The Global Programme to Enhance Reproductive Health Commodity Security

Annual Report 2011

UNFPA: Delivering a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled.

Reproductive health commodity security (RHCS) is achieved when all individuals can obtain and use affordable, quality reproductive health supplies of their choice whenever they need them.

Cover: In Djibouti, a portrait of young couple with their child.
Credit: Giacomo Pirozzi/Panos

CONTENTS

TABLES

ANNEX

FIGURES

FOREWORD

Delivering a world where every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled is a mission that demands a comprehensive approach to sexual and reproductive health and reproductive rights. UNFPA, the United Nations Population Fund, is a trusted development partner working in close collaboration with governments, non-government and civil society organizations, cultural and religious leaders and other stakeholders and valued partners. UNFPA works in 155 countries, with field offices in 128 countries.

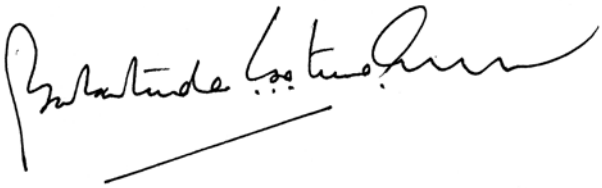
As the leader in the implementation of the Programme of Action of the International Conference on Population and Development (ICPD), UNFPA gives priority to two key targets of the Millennium Development Goals (MDGs): reducing maternal deaths and achieving universal access to reproductive health, including voluntary family planning. UNFPA launched two thematic funds to accelerate progress by catalyzing national action and scaling up interventions in critical areas.

The GPRHCS has mobilized $450 million since inception in 2007

The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) has mobilized $450 million since 2007 to ensure access to a reliable supply of contraceptives, condoms, medicines and equipment for family planning, HIV/STI prevention and maternal health. In 2011, the Global Programme provided pivotal and strategic support for the procurement of essential supplies and for capacity development to strengthen national health systems in 46 countries. In less than five years, countries began reporting impressive results: more couples are able to realize their right to family planning, more health centres are stocked with contraceptives and life-saving maternal health medicines, family planning is increasingly being prioritized at the highest levels of national policies, plans and programmes, and more governments are allocating domestic resources for contraceptives.

The Maternal Health Thematic Fund (MHTF) supports high maternal mortality countries to accelerate progress in reducing the number of women who die giving birth and in reducing associated morbidity. Its evidence-based business plan focuses on: emergency obstetric and newborn care; human resources for health, particularly through the Midwifery Programme; and the prevention and treatment of obstetric fistula, leading the Global Campaign to End Fistula. Together with GPRHCS, it also fosters HIV integration and supports synergistically specific areas of family planning in some countries. Supplementing UNFPA's core funds, the MHTF has mobilized $100 million since its inception in 2008 and currently, provides strategic support to 43 countries.

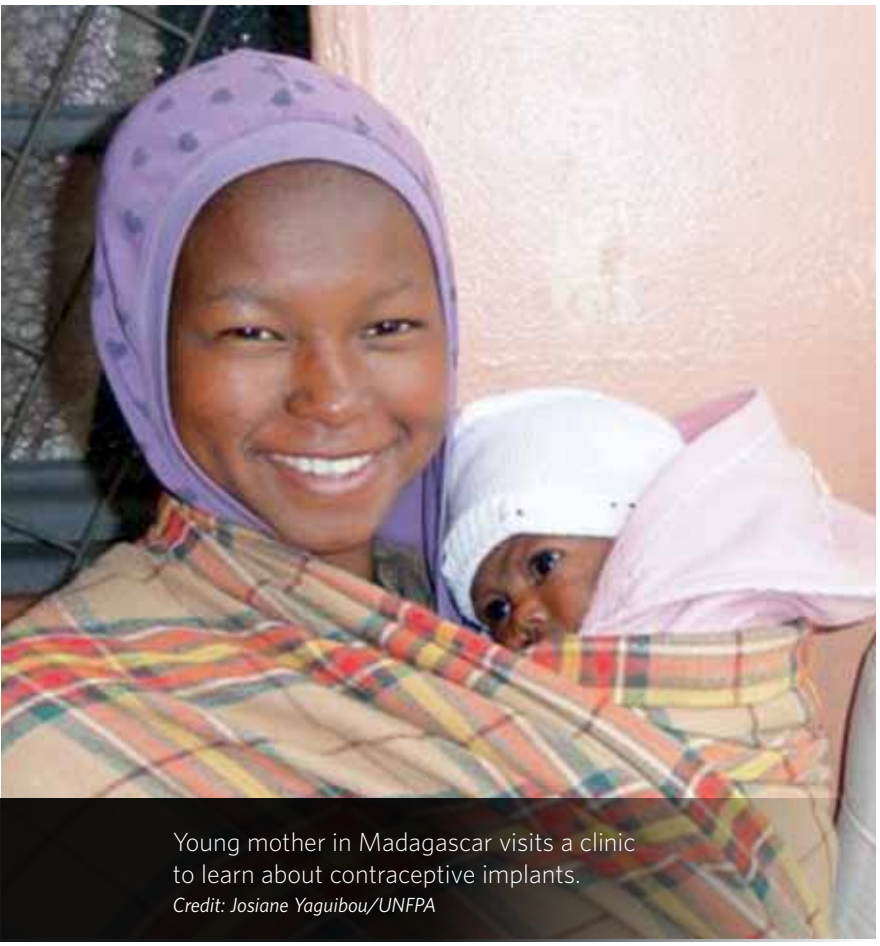
Working together, these initiatives support the UN Secretary-General's Global Strategy for Women's and Children's Health and are engaged in the UN Commission on Life-Saving Commodities for Women and Children. These and other actions are placing maternal health high on national and global agendas. The many achievements featured in this report demonstrate the importance of strong political commitment, adequate investments and enduring partnerships. I would like to take this opportunity to thank countries, donors, other partner organizations and all colleagues for their productive collaboration now and in the future.



Babatunde Osotimehin
Executive Director, UNFPA

EXECUTIVE SUMMARY

The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) is the UNFPA flagship programme to ensure access to a reliable supply of contraceptives, condoms, medicine and equipment for family planning, HIV/STI prevention and maternal health services. Progress in the five years since the programme was launched has been very significant. The Global Programme has mobilized $450 million since 2007. While the trend towards greater emphasis on capacity development continues, support to reproductive health commodities through the GPRHCS 2008-2011 includes contraceptives worth 56 million couple years of protection.



Young mother in Madagascar visits a clinic to learn about contraceptive implants.
Credit: Josiane Yaguibou/UNFPA

UNFPA provided multi-year support to 12 Stream 1 countries and funded targeted initiatives in 34 Stream 2 countries through the Global Programme in 2011. The increase in total number of countries from 45 in 2010 to 46 in 2011 reflects Nigeria's move from Stream 2 to Stream 1 status, thus increasing the number of Stream 1 countries from 11 to 12, and reflects the division of Sudan and South Sudan. Some additional *ad hoc* support was provided to Stream 3 countries. Total expenditure for 2011 was $76.3 million (provisional), with $32 million used for the provision of commodities and $44 million for capacity development.

Within UNFPA, the Global Programme worked in collaboration with the Maternal Health Thematic Fund to provide programmatic support to ensure that life-saving maternal health drugs and supplies were available in all facilities. The GPRHCS also worked closely with the HIV/AIDS Branch to increase the availability of contraceptives in countries with high HIV prevalence and among vulnerable populations.

Selected results and country highlights from 2011:

1. The increase in contraceptive prevalence rate (CPR) has continued from previous years. This trend was again confirmed in two countries where recent national data was available, Burkina Faso and Ethiopia. In Burkina Faso, CPR has increased from 13.3 per cent (MICS 2006) to 16.2 per cent (DHS 2010). In Ethiopia, CPR has nearly doubled from 13.9 per cent (DHS 2005) to 27.3 per cent (DHS 2011). Improved use of modern methods of contraceptive also has been recorded in other GPRHCS programme countries. In Madagascar, CPR rose by 11 percentage points from 18 per cent (DHS 2004) to 29.2 per cent (DHS 2008-9). In Niger, CPR increased from 11.7 per cent (DHS 2006) to 21 per cent (HMIS 2010).

2. Access to appropriate methods is improving. In 10 out of 12 Stream 1 countries, three modern methods of contraceptives were available in at least 80 per cent of service delivery points. In 2011, the percentage of service delivery points (SDPs) offering at least three modern contraceptive methods improved in Madagascar from 30.8 per cent 2009 to 97.2 per cent in 2011. In Ethiopia, the increase was from 60 per cent in 2006 to 97.2 per cent in 2011. In Nicaragua, the increase was from 66.6 per cent in 2008 to 100 per cent in 2011.

3. The five essential maternal health drugs were available in more than 60 per cent of service delivery points in 11 out of 12 Stream 1 countries, an increase of one above last year;

4. Six Stream 1 countries had no stock-outs in more than 60 per cent their service delivery points, remaining unchanged from the previous year;

5. National strategic plans are in place for reproductive health commodity security (RHCS) under government leadership and with the involvement of relevant stakeholders in 11 of 12 Stream 1 countries, excepting Haiti. This is consistent with last year. Among Stream 2 countries, however, the number of plans in place increased from 26 countries in 2010 to 32 out of 34 countries in 2011.

6. All Stream 1 and 2 countries have functional coordinating mechanisms for reproductive health commodity security. This includes the addition of Haiti since the previous year.

7. Essential medicines lists exist in all 46 countries.

8. All 46 countries include RHCS in their national Poverty Reduction Strategies as of 2011, ensuring its priority at the highest levels. This is a marked increase from 10 Stream 1 countries and 15 Stream 2 countries in 2010.

9. Budget lines for RH commodities, a strong indicator of government commitment, are present in 11 out of 12 Stream 1 countries, excepting Haiti. Budget lines for RHCS are present in 20 out of 34 Stream 2 countries. Governments are beginning to commit more of their national resources to contraceptives. Allocations increased in 2011 in Burkina Faso, Ethiopia, Lao PDR, Mali and Nicaragua (Ethiopia's nearly doubled). A budget line was established for the first time in Nigeria and in Sierra Leone.

10. National technical expertise for commodity forecasting and for managing procurement processes is being used in 10 out of 12 Stream 1 countries, up by two from last year;

11. Based on demand from countries, expenditure on capacity development continued to increase from 19.3 per cent in 2009 to 34 per cent in 2010 to 47 per cent in 2011, reflecting intensified efforts to build capacity and strengthen systems;

12. Funding levels for the GPRHCS reached an all-time high of $145 million in 2011, up nearly 30 per cent from the previous year.

Heightened awareness of RHCS was demonstrated in 2011 by the presence of First Ladies, Ministers of Health and Parliamentarians at the first United Nations High Level Meeting on Reproductive Health Commodity Security. There is momentum for new ways of working in family planning, catalyzed by indicators set in the Global Programme that are helping countries to create a strong base. Heightened attention to method mix, choice of method and the importance of preventing stock-outs or shortfalls are a few of the indicators that are creating a foundation for sustained RHCS.

Essential but underutilized commodities gained global attention in 2011 with establishment of the UN Commission on Life-Saving Commodities for Women and Children, for which UNFPA Executive Director Dr. Babatunde Osotimehin is vice-chair. Among the 'neglected commodities' championed by the Commission are contraceptive implants, emergency contraception and the female condom. UNFPA will take a lead role through the Global Programme to ensure access to these overlooked contraceptives along with the full range of methods and the ability of women to choose a method that fits their own fertility goals and life circumstances.

Broader partnership for RHCS was a theme throughout 2011. Non-governmental organizations (NGOs) are among the many valued partners that engage with UNFPA through the Global Programme. These partners help national governments with advocacy, technical training, developing models, delivering services and exchanging information. The Global Programme procured supplies for many NGOs and benefitted from close collaboration in many ways. Key partners in 2011 included International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), Population Services International (PSI), and the Universal Access to Female Condom Joint Programme.

Country reports submitted annually include an abundance of 'good practices' that are making a difference on many fronts: mobilizing political commitment and financial resources, strengthening the management of supply systems, and reaching underserved communities. Among these country-driven initiatives are the following examples from 2011:

- Evidence-based advocacy has mobilized high-level support for the national family planning strategy in **Ecuador,** including a personal commitment by the President of the Republic, along with Government support of $8 million for the strategy plus $7 million to procure modern contraceptives through UNFPA.

- Men's involvement has improved maternal health, including through modern family planning, in **Niger,** where the number of Schools for Husbands (Ecole des Maris) increased to 131 schools in the Zinder region plus 46 schools in Maradi. Planning began to launch the programme in Sierra Leone.

- Innovative approaches are reaching more women and girls, increasing demand for reproductive health services. A civil society organization is monitoring health commodities in **Sierra Leone,** reducing theft and enhancing accountability. Young women in **Senegal** are benefitting from the wisdom of more than 1,200 Bajenu Gox, older women community leaders with training in sexual and reproductive health. In Maputo, **Mozambique,** girls and women gain information and empowerment in weekly group discussions known as Bancada Feminina.

- The Government is making health a priority in **Madagascar,** where it is using CHANNEL software for control, transparency and follow-up in the management of health commodities. The commitment of Government was also demonstrated in **Nigeria** and in **Sierra Leone in 2011,** when lines for reproductive health commodities were established in their national budgets for the first time.

An independent review conducted in 2011 found that the GPRHCS has successfully set up country-level building blocks for reproductive health commodity security.[1] The Global Programme has continued in line with the UNFPA Strategic Plan, and planning began for the next five years of the programme, with discussion of elements such as a clear exit strategy; indicators for demand creation and sustainability; and emphasis on access to information, services and essential supplies for adolescents and youth.

[1] Synthesis Report, UNFPA Global Programme to Enhance Reproductive Health Commodity Security Mid-Term Review, January 2012

Woman from an ethnic group in northern Lao PDR obtains contraceptives at the village pharmacy.
Credit: Vincent Gautier/UNFPA

INTRODUCTION

Access is the aim inherent in all of the country-driven activities catalyzed by UNFPA support. Access is about going the last mile to reach a woman who wants to space or avoid pregnancy yet is hard-to-reach due to poverty, geography, ethnicity, disability, displacement or age. Having access means that national policies are in place, the logistics management information system is functioning and the supply chain ends with a quality method of choice in the hands of the people who need it, when they need it. Their reproductive rights – their human rights – depend on access. Ultimately, access to reproductive health commodities, including life-saving maternal health medicines, is a requirement for achieving the MDG and ICPD promise of *universal access to reproductive health.*

A secure, steady and reliable supply of reproductive health commodities has an impact on each of the three indicators associated with universal access to reproductive health: adolescent birth rate, maternal mortality ratio and youth HIV prevalence rate. The indicators are used globally to measure progress in achieving MDG 5 to improve maternal health. UNFPA joins with a wide range of partners in governments, other agencies and civil society in working towards this goal.

Reproductive health commodity security (RHCS) is achieved when all individuals can obtain and use affordable, quality reproductive health supplies of their choice whenever they need them. It has a pivotal and strategic role in accelerating progress towards the ICPD Programme of Action and the Millennium Development Goals.

UNFPA established the Global Programme to Enhance Reproductive Health Commodity Security in 2007 as a framework for assisting countries in planning for their own needs. It is a thematic fund created to catalyze national action. At the request of governments, UNFPA provides strategic and pivotal support to:

- Integrate reproductive health commodity security in national policies, plans, programmes and budget lines through advocacy with policy makers, parliamentarians and partners in government;
- Strengthen the delivery system to ensure a reliable supply, logistics information and supply management;
- Procure contraceptives and other essential reproductive health supplies and promote their use through various mechanisms such as community-based distribution;
- In partnership with the Maternal Health Thematic Fund and HIV/AIDS Branch, provide training to build skills at every step, from forecasting needs to providing quality information and services.

Since 1990, UNFPA has been considered to be the largest multilateral supplier of contraceptives and condoms, and the lead United Nations agency for reproductive health commodity security. However, funding shortages and a tendency to look at reproductive health commodities in isolation from other issues meant that support in this area was often substantial but *ad hoc.* UNFPA launched the Global Programme to Enhance Reproductive Health Commodity Security to provide a structure for moving beyond *ad hoc* responses to stock-outs towards more predictable, planned and sustainable country-driven approaches for securing essential supplies and ensuring their use. In only a few years, it is already yielding measureable results. It provides

support to: (1) develop capacity to strengthen health systems; and (2) procure reproductive health commodities. This fund is a catalyst for national efforts to build stronger health systems to procure essential supplies. In addition, UNFPA is the largest multilateral supplier of contraceptives and condoms.

The Global Programme applies selection criteria and designates the level of country support in terms of funding streams. It supports countries through three funding streams in order to address the specific needs of each country:

- **Stream 1** provides multi-year funding to a relatively small number of countries. These predictable and flexible funds are used to help countries develop more sustainable, human rights-based approaches to RHCS, thereby ensuring the reliable supply of reproductive health commodities and the concerted enhancement of national capacities and systems.
- **Stream 2** funding supports initiatives to strengthen several targeted elements of RHCS, based on the country context.
- **Stream 3** is emergency funding for commodities in countries facing stock-outs for reasons such as poor planning, weak infrastructure and low in-country capacity. Stream 3 also provides support for countries facing humanitarian situations, including natural or man-made disasters. In these settings, the GPRHCS works closely with UNFPA's Humanitarian Response Branch (HRB) and United Nations High Commissioner for Refugees (UNHCR) to deliver much-needed commodities in times of emergency. All funding through this stream is used for the provision of commodities.

2011 STREAM 1 COUNTRIES	2011 STREAM 2 COUNTRIES	
1. Burkina Faso	1. Benin	18. Lesotho
2. Ethiopia	2. Bolivia	19. Liberia
3. Haiti	3. Botswana	20. Malawi
4. Lao PDR	4. Burundi	21. Mauritania
5. Madagascar	5. Central African Republic	22. Namibia
6. Mali	6. Chad	23. Papua New Guinea
7. Mongolia	7. Congo	24. Sao Tome and Principe
8. Mozambique	8. Côte d'Ivoire	25. Senegal
9. Nicaragua	9. Democratic Republic of the Congo	26. South Sudan
10. Niger	10. Djibouti	27. Sudan
11. Nigeria	11. Ecuador	28. Swaziland
12. Sierra Leone	12. Eritrea	29. Timor Leste
	13. Gabon	30. Togo
	14. Gambia	31. Uganda
	15. Ghana	32. Yemen
	16. Guinea	33. Zambia
	17. Guinea-Bissau	34. Zimbabwe

Reporting on results

The outcome indicators against which progress is monitored include contraceptive prevalence rate (CPR) and unmet need for family planning. The programme is producing some impressive results, particularly in the 12 priority countries receiving the most comprehensive support.

Results-based management (RBM) is a priority for UNFPA. The GPRHCS Monitoring and Evaluation Framework was reviewed extensively in 2009 in a collaborative effort by UNFPA Country Offices, Regional Offices, donors and partners. Improvements in monitoring and reporting on indicators enabled the Global Programme to gather valuable data on progress and results in reproductive health commodity security at the national, regional and global levels. The programme is able to demonstrate specific achievements in this report because UNFPA has implemented results-based management – an approach for more effective and efficient ways of working.

This report looks at the results (goal, outcome and output) and associated indicators that are used to measure progress in the Global Programme to Enhance Reproductive Health Commodity Security. The results-based approach builds on the GPRHCS Monitoring and Evaluation Framework and the UNFPA Results and Resources Framework. This report presents both aggregate data and specific examples to highlight achievements in 2011. At the **goal** and outcome level, there is the goal of universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life. The **outcome** level seeks increased availability, access and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the Global Programme to Enhance RHCS focus countries. At the **output** level GPRHCS activities are supported to achieve four results: (1) Country RHCS strategic plans developed, coordinated and implemented by government with their partners; (2) political and financial commitment for RHCS enhanced; (3) Capacity and systems strengthened for RHCS; (4) RHCS mainstreamed into UNFPA core business.

Reporting on these results is based on analyzing achievements on key indicators associated with each output within the monitoring and Evaluation framework of the GPRHCS. This ensures the update of data on results at the national, regional and global level as may be applicable.

Structure of this report

This report showcases results in the 46 countries of the Global Programme, synthesizing and analyzing country reports and good practices received from all Stream 1 and Stream 2 countries. It begins by briefly providing context for the programme's goal and outcome. The core of the report is the section 'Results in 2011'. Additional information is provided in narrative sections about the global level and key issues. 'By the Numbers' includes management, procurement and financial reporting. Finally, the conclusion leads to the way forward – the next five years of the Global Programme.

Acknowledgements

The UNFPA Commodity Security Branch would like to acknowledge the contributions of all donors, without whom these accomplishments would not have been possible. Recognition for the results described in this report is also due to many valued partners in governments, other United Nations agencies and organizations, non-governmental organizations and civil society groups.

This annual report was produced by Desmond Koroma, monitoring and evaluation specialist, and Susan Guthridge-Gould, writer and editor. The consultants would like to acknowledge the guidance and oversight provided by Dr. Kechi Ogbuagu and Mr. Jagdish Upadhyay and the valuable contributions from numerous colleagues within the Commodity Security Branch and UNFPA Country/Regional Offices who provided the detailed information used in compiling the report.

CHAPTER ONE

GOAL OF THE GPRHCS

Through interventions in the area of reproductive health commodity security, the GPRHCS supports UNFPA's strategic interventions to achieve health outcomes at country level. The GPRHCS supports countries to *secure* a reliable supply of contraceptives and other essential supplies and *strengthen* service delivery systems. The aim is for countries to achieve RHCS outcomes as an integral part of their overall health sector interventions. This is accomplished through the GPRHCS results framework, which is intrinsically linked to the UNFPA Strategic Plan.

This section looks at indicators associated with the goal, providing context for the activities supported by UNFPA throughout the year.

The Global Programme is an intervention by UNFPA to achieve nationally set goals within the context of the Millennium Development Goals: The overarching goal is to contribute towards the achievement of universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life. Progress is measured through three indicators —adolescent birth rate, maternal mortality ratio and youth HIV prevalence rate—that are also globally used to measure progress in achieving MDG 5 to improve maternal health.

Young women in Bamako, Mali.
Credit: CommerceandCultureAgency/Getty Images

Goal:
Universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life.

Since goal-level results are contributed to by all actors, presentation of progress here should not be attributed to the GPRHCS or indeed UNFPA. This section is meant

to provide information on current levels of achievement in GPRHCS countries and place in context the support provided by the programme.

1.1 Adolescent birth rate

The adolescent birth rate (ABR) is a measurement of the number of births to women 15 to 19 years of age per 1,000 women in that age group. It represents the incidence of childbearing among adolescent women 15 to 19 years of age, which gives an idea of prevalence factors such as unprotected sex, early marriage and early childbearing. It has implications for the disruption of schooling among adolescent girls and their life chances. In GPRHCS Stream 1 countries, urban and rural differences exist in birth rates for adolescent girls in urban and rural areas. Figure 1 shows that in all the countries birth rates for urban girls are lower than for girls in rural areas. In countries such as Burkina Faso, Ethiopia, Madagascar

and Nigeria, birth rates for adolescents in rural areas are more than double that for girls in urban areas.

The incidence of teenage pregnancy and motherhood in these countries is higher among women in poor households than households with the highest wealth index, survey results have shown. In Haiti (DHS, 2005-06), for example, 21.5 per cent of females 15 to 19 years in the lowest wealth quintile had children or were pregnant at the time of the survey compared with 7.1 per cent of females in the highest wealth quintile. In the case of Nigeria (DHS, 2008), 32.2 per cent of females aged 15 to 19 years in the lowest wealth quintile had children or were pregnant at the time of the survey compared to 11.2 per cent in the highest wealth quintile.

Further disparities are also shown when education levels are taken into consideration. In Mali (DHS 2006) the percentages of females aged 15 to 19 years who had children or were pregnant at the time of the survey were 43.3 for those with no education, 31.2 per cent for those with primary education and 15.8 per cent for those with secondary education. The same pattern existed for Nicaragua (DHS 2006) where the percentage for women with no education (64.2 per cent) was nearly twice as high as for women with primary education (34 per cent) and nearly four times higher than women with secondary education (16.3 per cent). The GPRHCS supports countries to address the reproductive health needs of young people.

The adolescent birth rate for these countries range from 18.5 per 1,000 women (15-19) in Mongolia to 199 per 1,000 women (15-19) in Niger. The ABR in Stream 2 countries are within the same range. Among the Stream 2 countries only Ecuador has an ABR of less than 100.

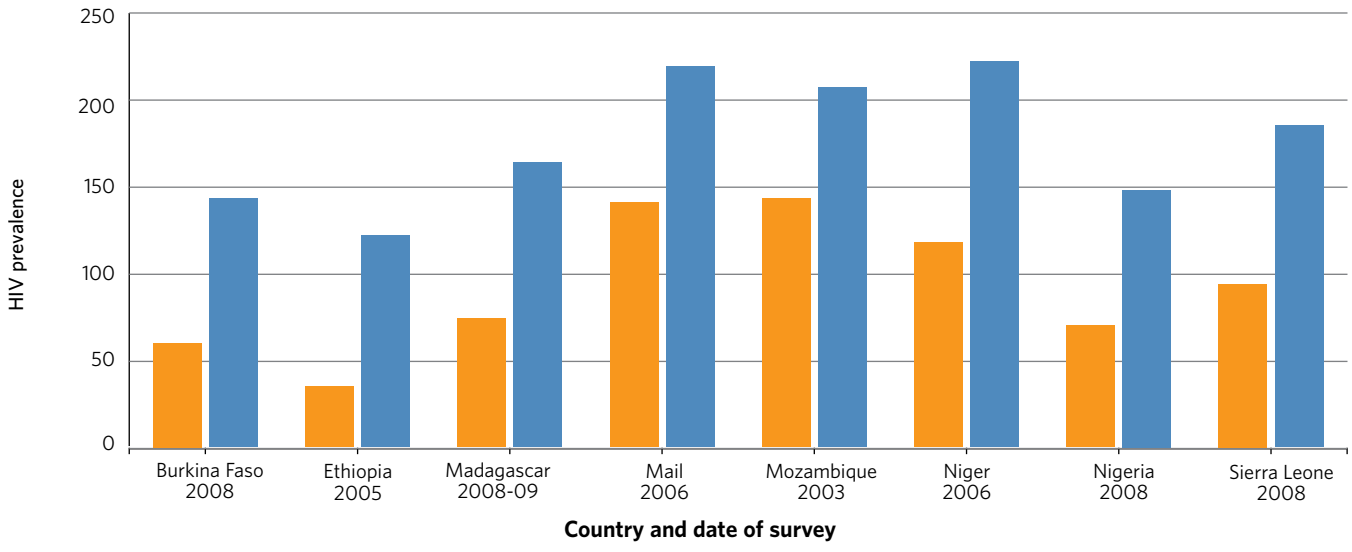
1.2 Maternal mortality ratio

Maternal mortality ratio (MMR) refers to the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.

MMR for GPRHCS Stream countries ranged from 65 maternal deaths per 100,000 live births for Mongolia to 970 for Sierra Leone, according to recent UN estimates, as shown in Table 2. Only three out of the 46 GPRHCS countries (Ecuador, Nicaragua and Mongolia) all of them outside of sub-Saharan Africa, have MMR of 100 or less.

The UN estimates further show that the lifetime risk of maternal death is higher in countries with high MMR than those with low MMR. This risk refers to the probability that a 15-year-old female will die eventually from a maternal cause if she experiences throughout her lifetime the risks of maternal death and the overall levels of fertility

Figure 1: Current fertility for women 15-19 in some GPRHCS Stream 1 countries



Source: Macro International Inc, 2012. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 23, 2012

and mortality that are observed for population of that country.

In 1990 the lifetime risks of maternal death were estimated to be worst in Niger (1 in 9), Mali (1 in 13), Nigeria (1 in 14), followed by Ethiopia, Lao PDR and Sierra Leone (1 in 15) and Mozambique (1 in 16). While all countries have shown improvements, the lifetime risks have greatly improved in Mongolia from 1 in 180 (1990) to 1 in 730 (2008); and, in Nicaragua from 1 in 96 (1990) to 1 in 300 (2008). With the exception of Mongolia and Nicaragua, the lifetime risk of maternal death is below 1 in 100 in the other 10 Stream 1 countries.

Through the GPRHCS, UNFPA has supported countries to adopt cost-effective strategies including the provision

Table 1: Adolescent birth rate for GPRHCS Stream 1 countries

Country	Adolescent birth rate*	
	Year	Per 1,000 women 15-19
Burkina Faso	2001	131.0
Ethiopia	2003	109.1
Haiti	2003	68.6
Lao PDR	2005	110.0
Madagascar	2008	148.0
Mali	2004	190.0
Mongolia	2007	18.5
Mozambique	2001	185.0
Nicaragua	2005	108.5
Niger	2004	198.9
Sierra Leone	2006	143.0

Source: * Population and Development Branch, Have we progressed on MDG5b; The empirical evidence in advancing Universal Access to Reproductive Health Technical Division, UNFPA New York, June 2010

Table 2: Maternal mortality ratio for GPRHCS Stream 1 countries

Country	Maternal mortality ratio (per 100,000 live births)	Country	Maternal mortality ratio (per 100,000 live births)
Burkina Faso	560	Mongolia	65
Ethiopia	470	Mozambique	550
Haiti	300	Nicaragua	100
Lao PDR	580	Niger	820
Madagascar	440	Nigeria	840
Mali	830	Sierra Leone	970

Source: Trends in Maternal Mortality: 1990 to 2008; Estimates Developed by WHO, UNICEF, UNFPA and the World Bank; Annex 1, page 23

life-saving maternal health medicines, training of skilled birth attendants, and provision of family planning information and services to prevent unwanted pregnancies and unsafe abortions. Other interventions such as provision of essential obstetric care are supported largely through the other strategic funding mechanisms.

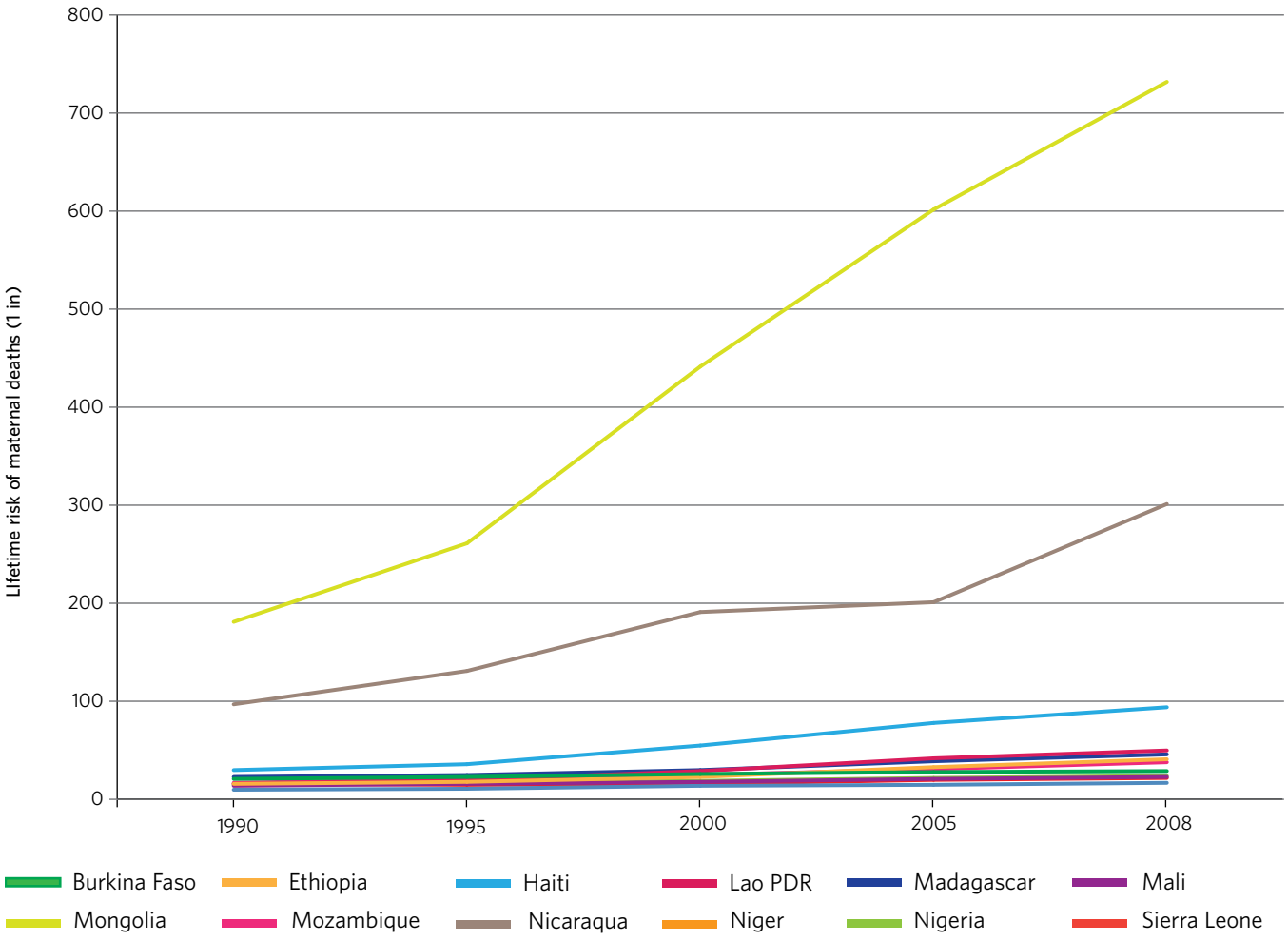
1.3 Youth HIV prevalence rate

One way in which the impact of HIV among young people has been assessed is by examining the percentage of young people aged 15-24 who are living with HIV out of total population in that age group. This indicator is important because it enables the assessment of the effect of the disease on young people which has implication for socio economic development especially at the national level.

According to UNAIDS[2], nearly 80 per cent of young people living with HIV are in sub-Saharan Africa. The report indicates that the HIV epidemic has been harsh on the lives of young women, who comprise 66 per cent of infections among young people worldwide. Available DHS data show that indeed HIV/AIDS is more prevalent among young females than young males. For instance, HIV prevalence among young people aged 15-24 in Liberia was found to be 0.5 per cent for males and 1.7 per cent for females (DHS

[2] http://data.unaids.org/pub/outlook/2010/20100713_outlook_young-people_en.pdf page 6

Figure 2: Trends in lifetime risk of maternal deaths in GPRHCS Stream 1 countries



Source: WHO/UNICEF/UNFPA/World Bank. Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Geneva, World Health Organization, 2010 (http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf).

Note: Estimates have been rounded according to the following scheme: <100, no rounding; 100–999, rounded to nearest 10; and >1000, rounded to nearest 100.

