3.8 European Union

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The European Commission (EC) began its involvement in HIV/AIDS support to developing countries through an initiative in the late 1980s aimed at all ACP (African, Caribbean and Pacific) countries who had signed the Second Lomé Convention on European aid to developing countries. Nearly all ACP countries responded to the emergency programme, which had at its head the EC AIDS Task Force housed within the EC's Directorate General for Developed, known as DGVIII. The main aim of the Task Force was initially to "to prepare, supervise, and follow up projects for the Commission."

In May 1993, and in recognition that HIV/AIDS would be a long term issue requiring longer term commitments and structures, a new Health and AIDS Unit was established within the formal structure of the Commission. Consisting of 5 full-time professionals, mainly physicians and economists, it is backed up with technical expertise provided by the AIDS Task Force. The main role of this new unit is to give technical support to departments within the Commission that deal with particular regions of the world, and to Commission delegations abroad, with the preparation, appraisal and monitoring of health projects and programmes in developing countries.

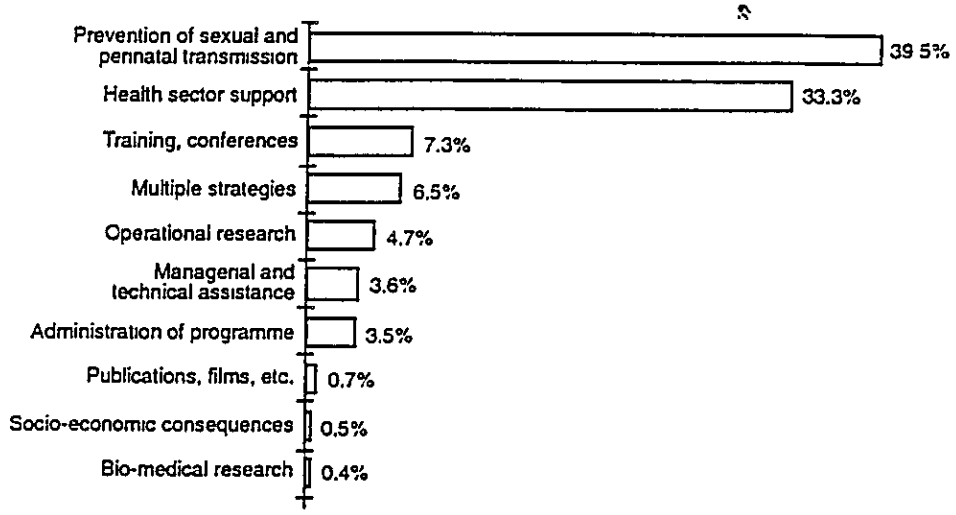
The objective of the Health and AIDS Unit is to integrate HIV/AIDS issues more into other health and development activities. Specific responsibilities include:

- development of, and monitoring the implementation policy guidelines
- programming of interventions
- supervising the preparation and implementation of HIV/AIDS interventions, using the technical assistance of the AIDS Task Force
- co-ordination, both internally between different departments of the Commission dealing with HIV/AIDS and externally, with other interested parties

Policy

Since the start of EC support of HIV/AIDS in developing countries, more than 220 projects have been supported. Of this number, 160 were specific to a particular country, with the remainder of projects regional initiatives. The types of projects supported by the EC are outlined in table 4.

Table 4: Distribution of EC funds committed to HIV/AIDS activities by type of intervention or strategy (1994)



Source: Action: The EC's response to HIV/AIDS in developing countries, 2nd edition, summer 1994

Nearly half of the projects have been in Africa, because African states make up the majority of signatories to the Lomé Conventions, and because so far Africa has the largest number of HIV infections and least amount of resources to cope.

Six goals have been identified for the EC's work on HIV/AIDS in developing countries:

1. minimise the number of new infections

2. prevent discrimination against, and exclusion of, those already ill, or infected by HIV, or at risk of infection

3. enable health systems to cope with the additional burden created by reorganisation; and to provide AIDS patients with care and enable them to die with dignity

4. minimise the effect of social and economic development

5. reduce the impact of some types of development projects on the spread of HIV and, conversely, to mobilise development effort on behalf of disadvantaged and marginalised people who are particularly at risk of HIV infection

6. increase scientific understanding of HIV/AIDS and of the possible interventions, and to monitor and evaluate progress

These six goals are followed by six policy principles derived from the general development policy of the EC and its member states. These are:

1. adaptation to risk environments - interventions should focus not only on individual behaviours but also on the social and structural determinants of exposure to risk

2. gender sensitivity and specificity - must be inherent in interventions and form part of long term objectives

3. social learning and respect for human rights - interventions need to avoid coercive and counter-productive models, and prevent discrimination

4. empowerment and responsibility - most HIV/AIDS activities cannot merely be administered but require motivation and support. Commitment is needed from individuals, communities, and government

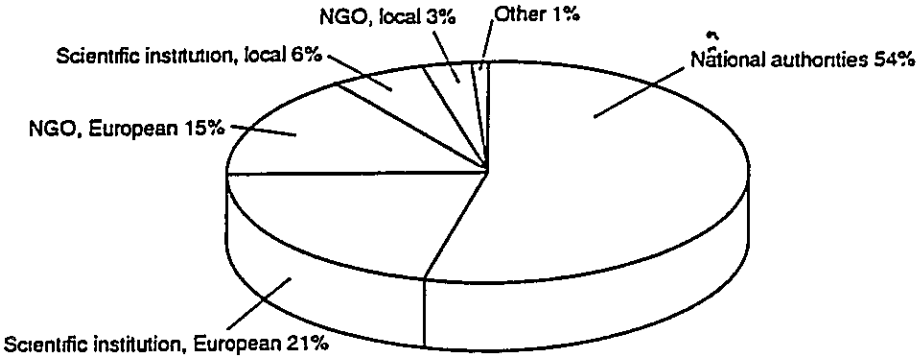
5. integration into a wider framework - HIV/AIDS work must be integrated into other community activities

6. timing - responses to HIV/AIDS need to take into account the differing stages of the epidemic. Every response should come at an appropriate state in the progress of the epidemic

Themes of particular importance within the EC's strategy include safe blood, diagnosis and treatment of sexually transmitted diseases (STDs), maternal transmission, education, training, strengthening the health service and health policies, and mitigating socio-economic impacts.

The EC collaborates both internally within European Union structures and within Europe, and externally with United Nations agencies, NGOs, and other donors and organisations involved in HIV/AIDS work. Recently, the EC extended its collaboration to include support for the International HIV/AIDS Alliance (see section 3.7.2.3). Because the EC is not able to implement all of its activities, it works through partners, usually governments. Other partnerships include universities, NGOs, and medical and educational institutions (see Table 5).

Table 5: Distribution of EC funds for HIV/AIDS activities by main partner

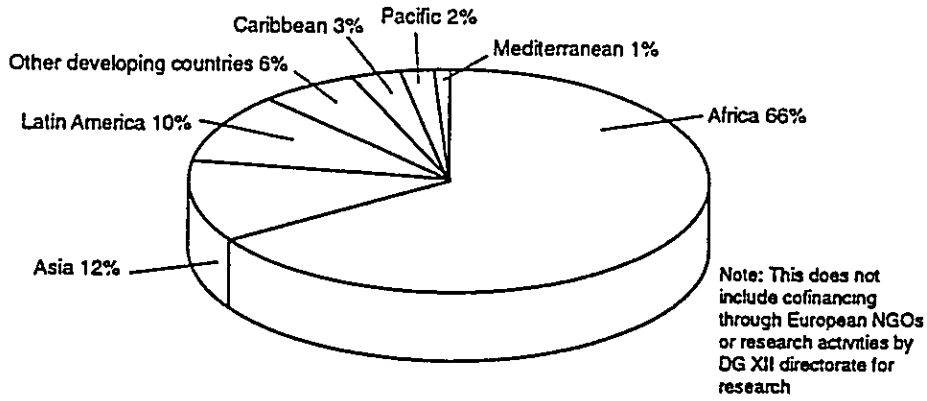


Source: Action: The EC's response to HIV/AIDS in developing countries, 2nd edition, summer 1994

Priority countries and regions

Table 6 shows that currently more than 66% of EU support for HIV/AIDS in developing countries is directed to African states. This is followed by Asia (12%), Latin America (10%), the Caribbean (3%), Pacific (2%), Mediterranean (1%), and all other developing countries (6%). As noted previously, countries who are signatories of the Lomé Conventions received the bulk of EU assistance.

Table 6: Regional distribution of EC funds committed to HIV/AIDS activities in developing countries



Source: Action: The EC's response to HIV/AIDS in developing countries, 2nd edition, summer 1994

HIV/AIDS as a priority issue

By establishing the Health and AIDS Unit in 1993, the EC signalled a high level of commitment to the issue. This is backed up by a continued expansion of financial and technical support, and is projected to increase over the coming years.

Barriers and restrictions

The EC recognises the importance of political leadership and supportive national policies within developing countries, without which progress against HIV/AIDS can be severely hindered. It also acknowledges that some religious and cultural practices can be incompatible with certain approaches to STD/HIV prevention but believes that communities are usually able to examine these practices and adapt them if supported by their leaders and government. Also, coercive approaches to HIV control are counter-productive, and may drive away the very people who need information, services, and support.

The EC bureaucracy itself is sometimes criticised as being too complex, confusing, and cumbersome to efficiently support HIV/AIDS initiatives. Decisions on funding requests can take many months, and reporting requirements are felt by many to be more rigorous than necessary.

Financial resources

From the period of 1986-91, the EC and its member states spent a total of US$281.291 million in support of the global AIDS strategies, meaning support to WHO's Global Programme on AIDS or to developing countries. This is more than that contributed by the USA during the same period, US$237.331 million, or the combined amount contributed by Norway, Sweden and Finland of US$143.069.[12]

Table 7 shows the breakdown in European contributions to the global AIDS strategy, including that of the European Commission, during the period of 1986-'91. The UK was the largest contributor with nearly US$60 million, followed by France (US$38.923 million), Denmark (US$36.896 million), and Germany (US$28.251 million).

[12] Source: *Action: The EC's response to HIV/AIDS in developing countries*, 2nd edition, 1994, page 9.

