FUNDING COMMON GROUND

COST ESTIMATES FOR INTERNATIONAL REPRODUCTIVE HEALTH

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ACRONYMS

CPR	Contraceptive Prevalence Rate
FP	Family Planning
ICPD	International Conference on Population and Development
IHP+	International Health Partnership Plus Related Activities
MBB	Marginal Budgeting for Bottlenecks (scenario)
MDG	Millennium Development Goal
MH	Maternal Health
MNH	Maternal and Newborn Health
NORAD	Norwegian Agency for Development Co-operation
PMNCH	Partnership for Maternal, Newborn and Child Health
POA	Programme of Action
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infection
Taskforce	Taskforce on Innovative International Financing for Health Systems
U.S.	United States of America
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPD	United Nations Population Division
WHO	World Health Organization

EXECUTIVE SUMMARY

With increased attention to reproductive health, including family planning and maternal health, advocates and policymakers are working to mobilize political and financial support to reach the International Conference on Population and Development (ICPD) and Millennium Development Goal (MDG) objective of universal access to reproductive health. A clear sense of funding requirements for international reproductive health is essential to carry out policy advocacy and plan to meet unmet needs.

To date, there are over a dozen estimates of the financial resources needed to improve reproductive health outcomes used by the sexual and reproductive health (SRH) community. Three are widely used and cited: Guttmacher Institute and the United Nations Population Fund's (UNFPA's), "Adding It Up" (2009); The UNFPA's update of the International Conference on Population and Development estimate (ICPD Update) (2009); and The Taskforce on Innovative International Financing for Health Systems Normative Approach estimate by the World Health Organization (WHO) (2009). Lack of understanding of these different estimates can lead to fragmented advocacy for financial prioritization of reproductive health. This in turn, can contribute to undermining global achievement of universal access to reproductive health, and make it more difficult to measure long-term progress.

The purposes of this report are to: (1) help advocates and policymakers better understand the reproductive health cost estimates currently in circulation; (2) build advocates' and policymakers' confidence in using estimates that reflect the specific needs they seek to address; and (3) promote more consistent use of the same numbers for the same purposes, particularly among financial requests to policymakers including donors.

We aim to accomplish this goal by analyzing and comparing the most frequently cited estimates, and presenting the range of current cost estimates.

Our analysis reveals that the three current estimates, as originally presented, are not directly comparable. The three current estimates rely on varying assumptions, interventions and users included in the costing, and ways that each presents the numbers. To make the three estimates roughly comparable to provide a range of costs, we standardize them to ensure that each includes current, additional and total funding for a given year, and that it integrates health system and programs costs with direct (service and supply) costs. Estimates that are presented in this manner are easy to translate into simple messaging for advocacy and planning. Standardization shows that **the estimated cost of fulfilling international family planning goals ranges from $6.7 billion to $7.7 billion annually,** with a notable convergence around $6.7 billion, as reflected in "Adding It Up" and the ICPD Update. The **estimated costs of reproductive, maternal and newborn health range from $15.2 billion to $23.7 billion annually,** with a convergence between "Adding It Up" and the ICPD Update at around $23 billion annually.

In the short term, we hope that explaining the components of each estimate will help advocates and policymakers make more informed choices about which to use in which context, and unite more easily around the same numbers for the same purpose. In the longer term, we hope that this analysis will contribute to a harmonization around one base cost estimate for each component of the ICPD, which would allow for as many partial costing exercises as needed to be pulled out for different purposes.

INTRODUCTION

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.[1]

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 (increasing 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. Also, estimates vary in the ways they are presented, for example whether they are single or multi-year, and what types of costs are included in an estimate for a program area like family planning.

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.[2]

Weak understanding of cost estimates undermines political and financial support for the ICPD and MDG goal of universal access to reproductive health.

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 esti-

1 See: PAI's March 2010 Washington Memo, "2011 International Family Planning Budget Request Largest Ever" for more on U.S. funding for international family planning and reproductive health.

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

mates 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.

…we hope that greater clarity among advocates about different cost estimates will enhance their ability to evaluate and use estimates, and communicate with policymakers. Clearer messaging from advocates and/or self-education will help policymakers respond more positively to funding requests.

This report focuses on the three most active recent estimates of resource requirements that include international family planning, reproductive and maternal health. Listed in reverse chronological order, they are: Guttmacher Institute and the United Nations Population Fund (UNFPA), "Adding It Up" (2009); The UNFPA's update of the ICPD estimate (ICPD Update) (2009); and the Taskforce on Innovative International Financing for Health

Our goal for the future would allow for as many partial costing exercises as needed for different purposes, as long as they draw from the same base numbers agreed upon by the research and advocacy community involved in costing and using the estimates.

Systems (Taskforce) Normative Approach cost estimate undertaken by World Health Organization (WHO) (2009). Annex 1 contains detailed analysis of these and ten other reproductive health cost estimates.[3]

In the short term, we hope that greater clarity among advocates about different cost estimates will enhance their ability to evaluate and use estimates, and communicate with policymakers. Clearer messaging from advocates and/or self-education will help policymakers respond more positively to funding requests. Ideally they will act by bringing funding more in line with actual needs. We hope that a clear understanding of funding needs will also facilitate better program planning and budgeting to meet universal access. Clear estimates can facilitate monitoring progress towards meeting funding goals and needs. And it is important to know if funding is sufficient and goals are still not met, since the effectiveness of funds or quality of programs may be the primary issue that needs to be corrected.

In the long term, we hope that this analysis will help unite advocate, policymakers and others around one original cost estimate for each component of the ICPD. Our purpose is not to question the usefulness of any of the estimates. Nor are we advocating for fewer policy and funding "asks," but rather for all of them to eventually draw on the same estimate for the same categories. Our goal for the future would allow for as many partial costing exercises as needed for different purposes, as long as they draw from the same base numbers agreed upon by the research and advocacy community involved in costing and using the estimates.

It is important to note that while the global cost estimates highlighted here are useful for advocacy and accountability purposes at the global and regional levels, they are not a substitute for country-specific estimates. Because of the macro scope of global cost estimates, even when they are based on a bottom-up costing methodology, they may not reflect actual needs in every country. However, any discrepancies are likely to even out at the regional and global levels. More work is needed to develop cost estimates at the country level.

3 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).

2 COSTING REPRODUCTIVE HEALTH

In 1994 at the ICPD, the international community agreed to the following common 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 resulted in a "costed package" that was adopted by United Nations member states (Box 1). 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.

The first redefinition of the costed ICPD package was around 1999 when treatment of HIV/AIDS was added to prevention of STIs including HIV/AIDS.[4] Over the last decade, aggregating HIV/AIDS with other areas of "population assistance" as defined in the ICPD has sometimes given the false impression that overall funding levels are growing and adequate. We recognize that addressing HIV/AIDS is an important part of reproductive health. However, we do not include estimates of funding needs for HIV/AIDS in the present analysis, given that HIV/AIDS activities overall do not face acute funding shortfalls, although more funding is needed for prevention activities (Global HIV Prevention Working Group 2009), and for integration with family planning (Myer et al. 2005).

Box 1. The ICPD POA Costed Reproductive Health Package

- Family Planning services and supplies;
- Basic reproductive health services, including maternal and newborn health;
- Prevention of STIs including HIV/AIDS;[5] and
- Basic research, data and population and development policy analysis (UNFPA 2004: para. 13.14)

Annex 2 contains the full text of the ICPD family planning and reproductive health components.

The second redefinition of the ICPD "costed package" came in 2009 with the ICPD Update, which replaced the broad category of reproduc-

4 UNFPA/NIDI began tracking funding for HIV/AIDS treatment in 1999 (UNFPA/NIDI 2009:6).

5 Treatment of HIV/AIDS was added subsequently.

tive health with "Sexual/Reproductive Health/ Family Planning," which encompass family planning and maternal health. In the ICPD Update, reproductive health interventions fall 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 have become scarce, and there is an upsurge in the number of costings of maternal (and newborn) health alone.

Each reproductive health estimate is composed of building blocks, or methodology and assumptions that make up a cost estimate.

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.

BUILDING BLOCKS OF AN ESTIMATE

Each reproductive health estimate is composed of building blocks, or methodology and assumptions that make up a cost estimate (Table 1). We used these building blocks as a framework for analysis of the cost estimates examined. In addition to describing each building block, in Table 1 we highlight recommendations to ensure estimates are user-friendly outside of the technical costing community, and signal directions that future estimates can move towards in a standardization/ harmonization process.