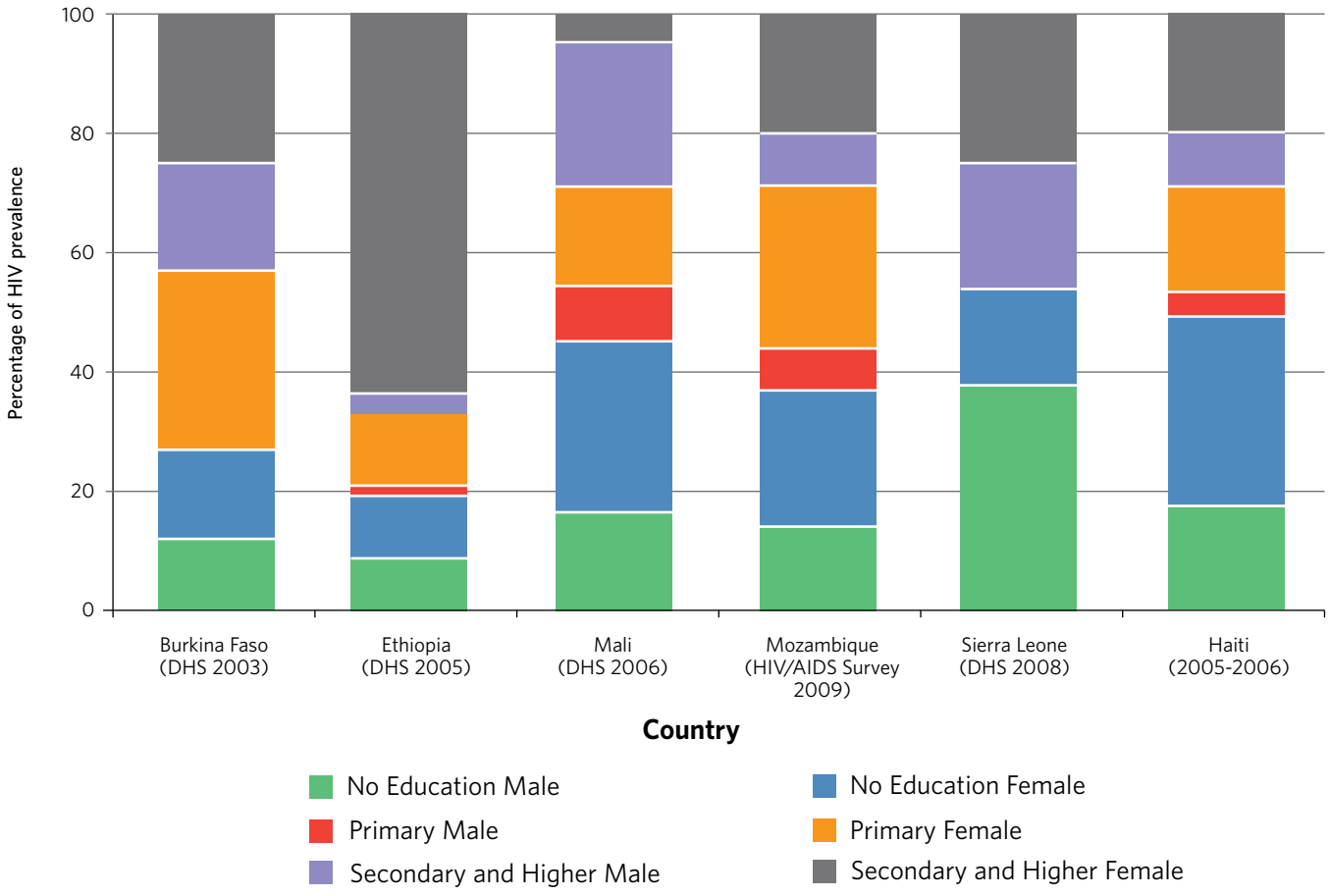
2007); in Mozambique it was 3.7 per cent for males and 11.1 per cent for females (HIV/AIDS Indicator Survey 2009) and in Haiti it was 0.6 per cent for males and 1.5 per cent for females (Mortality; morbidity and service utilization survey 2005-2006).

In Malawi, like other countries, although HIV prevalence among young people has decreased, the wide disparities between boys and girls still exist. Malawi shows a decreasefrom 2.1 per cent to 1.9 per cent for males and from 9.1 per cent to 5.2 per cent for females (DHS, 2004 and 2010). Patterns of disparities also exist by level of education and between urban and rural populations.

As shown in Figure 3, HIV prevalence among young people aged 15-24 years was found to be higher among females with secondary or higher education in Burkina Faso and Ethiopia, but in other countries it was higher among young people in the other education level categories, in particular among those with no education.

The patterns of HIV prevalence among young require well-focused strategies including comprehensive condom programming, awareness creation and delivery of sexual and reproductive health services. The GPRHCS has supported countries to undertake HIV/AIDS prevention and comprehensive condom programming activities. Along with support provided under other modalities, such as UBRAF, this support assists countries in their fight against HIV and AIDS.

Figure 3: HIV prevalence among young people aged 15-24 in selected GPRHCS Stream 1 countries by level of education



Source: HIV/AIDS Survey Indicators Database. http://www.measuredhs.com/hivdata/, March 23 2012.

CHAPTER TWO

Increasing Availability, Access and Use

The Global Programme to Enhance Reproductive Health Commodity Security contributes to UNFPA action to achieve results related to Millennium Development Goal 5: Improve Maternal Health, including target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, and target 5.B. Achieve, by 2015, universal access to reproductive health. The programme also contributes to the UNFPA Strategic Plan 2008-2012. Three sets of indicators have been adopted to assess progress in this regard.

The first set of outcome indicators relates to two family planning indicators derived from the UNFPA Strategic Plan, which are also indicators for MDG 5:

- contraceptive prevalence rate; and
- unmet need for family planning.

Data for these two indicators are sourced from national survey results (mostly DHS) or from national HMIS where available. Since surveys are conducted infrequently, updates for these indicators are presented when they are available.

The second set of outcome indicators measures progress for commodity security at country level:

- number of GPRHCS Stream 1 countries with service delivery points (SDPs) offering at least three modern methods of contraceptives;
- number of GPRHCS Stream 1 countries where five life-saving maternal/RH medicines from the list of UNFPA priority medicines are available in all facilities providing delivery services; and
- number of Stream 1 countries with service delivery points with 'no stock-outs' of contraceptives within last six months.

Annual national surveys are supported for Stream 1 countries to obtain data for these three indicators. The survey results help track availability of essential medicines and contraceptives at tertiary, secondary and primary SDP levels. These surveys are supported because the

A choice of modern contraceptive methods is displayed in Guinea.
Credit: Mariama Sire Kaba/UNFPA

Outcome:
Increased availability, access and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the Global Programme on RHCS focus countries.

health management information systems (HMIS) in the GPRHCS Stream 1 countries do not generate accurate information for these indicators. Since 2010, the Stream 1 countries have conducted the survey in accordance to a standardized methodology and survey guidelines that recommends a framework for choosing representative samples of service delivery points that provide modern contraceptive methods and maternal/reproductive health services in each country.

The third area focuses on tracking donor resources. The outcome indicator is 'Funding available for contraceptives including condoms'. Data for this indicator is sourced from UNFPA's donor support report published by the Commodity Security Branch based on information derived from donor databases. In each year's publication, the information is presented for the previous rather than the current year.

2.1 Unmet need for family planning

Unmet need for family planning is a statistical measure that calculates the percentage or number of sexually active women who say they want to stop childbearing or delay their next birth by at least two years but are not using any method of contraception. It is a valuable measure of progress and challenges of meeting the family planning felt needs of women.

UNFPA supports country-led family planning efforts through GPRHCS. Key activities include the provision of commodities; strengthening health systems; scaling up family planning demand creation activities; and working through national structures to help women overcome social, economic and physical barriers to family planning.

Using software to manage RH supplies in Madagascar.
Credit: UNFPA Madagascar

Table 3 shows unmet need for family planning in the 12 focus countries. Updated information is provided for Ethiopia, where unmet need has declined from 34 per cent (DHS 2005) to 25 per cent (DHS 2011The newly added Stream 1 country, Nigeria, is shown with an unmet need of 20 per cent. The range in data remains the same as in previous years. Unmet need in Stream 1 countries ranges from 10.7 per cent in Nicaragua to 37.5 per cent in Haiti. Unmet need in Stream 2 countries ranges from 3.8 per cent in Timor Leste to over 40 per cent in Uganda.

Addressing unmet need for family planning is important because it contributes to reducing maternal death by reducing the number of pregnancies, number of abortions and proportion of births at high risk. It also offers direct and indirect additional health, social and economic benefits including reducing infant mortality and slowing the spread of HIV/AIDS.

2.2 Contraceptive prevalence rate – modern methods

The use of modern methods of contraception has increased notably in several focus countries receiving sustained support from the GPRHCS. The indicator 'contraceptive prevalence rate (CPR) modern methods' refers to the proportion of women aged 15-49 who are using, or whose sexual partners are using, any modern method of contraception. It is measure of progress made in improving family planning outcomes for increased accessibility and use of contraceptives at national level.

New survey results for Burkina Faso show an increase in CPR from 13.3 per cent (MICS, 2006) to 16.2 per cent (DHS, 2010). New survey results for Ethiopia show an increase in CPR from 13.9 per cent (DHS, 2005) to 27.3 per cent (DHS, 2011) – nearly double. Table 4 and Figure 4 show updates on CPR for these two countries and add the new Stream 1 country, Nigeria, where CPR stands at 9.7 per cent (DHS 2008).

Disaggregated data show disparities in contraceptive use by education levels with women with higher education

Table 3: Unmet need for family planning for GPRHCS Stream 1 countries (percentage)

Country	Baseline (2008)	2009	2010	2011	Target (2013)
Burkina Faso	31.3 (MOH)	28.8 (MOH)	28.8 (MOH)	28.8 (MOH)	NA
Ethiopia	34.0 (DHS 2005)	34.0 (DHS 2005)	34.0 (DHS 2005)	25.0 (DHS 2011)	Less than 10%
Haiti	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	NA
Lao PDR	27.3 (LRHS 2005)	27.3 (LRHS 2005)	27.3 (LRHS 2005)	27.3 (LRHS 2005)	NA*
Madagascar	24.0 (DHS 2004)	19.0 (MOH)	19.0 (MOH)	19.0 (DHS 2009)	NA
Mali	31.2 (DHS 2006)	31.2 (DHS 2006)	31.2 (DHS 2006)	31.2 (DHS 2006)	NA
Mongolia	14.4 (ENDSA 2008)	14.4 (ENDSA 2008)	14.4 (ENDSA 2008)	14.4 (ENDSA 2008)	10%
Mozambique	18.4 (DHS 2003)	18.4 (DHS 2003)	18.4 (DHS 2003)	18.4 (DHS 2003)	NA
Nicaragua	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	8%
Niger	22.0 (MOH 2007)	NA	NA	NA	NA
Nigeria				20.0 (DHS 2008)	
Sierra Leone	28.0 (DHS 2008)	28.0 (DHS 2008)	28.0 (DHS 2008)	28.0 (DHS 2008)	40% reduction

* CPR target is set in MNCH Strategy rather than unmet need
Source: Updates compiled from 2011 GPRHCS country reports and related documents

Table 4: Contraceptive prevalence rate (modern methods): Stream 1 countries

Country	Baseline	2009	2010	2011	Target
Burkina Faso	8.6% (DHS 2003)	13.3% (MICS 2006)	13.3% (MICS 2006)	16.2% (DHS, 2010)	35% (2013)
Ethiopia	13.9% (DHS 2005)	30.0% (MOHS)	32.0% (MOHS)	27.3% (DHS 2011)	65% (2015)
Haiti	24.8% (DHS 2005-06)	24.8% (DHS 2005-06)	24.8% (DHS 2005-06)	24.8% (DHS 2005-06)	35% (2013)
Lao PDR	35.0% (LRHS 2005)	35.0% (LRHS 2005)	35.0% (LRHS 2005)	35.0% (LRHS 2005)	55% (2015)
Madagascar	18.0% (DHS 2004)	29.2% (MOHS)	29.2% (DHS 2008-09)	29.2% (DHS 2008-09)	36% (2012)
Mali	6.9% (DHS 2006)	6.9% (DHS 2006)	6.9% (DHS 2006)	6.9% (DHS 2006)	15% (2013)
Mongolia	40.0% (RHS)	52.8% (RHS 2008)	52.8% (RHS 2008)	52.8% (RHS 2008)	55% (2012)
Mozambique	11.7% (DHS 2003)	11.7% (DHS 2003)	12.2% (MOH)	12.2% (MOH)	34% (2015)
Nicaragua	69.8% (DHS 2007)	69.8% (DHS 2007)	69.8% (DHS 2007)	69.8% (DHS 2007)	72% (2013)
Niger	11.7% (DHS 2006)	16.5% (MOH)	21% (HMIS)	21% (HMIS)	18% (2012)
Nigeria	-	-	-	9.7% (DHS 2008)	-
Sierra Leone	-	7% (DHS 2008)	7% (DHS 2008)	7% (DHS 2008)	10.5% (2013)

Source: Compiled from 2011 GPRHCS country reports and related documents

Figure 4: Contraceptive prevalence rate (modern methods) for selected Stream 1 countries

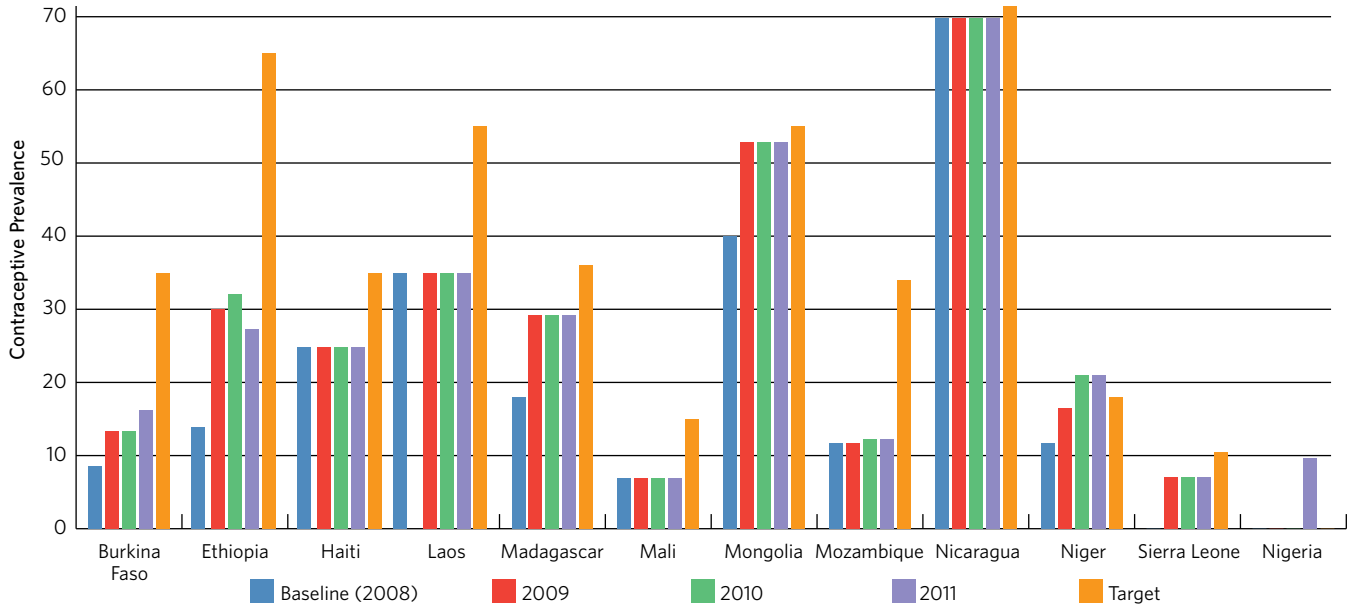
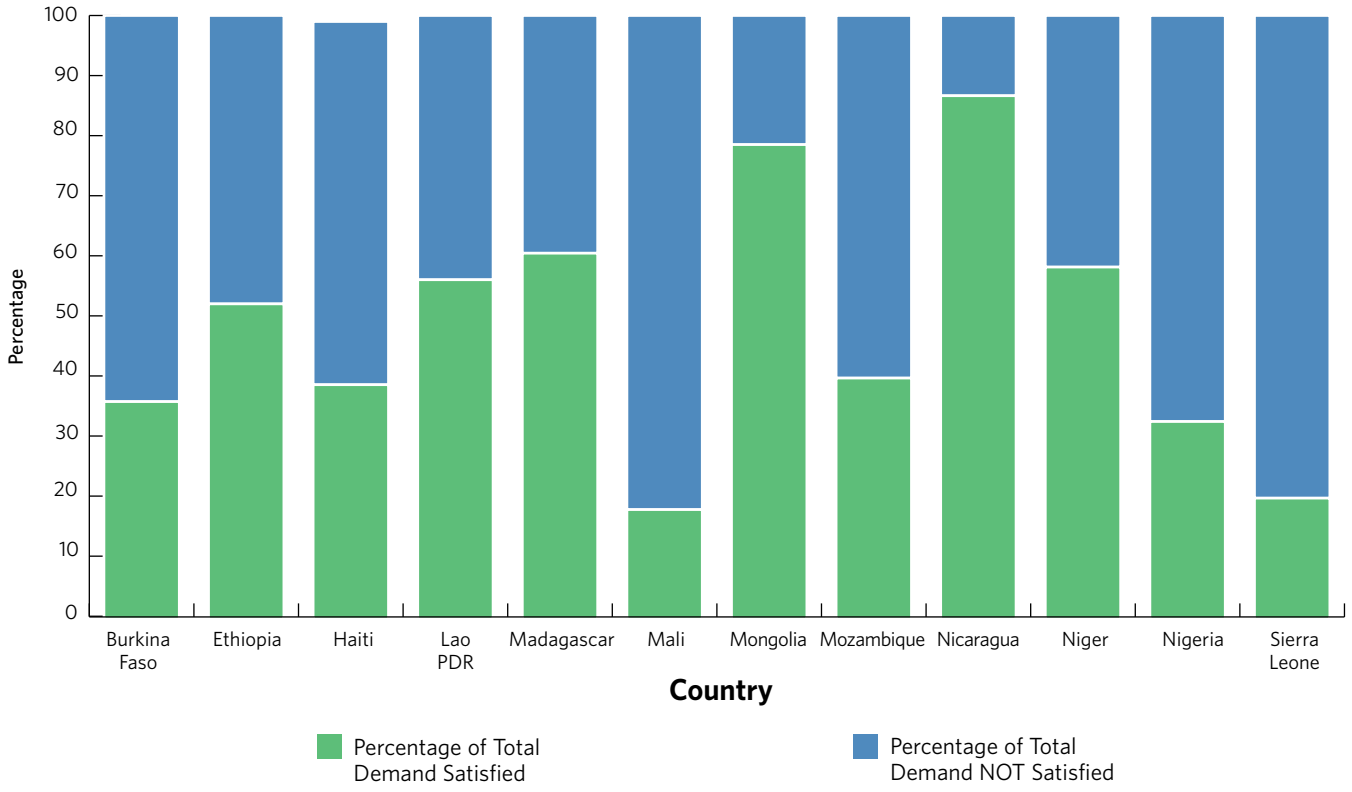


Figure 5: Family planning demand satisfied in GPRHCS Stream 1 countries



showing higher levels of contraceptive use. In the unique case of Nicaragua, the difference in contraceptive use for women with no education and those with secondary or higher level is narrower than for the other countries.

When wealth is taken into consideration, the percentages of current users of contraceptives are disproportionately higher among married women in the highest wealth quintile. In all countries, contraceptive use increases with the level of education of the women. Data also show disparities between rural and urban residence. CPR is four times higher among urban residents than rural residents in Burkina Faso (28.5 urban compared to 5.2 rural), Ethiopia (42.2 urban compared to 10.6 rural); Mali (13 urban compared to 4.2 rural) and Sierra Leone (14.2 urban compared to 3.8 rural).

Family planning demand satisfied

Data on unmet need and contraceptive prevalence rate provides for the computation of 'total demand' for family planning and the percentage of family planning demand that is satisfied. The concept focuses on computing the percentage of users of family planning with respect the sum of users and those who need family planning. The most recent data available for each country shown in Tables 3 and 4 have been used to generate data on contraceptive demand presented in Table 5 and Figure 5. The percentage of family planning demand satisfied is highest in Nicaragua (86.7 per cent) followed by Mongolia (78.6 per cent) and lowest in Sierra Leone (20 per cent) and Mali (18 per cent).

Family planning method mix

Family planning method mix provides information on the degree to which consumers use a range of methods. One way of assessing method mix is to measure the difference in prevalence rates between the most prevalent modern method in a country and the third-most prevalent method, divided by the total modern method prevalence[3]. On a ten-point scale, a higher value indicates a close-to-even spread and hence low concentration of users on a limited number of methods. This is normally interpreted as good and conducive for contraceptive security. On the other hand, a lower value on a ten-point scale is interpreted as high concentration of users among the methods and is interpreted as an unfavourable method mix. Table 6

[3] USAID | DELIVER PROJECT, Task Order 1. 2010. *Contraceptive Security Index Technical Manual*. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1; Page 9

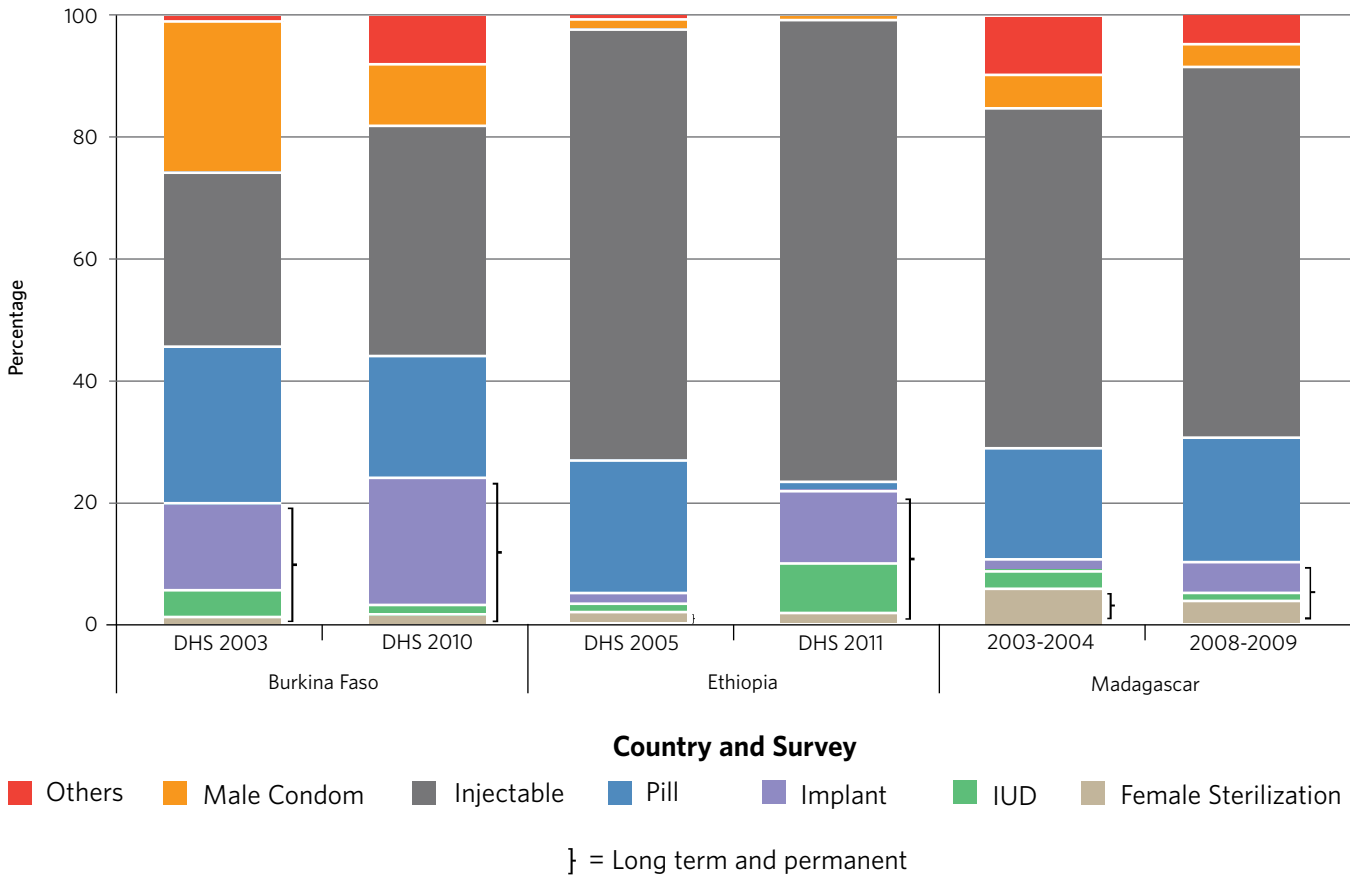
Table 5: Family planning demand satisfied in GPRHCS Stream 1 countries (percentage)

Country	Unmet need	Current use	Total demand	Percentage of total demand satisfied	Percentage of total demand NOT satisfied
Burkina Faso	28.8	16.2	45.0	36.0	64.0
Ethiopia	25.0	27.3	52.3	52.2	47.8
Haiti	37.5	24.8	62.3	39.8	60.2
Laos	27.3	35.0	62.3	56.2	43.8
Madagascar	19.0	29.2	48.2	60.6	39.4
Mali	31.2	6.9	38.1	18.1	81.9
Mongolia	14.4	52.8	67.2	78.6	21.4
Mozambique	18.4	12.2	30.6	39.9	60.1
Nicaragua	10.7	69.8	80.5	86.7	13.3
Niger	15.0	21.0	36.0	58.3	41.7
Nigeria	20.0	9.7	29.7	32.7	67.3
Sierra Leone	28.0	7.0	35.0	20.0	80.0

Table 6: Per cent distribution of currently married women age 15-49 by contraceptive method currently used for selected GPRHCS Stream 1 countries

	Burkina Faso		Ethiopia		Madagascar	
Modern method	DHS 2003	DHS 2010	DHS 2005	DHS 2011	2003-04	2008-09
Female sterilization	0.1	0.2	0.2	0.5	1.1	1.1
IUD	0.4	0.3	0.2	2.1	0.6	0.4
Implant	1.2	3.4	0.2	3.4	0.3	1.5
Pill	2.2	3.2	3.1	0.3	3.4	6.0
Injectable	2.5	6.2	9.9	20.8	10.2	17.9
Male condom	2.1	1.6	0.2	0.2	1	1.1
Others	0.1	1.3	0.1	0	1.7	1.2
Total for modern methods (M-CPR)	**8.6**	**16.2**	**13.9**	**27.3**	**18.3**	**29.2**
Method mix score on a 10-point scale	**9.5**	**8.1**	**3.0**	**3.2**	**5.4**	**4.3**

Figure 6: Per cent distribution of currently married women age 15-49 by contraceptive method currently used for selected GPRHCS Stream 1 countries



presents data for three Stream 1 countries with the most recent DHS.

The three methods with the highest prevalence in Burkina Faso accounted for 79 per cent of modern CPR in 2003 and the situation improved slightly to 67.9 per cent in 2010. The three methods with the highest prevalence in Ethiopia accounted for 95 per cent of modern CPR in 2005 and the situation improved slightly to 78 per cent in 2011. In Madagascar, the three highest methods accounted for 79.8 per cent of modern CPR in 2003-04 and the situation worsened slightly to 85.6 per cent in 2008-09. With a method mix score of 9.5 points in 2003 and 8.1 points in 2010, Burkina Faso has better spread of users among the methods and can be interpreted as having a better method mix than the other countries. The situation is not favourable in Ethiopia, where the method mix score was 3 points in 2005 and increased slightly to 3.2 points in 2011. Also in Ethiopia, the method with the highest prevalence in the two surveys (injectable) has increased in value from 9.9 per cent in 2005 to 20.8 per cent in 2011. Injectable contraceptives accounted for 71.2 per cent of CPR in 2005 compared to 76.2 per cent of CPR in 2011.

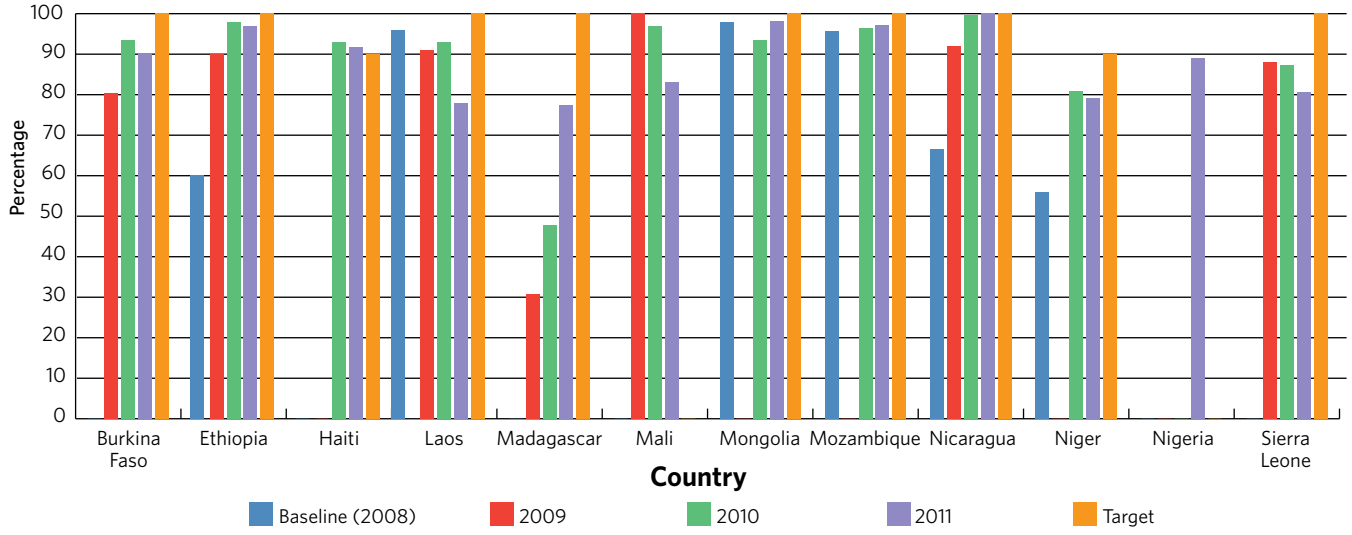
Prevalence for long-term and permanent methods

Figure 6 shows that the landscape is changing for long-term and permanent methods such as sterilization, IUD and implants. In Burkina Faso, these methods accounted for 19.8 per cent of CPR in 2003 and 24.1 per cent of CPR in 2010 – an increase that places it higher than the other countries in use of long-term and permanent methods. In Ethiopia, there has been substantial improvement in the prevalence of long-term and permanent methods – increasing from 4.3 per cent in 2005 to 22 per cent of CPR in 2011. In contrast, the prevalence of long-term and permanent methods declined slightly in Madagascar from 10.9 per cent in 2003-04 to 10.3 per cent of CPR in 2008-09.

2.3 Number of GPRHCS Stream 1 countries with service delivery points (SDPs) offering at least 3 modern methods of contraceptives

This indicator is critical to reproductive health commodity security. It assesses the percentage of service delivery points (SDPs) that report the availability of at least three types of modern methods of contraceptives. The modern methods under consideration are male condoms, female condoms, oral pills, injectables, IUDs, implants, and male and female sterilization. This indicator provides information for a better understanding of the efficiency of commodity distribution networks in a country and the availability of services when and where they are needed by clients. This

Figure 7: Percentage distribution of service delivery points offering at least three modern contraceptive methods, 2011 round of surveys



information is easily obtainable where HMIS are regularly updated. However, since this is not the case in the GPRHCS Stream 1 countries, the programme supports the conduct of annual surveys to obtain data for this indicator. Starting in 2010, a special tool has been adopted to facilitate the standardization of the survey in all countries.

The percentage of service delivery points offering at least three modern contraceptive methods has improved in four countries (Madagascar, Mongolia, Mozambique and Nicaragua). Overall, data in Table 7 and Figure 7 show that in 2011 the figure varied from 67 per cent in Lao PDR to 100 per cent in Nicaragua. The benchmark for this indicator has been achieved in 11 Stream 1 countries where more than 75 per cent of SDPs offered at least 3 modern methods of contraception.

The availability of three modern methods has improved at the primary-level SDPs in four Stream 1 countries (Madagascar, Mongolia, Nicaragua and Sierra Leone). The same can be said for the secondary-level SDPs where four countries (Ethiopia, Madagascar, Mali and Nicaragua) either recorded improvements or maintained last year's levels of achievement. At the tertiary SDP level, eight countries either recorded improvements or maintained last year's levels of achievement. Data is only available for 2011 in Nigeria, where three modern contraceptives were available at 97.1 per cent of tertiary-level SDPs. These results are shown in Table 8.

Nicaragua is the only GPRHCS country where 100 per cent of SDPs in both rural and urban areas have three modern methods of contraceptives available. More than 90 per cent do so in Ethiopia, Madagascar and Mongolia, as shown in Figure 8. With the exception of Sierra Leone and Haiti, the percentages of SDPs with three modern contraceptives available are higher in urban areas than rural areas.

Challenges to offering at least three modern methods of contraceptives

The aim is to ensure that service delivery points offer at least three modern contraceptive methods on a sustainable basis, as per national guidelines. These methods include male condom, female condom, oral pill, injectable,

Table 7: Percentage of service delivery points (SDPs) offering at least three modern methods of contraception in GPRHCS Stream 1 countries in 2008 to 2011

Country	Baseline (2008)	2009	2010	2011	Target (2013)
Burkina Faso	NA	80.4 (2009)	93.5	90.3	100 (2012)
Ethiopia	60.0 (2006)	90.0	98.0	97.2	100 (2010)
Haiti	0	NA	93.0	91.8	90.0 (2013)
Lao PDR	96.0 (2006)	91.0	93.0	67.0	100 (2012)
Madagascar	-	30.8	47.8	77.5	100 (2012)
Mali	-	100	97.0	83.0	NA
Mongolia	98.0	NA	93.5	98.2	100
Mozambique	95.7 (HIS 2008)	NA	96.5	97.1	100
Nicaragua	66.6 (2008)	92.0	99.5	100.0	100
Niger	56.0 (2008)	NA	80.9	79.0	90.0
Nigeria				89.0	
Sierra Leone	-	88.0*	87.2	80.5	100

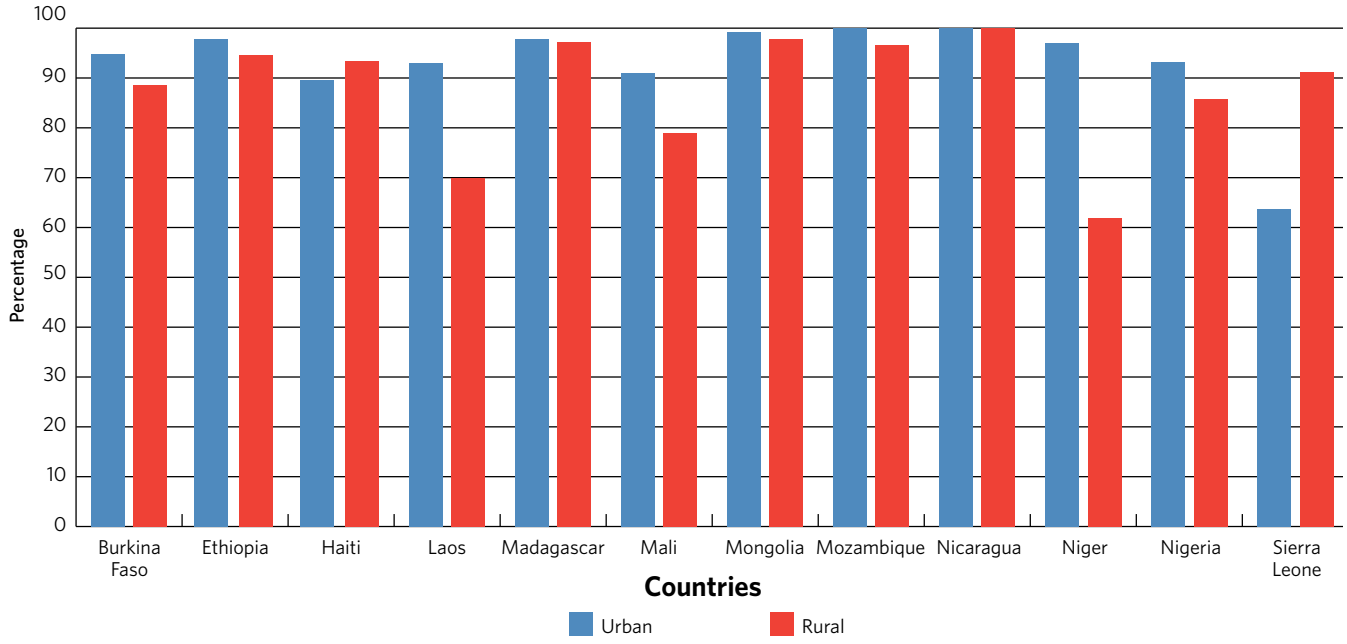
Source: GPRHCS 2010 country and related sample survey reports
Note: 2010 and 2011 data from sample surveys reports of each country conducted using standardized methodology
* Proportion with at least two modern methods available

Table 8: Percentage of sampled SDPs by type of facility, offering at least three modern methods of contraception in GPRHCS Stream 1 countries in 2010 and 2011*

	Primary		Secondary		Tertiary	
Country	2010	2011	2010	2011	2010	2011
Burkina Faso	92.0	89.6	100	92.7	100	100
Ethiopia	97.6	96.4	98.4	98.4	100	100
Haiti	91.0	90.9	94.0	93.5	93.0	100
Lao PDR	89.0	67.0	95.0	92.0	94.0	93.0
Madagascar	50.0	97.3	50.6	94.9	61.8	85.7
Mali	88.0	77.0	88.0	95.0	73.0	82.0
Mongolia	92.0	98.2	100	97.8	100	100
Mozambique	96.7	98.9	95.0	92.1	100	100
Nicaragua	99.5	100	100	100	-	-
Niger	80.0	78.0	100	97.0	100	100
Nigeria	-	84.0	-	94.3	-	97.1
Sierra Leone	70.0	90.2	76.0	58.2	78.0	50.0

Source: GPRHCS 2010 country and related sample survey reports
* Tertiary facilities are cardiology, dermatology and physical medicine and these do not stock essential maternal health medicines.