Table 7: European contribution to the global AIDS strategy 198-91 reported June 1991
Amount in millions US$

Region	To WHO/GPA	Through WHO/GPA	To country programme	Total
UK	37.424	10.372	11.544	59.340
France	4.349	0.245	34.329	38.923
Denmark	14.479	2.517	19.900	36.896
Germany	4.100	2.806	21.345	28.251
Netherlands	17.858	1.045	3.829	22.732
Italy	1.749		1.796	3.545
Belgium	0.987	0.057		1.044
Spain			0.800	0.800
EC/Community			89.760	89.760
Total	80.946	17.042	183.760	281.291

Source: Action: the EC's response to HIV/AIDS in developing countries, 2nd ed, 1994

The period of 1992-94 shows an actual increase in EC funding. In 1992, the EC's budget line was 6 million ECU[13] (US$7.2 million). This increased to 12.5 million ECU (US$15 million) in 1994.

Within the total amounts to be spent by the European Commission, they are predicting a shift in support, with social and economic impact taking a larger share. Direct efforts to minimise the spread of HIV will continue to take by far the largest share of funds. The Commission's forward financial commitment is not "fixed in concrete" but will be "reviewed in light of need." This message has been conveyed to the countries most afflicted by HIV/AIDS.

Technical expertise

From the beginning, the EC has sought to provide not only funding but also to develop technical expertise that would enable the full implementation of EC-supported projects. The AIDS Task Force continues to consist of highly skilled staff, with physicians, economists, and public health experts familiar with issues relating to HIV/AIDS and developing countries. Many of the personnel also have regional or country expertise. The creation of the Health and AIDS Unit in 1993 added five more technical experts and expanded the in-house expertise, particularly in the area of socio-economic issues.

[13] The exchange rate for the ECU used for these figures is 1 ECU = US$1.20.

Despite the availability of technical expertise in-house, the EC still relies on external consultants for specific projects, especially those with certain language skills or knowledge of particular countries. These consultants are almost always recruited from among EU member states. The AIDS Task Force maintains its own database of consultants for this purpose. Unfortunately, they do not allow it to be searched by outside agencies. They have also identified consultants through ACT-HIV in the UK (see section 3.7.1).

Examples of projects supported by the EC

- South Pacific Commission - in 1990 the SPC established an education and communication project on AIDS and STDs among its 22 member states, which included a documentation centre, information exchange activities, and help for local HIV/AIDS education initiatives. The EC was asked to support the SPC's work, and a four year programme was agreed focusing on young people. An education officer is helping to develop peer group education schemes in which young volunteers are trained to carry out educational activities with other young people, initially in three pilot countries.

- National AIDS Programme, Mozambique - since the establishment of the NAP in 1987, the EC was requested to help in the area of STD control. Since the pilot phase in 1988, the aim has been to strengthen the management of STDs and improve the diagnosis, treatment and counselling of STD patients. Support was given both at the reference level, at Maputo's central hospital, and at the application level, in the primary health centre. Second and third phases began in 1991 and have sought to boost clinical management and laboratory services.

- Health education for urban children in Chile - beginning in 1991, the EC supported a project aimed at reaching out-of-school young people (ages 12-15) in Santiago. After a pilot phase where materials were reviewed and initial research was conducted, games and role plays were developed and tested. The programme was assessed and found to be effective, and has now expanded.

Section 4

Contraceptive supply assistance

4.1 Section overview

Policies, strategies and activities

Contraceptive supply assistance is viewed by the study countries as part of population programmes, or in some cases as part of health and population programmes. Governments tend to see contraceptive supply assistance in terms of broad population policies, encompassing alleviation of poverty, education of girls, and the reduction of maternal and child mortality. Reproductive health is increasingly seen as a vital part of this approach.

Most policies include principles requiring that assistance be tied to the active participation of the recipient country. Government and NGO sector donors often stipulate that family planning services in developing countries will only receive funding if they include choice, respect for local culture, and sometimes attention to vulnerable groups.

IPPF and UNFPA are often utilised by donors to procure and deliver bulk quantities of contraceptive commodities, and they are widely recognised for their expertise in procurement and logistics. UNFPA was also credited for its role in facilitating co-ordination at country level between donors.

All respondents reported that contraceptive commodities they purchase must conform to minimum internationally recognised standards. The International Standards Organisation (ISO) provides the basis for most suppliers of contraceptives. Some agencies refer to standards set by the World Health Organisation (WHO). In addition, nearly all respondents added the requirement that contraceptives must also conform to the national specifications of the recipient countries, where these exist.

Although reported NGO sector activity was small, many NGOs noted that they would be in a position to undertake more contraceptive supply assistance if they had more resources. This was the most frequently cited barrier to expanded action in contraceptive supply.

Types of family planning services and contraceptive supplies provided

Where responses to the questionnaires were provided, and based on review of published documents on population activities, it emerged that all the study countries were providing condoms, injectables, and oral pills. Only male condoms are supplied at present, although several organisations indicated that they are considering the provision of the female condom in future.

Other contraceptives supplied included intrauterine devices, tubal ligation, and vasectomy, although to a lesser extent than condoms, injectables, and oral pills.

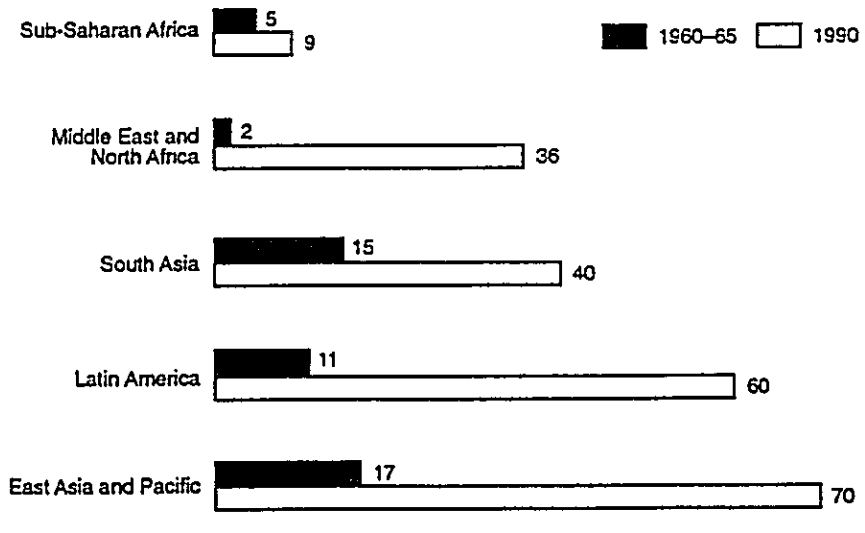
None of the study countries were providing mifepristone (RU486), and most of the respondents reported little if any support for abortion. It was noted by many respondents that abortion is a very politically sensitive issue, and most organisations have specific written policies covering abortion. In many cases, abortion is not supported, but menstrual regulation or help in instances where a women's life is in danger due to pregnancy would be accepted as part of family planning or population programmes.

Priority countries and regions

When it comes to contraceptive supply, many governments and NGOs do not use a list of priority countries or regions as criteria for assistance. The Netherlands and Sweden in particular noted that they do not have priority countries for contraceptive assistance. British government aid for contraceptive supply is tied to the same list of priority countries as for health and population aid.

Countries frequently cited as recipients of contraceptive supply assistance included Bangladesh, India, Kenya, Tanzania, and Zimbabwe. It is interesting to see how this compares to the prevalence of contraceptive use in developing countries (see Table 8).

Table 8: Prevalence of contraceptive use in developing countries



Source: J Ross: Family Planning and Child Survival Programs as Assessed in 1991. Population Council, 1992

Financial resources

Government expenditure on contraceptive supply favours multilateral channels, with most funding directed through UNFPA or IPPF. Data from 1990 indicates that the combined contribution from the six study countries amounted to US$207 million in that year. The top five contributors per capita in 1990 were, in order of rank: Norway, Sweden, Finland, Denmark, and the Netherlands. The UK was ranked ninth with a contribution that year of US$37 million (see Table 9).

Table 9: Contributions to world population assistance
(Ranked by per capita contributions)

Donor country	Per capita 1990 (US$)	Total population assistance, 1990 (US$ millions)	Share of year 2000 budget required for universal access to family planning (US$ millions)
Norway	11.98	50	above target
Sweden	5.02	43	42
Finland	4.28	21	23
Denmark	4.20	21	26
Netherlands	2.32	35	57
Canada	1.62	43	108
United States	1.12	281	1.199
Switzerland	0.96	6	48
United Kingdom	0.65	37	179
Germany	0.60	48	301
Japan	0.52	64	637
Belgium	0.25	3	37
Australia	0.24	4	50
France	0.15	9	235
New Zealand	0.12	0.4	9
Italy	0.03	2	200
Austria	0.03	0.2	31
Former USSR less than	0.01	0.6	668
Hong Kong	0.00	0	12
Ireland	0.00	0	7
Israel	0.00	0	8
Kuwait	0.00	0	7
Saudi Arabia	0.00	0	20
Singapore	0.00	0	62
Spain	0.00	0	62
United Arab Emirates	0.00	0	6
Total			4.000

Source: United Nations, compiled by Population Crisis Committee, 1994

Most governments reported stable budgets for contraceptive supply, and estimate that levels of spending in this area will remain constant or expand slightly in the coming years. An exception is Finland, which has experienced reductions in its population budget. From a high of US$21.4 million in 1991, its 1993 budget was down to US$6.6 million. The Netherlands is predicting an increase in funding for contraceptive supply, particularly in light of the World Population Conference in Cairo last year.

Due to economies of scale favouring large bulk purchasing of contraceptive commodities, NGO funding has tended to focus on the training of personnel in the provision of clinical and counselling services. When possible, NGO-supported projects in developing countries try to access contraceptives through national programmes which are often funded through bilateral assistance. Only small-scale activity was reported by NGOs in the area of contraceptive supply. With the exception of IPPF which reported an annual expenditure on contraceptive supply of US$10 million in 1994, NGO spending was usually in amounts under US$20,000 per project.

4.2 Denmark

4.2.1 Government - DANIDA (Danish International Development Agency)

Dr Finn Schleimann
DANIDA (Danish International Development Agency)
Ministry of Foreign Affairs
2 Asiatisk Plads
DK-1448 Copenhagen K
Denmark
Tel: 45 33 92 00 00 Fax: 45 31 54 05 33

Danish government responsibility for overseas contraceptive supply assistance resides within DANIDA (Danish International Development Agency). Unfortunately, DANIDA health and population staff were unable to respond to the study questionnaire, nor were they able to send information due to other work priorities and travel demands. Some information about DANIDA's overall development policies and strategies is included in section 3.2.