Table 1. Building Blocks of a Cost Estimate

BUILDING BLOCK	DESCRIPTION	RECOMMENDATION/COMMENT
Methodology	Some estimates use a bottom-up methodology in which individual country costs are aggregated to get regional and global totals, others use a top-down methodology, for example using average cost-per-user multiplied by regional prevalence or global rates.	Estimates should use a reliable methodology—for accuracy and credibility—and publish detailed information regarding that methodology. A methodology built from the bottom up is the most likely to reflect actual funding needs.
Interventions included	Different estimates include different packages of interventions—such as family planning or maternal health—and different single interventions within each set. For example, some estimates include a limited set of family planning methods while others include a large number.	To be comparable with the categories included in the original ICPD costing, estimates should include a full package of family planning, reproductive health, and maternal health services. For flexibility and use with different audiences, sets of interventions should be presented separately. For example, it makes sense to calculate reproductive and maternal health together, so long as non-maternal reproductive interventions can be broken out for advocacy with target audiences.
Direct, Systems and Programs Costs	Direct costs are those incurred directly as a result of the intervention, including health care professionals' time and equipment and supply costs. Program costs are associated with providing an intervention, including administration, training, and media. Systems costs are human resources and infrastructure costs that cannot be attributed to a specific intervention (Tan-Torres et al. 2003). Health systems and programs costs are generally calculated as a percent of direct costs.	Some estimates present these sets of costs separately, which makes it difficult to use a number for advocacy purposes that reflects the actual spending required. We recommend presenting direct, health systems and program costs together, and specifying the contribution of each to the total cost.
Countries included	Different estimates include different sets of countries. Some include the entire developing world, others focus on a subset, for example, of low income countries.	To fill the need for funding asks that are global in scope, estimates should include the entire developing world, not a subset. Ideally a subset of countries could be pulled out as needed.
Total or additional costs	Some estimates include only additional (or incremental) costs needed to achieve target coverage rates. Additional costs calculated for aid dependent or low income countries are often expected to be borne by donors, since governments and consumers are expected to be funding as much as they can.	For comprehensiveness and to reinforce the important role of governments in providing reproductive health services and supplies, estimates should include total costs, not only additional. Ideally total and additional costs could be broken out of each estimate.
Target coverage rates	The target coverage rate of an estimate is the end goal. Preference is generally given for universal or near universal coverage, in line with ICPD goals.	The estimate should assume acceptable rates of coverage based on the goals.

BUILDING BLOCK	DESCRIPTION	RECOMMENDATION/COMMENT
Timeframe	Different timeframes for scale-up of required resources are applied. While some estimates assume that all needs will be met in one year (or instantaneously), other estimates cover a series of years. For the latter, there are also different assumptions regarding whether costs are scaled-up at a steadily increasing pace; front loaded with most costs being scaled-up in the first few years; or back-loaded with most of the increased investment coming at the end of the time series.	Multiyear estimates should also be presented in a one year summary or average. They should also specify their assumptions regarding scale-up.
Cost sharing	The ICPD POA established that donors are expected to provide one-third of costs on average and domestic resources—out-of-pocket spending, government budgets, and the private sector—make up the remaining two-thirds. For program areas with a high burden in low income countries—such as HIV/AIDS—burden sharing is reversed. Donors are the implied source of funding in estimates that calculate additional funding needed in donor-dependent countries.	Cost sharing is fluid, and some people feel that the ICPD burden-sharing should be revisited. However, at the time of writing there was no consensus on this. Where an estimate does not specify cost sharing in a reproductive health estimate, one can assume the ICPD breakdown.
Political Acceptability	Estimates that have been endorsed or used by policymakers are likely to hold more weight with other policymakers. Estimates that are widely used within advocacy communities are also more politically acceptable than those that have not been cited.	Whether or not an estimate is endorsed or commonly used by a particular authority/ community should influence the decision to use that estimate in advocacy with that community.

3 THE COST ESTIMATES

In this section, we examine the most similar and widely used three estimates of financial resources to improve family planning, reproductive and maternal health outcomes that have been produced since 2008.[6] They are Guttmacher Institute and UNFPA, "Adding It Up" (2009); the ICPD Update (2009); and the Taskforce WHO Normative Approach (2009). The main features of all three estimates are summarized in Table 2. Annex 1 reviews these and ten other estimates in detail.

We find that as presented originally, there is little room for comparison across the three estimates because of their varying assumptions, interventions and users included in the costing, and ways that the numbers are presented, including:

- Whether they focus solely on additional funding needed or include current funding levels;
- If they include health systems and program costs with direct costs, or if these are presented separately;[7]
- Whether the estimate is provided as a single year number, given on an annual basis across a span of years, or aggregated over a series of years;
- Which countries and regions are costed;
- What interventions are costed; and
- Which/how many users are deemed as in need of services.

The remainder of this section includes a detailed analysis of each of these three estimates as they are originally presented, and highlights the ways that the estimates have recently been used. In the next section, we standardize these estimates to make them roughly comparable, to show the range currently in circulation.

"ADDING IT UP"

In December of 2009, Guttmacher Institute and the UNFPA published, "Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health," an update of their 2003 publication. The 2009 version estimates the costs of providing family planning, maternal and newborn health care to current users, and the minimum costs to meet unmet need in developing countries in a single year. They estimate the total cost of providing modern family planning at $6.7 billion: $3.1 for current users in 2008 and another $3.6 to meet unmet need. Maternal and newborn health costs $8.7 billion for current users and $14.3 billion to meet all unmet need, for a total of $23 billion. Notably, "Adding It Up" finds that there is $1.5 billion in potential cost saving from scaling up family planning alongside maternal and newborn care, because of the reduced financial burden resulting from fewer unintended pregnancies (Singh et al. 2009:27).

… there is little room for comparison across the three estimates because of their varying assumptions, interventions and users included in the costing, and ways that the numbers are presented.

"Adding It Up" uses UNFPA's Reproductive Health Costing Tool to calculate the estimate for family planning, and maternal and newborn health interventions. The estimate includes post-abortion

6 We excluded other estimates analyzed in Annex 1 from the body of the report because they are no longer in circulation, or because of their narrow focus. For example, we excluded two costings focused on the U.S. share, and one supply focused costing. We did not include the NORAD/Global Campaign for the Health MDGs (2008) costing because it has not been widely used in recent years (the Global Campaign cited a Taskforce estimate in its 2009 report).

7 **Direct costs** are those incurred directly as a result of the intervention, including health care professionals' time and equipment and supply costs. **Program costs** are associated with providing an intervention, including administration, training, and media. Systems costs are human resources and infrastructure costs that cannot be attributed to a specific intervention (Tan-Torres et al. 2003).

Table 2. Summary of Estimates of Resource Requirements for Family Planning, Reproductive or Maternal Health

Estimate	Interventions Costed (US$ billions)[8]	FP	RH	MH	Cost Included	Countries Included[9]	Timeframe
Guttmacher Institute and UNFPA, "Adding It Up"	Current	3.1		8.7	Direct & program and system	Developing	One year
	Additional	3.6		14.3			
	Total	6.7		23.0			
ICPD Update	Current:				Direct only	Developing & Transition	Annual 2009-2015
	Additional						
	Total (2010)[10,11]	2.6	7.9				
Taskforce WHO Normative Approach	Current				Direct only	49 low income	Cumulative 2009-2015
	Additional	8.4		11.8			
	Total						

Source: Annex 1

care. Expanded family planning services in "Adding It Up" include $0.8 billion for women and couples currently using traditional methods to move to modern methods.[12] "Adding It Up" does not include any reproductive health interventions outside of family planning and maternal health (Singh et al. 2009:35-36).

"Adding It Up" has been cited fairly widely to date. The 2003 version has historically been the basis for the request that U.S. Congress provide $1 billion in funding annually for international family planning. In separate speeches to the U.S. Senate Foreign Relations Committee's March 2010 hearing on global health, US President Bill Clinton and Bill Gates of the Bill and Melinda Gates Foundation both cited Guttmacher's findings of the benefits and cost savings of scaling up family planning and maternal and newborn health simultaneously.[13] "Adding It Up" has also been used in advocacy in preparation of the Group of 8 (G8)/Group of 20 (G20) country meetings in 2010 and other international fora.

ICPD UPDATE

In January of 2009, the UNFPA released an updated annual estimate of the minimum financial resources required to achieve the ICPD POA and MDG 5: Improve Maternal Health in preparation for the 42nd Session of the United Nations Commission on Population and Development (UN 2009). The revised estimate was subsequently approved by the Commission (UNFPA 2009B), making it a key estimate to use in advocacy at the United Nations.

The ICPD Update estimates the costs to achieve the ICPD goals in developing countries and

8 All costs are presented in 2008 dollars.

9 "Adding It Up" costs all developing countries as defined by the United Nations (Singh et al. 35). The ICPD Update includes all developing and transition countries as defined by the United Nations (UNPFA 2009A:22). The Taskforce estimates include the 49 lowest income countries as defined by the World Bank (WHO 2009:6).

10 See Annex 3 for annual estimates.

11 The ICPD Update estimate includes reproductive health costs as part of maternal health.

12 Personal communication from J Darroch (Guttmacher Institute) to authors, 22 March 2010.

13 See: http://foreign.senate.gov/hearings/hearing/20100310_2/ to download both statements.

countries in transition in the following three areas: (1) Sexual/reproductive health/family planning, which is made up of: (a) family planning; and (b) maternal health, which includes reproductive and newborn health; (2) HIV/AIDS, with numbers provided by UNAIDS that were subsequently revised downward; and (3) Basic research/data/policy analysis, which primarily includes costs associated with civil registries and census. Total costs for all three areas begin at $50 billion in 2009, and rise to $70 billion in 2015 (UN 2009). Annex 3 reproduces the full ICPD Update.

The estimate for sexual/reproductive health/family planning begins at $23.5 billion in 2009 and rises to $33 billion in 2015 (Table 2). UNFPA calculates direct costs for both family planning and maternal (and reproductive) health using their Reproductive Health Costing Tool which compiles drug, supply and material, and personnel costs of key interventions (Annex 1, Table 2), multiplies the cost by the number of likely users per country, adds up the country totals into regional figures (UNFPA 2009A:12,14,38). The $11 to $18 billion annually in programs and systems costs for sexual/reproductive health/family planning are presented separately.

Family planning direct costs include staff and supply costs for ten methods (Annex 1, Table 2), as well as extending services in spontaneous settlements (refugee camps), and screening and referral/counseling for gender based violence (UNFPA 2009A). The estimate does not include the costs of extending family planning services to women using less-effective traditional methods of family planning. It is not clear whether sexuality education/sensitization is included in the programs and systems costs (it is not in the direct costs for family planning).