Figure 8: Percentage of sampled SDPs by location, offering at least three modern methods of contraception in GPRHCS Stream 1 countries in 2011*



IUD, implant, female sterilization and male sterilization. However, as survey results have shown, important issues remain to be addressed. The challenges faced by some countries are explained below:

Burkina Faso: Staff attrition in some secondary SDPs meant that vasectomy, tubal ligation, IUD and implant were not readily available in 2011. Even where commodities were readily available, the absence of staff affected the availability of these methods to clients on a sustainable basis.

Ethiopia: Equipment was not available, facilities were not set up and/or there was a lack of trained providers: these are the major reasons why primary-level SDPs were not able to provide long-acting and permanent contraceptive methods in 2011. Also, this year's survey results included newly-constructed health posts in Oromia and SNNP regions, which were not yet able to provide all the requisite methods. Female condoms, for example, may not be registered by the country's drug authority and so may not be available in all SDPs, in particular in the country's rural SDPs.

Haiti: In 2010, the country had a much larger presence of humanitarian actors especially international NGOs, which contributed to the strengthening of supply and distribution systems even in the face of the Haitian earthquake tragedy. With the gradual phasing out of humanitarian relief operations, however, there has been a mass exodus of NGOs. This has affected the health systems and the ability of SDPs to offer the full complement of contraceptives to clients.

Lao PDR: The minor difference observed in the indicator 'availability of three modern methods of contraception' (83 per cent in 2010 and 80 per cent in 2011) is linked to an increase in the number of facilities surveyed and the fact that most were at the primary-SDP level, where lack of trained staff challenges the national system to provide the requisite number of contraceptives. The number of SDPs in the survey increased from 344 facilities in 2010 to 386 facilities in 2011. The challenge posed by lack of trained health care providers for certain health interventions also affected the ability of the family planning programmes to ensure three modern contraceptives are available in SDPs. This is especially the case for IUDs, which were not available in some SDPs because of lack of skilled personnel to insert them, especially at lower-level SDPs.

Motorbikes aid rural community-based distribution agents in Côte d'Ivoire
Credit: UNFPA Côte d'Ivoire

Mali: The reduction in the number of SDPs providing three modern methods of contraceptives to clients was influenced by several factors. Sometimes contraceptive methods were not offered because clients have not demanded them, such as the female condom and male sterilization, even when SDPs were supposed to provide the methods. This was often the case in private SDPs where methods offered are driven by demand for the services. Also, the lack of trained services providers caused a reduction in the number of health facilities that offered tubal ligation to clients. Furthermore, the number of SDPs in the survey increased from 153 facilities in 2010 to 166 facilities in 2011, most of which were in rural areas, where this indicator encounters the most challenges.

Niger: The slight decrease is attributable to the use of two different methodologies. In 2010, the survey was conducted as part of the EMOC needs assessment, for which data was collected from a limited number of SDPs (those who provided maternal services only). In 2011, the survey was conducted in line with the GPRHCS guidelines and data was obtained from a broad range of SDPs.

Sierra Leone: The introduction of a centralized drug distribution system by the Government of Sierra Leone in 2011 made it mandatory for all drugs including contraceptives to be distributed by one agency. The initial challenges of this system caused stock-outs of medicines and contraceptives in even tertiary and secondary SDPs. There was generalized unavailability of many drugs including contraceptives at SDPs. A process of engaging the services of an independent company to take over all procurement as well as the supply management system was finalized in 2012. This is expected to improve the distribution of commodities, including contraceptives.

2.4 Number of GPRHCS Stream 1 countries where 5 life-saving maternal/RH medicines from the list of UNFPA priority medicines are available in all facilities providing delivery services

To reduce maternal death, the availability of life-saving maternal/RH medicines at service delivery points is critical. UNFPA works with partners to support governments in ensuring that these medicines are available in adequate quantities and quality at all maternal health facilities. The 10 UNFPA priority medicines are Amoxicillin, Azithromycine, Benzathine Penicillin, Cefexime, Clotrimazole, Ergometrine, Iron/Folate, Magnesium Sulfate, Metronidazole and Oxytocin.

GPRHCS supports Stream 1 countries to gather survey data on the number of SDPs that have 5 life-saving medicines available. The indicator measures the functionality of the supply management system including the ability of countries to forecast their needs and then procure and manage commodities to efficiently meet those needs.

Table 9 shows that in eight out of the 11 countries where the survey has been conducted for two consecutive years, there have been improvements in the number of SDPs that have five life-saving medicines available. In Nicaragua, life-saving medicines continue to be available in almost all SDPs.

All the tertiary-level SDPs (100%) in Lao PDR, Madagascar, Mongolia, Niger and Nigeria have the five life-saving medicines, as shown in Figure 9. For Mali and Sierra Leone, more secondary-level SDPs had life-saving medicines than tertiary-level SDPs.

Urban facilities had more of the lifesaving medicines than the rural facilities, as shown in Figure 10, for Burkina Faso, Lao PDR and Haiti. Marked differences were observed between rural and urban SDPs in terms of SDPs with five life-saving medicines. This is in contrast to Mali, Nicaragua and Sierra Leone, where a higher percentage of rural SDPs with five life-saving maternal

Table 9: Percentage of SDPs with five life-saving maternal/RH medicines (including three UNFPA priority medicines) available in GPRHCS Stream 1 countries in 2010 and 2011

Country	2010	2011	Target (2013)
Burkina Faso	51.4	11.7	Y
Ethiopia	76.1	79.6	100
Haiti	60.8	61.1	NA
Lao PDR	13.0	41.0	NA
Madagascar	66.6	67.4	100
Mali	92.0	85.0	NA
Mongolia	76.8	86.8	98
Mozambique	68.4	69.9	NA
Nicaragua	99.5	98.3	100
Niger	60.6	84.0	100
Nigeria	-	85.1	
Sierra Leone	75.5	91.2	100

*Source: GPRHCS 2010 and 2011 country and related sample survey reports

health medicines were observed. For Niger, the percentages for rural and urban facilities are equal.

Challenges to making 5 life-saving maternal/RH medicines available

The surveys conducted in GPRHCS Stream 1 countries focused on whether all the SDPs surveyed provided i) the following three mandatory medicines: Magnesium Sulphate, Oxytocine and Ergometrine; and ii) any other two of the remaining medicines on the UNFPA priority list, which includes Amoxicillin, Azithromycine, Benzathine Penicillin, Cefexime, Clotrimazole, Ergometrine, Iron/Folate, Magnesium Sulfate, Metronidazole and Oxytocin.

One of the challenges encountered in achieving progress against this indicator is that different national protocols, policies and guidelines dictate the type of SDPs that are allowed to make certain medicines available. This challenge and others have affected results in some countries.

Burkina Faso: The survey found that according to national policy guidelines, provision of Magnesium Sulphate (an anti-convulsant) was not allowed for primary SDPs, which constituted a larger proportion of sampled facilities. Instead of magnesium sulphate, the most widely available anti-convulsant in Burkina Faso was Diazepam. As a result of the survey's findings regarding low availability of five life-saving medicines, UNFPA has initiated dialogue with the Government to expand availability of Magnesium Sulphate.

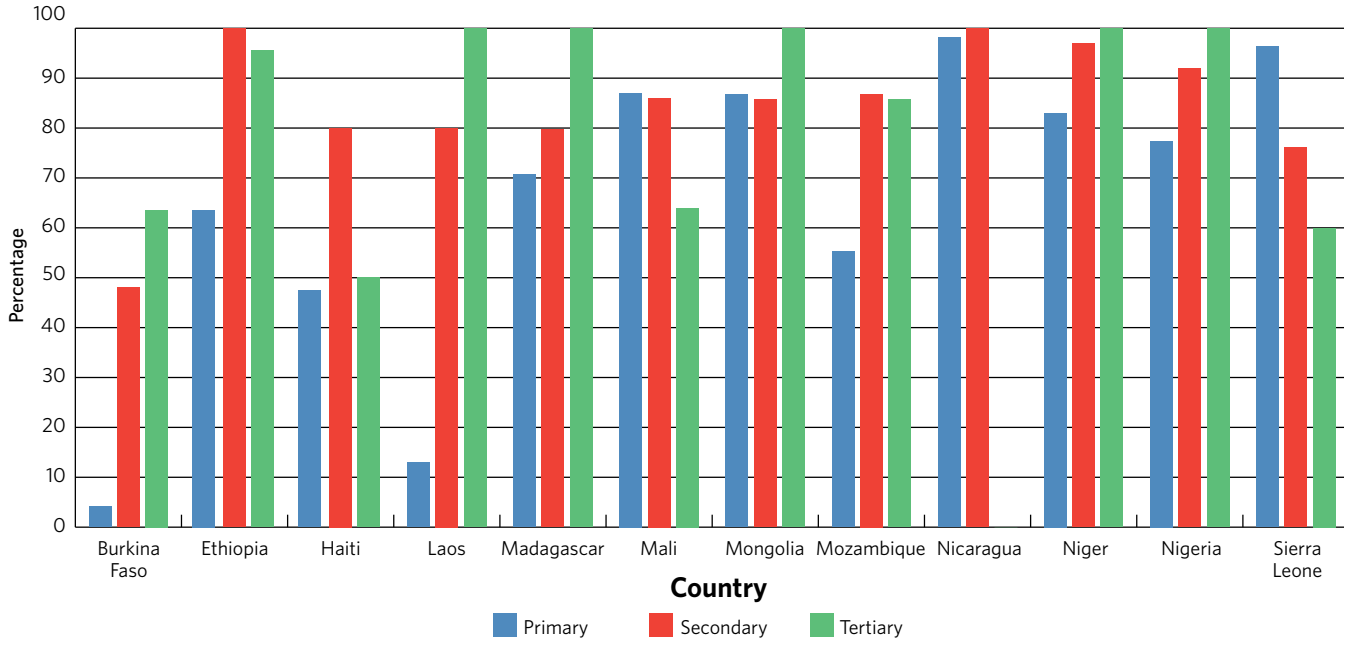
Haiti: With the gradual phasing out of humanitarian relief operations in 2011 came a mass exodus of NGOs. This has affected the ability of SDPs to make the required life-saving medicines available.

Lao PDR: In line with national policy guidelines, the use of Magnesium Sulfate is not allowed at primary level SDPs. Most of the other drugs were readily available at all levels.

Madagascar: As a result of the lingering social and political crisis, the reproductive health commodity needs of the country amounting to $8,000,000 in 2011 could not be mobilized by the Government. Presently, UNFPA is the only partner supporting the Ministry of Health in purchasing RH commodities, which is not enough to cover all the needs.

Mali: Differences in sampling procedures affected the slight change in the indicator for Mali. Sikasso region, the second largest in the country, was partially included in the 2010 survey, while information from the Kayes region was not included in the 2011 survey. In addition to these

Figure 9: Percentage of SDPs with five life-saving maternal/RH medicines (including three UNFPA priority medicines) available by type of SDPs in GPRHCS Stream 1 countries, 2011



differences, some private SDPs would only stock commodities that were in high demand and would not stock maternal health medicines, for example, where demand was judged to be low.

Mongolia: Oxytocin is only issued as prescribed by the national protocol, which limits the availability of the medicines at only secondary and tertiary levels.

Nicaragua: In the 2010 survey, 100 per cent of the 199 SDPs that provide delivery services had the five essential medicines available. In the 2011 survey, however, the sample was increased to 234 SDPs that provide delivery services. This expanded sample yielded 98.1 per cent at primary level and 100 per cent at secondary for SDPs offering the five life-saving medicines.

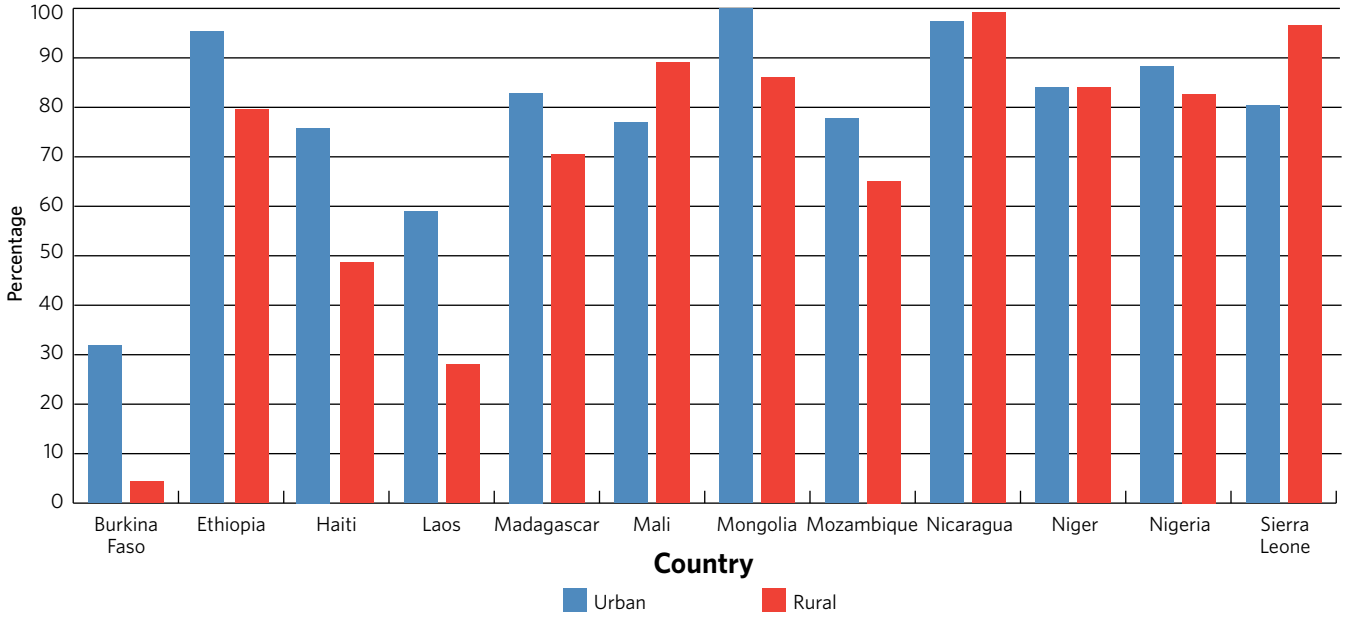
Sierra Leone: The introduction of a centralized drug distribution system by the Government of Sierra Leone in 2011 made it mandatory for all drugs, including contraceptives, to be distributed by one agency. The initial challenges of this system caused stock-outs of medicines in all types of SDPs.

The survey results provide significant insight into the problems that continue to challenge most of the Stream 1 countries in ensuring that rural areas (where most of the primary SDPs are located) are stocked with the requisite medicines that help prevent maternal morbidity and mortality. The survey results could be used to corroborate findings of National Emergency Obstetric and Newborn Care (EmONC) needs assessments, which often reveal that facilities providing delivery services are not adequately stocked with the necessary supplies and medicines to save a woman's life during childbirth. It is encouraging to note that some Stream 1 countries are making these medicines available in many rural facilities.

2.5 Number of Stream 1 countries with service delivery points with 'no stock-outs' of contraceptives within last six months

Ensuring that service delivery points always have contraceptives in stock to serve clients in line with national protocols is a priority for UNFPA's work with partners and governments through the GPRHCS. This involves timely forecasting, procurement and distribution of reproductive health commodities to avert stock-outs (shortages or shortfalls). It entails supporting countries to have fully functional logistics management information systems in place, an issue influenced by various factors at the national and sub-national levels.

Figure 10: Percentage of SDPs with five life-saving maternal/RH medicines (including three UNFPA priority medicines) available by location of SDPs in GPRHCS Stream 1 countries, 2011



A stricter application of the definition of 'no stock-out' has been applied in the surveys conducted over the past two years. In adherence to this standard, six countries (Ethiopia, Lao PDR, Madagascar, Mozambique, Nicaragua and Niger) have achieved the defined threshold of at least 60 per cent for this indicator. Table 10 shows that Ethiopia still continues to maintain a 'no stock-out' rate in 99 per cent of the SDPs.

Compared to the 2010 figures, however, the 'no stock-out' rate reflected a number of challenges and it decreased in most Stream 1 countries in 2011. Between 2010 and 2011, rates of 'no stock-out' in Burkina Faso decreased from 81.3 per cent to 12.8 per cent; Mongolia from 98 per cent to 38 per cent; and Nicaragua from 99.7 per cent to 65 per cent.

Contraceptives were more available in Ethiopia and Niger, where all levels of SDPs had 'no stock-out' rates of over 80 per cent, than in other countries. However, for Burkina Faso, Haiti, Mali and Sierra Leone, 'no stock-out' rates at all levels of SDPs were lower than 40 per cent, as shown in Figure 11.

Data presented in Table 11 shows that 'no stock-out' rates for 2011 are higher in rural areas in Haiti, Niger, Nigeria and Sierra Leone. In contrast, the 'no stock out' rates are higher in urban areas Burkina Faso, Ethiopia, Lao PDR, Madagascar and Mozambique.

Figure 12 shows that 'no stock-out' rate is higher for urban SDPs in Burkina Faso than in the other countries. For Haiti, Niger, Nigeria and Sierra Leone, the 'no stock-out' rates in urban areas are less than 50 per cent of the total SDPs surveyed in each country.

Individual modern contraceptive methods are tracked in the surveys. In Mali, 'no stock-out' rates in the last six months were male condom (72%), oral pills (78%), IUD (45%), implants (45%), injectables (80%) and female condom (36%). In Mozambique, the rates were male

Table 10: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months in GPRHCS Stream 1 countries, 2008 to 2011

Country	Baseline (2008)	2009	2010****	2011****	Target (2013)
Burkina Faso	NA	29.2 (2009)	81.3	12.8	100% (2012)
Ethiopia	60.0 (2006)	90.0 (2009)	99.2	98.8	100% (2012)
Haiti	NA	NA	52.5	26.4	NA
Lao PDR	NA	20.0*	36.0	84.0	80.0%
Madagascar	63.3 (2008)	74.4 (2009)	79.6	90.8	96.0% (2012)
Mali	-	NA	46.0	31.0	NA
Mongolia	100	100	97.6**	37.7	100%
Mozambique	NA	NA	24.1	81.0	NA
Nicaragua	66.0 (2008)	81.0 (2009)	99.7	64.5	92.0%
Niger	0	100 (2009)	99.1***	85.0	100% (2012)
Nigeria				44.0	
Sierra Leone	-	77.0	41.4	35.4	100%

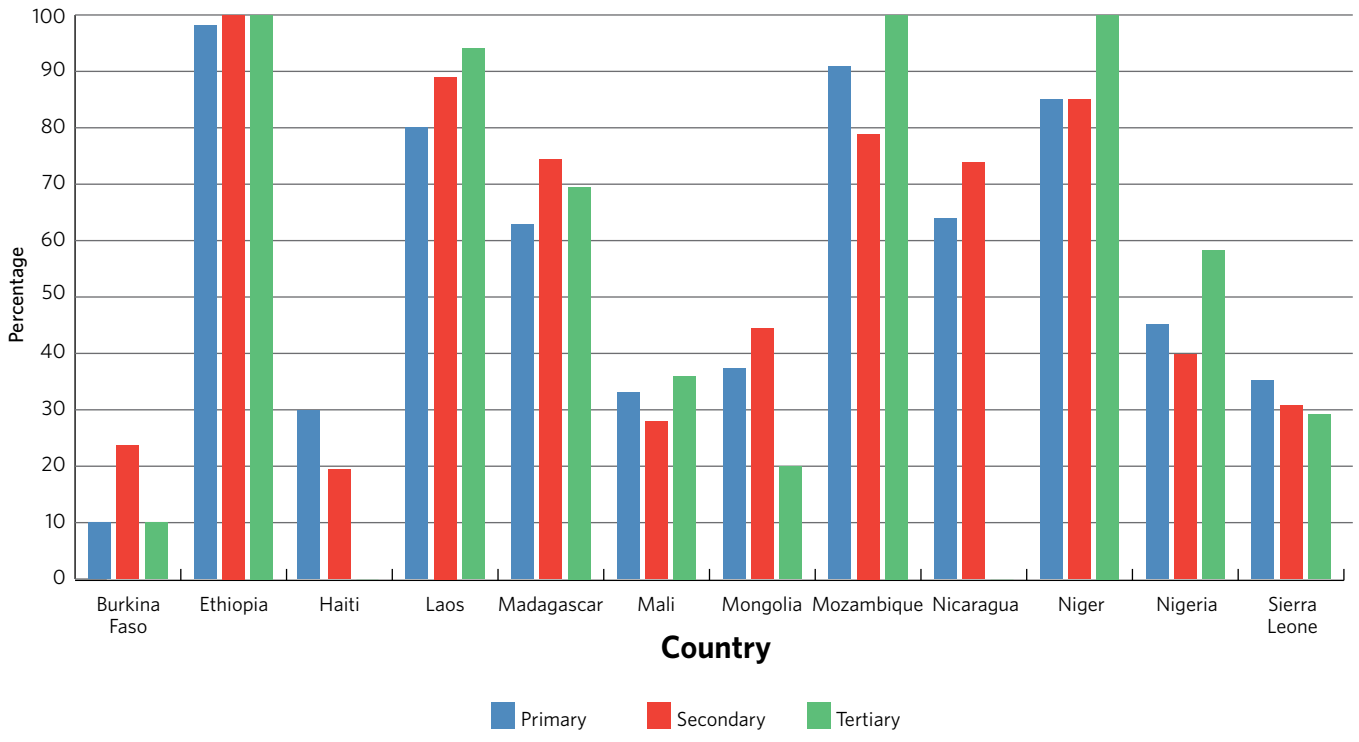
* For Lao PDR, the 2009 breakdown was: national = 20%, provincial hospitals = 50% district hospitals = 19% and health centre = 15%
** 100% in both tertiary and secondary facilities but 92% in primary facilities
*** 100% for tertiary institutions and 95.2% for secondary and 99.3% for primary
**** GPRHCS 2010 and 2011 country and related sample survey reports

Table 11: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months by location of SDP in GPRHCS Stream 1 countries, 2011

Country	By location	
	Urban	Rural
Burkina Faso	17.9	9.3
Ethiopia	99.0	98.2
Haiti	25.0	27.4
Lao PDR	89.0	80.0
Madagascar	74.2	61.8
Mali	32.0	31.0
Mongolia	37.8	37.7
Mozambique	85.7	80.2
Nicaragua	65.8	63.7
Niger	76.0	87.0
Nigeria	42.5	45.1
Sierra Leone	31.5	35.5

*Source: GPRHCS 2011 country and related sample survey reports

Figure 11: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months by type of SDP in GPRHCS Stream 1 countries, 2011



condom (77.4%); female condoms (47.4%); oral pills (71.5%); IUD (60.6%) and injectable (59.9%).

Challenges to ensuring 'no stock-outs' of contraceptives within last six months

Reasons for the reported levels of 'no stock-out' varied from country to country and are explained below:

Burkina Faso: SDPs that were not manned by qualified or trained staff to dispense methods like vasectomy, tubal ligation, IUDs and implants were recorded as having a stock-out of the commodity. Also, the decline in the country's 'no stock-out' rate in 2011 is because Burkina Faso experienced a stock-out of Jadelle (implant) when it took slightly longer than expected for stocks to be transferred from Rwanda, which had an overstock of the commodity.

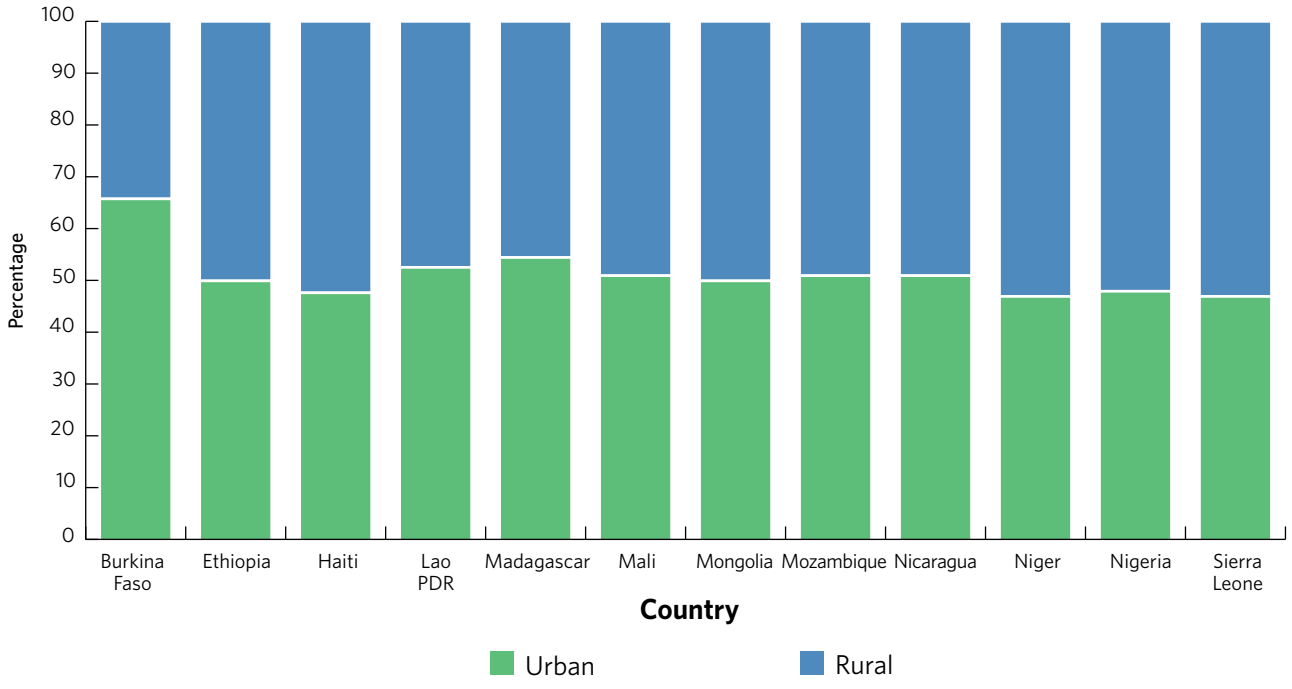
Ethiopia: No SDPs at the secondary or tertiary levels experienced shortages of contraceptives, garnering 'no stock-out' rates of 100 per cent in the last six months surveyed. However, primary level SDPs showed a very slight reduction in rates especially for new SDPs that were added to the survey in 2011. Rates also were affected by the non-availability of the female condom in some primary-level SDPs.

Haiti: Compared to 2010, there were a much smaller number of development partners especially NGOs in the country in 2011. With limited assistance, the health system has not been able to fully recover and respond to the needs of clients. Therefore the 'no stock-out' rate was far lower in 2011 compared to 2010.

Madagascar: The 'no stock-out' rate improved yet in 2011 Madagascar experienced shortfalls of Depo-Provera (injection) in 2011 because the supplier (Pfizer) did not deliver the commodity on time. Pfizer explained that they had to renew authorization to deliver this commodity in Madagascar but this was delayed. Another reason was that some SDPs reported 'no stock-out' levels for commodities such as IUDs and implants, yet they do not presently have the technical expertise to offer these methods.

Mali: The lack of trained service providers affected the provision of methods such as male and female sterilization especially at secondary-level SDPs. The survey showed that the methods that were in high demand had higher 'no stock-out' rates: injectable (90%), oral pill (87%) and male condom (82%). Also there was an increase in sample size from 153 facilities in 2010 to 166 facilities in 2011, and

Figure 12: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months by location of SDP in GPRHCS Stream 1 countries, 2011



the additional SDPs were mostly primary-level centres in rural areas where most methods are not available.

Mongolia: For 2011, the survey took into account a total of seven methods of contraception: male and female condoms, oral pills, IUDs, injectables, implants and the emergency pill. The latter two are generally not available all the time in all SDPs. Implanon, an implant, has not been widely introduced in Mongolia, nor is the emergency pill freely and continuously available in all three levels of SDPs. When these two methods are excluded, the 'no stock-out' rate increases to about 73 per cent. The rate is also affected by the lack of trained staff to provide methods such as male sterilization and female sterilization.

Nicaragua: As of 2010, the Ministry of Health has promoted the IUD as one of the most cost-effective modern methods of contraception and has required all SDPs at the first and second levels of care to provide this method. However, this call was not followed by the provision of basic equipment for insertion, training of adequate staff or an increase in the supply of IUDs to SDPs. Many SDPs were not prepared for the increase in demand for the method; hence the reduction in the 'no stock-out' rate especially for this method.

Niger: Generally, there are limited numbers of trained staff to provide certain methods like male sterilization, female sterilization, IUD and implant in line with national protocols. More specifically, a stock-out of Depo-Provera occurred, affecting the availability of the method in the regions of Maradi, Tahoua and Tillabery.

Sierra Leone: As previously stated, the centralisation of the distribution of drugs including contraceptives in the hands of one agency caused the stock-out of modern family planning methods in SDPs around the country.

2.6 Funding available for contraceptives including condoms

Data for this indicator is sourced from the Report on Donor Support for Contraceptives and Condoms published annually by the Commodity Security Branch of UNFPA. The 2010 report highlights trends in support from bi-lateral and multi-lateral donors as well as social marketing organizations and provides information on

Table 12: Trends in support for contraceptives and condoms among major donors, 2005-2011

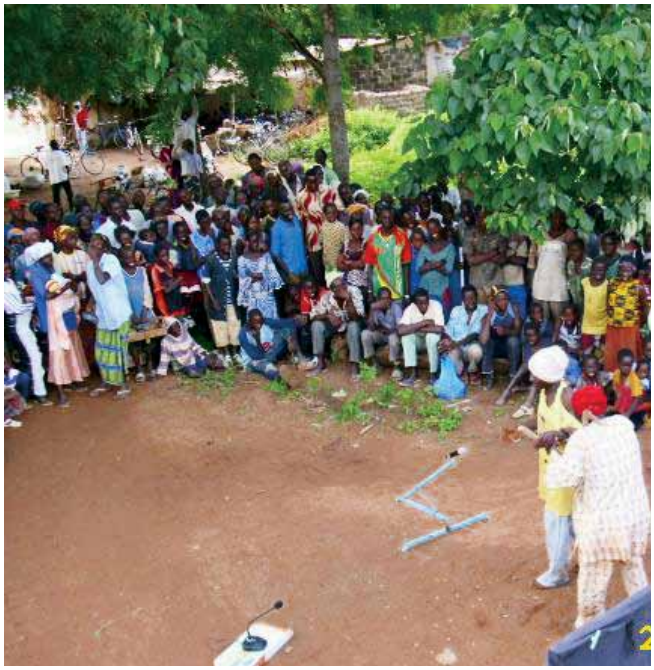
	Expenditure, in millions of US$						
Donors	2005	2006	2007	2008	2009	2010	2011
DFID	4.6	12.1	22.5	11.1	13.0	16.6	12.4
KFW	13.1	23.6	24.6	15.5	16.2	29.2	23.7
PSI	28.8	30.6	24.9	14.1	17.9	26.9	37.1
UNFPA	82.6	74.4	63.9	89.3	81.1	82.4	54.5
USAID	68.8	62.8	80.9	68.9	87.5	76.0	124.0
IPPF & MSI	9.6	5.1	6.4	14.9	23.0	4.1	6.9
DKT	0.0	0.0	0.0	0.0	0.0	0.0	53.1
Global Fund	0.0	0.0	0.0	0.0	0.0	0.0	11.5
Total	**207.5**	**208.6**	**223.2**	**213.7**	**238.8**	**235.2**	**323.2**

Source: Donor Support Reports 2005 to 2010

donor support for essential reproductive health commodities, including contraceptives and condoms.

The two major donors continue to be UNFPA and USAID, as shown in Table 12. While these donors accounted for 73 per cent of total spending on commodities in 2005, this declined to 67 per cent in 2010 and 55 per cent in 2011. Overall, from 2005 to 2011, donor support for contraceptives and condoms has increased by about $116 million. Yearly totals vary, as shown in Figure 13. Donor support increased from $207.5 million in 2005 to $223.2 million in 2007, decreased to $213.7 million in 2008, increased sharply to $238.8 million in 2009 and decreased slightly to $235.2 million in 2010 and increased to 323.2 million in 2011.