A review of externally published information suggests that Denmark's total assistance for population programmes was US$21 million in 1990.[14] More recent figures were not available.

Enquiries about DANIDA contraceptive supply assistance should be directed to the Health Department at DANIDA.

4.2.2 NGO sector

Five Danish NGOs thought to be active in contraceptive supply assistance were contacted for the study.[15] These were:

- World Assembly of Youth
- Danish Red Cross Society
- Red Barnet (Save the Children)
- Foreningen for Familieplanlaegning (Danish Family Planning Association)
- Danchurch Aid

Of these, World Assembly of Youth, Danish Red Cross and Red Barnet responded that they are not involved in contraceptive supply assistance.

Two NGOs, Foreningen for Familieplanlaegning and Danchurch Aid, noted limited activity in the area.

[14] Source: *UN Population Crisis Committee Report*, 1990.

[15] Full contact information for these organisations is contained in appendix A3.

4.2.2.1 Foreningen for Familieplanlaegning (Danish Family Planning Association)

Inge Bulow-Ludvigsen
Foreningen for Familieplanlaegning (Danish Family Planning Association)
Aurehojvej 2
DK-2900 Hellerup
Denmark
Tel: 45 31 62 56 88 Fax: 45 31 62 02 82

The Danish Family Planning Association does not supply contraceptives, but refers requests to IPPF who are able to supply at much lower cost. The Association's main assistance to developing countries consists of:

- training of trainers
- contraceptive information and counselling
- management of reproductive health
- training of sex educators

Source:

- letter written in response to questionnaire

4.2.2.2 Danchurch Aid

P Kristian Pedersen
International Department
Danchurch Aid
Sct. Peders Straede 3
DK-1435 Copenhagen
Denmark
Tel: 45 33 15 28 00 Fax: 45 33 15 38 60

Danchurch Aid, similarly, is not involved in contraceptive supply assistance. Although contraceptives such as condoms are distributed as part of broader projects related, for example, for counselling or education, Danchurch Aid is not taking part in mass distribution.

Danchurch Aid does have a procurement office and shipping department, but has provided supplies for blood supply screening, protection of health workers, refrigerators and vehicles, or for emergencies, not contraceptives.

Sources:

- telephone interview
- *AIDS strategy document* (undated)

4.3 Finland

Finnish support of contraceptive supply assistance is extremely limited. No NGO activity was reported. Study questionnaires were sent to:

- Finnish Red Cross Society
- Institute of Development Studies, University of Helsinki
- Development Cooperation, Helsinki School of Economics

Finland's Health and Development Cooperation Agency (HEDEC) responded with limited information for the purposes of this study.

4.3.1 Government - FINNIDA (Finnish International Development Agency)

Leena Viljanen
FINNIDA (Finnish International Development Agency)
Ministry for Foreign Affairs of Finland
Katajanokanlaituri 3
FIN - 00160 Helsinki
Finland
Tel: 358 0 134 161 Fax: 358 0 622 2576

Information about FINNIDA's overall development policies are contained in section 3.3. The government's overall reduction in funding for overseas aid has had an impact on all sectors, although support for population programmes appear to have remained fairly constant.

FINNIDA does not have exact policies for overseas aid, including for contraceptive supply assistance. Instead, each situation is considered separately. Strengths and weaknesses of the health care system are analyzed, with the ultimate aim of enabling service users to make choices which best suits their needs.

Priority regions and countries

These are the same as for those mentioned in section 3.3. No specific countries were mentioned as key recipients for FINNIDA support in the area of population.

Financial resources for population programmes

The bulk of Finnish support for population activities is channelled through funding to the UNFPA. In 1993 this amounted to US$6.6 million, a considerable reduction from US$17.8 million the previous year and US$21.4 million in 1991. UNFPA was the third largest UN agency receiving Finnish multilateral support, followed by the UNDP and World Food Programme.

Since 1989, FINNIDA has funded the WHO Collaborating Centre at Oulu University for research in human reproduction. Approximately US$600,000 is provided annually for this programme.

Support for bi-lateral populations programmes amounted to US$1.3 million in 1993, or 0.5% of Finland's total overseas aid. Specific information about how this money was spent was available.

4.3.2 Health and Development Cooperation Agency (HEDEC)

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Health and Development Cooperation Agency (HEDEC)
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PO Box 220
FIN - 00531
Helsinki
Finland
Tel: 358 0 3967 2041 Fax: 358 0 773 2922

As in the area of HIV/AIDS, HEDEC serves as a key contact point for FINNIDA in the area of contraceptive supply assistance. HEDEC itself is not involved in the implementation of contraceptive supply services, but does provide information support to overseas projects involved in this area. They can also assist programmes by helping to identify project experts and consultants within the fields of family planning and sexual and reproductive health.

Sources:

- questionnaire (from HEDEC)
- *Finland's Development Assistance 1993: annual report*
- HEDEC report, 1995

4.4 The Netherlands

4.4.1 Government - Ministry of Foreign Affairs

A Papineau Salu, Health Advisor
Ministry of Foreign Affairs
PB 20061
2500 EB The Hague
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Tel: 31 70 348 60 09 Fax: 31 70 348 59 56

Policy, strategies and activities

The aim of Dutch policy is to help reduce population growth by supporting a broad population policy, encompassing alleviation of poverty, education of girls, and reduction in maternal and child mortality. Reproductive health care and family planning are an essential part of this approach. These principles have been elaborated in a series of documents beginning with a 1988 memorandum *The population question and population policy as part of Dutch development cooperation.* It was further elaborated in 1990 in the policy document *A world of difference,* and again in 1993 in *A world of dispute.*

Since the 1970s, the Netherlands has channelled population activities support through multilaterals such as UNFPA and WHO, and international NGOs such as IPPF and the Population Council. In 1988 there was a policy shift and more scope for aid through bilateral contacts became a priority. Apart from bilateral aid to Indonesia's national family planning programme (now terminated) and a programme in Egypt, no bilateral activities have been developed since 1988. In 1992 the Minister for Development Cooperation stated emphatically that the Netherlands wanted to support more programmes through bilateral channels, and options are being explored in a number of countries.

The Netherlands sees population policy as an integral part of development policy. Special areas of attention include concern for urban poverty, women's autonomy, the environment and support for research, with particular attention to the relationship between population, environment and sustainable development.

The Netherlands favours multilateral channels (UNFPA, WHO, UNDP or UNICEF) for the supply of contraceptives and also seeks to promote local production and support distribution.

The principles underlying Dutch population policy as regards population issues are as follows[16]:

- an active population policy should be consciously chosen by a country. The policy should be based in part on a knowledge of demographic data

[16] From *Family planning and reproductive health in development cooperation,* Sectoral policy document of Development Cooperation No. 6, 1994.

- the policy should be supported politically and the government should be prepared to pay for as much of it as it can afford

- there should be recognition of the fact that the freedom of men and women to decide how many children to have and when to have them is a basic human right

- the alleviation of poverty should form an integral part of a country's development policy. Adequate attention must be paid to social matters, particularly in countries where structural adjustment programmes are being carried out

- women's physical, economic, cultural and social autonomy and improving their status should be important features of a county's policy. Economic independence enables women to have more say in the exercise of their reproductive rights

- education raises women's status and increases their autonomy; it also has a considerable effect on the number and health of the children they have. A good population policy is conditional upon increasing access to and improving the standards of education for girls

- attention should be devoted to health, and to standards of and access to health care facilities especially. Particular areas for attention include the care of mothers and children, immunisation, improving the nutrition of women and children, HIV/AIDS and the treatment of sexually transmitted diseases, and good medicine supplies; facilities in all these areas should also be available to the urban poor

- legislation and the legal system in a country are important parameters for the implementation of a good population policy. Legislation and regulations are particularly important with regard to subjects such as the recognition of general human rights, raising the legal age for marriage, the right to provide information freely, the free availability of contraceptives, the legality of abortion, improvements in the status of women and the prevention of discrimination

The Ministry has outlined the following principles to help inform its support of family planning:

- choice
- no compulsion or reward
- respect for local culture
- attention for vulnerable groups
- attention for men

Two points within Dutch government policy deserve special notice here. The first concerns access to safe abortion. The policy states that 'safe abortion should be made possible and accessible as part of a total range of provisions and services. It should be noted in this context that the Netherlands Government in no way seeks to promote abortion as an easy form of contraception. The Netherlands believes that safe abortion facilities should be available and accessible and intends to bring up the subject in policy dialogue with national governments.'

The second policy worth mentioning concerns contraceptive supply specifically: 'uninterrupted supply of contraceptives is very necessary but not in itself sufficient for a good population policy.'[17]

Activities which may receive support from the Netherlands include:

- the supply and production of contraceptives and more specifically the inclusion of contraceptives in essential drugs programmes
- the provision of facilities and services for groups which ordinary health care is not reaching

The Netherlands can assist with setting up of local contraceptive production capacity, whether it be a total production process or only part of it, such as the packaging of contraceptive pills. There is recognition that setting up local production is not easy, or cheap, particularly at the beginning, and in most cases it will still be necessary to import raw materials. There must be an adequate market, and technical expertise must also be available and existing patent rights must be taken into account.
Key points in Dutch policy guidelines are:

- has a feasibility study been conducted?
- consideration must be given to whether sufficient knowledge and expertise is available for quality and hygiene standards to be met
- check whether the information provided as part of the packaging of contraceptives comprehensibly and accurately indicates their effectiveness, side-effects, contra-indications, use-by-date and how they should be used

The Ministry policy guidelines also emphasise the importance of continual supply of contraceptives for programme success. They therefore recommend devoting attention to the whole process of supply when a programme is being set up including storage at ports and airports, transport and distribution. Cooperation and coordination are desirable, for example by including contraceptives in essential drugs programmes, making them available as part of ordinary primary health care.

Key points for attention are:

- legislation in order to avoid delays upon import
- check whether the government departments concerned (eg Ministry of Finance, Ministry of Trade and Ministry of Health) are cooperating sufficiently
- consideration to be given to any bottlenecks which may exist in the supply route and to the role played by civil servants. Are there any ways of resolving the bottlenecks?

[17] From *Family planning and reproductive health in development cooperation*, Sectoral policy document of Development Cooperation No. 6, 1994, page 47.