In addition to antenatal and obstetric care, maternal health direct costs include newborn health interventions, screening and treating reproductive organ cancers, and treating urinary tract infections (UNFPA 2009A). The ICPD Update is the only one of the three estimates to include reproductive health interventions for non-pregnant women, although these costs are embedded within maternal health costs and are not comprehensive. For instance, the cost of providing safe abortion—where legal—is not included. It is not clear whether the ICPD Update includes management of post-abortion complications, or post-abortion care and counseling. Preventing and treating STIs including HIV/AIDS is another major component of reproductive health. These costs are currently included in a separate HIV/AIDS portion of the ICPD Update, which was produced by UNAIDS (UNFPA 2009A:24).

The ICPD Update estimate for sexual/reproductive health/family planning begins at $23.5 billion in 2009 and rises to $33 billion in 2015.

To date, the ICPD Update has been cited primarily in connection with efforts at the UN, which is logical since the numbers are endorsed by member states. For example, the 2010 Report of the Secretary General on the flow of financial resources for the ICPD uses the new cost estimates to measure progress towards meeting the financial commitments of the ICPD (UN 2010:17).

TASKFORCE ON INNOVATIVE FINANCING FOR HEALTH SYSTEMS

In September 2008, world leaders launched a Taskforce on Innovative Financing for Health Systems to make recommendations to the 2009 meeting of the G8 countries on how innovative aid and financing mechanisms can fill resource gaps to strengthen health systems in the 49 poorest countries in the world. In May 2009, Taskforce members released Working Group reports on: (1) constraints to scaling up and costs; and (2) raising and channeling funds. The Working Group 1 report contains two estimates of additional resources needed to scale up interventions to meet the health MDGs: the WHO Normative Approach and the Marginal Budgeting for Bottlenecks (MBB) approach (Taskforce 2009).

We exclude the MBB approach from our comparison of cost estimates because it has not gained traction within the international family planning and reproductive health communities. It is often seen as low, and not reflective of the kind of facilities-based expansion of coverage that is considered best practice.

WHO estimates total additional costs for the seven years between 2009 and 2015 for all the health MDGs at $251.4 billion. Direct costs for family planning and maternal health are $8.4 billion and $11.8 billion, respectively, over the same time period.

TASKFORCE NORMATIVE APPROACH

The WHO Normative Approach, carried out by WHO with UNAIDS, UNFPA, Futures Institute and USAID/DELIVER, costs the amount of additional funding needed to "scale up county health systems to a level that is considered 'best practice' by experts and practitioners" (Taskforce 2009:7). WHO's methodology relies primarily on a costing model developed by WHO in 2005.[14] The assumptions about service expansion focus on facilities, with a rapid initial scale up of investments such that infrastructure would be operational before 2015 (Taskforce 2009:7).

The methodology used by WHO specifies required activities and levels of coverage, the inputs necessary to scale-up services and systems, and then uses country prices to estimate costs (WHO 2009:2). WHO estimates total additional costs for the seven years between 2009 and 2015 for all the health MDGs at $251.4 billion. Direct costs for family planning and maternal health are $8.4 billion and $11.8 billion, respectively, over the same time period. $185.7 billion in health systems costs are presented separately (Taskforce 2009:67).

In November 2009, The Partnership for Maternal, Newborn and Child Health released the Consensus for Maternal, Newborn and Child Health (PMNCH). Using elements from the WHO Normative Approach estimate, the Consensus calls for $30 billion in additional funding for management of childhood illness, immunization, maternal health and family planning over 2009-2015. Annual costs range from $2.5 billion in 2009 to $5.5 billion in 2015.[15] In line with the WHO costing, programs and systems costs are assumed to be separate (Partnership 2009).

14 Personal communication from K. Stenberg (WHO) to author, 7 January 2010.

15 Personal communication from A. Starrs (Family Care International) to authors, 27 March 2010.

4 COMPARISON OF THE COST ESTIMATES

Analysis in the previous section shows that the three cost estimates vary greatly and are not directly comparable. In this section, we make the estimates standard, to enable comparison across numbers. The methodology used to standardize each estimate is presented in the following pages, and described in more detailed in Annex 4. We standardize each estimate to ensure that it: (1) includes current, additional and total funding; (2) integrates health system and programs costs with direct costs; and (3) is given for a single year. We prioritize these factors because they are the most fundamental differences between the numbers that inhibit comparison.

Estimates with all three of these qualities most easily translate into simple messaging for advocacy. As we move towards a harmonized approach to costing, standardization with flexibility to pull out subsets of interventions, countries and users, will be important.

There are many other elements that could be standardized such as variations across countries included, interventions, and users in need of services. For example, we identified a number of interventions that the ICPD Update does not cost that could be added.[16] However, modifying estimates currently in circulation can complicate messaging, so the costs and benefits of adapting a cost estimate should be carefully weighed. A common alternative is to mention the costs that are excluded from an estimate that should be considered additional.

FAMILY PLANNING

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.

As we move towards a harmonized approach to costing, standardization with flexibility to pull out subsets of interventions, countries and users will be important.

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.

METHODOLOGY

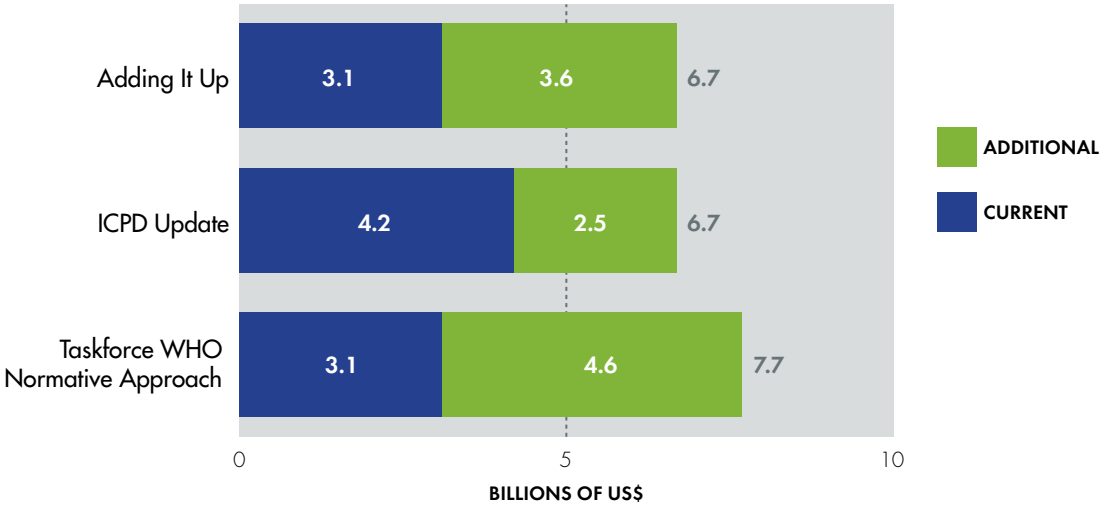
In standardizing the estimates, we make sure that they: (1) include current, total and additional funding; (2) integrate direct and health system and program costs; and (3) cover a single year.

"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;

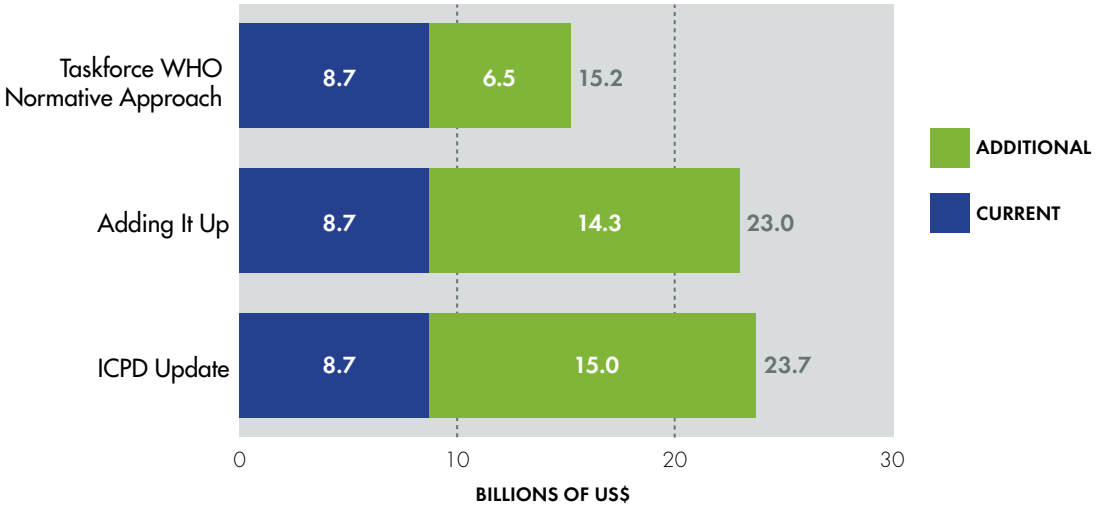
16 Depending on the target audience, advocates and policy makers may want to add these costs. For example, the maternal (reproductive) health number does not include the cost of preventing and treating STIs, which are included in the HIV/AIDS estimate provided by UNAIDS. Advocates and policy makers may wish to adjust for STIs when they use the maternal (and reproductive) health estimate alone. Also, in line with the MDG 5B target, the ICPD Update does not include the costs of women and couples using traditional methods of family planning to switch over to more effective modern methods. Advocates and policy makers could add the $0.8 billion for traditional method users used to calculate "Adding It Up" (2009) in order to include the cost of providing services to these women and couples [Estimate of traditional method users based on personal communication from J Darroch (Guttmacher Institute) to authors, 22 March 2010].

