 13.14).

The framework of the ICPD costing set the standard for costings since, although the package has been modified over the years to reflect changing priorities in the reproductive health community. In recent years, costings have tended to frame reproductive health interventions under the subcategory of maternal health. This is likely in line with the recent shift in focus to MDG 5: Improve Maternal Health, which initially did not include the target of universal access to reproductive health. Costings of non-maternal reproductive health interventions such as reproductive tract infections and reproductive organ cancers have become scarce, and there is an upsurge in the number of costings of maternal (and newborn) health alone.

To avoid confusion, we use the disaggregated categories of family planning, reproductive health and maternal health throughout the paper. In line with the ICPD, we conceptualize them all within the broader category of reproductive health.

METHODOLOGY AND FINDINGS

Every reproductive health estimate is composed of a set of building blocks, or methodology and assumptions. Using these building blocks, we analyzed the three most active recent estimates of resource requirements that include international reproductive health, including family planning and maternal health.[3] They are:

- Guttmacher Institute and the United Nations Population Fund (UNFPA), "Adding It Up" (Singh, Darroch, Ashford and Vlassoff 2009);
- The UNFPA's update of the ICPD estimate (ICPD Update) (UNFPA 2009); and
- The Taskforce on Innovative International Financing for Health Systems (Taskforce) Normative Approach cost estimate undertaken by World Health Organization (WHO) (Taskforce 2009; WHO 2009).

We find that the three most active current estimates—as originally presented—are not directly comparable because they rely on varying assumptions such as interventions, users, and countries included in the costing, and ways that each presents the numbers.

2 Treatment of HIV/AIDS was added subsequently.

3 Annex 1 of the English version of the report contains detailed analysis of these and ten other reproductive health cost estimates. Listed in chronological order, they are: Guttmacher Institute and UNFPA, "Adding It Up" (2009); ICPD Update (2009); Taskforce WHO Normative Approach (2009); Taskforce Marginal Budgeting for Bottlenecks (MBB) Approach (2009); "Making the Case" (2009); "The Donor Supply Gap"/ Reproductive Health Supplies Coalition (2009); NORAD/Global Campaign for the Health MDGs (2008); "1 Billion Ask" (2008) ; Partnership for Maternal, Newborn and Child Health (2008); Millennium Project (2006); WHO "Make Every Mother and Child Count" (2005); Guttmacher Institute and UNFPA, "Adding It Up" (2003); ICPD POA (1994).

To make the three estimates roughly comparable to provide a range of costs, we standardize them to ensure that each includes: Costs to cover current users, plus additional funding needed to scale-up coverage; health system and programs costs integrated with direct (service and supply) costs; and Funding needed for a single year.[4] We find that estimates presented in a single year with integrated costs most easy to translate into simple messaging for advocacy.

Below is a summary of the standardization process for each of the three estimates:

- **Adding It Up:** We did not need to standardize "Adding It Up" because it is presented in the form that we have chosen for comparison purposes: it mentions current, additional and total funding needed; health system costs and direct costs are presented together; and the estimate is for a single year. Where other estimates do not include the cost of providing services to current users, we substituted the baseline estimates for family planning and maternal health from "Adding It Up;"
- **ICPD Update:** Within the category of "sexual/reproductive health/family planning," programs and systems-related costs are presented separately from "family planning direct costs" and "maternal health direct costs" (United Nations 2009:16). To standardize the ICPD Update and to make it more useful for advocacy, we allocated health systems and program costs proportionally between family planning and maternal (and reproductive) health.[5] The ICPD Update is also presented across a series of years: 2009-2015. For comparison purposes, we calculate a single-year annual average for the integrated family planning and maternal (and reproductive) health numbers.
- **Taskforce WHO Normative Approach:** For comparison purposes, proportionally allocated the health system costs to direct costs for family planning and maternal health, and averaged the costs by year. Since this estimate only includes additional funding, we used the estimate for current users from "Adding It Up" to approximate total funding.

4 There are other elements that could be standardized such as variations across countries included, interventions, and users in need of services. However, modifying estimates can complicate messaging, so the costs and benefits of adapting a cost estimate should be carefully weighed. An alternative is to mention the costs that are excluded from an estimate that should be considered additional.

5 The formula we used to allocate programs and systems costs, using family planning as an example, is: [FP direct ÷ (FP direct + MH direct) x programs and systems costs] + FP direct.