- check whether storage facilities and transport vehicles meet quality requirements and whether care is taken to ensure compliance with regulations. Assess what measures can be taken to improve the situation

The Ministry of Foreign Affairs has no specific policy on the supply of contraceptives, but focuses on stimulating the acceptance of contraceptives in essential drugs lists.

The preferred strategy of the Ministry is to work through reproductive health programmes.

Type and availability of contraceptives

The Ministry indicated that it funds the following types of family planning services and contraceptive supplies:

condoms
injectables
intrauterine devices
oral contraceptives
male and female sterilisation
Norplant

Abortion and RU486 are not provided.

Legal issues, regulations and guidelines

Technical specifications are not applicable. The same regulations apply as for the procurement of other goods such as drugs: this means international competitive bidding.

Priority countries and regions

Given the lack of a more specific policy, there are no priority countries and regions.

Financial assistance and other factors affecting supply

Information about the annual budget for contraceptive supply is not available and the proportionate support provided through multilateral, bilateral and NGO channels is also not available. Sources outside the Ministry estimate that the total population assistance in 1990 from the Netherlands was US$35 million.[18]

The level of funding for contraceptive supply through the Ministry of Foreign Affairs is thought to be likely to increase, but integrated with support for reproductive health. The Ministry stated in 1994 that 'the Netherlands is not to reduce its financial contributions to multilateral organisations and international NGOs in the years ahead. Some may be raised, partly on the basis of the results of the World Population Conference in Cairo.'[19]

[18] From *UN Population Crisis Committee Report*, 1990.

[19] From *Family planning and reproductive health in development cooperation*, Sectoral policy document of development cooperation no. 6, 1994, page 45.

The Netherlands has been one of the UNFPA's most important donors since its establishment, and the UNFPA's objectives and principles are much the same as those of the Netherlands. UNFPA received a general contribution of 58 million guilders (US$33 million) in 1993. This includes amounts which are passed on by the Fund (in additional to the usual 10% of the annual contribution to UNFPA) to international NGOs:

- IPPF - received 5.8 million guilders (US$ 3.3 million) in 1993
- Population Council - has received 250,000 guilders (US$144,000)

The Netherlands contributes to the WHO Human Reproduction Programme and to the Global Programme on AIDS (GPA). In 1993 WHO/HRP received 750,000 guilders (US$430,000), GPA 9 million guilders (US$5.16 million), and UNICEF a general contribution of 37 million guilders (US$21.3 million). The Netherlands is urging UNICEF to implement its family planning policy, drawn up in 1993.

Research

The Netherlands advocates a balanced approach to research between biomedical research and research in the social and behavioral sciences. It emphasises ethical aspects of research, with a focus on reproductive health and a multi-faceted broad approach. A critical stance with regard to research into a contraceptive vaccine for women is taken.

Sources:

- questionnaire
- *Family Planning and Reproductive Health in Development Cooperation,* Sectoral Policy Document of Development Cooperation no. 6, Ministry of Foreign Affairs, 1994

4.4.2 NGO sector

Contraceptive supply assistance through NGOs is limited in the Netherlands. Questionnaires were sent to the following in the NGO sector:

- World Population Foundation
- HIVOS
- ICCO
- NOVIB

Catholic NGOs, including Memisa Medicus Mundi and CEBEMO, were not sent the contraceptive supply assistance questionnaire.

Of the NGOs contacted, only the World Population Foundation and ICCO stated that they were involved in family planning assistance, although this does not include contraceptive supply.

4.4.2.1 World Population Foundation (WPF)

Janneke W Roos, Head
Projects and Training
World Population Foundation (WPF)
Derkinderenlaan 14
1251 EM Laren
The Netherlands
Tel: 31 21 538 25 51 Fax: 31 21 538 94 33

WPF, established in 1987, formulates and manages sexual and reproductive health projects in developing countries, and provides technical support in collaboration with local organisations (government and NGO) and multilateral and bilateral donors. WPF through its own staff, consultants network and collaboration agreement with the Consultancy Group for Maternal Health and Family Planning, provides international consultancies, service delivery and training, and is involved in advocacy and education on population issues.

WPF's main activities are related to family planning programme management, for example as the executing agency for a UNFPA and Dutch government programme in the Philippines, and providing technical backup in-country to family planning and maternal and child health programmes such as project management and IEC activities in Burkina Faso for UNFPA and the Dutch government, monitoring population activities in Indonesia for the Dutch government, and providing clinical services in Tanzania sponsored by the SK-Foundation.

WPF is not involved in the procurement or provision of contraceptives supplies to developing countries.

Source:

- *World Population Foundation Document*, May 1995

4.4.2.2 ICCO (Inter-Church Agency for Development Cooperation)

Bert Noordergraaf
Policy Department
ICCO (Inter-Church Agency for Development Cooperation
PO Box 151
3700 AD Zeist
The Netherlands
Tel: 31 34 042 78 11 Fax: 31 34 042 56 14

ICCO is providing contraceptives as part of ongoing programmes, in particular condoms as part of health education and promotion activities. No specific breakdowns or financial information was available.

Sources:
- questionnaire
- telephone interview

4.5 Norway

4.5.1 Government - NORAD (Norwegian Agency for Development Cooperation)

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Health Division
NORAD (Norwegian Agency for Development Cooperation)
PB 8034 Dep.
030 Oslo
Norway
Tel: 47 22 31 44 00 Fax: 47 22 31 44 01

NORAD was unable to specifically respond to the study questionnaire, stating that their data on contraceptive supply assistance is not accessible in the format requested. Although NORAD publishes detailed information about its aid, sector breakdowns do not include population programmes and/or contraceptive supply. Norway is, however, known to be a large contributor to population activities. Since the early 1970s, Norway has been devoting 10% of its overseas aid to population activities.[20]

Multilateral funding for population programmes by NORAD has focused on support to the World Bank as part of special funds for Bangladesh, and to the UNFPA. Specific figures were not available. Review of external documentation suggests that Norway's population assistance was US$50 million in 1990.[21] More recent estimates were not available.

4.5.2 NGO sector

The main Norwegian NGOs were contacted regarding contraceptive supply assistance. These were:

- Norwegian Red Cross
- Norwegian Church Aid
- Redd Barna
- Norsk Forening for Familieplanleggning (Norwegian Family Planning Association)

None of these NGOs reported involvement in developing country contraceptive supply assistance.[22] However, follow-up interviews revealed that many Norwegian NGOs incorporate small-scale condom distribution as part of existing programmes, but no specific figures are available.

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[20] Source: *Family planning and reproductive health in development cooperation*, Sectoral policy document of Development Cooperation No. 6, 1994.

[21] Source: *UN Population Crisis Committee Report*, 1990.

[22] Each of these agencies returned a questionnaire and were follow-up by telephone.

4.6 Sweden

4.6.1 Government - SIDA (Swedish International Development Agency)

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Health Division
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Sweden
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Since the 1930s, Sweden has promoted the right to information about and access to affordable methods of contraception, promoted by RFSU (Swedish affiliate of IPPF). In the 1960s Sweden signed the first bilateral international agreement in the family planning field, and has worked actively within the UN, at an early stage, to put family planning on the international agenda. Sweden was also a major supporter behind the formation of UNFPA and IPPF.

SIDA views counselling and access to contraceptives as a component of primary health care and within the framework of maternal health care. Programmes supported by SIDA have focused on supplying modern contraceptives like the pill, IUDs, injections and implants, and to a lesser degree barrier methods including the condom and diaphragm.

Policies, strategies, and activities

The Swedish attitude to family planning has been, from the beginning, that programmes should be based on the welfare and needs of the individuals and families concerned. Later developments have highlighted the need to enlarge the concept of family planning to sexual and reproductive health. SIDA's increased attention to adolescents and other neglected groups, for example, necessitates a conceptual change from the term family planning to fertility regulation or contraceptive services and counselling.

SIDA sees its future focus as[23]:

- support to extended services for contraceptive methods to all individuals regardless of age, sex and marital status
- support to the development of user controlled contraceptives, particularly barrier methods which can be controlled by women and which provide protection against STDs
- support to programmes for medically safe abortions and those making menstrual regulation methods available

[23] Source: *Sexual and reproductive health: development cooperation to promote sexual and reproductive health - an action plan of the Health Division of SIDA*, 1994.

- highlighting the abortion issue in international fora and in the development cooperation dialogue
- support to groups working to prevent unwanted pregnancies and promote the right to safe and legal abortion
- support to programmes for integrated post abortion family planning service responsive to women's needs

Type and availability of contraceptives

SIDA indicated that it currently supports the supply of the following contraceptives in developing countries:

abortion
condoms (not female condoms)
injectables
intrauterine devices
oral contraception
tubal ligation
vasectomy

Technical standards and specifications used for procurement

The procurement of contractives through SIDA follows the specifications of the International Standards Organisations (ISO), as well as conforming to the requirements of the recipient country where these exist.

Priority countries and regions

SIDA has no priority countries for contraceptive supply.

Financial assistance and other factors affecting supply

SIDA was unable to provide specific budget estimates for its annual expenditure on contracetive supply. They emphasise that their priority is to support sexual and reproductive health programmes, which may result in increased funding for contraceptive supply as part of these programmes.

SIDA's multlilateral support to UNFPA was SEK140 million (US$18.84 million in 1993-94, down by 7% from the previous fiscal year. Extra budgetary contributions were made to family planning associations via UNFPA to Nicaragua, Vietnam, Anglola, and Uganda. SIDA funding for IPPF was SEK89 million (US$11.98 million) during 1993-94.[24]

[24] Source: *Health sector support: facts and figures, 1992-1994*, 1994.

Statistics on funding by SIDA for country programmes in the area of contraceptive supply was not available, although they offered the example of Kenya in their questionnaire, where SEK10 million (US$1.35 million) has been provided in 1994-95 for the procurement of oral contraceptive pills.

4.6.2 NGO sector

Several Swedish NGOs were contacted regarding contraceptive supply assistance. These were:

- RFSU (Riksforbundet for sexuell upplysning) Swedish Association for Sex Education
- Swedish Red Cross
- Swedish Church Mission
- ARO
- Radda Barnen (Save the Children)

None of these NGOs are involved in contraceptive supply assistance to developing countries.[25]

RFSU's reported activities which focus primarily on sexuality education and with adolescents. Sometimes condoms are used as part of a campaign, but RFSU is not involved in contraceptive supply.[26]

Sources:

- questionnaire and telephone interview
- *Sexual and reproductive health: development cooperation to promote sexual and reproductive health - an action plan of the Health Division at SIDA*, 1994
- *Health sector support: facts and figures 1992-1994*, 1994

[25] Based on questionnaire responses and follow-up telephone interviews.