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.

Table 3. Amended Global Funding Needs for Family Planning and Maternal (and Reproductive) Health, 2009-2015 (Billions of US$ 2008)[17]

	2009	2010	2011	2012	2013	2014	2015	Annual Average
Total Family Planning	6.5	6.8	7.0	7.0	6.8	6.6	6.1	6.7
Direct Costs	2.3	2.6	2.9	3.2	3.5	3.9	4.1	3.2
Programs and Systems Costs	4.2	4.2	4.3	3.8	3.3	2.7	2.0	3.5
Total Maternal (and Reproductive) Health	17.0	20.6	23.5	25.0	25.9	26.7	26.9	23.7
Direct Costs	6.1	7.9	9.5	11.4	13.5	15.8	18.0	11.7
Programs and Systems Costs	10.8	12.7	14.0	13.6	12.5	11.0	8.9	11.9
Sexual/ Reproductive Health/ Family Planning[18]	23.5	27.4	30.7	32.0	32.7	33.3	33.0	30.4

health system costs and direct costs are presented together; and the estimate is for a single year. Where other estimates do not include 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, included as Annex 3). To standardize the ICPD Update and to make it more useful for advocacy, we recommend allocating health systems and program costs proportionally between family planning and maternal (and reproductive) health.[19] The formula for allocating health system and program costs to direct costs is detailed in Annex 4.[20] The results of our calculations for family planning and maternal (and reproductive) health from 2009 to 2015 are presented in Table 3.

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.
Also, the ICPD Update provides an estimated cost for total users of sexual/reproductive health/family planning: current users plus additional users in need of services. To approximate additional users for comparison, we substitute the estimate for

The estimated costs of international family planning range from $6.7 billion to $7.7 billion annually.

17 Authors' calculations based on numbers in United Nations (2009A), also included in Annex 3. Numbers are presented in 2008 dollars and will need to be adjusted for inflation over time.

18 We use the cost categories as defined by UNFPA.

19 Separating out programs and systems-related costs is useful in that it highlights the enormous scale-up in health systems required to significantly improve SRH. However, it is not helpful for advocacy purposes, because only using direct service costs makes the real costs of providing services and supplies appear artificially low. Also, actual expenditures for these interventions generally fund direct and programs and systems costs together within an overall project or program. In tracking, comparing the direct cost figures against reported spending (including direct + programs and systems) would inflate numbers and lead to overly optimistic reporting of funding flows.

20 We use a simplified formula of allocating the relative percentage share of systems costs to the direct costs in each program area.

current users from "Adding It Up" and subtract that number from the total estimate.

TASKFORCE: WHO NORMATIVE APPROACH

For comparison purposes, we averaged the direct and health systems costs by year and allocated a portion of the health system costs to direct costs for family planning and maternal health based on each program area's share of the total program and disease costs (calculations in Annex 4). Using this methodology, total estimated costs (direct plus systems costs) for family planning are $4.6 billion, and $6.5 billion for maternal health. Since this estimate only includes additional funding, we used the estimate for current users from "Adding It Up" as a substitute to enable us to approximate total funding.

5 CONCLUSIONS AND RECOMMENDATIONS

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 goal of universal access to reproductive health. 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 SRH 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.

…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.

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.

ANNEX 1 TABLE 1 ANALYSIS OF COST ESTIMATES

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health [21]	Scope/Assumptions
Guttmacher Institute and UNFPA, "Adding It Up" (2009)	Estimates the costs of providing family planning, maternal and newborn health care to current users, and to meet unmet need in all developing countries in 2008 (Singh et al. 2009:14,35). Assumes all needs will be met in a single year. Includes an estimate of the cost of investing in both family planning and maternal and newborn care simultaneously: $24.6 billion for expanded family planning and maternal and newborn care, versus $26.1 billion for expanded maternal and newborn care only (Singh et al. 2009: 27,36).	Direct costs for family planning and maternal and newborn health calculated using UNFPA's Reproductive Health Costing Tool. Programs and systems (indirect) costs based on UNFPA's estimates (Singh et al. 2009:14,35), calculated as a percent of direct costs (Singh 2010).	The cost of providing 603 million users of modern family planning services in developing countries in 2008 was $3.1 billion. The cost of providing the 215 million women in the developing world with unmet need with modern family planning would be an additional $3.6 billion. In other words: $3.1 billion—Current users $3.6 billion—Meet unmet need $6.7 billion—Total cost (Singh et al. 2009:17-18).	The cost of providing current users with maternal and newborn care in the developing world in 2008 was $8.7 billion. The cost of expanded maternal and newborn care to meet the recommended standard would be an additional $14.3 billion, for a total cost of $23 billion (Singh et al. 2009:23). In other words: $8.7 billion—Current users $14.3 billion—Meet unmet need $23.0 billion—Total cost (Singh et al. 2009:23).	**Countries included:** All developing countries as defined by the United Nations (Singh et al. 2009:35). **Systems costs:** For family planning, programs and systems costs are included in the totals and presented separately (Singh et al. 2009:17). For maternal and newborn health, systems costs are embedded within the total service costs (Singh et al. 2009:24,36). Indirect (systems) costs include "overhead costs for program management, supervision, health education, monitoring and evaluation, advocacy, human resources training, information systems, commodity supply systems, and capital costs for maintaining and expanding the physical capacity of health facilities" (Singh et al. 2009:35). **Traditional method users:** Included as having unmet need for modern contraceptives (Singh et al. 2009:14). **Cost Sharing:** Additional costs would be borne by a combination of domestic and international funding sources. Low income countries would require more support from the international community (Singh et al. 2009:19). **Supply focus:** Family planning contraceptive commodity and supply costs are presented separately (Singh et al. 2009:17). Maternal and newborn health supply costs are embedded within direct costs (Singh et al. 2009:24).

21 Cost estimates for promoting newborn health are typically integrated into estimates for providing maternal health. We have included newborn health here where it is integrated with maternal health costings.

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
Guttmacher Institute and UNFPA, "Adding It Up" (2009) *(continued)*					**Coverage:** Current use, no use and 100% of needs met (Singh et al. 2009:14).
ICPD Update (2009)	Update of the resource requirements to achieve the costed components of the ICPD POA, interpreted as: (1) Sexual/reproductive health/ family planning (2) HIV/AIDS; (3) Basic research/data/policy analysis (UNFPA 2009A). Total costs (which include interventions for sexually transmitted infections including HIV/AIDS; and basic research, data, and policy analysis) estimated to be:[22] 2009: $48.98 billion 2010: $64.72 billion 2011: $67.76 billion 2012: $68.19 billion 2013: $68.63 billion 2014: $69.59 billion 2015: $69.81 billion Total: $457.68 billion[23] Estimates also provided by region (UNFPA 2009A:22-23).	SRH costs were calculated using a Reproductive Health Costing Tool which compiles direct costs (drugs, supplies and other materials; and personnel) of 38 interventions; multiplies the cost by the number of likely users in each country; then adds up the cost per country and region (UNFPA 2009A: 12, 14, 38). The figure for HIV/AIDS was taken from UNAIDS, which subsequently revised their estimate downward (UNPFA 2009A:24).	Direct costs are estimated at:[24] 2009: $2.34 billion 2010: $2.62 billion 2011: $2.90 billion 2012: $3.21 billion 2013: $3.53 billion 2014: $3.87 billion 2015: $4.10 billion Total: $22.57 billion (UNFPA 2009A:22).	Maternal health direct costs, which include some reproductive health interventions are estimated to be:[25] 2009: $6.11 billion 2010: $7.87 billion 2011: $9.49 billion 2012: $11.38 billion 2013: $13.46 billion 2014: $15.75 billion 2015: $18.00 billion Total: $82.06 billion (UNFPA 2009A:22).	**Countries included:**[26] All developing and countries in transition (UNFPA 2009:22). **Systems costs:**[27] Presented separately, and calculated as a percentage of direct costs. Programs and systems costs average $15.43 billion per year (UNFPA 2009A:13-14). **Traditional method users:**[28] Counted as having met need for family planning (UNFPA 2009A:14). **Cost Sharing:**[29] Unspecified, but can assume 1/3 domestic 2/3 donor breakdown (see UNFPA 2004). **Supply focus:**[30] Embedded within direct costs. **Coverage:**[31] Family planning: unmet need reduced to zero in 2015;[32] reproductive/ (maternal) health: 100% coverage by 2015 (UNFPA 2009A:14).

22 We have included total costs in the overview column when they are different than the cost estimates for family planning and reproductive and maternal health, for example when the total costs include additional interventions.

23 UNFPA (2009A) estimates are presented in 2008 U.S. dollars (UNFPA 2009:14).

24 Direct costs are incurred from providing a service, and generally include staff and supply costs.

25 See Annex 2 for a list of interventions included in each costing.

26 Which countries are included in the cost estimate.

27 Whether systems costs are included in the family planning and reproductive health cost estimates, or presented separately.

28 Whether women and couples using traditional methods of family planning are included as having unmet need, and are therefore included in the cost of increasing the modern method users.

29 Whether the cost estimate specifies where resources should originate.

30 Whether the cost estimate includes separate line items for supply costs that may be useful for supply-related research and advocacy.

31 Target coverage rates assumed in the cost of scaling-up services and supplies.

32 Target contraceptive coverage by country equals contraceptive prevalence (traditional and modern methods) plus unmet need for family planning (Friedman 2009).