Expenditure on male condoms has been higher for all years than for any other commodity, as shown in Figure 15. The percentage donor support for long-term contraceptive methods (IUDs and implants) increased from 4.8 per cent in 2005 to 11.8 per cent in 2008 and reached 16.4



Community theatre reaches rural audiences in Burkina Faso with messages about family planning. *Credit: UNFPA Burkina Faso*

Table 13: Trends in CYP for contraceptive commodity support by donors, 2005-2011

Contraceptive Commodity	CYP per year							
	2005	2006	2007	2008	2009	2010	2011	Total (2005 to 2011)
Male Condom (FP)	6,114,308	5,588,278	8,071,223	5,901,258	6,802,989	6,993,128	9,192,183	48,663,367
Female Condom (FP)	17,543	33,534	41,120	45,473	94,606	46,014	51,408	329,699
Oral Contraceptive	13,488,820	11,910,886	12,812,580	15,559,921	9,735,427	10,792,169	15,182,474	89,482,277
Emergency Contraceptive	152,441	251,484	114,480	491,270	237,914	163,131	225,062	1,635,783
Injectable	16,772,305	16,921,649	17,431,727	23,612,963	19,808,911	22,420,907	19,891,409	136,859,871
IUD	70,965,819	11,828,109	25,142,734	13,082,391	28,736,297	28,605,353	28,884,403	207,245,105
Implant	542,665	716,755	2,154,730	2,638,360	4,734,735	6,153,538	5,932,423	22,873,205
Total CYPs	**108,053,902**	**47,250,696**	**65,768,593**	**61,331,636**	**70,150,878**	**75,174,239**	**79,359,362**	**507,089,307**

Source: CSB-UNFPA (August 2011); Donor Support for Contraceptives and Condoms for Family Planning and STI/HIV Prevention 2011

Figure 13: Trends in total donor support by year, 2005 to 2011

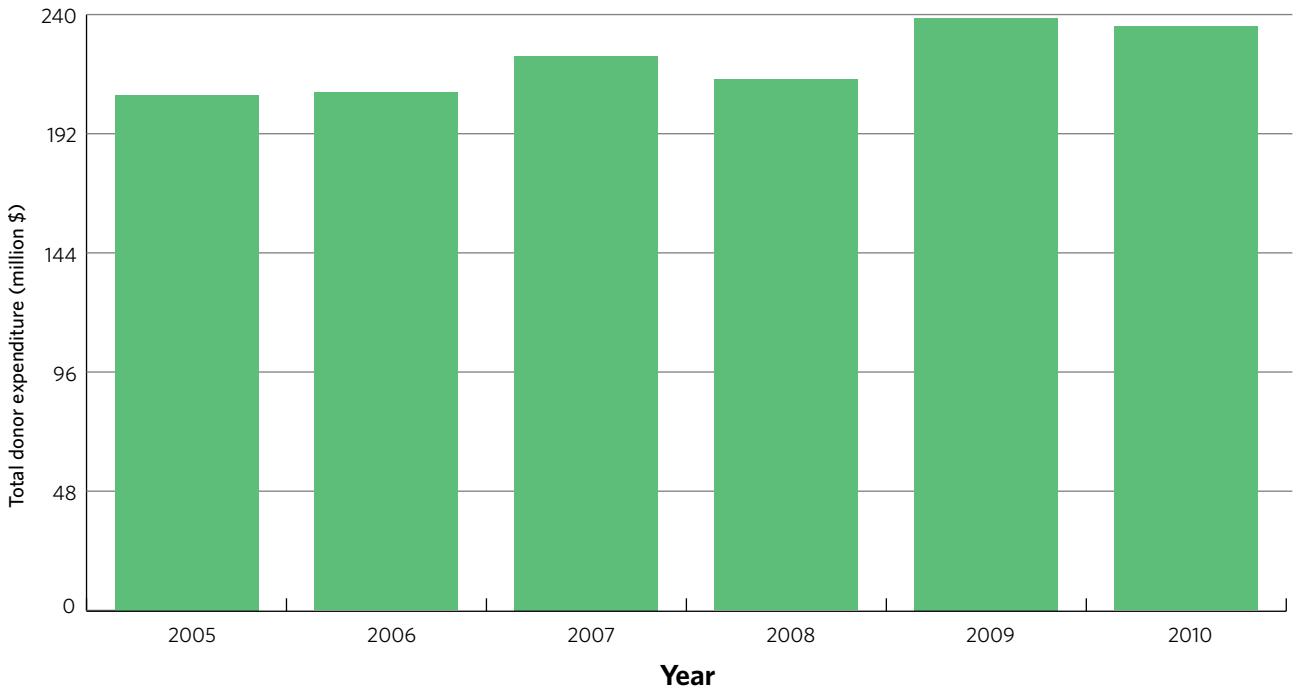
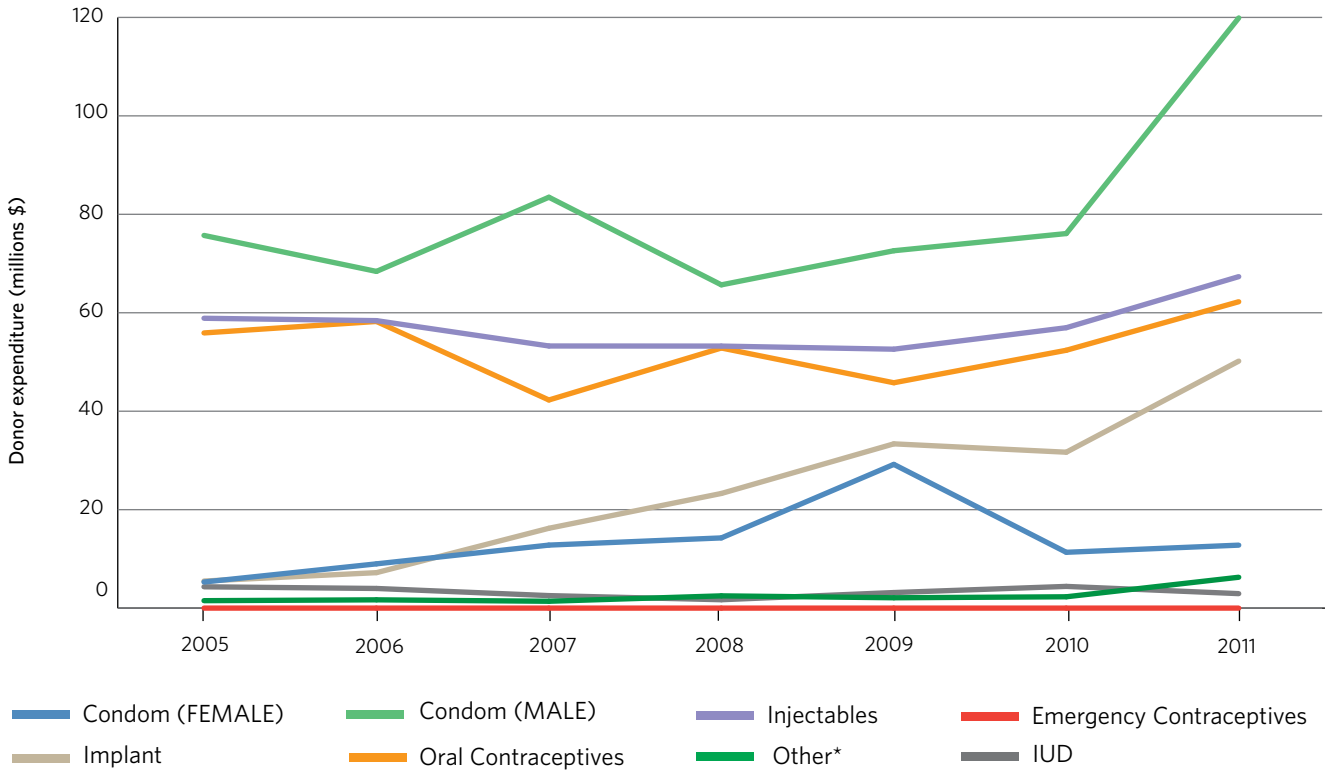


Figure 14: Trend in donor expenditure by commodity, 2005 to 2011



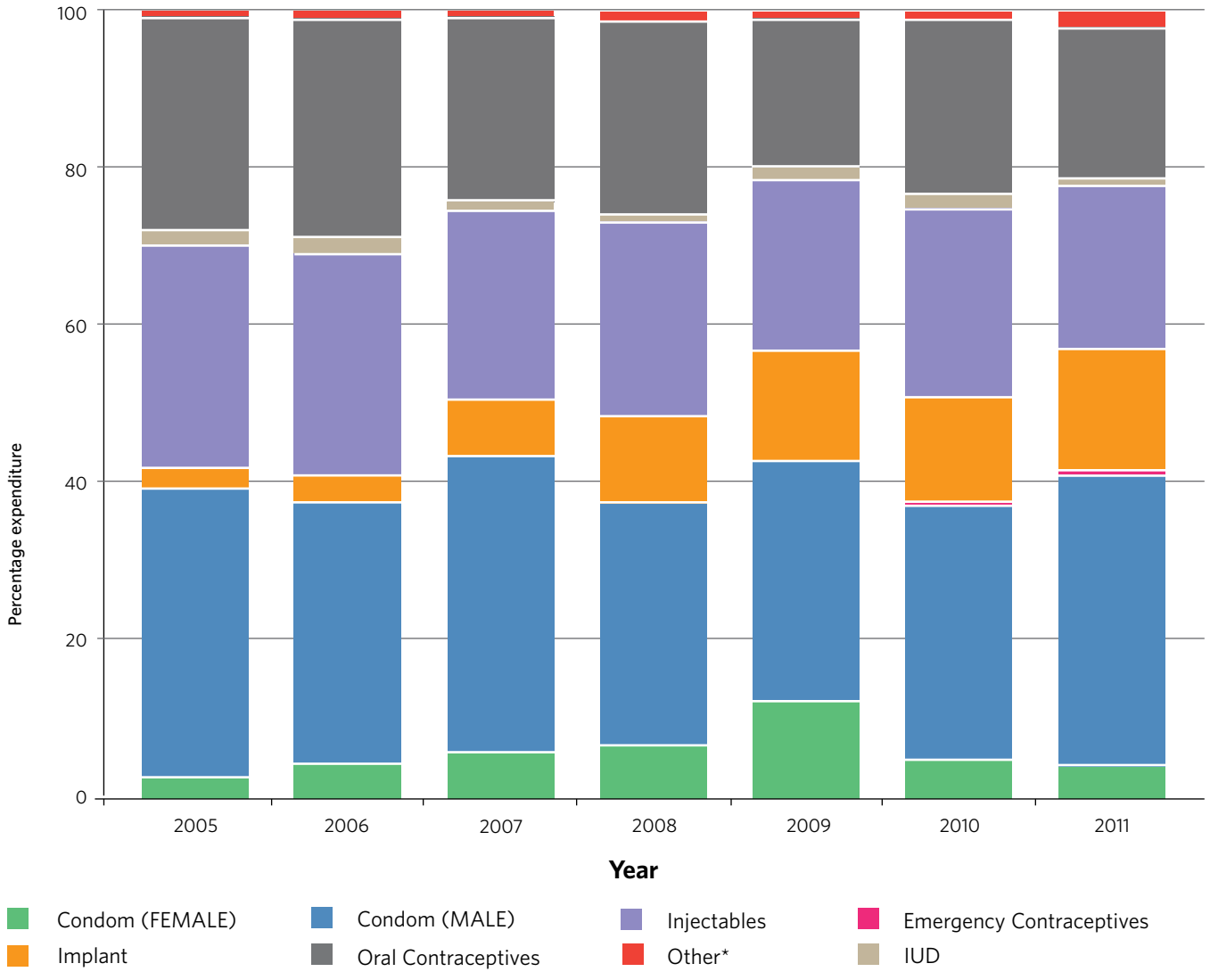
* Includes emergency contraceptives, vaginal tablets, foams/jellies, and sampling/testing EXCEPT for 2010 and 2011 where Emergency contraceptive has been separately accounted for.

per cent in 2011. After reaching a peak of $29.2 million in 2009, the donor support for female condoms substantially decreased to $11.3 million in 2010but increased slightly to $12.8 million in 2011. Expenditures on IUDs and other methods, including emergency contraceptives, have each remained below $5 million over the past six years.

Donor support for implants has increased from 2.7 per cent of total expenditure in 2005 to 15.5 per cent of total expenditure in 2011. Expenditure on female condoms increased from 2.6 per cent of total expenditure in 2005 to 12.2 per cent in 2009; however, it declined to 4.0 per cent of total expenditures in 2011, as shown in Figure 15.

Donor support for contraceptives and condoms can be described in terms of Couple Years of Protection (CYP). Donor support from 2005 to 2010 amounted to about 392.3 million CYP. For the six years under consideration, donor expenditures resulted in the procurement of contraceptives that would provide protection for 392.3 million couples for one year. CYP refers to the estimated protection provided by contraceptive methods during a one-year

Figure 15: Trend in donor expenditure by commodities, 2005-2011



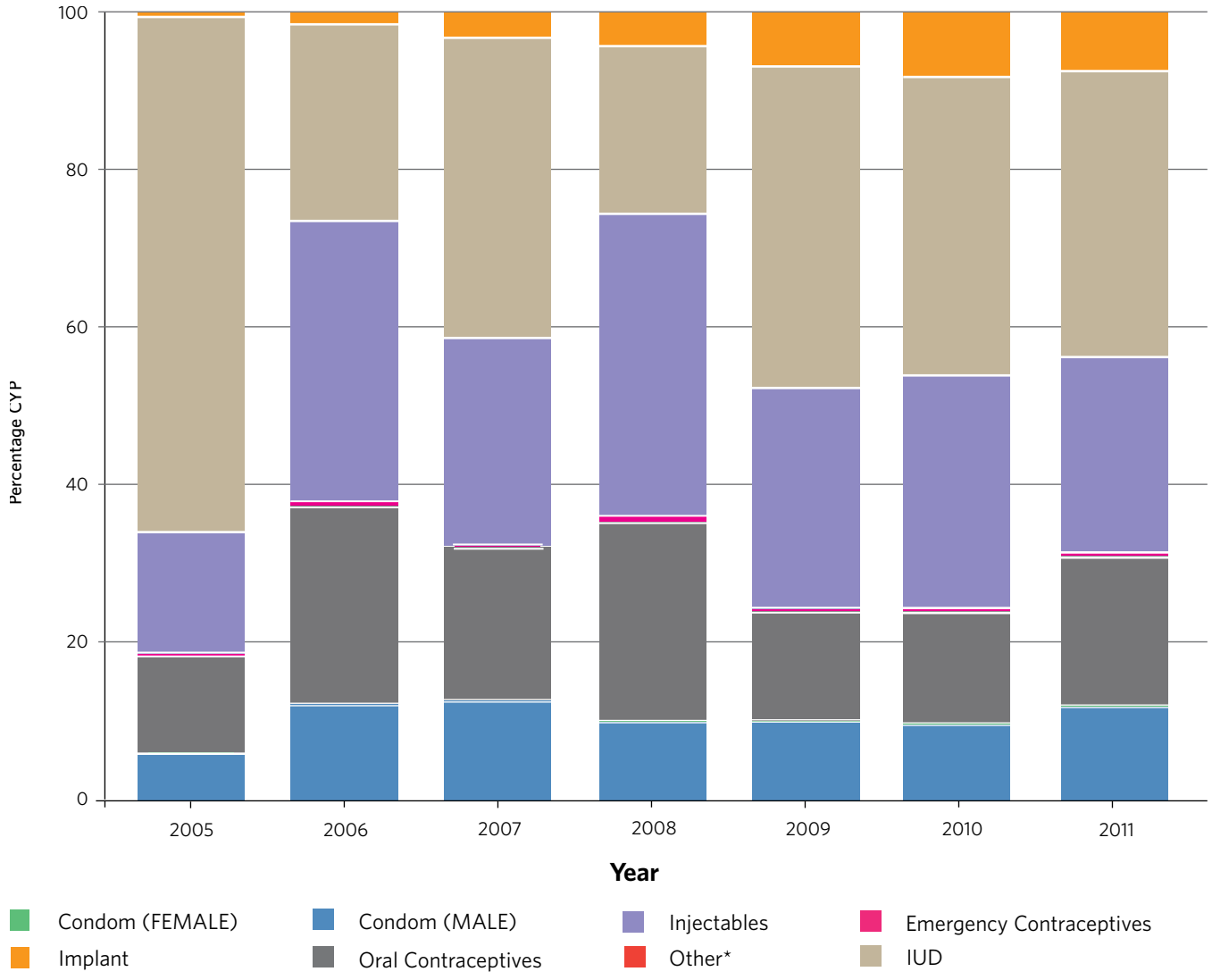
* Includes emergency contraceptives, vaginal tablets, foams/jellies, and sampling/testing EXCEPT for 2010 where Emergency contraceptive has been separately accounted for

period based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The term 'CYP' reflects distribution and is a way to estimate coverage and not actual use or impact (Guttmacher CYP memo, September 20, 2011).

CYP was highest at 108 million in 2005 but decreased sharply to 47.25 million in 2006 before increasing gradually to 79.4 million in 2011. Figure 16 shows that the three major contributors to CYP for 2005 to 2011 were IUDs and injectables and oral contraceptives.

With the growing need for family planning in the developing world, there is an urgent need for increased investment in family planning, including donor expenditures on contraceptives. This is necessary to reach the more than 215 million women in the developing world who want to delay or avoid pregnancy but are not using family planning.

Figure 16: Trends in CYP for contraceptive commodity support by donors, 2005-2011



CHAPTER THREE

Catalyzing National Political and Financial Commitment

Outputs that speak to political and financial commitment to reproductive health commodity security are presented in this section: i) Country RHCS strategic plans developed, coordinated and implemented by government with their partners, ii) Political and financial commitment for RHCS enhanced.

Countries are supported to formulate and implement RHCS strategies that are well-integrated into health sector interventions. Stream 1 countries are especially assisted to ensure that relevant structures are in place to facilitate the institutionalization RHCS processes and actions. Specific actions and processes supported include preparation and implementation of RHCS strategies and action plans; integration of RHCS issues into key sectoral strategies; establishment of functional coordinating bodies under the leadership of government; and ensuring RH commodities, including contraceptives, are included in the Essential Medicines List (EML) of each country.

13 year old school girl in Ethiopia.
Credit: Mikkel Ostergaard/Panos

Output 1:
Country RHCS strategic plans developed, coordinated and implemented by government with their partners.

3.1 Number of countries where RHCS strategy is integrated with national RH/SRH, HIV/AIDS, gender & reproductive rights strategies

The indicator is used to assess the integration of appropriate RHCS issues into three thematic strategies. It is reported for both Stream 1 and 2 countries and provides information on progress made by each country in implementing RHCS

activities within the context of broader sectoral interventions such as sexual and reproductive health and reproductive rights (RH/SRH), HIV/AIDS and gender.

All Stream 1 countries have integrated reproductive health commodity security into their RH/SRH strategies as well as into their respective HIV/AIDS strategies, as shown in Table 14 and Figure 17. The number of countries that have integrated RHCS into their gender strategies increased from seven countries in 2010 to nine countries in 2011, including Nigeria, the new Stream 1 country.

More countries are integrating RHCS into sexual and reproductive health and reproductive rights strategies. Among the 34 Stream 2 countries, the number increased from 26 countries in 2010 to 32 countries in 2011. Similar progress is also reported for the

Table 14: RHCS strategy integrated into sectoral strategies in Stream 1 countries, 2010 and 2011

Country	RHCS strategy integrated into sectoral strategies					
	RH/SRH		HIV/AIDS		Gender	
	2010	2011	2010	2011	2010	2011
Burkina Faso	Y	Y	Y	Y	Y	Y
Haiti	Y	Y	Y	Y	N	N
Ethiopia	Y	Y	Y	Y	Y	Y
Lao PDR	Y	Y	Y	Y	N	Y
Madagascar	Y	Y	Y	Y	N	N
Mali	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y	Y	Y
Nicaragua	Y	Y	N	Y	N	N
Niger	Y	Y	Y	Y	Y	Y
Nigeria*	NA	Y	NA	Y	NA	Y
Sierra Leone	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**11**	**12**	**10**	**12**	**7**	**9**

Source: *Nigeria was designated as a Stream 1 country in 2011, thus information for 2010 is in the Stream 2 table

Figure 17: RHCS Strategy integrated into sectoral strategies in Stream 1 countries, 2010 and 2011

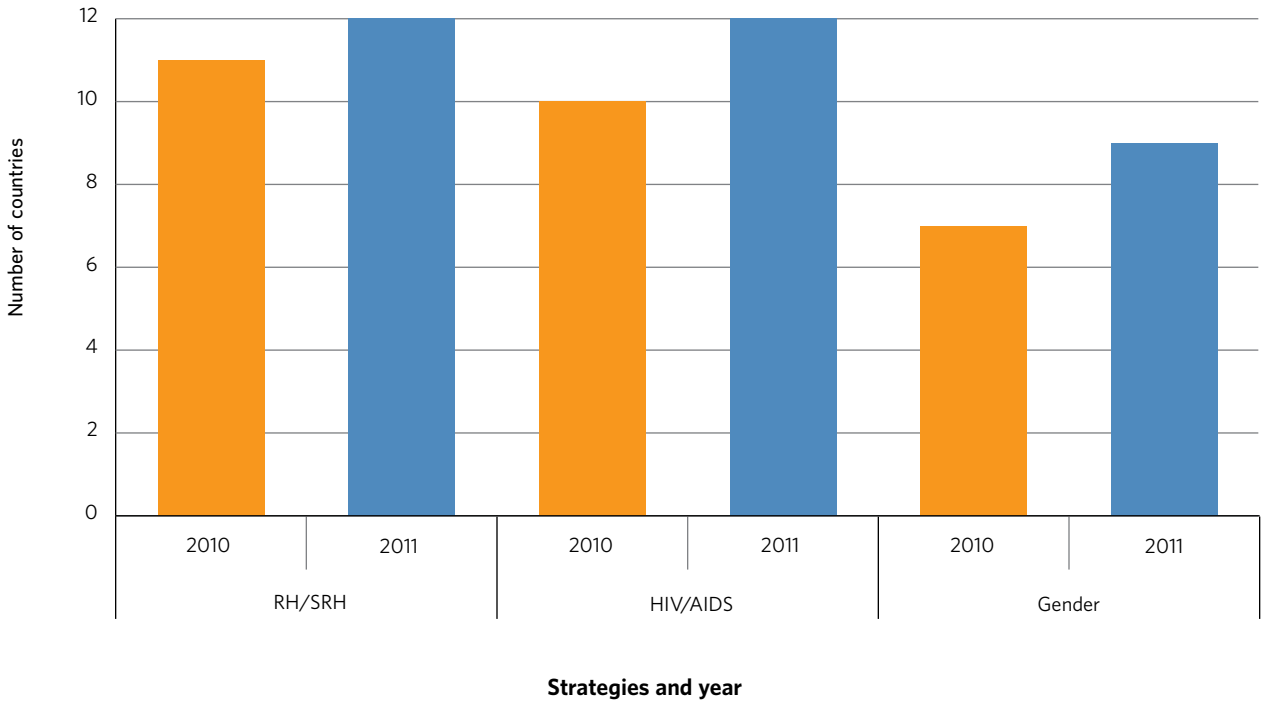


Table 15: RHCS strategy integrated into sectoral strategies in Stream 1 countries, 2010 and 2011

Country	RHCS strategy integrated into sectoral strategies					
	RH/SRH		HIV/AIDS		Gender	
	2010	2011	2010	2011	2010	2011
Benin	Y	Y	Y	Y	N	Y
Bolivia	Y	Y	Y	Y	N	Y
Botswana	Y	Y	Y	Y	Y	Y
Burundi	Y	Y	Y	Y	N	Y
Central African Republic	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	N	N
Congo	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	Y
Democratic Republic of the Congo	Y	Y	Y	Y	Y	Y
Djibouti	N	Y	N	Y	N	Y
Ecuador	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y
Gambia	Y	Y	Y	Y	N	N
Ghana	N	Y	Y	Y	Y	Y
Guinea	Y	Y	N	Y	N	N
Guinea-Bissau	Y	Y	N	Y	N	N
Lesotho	Y	Y	Y	Y	N	N
Liberia	Y	Y	Y	Y	N	Y
Malawi	Y	Y	Y	Y	N	Y
Mauritania	Y	Y	Y	Y	Y	Y
Namibia	Y	Y	Y	Y	Y	Y
Nigeria*	Y	NA	-	NA	Y	NA
Papua New Guinea	-	Y	-	Y	-	N
Sao Tome and Principe	N	Y	N	N	N	N
Senegal	Y	Y	Y	Y	Y	Y
South Sudan	-	Y	-	N	-	N
Sudan	-	Y	-	N	-	N
Swaziland	Y	Y	Y	Y	N	N
Timor Leste	-	Y	-	Y	-	N
Togo	-	Y	-	Y	-	Y
Uganda	Y	Y	Y	Y	Y	Y
Yemen	-	Y	-	N	-	N
Zambia	Y	Y	Y	Y	N	Y
Zimbabwe	Y	Y	N	Y	N	Y
Total for 'Yes'	**26**	**34**	**23**	**30**	**14**	**22**

Source: * Nigeria was designated as a Stream 1 country in 2011, thus updates for 2011 are in the Stream 1 Table

Figure 18: RHCS Strategy integrated into sectoral strategies in Stream 2 countries, 2010 and 2011

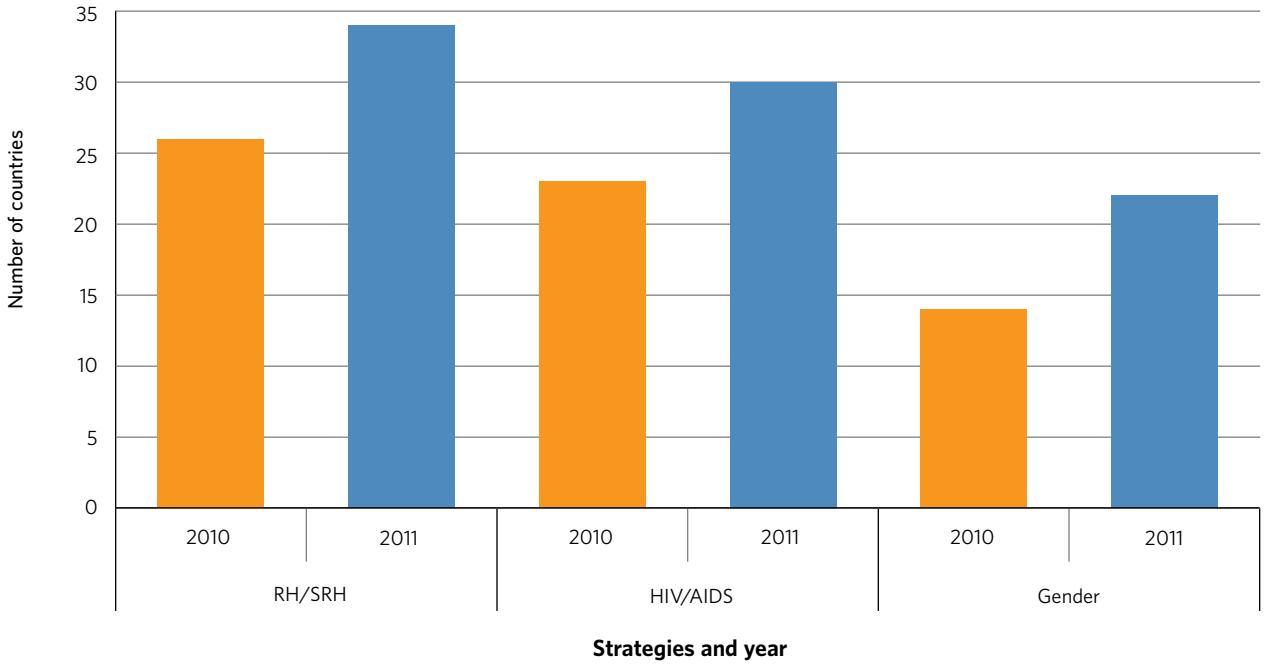


Table 16: RHCS strategies/action plans in Stream 1 countries, 2009 to 2011

	RHCS strategies/action plans in Stream 1 countries					
	Have RHCS strategy/action plan			If yes, elements being implemented		
Country	2009	2010	2011	2009	2010	2011
Burkina Faso	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y
Haiti	N	N	N	N	N	N
Lao PDR	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y
Mali	N	Y	Y	N	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	N	Y	Y
Nicaragua	Y	Y	Y	N	Y	Y
Niger	Y	Y	Y	Y	Y	Y
Nigeria*	-	-	Y	-	-	Y
Sierra Leone	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**9**	**10**	**11**	**7**	**10**	**11**

* Nigeria was designated as a Stream 1 country in 2011, thus information for 2010 is in the Stream 2 table
** For contraceptives only

integration of RHCS issues into strategies for HIV/AIDS and gender, as shown in Table 15 and Figure 18.

There are several reasons why RHCS issues may not be integrated in sectoral strategies, including the absence of such a strategies. Sao Tome and Principe, Yemen, South Sudan and Sudan indicated no HIV strategy in place. Chad, Guinea, Guinea-Bissau, Haiti and Madagascar indicated no gender mainstreaming strategy in place.

3.2 Number of countries with strategy implemented (national strategy/action plan for RHCS implemented)

This indicator looks at progress made in formulating and implementing RHCS strategies and action plans.. The number of countries implementing elements of RHCS strategies and action plans has increased from 7 in 2009 to 11 in 2011, as shown in Figure 19.

For Stream 2 countries, progress was made with the existence of an RHCS strategy/action plan reported in Gambia, Liberia and Mauritania for the first time in 2011, as shown in Table 17. Implementation is also taking place in six more countries compared to last year. Figure 20 indicates that 30 countries are now implementing the RHCS strategy/action plan compared to 24 last year.

3.3 Number of countries with functional coordination mechanism on RHCS or RHCS is included in broader coordination mechanism

This indicator assesses progress made towards having a functional coordinating mechanism in place on RHCS under the leadership of government and with the participation of a broad range of partners.

With action taken in Haiti in 2011, all the GPRHCS Stream 1 countries now have a coordination mechanism in place and the mechanism includes RHCS issues and has terms of reference, as shown in Table 18 and Figure 21. For Stream 2 Countries, progress has been made in Burundi, Djibouti, Guinea and Sao Tome and Principe. All of the 34 Stream 2 countries now have a coordination mechanism, as reported in Table 19 and Figure 22. The mechanism includes RHCS issues 33 countries (the exception being Djibouti) compared to 25 countries in 2010.

Figure 19: Number of Stream 1 countries with RHCS strategy being implemented

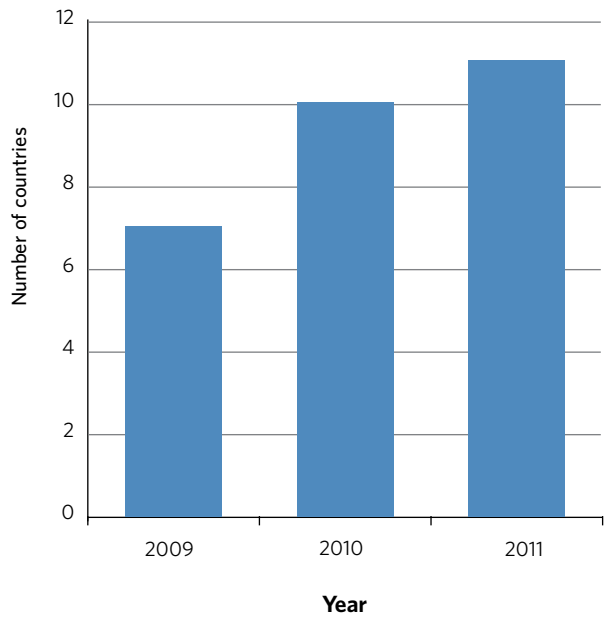


Figure 20: Number of Stream 2 countries with RHCS strategy being implemented

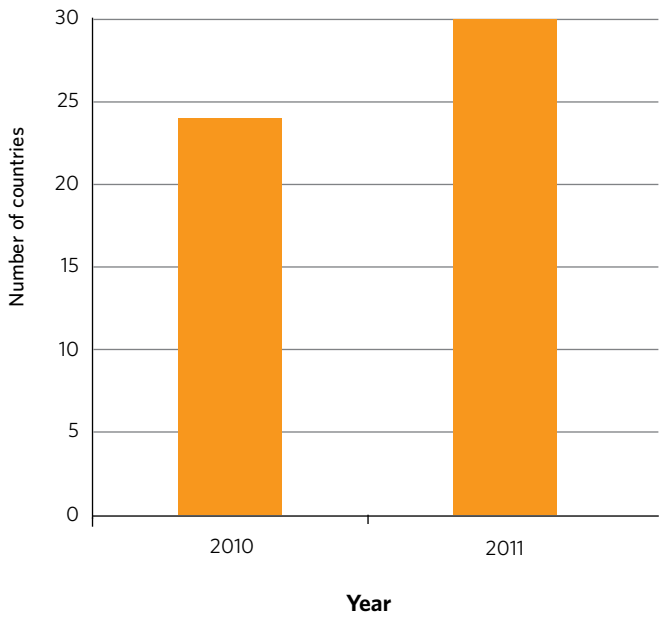


Table 17: RHCS strategies/action plans in Stream 2 countries, 2010 and 2011

Country	RHCS strategies/action plans			
	Have RHCS strategy/action plan		If yes, elements being implemented	
	2010	2011	2010	2011
Benin	Y	Y	Y	Y
Bolivia	Y	Y	Y	Y
Botswana	Y	Y	Y	Y
Burundi	Y	Y	Y	Y
Central African Republic	Y	Y	Y	Y
Chad	Y	Y	Y	Y
Congo	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	N	Y
Democratic Republic of the Congo	Y	Y	Y	Y
Djibouti	Y	Y	Y	Y
Ecuador	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y
Gabon	Y	Y	Y	Y
Gambia	N	Y	N	Y
Ghana	Y	Y	Y	Y
Guinea	Y	Y	Y	Y
Guinea-Bissau	Y	Y	Y	Y
Lesotho	Y	Y	N	Y
Liberia	N	Y	N	N
Malawi	Y	Y	Y	Y
Mauritania	N	Y	N	Y
Namibia	Y	Y	Y	Y
Nigeria*	Y	NA	Y	NA
Papua New Guinea	-	N	-	N
Sao Tome and Principe	Y	Y	Y	Y
Senegal	Y	Y	Y	Y
South Sudan	-	Y	-	Y
Sudan	-	N	-	N
Swaziland	Y	Y	Y	Y
Timor Leste	-	Y	-	Y
Togo	-	Y	-	Y
Uganda	Y	Y	Y	Y
Yemen	-	Y	-	N
Zambia	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y
Total for 'Yes'	**26**	**32**	**24**	**30**

* Nigeria was designated as a Stream 1 country in 2011, thus updates for 2011 are in the Stream 1 table

Table 18: Coordinating mechanism in place in Stream 1 countries, 2009 to 2011

Country	Coordinating mechanism in Stream 1 countries						
	National country coordinating mechanism exists			If yes, RHCS issues included in institutional mechanism		If yes, does mechanism have TOR	
	2009	2010	2011	2010	2011	2010	2011
Burkina Faso	Y	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y	Y
Haiti	N	N	Y	N	Y	N	Y
Lao PDR	Y	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y	Y
Mali	Y**	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y	Y	Y	Y
Nicaragua	Y	Y	Y	Y	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y	Y
Nigeria*	-	-	Y	-	Y	-	Y
Sierra Leone	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**10**	**10**	**12**	**10**	**12**	**10**	**12**

* Nigeria was designated as a Stream 1 country in 2011, thus information for 2010 is in the Stream 2 table

Figure 21: Number of Stream 1 countries with national coordinating mechanisms

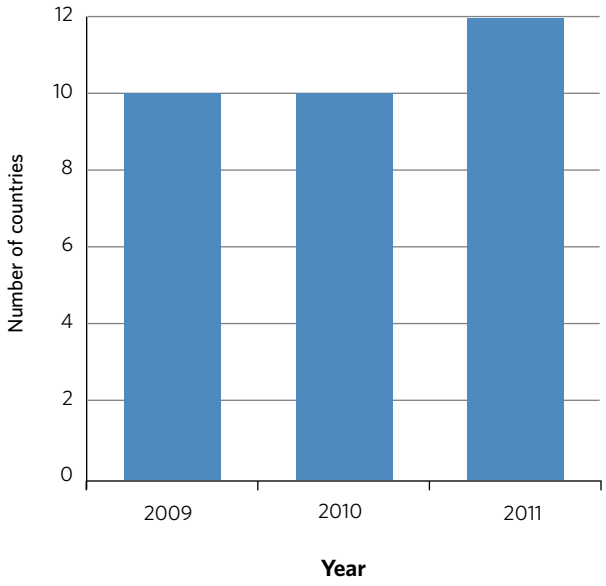


Figure 22: Number of Stream 2 countries with national coordinating mechanisms

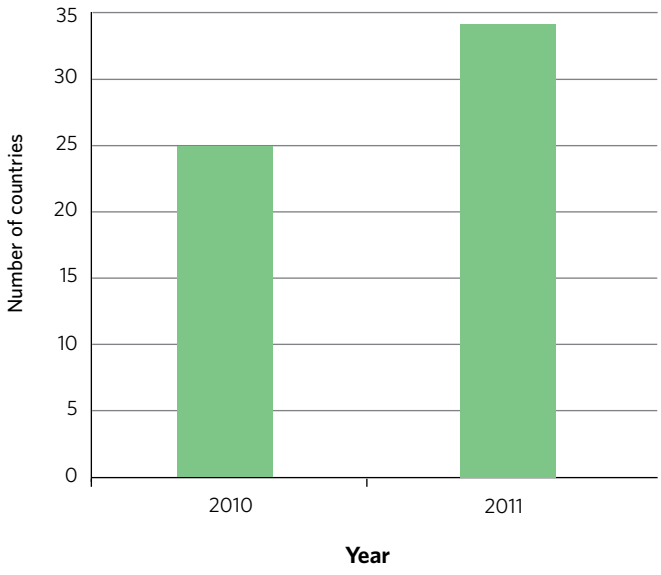


Table 19: Coordinating mechanism in place in Stream 2 countries, 2010 and 2011

Country	RHCS strategy integrated into sectoral strategies					
	National country coordinating mechanism exists		If yes, RHCS issues included in institutional mechanism		If yes, does mechanism have TOR	
	2010	2011	2010	2011	2010	2011
Benin	Y	Y	Y	Y	N	Y
Bolivia	Y	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y
Burundi	N	Y	-	Y	-	Y
Central African Republic	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y
Congo	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	Y
Democratic Republic of the Congo	Y	Y	Y	Y	Y	Y
Djibouti	N	Y	N	N	N	Y
Ecuador	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y
Gambia	Y	Y	Y	Y	N	Y
Ghana	Y	Y	Y	Y	Y	Y
Guinea	N	Y	N	Y	N	Y
Guinea-Bissau	Y	Y	Y	Y	-	Y
Lesotho	Y	Y	N	Y	Y	Y
Liberia	Y	Y	Y	Y	Y	Y
Malawi	Y	Y	Y	Y	Y	Y
Mauritania	Y	Y	Y	Y	Y	Y
Namibia	Y	Y	Y	Y	-	Y
Nigeria*	Y	NA	Y	NA	Y	NA
Papua New Guinea	-	Y	-	Y	-	Y
Sao Tome and Principe	N	Y	N	Y	N	N
Senegal	Y	Y	N	Y	N	N
South Sudan	-	Y	-	Y	-	Y
Sudan	-	Y	-	Y	-	Y
Swaziland	Y	Y	Y	Y	Y	Y
Timor Leste	-	Y	-	Y	-	Y
Togo	-	Y	-	Y	-	Y
Gambia	Y	Y	Y	Y	N	Y
Uganda	Y	Y	Y	Y	N	Y
Yemen	-	Y	-	Y	-	Y
Zambia	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**25**	**34**	**23**	**33**	**19**	**33**

* Nigeria was designated as a Stream 1 country in 2011, thus information for 2010 is in the Stream 2 table

3.4 Number of countries with essential RH commodities in EML (contraceptives and life-saving maternal/RH medicines in EML)

The indicator provides a measure for the progress made by GPRHCS countries in ensuring that an Essential Medicines List (EML) is in place, and that the list is revised to contain all the modern contraceptives and the 10 priority reproductive health medicines, in line with national protocols and guidelines.