[26] Source: letter and follow-up telephone interview in response to study questionnaire.

4.7 United Kingdom

4.7.1 Government - Overseas Development Administration (ODA)

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Overseas Development Administration (ODA)
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Policy, strategies and activities

British support for contraceptive supply is viewed within the context of policies for health and population. These have been elaborated in section 3.7.1 of this report.

Since 1991, four major themes have emerged as part of ODA's goals for health and 'children by choice':

- health care management and health sector reform
- better reproductive health and children by choice
- reduced illness and death from communicable diseases, especially malaria, tuberculosis, and HIV
- better health services in emergency situations

ODA's objective is to help more women and men to choose when to have children by improving access to good family planning. This includes the provision of contraceptives to help women and men access the methods they want to use,[27] and better reproductive health through:

- improving access to services for safer childbirth
- treatment for STDs
- prevention of infertility
- reducing the effects of female genital mutilation
- promoting a range of good quality family planning services
- creating better educational opportunities for women

[27] Source: questionnaire response and *Children by choice not chance*, 1993.

Contraceptive supply assistance from the ODA is provided directly with the help of groups such as IPPF and UNFPA to assist in procurement and supply. ODA seeks to co-ordinate the provision of contraceptives by participating in local donor group and government fora, and by participating in UNFPA fora to consider contraceptive requirement issues.

Type and availability of contraceptives

ODA has indicated that it funds the following:

condoms
injectables
intrauterine devices
oral contraception

Pessaries and spermicides are also provided by the ODA.

There is currently no funding for tubal ligation or vasectomy, but the ODA is prepared to consider support in this area. The ODA is currently not supporting abortion and does not promote it as a means of family planning.

Priority countries and regions

Countries prioritised to receive contraceptive supply assistance from ODA are the same as for HIV/AIDS. Not all of these, however, are currently provided with contraceptive supply assistance. The countries are:

Africa: Kenya, Uganda, Tanzania, Ghana, Nigeria,Zimbabwe, Zambia, and Malawi

Asia: Pakistan, India, Bangladesh, and Nepal

Recent additions to the ODA list: South Africa, Namibia, Cambodia, Russia, Kazahkstan, Kyrgyzstan, and Peru.

Technical specifications

Contraceptives are provided which meet the standards and specifications required by the relevant ministries of recipient countries. Where no specifications exist, ODA follows the recommendations of WHO.

There are general ODA procedures for procurement which pertain to contraceptives, such as ensuring transparency and accountability.

The ODA is not tied to the purchase of contraceptives manufactured in the UK. However, it has a memorandum of understanding that specifies IPPF as a specialist procurement agent for certain contraceptives. The Crown Agents are also used for procurement, although this is not required.

Financial resources

The ODA expects to commit at least £100 million (US$156 million) on population and reproductive health projects in 1994-95. A significant portion of this budget will be spent on contraceptives, but the ODA was unable to specify exact figures. £10 million (US$15.6 million) per year is a rough estimate.[28]

ODA's policy of seeking co-ordination and collaboration with IPPF and UNFPA is reflected in its annual contribution to these two agencies. In 1994, £7.5 million (US$11.7 million) was contributed to IPPF, and £8.5 million (US$13.26 million) to UNFPA. Overall, however, ODA support is primarily bilateral, and last year this amounted to £28.99 million (US$45.22 million).

Contraceptive supply is also financed through various NGO projects via the ODA's Joint Funding Scheme. In 1994 this amounted to £696,374 (US$1.08 million).[29]

Some specific country project funding by ODA for contraceptive supply includes:[30]

- £7.6 million (US$11.9 million) for spermicides in Pakistan 1994-97
- £3.3 million (US$5.15 million) for condoms and injectables in Nigeria in 1993
- £1.1 million (US$1.72 million) for condoms and oral contraceptives in Orissa, India 1994-98
- £2 million (US$3.12 million) for the provision of Depo Provera and IUD kits in Kenya 1991-94
- £1.2 million (US$1.87 million) for the provision of Depo Provera and Norplant in Peru 1994-95
- £1.5 million (US$2.34 million) for oral pills in Bangladesh 1994

The ODA expects to continue support for contraceptive supply in future, and predicts that existing levels of support will be maintained and possibly expanded.

[28] Source: informal communication to AHRTAG by ODA.

[29] Source: questionnaire from John Worley, ODA.

[30] Source: questionnaire from John Worley, ODA.

Research

A balance between biomedical and social research is sought by the ODA and reflected in the work it will fund. Some examples of research supported by the ODA in 1994 include:

- £53,578 (US$83,581): Hypertension in pregnancy, Jamaica
- £14,076 (US$21,958): Socio-cultural determinants of induced abortion in developing countries
- £2,299 (US$3,586): Evaluation of training skills and practice of traditional birth attendants, Tanzania
- £79,552 (US$124,101): The management of Eclampsia-controlled trial of magnesium sulphate and diazepam to reduce maternal mortality
- £13,852 (US$21,609): Assessment of reproductive health needs of out-of-school adolescents, Nigeria

Sources:

- questionnaire
- *Children by choice not chance*, 1993
- *British overseas aid, annual review 1994*, 1994
- *British aid for health and population*, ODA briefing paper no. 4, 1995
- *Health and population policy statement*, ODA, 1994

4.7.2 NGO sector

4.7.2.1 International Family Health (IFH)

Susan Crane, Executive Director
International Family Health (IFH)
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UK
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International Family Health (IFH) was established in 1991 and aims to "improve the health of people in developing countries through the promotion and delivery of products for health, child spacing and disease prevention." It works to ensure that local projects in developing countries have access to the education, expertise and commodities they need to address their specific health needs. IFH plans to expand activities in the areas of family planning and particularly in the field of social marketing. Its 1994 budget expenditure totalled £517,464 (US$807,244).

Policy, strategies and activities

IFH does not have a written policy on the provision of contraceptives, nor have they been supplying these to partners as yet, although several projects are expected to begin later in 1995. Despite this, IFH adheres to the following principles:

- IFH will only support the supply of contraceptives which have been scientifically proven to be effective and non-harmful to users
- contraceptives supplied through IFH must comply with international standards
- support will only be provided where appropriate measures are in place for counselling, informed choice and suitable back-up

Current strategies mainly relate to condom and oral contraceptive supply. During 1995, IFH is supporting several projects in India (both for family planning and HIV/AIDS prevention) which will include the supply of condoms and a subsidy for the cost of the pill. Another project in Nigeria will provide equipment necessary for the treatment of incomplete abortions.

A new strategy which IFH is trying to implement is the creation of a European consortium of international NGOs, advertising firms and pharmaceutical companies to work together on the supply of contraceptives for social marketing programmes around the world. Such a consortium would pool expertise and provide a useful channel for donor agencies. They have received positive feedback to this concept but have no firm commitments for further development as yet.

Family planning services and contraceptive supplies which IFH will provide include:

abortion
condoms (not female condom)
injectables
intrauterine device (IUD)
oral contraception
tubal ligation
vasectomy

IFH requires that contraceptives meet international standards. Supplies are procured locally or within the region when possible, and same specifications apply.

Priority regions and countries

IFH's priority regions at present are Africa and Asia.

Barriers or restrictions

The main barriers faced by IFH relate to funding and medical restrictions. The amount of funding available for commodity supply limits the amount of work IFH is able to undertake, since many funders are reluctant to supply funds for the quantity of contraceptives normally

required for a large-scale social marketing project. Medical restrictions pose a barrier in countries where only limited types of contraceptives are approved for use, or where the only approved contraceptives are made in the project country and the quality is not sufficient (this normally relates to oral contraceptives). Other barriers relate to the high levels of duty placed on contraceptives that are imported to developing countries and the length of time it takes for governments to provide import approvals and clearing from ports.

Financial resources

IFH projects including contraceptive supply are still not yet implemented, and therefore budget figures are not available.
Its total budget expenditure for 1994 was £517,464 (US$807,244).

Examples of projects supported by IFH

- supply of subsidised condoms for a community-based social marketing pilot project in Madras, India 1995-98
- supply of subsidised condoms and oral contraceptives for an AIDS/STD prevention project with lorry drivers in southern India 1995-98
- provision of equipment for managing incomplete miscarriages for a training project with the Christian hospital network in Nigeria (CHAN) 1995'-97

Sources:

- questionnaire
- *Annual report 1993/1994*

4.7.2.2 International Planned Parenthood Federation (IPPF)

Barbara Herman, Head
Resource Development
International Planned Parenthood Federation (IPPF)
Regent's College, Inner Circle
Regent's Park
London NW1 4NS
UK
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IPPF is the world's leading voluntary family health care organization, working on a global scale to promote and provide reproductive health and family planning services, and to develop public support for sustainable population, environment and development policies. The Federation was founded 40 years ago by eight family planning associations (FPAs) and today has 140 member countries. It collaborates worldwide with governments and with international, non-governmental and community organisations. IPPF's 1994 annual report forecast an annual total expenditure of nearly US$115 million.

Policies, strategies and activities

Last year IPPF's Members' Assembly unanimously approved a strategic plan presenting the following 3 overall goals for the organisation:

1. to advance the basic human right of all women, men and youth to make free and informed choices regarding their own sexual and reproductive health, and advocate for the means to exercise this right; and ensure that women's equality and right to family planning, sexual and reproductive health remain a priority in national and international development policies

2. to respond to the increased unmet need for family planning, sexual and reproductive health services; address in particular the needs of marginal and disadvantaged groups within society; and work in partnership with governments, international agencies and private organizations

3. to operate a democratic Federation and provide leadership in planned parenthood through the efforts of a capable and committed body of volunteers and staff; sustain a secure, diversified funding base for the Federation; and maintain accountability in all aspects of IPPF's work

IPPF's specific policies governing contraceptive supply assistance was adopted by its Central Council in November 1990[31]. On the purchase of contraceptives, it is IPPF policy:

1. only to offer a range of contraceptives whose formulation and specifications have been reviewed and recommended by the IPPF International Medical Advisory Panel (IMAP)

2. to specify and guarantee adherence to internationally accepted quality assurance standards to ensure that all contraceptives procured and supplied are of known quality, regardless of the manufacturer or the country of origin

3. to supply contraceptives that meet a specific pharmacological composition or specification at the lowest possible price

4. that member FPAs may in exceptional circumstances use IPPF funds to purchase specific brands when approved by the relevant Regional Director

IPPF's purchase policy further states that "it is the policy of IPPF to ensure that appropriate goods and services of the highest quality are obtained at the lowest possible cost through the establishment of and adherence to recognised working procedures."