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health [21]	Scope/Assumptions
Taskforce WHO Normative Approach (2009)	One of two estimates of the additional (or incremental) cost of achieving the health related MDGs (4, 5 and 6) in 49 low income countries, conducted as part of the Taskforce on Innovative International Financing for Health Systems of the International Health Partnership Plus Related Activities (IHP+). The estimated costs of achieving MDG 5 include universal access to family planning and improving maternal health. The WHO Normative approach was carried out by WHO with UNAIDS, UNFPA, Futures Institute and USAID/ DELIVER. Total costs, including for MDGs 4 and 6: 2009: $19.34 2010: $27.47 2011: $36.01 2012: $41.79 2013: $39.56 2014: $42.11 2015: $45.16 Total: $251.44[33]	This costing approach specifies required activities and levels of coverage, the inputs necessary to scale-up services and systems, then uses country prices to estimate costs (WHO 2009:2). The WHO Normative approach costs the amount of funding needed to "scale up county health systems to a level that is considered 'best practice' by experts and practitioners" (Taskforce 2009:7). This approach to service expansion focuses on facilities, and envisions a rapid initial scale up of investments such that infrastructure would be operational before 2015 (Taskforce 2009:7,41,66).	Annual direct costs to provide family planning in 49 low income countries are: 2009: $1.00 billion 2010: $1.22 billion 2011: $1.46 billion 2012: $1.39 billion 2013: $1.32 billion 2014: $1.16 billion 2015: $0.88 billion Total: $8.43 billion (WHO 2009:2). UNFPA provided the cost estimate for family planning using the same methodology as the ICPD Update, but with the assumptions of this cost exercise (WHO 2009:8).	The annual direct cost of maternal health is: 2009: $0.70 billion 2010: $0.91 billion 2011: $1.21 billion 2012: $1.50 billion 2013: $2.03 billion 2014: $2.51 billion 2015: $2.97 billion Total $11.82 (WHO 2009:2).	**Countries included:** 49 low income countries, as defined by the World Bank (WHO 2009:6). **Systems costs:** The direct service costs include "those costs which would be specific to the program and not counted under the systems wide construction costs," (WHO 2009:23). The estimated $186 billion needed over the 2009-2015 period for health systems strengthening is costed separately (WHO 2009:18).[34] **Traditional method users:** Counted as having met need for family planning (Friedman 2009). **Cost Sharing:** N/A **Supply focus:** Includes line items for family planning and maternal health drugs and commodities (WHO 2009:22). **Coverage:** Family planning: universal/ unmet need equals zero (WHO 2009:49). Target set to meet current unmet need plus current total contraceptive prevalence rate (modern and traditional methods) (Friedman 2009). Maternal and reproductive health: universal or near universal (WHO 2009:38-49-53).
Taskforce Marginal Budgeting for Bottlenecks (MBB) Approach (2009)	One of two estimates of the incremental cost of achieving the health related MDGs in 49 low income countries, conducted as part of the Taskforce on Innovative International Financing for Health Systems of the IHP+. The costs of achieving MDG 5 include universal access to family	The MBB approach identifies bottlenecks, or constraints to scaling up health systems and the strategies to remove them. It costed three scaling-up scenarios:	Total direct and program costs for family planning over the 2009-2015 period, by scenario are: • Maximum: $3.02 billion • Medium: $2.81 billion	Total direct maternal and newborn health cost over the 2009-2015 period, by scenario are: • Maximum: $7.51 billion • Medium: $5.62 billion	**Countries included:** 49 low income countries (Taskforce 2009:66). **Systems costs:** Health systems costs are listed separately, and equal $137.85 billion over the time period under the Medium scenario (Taskforce 2009:67).

33 WHO Normative Approach costs are presented in 2005 U.S. dollars (WHO 2009:30).

34 This includes infrastructure, equipment and vehicles; health workers; supply chain and logistics systems; health financing; strengthening governance of health systems; and bolstering health information systems (WHO 2009:18).

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
Taskforce Marginal Budgeting for Bottlenecks (MBB) Approach (2009) *(continued)*	planning and improving maternal health. The MBB approach was carried out by the World Bank and UNICEF, with collaboration from UNFPA and the Partnership on Maternal Newborn and Child Health (Taskforce 2009:66). Total costs, including for MDGs 4 and 6: Between $67.46 and $227.24 billion over the 2009-2015 period (Taskforce 2009:67).	(1) Maximum scenario: reaching and surpassing the health MDGs; (2) Medium scenario: Reaching the health MDGs, and contributing to MDGs 1 and 7; and (3) Minimum scenario: prioritizing the "highest impact and lowest cost interventions and strategies (Taskforce 2009:66). The Medium scenario is cited most often. This approach envisions a scale up of community based services before expanding clinical services, which is set to become fully operational after 2015 (Taskforce 2009:41).	• Minimum: $2.19 billion (Taskforce 2009:67).	• Minimum: $3.72 billion (Taskforce 2009:67).	**Traditional method users:** Unspecified. **Cost Sharing:** N/A **Supply focus:** None. **Coverage:** Unspecified; would vary by scenario.
"Making the Case" (2009)	A call for renewed U.S. financial support for family planning by five former directors of USAID's Office of Population and Reproductive Health (Speidel et al.:cover).	This estimate calculates the annual rate of increase in modern contraceptive use in 52 countries receiving USAID assistance, multiplied by per user cost of providing modern family planning services ($17.23), divides the total cost by one third to calculate the donor share, then (see UNFPA 1994 for precedent). Based on historical record of U.S. funding for family planning and reproductive health, multiplied the donor portion by 45% to get U.S. share (Speidel et al. 2009: 12-13).	2010: $1.21 billion 2011: $1.23 billion 2012: $1.38 billion 2013: $1.47 billion 2014: $1.56 billion Total: $6.85 billion (Speidel et al.: 1,7).	N/A	**Countries included:** Begins with 52 countries that received USAID funding in 2007, expanding to 69 countries (Speidel et al. 2009:1). **Systems costs:** Unspecified. **Traditional method users:** Included as having unmet need for family planning (Speidel et al. 2009:2). **Cost Sharing:** Ask specific to USAID. Underlying background calculations were broader (Speidel et al. 2009:13). **Supply focus:** Supplies are included in the costing but not broken out (Speidel et al. 2009:12-13). **Coverage:** Unspecified.

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
SUPPLY FOCUS: "The Donor Supply Gap"/ Reproductive Health Supplies Coalition (2009)	An update of the 2001 "Contraceptive Projections and the Donor Gap" estimating the cost of scaling-up ***contraceptive coverage in countries that depend almost entirely on donors for contraceptive supplies***. This is compared against current donor funding trends to highlight the 'donor gap' (Ross, Weissman and Stover 2009:5,19).	Estimated funding needs calculated based on projected demand for contraceptives, and supply costs for married and unmarried users under two scenarios: (1) Unmet need for family planning is universally satisfied by 2015 to meet the ICPD and MDG goals; (2) Contraceptive prevalence gradually increases based on historical trends to meet the United Nations Population Division (UNPD) medium variant fertility projections (RHSC 2009: 5,23-25).[35]	Annual donor share of contraceptive commodity costs by scenario and year: • Unmet need by 2015 2015: $408 million 2020: $450 million • UN Pop Medium Variant 2015: $353 million 2020: $406 million Donor financing for contraceptive commodities in 2007 was $223 million (Ross, Weissman and Stover 2009:19).	N/A	**Countries included:** 88 developing countries that are dependent on donor funding for contraceptive supplies (RHSC 2009: 5,7,21). **Systems costs:** N/A. **Traditional method users:** Included (Ross, Weissman and Stover 2009:7). **Cost Sharing:** N/A **Supply focus:** Entirely focused on supplies. **Coverage:** Varies by scenario.
NORAD/Global Campaign for the Health MDGs (2008)	Additional cost necessary to scale up family planning, antenatal care, births in quality facilities, postnatal and child health care to 95% in 51 aid dependent countries, to accelerate achievement of MDGs 4 and 5. Costing was undertaken by the "MDG4&5 Costing and Impact Estimate Group" requested by the office of the Prime Minister of Norway. Membership included experts from WHO, UNFPA, UNICEF, World Bank, Aberdeen University, Southampton University and the Norwegian Agency for Development Co-operation (NORAD).	Unspecified.[36]	Family planning contraceptive and program costs to scale up coverage: 2009: $0.8 billion 2010: $0.88 billion 2011: $0.97 billion 2012: $1.06 billion 2013: $1.16 billion 2014: $1.27 billion 2015: $1.21 billion Total: $7.45 billion The Global Campaign also estimated the same	Maternal and newborn health commodity and program costs:[37] 2009: $1.65 billion 2010: $2.13 billion 2011: $2.67 billion 2012: $3.30 billion 2013: $4.03 billion 2014: $4.68 billion 2015: $5.36 billion Total: $23.82 billion For 68 developing countries maternal and	**Systems costs:** Program and systems costs are embedded within the costing figures (Global Campaign 2008B). 40% of costs assumed to be for health systems (Global Campaign 2008A:51) **Traditional method users:** Unspecified. **Cost Sharing:** Unspecified. **Supply focus:** Embedded within costings. **Coverage:** 95% (Global Campaign 2008A:51; Global Campaign 2009B).

35 Based on historical donor funding trends, future donor resource needs for contraceptives are projected and compared with current donor funding to highlight the 'donor gap,' or "expected shortfall in commodity funding unless resources for commodities are increased substantially" (Ross, Weissman and Stover 2009:5,19).

36 The authors requested the technical background document to the 2008 report on the 16th of October 2009 via the NORAD website: www.norad.no/globalcampaign. Document author, year and title: MDG4&5 Costing and Impact

37 Estimated additional funding to increase coverage at birth and the days around birth—the riskiest time to mothers and babies—is $2.4 billion in 2009 rising to $7 billion in 2015 (Global Campaign 2008A:52).