All Stream 1 countries in the GPRHCS have an Essential Medicine List in place and the lists contain all UNFPA and WHO essential and life-saving maternal health medicines, as shown in Table 20. In 2010, two countries reported that their EMLs do not contain all the modern contraceptive methods. In Nicaragua, female condoms are not included on the list and, in Mozambique, the list did not include implants that year. In 2011, Mozambique reported progress and now has all of the modern contraceptives included on its list.

Figure 23 shows that an EML exists in all the 34 Stream 2 countries in 2011. For 30 of these countries the lists include all the modern contraceptive methods and for 32 countries the list contains all the life-saving maternal health medicines. Table 21 shows that in Ecuador, Ghana, Malawi and Namibia the list does not include all the modern contraceptives methods; and in Lesotho and Togo the list does not contain all the life-saving maternal/RH medicines. In countries such as Namibia and Lesotho steps are being taken to revise the list to ensure that it contains all the relevant commodities.

Table 20: Stream 1 countries with essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML; and, who have signed MOU between Government and UNFPA for GPRHCS implementation in 2011

Country	Essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML in 2011			Government has signed MOU for GPRHCS implementation
	National country coordinating mechanism exists	If yes, RHCS issues included in institutional mechanism	If yes, does mechanism have TOR	
Burkina Faso	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y
Haiti	Y	Y	Y	Y
Lao PDR	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y
Mali	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y
Nicaragua	Y	N	Y	Y
Niger	Y	Y	Y	Y
Nigeria	Y	Y	Y	Y
Sierra Leone	Y	Y	Y	Y
Total for 'Yes'	**12**	**11**	**12**	**12**

* Nicaragua shows 'No' for contraceptives because it does not include the female condom

Output 2:
Political and financial commitment for RHCS enhanced

The Global Programme keeps track of progress regarding the commitment of both donors and governments. The GPRHCS provides support to countries to integrate RHCS issues into their sectoral and national development strategies and programmes. Such mechanisms enhance political and financial commitment. Key indicators identified to gauge the achievement of this output include availability of funding for GPRHCS through multi-year donor pledges, signing of MOUs with Stream 1 country governments, mainstreaming of RHCS issues in policies and strategies in the work of global and regional organizations and partners, inclusion of RHCS priorities in national and sectoral policies and plans, and the maintenance of allocation within budget lines for contraceptives at country level.

Flood-affected Sri Lankans receive dignity kits. Contraceptives were also procured via the GPRHCS Stream 3. *Credit: UNFPA Sri Lanka.*

3.5 Funding mobilized for GPRHCS on a reliable basis (e.g. multi-year pledges)

This indicator provides information on resources mobilized from pledges made by donors for the implementation of the Global Programme to Enhance Reproductive Health Commodity Security. It ascertains the results of resource mobilization efforts undertaken by the UNFPA Commodity Security Branch to support countries for the programmme's implementation.

Close to $365 million has been mobilized by UNFPA from various donors in support of the GPRHCS (Table 22). This amount has increased steadily from $55.3 million in 2008 to $144.9 million in 2011 (Figure 24).

Figure 23: Stream 2 countries with essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML in 2011

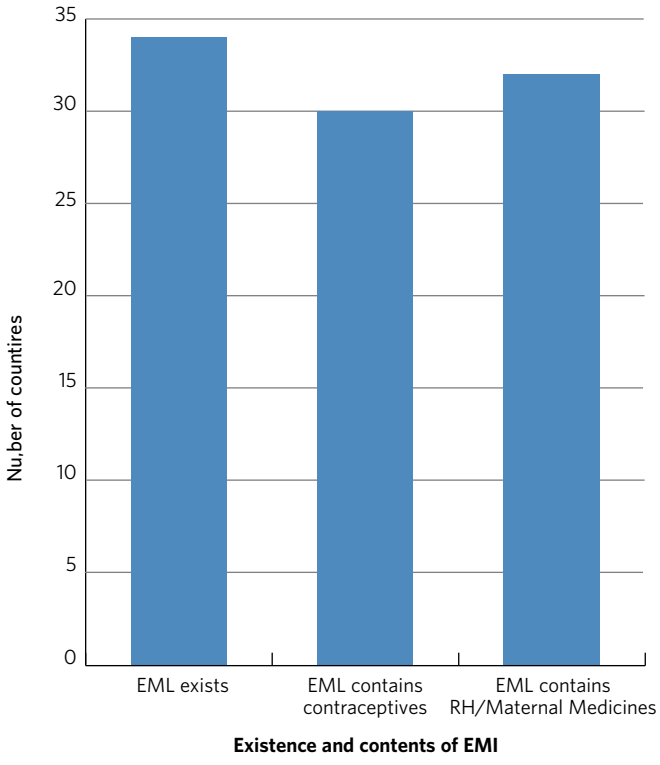


Table 21: Stream 2 countries with essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML in 2011

Country	Essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML in 2011		
	EML exists in the country	If yes, does EML contains contraceptives	If yes, does EML contains maternal drugs
Benin	Y	Y	Y
Bolivia	Y	Y	Y
Botswana	Y	Y	Y
Burundi	Y	Y	Y
Central African Republic	Y	Y	Y
Chad	Y	Y	Y
Congo	Y	Y	Y
Côte d'Ivoire	Y	Y	Y
Democratic Republic of Congo	Y	Y	Y
Djibouti	Y	Y	Y
Ecuador	Y	N	Y
Eritrea	Y	Y	Y
Gabon	Y	Y	Y
Gambia	Y	Y	Y
Ghana	Y	N	Y
Guinea	Y	Y	Y
Guinea-Bissau	Y	Y	Y
Lesotho	Y	Y	N
Liberia	Y	Y	Y
Malawi	Y	N	Y
Mauritania	Y	Y	Y
Namibia	Y	N	Y
Papua New Guinea	Y	Y	Y
Sao Tome et Principe	Y	Y	Y
Senegal	Y	Y	Y
South Sudan	Y	Y	Y
Sudan	Y	Y	Y
Swaziland	Y	Y	Y
Timor Leste	Y	Y	Y
Togo	Y	Y	N
Uganda	Y	Y	Y
Yemen	Y	Y	Y
Zambia	Y	Y	Y
Zimbabwe	Y	Y	Y
Total for 'Yes'	**34**	**30**	**32**

Resources were mobilized from five donors in 2011: Australia, Denmark, Luxembourg, Netherlands and United Kingdom (Figure 25). The Netherlands and the United Kingdom have been the two highest donors, with their joint share contributions to the GPRHCS increasing from 77.4 per cent in 2008 to 98.7 per cent in 2010, declining slightly to 89.6 per cent for 2011.

In Benin, midwives receive training to insert long-acting contraceptive implants. *Credit: Nadine Azifan/UNFPA*

3.6 UNFPA signed MOUs with Stream 1 country governments

A formal agreement with the UNFPA Country Office for the implementation of GPRHCS is signed with each Stream 1 country. This Memorandum of Understanding (MOU) spells out the expectations of each party and therefore provides a formal basis for cooperation, commitment and partnership for the implementation of the programme. It defines the common agreement; the roles and responsibilities of each party; modalities for making support available; and commitments pertaining to monitoring, evaluation, reporting and other activities. Nigeria was designated a Stream 1 country, bringing the total number of Stream 1 countries up from 11 in 2010 to 12 in 2011. All Stream 1 countries have signed an MOU with UNFPA for the implementation of the GPRHCS (Table 16).

Although it is not mandatory, Stream 2 countries are also encouraged to sign MOUs. This can provide a basis for encouraging and working with governments, where feasible, for the prioritization of RHCS and for commitment of domestic resources towards the achievement of identified common objectives.

Table 22: Amount mobilized from donor countries in US$

Country	2008	2009	2010	2011	Total
Australia	-	-	-	10,893,246	10,893,246
Denmark	-	-	-	3,586,157	
Canada	-	1,996,805	-	-	1,996,805
Finland	2,590,674	-	-	-	2,590,674
France	-	-	272,109	-	272,109
Ireland	1,557,632	-	-	-	1,557,632
Luxembourg	557,103	591,716	544,218	569,800	2,262,837
Netherlands	34,114,379	45,831,976	39,807,880	33,783,783	153,538,018
Spain	7,772,021	7,396,450	-	-	15,168,471
Spain (Catalonia)	-	563,471	420,168	-	983,639
United Kingdom	8,695,652	16,474,465	54,464,816	96,092,987	175,727,920
Total	**55,287,461**	**72,854,883**	**95,509,191**	**144,925,973**	**364,991,351**

* In 2011, DFID made available a total of $96,092,987, of which $55,910,543.13 was earmarked as support for the procurement of long-term methods (implants) and scheduled to be programmed in 2012.

Figure 24: Resources mobilized for GPRHCS, 2008 to 2011

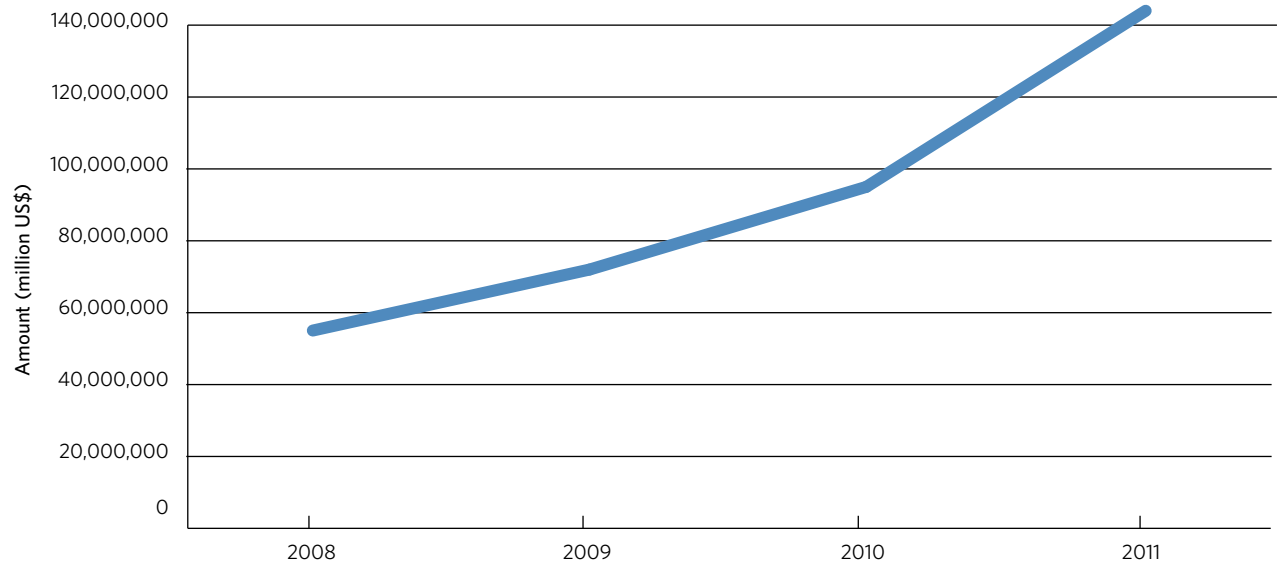
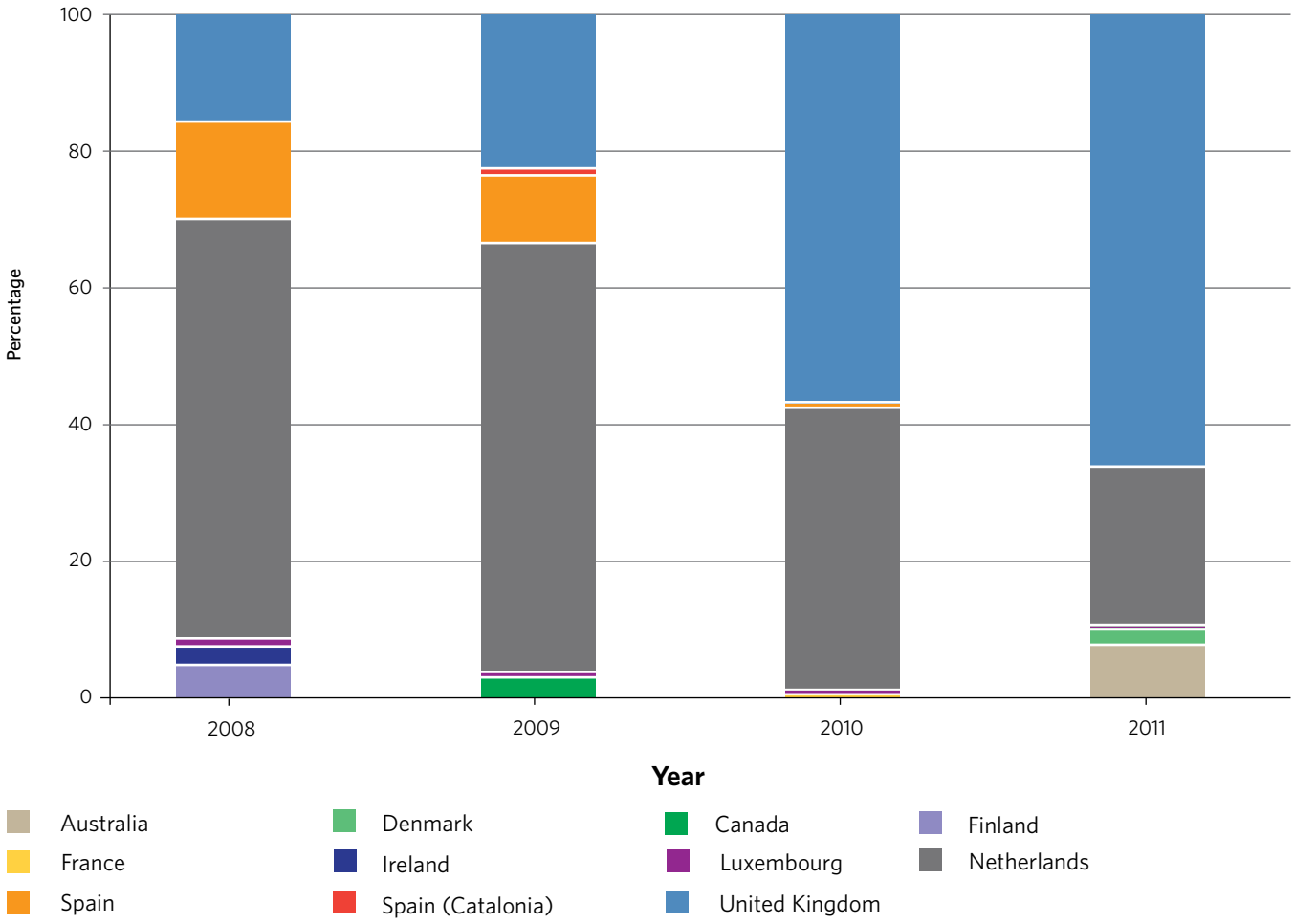


Figure 25: Resources contributed by donors to GPRHCS, 2008 to 2011



3.7 RHCS mainstreamed in regional policies and strategies through UNFPA work with global, bilateral and regional organizations/partners

This indicator assesses the results of actions taken during the year to have RHCS issues infused into the policies, plans and activities of organizations and partners. It reflects the work done to build capacity and support RHCS strategy development and implementation of actions at sub-regional level.

In 2011, technical assistance was provided to the East Africa Community (EAC) and the Intergovernmental Authority on Development (IGAD) to identify specific strategic areas for sexual and reproductive health and reproductive rights and RHCS programming within their various mandates. A capacity assessment mission supported both organizations (using the UNFPA PPM guidelines) in providing evidence regarding areas of strengths and weaknesses as well as opportunities for UNFPA collaboration. LOUs were subsequently signed regarding partnership arrangements and areas for continued collaboration. GPRHCS continued to work with IGAD to address the RH commodity needs of vulnerable populations in the Horn of Africa, which will be continued in 2012.

3.8 Number of countries that have included RHCS priorities in a) PRSP and b) Health sector policy and plan and SWAps

UNFPA works with partners at the country level to ensure that critical health issues are part of the national planning and programming processes. Advocacy for the inclusion of RHCS issues into plans, programmes and budgets is a major strategy. UNFPA Country Offices work with various stakeholders for the inclusion of RHCS key issues into Poverty Reduction Strategy Papers (PRSP), national health sector policies and plans, and Sector-Wide Approaches (SWAp) for the health sector.

Remarkable progress has been made in this area, with all Stream 1 countries reporting inclusion of RHCS in their

Table 23: RHCS issues included in PRSP, health policy & plan, and SWAp in Stream 1 countries, 2010 and 2011

	RHCS issues included in PRSP, health policy & plan, and SWAp					
	National country coordinating mechanism exists		If yes, RHCS issues included in institutional mechanism		If yes, does mechanism have TOR	
Country	2010	2011	2010	2011	2010	2011
Burkina Faso	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y
Haiti	Y	Y	Y	Y	N	N
Laos	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y
Mali	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y
Mozambique	N	Y	Y	Y	N	Y
Nicaragua	Y	Y	Y	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y
Nigeria	-	Y	-	Y	-	Y
Sierra Leone	Y	Y	Y	Y	N	Y
Total for 'Yes'	**10**	**12**	**11**	**12**	**8**	**11**

* Nigeria was designated as a Stream 1 country in 2011, thus information for 2010 is in the Stream 2 table

Figure 26: RHCS issues included in PRSP, health policy & plan, and SWAp in Stream 1 countries, 2010 and 2011

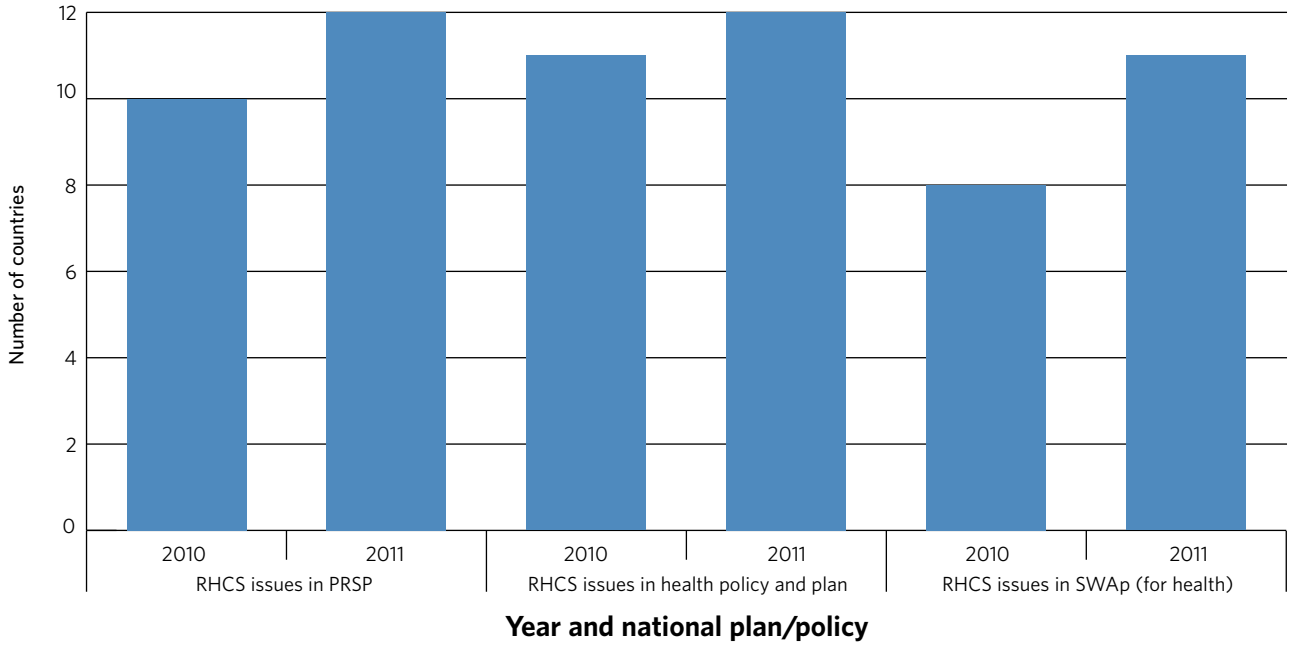


Figure 27: RHCS issues included in PRSP, health policy & plan, and SWAp in Stream 2 countries, 2010 and 2011

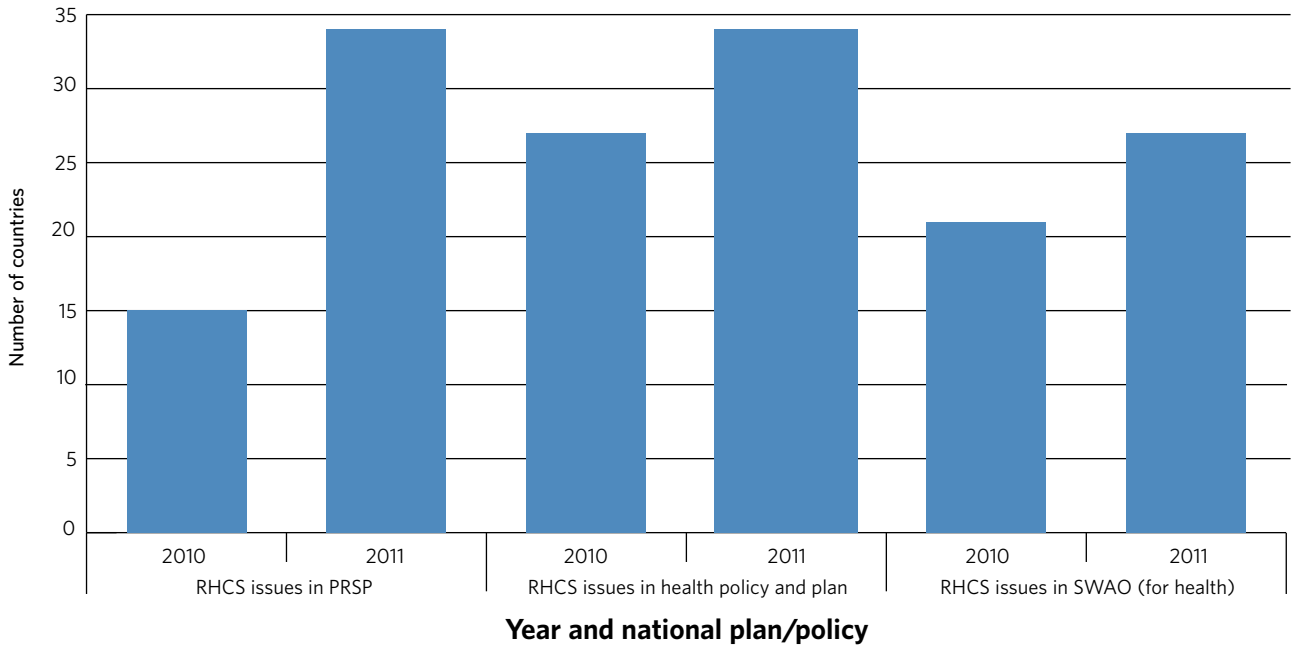


Table 24: RHCS issues included in PRSP, health policy & plan, and SWAp in Stream 2 countries, 2010 and 2011

Country	RHCS issues included in PRSP, health policy & plan, and SWAp					
	RHCS issues in PRSP		RHCS issues in health policy & plan		RHCS issues in SWAp (for health)	
	2010	2011	2010	2011	2010	2011
Benin	N	Y	Y	Y	Y	Y
Bolivia	N	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y
Burundi	N	Y	Y	Y	N	Y
Central African Republic	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	-	N
Congo	Y	Y	Y	Y	-	Y
Côte d'Ivoire	N	Y	Y	Y	Y	Y
Democratic Republic of Congo	Y	Y	Y	Y	Y	Y
Djibouti	N	Y	N	Y	N	N
Ecuador	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y
Gambia	N	Y	Y	Y	Y	Y
Ghana	Y	Y	Y	Y	Y	Y
Guinea	N	Y	Y	Y	Y	Y
Guinea-Bissau	N	Y	Y	Y	Y	Y
Lesotho	N	Y	Y	Y	Y	Y
Liberia	N	Y	Y	Y	N	Y
Malawi	N	Y	Y	Y	Y	Y
Mauritania	N	Y	Y	Y	N	Y
Namibia	-	Y	-	Y	-	Y
Nigeria	N	-	Y	-	Y	-
Papua New Guinea	-	Y	-	Y	-	Y
Sao Tome and Principe	Y	Y	Y	Y	Y	Y
Senegal	Y	Y	Y	Y	Y	Y
South Sudan	-	Y	-	Y	-	N
Sudan	-	Y	-	Y	-	N
Swaziland	Y	Y	Y	Y	-	N
Timor Leste	-	Y	-	Y	-	Y
Togo	-	Y	-	Y	-	N
Uganda	Y	Y	Y	Y	Y	Y
Yemen	-	Y	-	Y	-	N
Zambia	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**15**	**34**	**27**	**34**	**21**	**27**

* Nigeria was designated as a Stream 1 country in 2011, thus updates for 2011 are in the Stream 1 table

poverty reduction strategies. As of 2011, RHCS issues are integrated in Mozambique's PRSP. Regarding health policies and plans, all the Stream 1 countries have RHCS issues in such documents including Nigeria, the new Stream 1 country. The number of Stream 1 countries with RHCS issues in Sector-Wide Approaches for the health sector increased from 8 in 2010 to 11 in 2011.

Similar progress is also reported for Stream 2 countries. The number of Stream 2 countries with RHCS issues integrated in PRSPs increased from 15 in 2010 to 34 in 2011. Also, the number of Stream 2 countries with RHCS issues in their health sector plans increased from 27 in 2010 to 34 in 2011. The number of countries with RHCS issues integrated into Sector-Wide Approaches for the health sector increased from 21 in 2010 to 27 in 2011.

Progress made in ensuring that RHCS issues are now integrated in national planning and programming documents in more GPRHCS Stream 1 and 2 countries indicates that countries are showing commitment and desire to prioritize RHCS issues and take actions to address the challenges.

Table 25: Existence of line item for contraceptives in national budget for GPRHCS Stream 1 countries, 2011

Country	Contraceptive in national budget line item
Burkina Faso	Y
Ethiopia	Y
Haiti	N
Lao PDR	Y
Madagascar	Y
Mali	Y
Mongolia	Y
Mozambique	Y
Nicaragua	Y
Niger	Y
Nigeria*	Y
Sierra Leone	Y
Total for 'Yes'	**11**

Table 26: Existence of line item for contraceptives in national budget for GPRHCS Stream 2 countries, 2011

Country	Contraceptive in national budget line item
Benin	Y
Bolivia	Y
Botswana	Y
Burundi	Y
Central African Republic	Y
Chad	N
Congo	Y
Côte d'Ivoire	N
Democratic Republic of Congo	N
Djibouti	N
Ecuador	Y
Eritrea	Y
Gabon	N
Gambia	Y
Ghana	N
Guinea	Y
Guinea-Bissau	N
Lesotho	Y
Liberia	Y
Malawi	N
Mauritania	N
Namibia	N
Papua New Guinea	Y
Sao Tome and Principe	Y
Senegal	Y
South Sudan	N
Sudan	N
Swaziland	Y
Timor Leste	N
Togo	Y
Uganda	Y
Yemen	N
Zambia	Y
Zimbabwe	Y
Total for 'Yes'	**20**

3.9 Number of countries maintaining allocation within SRH/RHCs budget line for contraceptives

This indicator is used to assess the willingness of governments to allocate resources for the procurement of contraceptives. The willingness of government to allocate their own resources, irrespective of assistance received from donors in this regard, is indeed a very powerful show of commitment to investing in family planning and in reproductive health commodity security.

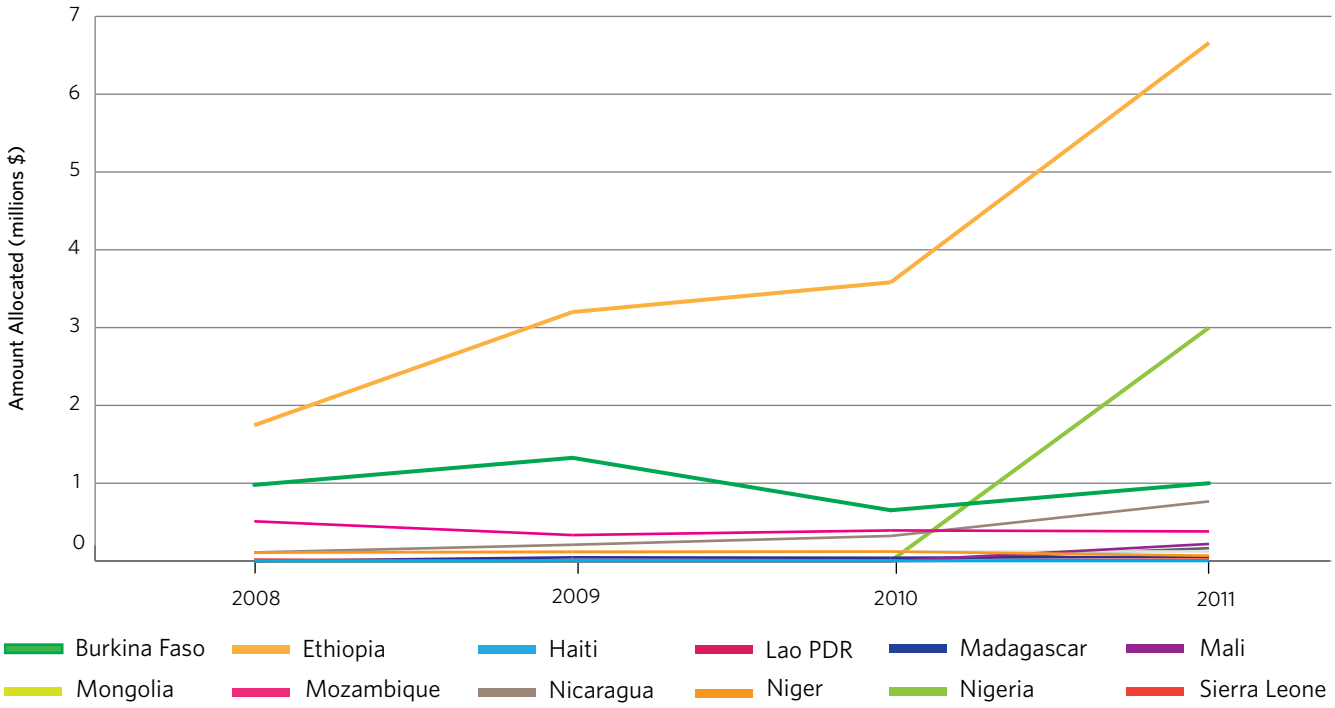
Eleven Stream 1 countries indicated that their government budget contains line item for the procurement of contraceptives, the exception being Haiti. The amount allocated increased compared to last year in Burkina Faso, Ethiopia, Mali, Mongolia and Nicaragua. Government allocation for contraceptive has remained higher in Ethiopia than all the other Stream 1 countries and in 2011 three countries made allocations of at least one million dollars (Ethiopia, $6.7 million; Nigeria, $3 million; and Burkina Faso, $1 million). The percentage of allocations spent has ranged from a low of 63 per cent in Madagascar for 2009 to a high of 100 per cent for all the countries that allocated resources to contraceptives in 2010.

Among Stream 2 countries, the Government of Peru increased its budget allocation by approximately 100 million soles (US$ 35.7 millions) for maternal and family planning activities. Also, Panama is currently procuring commodities amounting to US$ 1 million per year. In Ecuador, the government channeled US$7 million through UNFPA for the third party procurement of RH commodities between November 2010 and February 2011. The fact that governments are allocating resources for procurement of contraceptives, even in this period of economic downturn, is a strong show of commitment.

Table 27: Government budget allocation for contraceptives in GPRHCS Stream 1 countries, 2008 to 2011

Country	Amount allocated in US$			
	2008	2009	2010	2011
Burkina Faso	978261	1,326,087	652174	1,000,000
Ethiopia	1,745,213	3,200,000	3,581,849	6,659,500
Haiti	0	0	0	0
Laos	18,500	0	0	18,750
Madagascar	109,524	119,168	121,126	68,501
Mali	0	0	0	218,917
Mongolia	0	47000	41188	55,000
Mozambique	510,000	333,079	392,913	379,962
Nicaragua	110,158	208,723	321,935	765,940
Niger	103,734	103,734	122,222	122,222
Nigeria	0	0	0	3,000,000
Sierra Leone	0	0	0	165,000

Figure 28: Government budget allocation for contraceptives in GPRHCS Stream 1 countries, 2008 to 2011



CHAPTER FOUR

Strengthening Health Systems: Integration, Logistics and Mainstreaming

This section looks at results that relate to the strengthening of health systems through various kinds of capacity building. The focus is on capacity and systems strengthened for RHCS, and RHCS mainstreamed into UNFPA core business.

Strengthening the capacity of developing countries contributes to achieving health and other outcomes. In the area of RHCS, strengthened country capacity allows for sustainable progress and helps to ensure that commodities procured can be distributed in an efficient and effective manner. It is for this reason that the GPRHCS focuses on actions at national and international levels related to supporting country efforts to train staff and strengthen systems and institutions. The achievement of this output is measured by examining efforts related to forecasting and procurement systems as well as the existence of functioning logistics management information systems within GPRHCS countries.

Output 3:
Capacity and systems strengthened for reproductive health commodity security

A clerk works at a computer in Vientiane.
Credit: Pascal Deloche/Godong/Panos

4.1 Number of countries using AccessRH for procurement of RHCs

AccessRH is an innovative procurement mechanism supported by key global partners working in the area of procurement. The indicator measures the extent to which AccessRH has been adopted by countries for the procurement of reproductive health commodities and the extent to which this has reduced the lead time by 20 per cent (time between ordering the commodity and its arrival in the country).

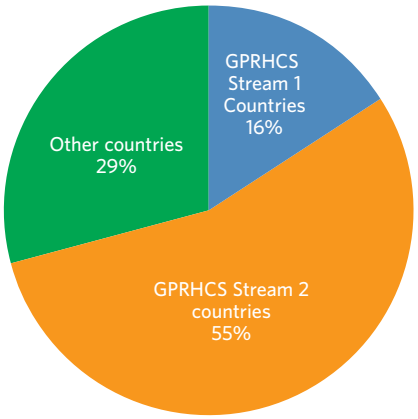
The objective of AccessRH is to improve access to quality, affordable reproductive health commodities and reduce delivery times for government and NGO clients and to provide enhanced information for planning and tracking. In 2010, the UNFPA Commodity Security Branch (CSB) agreed to allocate $10 million to the UNFPA Procurement Services Branch (PSB) to build an inventory of reproductive health commodities (at manufacturers' warehouses). The funds also were used for sampling and testing orders conducted for all batches manufactured, in accordance with UNFPA's Quality Policy, and to provide insurance coverage for the goods while in the manufacturers' warehouses. AccessRH was launched in late 2010 and implemented in 2011 by PSB under the auspices of the Reproductive Health Supplies Coalition. At this time, 53mm male standard condoms (with plain silver foil) were designated as the first commodity item to be held in stock, from which a number of orders could be filled.

In 2011, 74 shipments were dispatched to **55 countries** from AccessRH stock. The shipments were in the names of both UNFPA Country Offices and third party clients. GPRHCS countries accounted for 71 per cent of the $4.04 million worth of shipments of male condoms made to various countries in 2011.