IPPF purchases are made in collaboration with UNFPA, USAID and WHO, and supplier relationships are built on these strategic alliances. It is also IPPF procedure to negotiate long term purchase contracts, so as to achieve the most favourable arrangements.

[31] These include policy 3.10 *Guidelines for the purchase of contraceptives*, and policy 3.9 *Purchasing*, both adopted by IPPF's Central Council in November 1990.

In supplying contraceptive products, IPPF is guided by the IPPF Hormonal contraceptive directory, and the recommendations of its Interactional Medical Advisory Panel.

Family planning services and contraceptive supplies which IPPF will provide include:

condoms (no female condoms at present)
injectables
intrauterine device (IUD)
oral contraception
medical equipment for abortion, tubal ligation, and vasectomy

Priority regions and countries

IPPF reports that it currently sees the Africa and South Asia regions as priorities for its technical assistance, although it has substantial programmes in many more regions and countries.

Regional highlights reported by IPPF[32] include:

Africa

- high rates of population growth continue to generate huge demand for family planning services requiring an expansion of FPA activity and support
- with more than 7.5 million people estimated to be HIV positive in Africa, FPAs will need to step up efforts to integrate HIV prevention into family planning activities
- clinic facilities are being upgraded in more than 20 countries, and included collaboration with the Japanese Organisation for International Co-operation in Family Planning (JOICFP) in developing and implementing integrated parasite control, nutrition and family planning projects with new initiatives planned in Guinea and Sierra Leone

Arab world

- efforts have focused on strategic planning and expanded family planning services, including HIV/STD prevention initiatives
- the illegality of abortion in most countries of the region (except Tunisia) has severely restricted choices for women with unwanted pregnancies. In 1993 the Arab world region published a widely acclaimed report on the Damascus Conference on Unsafe Abortion
- young people under the age of 20 constitute over one-third of the population for the region, and special efforts aimed at increasing programmes and services for youth are expanding

[32] Excerpted from *Annual report 1993'-94.*

East/South East Asia

- traditional family planning services are being enhanced to include sexual and reproductive health issues including diagnosis, treatment, and prevention of STDs
- some FPAs in the region, such as in the Philippines, are monitoring government legislation and advocating against restrictive legal measure concerning family planning

South Asia

- except India, abortion is illegal throughout the region. FPAs have recognised the necessity of addressing unsafe abortion as part of their general concern for quality of care in family planning services
- women's status remains low, and all FPAs are involved in projects aiming to increase women's earning potential through skills development training and adult literacy courses

Barriers and restrictions

IPPF indicated that numerous barriers and restrictions could be cited, but essentially can be summarised by the following:

- constraints on FPA due to lack of funding
- lack of appropriate outlets for services
- in some countries, religious and political opposition to family planning services

Financial resources

IPPF's annual budget for contraceptive supply assistance is US$10 million, and is likely to increase in future. This represents less than 10% of IPPF's total annual budget.

Examples of projects supported by IPPF

- sexual health and community development project - a new initiative involving 6 FPAs in Africa, Asia and the Caribbean to better understand the real sexual health needs and concerns of people in the communities they serve. The FPAs are encouraging groups to articulate their concerns and to identify the issues which lie behind these. The project embraces traditional programme areas (such as reproductive health, family planning, STD control and HIV/AIDS) but also includes an area largely ignored by current programmes which is community concerns about sexuality and human relations
- Jordanian Family Planning and Protection Association (JFPPA) - operates 14 clinics, 2 of which are mobile, to provide high-quality family planning and related reproductive health services. The Association now meets one-third of the demand for contraception in Jordan: 60,000 clients made more than 96,000 visits in 1993

- in Bangladesh, the FPA has organised a series of orientation meetings for local religious leaders (Imams) and local opinion leaders with the object of enlisting their support for the promoting of the family planning in the light of the Holy Qur'an and the Hadith

Sources:

- questionnaire
- *Annual report 1993-1994*
- *Annual report 1992-1993*
- IPPF International Medical Advisory Panel statements
- IPPF Central Council policy states, November 1990

4.7.2.3 Marie Stopes International (MSI)

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The work of Marie Stopes International (MSI) focuses on strengthening the capacity of local organisations to provide good quality family planning and reproductive health services. It takes a flexible approach to its work and does not generally formulate policies and guidelines to apply to projects and partners.

Policy, strategies and activities

MSI does not enforce rules, regulations or policies on the provision of contraceptive assistance in overseas programmes. The NGO partners with whom MSI provides technical assistance conform to the regulations set by the local ministry of health, UNFPA, or USAID as appropriate.

The overall mission of MSI is "children by choice not chance", with activities centred around the provision of technical assistance to reproductive health projects run by overseas NGO partners.

MSI does not consider abortion as a method of family planning. However, MSI and its partners do provide menstrual regulation and treat septic and incomplete abortions in those countries where it is legal to do so. The family planning services for which MSI provides technical assistance to overseas partners therefore includes the following (where they can be provided legally):

oral contraceptive pills
condoms (some programmes are exploring the possibility of providing the female condom)
injectables (ie depo-provera and cyclo-fem)
intrauterine devices
tubal ligation (mini-lap and laparoscopy)
vasectomy
Norplant

Other activities include:

foam tablets
advice and counselling on natural contraceptive methods
RU 486 (UK only)
RTI/STD screening
ante natal and post natal care
obstetrics
child health care and immunisations
family planning counselling
infertility counselling
menstrual regulation (in countries where it is legal)
HIV counselling and education
information and education activities

MSI does not apply technical specifications to the procurement of contraceptive products as overseas partners are encouraged to establish their own specifications based on those set by the local ministry of health, UNFPA or USAID as appropriate. Partners then make their own purchase arrangements for contraceptive supplies through local sources. MSI only becomes involved when supplies are not available locally or regionally and then only on a short term basis and following the specifications of the partner concerned.

Priority regions and countries

Africa:	Sierra Leone, Madagascar, South Africa, Uganda, Tanzania, Kenya, Malawi, Zimbabwe, Ethiopia and the Gaza Strip
Asia:	India, Sri Lanka, Bangladesh, Nepal, Pakistan, Indonesia, Philippines, and Vietnam
Latin America:	Nicaragua, Bolivia, Haiti, and Mexico

Barriers or restrictions

Those most commonly encountered by MSI and its partners are:

- government policies which restrict the range of services available
- poor distribution channels
- lack of access for women and for people in rural areas (ie transportation

- lack of choice or lack of availability of the full range of methods
- lack of knowledge about different methods or inaccurate information
- inconsistent quality and poor availability of contraceptive supplies in-country
- attitudes among the community leaders and government which may tend to encourage high fertility levels or discourage the uptake of modern contraceptive methods
- low awareness or motivation among potential users

Financial resources

MSI's annual turnover for all its reproductive health activities in 1994 was £1.5 million (US$2.34 million). This figure is expected to increase in future.

Projects supported by MSI

- condom social marketing, family planning and AIDS prevention programme for high-risk couples in Addis Ababa and surrounding areas of Ethiopia
- project to establish a domiliciary village-based family planning service offering all spacing methods including injectables for women in two Mahaweli system areas of Sri Lanka
- cross-cultural study for the World Bank on adolescents' access to family planning and reproductive health education and services in Kenya and Nicaragua

Source:

- questionnaire and letter
- *Marie Stopes International Factsheets*
- Year One Progress Report: *Project to establish a domiciliary village-based family planning service,* December 1994
- *Annual report: a condom social marketing programme for high-risk couples in Addis Ababa,* November 1993
- *Final report: a cross-cultural study of adolescents' access to family planning services,* February 1995

4.7.2.4 Population Concern

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UK
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Population Concern is a registered UK charity with 15 full-time staff and an annual budget (1994) in excess of £1.2 million (US$1.87 million). They are recognised by the United Nations Population Fund and work in collaboration with the International Planned Parenthood Federation. Their stated aims are to:

- advance the education of the public about the inter-related issues of population, environment, resources and development, with particular reference to the consequences of population growth, including poverty, food shortages, environmental degradation, resource depletion, social disruption and economic stagnation

- preserve and protect the good health both mental and physical of parents, young people and children and to alleviate poverty, hardship and distress caused by unwanted pregnancies

Nearly 60% of Population Concern's income in 1994 was reported from government organisations, mainly the Overseas Development Administration (UK) and the European Commission. Annual income has steadily increased since 1991 when it was just over £400,000 (US$642,000).

70% of the budget is spent on overseas projects. A small portion of the budget, 5%, is allocated towards UK projects and education, and the remainder of the budget is for information/media, fundraising, and administration.

Policy, strategies and activities

No written policy was provided for the purpose of this study, and only limited information was available through a brief telephone conversation with Population Concern's director and from the 1994 annual review. Nonetheless, the following points emerge:

- Population Concern works through partner organisations, usually NGOs or family planning associations

- emphasis is placed on working with youth and women

- although contraceptive supply forms part of Population Concern's activity, the main emphasis of support appears to be in training and service delivery

- grants to overseas partners range from as little as £1,330 (US$2,075) for training women in primary health care and family planning in Ghana, to a high of £49,532 (US$77,270) for training health assistants in family planning in Ethiopia

No information was provided concerning the types of family planning services supported by Population Concern, nor about technical specifications.

Priority countries and regions

Projects have been established in Africa and Asia, and include:

Africa: Ethiopia, Gambia, Ghana, Kenya, Sierra Leone and Tanzania

Asia: Bangladesh, India, Nepal, and Pakistan

Examples of projects supported by Population Concern

- contraceptives for family planning in Gambia via the Family Planning Association - £13,673
- construction of an outreach clinic at Nkubu to improve accessibility to family planning services - £12,234
- training and development for youth leaders in family life education in Pakistan - £10,228

Sources:

- Annual report 1994
- telephone interview with Population Concern director

4.8 European Union

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There is no centralised source of information or documentation concerning EC policies and strategies on contraceptive supply assistance in developing countries, nor is there a focal point for this activity.