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
NORAD/Global Campaign for the Health MDGs (2008) *(continued)*	Total costs, including for child health are: $7.2 billion in 2009 growing to $18.4 billion in 2015 (Global Campaign 2008A:51)[38]		costs for 68 developing countries: costs begin at $1.2 billion in 2009 rise to $1.9 billion in 2015 (Global Campaign 2008B).	newborn health costs begin at $2.2 billion in 2009 and grow to $6.2 billion in 2015 (Global Campaign 2008B).	
"1 Billion Ask" (2008)	The justification behind the advocacy community ask for international family planning and reproductive health (PAI 2008).	Calculated using the inflation-adjusted additional global expenditures in Singh et al. (2003) ($4.42 billion), divided by the 1/3 donor share ($1.47 billion), weighted by the U.S. share of donor country gross national income (38%), which equals $562 million. Then add $464 million of bilateral and multilateral family planning-reproductive health assistance appropriated in fiscal year 2008, equals $1.03 billion (PAI 2008).	$1.03 billion for family planning and reproductive health.		**Countries included:** Hybrid of developing countries and USAID recipients **Systems costs:** See Guttmacher 2003. **Traditional method users:** See Guttmacher 2003. **Cost Sharing:** Ask specific to the U.S. Government. **Supply focus:** See Guttmacher 2003. **Coverage:** See Guttmacher 2003.

38 Costing figures incorporate a 3% adjustment for inflation (Global Campaign 2008B). Interestingly, Global Campaign (2009:53) cites the High Level Taskforce cost estimates.

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
Partnership for Maternal, Newborn and Child Health (2008)[39]	Additional funding needed to improve maternal, newborn and child health in 75 countries with the highest burden of maternal, newborn and child deaths. Total cost to scale-up maternal, newborn and child health: $10.2 billion per year.	This costing takes the $9.2 billion in additional annual resources required each year to increase coverage of maternal, newborn and child health interventions in 75 countries ($3.9 billion dollars for maternal and newborn health [WHO 2005A:98] plus $5.3 billion for child health [WHO 2005A:116])[40] ***and adds $1 billion per year for full coverage of family planning based on UNFPA's guidance.*** The $3.9 billion from WHO (2005) includes $1.6 billion in family planning costs for the post-partum period (Partnership 2008:3).	$1 billion over existing funding levels, plus funding for postpartum family planning (Partnership 2008:3).	$3.9 billion per year in additional funding for maternal health (Partnership 2008:3).	**Countries included:** 75 countries with the highest burden of maternal, newborn and child deaths (Partnership 2008:3). **Systems costs:** Included in the overall costing, unclear whether they were included in the $1 billion for family planning (Partnership 2008:3). **Traditional method users:** Unspecified. **Cost Sharing:** Combines external donor and domestic resources needed (Partnership 2008:1) **Supply focus:** Supply costs are embedded in the costing (Partnership 2008:3). **Coverage:** For maternal health, 70% by 2015 (Partnership 2008:3).
Millennium Project (2006)	A revised cost estimate to achieve the ICPD POA and demonstrate impact of investments in sexual and reproductive health (SRH) on all the MDGs. Total Costs: Annual costs for basic reproductive health including family planning, STIs and HIV/AIDS, and research, data and population development policy: 2005 :18.2 billion 2010 : 29.8 billion 2015 :35.8 billion[41] (Vlassoff and Bernstein 2006 in Bernstein and Juul Hansen 2006:144).	The estimate includes direct service delivery costs—drugs, commodity and equipment costs, personnel needs, basic overhead, and other investments—for basic maternal and reproductive health services including family planning. Then they added overhead costs, systems improvement costs, and additional capital and human resources (Bernstein and Juul Hansen 2006:143,161). Calculations were done at the regional and sub-regional level, and then added totaled (Bernstein 2009).	The estimated annual total direct service costs (defined at left) for basic reproductive health services, including family planning are: 2005 :13.9 billion 2010 :19.4 billion 2015 :24.4 billion (Vlassoff and Bernstein 2006 in Bernstein and Juul Hansen 2006:144)		**Countries included:** Unspecified. Presumably developing world. **Systems costs:** Embedded within costing (Bernstein and Juul Hansen 2006:144). **Traditional method users:** Not costed; Counted as having met need in the baseline Contraceptive Prevalence Rate (CPR) (Bernstein 2009). **Cost Sharing:** Not specified. **Supply focus:** Supply costs are embedded within costing. **Coverage:** Two scenarios: (1) CPR projected to meet unmet need; (2) CPR increasing consistent with UNPD medium variant population projection (Bernstein 2009).

39 As of November 2009, the Partnership is using the Taskforce WHO Normative Approach estimate. See: http://www.who.int/pmnch/topics/maternal/consensus_12_09.pdf.

40 $3.9 billion and $5.3 billion is obtained by taking an annual average of the total estimated scale-up costs of $39.0 billion and $52.4 billion which are cumulative for 10 years for MNH and child health respectively (WHO 2005A).

41 Costs associated with this estimate are presented in 2005 U.S. dollars (Bernstein and Juul Hansen 2006:144).

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
WHO "Make Every Mother and Child Count" (2005)	Additional cost of scaling-up Maternal and Newborn Health (MNH) to near universal coverage in 75 countries between 2006 and 2015.	Cost estimates were built up for key health and systems interventions considered necessary to scale-up MNH services. These include direct service, programmatic and health systems strengthening and are built by cost category annually from 2006 to 2015 for 75 countries. The costing takes a primary health care approach, integrating MNH into existing public health programs (WHO 2005B:7). The 75 countries were grouped into four 'Health System Constraint' categories based on current service coverage and strength of health system. Two scale-up scenarios were then developed: (1) Countries in the four constraint categories were assigned different scale-up rates based on capacity, with an average scale-up to 73%; (2) An alternative scale up to 95% (universal) coverage (WHO 2005B:16-19).	Estimated costs included post-partum family planning integrated with MNH services, which would cost an estimated $1.6 billion over the ten year period (WHO 2005B:59).	The total annual incremental costs for scaling-up MNH increases from $1 billion in 2006 to $6.1 billion in 2015, for a cumulative total of $39.28 billion under a scenario where coverage is projected at 73%. (WHO 2005B:59).[42] Under a rapid scale-up scenario of 95% coverage, the incremental costs total $55.66 billion over the ten year period (WHO 2005B:60).[43]	**Countries included:** 75 countries that account for the bulk of the world's population, maternal and child mortality and morbidity (WHO 2005B:8,27). **Systems costs:** Health systems and program costs are presented separately (WHO 2005B:12,39-46,59).[44] **Traditional method users:** Not included in the costing.[45] **Cost Sharing:** N/A. **Supply focus:** Supplies (combined with drugs and lab tests) are embedded in service costs, and presented separately (WHO 2005B:21-22). **Coverage:** Two scale-up scenarios at 73% and 95% coverage (WHO 2005B:7,20).

42 Costs are presented in 2004 dollars, include 3% inflation (WHO 2005B:12).

43 The $55 billion is calculated by summing the values in the "Grand Total" column in Table 6.5.

44 Costed items in these categories are program management, supervision, health education, advocacy, monitoring & evaluation, infrastructure, transport, and training (WHO 2005B:59).

45 Projected contraceptive prevalence rate for post-natal family planning is based on the current users of any modern methods and assumed constant over time (WHO 2005B:50).

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
Guttmacher Institute and UNFPA, "Adding It Up" (2003)	Estimated annual cost of providing modern family planning to current users and women with unmet need for family planning. ***Assumes all needs would be met in a single year.***	Costs of contraceptive services were calculated using a 2002 UNFPA compilation of costs of family planning interventions. Costs include labor, drugs and supplies and overhead for each method (Singh et al. 2003:34-35).	Annual cost for current users: $7.1 billion[46] Expanded coverage to women and couples with unmet need: $3.9 billion Total: $11 billion (Singh et al. 2003; Vlassoff et al. 2004:45,47).	N/A	**Countries included:** All developing countries (Vlassoff et al. 2004:37, 84). **Systems costs:** Integrated into intervention costs, per intervention (Vlassoff et al. 2004:40). **Traditional method users:** Included as having unmet need (Vlassoff et al. 2004:38). **Cost Sharing:** Unspecified. **Supply focus:** Includes supply costs by intervention (Vlassoff et al. 2004:39-41). **Coverage:** Universal access (Vlassoff et al. 2004:37).
CPD POA (1994)	Estimate of the annual resource requirements to achieve universal access to reproductive health, including family planning (UNFPA 2004 Chapter 7). Costed areas of the ICPD Program of Action are: (1) Universal access to reproductive health services; (2) Family planning services; (3) Prevention (and eventually treatment) of sexually transmitted infections including HIV/AIDS; and (4) Basic data collection and analysis (UNFPA 2004 para 13.14). Total Costs (adjusted for inflation):[47] 2000: $17.0 ($24.74) billion 2005: $18.5 ($26.93) billion 2010: $20.5 ($29.84) billion 2015: $21.7 ($31.58) billion (UNFPA 2004 para 13.15).	For family planning: Estimated costs per user per region according to prevalence rates, scaling up to meet current unmet demand and growing demand as services become more available, with CPR in developing countries averaging over 69 percent in 2015 (UNFPA 1994:2). Calculations were done at the regional and sub-regional level, and then added totaled (Bernstein 2009). For reproductive health: Assumed to be beyond what was included in the FP estimate, and interventions that could be provided as part of the primary health care	2000: $10.2 ($14.85) billion 2005: $11.5 ($16.74) billion 2010: $12.6 ($18.34) billion 2015: $13.8 ($20.08) billion (UNFPA para 13.15(a)).	2000: $5.0 ($7.28) billion 2005: $5.4 ($7.86) billion 2010: $5.7 ($8.3) billion 2015: $6.1 ($8.88) billion (UNFPA para 13.15(a)).	**Countries included:** Developing countries and countries with economies in transition (UNFPA 2004 para 13.15). **Systems costs:** Delivery systems costs are included in the family planning component (UNFPA 1994: executive summary).[48] **Traditional method users:** Included in baseline CPR as having met need (Bernstein 2009). **Cost Sharing:** 1/3 external sources, with a greater share for low-income countries. 2/3 domestic resources (UNFPA 2004 para 13.16). Domestic resource include those from governments, nongovernmental organizations, and the private sector (including out of pocket spending) (UNFPA 1994:executive summary). **Supply focus:** Supply costs are embedded within the costing.