Third party clients in 2011 included Ministries of Health, National AIDS Control Councils, international NGOs and United Nations agencies. As shown in Figure 30, the third party clients' shipments were made to 45 countries in various parts of the world, with 29.5 per cent of the shipments going to Africa, 18 per cent to Asia, 18 per cent to Eastern Europe and Central Asia , and 13.6 per cent to Caribbean countries. The third party shipments included shipments made to 6 GPRHCS Stream 1 countries (Ethiopia, Haiti, Lao PDR, Mongolia, Mozambique and Niger) and 10 GPRHCS Stream 2 countries (Benin, Congo, Ecuador, Ghana, Guinea, Lesotho, Papua New Guinea, Sao Tome and Principe, South Sudan and Zambia).

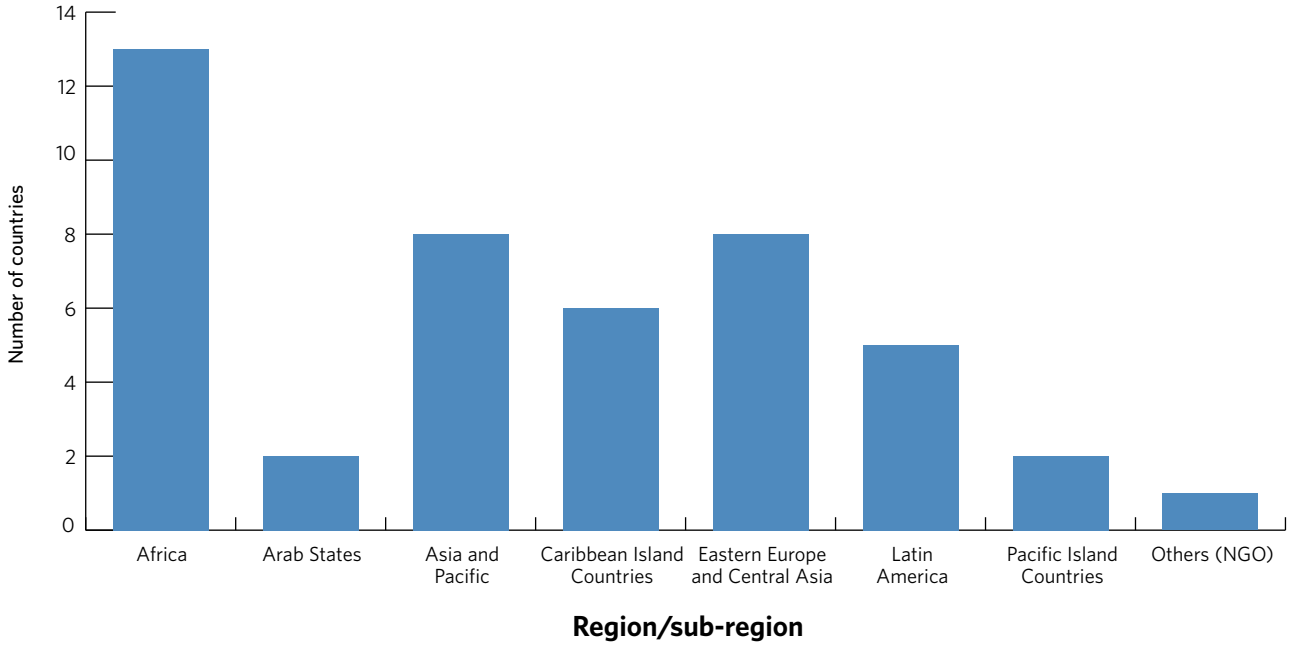
Clients ordering from AccessRH inventory **waited approximately 10 fewer weeks for their orders** compared to clients ordering condoms that needed to be produced at the time of order. This indicates that AccessRH helped to reduce lead-time for the procurement of condoms. In addition to activities related to inventory, AccessRH has stabilized ordering, financial recording and reconciliation processes based on experience gained in 2011. These processes and related documents are available on the web site: www.myAccessRH.org.

Figure 29: Percentage distribution of cost of commodities (in US$) shipped by AccessRH by destination of shippment in 2011



Source: "Table 2: AccessRH Project dispatched quantities as at 31st Dec 2011" in *PSB Update on CSB Funded Access RH Revolving Fund Quarterly Update 31st December 2011*

Figure 30: Number of countries to which third party clients made shipments through AccessRH by region/sub-region in 2011



Source: PSB datasheet

4.2 Number of pre-qualified suppliers of IUDs and condoms for use by UNFPA and partners

The indicator measures the efforts of the UNFPA-WHO partnership for ensuring quality supplies of IUDs and condoms from a set of prequalified and re-qualified manufactures.

The Prequalification Scheme for male condoms and IUDs has been in place since 2001 and WHO delegated UNFPA to manage the scheme in 2005. The scheme is well-established and is benefiting governments, NGOs and other United Nations agencies. With the aim of expanding the number of prequalified suppliers from all geographical regions, the process involves document review, factory inspections and sampling and testing of products with periodic re-qualifications every three years. Each year at least 10 factories (new and re-qualifications) go through the process.

Twenty-six male condom factories and eight IUD factories had successfully completed the process as of 31 December 2011, and were listed on the prequalified list. This was an increase from 23 male condom factories in 2010, while the number of IUD factories remained the same.

The newly revised and published specifications and procurement guidelines for male condoms and Copper T 380A IUD (2010) were widely disseminated in 2011 to Ministries of Health, national regulatory authorities and national quality control laboratories. A similar process for female condoms has been under development following the WHO/UNFPA Technical Review Meetings held in 2008 and 2011 in Geneva, Switzerland, and involving technical experts and advisors, researchers, scientists, regulatory authority officials, WHO/UN and other partner agencies. Participants at the meeting in April 2011 reviewed nine different female condom designs of different shapes, insertion and retention features. They recommended that two designs proceed to the onsite inspection stage, with the aim to increase the number of prequalified female condom products.

In the area of quality assurance of RH commodities, efforts continued to foster stronger partnerships and collaboration, focusing on capacity building and knowledge sharing between UNFPA/WHO/FHI360 and national government institutions. In 2011, technical workshops were held with national quality control laboratories, national regulatory authorities, and Ministry of Health officials responsible for regulation and quality control of RH commodities. Two workshops were held in East and Southern Africa covering the countries surrounding Tanzania and Namibia.

4.3 Number of Stream 1 countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian)

This indicator assesses the extent to which countries effectively prepare procurement plans for their RH commodity needs at the beginning of the year such that no requests are made outside the plans (except for humanitarian situations). The indicator is important because it focuses on building capacity so that countries are able to make good annual procurement plans and, most importantly, carry out actual procurement according to the plan.

Eight Stream 1 countries in 2011 made no *ad hoc* requests for commodities, as in 2010. Burkina Faso, Mali, Mozambique and Nigeria made requests for RH commodities in 2011, in part to accomodate the transfer of a stock of Jadelle from Rwanda that assisted in averting stock-out in Burkina Faso. Also in Burkina Faso, a request was made to avert stock-out of Depo-Provera due to a greater increase in demand than expected. In Mozambique an *ad hoc* request was made because demand creation activities during

Traditional leaders speak on family planning in Burkina Faso.
Credit: UNFPA Burkina Faso.

celebrations of the national health programme boosted demand for contraceptives. Also, the Government could not procure commodities as was planned and therefore requested that UNFPA procure RH medicine, including contraceptives. The removal of user fees in April 2011 by the government of Nigeria led to an unprecedented increase in demand for contraceptives and in order to mitigate stock-outs, the UNFPA Country Office collaborated with partners to procure additional commodities.

For Stream 2 countries, 18 countries made no *ad hoc* requests for commodities in 2011 compared to 17 in 2010. In Côte d'Ivoire, steps were taken to procure additional commodities because of the need to avert stock-out during the post-election crisis period as well as to support the implementation of the policy of free medical care instituted by the Government in 2011. In Lesotho, there was an urgent and unexpected request to partner with PSI on female condom promotion. In Djibouti, the closure of a maternity facility run by the French Army prompted the UNFPA Country Office to make ad hoc requests for equipment and RH medicines and contraceptives to ensure that the health centres were operational. Some maternal and RH kits were purchased in response to the emergency situation in the Horn of Africa.

Table 28: Stream 1 countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian) in 2011

Country	Made 'no ad hoc request'
Burkina Faso	N
Ethiopia	Y
Haiti	Y
Lao PDR	Y
Madagascar	Y
Mali	N
Mongolia	Y
Mozambique	N
Nicaragua	Y
Niger	Y
Nigeria	N
Sierra Leone	Y
Total for 'Yes'	**8**

Table 29: Stream 2 countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian) in 2011

Country	Made 'no ad hoc request'
Benin	N
Bolivia	Y
Botswana	Y
Burundi	Y
Central African Republic	N
Chad	N
Congo	Y
Côte d'Ivoire	N
Democratic Republic of Congo	N
Djibouti	N
Ecuador	Y
Eritrea	N
Gabon	Y
Gambia	N
Ghana	Y
Guinea	Y
Guinea-Bissau	Y
Lesotho	Y
Liberia	Y
Malawi	Y
Mauritania	Y
Namibia	Y
Papua New Guinea	N
Sao Tome and Principe	N
Senegal	N
South Sudan	N
Sudan	N
Swaziland	Y
Timor Leste	N
Togo	N
Uganda	Y
Yemen	N
Zambia	Y
Zimbabwe	Y
Total for 'Yes'	**18**

4.4 Number of Stream 1 countries forecasting for RH commodities using national technical expertise

Training of national experts to carry out forecasting for RHCS is an important strategy of building country capacity for reproductive health commodity security. The indicator assesses the existence of national staff, in government institutions, that are responsible for forecasting RH commodity needs for their countries.

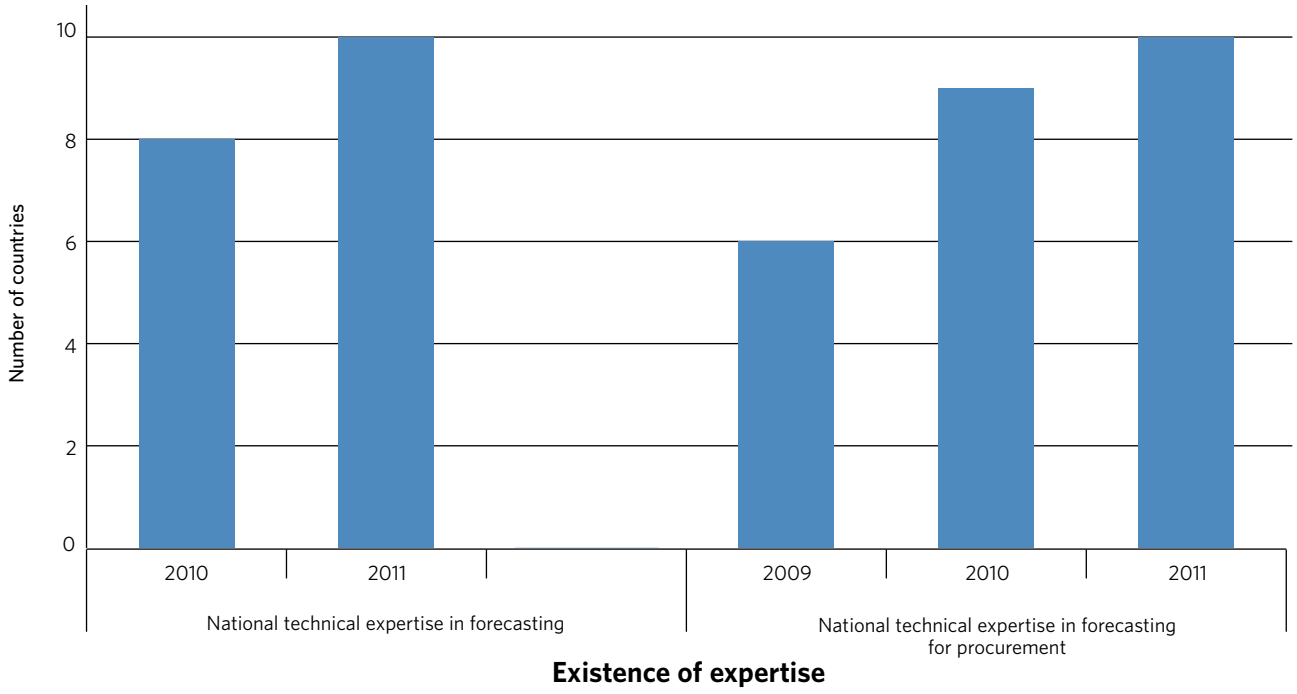
The number of Stream 1 countries with national technical expertise in the Ministry of Health or in other government agencies for forecasting for reproductive health commodities increased from 8 in 2010 to 10 in 2011, when improvements were made in Mozambique and Niger. Also, Nigeria reported that staff in the Ministry of Health have very limited capacity in forecasting and, while they are involved in data collection for forecasting, the actual process has been carried out largely by the USAID | DELIVER PROJECT in the past three years. For Lao PDR, the process is assisted by UNFPA and UNICEF.

4.5 Number of Stream 1 countries managing procurement process with national technical expertise

The engagement of nationals in the management of procurement processes is a key step to ensuring country ownership, institutionalization of skills and capacities for RHCS, and sustainability in the future. This indicator tracks the existence of nationals responsible for procurement of RH commodities in a government agency in GPRHCS Stream 1 countries. It gauges the extent to which capacities of nationals have been built for managing the procurement of RH commodities.

The number of Stream 1 countries with national technical expertise increased from 9 in 2010 to 10 in 2011, as shown in Table 24. Although Lao PDR reported the existence of such an expertise for 2010, in 2011 the function was performed by an International Procurement Expert provided through a grant from The Global Fund to Fight AIDS, Tuberculosis and Malaria.

Figure 31: Stream 1 countries using national technical experts for forecasting and procurement of RH commodities



4.6 Number of Stream 1 countries with functioning LMIS

Through the GPRHCS, capacity building support is provided to countries for the strengthening of logistics management information systems (LMIS) to improve on the process of managing the procurement and distribution of RH commodities. The indicator measures aspects of the system to ascertain its effectiveness in providing relevant information about the ability of the system to provide data on current and up-to-date stock levels; data on distribution of essential life-saving medicines; data on distribution of modern contraceptives; number of users for each modern contraceptive method; and, product particulars including expiry date.

All of the 12 Stream 1 countries have a functional LMIS in place in 2011 compared to only seven countries in 2010. However, the level of functionality varied from country to country. Data on modern contraceptives, lifesaving medicines, monthly consumption data, stock status at all levels and information on expiry dates of all products were available in most of the systems. Most systems lacked the ability to provide information on the number of users of all products; only 5 out of the 12 countries indicated that they had an LMIS that could provide such information.

4.7 Number of Stream 1 countries with co-ordinated approach towards integrated health supplies management system

The indicator assesses the existence of a **unified** procurement and distribution system for health supplies that includes RH commodities, including modern methods of contraception and priority medicines. In many countries, contraceptive commodity logistic systems were largely

Table 30: Stream 1 countries using national technical experts for forecasting and procurement of RH commodities

	Stream 1 countries using national technical experts for forecasting and procurement of RH commodities				
	Expertise forecasting in MOH		Expertise for procurement of RH commodities		
Country	2010	2011	2009	2010	2011
Burkina Faso	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y
Haiti	Y	Y	N	N	Y
Lao PDR	N	N	N	Y	N
Madagascar	Y	Y	Y	Y	Y
Mali	Y	Y	N	Y	Y
Mongolia	Y	Y	N	Y	Y
Mozambique	N	Y	N	N	Y
Nicaragua	Y	Y	Y	Y	Y
Niger	N	Y	Y	Y	Y
Nigeria	-	N	-	-	N
Sierra Leone	Y	Y	Y	Y	Y
Total for 'Yes'	**8**	**10**	**6**	**9**	**10**

parallel systems in response to donor demands and to the need for timely data for addressing logistic needs. To ensure efficiency and sustainability, there is a need for unified procurement and distribution systems that would cater for all commodities within the health system. The indicator assesses the existence of such a unified mechanism for managing all health supply systems that takes into account the procurement and distribution of RH commodities.

Nine out of the 12 Stream 1 countries had coordinated and integrated health supplies management systems in 2011; of these, the systems in five countries contain both a) an integrated **procurement** mechanism for contraceptives and RH medicines and b) an integrated **supply/distribution** mechanism for contraceptives and RH medicines. The five countries were Burkina Faso, Ethiopia, Mongolia, Nicaragua and Niger. Overall, supply and distribution is more integrated than procurement.

In Lao PDR in 2011, a national scoping exercise on the feasibility of an integrated/unified LMIS was carried by the UNFPA Asia-Pacific Regional Office in collaboration with the University of Canberra, Australia, and other international experts. The recommendations of the feasibility study were accepted by the Government and a pilot project was initiated. This will be expanded to cover a number of provinces and the results will enable the government to scale up the integration of various logistics management systems into one efficient system for the entire country.

4.8 Number of Stream 1 countries adopting/adapting a health supply chain management information tool

Adopting or adapting a health supply chain management information tool can be critical to ensuring efficiency in the distribution of health supplies. In Stream 1 countries, GPRHCS has consistently supported efforts to improve

Table 31: Number of Stream 1 countries with co-ordinated approach towards an integrated health supplies management system

	Stream 1 countries with co-ordinated approach towards an integrated health supplies management system		
	Integrated supply management system exists	System includes an integrated **procurement mechanism** for contraceptives and RH medicines	System includes an integrated **supply/distribution mechanism** for contraceptives and RH medicines
Country	2011	2011	2011
Burkina Faso	Y	Y	Y
Ethiopia	Y	Y	Y
Haiti	N	NA	NA
Lao PDR	N	NA	NA
Madagascar	Y	N	Y
Mali	Y	N	Y
Mongolia	Y	Y	Y
Mozambique	Y	N	Y
Nicaragua	Y	Y	Y
Niger	Y	Y	Y
Nigeria	N	NA	NA
Sierra Leone	Y	N	Y
Total for 'Yes'	**9**	**5**	**9**

supply management systems, especially through the adoption of computer-based logistics management information systems. Various types of computer software are currently in use, including CHANNEL and PIPELINE. This indicator assesses the existence of a computerized health supply chain management information system in the country through the use of any relevant software.

All GPRHCS Stream 1 countries have in place computerized tools for supply chain management, in 2010 as well as in 2011 (Table 27). CHANNEL software continues to be the most popular tool for adaptation and is currently in use in countries including Burkina Faso, Ethiopia, Haiti, Mongolia and Sierra Leone. The web-based version of this software is now being used by some countries. Pipeline is being used as a supply chain management tool in Mozambique and Nigeria.

In Sierra Leone, CHANNEL was adapted for the management and reporting on all contraceptives and maternal health medicines in support of the free medical care services declared by the Government. The Minister of Health now monitors the distribution of reproductive health commodity security in a timely manner, directly from her office computer. Web-based CHANNEL software has been adapted in Mongolia and translated into the Mongolian language for use at the central and provincial levels nationwide.

Output 4:
RHCS mainstreamed into UNFPA core business (UN reform environment)

What steps have been taken by UNFPA (Headquarters, Country and Regional Offices) to integrate RHCS issues into important United Nations planning documents and processes at the country level? The integration of key RHCS issues into UN planning processes enables country offices to mobilize resources, support programme planning, build capacity and provide technical assistance - all in support of assisting governments to achieve outcomes for reproductive health commodity security.

Table 32: Number of Stream 1 countries adopting/adapting a health supply chain management information tool

Country	Country adopted supply management tools	
	2010	2011
Burkina Faso	Y	Y
Ethiopia	Y	Y
Haiti	Y	Y
Lao PDR	Y	Y
Madagascar	Y	Y
Mali	Y	Y
Mongolia	Y	Y
Mozambique	Y	Y
Nicaragua	Y	Y
Niger	Y	Y
Nigeria	-	Y
Sierra Leone	Y	Y
Total for 'Yes'	**11**	**12**

The output and its related indicators track UNFPA's efforts to make RHCS a priority issue within the United Nations planning documents and also in partnership processes at the country level. By making RHCS a strategic issue, UNFPA Country Offices are well placed to advocate and mobilize resources, make a case for RHCS during programme planning processes, provide technical and other capacity building support to governments and other partners, and build a mass of partnership in support of RHCS activities.

4.9 Expenditure of UNFPA/CSB core resources for RHCS increased

The Commodity Security Branch is the branch within UNFPA that manages its reproductive health commodity security functions. This indicator is provides information on the amount of support that UNFPA provides from its core resources for the implementation of RHCS functions and activities. At the same time, actions are being taken to mobilize resources from donors in support of RHCS interventions.

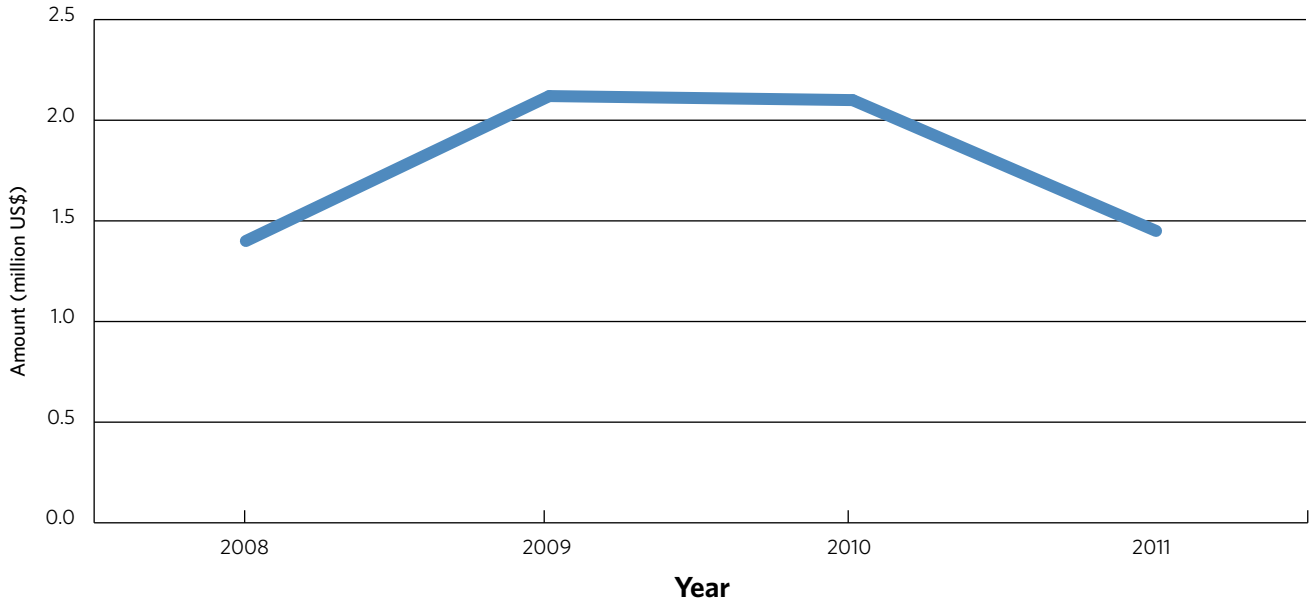
The amount allocated from UNFPA core resources to the Commodity Security Branch principally for the management and implementation of the GPRHCS and other interventions is shown in Figure 32. The amount increased from $1.33 million in 2008 to $2.12 million in 2009; it remained roughly the same by 2010 before decreasing to $1.45 million in 2011. This decrease is due to austerity and other measures that are being instituted by the agency as it continues to face reductions in donor contributions to the core funds. This could also be attributable to the continuing impact of the global financial downturn.

4.10 GPRHCS planning takes into account lessons learned in RHCS mainstreaming

Building on previous years' achievement requires taking into account what worked, what did not work and the reasons behind those outcomes when planning for the current year. Countries implementing the GPRHCS are expected to report on lessons learned that were taken into consideration to improve on the various aspects of the programme. Table 33 shows that with the exception of Haiti, all Stream 1 countries took into account lessons learned in 2010 for the implementation of programmes in 2011.

For Stream 1, the issues taken into account varied from country to countryIn Madagascar, for example,

Figure 32: Amount allocated to CSB (million US$)



transportation problems that affected the distribution of commodities in 2010 were addressed through the creation of common distribution networks that included contraceptives. This ensured that contraceptives were readily available in SDPs, as reported in Tables 7 and 9 which show that availability of contraceptives and life-saving maternal health medicines improved in 2011 compared to 2010. In Burkina Faso, steps were taken to involve key actors, including community leaders, in promoting family planning. In Ethiopia, initiatives were scaled up to increase the uptake of long-acting family planning methods in order to increase the new acceptor rates. In Mali, Nicaragua, Sierra Leone and Mozambique, necessary steps were taken to strengthen LMIS including forecasting and distribution of RH commodities, helping to sustain product and service availability to clients. In Nicaragua, the inclusion of RHCS issues in the SWAp made it possible to procure contraceptives through national processes and hence ensure sustainability in product and service availability. In Nigeria, successful resource mobilization advocacy efforts at the federal level resulted in the availability of federal funding for RHCS, and steps are being taken to replicate similar outcomes at the state level.

Table 33: GPRHCS planning in 2011 for Stream 1 countries takes into account lessons learned

Country	GPRHCS planning in 2011 takes into account lessons learned in RHCS mainstreaming
Burkina Faso	Y
Ethiopia	Y
Haiti	N
Lao PDR	Y
Madagascar	Y
Mali	Y
Mongolia	Y
Mozambique	Y
Nicaragua	Y
Niger	Y
Nigeria	Y
Sierra Leone	Y
Total for 'Yes'	**11**

Table 34: GPRHCS planning in 2011 for Stream 2 countries takes into account lessons learned

Country	GPRHCS planning in 2011 takes into account lessons learned in RHCS mainstreaming
Benin	Y
Bolivia	Y
Botswana	Y
Burundi	Y
Central African Republic	Y
Chad	Y
Congo	Y
Côte d'Ivoire	Y
Democratic Republic of Congo	Y
Djibouti	N
Ecuador	Y
Eritrea	N
Gabon	N
Gambia	Y
Ghana	Y
Guinea	Y
Guinea-Bissau	Y
Lesotho	Y
Liberia	Y
Malawi	Y
Mauritania	Y
Namibia	N
Papua New Guinea	Y
Sao Tome and Principe	Y
Senegal	Y
South Sudan	Y
Sudan	N
Swaziland	Y
Timor Leste	N
Togo	Y
Uganda	Y
Yemen	N
Zambia	Y
Zimbabwe	Y
Total for 'Yes'	**27**

Results for Stream 2 show that 27 out of 34 countries took into account lessons learned in 2010 for GPRHCS planning in 2011 (see Table 29). In Bolivia, the institution of mechanisms ensured that stock levels were monitored and appropriate action taken to ensure availability. In Botswana, lessons from 2010 implementation allowed for the integration of RH commodities into the management mechanisms for essential health supplies and medicines to avoid parallel efforts. Currently, discussions are being held with the Ministry of Health regarding the adoption of CHANNEL and its linkage and use with other systems, including for ARVs. In the Central African Republic, where the weak logistics system posed problems, UNFPA generated action to bring together partners including NGOs to improve the distribution network and communications between warehouses and health facilities in project areas.

In 2010, it became apparent to the UNFPA Country Office in Lesotho that NGOs can easily adapt to the local environment and have a comparative advantage in reaching communities with condom messages. This prompted the scaling up of efforts in 2011 to work closely with NGOs to intensify action to reach more people in various communities. In Liberia and Malawi, programming for young people was scaled up to ensure improved access to services and information. In Ecuador, GPRHCS funds were leveraged to generate closer policy dialogue and advocacy with government, which provided the much-needed sustained interest and action required for national capacity building. One of the key lessons learned in South Sudan was that building the capacity of government partners enhanced their commitment and passion to work towards scaling up RHCS programming. In Swaziland, due to the low implementation of programme activities and low absorption of resources, a multi-partnership to improve RHCS programming was established with the involvement of the Ministry of Health, UNFPA, FLAS and Management Sciences for Health (MSH) with clearly defined roles for each partner. In Togo, scaling up demand generation activities led to an increase in demand for modern family planning, especially long-term contraceptive methods. This prompted the procurement of these products to ensure that clients were served and to avoid no stock-outs. Similarly, the acute shortage of contraceptives experienced in Uganda prompted the special earmarking of funds for contraceptives procurement in the Joint Program on Population. Most importantly, advocacy activities led to an increase in government allocation RH commodities from $750,000 to $4,000,000 in 2011.

Incorporating lessons learned into succeeding programming years enables each country to build on successes or to address the challenges they face in addressing RHCS issues. It helps build linkages in annual work plans for continuity and contributes to the replication of good practices.

Women leaders known as 'Bajenu Gox' receive training in reproductive health issues to support younger women in Senegal. *Credit: UNFPA Senegal.*

4.11 Number of countries with RHCS priorities included in CCA, UNDAF, CPD, CPAP and AWP

UNFPA Country Offices are expected to work within partnership frameworks at the country level, including with UN Country Teams, to ensure that issues that are important to UNFPA's mandate are incorporated into strategies for supporting governments in addressing national development challenges. This indicator assesses the performance of UNFPA Country Offices in ensuring that RHCS priorities are integrated into UN programming processes. Table 35 shows that more countries have succeed in including RHCS priorities into UN programming processes. In 2011, all countries reported that RHCS issues were included in these key documents: Annual Work Plans (AWP), Common Country Assessment (CCA), Country Programme Action Plan (CPAP), Country Programme Documents (CPD), United Nations Development Assistance Framework (UNDAF).

As shown in Table 36, similar progress is being made among Stream 2 countries where the number of countries with RHCS issues integrated into CCAs and UNDAFs increased by 12 and 6 countries respectively. As in the case of Stream 1, all the 34 Stream 2 countries reported that RHCS issues are included in their CPD/CPAP and AWP documents.

4.12 Number of UNFPA Country Offices with increasing funds allocated to RHCS

While GPRHCS mobilizes funds for RHCS interventions especially at country level, each country office is expected to allocate, and even mobilize additional resources for the programme. The indicator assesses the extent to which countries have been supporting the implementation of RHCS activities with additional resources either from core funds or mobilized from other sources.

Table 35: Stream 1 countries with RHCS priorities included in: a) CCA, b) UNDAF, c) CPD, d) CPAP and e) AWP

	Stream 1 countries with RHCS priorities included in various programming documents									
	RHCS included in CCA		RHCS included in UNDAF		RHCS included in CPD		RHCS included in CPAP		RHCS included in AWP	
Country	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ethiopia	N	N	Y	Y	Y	Y	Y	Y	Y	Y
Haiti	N	N	Y	Y	Y	N	Y	Y	Y	Y
Lao PDR	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Madagascar	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mali	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nicaragua	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Niger	N	N	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria	-	Y	-	Y	-	Y	-	Y	-	Y
Sierra Leone	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**3**	**9**	**10**	**12**	**11**	**12**	**11**	**12**	**11**	**12**

* Nigeria was designated as a Stream 1 country in 2011, thus information for 2010 is in the Stream 2 table

Table 36: Stream 2 countries with RHCS priorities included in: a) CCA, b) UNDAF, c) CPD, d) CPAP and e) AWP

	Stream 2 countries with RHCS priorities included in various programming documents									
	RHCS included in CCA		RHCS included in UNDAF		RHCS included in CPD		RHCS included in CPAP		RHCS included in AWP	
Country	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Benin	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Bolivia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burundi	N	N	N	N	N	Y	Y	Y	Y	Y
Central African Republic	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Congo	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Democratic Republic of Congo	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Djibouti	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ecuador	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gambia	Y	Y	N	Y	N	Y	Y	Y	Y	Y
Ghana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Guinea	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Guinea-Bissau	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lesotho	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Liberia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Malawi	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mauritania	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Namibia	N	Y	N	Y	N	Y	Y	Y	Y	Y
Nigeria	Y	-	Y	-	Y	-	Y	-	Y	-
Papua New Guinea	-	Y	-	Y	-	Y	-	Y	-	Y
Sao Tome and Principe	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Senegal	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
South Sudan	-	Y	-	Y	-	Y	-	Y	-	Y
Sudan	-	Y	-	Y	-	Y	-	Y	-	Y
Swaziland	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Timor Leste	-	Y	-	Y	-	Y	-	Y	-	Y
Togo	-	Y	-	Y	-	Y	-	Y	-	Y
Uganda	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Yemen	-	Y	-	Y	-	Y	-	Y	-	Y
Zambia	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**21**	**33**	**26**	**33**	**25**	**34**	**29**	**34**	**29**	**34**

* Nigeria was designated as a Stream 1 country in 2011, thus information for 2010 is in the Stream 2 table

Among Stream 1 countries, resources allocated to RHCS activities from UNFPA Country Office funds decreased in Mali and Niger in 2011 but remained the same in Burkina Faso and Haiti, compared to 2010. Increases in country office funds allocated to RHCS were reported in 10 countries in 2010 and 8 countries in 2011.

Among Stream 2 countries, such allocations increased in 19 countries in 2010 and in 22 countries in 2011. such allocations decreased from 2010 to 2011 in seven countries (Congo, Djibouti, Guinea-Bissau, Lesotho, Sudan, Uganda and Zimbabwe). Allocations remained the same in five countries (Bolivia, Guinea, Liberia, Malawi and Senegal) when compared to last year.

4.13 Number of countries with all the relevant joint UN programmes for SRH and MNH that include RHCS

In most countries the UN Country Teams often identify a common area of joint support and intervention through the formulation of a UN Joint Programme. UNFPA Country Offices are expected to ensure that RHCS issues are included in such programmes where they exist for the health sector generally and in particular for sexual and reproductive health and maternal and newborn health. The inclusion of RHCS issues into a joint programme facilitates the provision of joint support for maternal health medicines, including contraceptives, and helps to build capacities and strengthen systems — all of which is complementary to strategies for improved SRH and maternal health. This indicator assesses the extent to which UNFPA Country Offices, with joint UN Programmes, have been able to have RHCS issues included in relevant thematic programmes.

In Gabon, condoms are distributed at kiosks in a public-private marketing partnership. *Credit: UNFPA Gabon*

In 2011, 10 Stream 1 countries reported the existence of Joint UN Programmes for sexual and reproductive health and maternal and newborn health that include RHCS. Twenty Stream 2 countries reported the existence of UN Joint Programmes for SRH and MNH and for 18 of those countries (with the exception of Ghana and Mauritania) RHCS issues were included in the joint programmes.

4.14 Number of national/regional institutions providing quality technical assistance on RHCS in the areas of training and workshops

The Global Programme to Enhance Reproductive Health Commodity Security supports regional institutions to provide capacity development services to countries. This is carried out in each of the UNFPA geographic regions in close collaboration with the regional offices. Such activities support the UNFPA regionalization process, i.e. where regional and national institutions and consultants are to be enabled to support Country Offices in diverse fields; with regional offices and sub-regional offices providing the needed oversight. In the case of RHCS, special efforts are made to build capacities of institutions and consultants for the provision of quality technical assistance.

In Southern and Eastern Africa, three RHCS consultants were supported to participate in the Supply Chain Management and Quantification of Health Commodities Course organized by the Eastern and Southern African Management Institute (ESAMI) in Arusha, Tanzania. This resulted in one of the consultants providing technical assistance to Zimbabwe in the development of the national RHCS strategy. The UNFPA SRO in Johannesburg will utilize the services of these consultants to provide technical assistance to countries in 2012.

RHCS was promoted through several partnerships in Latin America and the Caribbean (LAC) in 2011, notably with FLASOG, CLAE, Reprolatina, PRISMA and CIES.

The Latin-American Federation of OB&GYN Associations *(Federación Latinoamericana de Sociedades de Obstetricia y Ginecología*, FLASOG) has in the past partnered with the UNFPA Regional Office in Latin America to support interventions in the area of sexual and reproductive health. In 2011, FLASOG provided support in ensuring a better understanding of sexual and reproductive rights among its membership in Argentina, Brazil, Peru and Venezuela. As a result, a Risk and Harm Reduction Services plan was developed for the main maternity service in Caracas. In collaboration with other partners, FLASOG also contributed to the development of a discussion paper for the reduction of unsafe abortion with respect to the use of misoprostol. FLASOG also worked through its specialized team to address concerns relating to Emergency Contraception (EC). Working in alliance with CLAE has generated a valuable exchange between the medical community and the legal community on the incorporation of EC into essential medicine lists in Latin American countries. Specific actions were taken in Chile, Guatemala and Honduras to ensure that authorities give EC the importance it deserves. FLASOG also contributed to the strengthening of the interdisciplinary dialogue on sexual violence issues and women's access to justice and RH services, including access of victims to comprehensive care. In the area of adolescent reproductive health, UNFPA supported efforts by FLASOG to analyze secondary information that provides highlights the extent of teenage pregnancy among girls under the age of 15 years in Latin America and the Caribbean. The results show that in countries such as Dominican Republic, Nicaragua, Panama and Peru, teenage pregnancy is on the increase in this age group. These research findings will be useful for the conduct of advocacy and design of programmes for targeted interventions.

