FUNDING FOR REPRODUCTIVE HEALTH IN CONFLICT-AFFECTED COUNTRIES

A study by the RAISE Initiative, the London School of Hygiene & Tropical Medicine, and King's College London shows that funding for reproductive health (RH) in conflict-affected countries is largely inadequate and – despite generally worse RH indicators – lower than in comparable non-conflict-affected countries.

The International Conference on Population and Development (ICPD), held in Cairo in 1994, identified the reproductive rights of conflict-affected populations, such as refugees and internally displaced persons, to be equal to those of people everywhere.[1] Yet the capacity of these populations to realise their rights is severely compromised in conflict settings, exposing them to increased risk of death, disease, or disability.[2 3 4]

The critical importance of RH to achieving many of the Millennium Development Goals (MDGs) is well established and recognised by the international community.[5] Although important progress has been made since 1994 in providing RH services to conflict-affected populations, the humanitarian community is far from meeting all RH needs.[6]

The United Nations estimates that almost $50 billion is needed to meet RH needs in all developing countries in 2009; up to $70 billion will be needed in 2015.[7] While donor assistance to RH activities has increased over time, it remains insufficient to ensure the implementation of ICPD and MDG commitments.[8 9]

Most conflict-affected countries rely heavily on international aid and humanitarian assistance for basic service provision, as internal state capacities are often limited.

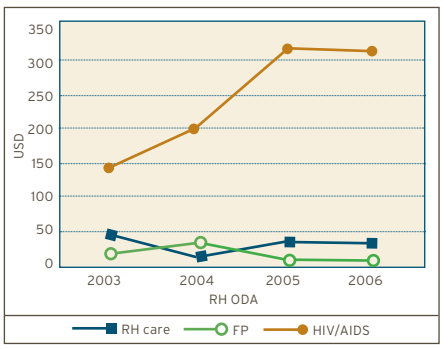
Reliable information on aid disbursements in these settings is key to increasing aid effectiveness. Yet little is known about aid disbursements for RH in conflict-affected countries.

To address this knowledge gap, researchers from the RAISE Initiative,[10] the London School of Hygiene & Tropical Medicine, and King's College London investigated disbursements of official development aid (ODA) for RH activities in 18 conflict-affected countries between 2003 and 2006, using data from the Creditor Reporting System and the Financial Tracking System databases. Published in the online medical journal *PLoS Medicine*, "Tracking of official development assistance for reproductive health in conflict-affected countries" is the first systematic analysis of ODA disbursement for RH to conflict-affected countries.

Study findings

The study reveals notable inequity in funding for RH to conflict-affected countries. During the period 2003-2006, it was found that:

- An annual average of $20.8 billion in total ODA was disbursed to 18 conflict-affected countries,[11] of which an annual average of $509.3 million, or 2.4%, was allocated to RH. This translates to $1.30 per capita per year.
- Of the annual average of $509.3 million ODA for RH, only 1.7% was disbursed to support family planning activities compared to 46.7% to support HIV/AIDS control efforts.
- While a 77.9% increase of ODA for RH was observed over the assessed period, this increase was largely due to a 119.4% increase of ODA disbursement for HIV/AIDS and sexually transmitted infection control. In contrast, funding for other main RH activities, including family planning, dropped by 35.9% (Box 1).



Box 1: ODA disbursement to 18 conflict-affected countries between 2003-2006 for three selected RH areas.

A comparison of conflict-affected countries qualifying as "least developed countries" (LDCs) to comparable non-conflict-affected LDCs shows that less ODA is disbursed

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for RH in conflict-affected LDCs, despite generally worse RH-related indicators in these countries.[12 13] For example, six out of eight LDCs with the world's highest maternal mortality ratios are conflict-affected: Afghanistan, Angola, Chad, Liberia, Sierra Leone, and Somalia.

Between 2003 and 2006, an annual average of 4.4% of all ODA disbursed to sampled conflict-affected LDCs was allocated to RH activities, compared to 8.9% in sampled non-conflict-affected LDCs (Box 2).

2003-2006	LDC conflict	LDC non-conflict
MMR	1041.3	719.69
CPR	10.6	18
TFR	5.9	5
HIV	2.9	4.5
RH ODA per capita in USD	1.5	2.3
RH % of all ODA	4.4	8.9

Box 2: Average indicators and ODA for 18 conflict-affected LDCs and 36 non-conflict-affected countries.

MMR = maternal mortality ratio
CPR = contraceptive prevalence rate
TFR = total fertility rate
HIV = HIV/AIDS rate

Discussion

This study suggests that while overall RH ODA to conflict-affected countries increased during the study period, this increase was not reflected in ODA for non-HIV/AIDS activities.