46 These costs are presented in 2003 dollars. Inflation-adjusted costs (in 2008 dollars) are: current=$7.1 ($8.31) billion; expanded=$3.9 ($4.56) billion; total=$11 ($12.87) billion. Inflation calculated using the US Bureau of Labor Statistics Inflation Calculator: http://data.bls.gov/cgi-bin/cpicalc.pl. Calculations done on 10 August 2009.

47 Inflation calculated using the US Bureau of Labor Statistics Inflation Calculator: http://data.bls.gov/cgi-bin/cpicalc.pl. Calculations done on 10 August 2009.

48 Roughly 75 percent of family planning costs are for improving service delivery (UNFPA 1994: executive summary).

Costing	Overview	Methodology	Cost Estimates: Family Planning	Cost Estimates: Reproductive, Including Maternal Health	Scope/Assumptions
CPD POA (1994) *(continued)*		system. Costs per user were estimated to be an additional $1.03 per capita per year (in $1994) based on the Safe Motherhood Initiative cost.			**Coverage:** Universal. For family planning: 69 percent in 2015 (UNFPA 1994:2).

ANNEX 1 TABLE 2
RELEVANT INTERVENTIONS INCLUDED IN COST ESTIMATES[49]

Costing	Family Planning	Reproductive, Maternal, and/or Newborn Health
Guttmacher, "Adding It Up" (2009)	Method, medical supply and labor costs for pills, IUDs, injectables, implants, condoms, male and female sterilization, and other supply methods (Singh et al. 2009:35-36).	Drug, supply, material, labor and hospitalization costs for: Antenatal care: routine care, treatment of severe anemia and hypertensive disorders of pregnancy, and malaria prevention and treatment; Delivery care: routine care, as well as emergency prereferral care, assisted delivery, cesarean section, and care for prelabor rupture of membranes, prolonged labor, hemorrhage, puerperal sepsis and eclampsia; Treatment for complications related to delivery: obstetric fistula, urinary tract infections and mastitis; Postpartum care; Postabortion care; Newborn care: routine care and treatment for complications, including sepsis, birth asphyxia and breathing difficulties, and low birth weight (Singh et al. 2009:36).
ICPD Update (2009)	Male and female condoms, oral contraceptives (pill), emergency contraception, spermicides, Intra-uterine Device (IUD), injectables, implants (Norplant), and female and male sterilization (UNFPA 2009A:33). Costs of extending services in camps and spontaneous settlements, and screening and referral/counseling for gender based violence were also included in the family planning direct costs (UNFPA 2009A:15-16).	Antenatal Care (ANC) and Delivery Care: ANC, malaria prevention within ANC, malaria treatment within ANC, treatment of severe anaemia, delivery care, postpartum care. Obstetric Complications: Prolonged labor (>18 hours), forceps or vacuum-assisted delivery, eclampsia/severe pre-eclampsia, cesarean section, prelabour rupture of membranes, emergency pre-referral care, postpartum hemor-rhage, puerperal sepsis, hypertensive disorders of pregnancy, management of post-abortion complications. Other Maternal Conditions: Obstetric fistula, urinary tract infection, mastitis Newborn Interventions: Routine newborn care, newborn sepsis/infections, birth asphyxia/ breathing difficulties, low-birth weight (UNFPA 2009A:33). Screening for and treating of reproductive organ cancers is also included in the maternal health direct costs (UNFPA 2009A:15-16).

49 In all cases except WHO 2005, we have provided the most detailed information available from the documents reviewed. However, descriptions provided are not always comparable.

Costing	Family Planning	Reproductive, Maternal, and/or Newborn Health
Taskforce WHO Normative Approach (2009)	Oral Contraceptives, injectables, male and female condom, intra-uterine device, implant, male and female sterilization (WHO 2009:49).	Postpartum administration of anti-D immuno-globulin; postpartum care in the maternity ward; postpartum care, follow-up visit; postpartum counseling on family planning; screening all pregnant women for blood group isoimmuni-zation; management of mastitis; management of postpartum depression; safe abortions/ management of abortion complications; treatment of bacterial vaginosis or trichomoniasis infection in pregnancy; treatment of chlamydia in pregnancy; treatment of complications during childbirth; treatment of eclampsia; treatment of gonorrhea in pregnancy; treatment of hookworm infection (antenatal care); treatment of urinary tract infection during pregnancy; treatment of anaemia in pregnancy; treatment of hypertension in pregnancy; treatment of pre-eclampsia; treatment of syphilis in pregnancy; treatment of vaginal candida infection in pregnancy; antenatal care, routine; childbirth care, routine (WHO 2009:49-53).
Taskforce Marginal Budgeting for Bottlenecks (MBB) Approach (2009)	Not specified.	Tetanus toxoid; screening for pre-eclampsia; screening and treatment of asymptomatic bacteriuria; normal delivery by skilled attendant; active management of the third stage of labor; Initial management of post-partum hemorrhage; drugs for preventing malaria-related illness in pregnant women and death in the newborn; treatment of severe pre-eclampsia or eclampsia; assisted delivery and vacuum extraction at basic emergency obstetric care level; management of obstructed labor, breech and fetal distress at comprehensive obstetric care level (caesarean section); referral care for severe post-partum hemorrhage; management of maternal sepsis; medical termination of pregnancy / management of complicated abortions; family planning; Iron/ folic acid supplements; multi micronutrients; deworming; calcium supplements (Taskforce 2009A:83). Note: Although family planning is included as an intervention contributing to maternal health, it has a separate line item in the costing.
"Making the Case" (2009)	Modern contraceptives (Speidel et al. 2009:12).	N/A

Costing	Family Planning	Reproductive, Maternal, and/or Newborn Health
"The Donor Supply Gap"/ Reproductive Health Supplies Coalition (2009)	Sterilization, intrauterine devices, pill, injectables, condoms (for family planning and preventing HIV and other sexually transmitted diseases) and implants (Ross, Weissman and Stover 2009:15).	N/A
NORAD/Global Campaign for the Health MDGs (2008)	Family planning contraceptive and program costs (Global Campaign 2008B).	Maternal and newborn health commodities and program costs (Global Campaign 2008B).
1 Billion Ask (2008)	See Guttmacher 2003.	Reproductive health interventions are included in U.S. appropriations portion of this estimate.
Partnership for Maternal, Newborn and Child Health (2008)	Family planning, as estimated by UNFPA (Partnership 2008:3). Post-partum family planning is included in WHO 2005.	"Costs for human resources (salaries and training, including for community health workers), commodities (drugs, vaccines, supplies), program management and supervision, maintenance and upgrading of buildings and equipment, overhead costs, and information, education and communication" (Partnership 2008:3). See WHO (2005) for more.
Millennium Project (2006)	Family planning (Bernstein and Juul Hansen 2006:143).	Basic reproductive and maternal health services related to, "Safe delivery, emergency obstetric care and neonatal survival/infant mortality interventions" (Bernstein and Juul Hansen 2006:143).
WHO "Make Every Mother and Child Count" (2005)	Post-partum family planning and counseling on family planning (WHO 2005A:23).	67 clinical interventions which are provided during pregnancy, labor, childbirth, the post-partum and post natal periods include: Routine antenatal care, situational antenatal care (in endemic areas, depending on epidemiological situation), additional and pre-referral antenatal care (early detection and management of diseases or conditions); treatment of severe illnesses or complications during pregnancy; routine child birth care; treatment of complications during childbirth; routine postpartum care in the maternity ward; postpartum care follow-up visit (WHO 2005A:31-32). Safe abortion and abortion care services are included. 8 programmatic and health system strengthening interventions: Program planning and management; supervision of service and staff; health education; advocacy; and monitoring and evaluation; infrastructure upgrading and maintenance, transport and telecommunication; and human resource development (WHO 2005A:16).

Costing	Family Planning	Reproductive, Maternal, and/or Newborn Health
Guttmacher, "Adding It Up" (2003)	Labor, drugs and supplies, and overhead for: IUD, injectables, oral contraceptives, condoms, female sterilization and vasectomy (Vlassoff et al. 2004:40).	N/A
ICPD POA (1994)	"Commodities and service delivery; capacity-building for information, education and communication regarding family planning and population and development issues; national capacity-building through support for training; infrastructure development and upgrading of facilities; policy development and program evaluation; management of information systems; basic service statistics; and focused efforts to ensure good quality care" (UNFPA 2004 para 13.14(a)). This component includes all delivery systems costs (UNFPA 1994: executive summary; UNFPA 2004 para 13.14(a)).	"Information and routine services for prenatal, normal and safe delivery and post-natal care; abortion (as specified in paragraph 8.25); information, education and communication about reproductive health, including sexually transmitted diseases, human sexuality and responsible parenthood, and against harmful practices; adequate counseling; diagnosis and treatment for sexually transmitted diseases and other reproductive tract infections, as feasible; prevention of infertility and appropriate treatment, where feasible; and referrals, education and counseling services for sexually transmitted diseases, including HIV/AIDS, and for pregnancy and delivery complications" (UNFPA 2004 para 13.14(b)).