Policy

It is possible that there will be some small-scale contraceptive supply activity spread among the various departments within the EC's Directorate General for Development (DG), but the EC has no specific set of guidelines or policies governing contraceptive supply. It was described as a very small element of EC development activities, and usually involves the provision of condoms.

Consistent with the EC's policies in the health area, it prefers to approach contraceptive supply through integration with existing programmes and structures rather than by establishing vertical programmes. However, the EC is willing to consider urgent and crucial needs for contraceptive supplies, particularly where other donors may not be in a position to respond.

The one instance where this has occurred so far has been in Bangladesh, resulting in the establishment of a 20 million ECU (US$24 million) programme over 5 five years. Since 1991 the programme has been involved in the procurement of condoms, and expects to supply 800 million to Bangladesh by the completion date of 1996.

In its procurement of condoms, the EC follows WHO technical specifications. They will also utilise the procurement services of other agencies, including from IPPF and UNFPA.

Priority regions and countries

No contraceptive supply activity is supported by the EC in Latin America and the Caribbean, and only small-scale activities exist in other developing countries as part of larger health programmes.

Bangladesh represents the one exception, with a large-scale 5 year programme to supply 800 million condoms.

Limited activity takes place in Africa and Asia.

Financial resources

No annual budget is allocated for contraceptive supply assistance, but urgent needs could be met through a special allocation, such as in Bangladesh (US$24 million over 5 years). Otherwise, contraceptive supply assistance is integrated within existing programme and initiatives, and therefore no budget breakdown is available.

Examples of projects supported by the European Union

- support to population NGOs in Karachi, Pakistan, focusing on capacity building and including a small contraceptive supply component
- provision of 800 million condoms in Bangladesh over 5 years

Source:

- interview with Dr Ines Perrin, DGI, European Commission

Appendix A

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The Netherlands

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Policy paper, June 1992

NOVIB and HIV/AIDS, Working Paper Project Department, February 1993

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Norway

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Sweden

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Swedish Development Assistance for the Control of AIDS, January 1992

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HIV/AIDS: what's the problem?, SCF, 10 May 1994

Draft guiding principles for the management of national staff with HIV and other chronic conditions, SCF, July 1994

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome - a policy paper for Save the Children Fund, 1 February 1992

SCF HIV/AIDS inventory, July 1994

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Annual report 1993/1994, IFH

Annual report 1993-1994, IPPF

Annual report 1992-1993, IPPF

IPPF International Medical Advisory Panel statements

IPPF Central Council policy states, November 1990

Marie Stopes International Factsheets

Year One Progress Report: *Project to establish a domiciliary village-based family planning service*, December 1994

Annual report: a condom social marketing programme for high-risk couples in Addis Ababa, November 1993

Final report: a cross-cultural study of adolescents' access to family planning services, February 1995

European Union

Action: the EC's response to HIV/AIDS in developing countries, 2nd updated edition, 1994

Appendix B

Questionnaires for the study

Questionnaire[1]

HIV/AIDS prevention and care support available through FINNIDA

Name of person completing questions:_____

Contact information for this person:_____

_____

Where appropriate, please feel free to attach reports and documentation instead of responding to particular questions

Answers may be written on separate sheets of paper

Development policy on HIV/AIDS issues:

1. What is the focal point or primary contact within FINNIDA for issues relating to HIV/AIDS? If several departments deal with HIV/AIDS, please list these.

2. What is FINNIDA's current policy and objectives concerning HIV/AIDS prevention and care overseas? If you have a written policy statement, could you please attach it?

3. Please describe FINNIDA's strategies and activities for HIV/AIDS prevention and care overseas, or attach relevant documentation.

[1]Please send your response, along with any supporting documentation such as recent annual reviews or trip reports, to: Christopher Castle, Information Coordinator, AIDS Programme, AHRTAG, 29-35 Farringdon Road, London EC1M 3JB, UK. Tel. 44 171 242 0606; FAX 44 171 242 0041.

4. Please list any priority countries and/or regions for FINNIDA support of HIV/AIDS prevention and care activities.

5. How much is HIV/AIDS a priority issue within FINNIDA, and how is this likely to change in future? What barriers or problems exist in relation to this area within FINNIDA?

6. How has FINNIDA support for HIV/AIDS evolved over the past few years? Can you identify future trends concerning FINNIDA support in this area?

7. What types of HIV/AIDS activities is FINNIDA unlikely or unwilling to support?

8. Please list examples of up to three HIV/AIDS projects supported by FINNIDA, or attach documentation with this information if you prefer.

Financial resources for HIV/AIDS:

9. What is FINNIDA's annual budget for HIV/AIDS prevention and care activities in developing countries (based on the latest available figures)? How does this compare to FINNIDA's overall spending on health and/or development?

10. Is the amount of funding available for HIV/AIDS activities expected to increase or decrease over the next five years?

11. What is the current breakdown of FINNIDA funding for HIV/AIDS activities in terms of NGO, bilateral, and multilateral support? How is this expected to shift over the next five years?

12. Are there certain countries and/or specific projects which receive the bulk of FINNIDA funding for HIV/AIDS? If so, which ones?

Research priorities for STDs (including HIV):

13. What STD/HIV prevention and care research is currently supported by FINNIDA?

14. Which research priorities are likely to grow in importance?

Technical expertise on HIV/AIDS:

15. What types of technical expertise on HIV/AIDS is most often required by FINNIDA or FINNIDA-funded programmes?

16. What technical expertise on HIV/AIDS-related issues is available within FINNIDA?

17. Does FINNIDA recruit external expertise on HIV/AIDS? If so, from where?

Other initiatives in Finland to support HIV/AIDS prevention and care in developing countries:

Please list up to three other organisations or agencies supporting HIV/AIDS work in developing countries (please include information on how they can be contacted).

Thank you for completing the questions

Questionnaire[1]

Contraceptive supply assistance available through FINNIDA

Name of person completing questions:_____

Contact information for this person:_____

_____

Where appropriate, please feel free to attach reports and documentation instead of responding to particular questions

Answers may be written on separate sheets of paper

1. What is FINNIDA's current policy and objectives for contraceptive assistance overseas? If you have a written policy statement, could you please attach it?

2. Please describe FINNIDA's strategies and activities for contraceptive supply assistance overseas, or attach relevant documentation.

3. Please list any priority countries and/or regions for FINNIDA contraceptive supply assistance.

[1]Please send your response, along with any supporting documentation such as recent annual reviews or trip reports, to: Christopher Castle, Information Coordinator, AIDS Programme, AHRTAG, 29-35 Farringdon Road, London EC1M 3JB, UK. Tel. 44 171 242 0606; FAX 44 171 242 0041.

4. Please tick the type of family planning services and contraceptive supplies that are funded by FINNIDA:

_____ abortion

_____ condoms (does this include female condoms?)

_____ injectables

_____ intrauterine device (IUD)

_____ mifepristone (RU486)

_____ oral contraception

_____ tubal ligation - female sterilisation

_____ vasectomy - male sterilisation

_____ other (please state):

5. What are the technical specifications applied to the procurement of contraceptive products supplied from FINNIDA for overseas use? If supplies are procured locally, do you impose specifications?

6. Are there regulations affecting procedures for procuring contraceptive products through FINNIDA? If so, please provide this information.

7. What is FINNIDA's annual budget for contraceptive supply assistance (based on the latest available figures)?

8. Is the level of funding for contraceptive supply through FINNIDA likely to increase or decrease in future?

9. Approximately what percentage of FINNIDA contraceptive supply is provided through NGOs, bilateral and multilateral agencies? How is this likely to shift in future?

10. Can you describe any future trends relating to FINNIDA's contraceptive supply assistance? What are the main problems or barriers experienced by FINNIDA in this area?

11. Could you please provide up to three examples of projects supported by FINNIDA working on contraceptive services in developing countries? Please attach documentation with this information if you prefer.

Thank you for completing the questions

Questionnaire[1]

HIV/AIDS prevention and care support available through HIVOS

Name of person completing questions:_____

Contact information for this person:_____

_____

Where appropriate, please feel free to attach reports and documentation instead of responding to particular questions

Answers may be written on separate sheets of paper

Development policy on HIV/AIDS issues:

1. What is the focal point or primary contact within HIVOS for issues relating to HIV/AIDS? If several departments deal with HIV/AIDS, please list these.

2. What is HIVOS' current policy and objectives concerning HIV/AIDS prevention and care overseas? If you have a written policy statement, could you please attach it?

3. Please describe HIVOS' strategies and activities for HIV/AIDS prevention and care overseas, or attach relevant documentation.

[1]Please send your response, along with any supporting documentation such as recent annual reviews or trip reports, to: Christopher Castle, Information Coordinator, AIDS Programme, AHRTAG, 29-35 Farringdon Road, London EC1M 3JB, UK. Tel. 44 171 242 0606; FAX 44 171 242 0041.

4. Please list any priority countries and/or regions for HIVOS support of HIV/AIDS prevention and care activities.

5. How much is HIV/AIDS a priority issue within HIVOS, and how is this likely to change in future? What barriers or problems exist in relation to this area within HIVOS?

6. How has HIVOS support for HIV/AIDS evolved over the past few years? Can you identify future trends concerning HIVOS support in this area?

7. What types of HIV/AIDS activities is HIVOS unlikely or unwilling to support?

8. What barriers or restrictions does HIVOS most often encounter when supporting HIV/AIDS activities?

9. Does HIVOS support any research on HIV and other STDs? If so, please describe.

Financial resources for HIV/AIDS:

10. What is the overall annual budget available through HIVOS for HIV/AIDS prevention and care activities in developing countries (based on the latest available figures)?

11. Is the amount of funding available through HIVOS for HIV/AIDS activities expected to increase or decrease over the next five years?

Technical expertise on HIV/AIDS:

12. What types of technical expertise on HIV/AIDS is most often required by HIVOS or HIVOS-supported programmes?

13. What technical expertise on HIV/AIDS-related issues is available within HIVOS?

14. Does HIVOS recruit external expertise on HIV/AIDS? If so, from where?

Projects supported by HIVOS:

15. Could you please provide up to three examples of projects supported by HIVOS on HIV/AIDS in developing countries?

Thank you for completing the questions

Questionnaire[1]

Contraceptive supply assistance available through Marie Stopes International

Name of person completing questions:_____

Contact information for this person:_____

_____

Where appropriate, please feel free to attach reports and documentation instead of responding to particular questions

Answers may be written on separate sheets of paper

1. What rules, regulations, and policies govern Marie Stopes International's provision of contraceptive assistance to overseas programmes? If you have a written policy statement, could you please attach it?