Potential explanations for these findings include:

- Low prioritisation of RH by donors, as well as recipient governments and humanitarian agencies, resulting in a lack of funds and demand for funding for RH activities.
- Lack of information on RH needs in conflict-affected countries, including the impact and effectiveness of RH-related activities, to help inform ODA decisions.
- Lack of capacity to implement RH activities.
- Short-term funding cycles that do not support the longer term benefits of improved RH outcomes.

The findings of this study are consistent with the outcome of a RAISE study (forthcoming)[14] assessing the extent to which RH is addressed in national and international humanitarian policies. The RAISE policy study suggests that while polices and guidelines related to HIV/AIDS and/or gender-based violence are well presented, references to family planning and emergency obstetric care are severely lacking.

Recommendations

The funding study provides evidence of inequity of RH ODA disbursement between conflict-affected and non-conflict-affected countries, and explicitly demonstrates a decline in funding for non-HIV/AIDS RH activities in conflict-affected countries.

To ensure RH needs in conflict settings are addressed and adequately funded, multilateral agencies, donors, and host governments should:

- Address the full range of RH needs, including family planning and emergency obstetric care, in humanitarian policies and needs assessments.
- Ensure that all RH areas, including family planning and emergency obstetric care, are adequately funded, and that HIV/AIDS-related ODA is not provided at the expense of other RH activities.
- Monitor and evaluate RH ODA expenditure, via existing data collection systems, in order to improve the efficiency and effectiveness of aid.
- Support additional research to determine funding requirements in conflict-affected countries.

Please visit PLoS Medicine *for the full study (www.plosmedicine.org).* PLoS Medicine *is a peer-reviewed, international, open-access journal publishing important original research and analysis relevant to human health.*

This study was initiated by the *Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative*, a programme that seeks to bring about change in the way RH is addressed in humanitarian settings by all actors involved. One of the core goals of the programme is to generate evidence-based data in order to highlight existing gaps, challenges, and opportunities to promote access to quality RH services in humanitarian settings at policy and operational levels.

The funding study is a critical element of the RAISE research agenda. It provides solid evidence that despite generally worse RH indicators in humanitarian settings, funding for RH in these settings is lower than in development settings. By disseminating its unique findings, the RAISE Initiative aims to encourage a rethinking of current funding realities in humanitarian settings.

[1] *United Nations. Programme of Action, International Conference on Population and Development. Cairo, 5-13 September 1994. New York: United Nations, 1995*

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[3] *Bosmans M, Chikuru M, Claeys P, Temmerman M. Where have all the condoms gone in adolescent programmes in the Democratic Republic of Congo. Reproductive Health Matters, 2006, 14(28):80-88*

[4] *Women's Refugee Commission, UNFPA. We Want Birth Control: Reproductive Health Findings in Northern Uganda. June, 2007, New York/Washington D.C. http://www.womenscommission.org/pdf/ug_rha.pdf*

[5] *UN Resolution A/RES/60/1; 2005 World Summit Outcome, paragraphs 57g and 58c, General Assembly, United Nations, 24 October 2005, New York. http://www.undemocracy.com/A-RES-60-1.pdf*

[6] *Inter-agency global evaluation of reproductive health services for refugees and internally displaced persons. IAWG, November 2004. http://www.iawg.net/resources/2004_global_eval*

[7] *UN Resolution E/CN.9/2009/5; Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development, 42nd session of the Commission on Population and Development, March 2009, United Nations, New York. http://www.un.org/esa/population/cpd/cpd2009/comm2009.htm*

[8] *Senanayaje P, Hamm S. Sexual and reproductive health funding: donors and restrictions. Lancet, 2004, 363(9402):70*

[9] *Bernstein S, Say L, Chowdhury S. Sexual and reproductive health: completing the continuum. Lancet, 2008, 371(6920):1225-26*

[10] *RAISE is a joint initiative of the Columbia University Mailman School of Public Health and Marie Stopes International.*

[11] *Afghanistan, Angola, Burundi, Central African Republic, Chad, Democratic of Congo, Eritrea, Iraq, Liberia, Myanmar, Nepal, Sierra Leone, Somalia, Sri Lanka, Sudan, East Timor, Uganda*

[12] *RAISE Fact Sheets: Comprehensive Reproductive Health Care, 2008. http://www.raiseinitiative.org/library/pdf/fs_crhc_uk.pdf*

[13] *Contraceptive prevalence rate for modern contraceptive methods based upon data and definitions from 'World Contraceptive Use 2005', United Nations Department of Economic and Social affairs, Population Division, 2006. http://www.un.org/esa/population/publications/contraceptive2005/WCU2005.htm*

[14] *The RAISE Initiative, A review of the policy environment on reproductive health in emergencies, 2009, London. In production*