ANNEX 2 KEY REPRODUCTIVE HEALTH INTERVENTIONS LISTED IN THE ICPD POA

Paragraph 13.14 of the 1994 ICPD POA defines the "Costed Package" as:

> "Basic reproductive health, including family-planning services, involving support for necessary training, supplies, infrastructure and management systems, especially at the primary health-care level, would include the following major components, which should be integrated into basic national programs for population and reproductive health:
>
> In the **family-planning services** component—contraceptive commodities and service delivery; capacity-building for information, education and communication regarding family planning and population and development issues; national capacity-building through support for training; infrastructure development and upgrading of facilities; policy development and program evaluation; management information systems; basic service statistics; and focused efforts to ensure good quality care;
>
> In the **basic reproductive health services** component - information and routine services for **prenatal, normal and safe delivery and post-natal care; abortion** (as specified in paragraph 8.25); information, education and communication about reproductive health, including sexually transmitted diseases, human sexuality and responsible parenthood, and against harmful practices; adequate counseling; diagnosis and treatment for **sexually transmitted diseases and other reproductive tract infections,** as feasible; prevention of **infertility** and appropriate treatment, where feasible; and referrals, education and counseling services for **sexually transmitted diseases,** including HIV/AIDS, and for pregnancy and delivery complications" (UNFPA 2004:para 13.14)."

Paragraph 7.6 of the ICPD POA recommends the following, more detailed list of the same interventions:

> "Reproductive health care in the context of primary health care should, inter alia, include: **family-planning** counseling, information, education, communication and services; education and services for **prenatal care, safe delivery and post-natal care,** especially breast-feeding and infant and women's health care; prevention and appropriate treatment of **infertility; abortion** as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; **treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions;** and information, education and counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, **infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases,** including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programs."

ANNEX 3 ICPD UPDATE FULL COST ESTIMATE

Revised ICPD Cost Estimates, By Sub-Region, 2009-2015 (Millions of US$)

Region/year	2009	2010	2011	2012	2013	2014	2015
Global	48,980	64,724	67,762	68,196	68,629	69,593	69,810
Sexual/Reproductive Health/Family Planning	23,454	27,437	30,712	32,006	32,714	33,284	33,030
Family Planning Direct Costs	2,342	2,615	2,906	3,209	3,529	3,866	4,097
Maternal Health Direct Costs	6,114	7,868	9,488	11,376	13,462	15,746	18,002
Programmes and Systems Related Costs	14,999	16,954	18,319	17,422	15,723	13,672	10,931
HIV/AIDS	23,975	32,450	33,107	33,951	34,734	35,444	36,189
Basic Research/ Data/Policy Analysis	1,551	4,837	3,943	2,239	1,181	864	591
Sub-Saharan Africa	20,063	27,075	29,473	29,869	30,292	30,022	28,980
Sexual/Reproductive Health/Family Planning	8,482	10,612	12,596	12,675	12,764	12,184	10,731
Family Planning Direct Costs	329	414	506	606	713	827	931
Maternal Health Direct Costs	1,429	1,833	2,280	2,771	3,306	3,883	4,411
Programmes and Systems Related Costs	6,725	8,366	9,809	9,298	8,746	7,473	5,389
HIV/AIDS	11,228	15,891	16,227	16,746	17,243	17,638	18,110
Basic Research/Data/Policy Analysis	353	571	651	449	285	200	139
Asia and the Pacific	17,549	23,281	23,923	23,788	23,862	24,415	25,245
Sexual/Reproductive Health/Family Planning	9,055	10,278	11,027	11,753	12,124	12,820	13,533
Family Planning Direct Costs	1,434	1,552	1,675	1,803	1,937	2,077	2,156
Maternal Health Direct Costs	2,799	3,664	4,299	5,110	6,018	7,024	8,054
Programmes and Systems Related Costs	4,822	5,062	5,053	4,840	4,169	3,719	3,323
HIV/AIDS	7,853	10,687	10,848	11,048	11,207	11,409	11,525
Basic Research/ Data/Policy Analysis	641	2,316	2,048	987	530	186	187
Latin America and Caribbean	6,366	7,591	7,439	7,775	7,699	7,966	8,320
Sexual/Reproductive Health/Family Planning	3,132	3,401	3,627	3,837	3,922	4,119	4,347
Family Planning Direct Costs	310	343	378	414	452	492	518
Maternal Health Direct Costs	958	1,182	1,431	1,706	2,009	2,340	2,680
Programmes and Systems Related Costs	1,864	1,876	1,818	1,717	1,461	1,286	1,150
HIV/AIDS	3,072	3,461	3,562	3,630	3,703	3,770	3,867
Basic Research/ Data/Policy Analysis	162	729	250	309	74	78	106
Western Asia and North Africa	2,795	3,685	3,418	3,538	3,501	3,865	3,721
Sexual/Reproductive Health/Family Planning	1,852	2,009	2,130	2,232	2,258	2,339	2,415
Family Planning Direct Costs	178	204	231	261	292	325	346
Maternal Health Direct Costs	603	735	873	1,019	1,171	1,328	1,471
Programmes and Systems Related Costs	1,071	1,070	1,025	953	796	686	598
HIV/AIDS	798	1,095	1,112	1,131	1,146	1,163	1,183
Basic Research/ Data/Policy Analysis	145	582	177	174	97	363	123
Eastern and Southern Europe	2,204	3,091	3,508	3,226	3,275	3,326	3,542
Sexual/Reproductive Health/Family Planning	933	1,137	1,334	1,510	1,645	1,824	2,004
Family Planning Direct Costs	91	103	116	125	135	145	146
Maternal Health Direct Costs	324	454	605	771	960	1,171	1,386
Programmes and Systems Related Costs	517	579	613	614	551	508	471
HIV/AIDS	1,023	1,316	1,358	1,397	1,435	1,465	1,503
Basic Research/ Data/Policy Analysis	248	638	816	320	195	38	35

Source: United Nations 2009.

ANNEX 4 METHODOLOGIES

APPORTIONING HEALTH SYSTEMS AND PROGRAM COSTS TO DIRECT COSTS IN THE ICPD UPDATE

To apportion health systems and programs costs to direct costs, we first calculate the proportion of family planning and maternal (and reproductive) health direct costs by year (step A, below). We then multiply the total health systems and programs costs that year by that proportion (step B). Then we add the proportionate share for that intervention to the direct costs (Step C). Using family planning (FP) to illustrate how we allocated programs and systems costs between FP and maternal health (MH) for a given year, the calculation is:

$$\underset{\text{STEP A}}{\left[\text{FP}_{\text{DIRECT}} \div \left(\text{FP}_{\text{DIRECT}} + \text{MH}_{\text{DIRECT}}\right)\right.} \times \underset{\text{STEP B}}{\text{PROGRAMS AND SYSTEMS COSTS}}\left.\right] + \underset{\text{STEP C}}{\text{FP}_{\text{DIRECT}}}$$

We use the same methodology to apportion health system costs to direct costs for the Taskforce estimates. This is explained further below.

METHODOLOGY FOR STANDARDIZING ESTIMATES

CALCULATIONS FOR INTERNATIONAL FAMILY PLANNING:

Adding it Up: From Singh et al. (2009:17).

ICPD Update: Current users provided by J Darroch, personal communication 22 March 2010. Average annual cost, program and system costs integrated based on authors calculations (see Table 2). Additional costs based on total costs minus current users.

Taskforce WHO Normative Approach: Current users based on number from "Adding It Up." Additional costs based on the annual average of direct costs, plus the annual average health systems costs multiplied by family planning direct costs as a percent of total program and disease costs. From data in Taskforce (2009:67). Formula: ($8.43/7) +[($185.73/7)*(8.43/65.7)]=$4.6.

PMNCH: Current users based on number from "Adding It Up." Additional costs from Partnership (2008:3), which includes $1.6 billion for postpartum family planning based on WHO (2005A), plus $1 billion for non-postpartum women per advice from UNFPA (Partnership 2008:3).

CALCULATIONS FOR INTERNATIONAL REPRODUCTIVE, MATERNAL AND NEWBORN HEALTH:

Adding it Up: From Singh et al. (2009:24).

ICPD Update: Current users based on number from "Adding It Up." Average annual cost, program and system costs integrated based on authors calculations (see Table 2). Additional costs based on total costs minus current users.

Taskforce WHO Normative Approach: Current users based on number from "Adding It Up." Additional costs based on the annual average of direct costs, plus the annual average health systems costs multiplied by family planning direct costs as a percent of total program and disease costs. Based on Taskforce (2009:67). Formula: ($11.82/7)+[($185.73/7)*($11.82/$65.7)]=$6.5.

PMNCH: Current users based on number from "Adding It Up." Additional costs from Partnership (2008:3).

Box 2. Standardized Annual Estimates of Funding Needs (US$ Billions)

	Current Users	Additional Needed	Total
International Family Planning Estimates			
Adding It Up	3.1	3.6	6.7
ICPD Update	4.2	2.5	6.7
Taskforce WHO Normative Approach	3.1	4.6	7.7
International Reproductive, Maternal and Newborn Health Estimates			
Adding It Up	8.7	14.3	23.0
ICPD Update	8.7	15	23.7
Taskforce WHO Normative Approach	8.7	6.5	15.2

Source: Authors' calculations (directly below)

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