2. Please describe Marie Stopes International's current strategies and activities for contraceptive supply assistance overseas, or attach relevant documentation.

3. Please list any priority countries and/or regions for Marie Stopes International contraceptive supply assistance or family planning services.

[1]Please send your response, along with any supporting documentation such as recent annual reviews or trip reports, to: Christopher Castle, Information Coordinator, AIDS Programme, AHRTAG, 29-35 Farringdon Road, London EC1M 3JB, UK. Tel. 44 171 242 0606; FAX 44 171 242 0041.

4. Please tick the type of family planning services and contraceptive supplies that are funded by Marie Stopes International:

_____ abortion

_____ condoms (does this include female condoms?)

_____ injectables

_____ intrauterine device (IUD)

_____ mifepristone (RU486)

_____ oral contraception

_____ tubal ligation - female sterilisation

_____ vasectomy - male sterilisation

_____ other (please state):

5. What are the technical specifications applied to the procurement of contraceptive products supplied from Marie Stopes International for overseas use? If supplies are procured locally, do you impose specifications?

6. What barriers or restrictions do you most often encounter when supporting family planning/contraceptive services in developing countries?

7. What is the size of your annual budget for for contraceptive supply assistance (based on the latest available figures)? Is this likely to increase or decrease in future?

8. Could you please provide up to three examples of projects supported by Marie Stopes International working on the delivery of contraceptive services in developing countries?

Thank you for completing the questions

Appendix C

Contact data for organisations in the study

Denmark

Government

DANIDA (Danish International Development Agency)
Ministry of Foreign Affairs
2 Asiatisk Plads
DK-1448 Copenhagen K
Denmark
Tel: 45 33 92 00 00 Fax: 45 31 54 05 33

NGO sector

Danchurch Aid
International Department
Sct. Peders Straede 3
DK-1453 Copenhagen
Denmark
Tel: 45 33 15 28 00 Fax: 45 33 15 38 60

Danish Red Cross
International Departement
PO Box 2600
27 Blegdamsvej
DK-2100 Copenhagen
Denmark
Tel: 45 31 38 14 44 Fax: 45 31 38 39 66

Foreningen for Familieplanlaegning (Danish Family Planning Association)
Aurehojvej 2
DK-2900 Hellerup
Denmark
Tel: 45 31 62 56 88 Fax: 45 31 62 02 82

Red Barnet
Brogardsvaenget 4
DK 2820 Gentofte
Denmark
Tel: 45 31 680 888 Fax: 45 31 680 510

World Assembly of Youth (WAY)
Ved Bellahoj 4
2700 Bronshoj
Copenhagen
Denmark
Tel: 45 31 60 77 70 Fax: 45 31 60 57 97

Finland

Government

FINNIDA (Finnish International Development Agency)
Ministry for Foreign Affairs of Finland
Katajanokanlaituri 3
FIN - 00160 Helsinki
Finland
Tel: 358 0 134 161 Fax: 358 0 622 2576

NGO sector

Development Cooperation
Helsinki School of Economics
Helsinki
Finland

Family Planning Association of Finland
Vaestolii
Kalevankatu 16
00100 Helsinki 10
Finland
Fax: 358 0 640 235

Finnish Red Cross
Tehtaankaut 1a
00140 Helsinki
Findland
Tel: 358 0 12931 Fax: 358 0 654 149

Health and Development Cooperation Agency (HEDEC)
Siltasaarenkatu 18c
PO Box 220
FIN - 00531
Helsinki
Finland
Tel: 358 0 3967 2041 Fax: 358 0 773 2922

Institute of Development Studies
University of Helsinki
Helsinki
Finland

The Netherlands

Government

Ministry of Foreign Affairs
Dir-General International Cooperation
DST/TA
PB 20061
2500 EB The Hague
The Netherlands
Tel: 31 70 348 60 09 Fax: 31 70 348 59 56 or 62 56

NGO sector

AIDS Coordination Bureau (ACB)
Royal Tropical Institute
Information and Documentation Department
Mauritskade 63
1092 AD Amsterdam
The Netherlands
Tel: 31 20 568 8428 Fax: 31 20 665 4423

CEBEMO
P O Box 77
2340 AB Oegstgeest
The Netherlands
Tel: 31 71 159 377 Fax: 31 71 175 391

HIVOS
Raamweg 16
2596 HL Den Haag
The Netherlands
Tel: 31 70 363 69 07 Fax: 31 70 361 74 47

ICCO (Inter-Church Agency for Development Cooperation)
PO Box 151
3700 AD Zeist
The Netherlands
Tel: 31 34 042 78 11 Fax: 31 34 042 56 14

Memisa Medicus Mundi
PO Box 61
3000 AB Rotterdam
The Netherlands
Tel: 31 10 414 48 88 Fax: 31 10 404 73 19

NOVIB
Amaliastraat 7
2514 JC Den Haag
The Netherlands
Tel: 31 70 342 16 21 Fax: 31 70 361 44 61

Rutgers Stichting
Postbus 17430
Groot Hertoginnelaan 201
2502 CKs Gravenhage
The Netherlands
Tel: 31 70 363 17 50 Fax: 31 70 356 10 49

World Population Foundation
Derkinderenlaan 14
1251 EM Laren
The Netherlands
Tel: 31 21 538 25 51 Fax: 31 21 538 94 33

Norway

Government

NORAD
Health Division
PB 8034 Dep.
0030 Oslo
Norway
Tel: 47 22 31 44 00 Fax: 47 22 31 44 01

Norwegian Board of Health
AIDS Advisor to Norwegian Ministry of Foreign Affairs
PB 8128 Dep.
0032 Oslo
Norway
Tel: 47 22 34 90 32 Fax: 47 22 34 88 68

NGO sector

Norwegian Church Aid
PO Box 4544 Torshov
N-0404 Oslo
Norway
Tel: 47 22 22 22 99 Fax: 47 22 22 24 20

Norwegian Red Cross
PO Box 6875 St Olavs Plass
N-0130 Oslo
Norway
Tel: 47 22 94 30 30 Fax: 47 22 20 68 40

Norsk Forening for Familieplanlegging
Roahellinga 15
0755 Oslo
Norway
Tel: 47 22 08 20 26 Fax: 47 22 08 20 61

Redd Barna (Norwegian Save the Children)
PO Box 6200 Etterstad
N-0602 Oslo
Norway
Tel: 47 22 57 00 80 Fax: 47 22 68 85 47

Sweden

Government

SIDA
Health Division
Birger Jarlsgatan 61
S-105 25 Stockholm
Sweden
Tel: 46 8 728 51 00 Fax: 46 8 612 63 80

NGO sector

ARO
Barnangsgatan 23
11641 Stockholm
Sweden
Tel: 46 8 644 93 95 Fax: 46 8 640 36 60

Radda Barnen
Box 27320
S-102 54 Stockholm
Sweden
Tel: 46 8665 0100 Fax: 46 8 661 42 91

RFSU (Swedish Association for Sex Education)
Drottingholmsvagen 37
PO Box 12128
S-102 24 Stockholm
Sweden
Tel: 46 8 692 07 00 Fax: 46 8 653 08 23

Swedish Red Cross
Box 27316
102 54 Stockholm
Sweden
Tel: 46 8 665 56 00 Fax: 46 8 662 18 05

United Kingdom

Government

Overseas Development Administration (ODA)
Health and Population Division
94 Victoria Street
London SW1E 5JL
UK
Tel: 44 171 917 7000 Fax: 44 171 917 0019

NGO sector

ACT-HIV
75-79 York Road
London SE1 7NJ
UK
Tel: 44 171 928 299 Fax: 44 171 928 6266

Charity Projects
1st Floor, 74 New Oxford Street
London WC1A 1EF
UK
Tel: 44 171 436 1122 Fax: 44 171 436 1541

Christian Aid
PO Box 100
London SE1 7RT
UK
Tel: 44 171 620 4444 Fax: 44 171 620 0719

International Family Health (IFH)
5th Floor - Parchment House
13 Northburgh Street
London EC1V 0AH
UK
Tel: 44 171 336 6677 Fax: 44 171 336 6688

International HIV/AIDS Alliance
Barratt House
341 Oxford Street
London W1R 1HB
UK
Tel: 44 171 491 2000 Fax: 44 171 491 2001

International Planned Parenthood Federation (IPPF)
Resource Development
Regent's College, Inner Circle
Regent's Park
London NW1 4NS
UK
Tel: 44 171 486 0741 Fax: 44 171 487 7950

Marie Stopes International (MSI)
62 Grafton Way
London W1P 5LD
UK
Tel: 44 171 388 3740 Fax: 44 171 388 1946

Population Concern
178-202 Great Portland Street
London W1N 5TB
UK
Tel: 44 171 631 1546 Fax: 44 171 637 9582

Save the Children Fund (SCF)
17 Grove Lane
Camberwell
London SE5 8RD
UK
Tel: 44 171 703 5400 Fax: 44 171 703 2278

UK NGO AIDS Consortium
37-39 Great Guildford Street
London SE1 0ES
UK
Tel: 44 171 401 8231 Fax: 44 171 401 2124

European Union

EC AIDS Task Force
10, rue de Geneve, Box 7
4th Floor
1140 Brussels
Belgium
Tel: 32 2 245 43 90 Fax: 32 2 215 67 47

DGI - European Commission
Rue de la Loi 200
B-1049 Brussels
Belgium
Tel: 32 3 299 2031 Fax: 32 2 296 3697

Appendix D

Currency exchange rate table

The rates of exchange used througout the report are based on US$1.00 =

Denmark (Danish Krone - Dkr)	6.09
Finland (Markka - Fmk)	4.74
The Netherlands (Guilder - Dfl)	1.74
Norway (Norwegian Krone - Nkr)	6.76
Sweden (Swedish Krona - Skr)	7.43
United Kingdom (Sterling - £)	0.64
European Union (ECU)	0.83

Source: Financial Times, *Guide to world currencies*, 30 December 1994.

AHRTAG

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Registered no. 1322161 (England)