The UNFPA LAC Regional Office has partnered with Reprolatina to promote, monitor and evaluate the use of the WHO Decision-Making Tool for Family Planning Clients and Providers (DMT). Assessments conducted in 2011 provided information on the usefulness of the tool in various country contexts. This included Uruguay, with no experience in the use of the tool; Peru, where the tool was available but not used in the public sector; and Honduras, where the use of the DMT was limited to very few clinics in the public sector. Training and technical assistance were provided to ensure maximum benefit is derived in the adoption of the tool, e.g. technical assistance provided by Reprolatina to Boliva, El Salvador and Honduras resulted in the training of 23 providers of adolescent services on the use of the DMT.

The UNFPA Regional Office in Latin America also collaborated with PRISMA and the Center for Research and Health Studies at the Universidad Nacional Autonoma de Nicaragua (UNAN CIES) to provide technical assistance to ministries of health, social security institutions and NGOs in Latin America. This partnership resulted in support provided to Ecuador for RH Service Cost Analysis carried out under the coordination of the Ministry of Public Health. The study provided evidence-based updated information about maternal, perinatal and reproductive health management in Ecuador. In Nicaragua, PRISMA and CIES contributed to assessing the Ministry of Health's preventive interventions and their contribution to reducing cervical cancer morbidity and mortality in six provinces. Of special significance was the design and piloting of a web portal for two distance learning courses, which was made possible through collaboration between the UNFPA Regional Office in Latin America and PRISMA–CIES. Through the portal two on-line courses (RHCS and EmOC) have been piloted and publications, research papers and related materials have been posted for access by users.

In the Asia and the Pacific region, a regional training workshop on Warehousing Guidelines and Standards was organized by the UNFPA Asia Pacific Regional Office (APRO) in collaboration with the International Council on Management of Population Programs (ICOMP). Among the 40 participants from 17 countries were national officials from the Ministry of Health, directors of the central warehouse and staff from UNFPA Country Offices. In addition, the APRO adviser conducted a training of trainers workshop on RHCS Programme Management for central- and regional-level managers in Timor Leste. Thirty government officials participated in the one-week training and prepared their individual action plans for implementation upon return to their countries.

In Mongolia, UNFPA APRO collaborated with the School of Pharmacy at the University of Medical Sciences in Ulaanbaatar to conduct a training of trainers (TOT) workshop. The objective was to build the capacity of trainers

who will take on the task of introducing new topics related to RHCS and family planning and, as part of the exercise, to upgrade the training curriculum for pharmacists. This was also part of the ongoing support provided by APRO to the School of Pharmacy for the strengthening of the technical capacity in the university through the periodic review, revision and update of the training curriculum. Seven staff members from the faculty and national staff from UNFPA Country Office participated in the training. Selected staff members from the faculty also participated in the Regional Training Workshop on Warehousing that was organized by APRO in collaboration with ICOMP (Malaysia).

A training course on RHCS for the Pacific Island Countries was organized by the UNFPA SRO in Suva, Fiji, in collaboration with the University of Canberra. The training, a sequel to the one organized in 2010, was for managers of RH commodity supply systems. It took place in Cook Islands, Federated States of Micronesia (Yap and Chuuk States), Papua New Guinea (East Sepik and New Ireland Provinces), and the Solomon Islands (Western Province) and was attended by participants from these four countries. Many of the participants found the training to be practical and applicable to diverse areas of sexual and reproductive health. This new training approach for a highly technical subject like RHCS received favorable reviews. As a result of the training and ongoing support, 10 Pacific Island Countries have mainstreamed contraceptives into an integrated supply management systems with a sharpened focus on life saving RH medicines and RH commodities.

The School of Public Health at Addis Ababa University has in the past collaborated with UNFPA Country Office in Ethiopia to organize orientation courses on RHCS for the students undertaking diploma courses in Public Health. In 2011, this resulted in the development of curriculum in RHCS to be used as one of the components of the diploma courses; it could also be adapted for a short-term course for orientation in RHCS. The RHCS curriculum covered various areas including concepts and definitions, policies and strategies within national contexts, technical and commodity assessment tools aspects of logistics management and advocacy for RHCS. In December 2011, a training of trainers (TOT) course gathered 24 participants, including 14 from the Public Health School. Other participants were from the University's School of Pharmacy, the Federal Ministry of Health, (FMOH), DKT (a social marketing organization in Ethiopia), JSI/Ethiopia and the UNFPA Country Office. This class of trainees will be expected to serve as trainers for the expansion of human resource in RHCS at national and even regional levels.

In Eastern Europe and Central Asia, the UNFPA Regional Office collaborated with IPPF EN in the conduct of a study, the'In-Depth Analysis of Family Planning and Reproductive Health Contraceptive Security In seven Middle-Income Countries in Eastern Europe and Central Asia'. The study covered seven countries (Armenia, Azerbaijan , Bosnia and Herzegovina, Bulgaria, Macedonia, Kazakhstan and Serbia. The objective of the study was to gather and analyze data on factors influencing access to and utilization of modern family planning methods with particular attention to vulnerable populations in the selected middle-income countries (MICs). The findings of the study supplement a review by UNFPA of RHCS in the region and will contribute to the establishment of client-centred family planning and RHCS strategies. In addition to specific country findings, the cross-country priority issues highlighted in the report include:

- perception of modern contraception as unsafe;
- inadequate knowledge, attitudes and availability of service providers;
- imited range of contraceptive methods restricting client choice;
- cost as a factor in non-use of modern contraception;
- social norms and expectations regarding sex and sexuality;
- difficulties for young people in accessing appropriate contraceptive services; and
- lack of government commitment to contraceptive security.

These issues form a strong basis for dialogue and engagement with policy makers in the sub-region.

4.15 Cluster achievements

GPRHCS support goes beyond Stream 1 and 2 countries and includes various UNFPA geographic sub-regions. The support is often meant to be catalytic and targeted at addressing specific country needs. In these 'cluster countries', UNFPA Sub Regional Offices work with the Country Offices in ensuring that technical and programmatic support are provided to strengthen country programmes

and ensure sustainability of RHCS interventions. The cluster countries include Pacific Island Countries, Eastern European and Central Asian countries, countries of the Caribbean and countries in the Arab States.

Pacific Island countries

While contraceptive prevalence in most countries has increased over the past 20 years, rates have stagnated around 35 to 40 per cent in many countries. Rates in Solomon Islands and Kiribati remain below 30 per cent. Through the GPRHCs, UNFPA works with Pacific Island Countries (PICs) to strengthen sexual and reproductive health and family planning services. Most PICs have developed National Medicines Policies that establish the framework and infrastructure for the supply of commodities. Within this framework is the National Medicines and Therapeutics Committee (NDTC), which serves as a coordinating mechanism. Presently six PICs (Fiji, Cook Islands, Solomon Islands, Tonga, Tuvalu and Vanuatu) have NDTCs that have RHCS issues included in their terms of reference. Working closely with national counterparts, GPRHCS has supported, through its focal points, the creation of the enabling environment for RH policies and RHCS. Currently, RHCS issues are included in the RH policies of four PICs the HIV policies of three PICs. A mapping exercise undertaken in 2011 revealed that all PICs now have lifesaving maternal medicines included in their Essential Medicines List.

The pre-positioning of 18 months of RH supplies at the Fiji PSRO warehouse contributed to meeting the requests made by the countries in this region for commodities. No country made ad hoc requests for RH commodities in 2011. Only two PICs (Fiji and Palau) have direct budget support for contraceptives. This calls for advocacy for the other countries to invest in RHCS to ensure that a broader range of issues are addressed and interventions are sustainable. The training programme supported in partnership with the University of Canberra continued in 2011 with the training of RH/RHCS focal points in the PICs.

Eastern Europe and Central Asian countries

The reproductive health care system in Turkmenistan has achieved significant results in dramatically decreasing maternal mortality, with support from UNFPA over the past decade. Turkmenistan is close to achieving MDG 5(A). Access of women to RH services, including in rural areas, has increased significantly. Turkmenistan carried out activities to identify best practices for establishing monitoring systems and for quality assurance as efficient management tools for RH. This resulted in the establishment of a national monitoring group on quality assurance in RH systems within the Ministry of Health and Medical Industry. The group selected family planning as a pilot area for their work. An assessment tool was designed for examination of various dimensions of the health system including technical performance, effectiveness of care, service delivery (safety, access and continuity), and physical infrastructure. The tool is now being used to routinely assess the quality of services.

In Uzbekistan, GPRHCs provided support in 2011 for the development and adoption of CHANNEL computer software, including support for training and the provision of basic equipment. Initially piloted in Fergana province, it has helped improve on the logistics management information system. It has enabled accurate forecasting of needs based on rigorous analysis of information. It also provides information for the routine monitoring of stock levels, and

This woman wears a "No Condom, No Sex" T-shirt with a UNFPA logo as she returns from her flooded fields in the Pacific Islands.
Credit: Ariela Zibiah/UNFPA

hence stock transfers to avert stock-out at SDPs. The availability of a logistics guideline and capacity development on improved storage practices has contributed to ensuring the efficiency of the system. In June-July 2011, survey of a sample of 32 primary health care facilities in eight provinces showed that contraceptive stock levels improved at the primary health care level. Almost all SDPs use newly introduced LMIS requesting/reporting forms and have adequate contraceptive stock levels. According to MoH statistics nearly 100 per cent of SDP offered all methods modern contraceptives in 2011.

In Kazakhstan, the GPRHCS supported an assessment of the quality of arrangements of family planning care from the viewpoint of reproductive health service providers. The 2011 assessment provided recommendations on issues such as inclusion of contraceptives on the essential medicines list, free distribution of contraceptives or reduction in charges for vulnerable populations, instituting budget lines for the procurement of contraceptives, and ensuring appropriate involvement of the public sector in the provision of family planning services. Another study supported focused on women's access to sexual and reproductive healthcare in general and family planning in particular, which drew the attention of the Ministry of Healthcare to unacceptably high unmet needs to family planning (11.6 per cent as of MICS 2010), adolescents birth rate (about 30 per 1000 girls aged 15-19) and high prevalence of STIs. These studies will form the basis for engaging government and other partners to address the challenges to RH and family planning in Kazakhstan

In Tajikistan, GPRHCS supported Government action to rehabilitate warehouses and strengthen transportation systems. This facilitated the distribution of RH commodities and helped to aver stock-outs at service delivery points. Also, UNFPA initiated advocacy activities with policy makers on the need to for strengthening RH programmes in the country through a stronger show of commitment and budgetary support.

In Kyrgyzstan, support continued for the expansion of CHANNEL at the health facility level. In 2011, health professionals received training in the Osh and Djalalabad regions of the country. However, there is high staff turnover and a lack of computers in rural areas of the country. In 2011, the UNFPA Country Office published a manual, *Modern methods of family planning,* for faculties to use in training health professionals. The training course in the manual was integrated into the curricula of the Kyrgyz State Medical Institute for Postgraduate Education and Continued Training.

Moldova was supported with a consignment of contraceptive commodities that were distributed based on the common agreed Plan of Distribution with the MoH to Reproductive Health Cabinets. The stock of contraceptives was distributed to Transnistria, a break-away region of Moldova. Unmet need for family planning is especially high in the Transnistria region, where abortions are much more common than in other parts of Moldova. Also in Transnistria the pattern of HIV/AIDS infection is shifting from intravenous drug use to sexual transmission, which has increased substantially during last two years. Adolescent pregnancy accounts for 14 per cent of total pregnancies with almost 10 per cent of abortions annually being performed on adolescents. UNFPA's programme activities in Transnistria support RH/FP services, including procurement and distribution of free of charge contraceptives in the region.

Caribbean countries

During 2011 UNFPA worked in the Caribbean cluster countries with a broad range of partners including the Red Cross, faith-based organizations, ministries of health, ministries of finance, ministries for youth and sports, IPPF affiliates, NGOs providing services to the MoH, national HIV and AIDS programmes, groups of young leaders and other UN agencies. The UNFPA Sub-Regional Office for the Caribbean and the Country Offices used different approaches to improve the knowledge of staff in regional implementing partners on issues such as logistics management, forecasting and procurement of RH commodities, and contraceptive technology.

In Belize, a consultant was supported to conduct interviews with key persons working at the judiciary system and the health system in November and December 2011. Towards the end of 2011, a study was commissioned to serve as input for the proposed policy document on legal barriers to sexual and reproductive health services. The study provides information on gaps that exist between the age of sexual consent and the ability for adolescents to freely access sexual and reproductive health services in Belize. The findings will inform advocacy in Belize and will serve as a standard of precedence in the Caribbean. This information

will further inform the development of legislative models to ensure that no legal barriers exist in adolescents accessing SRH information and services. Also, a series of training sessions were held on contraceptive technology in Grenada, Guyana, Jamaica, and Trinidad and Tobago.

In Jamaica, 64 community nurses received training in RH and family planning. In Guyana, 22 nurses and 5 medical doctors participated in training on IUD insertion. In Grenada, 48 nurses received training and in Trinidad and Tobago 18 medical doctors and 35 nurses. The Sub Regional Office also provided technical and programmatic support to MoH in Anguilla, Antigua, Bahamas, Barbuda, Grenada, Guyana, Jamaica, St. Vincent and the Grenadines, and Suriname. The support included the revision of medical protocols to treat victims of sexual violence; inclusion of new contraceptive technology such as female condoms, sub-dermal implants, Progestine active IUDs; creation of national humanitarian response protocols to include SRH; and guidance on how to ensure RHCS during humanitarian settings with governments and the Red Cross. Special support was also provided to groups of sex workers and women living with HIV with emphasis in positive prevention and reduction of stigma and discrimination.

In Suriname, training on the Family Planning Decision Making Tool was expanded I n2011 through the translation of the materials into Dutch and printing and distribution of documents to facilitate the training of health care providers. The documents were also translated in some of the local maroon and Amerindian languages. The Facts & Myth Wheel was also translated in Dutch and 300 small wheels were printed for use by health care providers, schools and clients. In total, 109 health workers received training on the DMT, ensuring that at least one health care worker would be able to use the tool in 40 per cent of rural clinics served by the Medical Mission (Lobi Foundation) and 50 per cent of the clinics in the coastal area served by the Regional Health Division. Also 80 per cent of volunteer counsellors in the teenage mothers programme of the Ministry of Sport and Youth participated in trianingon how to use the DMT when working with their clients, in particular to look at postponing a second unplanned pregnancy while they are still in school.

In Guyana, the RHCS priority was to establish a logistics management information system throughout the country's 10 administrative regions. The Ministry of Health's Materials Management Unit and MIS Department received support from the GPRHCS.. The assistance resulted in the training and sensitization of key public health professionals and stakeholders from hospitals and health centres in regions 2, 3, 6 and 7. A number of personnel with responsibility for managing commodities also received RHCS training, including community health workers from outlying health posts, pharmacy assistants, cytotechnologists, lab technicians, rehab assistants and stores clerks from the hospitals.

In the Arab States sub-region, the security situation was a very important factor that affected programme implementation, especially regarding technical support from Cairo where the regional office is located. Despite challenges, the Regional Office held a training of trainers (TOT) workshop for strengthening national capacity to plan and advocate for reproductive health commodity needs. The workshop was attended by fourteen RH and commodity experts from the ministries of health and UNFPA focal points from Egypt, Morocco, Somalia, Sudan and Yemen. The workshop was conducted in English with simultaneous translation to Arabic and French. It introduced a number of essential elements needed to achieve RHCS using a curriculum developed by the UNFPA Commodity Security Branch. The training also facilitated sharing of country experiences and identification of country-specific issues and action points for the coming year. In addition, a joint UNFPA ASRO and PSB Regional Workshop was conducted on Long Term Agreements (LTA) for Country Office and ASRO staff. The workshop targeted procurement and logistics focal points as well as Operation Managers and included an introduction to recent development on International Public Sector Accounting Standards (IPSAS).

CHAPTER FIVE

Advocacy, Partnership and Market Shaping

This section provides summaries on a broad range of activities initiated and carried out at the global level to strengthen commitment and promote partnership around issues that are at the heart of the UNFPA mandate and relate to RHCS.

5.1 UN Commission on Life-Saving Commodities for Women and Children

A high-level commission to improve access to essential but overlooked health supplies that could save the lives of millions of women and children every year was established in March 2012 by UNICEF and UNFPA. The UN Commission on Life-Saving Commodities for Women and Children is part of the United Nations Secretary-General's Every Woman Every Child initiative in support of achieving the health-related Millennium Development Goals. The founding co-chairs of the Commission are President Goodluck Jonathan of Nigeria and Prime Minister Jens Stoltenberg of Norway. The UNFPA Executive Director Dr. Babatunde Osotimehin and the UNICEF Executive Director Anthony Lake will serve as vice-chairs of the Commission. Membership will include global stakeholders from the public, private and civil society sectors.

Family planning training at Tajikistan's medical university.
Credit: Parviz Boboev/UNFPA

The Commission focuses on high-impact health supplies that can reduce the main causes of child and maternal deaths, as well as innovations that can be scaled up, including mechanisms for price reduction and supplies stability. The Commission aims to:

- reduce financial barriers to access through social protection mechanisms, such as fee waivers, vouchers and social insurance, and global financial mechanisms, such as pooled procurement;
- create incentives for international and local manufacturers to produce and innovatively package overlooked supplies;
- identify fast-track regulatory activities to accelerate registration and reduce registration fees for a special list of products to encourage a focus on quality medicines.

The Commission will advocate at the highest levels to build consensus around priority actions for increasing the availability, affordability, access and rational use of overlooked

health supplies that will prevent premature death and disease among children under five years old and women of childbearing age.

Since the creation of the Commission was announced, CSB has provided technical leadership to the issue within UNFPA and in partnership forums with UNICEF. In 2011, a series of technical meetings were held and support provided to ensure that the Commission's architecture is institutionalized as planned. Issues relating to the work of the Commission formed part of a major engagement of UNFPA with members of the Reproductive Health Supplies Coalition for the identification of contraceptive commodities for inclusion under the family planning mandate of the Commission.

The three overlooked contraceptive methods selected for inclusion are implants, emergency contraception and the

female condom. The work of the Commission will contribute to ensuring access for all to a full range of contraceptive methods and the ability of women to choose a method that fits within their own fertility goals and life circumstances. For more information on the Commission, visit www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities.

5.2 Joint interagency work on priority medicines for mothers and children

The List of Priority Medicines for Mothers and Children developed jointly by WHO with UNICEF and UNFPA was launched at the 18th meeting of the WHO Expert Committee in March 2011, in Accra, Ghana. The medicines were chosen based on evidence of efficacy and safety for preventing or treating major causes of sexual and reproductive, maternal, newborn and child mortality and morbidity. In addition, medicines were included for the prevention of pre-term birth and palliative care. All the medicines listed are included in the current versions of the WHO Model List of Essential Medicines, the WHO Model List of Essential Medicines for Children and WHO treatment guidelines. All medicines on the priority lists are or may be available in countries with the exception of those which require further research and development. The meeting in Accra facilitated the consideration of proposals for addition of medicines, or deletion of medicines, from the 16th WHO Model List of Essential Medicines and the 2nd WHO Model List of Essential Medicines for Children. It also considered proposal on new directions to improve rational use of medicines and reviewed a proposal on 'missing' essential medicines as well as new category of 'non-essential medicines for public health'.

5.3 Emergency/humanitarian response

In 2011 the joint UNFPA-UNHCR Commodities Initiative continued to provide male and female condoms, RH Kits and other essential life-saving medicines and supplies for conflict, post-conflict, refugees and displaced populations, with support from GPRHCS and in collaboration with Humanitarian Response Branch and Procurement Services Branch.

5.4 Coordinated Assistance for Reproductive Health Supplies (CARhs)

Originally called the Countries-At-Risk (CAR) Group, the name was changed to Coordinated Assistance for Reproductive Health Supplies (CARhs) Group in May

Members of the Bandé Magaria School for Husbands.. *Credit: UNFPA Niger*

2010 to reflect the nature of the group's work. The Group works under aegis of the System Strengthening Working Group of the Reproductive Health Supplies Coalition (RHSC). Members of CARhs include UNFPA's Commodity Security Branch and Procurement Services Branch, USAID, the RH Interchange Secretariat, and the USAID | DELIVER Project. Other members participate on an ad hoc basis according to need, including the World Bank, KfW, the UN Foundation (Pledge Guarantee for Health staff), the RHSC and MSI. The main focus of CARhs work is on contraceptives and condoms in countries on the verge of a shortage or stock-out. It helps coordinate the efforts and response of the global donor community during through monthly meeting where members share information, identify possible countries where shortages might occur and work out coordinated efforts to address the problems.

As of September 2011, CSB-UNFPA assumed the role of Secretariat for the CARhs and hence steered efforts to address problems relating to the supply of contraceptives and condoms. Between October 2010 and September 2011, CARhs dealt with (to conclusion) a total of 168 distinct commodity issues. Highlights of issues dealt with in 2011 include the following: information was shared on upcoming shipments, a possible stock-out of male condoms in Tanzania was ascertained; advocacy urged reduction in time RH commodities spent waiting to be cleared from the port in Mozambique; Nicaragua's MoH procured generic products rather than seeking assistance from the global donor community when an item was in low supply; local stakeholders worked in Senegal to better coordinate information to track stock levels; examining Nigeria's clearing process that has led to millions of dollars' worth of RH supplies being stuck at the ports; providing assistance for ordering 6 million condoms for a new military HIV/AIDS prevention program in Burundi, and in Togo coordination with USAID to respond to shortages.

The CARhs Group has fostered closer cooperation in the area of commodity support among members especially between UNFPA and USAID including at the country level. The resources of two expansive and global networks of country office staff are effectively shared to address existing bottlenecks. A major strength of the CARhs is the consistent participation of key organizations, as well as the openness of discussions.

5.5 Reproductive Health Supplies Coalition

The Reproductive Health Supplies Coalition (RHSC) is a global partnership of more than 150 public, private, and non-governmental organizations dedicated to ensuring that all people in low- and middle-income countries can access and use affordable, high-quality supplies to ensure their better reproductive health. UNFPA is a leading member of the Coalition with two staff members on the Executive Committee. The RHSC functioned in three working groups to address various issues.

The Market Development Approaches Working Group contributes to the goal of reproductive health supply security through a greater focus on the 'total market', which includes the private and commercial sectors. The Resource Mobilization and Awareness Working Group works to secure political support and increase financial resources for enhancing the availability of RH supplies, both at country and global level. The Systems Strengthening Working Group aims to strengthen the global, regional, and country systems needed to ensure a reliable and predictable supply of RH commodities, primarily in the public sector. The Coalition also has a Caucus on New/Underused RH Technologies, a Latin America and Caribbean Forum and a Francophone Forum for Africa.

Specific initiatives of the Coalition include AccessRH, Coordinated Assistance for RH supplies (CARhs), participation in the Quality Reproductive Health Medicines (QuRHM) Strategy, and other activities. Through the HandtoHand Campaign, UNFPA works with coalition members to ensure that the needs of 100 million new users of modern contraception are met by 2015. Through the GPRHCS, UNFPA contributes to this effort by strengthening systems and making contraceptives available in Stream 1 and Stream 2 countries.

5.6 Marie Stopes International (MSI)

Between September 2010 and September 2011, GPRHCS provided approximately $2 million worth of RH commodity supplies to MSI. The donations was composed of Oral Contraceptives (547,000 cycles), Injectables (306,000 pieces), Inter-Uterine Devices (IUDs) (258,500 pieces), Implants (64,956 pieces)

Female Condoms (8,000 pieces). The estimated total Couple Years of Protection provided by these commodities was approximately 1,736,000 CYP. MSI estimates (using its Impact Calculator)[4] that the CYPs would translate to the following results; 506,703 unwanted averted; 68,085 unsafe abortions averted; and 1,426 maternal deaths averted.

The commodities donated by UNFPA through the GPRHCS to Marie Stopes Sierra Leone amounted to about 24,400 CYP. This contributed to ensuring MSSL could reach clients, mostly women below 25 years of age, in various vulnerable communities with quality RH and family planning services. An indication of impact is shown through the case of a mother of four not able to afford to pay Le6,000 (about US$1.30) for the service other health centres. Making the contraceptives available to her free of charge, MSI has enabled her to avoid pregnancies and strive to support her children.

In Tanzania, MST teams are often overwhelmed by demand but unable to meet the needs of women especially with their preferred methods (including long-term methods). GPRHCS donations amounting to 16,640 units of Jadelle (implants) and 10,000 T380A IUDs were shipped to Marie Stopes Tanzania (MST). This donations contributed to work being done by MST in hard-to-reach areas of south of Dodoma region. During a community outreach visit, in one settlement, the women queuing to receive services would not allow the MST team to return with any implants remaining. A batch of 80 had to be utilized in a single day, leaving none for distribution at the 17 other communities the team intended to visit. The overwhelming demand came about with very little demand generation in that community. The team simply put up notices at the government facility and paid a town-crier to notify the community that MST was visiting to offer free family planning services. The word spread among the women who queued up early in the morning to receive the service. The story of a 19-year-old woman in Mpwapwa district (Dodoma) provides an insight into the contribution the donation has made to MSI's work in poor rural communities. She said she became pregnant when she was in Rudi Secondary School and was expelled from school. Her mother was very angry because she expected her daughter to attend college and get a job to help her. The young woman and her partner wanted to use a long-lasting implant, which was available in the community dispensary at a charge of 5,000 to 10,000 Tsh, ($US 3 to 6) – a price most of the women in the village cannot easily afford. Through the services provided by Marie Stopes Tanzania, she acquired an implant that will last three years; enabling her to avoid pregnancy while completing her secondary education.

RH commodities were shipped to 23 countries (Afghanistan, Bolivia, Burkina Faso, Cambodia, Ghana, Kenya, Madagascar, Malawi, Mali, Mongolia, Myanmar, Nepal, Nigeria, Pakistan, Papua New Guinea, Philippines, Sierra Leone, Sudan, Tanzania, Timor Leste, Uganda, Zambia and Zimbabwe). In each of these countries, similar effects have been achieved through the work of MSI in general and in particular through the contributions of the commodities provided by UNFPA.

5.7 AccessRH

AccessRH is a UNFPA-managed reproductive health procurement and information service implemented under the auspices of the Reproductive Health Supplies Coalition. The goals of AccessRH are to improve access to quality, affordable reproductive health commodities and reduce delivery times for government and NGO clients; and to provide enhanced information for planning and tracking. Groundwork in 2010 enabled the project to offer a catalog, handle orders, launch a web site (myAccessRH.org), and scale up operations in 2011.

Funding provided by the GPRHCS allowed AccessRH to build up a stock of standard 53mm male condoms with the aim of reducing lead time (see section 4.1 above). AccessRH shipped condoms from inventory 10 weeks faster than procurers whose condoms needed to be manufactured at the time of order. Accordingly, 61 clients in 54 countries benefitted from this shorter wait time (including external clients and UNFPA Country Offices). By the end of December 2011, AccessRH has spent nearly $6.5 million on condom inventories held at three prequalified manufacturers. There are plans to broaden the range of contraceptives available so as to further reduce lead times for a wider range of products and larger number of clients.

[4] Corby N, Boler T and Hovig D. *The MSI Impact Calculator*: Methodology and Assumptions, London: Marie Stopes International, 2009.

5.8 Prequalification and Quality Assurance policy/WHO

By the end of 2011, 26 male condom factories and 8 IUD factories had been prequalified for male condom and IUDs respectively. A similar process was initiated for female condoms with the holding of WHO/UNFPA Technical Review Meetings in April 2011. The meeting was attended by technical experts and advisors, researchers, scientists, regulatory authority officials, WHO/UN and other partner agencies who reviewed and recommended two out of the nine different designs of female condoms for consideration. These two designs would proceed to on-site inspection stage with the aim to increase number of prequalified female condom products (see section 4.2 above).

Limited quality assured procurement options for either WHO prequalified or Stringent Regulatory Authority approved hormonal contraceptives and maternal health medicines led to the development of a Quality Assurance (QA) policy defining interim processes. With the aim to identify more sources of quality assessed and approved hormonal contraceptive and maternal health medicines, implementation of the newly approved UNFPA QA Policy for Reproductive Health Medicines commenced in April 2011. Thirteen generic hormonal contraceptive manufacturers responded to the Expression of Interest posted by UNFPA. In total, 32 different hormonal contraceptives and maternal health medicinal products were reviewed by a committee of five technical experts who had extensive experience in dossier assessments, pharmaceutical technical data and regulatory affairs. The product categories reviewed included combined oral contraceptives, progestogen-only pills, injectable hormonal contraceptives, emergency contraception, implants, oxytocin and products for the prevention and treatment of eclampsia. This work has involved partnerships with WHO, Concept Foundation and other partner agencies that are part of the Reproductive Health Supplies Coalition. A number of products are undergoing onsite inspections to better advise on level of quality and risk analysis while promoting submission for WHO prequalification.

5.9 New UNFPA cluster approach to programme implementation

Under the leadership of the Executive Director, Dr. Babatunde Osotimehin, UNFPA formulated a Business Plan (The Way Forward) in 2011 to provide a strategic focus for the organization. It calls for working together across the organization to achieve the core goals of universal access to sexual and reproductive health (including family planning), promotion of reproductive rights and reduction of maternal mortality. The Business Plan calls for the implementation of the UNFPA Strategic Plan 2012-2013 through the adoption of two clusters — the Women's

Men ask reproductive health questions at a 'School for Husbands' meeting in Niger. *Credit: UNFPA Niger*

Reproductive Health Cluster and the Adolescents and Youth Cluster.

The Chiefs of the Commodity Security Branch and of the Reproductive Health Branch have been appointed to serve as cluster leaders for the Women's Reproductive Health Cluster and Adolescents and Youth Cluster, respectively. Consultations and planning meetings have resulted in the identification of pilot countries for intensive implementation of the approach for which work plans have been developed. The aim is to work across all the units of the organization and at all levels (headquarters, regional and country) to support the priority countries design and implement programmes aimed at maximizing results related to women's reproductive health and young people, taking into consideration very critical dimensions such as gender and human rights, generation of data and research for evidence-based programming, advocacy and policy dialogue. The clusters will support the alignment of the Thematic Funds and other programming activities especially at the country level. The intent of the clusters is to ensure cohesive work among the Technical Division units, Thematic Funds, Joint Programmes, and Regional and Country Programmes to achieve results of the Strategic Plan.

5.10 Executive Director's Task Team for addressing unmet needs for family planning

The arrival of a new Executive Director and subsequent re-evaluation of policies and programmes, and the Mid-Term Review of UNFPA's Strategic Plan (2008 to 2011), have encouraged the agency to pursue an even greater focus on family planning. One step in this direction is reaching out to key partners for support towards building country capacity to deliver better results on family planning. During an interaction with donors and partners of UNFPA, the new Executive Director called for the establishment of a task team that would serve as an advisory panel and assist UNFPA in work in a cohesive manner in partnership to address the challenges for reducing unmet need for family planning.

The Task Team is expected to work in an advisory capacity with UNFPA to support partnership efforts to determine the current magnitude and cost estimates of unmet need for family planning and maternal health service delivery; support UNFPA's effort to prepare and adopt a revised GPRHCS Strategy Document (2013–2018); and provide strategic guidance for the finalization of the UNFPA Concept Note on Family Planning. Other priorities include supporting evidence-based advocacy and resource mobilization for RHCS and for reproductive health including family planning, ensuring effective coordination and harmonization of efforts to revitalize family planning, and focusing on upcoming miles-stones as advocacy opportunities. Members of the Task Team include partners such as key bilaterals, NGOs, technical institutions and private sector enterprises.

5.11 Bill and Melinda Gates support for strengthening transition planning and advocacy at UNFPA

When the new Executive Director of UNFPA was appointed in January 2011, work was initiated for project support by Bill and Melinda Gates Foundation. The proposed grant would support the Executive Director and his leadership team to:

- Work on a new Business Plan and revised Strategic Plan to encompass stronger family planning service delivery and information in all relevant programme areas such as adolescent and youth programmes, sexual and reproductive health programmes, HIV prevention and demographic analysis;
- Strengthen its internal monitoring systems to better track resources allocated to this area; and
- Support UNFPA's advocacy with other major donors and select target countries to increase their focus on meeting the unmet need for reproductive health including family planning.

Activities to be undertaken with the grant will be complementary to issues supported by thematic funds such as the GPRHCS and MHTF. The grant of $1,500,000 was awarded to UNFPA in 2011 to be utilized by September 2013. The resources will support activities that are complementary to the results and milestones of the thematic funds especially the GPRHCS and MHTF.

5.12 Capacity Building in Procurement workshops

Workshops for Capacity Building in Procurement were conducted in Mongolia, Mozambique and Mali resulting in 74 participants trained, including 15 trainers. It is envisaged that trainers advancing in this area may become

future co-facilitators in other countries in their region when the language permits, thereby promoting South-South collaboration.

Training leads to institutionalization

In 2010, UNFPA reported on the success in Mongolia with institutionalizing the Procurement Training Package in collaboration with the MOH, the University of Health Science and their School of Pharmacy faculty. Much of this success is attributed to the fact that some of the trainers trained were professors at the School of Pharmacy and thereby able to establish viable continuity of the training. In 2011, other participants put forward the suggestion to address the weaknesses in the procurement laws. The facilitated workshops are conducted at the line manager level, thereby allowing persons with reasonable influence and good insight into the processes to generate change where needed and to allow discussions and recommendations that lead to key results, with a wider impact.

In March 2011 and backed by the School of Pharmacy, the core group met again with the guidance of UNFPA Procurement Services Branch to re-visit the composition of their tender documents in order to allow these documents to be utilized for Long Term Agreements. In addition, the evaluation methodology developed to meet higher quality standards for medicines was reviewed, and guidelines were prepared to allow the group to work on a proposal for submission to Parliament. A spin-off from this work, as had been suggested during the training, was the increased transparency through applying the higher quality standards in the evaluation process, thereby addressing corruption. Parliament received the proposal in June with positive reviews and subsequently approved the amendment bill necessary to implement the new procurement laws.

E-learning addresses human resources need

Many countries say their biggest challenge in training is the rotation of staff in governments, especially at the lower levels. To meet this challenge the strategy has been to train trainers but also to develop e-learning and make it accessible to all external partners. An e-learning module at the basic level was developed in 2011 and at the time of writing this report, is ready to go live and be translated from English to French and Portuguese pending funding. Participants in the workshops have also demonstrated a keen interest in using this module which generates a certificate upon successful completion.

The module also introduces other UN organizations and their strategic areas of supply where economies of scale can be achieved, catalogues viewed for prices and specifications and delivery times planned. It is also envisioned that this module may be expanded to include the 'how to' training for the AccessRH platform for online purchasing. As in previous years, the training package was expanded and updated in 2011 and translated to Portuguese to accommodate training in Mozambique. All new modules were translated to French and updated from the original 2009 model.

Other activities strengthening procurement

For Mozambique, it is foreseen that a capacity building strategy will be developed. A Gap Analysis was commissioned in 2010 and it would appear that the outcome, although containing highlights of many serious issues related to personnel capacity, has not been addressed. The 2011 training workshop was the first effort which took account of the analysis, with key results to be presented in 2012 results.

An educator in Toukoro Woloma shares family planning information.
Credit: UNFPA Burkina Faso.

Mothers in Senegal learn about reproductive health, including family planning. *Credit: UNFPA Senegal*

In Mali, training revealed a large gap in sufficient numbers of personnel in key technical areas, such as pharmacists. Given the current situation in the country, it is difficult to assess what can be done in the immediate term. However, in the long term the programme would benefit from support to the pharmacy faculty. In all countries where training has been undertaken, pharmacists are the group that captures procurement most readily (apart from procurement personnel).