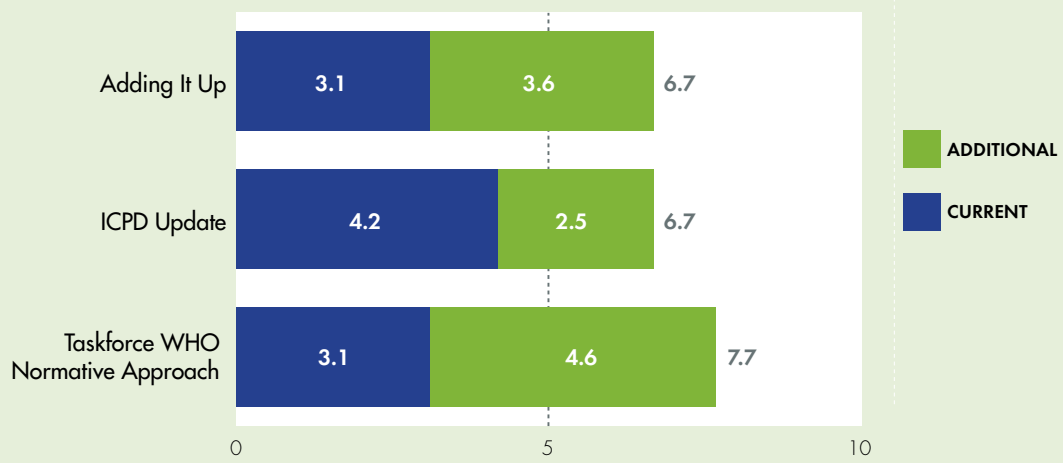
Family Planning

We find that the **estimated costs of international family planning range from $6.7 billion to $7.7 billion annually** (Chart 1). The most striking feature of the range of estimates for international family planning is the relatively narrow range, although the $1 billion difference constitutes around ten percent of the higher number. There is also a **convergence of "Adding It Up" and the ICPD Update around $6.7 billion annually**, which is likely the result of using the same costing tool, and various assumptions leading to complementary estimates.

Reproductive, Maternal and Newborn Health

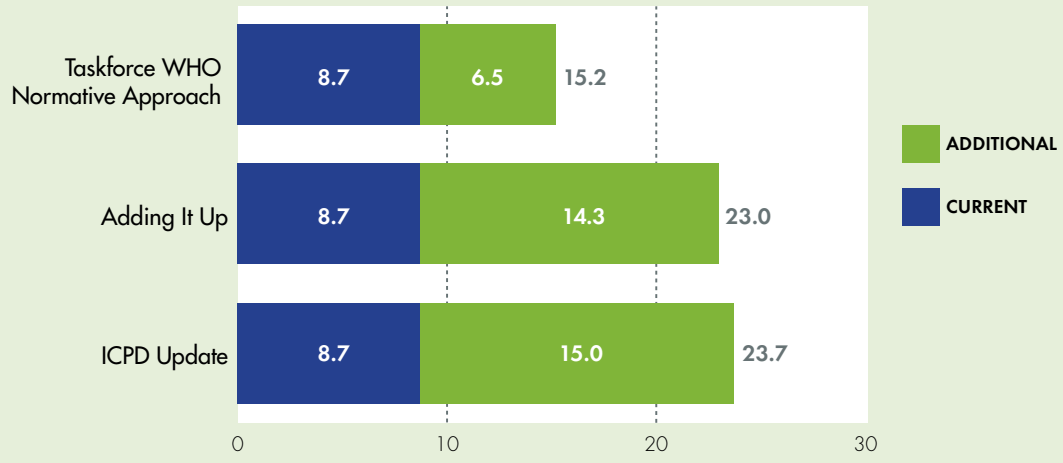
The estimated costs of reproductive, maternal and newborn health vary widely, ranging from $15.2 billion to $23.7 billion annually, nearly a 40 percent difference (Chart 2). Again, there is a **convergence between "Adding It Up" and the ICPD Update at $23 and $23.7 billion**, respectively. It is important to note that all three estimates cost maternal and newborn health interventions, but the ICPD Update is the only estimate reviewed that includes any non-maternal reproductive health interventions, specifically the cost of screening and treating reproductive organ cancers.

CHART 1. STANDARDIZED COST ESTIMATES FOR FAMILY PLANNING



Source: Authors' calculations. See below and Annex 4.

CHART 2. STANDARDIZED COST ESTIMATES FOR MATERNAL & NEWBORN HEALTH



Source: Authors' calculations. See below and Annex 4.

CONCLUSIONS

Advocates are stepping up engagement with policy makers around financial needs to reaching the ICPD and MDG goals, to take advantage of current attention to family planning, reproductive and maternal health and build on global support to achieve the ICPD POA and MDG 5. A clear sense of the current estimates of funding requirements for international family planning, reproductive and maternal health is essential as they develop funding asks.

We analyze the thirteen most active recent estimates of resource requirements for international family planning, reproductive and maternal health in circulation, and identify three that are most widely used within the sexual and reproductive health community, namely: Adding It Up, the ICPD Update, and the Taskforce WHO Normative Approach estimate.

Our analysis shows that the three cost estimates, as originally presented, are not directly comparable, primarily because they use different assumptions and present numbers differently. We standardize the estimates to make them roughly comparable, ensuring that each includes current, additional and total funding for a given year, and that health system and programs costs and direct costs are integrated. The standardized estimated costs of international family planning range from $6.7 billion to $7.7 billion annually, with a notable convergence around $6.7 billion annually. The estimated costs of reproductive, maternal and newborn health vary widely, ranging from $15.2 billion to $23.7 billion annually, with a convergence around $23 billion annually. More work is needed to develop a clear understanding of funding needs for reproductive health interventions for women who are not pregnant or postpartum, or are not of child-bearing age.

We also identify a number of building blocks of cost estimates and include recommendations to make future estimates user-friendly for non-technical audiences. In particular, we find that differences in presentation can either help or hinder efforts to use the numbers in advocacy, with single-year, integrated numbers being the most adaptable to easy messaging for policymakers. We encourage specialists that develop estimates spanning a range of years and including direct and health systems and programs costs to publish single-year, integrated summaries of their estimates.

In the long term, we hope this report will be a step towards a future where there is broad consensus around one global cost estimate for family planning, reproductive and maternal health, and all asks for the same interventions are based on the same original cost estimates. This estimate would have to allow different constituencies to pull out partial cost estimates for advocacy purposes with different needs on the basis of interventions, regions, and cost components such as supply or labor costs.

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