In November 2011, UNFPA co-financed and co-facilitated the 2nd Conference of the Pharmaceutical Society of Papua New Guinea. The event focused on capacity building. Having embarked on an ambitious programme to generate more pharmacists and procurement specialists, Papua New Guinea is looking to obtain more capacity building options and looking at a variety of financing methods. GPRHCS therefore became the focus of the meeting in generating discussions on a variety of solutions, e.g. AccessRH, capacity building and technical assistance.

A new newsletter was launched in December 2011 that captures the updates of Procurement Capacity Building in GPRHCS and other areas of UNFPA PSB (e.g. Quality Assurance and AccessRH). As annex to the Newsletter a dashboard was developed to share the progress in this area of countries and to inspire others to follow suit.

5.13 Condom programming

UNFPA is the largest public-sector procurer of male condoms and the second largest of female condoms in the world. Within the UN system, UNFPA is the lead agency for all aspects of condom programming. Condoms must be universally available – either free or at low cost – and marketed widely to motivate people to use them. They are the only method available that offers dual protection from sexually transmitted infections, including HIV, and unintended pregnancy. UNFPA promotes comprehensive condom programming (CCP), which seeks to ensure that those at risk of STIs, including HIV, and unintended pregnancy:

- are motivated to use male and/or female condoms;
- have access to quality condoms; have accurate condom information and knowledge;
- use condoms correctly and consistently.

Comprehensive condom programming is an integrated approach consisting of leadership and coordination of partners, demand, supply and support functions.

In UNFPA, support for CCP is provided by the HIV/AIDS Branch, in close collaboration with the GPRHCS, the Humanitarian and Procurement Services Branches. These four entities have distinct but complementary roles and responsibilities to have a maximum impact at country level. UNFPA plays a key role in the Global Condom Initiative, which was launched in 2005 to increase both demand for, and supply of, condoms at the national level. CCP activities include support for governments of low- and middle-income countries to advocate for the removal of laws and policies that prevent condom access and utilization by key populations, such as young people, men who have sex with men, to establish a budget line for male and female condoms, and to allocate adequate national financial and human resources to procure and programme these commodities. This includes motivating users, strengthening service providers and developing educational materials to promote consistent and correct condom use.

Support to condom programming

In 2011, UNFPA's Global Programme on RHCS continued to contribute to this initiative. The following activities are selected examples of support to condom programming.

More than 875 sex workers in Ethiopia received training as peer educators in a series of 35 two-day training sessions by the Wise Up programme and its partner Timret Lehiwot Ethiopia in 2011. Training focused on HIV/STI prevention and other risks to sex workers. Wise Up promotes the proper and consistent use of condoms among sex workers and their clients using outreach, peer education, campaigns and IEC/BCC.

In Lao PDR, an advocacy meeting to initiate a national document and coordination mechanism for comprehensive condom programme gathered the Ministry of Health, Centre for HIV/AIDS and STIs (CHAS) and UNFPA.

A situation analysis for comprehensive condom programming was carried out in Madagascar with UNFPA financial and technical assistance. The Global Programme also procured 1 million male condoms and 100,000 female condoms in 2011, primarily for high-risk groups such as sex workers.

In Mozambique, strong coordination continued between the Condom Programming Coordination Group and the RHCS Task Force, both supported by the Ministry of Health. The Condom Group promotes initiatives that improve forecasting, acquisition, storage, distribution, promotion and condom use as one way to reduce and prevent STIs/HIV/AIDS and unwanted pregnancies. In 2011, activities included training-of-trainers for 28 new trainers in correct and consistent condom use and also training for peer educators in the police force; meetings to support provincial warehouse managers in all provinces; printing and distribution of BCC materials and cataloguing of all such materials and media activities in the country regarding condom programming; acquisition of 230 pelvic models; and condom promotion during a major sporting event. Distribution of condoms to 128 districts in the country included some 68 million male condoms and 1 million female condoms.

Implementation of the comprehensive condom programming strategic plan continued in Sierra Leone. CCP training was provided to 80 condom distributors. In Freetown, 40 youth volunteers received training to promote and distribute condoms in 10 locations, e.g. lorry parks, car wash centres, marketplaces, the university campus and some public offices. About 2,000 pregnant women who received testing and sensitization on HIV/AIDS also participated in training as voluntary peer educators for condom promotion, especially of the female condom. Three networks for CCP have been established. The formation of the Sierra Leone Inter Religious AIDS Network (SLIRAN) has been a major breakthrough in HIV prevention in general and condom promotion in particular; the group is now helping to diffuse myths around condom use. Twelve large billboards featuring popular female musicians helped to promote female condoms. About 3.5 million male condoms and 25,000 female condoms were distributed through CCP activities in 2011. To help facilities report on condom distribution, 2,000 booklets containing 50 pages of condom reporting forms were distributed to partners.

CHAPTER SIX

Key Issues in RHCS

Each year several key issues come to the forefront and claim the spotlight in the annual report. In 2011, the issues selected include: family planning, youth and adolescents, middle income countries, and innovate approaches especially to reach underserved communities. This is not an in-depth analysis but a reflection on some of the many diverse areas of work addressed by the Global Programme to Enhance Reproductive Health Commodity Security.

6.1 RHCS and family planning

Family planning enables women and couples to determine the timing and spacing of their children. It is one of the most cost-effective public health interventions, with far-reaching benefits extending to education and health and economic opportunity. People who practice modern family planning need a supply of contraceptives, including condoms, they can count on. With support from UNFPA, governments in developing countries are creating the conditions for success, ranging from strong national policies to well-stocked warehouses, to health workers trained to provide family planning information and services and ensuring services that are readily available to all including the most underserved groups of the population.

Couple in Cabo Delgado province, Mozambique.
Credit: Frank Guiziou/Getty Images

Family planning is a cornerstone of UNFPA's rights-based approach to promoting integrated sexual and reproductive health (SRH), ensuring that all individuals are empowered to exercise the right to determine the size of their families and the spacing of their children. UNFPA is currently consolidating and redefining its family planning strategy. In recent years, the Global Programme has supported country-driven efforts addressing the supply side, demand side, enabling environment and inter-linkages with approaches for integrated SRH.

In 2011, support tended to focus on the supply side, yet there was also action on the demand side that resulted in expanded access at the community level and improved quality of care. The present monitoring and evaluation framework lacks an indicator on demand creation, making it a challenge to demonstrate progress. Nevertheless, there are numerous examples of that aim to increase the demand for services, particularly among the persons in greatest need, by increasing knowledge and awareness

around family planning for men and women, improving the services' visibility, addressing perceived risks associated with contraception.

Improving access to family planning for women with HIV

A public-private partnership for RHCS in **Swaziland** scaled up access to family planning in all service delivery areas, including sites for standard antiretroviral therapy (ART). Two universities, the Ministry of Health and other partners supported training for more than 150 midwives on modern methods of contraception, along with nurse training for logistics management information (see photo of workshop with Nazarene University graduating midwives). The number of facilities offering family planning services was extended to an additional 24 health facilities in three of the country's four regions (Hhohho, Manziniand and Shiselweni). New data from the Multiple Indicator

Cluster Surveys (MICS 2010/11) and SAM 2010 show improved access to, and distribution of, family planning services for all those in need. CPR has increased from 51 per cent to 65 per cent and unmet need for family planning has decreased from 24 per cent to 13 per cent, according to data in the MICS 2010/11. Progress will be monitored on an annual basis through Ministry of Health reports.

Community mobilization

In **Niger**, the extension of the Schools for Husband to more districts is set to involve many more men in mobilizing their communities to improve reproductive health, in particular though the uptake of family planning and peri-natal cares. In **Timor Leste**, faith-based organizations and religious leaders have joined the UNFPA Country Office to promote family planning among the population. In 2011, the national family planning conference was attended by the President of the Republic and the Bishop of Dili, both of whom addressed the gathering and encouraged their followers to practice family planning for the better health of mothers and children. The church in Timor Leste has now started promoting family planning and CPR has shown an increase during 2011. In **Senegal**, women role models in income generating activities have been used to encourage other women at community level to use family planning services.

Community based distribution

In **Burkina Faso**, the provision of contracts to NGOs is leading to an increase in the use of modern methods of family planning. The approach to integrated community based distribution of family planning services is based on awarding contracts to NGOs at the community level to carry out demand generation (e.g. providing information and referral services for women). In **Zimbabwe**, measures to motivate community based distribution (CBD) agents have strengthened CBD programmes, and the productivity boost launched with DFID support in 2009 was expanded geographically in 2011 to reach new and resettled areas not adequately covered by existing services. The aim is to reduce unmet need for family planning particularly for underserved communities and people living in hard-to-reach areas Results include training in family planning promotion for 345 CBD agents in all of the country's eight rural provinces, including field training and the development and distribution of jobs aids and manuals.

Advocacy for family planning

At the ASEAN Inter Parliamentary Assembly of Women Parliamentarians in **Cambodia**, the RHCS adviser to UNFPA APRO advocated a more proactive role for promoting RHCS and family planning in the region. This supported the goal of the parliamentarian's to accelerate achievement of MDG 5 and they issued a declaration at the end of the seminar that contained a commitment to promote family planning and ensure RHCS in the region.

Expanding family planning in humanitarian settings

As part of the emergency response in **South Sudan**, 54 oral and injectable contraception kits and 22 IUD kits were distributed through partners. UNFPA also entered into partnership with USAID and received a quantity of family planning commodities for distribution. In partnership with American Refugee Committee, more than 42 health care workers and 270 community based distribution agents gained knowledge and skills about family planning, then provided some 2,000 community members across three states in South Sudan with increased awareness and knowledge about modern family planning methods. Training for peer educators increased knowledge of family planning methods and issues among more than 170 young people.

Reducing inequities in access to family planning

Sustained political and financial commitment by increasing access to modern contraceptives in **Nicaragua** has made an impact in unmet need for family planning, in particular by reducing the disparity between urban and rural population by some 10 per cent. In **Madagascar**, CPR is increasing as a result of improved access to long term family planning methods. UNFPA, in collaboration with MSD/Organon, supported the Ministry of Public Health to open 568 new access points for the sub-dermal implant, Implanon, with 704 providers trained in insertion and removal. During this training, there were 605 insertions and 67 removals, with the latter mainly due to a desire for a child.

In **Cameroon**, 20 Community Based Services (CBS) trainers are now trained to train (and retrain) Community Based Services Volunteers in selected health districts in the Eastern Region on RH issues, including family planning. As a result, there are 50 new volunteers in two health districts trained to build community awareness on reproductive health, including family planning, to increase demand and provide a number of contraceptive methods. A song

was produced to raise awareness about family planning, delivery and birth. It is broadcast on television, radio and the Internet.

Ensuring clients get the right contraceptive method

In the Caribbean sub-region, training and printing of materials focused on the Decision Making Tool (DMT) for family planning clients and providers. The DMT was translated into Dutch and 250 copies were printed. In **Suriname**, essential parts were also translated in some of the local Maroon and Amerindian languages. The Facts & Myth Wheel was also translated into Dutch and 300 small wheels were printed to increase usability among health care providers, school and clients in Suriname, while large wheels were printed to be used for training purposes. Dissemination of these tools was called for in the 2010 Annual Work Plan. In Suriname, training reached 109 health workers, covering the main clinic and about half of rural and coastal clinics; another 10 volunteers counselors working with adolescent mothers received training in the DMT. Demand for IUDs and injectables has increased as result, though these options are not generally available.

6.2 Young people and adolescents

Making information, services and RH commodities accessible to youth

UNFPA's focus on adolescents and youth is based on the recognition that young people, particularly those living in poverty, have been virtually ignored in policies and programmes. Adolescents, even married ones, and especially girls, often have little or no access to reliable information and services to protect themselves against unintended consequences of sexual relations. Globally, the number of adolescents and young people is at an all-time high. In 2012, the world had 1.6 billion persons aged 12-24, of which 721 million were adolescents aged 12-17 and 850 million were youth aged 18-24.

Attention to young people's rights and needs has been growing but has not always translated into effective investments. In 2010, a review of national poverty reduction strategies showed that three out of four of them did not identify young people as a major group experiencing poverty despite evidence to the contrary. Furthermore, only 33 per cent of the strategies involved consulting young people. In most regions, the numbers of both adolescents and youth are expected to decline or change little over the coming decades. The fast growth in the number of young people in Africa will likely have profound social and economic implications because it is occurring in places where the proportion of youth who are unemployed and the proportion of working youth who are poor are higher in comparison with adults.[5]

In 2011, the UNFPA Global Programme on Reproductive Health Commodity Security focused more attention towards meeting the unmet needs of adolescents and youth. Issues of concern include early sexual activity, teenage births, risk of death for teenage mothers, HIV and other sexually transmitted infection, genital mutilation/cutting, and forced sex.

Access to family planning services

The Family Planning Association of **Malawi** (FPAM) has increased access to SRH and HIV prevention services for young people and adolescent girls using mobile clinic to reach rural and underserved areas. This has resulted in more adolescents and youth seeking family planning services at FPAM clinics, with an increase from 4,150 in 2007 to 11,095 in 2010. Access to HIV counseling and testing has increased from 5,401 in 2007 to 10,877 in 2011, and access to emergency contraception from 208 to 535 young clients.

In **Uganda**, a multi-faceted strategy in the Yumbe District has resulted in a significant increase in demand and utilization of FP services, from 140 to 804 clients. In addition, men came out strongly to support their partners for use of the long-term and permanent methods, and district political and religious leaders have integrated family planning into their messages to community members when dealing with overall development programmes.

In 2011, Reprolatina and UNFPA continued a second phase of the LAC regional initiative to promote, monitoring, evaluate and scale-up the use of WHO's Family Planning Technical Guidance. Through Reprolatina's technical assistance, providers of adolescent services were trained on the use of the DMT (22 in **El Salvador**, 23 in **Honduras**, 23 in **Bolivia** with the MoH). Twenty two and three providers were trained respectively in each country. The key factor in success is an innovative, participatory educational methodology that goes from theory to practice.

[5] Source: SG report to CPD at its 45th session, April 2012

In Mongolia, pharmacy students train in RHCS as part of the curriculum. *Credit: UNFPA Mongolia*

It has four principles: personal and professional empowerment, knowledge and technical skills, organizational development, facilitation of social and cultural transformation. Results are just coming in, but monitoring visits in El Salvador showed that providers trained by Reprolatina are using the DMT properly and are actively contributing to the improvement of the quality of services.

In **Nicaragua**, adolescent's access to Profamilia NGO services and reproductive health commodities increased, with PRISMA support in the form of methodologies, strategies and guidelines. Teen access through commercial franchises was also improved, as was the central warehouse storage and services. Also, the Health Commodity Center (CIPS) of the MoH conducted a situational diagnosis and developed a plan to enhance management of medical supplies, including RH supplies.

Empowerment and awareness-raising

In **Mozambique**, young girls resort to dangerous and illegal practices to terminate their unwanted pregnancies. The "Bancada Feminina" is a two-hour meeting forum held every week for women and girls between the ages of 12 and 35, who gather to share and discuss their personal and pressing issues related to SRH. It is a platform where participants can exhibit a significant improvement in self-worth and demonstrate the way they negotiate for their own well-being. The young women who attend regularly know more about SRH services and rights.

Members of the African Youth and Adolescent Network on Population and Development (AfriYAN) from 32 African countries met for a workshop in Addis Ababa, Ethiopia, in November 2011. AfriYAN's mission is the promotion and advancement of greater youth participation in Africa's development by strengthening leadership and advocacy skills. Participants prepared presentations on SRH and RHCS, working in liaison with UNFPA RHCS focal points in their respective countries; some visited clinics and pharmacies.

A working group was formed in South America for the Prevention of Teenage Pregnancy in Andean countries, and the Latin-American Federation of OBS&GYN Associations (FLASOG) created a work group on teenage pregnancy in girls under the age of 15 in Latin America and the Caribbean.

6.3 RHCS and middle income countries

Middle income countries (MICs) are countries that fall into the middle-income range set by the World Bank's World Development Indicators. In a number of middle-income countries, insufficient resources are devoted to health care services and in cases where these are sufficient, inefficiencies make them scarce. Additionally, the RHCS policy sphere struggles to compete for resources with other public health issues or simply traditional unsolved health policy and financing related issues as well as logistic management inefficiencies across public health services threaten sustainable improvement. Progress towards Reproductive Health Commodity Security is also challenged by political, economic and structural changes including health sector reforms. CPR averages overlook disparities among and within countries.

The GPRHCS support to MICs has largely been directed to support a few selected countries in Latin America and Eastern Europe. It is not the moderate financial contributions that determine the UNFPA role in MICs, but the organization's ability to offer high-quality and timely policy and technical advice complemented by advocacy, coordination, and networking. Focused upstream technical assistance is yielding positive results, This support is helping to develop public policies, generate an enabling environment

for policy dialogue, and mobilize political and resources from public funding.

Strengthening systems, mobilizing resources

Technical assistance and evidence-based advocacy in **Ecuador** supported the development of a National Family Planning Strategy led by the MOH and endorsed by Ecuador's President. The first stage was to build a common understanding and technical basis among central and regional MOH representatives on RHCS principles and practice as part of moves towards achieving universal access to family planning. In addition, the government centralized the procurement of commodities in what was previously a decentralized system as a result of evidence based research supported by UNFPA. As part of this process, the government signed a third party procurement agreement with UNFPA. During the period November 2010 to February 2011 some US$7 million of government funds were channeled through UNFPA for the procurement of RH commodities. (The GPRHCS investment on capacity development during the last three years has totaled US$701,061.)

For the first time, **Kazakhstan**'s Government allocated resources from the central budget to cover the needs of contraceptives for 100 per cent of women with identified contraindications to pregnancy, including sexually active adolescents, subject to consent of their parents or legal guardians. Though there is no separate budget line for contraceptives, the assessed amount is $300,000. This is attributed to evidence-based advocacy and public opinion. Also in 2011, UNFPA supported the analysis of family planning cabinets against WHO standards and a rights-based analysis of women's access to sexual and reproductive health and family planning. Both reports were presented at a national-level meeting with led by the National Commission for Women Affairs and Family-Demographics Policy under President of Kazakhstan, and with the Ministry of Healthcare.

A results-based budget planning process in **Peru** supported the Government's efforts to generate a cost structure and to train regional authorities to incorporate LMIS costs into the annual budget planning process. In addition, technical assistance improved the implementation of the supply chain distribution system in remote rural zones. Peru's government increased the corresponding budget allocation by approximately 100 million soles (US$ 35.7 millions) for maternal health and family planning, including activities to reduce unmet need in family planning. The technical assistance also focused on conducting a study to determine how demographic trends will alter health profiles and together with a costing exercise of RH package is used to identify budget needs to address future health demands. (The GPRHCS investment on capacity development during the last three years has totaled US$346,675.)

Panama's technical assistance programme started with an assessment of the Public Supply Chain followed by the establishment of a National RHCS Committee. This led to the development of a National Logistic Management System plan. As part of the plan, Panama received technical assistance to standardize commodities supplies storage practices with the development of National Guidelines for Storage and Warehousing. The government is currently procuring commodities for a total value of about US$ 1 million per year, starting in 2011 through UNFPA to secure the supply of quality modern contraceptives nationwide. (The GPRHCS investment on capacity development during the last three years has totaled US$221,546.)

UNFPA is the sole ongoing supplier of contraceptives to the public sector in **Tajikistan**, where in 2010 and 2011 'top up' of the logistics management information system is increasing national ownership and accountability in family planning programmes. Progress included the rehab and expansion of central and regional storekeeping warehouses, including fully-functional LMIS and data reporting; provision of two trucks to distribute supplies to remote mountainous areas; and ongoing advocacy to promote ownership and sustainable funding at all levels.

Uzbekistan's new logistics management information systems (CLMIS) is now operational nationwide, a survey confirmed in 2011, with complete government leadership and ownership. UNFPA support has included evidence-based advocacy, provision of some office equipment, technical advice and training. Training for LMIS in 2010 and 2011 reached more than 1,700 service providers at the primary health care level in all provinces of the country.

The GPRHCS can play an important catalytic and strategic role supporting MICs to advocate for more resources and to mobilize political and social support for RHCS. Effective areas of focus include collecting data and using it for evidence-based advocacy, addressing disparities in access to family planning among underserved populations,

advocacy to leverage and to mobilize resources from the country, donors and the private sector; capacity building in RHCS-related issues for staff and partners; facilitating South-South cooperation and building regional and/or sub-regional platforms; and promoting the participation of civil society in decision-making and monitoring of RHCS and family planning implementation. Greater support for FP and all other RH services along the continuum of care is needed to achieve MDG 5b. Efforts must focus on reducing the disparities in access and use, especially by reaching the most vulnerable or disadvantaged groups and meeting the specific needs of the young people.

6.4 Innovations to reach the underserved

Leaps forward can be made when an initiative takes an innovative approach that can be scaled up not only in the country of origin but in many countries facing similar challenges. Playing a catalytic role in nations is a priority for the Global Programme, and such innovations offer special opportunities as good practices to be widely shared.

6.4.1 Engaging men to improve reproductive health: The Schools for Husbands in Niger

Men can be a powerful ally in women's access to reproductive health services. The Government of **Niger** in collaboration with UNFPA has developed the strategy ***Ecole des Maris*** (Schools for Husbands), which is an initiative to involve men in the promotion of reproductive health and promote behavioral change towards gender equality. Niger has one of the highest maternal mortality rates in the world.

In 2007, UNFPA conducted a qualitative study that found men were one of the main obstacles to women's access to RH information and services. In 2008, the concept of the Schools for Husbands was defined with the Ministry of Health and a participatory stakeholder workshop gathered all involved parties, i.e. regional administrative and health authorities, health agents, national NGOs and married men from local communities. This participatory approach ensured alignment with the local cultural and religious values, and continues to be used during implementation.

Eleven pilot schools started in two districts in the Zinder region in 2008. In 2010, the strategy was expanded to all six districts of this region, and as of 2011, a total of 131 schools are operational in Zinder. In another region, Maradi, 46 schools were established in 2011. The target group is married men, 25 years or older who, as unpaid volunteers, participate in sensitization on the importance of RH services.

A School for Husbands is a place of discussion, decision making and action. There is a spirit of volunteerism and community involvement, with the emergence of husbands as responsible actors in their own development. All members are equal; the school is structured but not organized into a hierarchy, which reinforces a united group spirit. The principles of active listening and mutual respect are essential. In order to ensure this equality within the group during each meeting, a different member is identified to gather information (such as the RH indicators from the local health centre) and facilitate the discussions, which reinforces the principle that all members are leaders. The aim of *Ecole des Maris* is to make the husbands role models for their community and thereby bring about change.

In general, there are 8 to 12 members per school, and no more than five schools per health centre. Selection criteria, determined by husbands, are adaptable but often are as follows: to be married, to allow your wife (or wives) to use RH services, to be at minimum 25 years old, to volunteer (unpaid), to accept participation by your wife (or wives) in local associations, to be available for your school, to possess moral values, to advocate harmony in your family, to support your family. A school meets two times per month to discuss and analyze specific challenges related to RH in the community, and to propose solutions. For example, a school may notice a decrease in prenatal consultations and decide to conduct sensitization by identifying the pregnant women in the village, and visiting their husbands to discuss any obstacles.

To support the schools, two local NGOs supervise each school. One NGO is specialized in capacity building and community work, and is in charge of what is called the 'coach' – a leader responsible for 10 to 12 schools. The coach monitors the capacities of each school, assists in implementing activities, and assists in bi-monthly meetings. The coach helps the group to resolve problems and find appropriate solutions. The coach also assists the group in developing an action plan and monitors the progress. To facilitate this work UNFPA Niger and its partners have developed what is called a Monitoring Journal (Cahier de

Suivi). The second NGO bring technical reinforcement by providing counseling and information on RH services (prenatal care, contraceptive methods etc.), to ensure the husbands access to knowledge. In addition to the coach, a 'moderator' assists the school. This person may be a local health agent, midwife or religious leader. There is close collaboration with the local health agents and structures such as the administrative and traditional authorities, which ensures the strategy's sustainability.

Members of the regional health structures, local health agents and coaches receive a four-day training in the strategy of *Ecole des Maris*. The husbands also receive a training which is based on four modules: leadership; group dynamics; coaching techniques; and communication techniques, advocacy and negotiation.

A key challenge in this strategy is how to ensure a continuous motivation of the husbands. Responses include the exchange of good practices and efforts to motivate the members to continuously approve their results. Not all schools can be expected to work well and UNFPA Niger has closed down around 10 schools that did not show enough motivation. Another challenge is to ensure transfer to the next generation. A mechanism is being developed to integrate young men in a sort of preparation phase to their adult life, where the members work with these groups to sensitize them on RH issues.

Documented results include (1) behavioral change amongst men, from conservative attitudes to involvement and commitment of men in favor of RH with better dialogue, listening and understanding of health issues observed since the husbands have joined Ecole des Maris; (2) improvements in RH indicators, e.g. the RH indicator on postnatal consultations in the Bandé community in Zinder increased from 13 per cent in the first trimester of 2009 to 40 per cent in 2011; (3) Results beyond initial objectives include construction of public lavatories for health centres, construction of houses for midwifes to allow better RH services, and participation of members in sensitization during vaccination campaigns and other health activities.

The coherence of *Ecole des Maris* with socio-cultural and religious values ensures appropriation of the strategy. Also, the fact that members contribute actively and have a role to play in the development of their community keeps them motivated for the voluntary work. Monitoring visits shows an outside interest in the husbands' results and represents opportunities to demonstrate their work. An integrated approach ensures a good synergy amongst actors and structures involved, e.g. NGOs, health centers, religious and traditional leaders. The involvement of men in the promotion of RH is a decisive positive factor of behavioral change, based on access to accurate information on RH, contraceptives, prenatal care, etc. The personal involvement of each husband allows a better understanding and helps to put an end to certain taboos and misconceptions.

Ecole des Maris is based on participatory approach wherefore it can be easily adapted to the values and needs of a community and replicated in many other settings. The strategy has had a positive impact on RH, but can easily be adapted or expanded to other thematic areas depending on the priorities of each context. UNFPA Niger is planning to integrate thematic areas such as forced marriage and prevention of malnutrition, reinforcing and continuing the development of the husbands' capacities and knowledge. *Ecole des Maris* has been implemented by the Gender and Human rights component in Niger, but with the amelioration of RH as a main objective, which has ensured a less "medical" approach with a stronger focus on behavioral change and enhanced linkages in programming.

6.4.2 Bancada Feminina: A space to address sexual and reproductive health and rights in Mozambique

Empowering women and girls is the aim of the *Bancada Feminina* (Women's Caucus) in Maputo, **Mozambique**. For two hours each week, women and girls between the ages of 12 and 35 years meet at several locations in Maputo to discuss personal and pressing issues related to sexual and reproductive health. This initiative was launched in 2008 and has now emerged to become a popular event among the target audience. Between 20-70 participates take part in this meeting forum each time that takes place, at locations including *Associação Moçambicana para Desenvolvimento da Família* (AMODEFA), community centres, schools, and the office of the *Gabinete de Atendimento a Mulher e a Criança Vitima de Violencia*, which receives victims of violence.

Participants come from a broad range of socio-economic and educational backgrounds. Some live in the city and some in the communities on the outskirts of the Maputo. At every meeting forum the group decides the issues to be discussed, which often include issues related to partners,

use of contraceptives, abortion, gender equality, small-scale business opportunities, decisions related to reproductive health, and violence against women.

Young female coordinators from AMODEFA facilitate the meeting forums. They have been trained in human rights, sexual reproductive health and other social areas related to women. Sometimes special guests are invited to take part in the discussion, serving as role models.

One of the main challenges is related to the continuity of the intervention as the women and girls, sometimes due to other obligations, miss various meetings; the consistency of the impact decreases as a result. Another challenge is the reluctance of some participants to share their problems or issues in the group discussion, which may be attributed to shyness and passivity. Some participants face challenges in moving forward to apply the new knowledge, ideas and strength in their daily life. The age difference between girls of 12 and women of 35 has been an obstacle for some younger girls, who do not feel comfortable and confident enough to share their problems with the group.

The concept of *Bancadas Femininas* is gaining exposure through advocacy and is being replicated by several local NGOs and integrated into the efforts of AMODEFA partners. Young women themselves report improvements in their level of decision making with respect to their sexual reproductive health, rights and self-esteem. Another positive result is the involvement of the men in the forums. Media coverage, notably by national television, has mobilized more women to attend.

A choice of modern contraceptive methods in Madagascar.
Credit: UNFPA Madagascar

Current national policy in Mozambique provides several opportunities for the advancement of adolescent and youth sexual and reproductive health and rights and HIV prevention. However, progress has been more visible at policy level than in service delivery and increase of demand. In Mozambique, it is traditionally taboo to discuss sexual and reproductive health with adolescents. Lack of employment and educational opportunities, and the social and cultural environment, contribute in many cases to an early sexual activity among young people – often unprotected – which put them at risk of several SRH related illnesses. Many girls and young women become pregnant, drop out of school and suffer severe social stigma for dishonoring their families. Young girls turn to abortion, which is illegal, and risk dangerous practices. Some 41 per cent of girls aged 15-19 years are either mothers or pregnant; 36.8 per cent of the total number of maternal deaths (500/100,000 live births) occur among women aged 15-24 years; and girls and young women are four times more likely to be infected by HIV than boys and young men. It is especially important to create a comfortable space for dialogue and exchange of views and experiences across the young people.

6.4.3 Institutionalizing RHCS within university curriculum for pharmacists in Mongolia

Long-term sustainability and national ownership have been the cornerstones of the support provided by GPRHCS to member countries. In **Mongolia**, the Government in collaboration with the Asia Pacific Regional Office of UNFPA, created a plan to incorporate RHCS trainings in the ongoing curriculum of School of Pharmacy of the Health Sciences University of Mongolia so that all new pharmacists in the country who graduate after 2015 will have received training and skills in various aspects of RH commodity security during their university years.

A Memorandum of Understanding was signed by the Ministry of Health of Mongolia (MoH), UNFPA and the Health Sciences University of Mongolia (HSUM) whereby the regional office agreed to provide technical support for the development of curriculum and also to build

the capacity of the faculty at the School of Pharmacy to undertake the activity. UNFPA supported the participation of teachers of the School of Pharmacy in an international training programme on RHCS conducted by BKKBN (Indonesia) and also in regional and local level workshops. In 2010 APRO provided technical assistance in development of pre-and in-service RHCS curriculum and reviewed the proposed training materials developed jointly by the School of Pharmacy and UNFPA country office.

Three types of training modules were developed for (1) service providers at the grass root levels; (2) provincial RH programme managers and warehouse specialists; and (3) policy makers. APRO provided support for developing and improving the facilitation skills of the faculty and ensured that the trainings were practical and skills-based. The modules have now been developed and reviewed. The trainings for in-service staff were initiated in 2011 and the first trainings for pre-service students are expected to roll out during the academic session in 2012.

6.4.5 How civil society organizations monitor health commodities for accountability and transparency in Sierra Leone

UNFPA supports the Health for All Coalition – a civil society organization in **Sierra Leone** – to work towards the establishment of a robust, independent monitoring and evaluation system that will monitor health commodities at all levels and ensure that sustainable mechanisms are in place for the procurement and supply of reproductive health commodities.

This approach is an innovative response to a challenging situation. More than 50 per cent of drugs and medical supplies meant for public health facilities went unaccounted for in Sierra Leone, both before and after the end of the civil war. Until 2011, Sierra Leone had no budget for reproductive health commodities, despite the high maternal mortality ratio (857 per 100,000 live births). The drugs supply chain management system faced many challenges:

- poor accounting and transparency systems;
- poor record keeping, management and reporting for drugs;
- general lack of stewardship of the drugs and supplies;
- ineffective drugs distribution system;
- stock out of essential Family Planning and RH life-saving drugs and supplies;
- theft of drugs meant for public health facilities being recycled to private pharmacies, sold in the street or smuggled to neighbouring countries.

In 2009, the Ministry of Health and Sanitation introduced CHANNEL, an electronic logistics management information system (LMIS) to manage and track health commodities, with support from UNFPA that also included logistics support and the upgrade of some medical stores. In April 2010, the Government of Sierra Leone, with support from its development partners, introduced the Free Health Care Initiative with the aim of providing accessible, affordable and quality health care to pregnant women, lactating mothers and children under five.

Government and development partners saw the need to strengthen the drug supply chain management system through oversight and performance monitoring. This would address the problems in the health system and help to achieve the successful implementation of the free health care initiative. A key role was awarded to a civil society organization (CSO) active in 'voice', accountability and advocacy in the health sector. The Health For All Coalition-Sierra Leone (HFAC-SL) was contracted, with support from UNFPA, to undertake monitoring of health commodities and supplies, advocate for a sustainable drugs supply management system, and advocate for including funds for RH commodities in the national health budget.

The aim is for the Health For All Coalition to contribute to a robust, independent monitoring and evaluation system. This system will monitor health commodities at all levels and ensure that sustainable mechanisms are in place for the procurement and supply of RH commodities.

The approach is working. It is effective in improving accountability and transparency in the management and use of health commodities in Sierra Leone. The Health For All Coalition has encouraged health personnel to change their attitude and be more responsible in the management and use of public goods. A close monitoring strategy – from the quay and airport to central medical store, to district medical stores and peripheral health units – is showing results: theft of drugs has been reduced, availability of drugs at facility level has increased, and access to health services and drugs has increased. This partnership between the Health For All Coalition and UNFPA is yielding demonstrable results:

- Incidences of interception of stolen drugs have decreased by 25 per cent from 2010 to 2011;
- Leakages of drugs and supplies have been reduced. For example, HFAC drug monitors discovered a total of 450 cartons of excess drugs worth $85,000 and returned them to the central medical store. Also, 24 CCTV cameras have been installed in the Central Medical store;
- Accountability in the management and use of drugs has increased: The percentage of drugs accounted for increased from 50 per cent prior to 2010 to 93 per cent in 2011;
- More women and children under five are accessing free health care: In 2011, deliveries in health facilities increased by 45 per cent; uptake of family planning methods increased by 140 per cent; and children under five accessing health care increased by 214 per cent.
- Sierra Leone made a budget allocation for RH commodities for the first time in 2011, of approximately $165,000.

A sign of success is an MOU with DFID, UNICEF and the Anti-Corruption Commission that recognizes HFAC's legitimate and formal monitoring function.

Challenges to implementation have been effectively addressed. When health care providers rejected HFAC drug monitors as policing rather than complementing their work, HFAC met with key officials in the MoH and set up a sensitization tour in all 14 districts across the country. At district level HFAC met with all in-charges and store managers to raise awareness on roles and responsibilities. When HFAC reported evidence of misuse and no action followed, HFAC engaged directly with the Minister of Health and other high-level officials and partners including the Anti-Corruption Commission. HFAC now reports directly into the Health Sector Coordinating Committee, and presents reports to the President of Sierra Leone in the presence of senior government officials and the UN, donor community, NGOs and civil society. When funding and logistics hindered HFAC monitors at district level, a full review was conducted and reviewed with donors. UNFPA equipped HFAC with two monitoring vehicles, 14 motorbikes, four digital cameras, one photocopier and a printer. When HFAC found it difficult to obtain information and documents, a drug distribution matrix was created with UNFPA, DFID, MoHS and UNICEF featuring every stakeholder in the drug distribution process. Strategic response to obstacles is a key to success.

6.4.6 Bajenu Gox: Training 'grandmothers' to assist pregnant women in Senegal

The community approach to promoting maternal health has been strongly developed in Senegal, particularly through the ***Bajenu Gox*** ('godmothers' or 'grandmothers') who promote good maternal and newborn health practices in each village. UNFPA provided technical and financial support to formulate the Bajenu Gox strategy and to train the first 56 women in the district of Kolda – all recognized as leaders in their communities. With continued UNFPA support, more than 1,200 women in three regions have received training to become *Bajenu Gox*.

In 2009, the President of the Republic called for the establishment of an innovative strategy called Community Initiative Bajenu Gox. It is based on traditional values around the involvement of the paternal aunt in monitoring a pregnant woman and the mother-child pair, a tradition of solidarity where the older women assist the younger women with health care. This aunt is represented in the strategy by women community leaders who serve as godmothers of women in their neighborhood or village during pregnancy, childbirth and postpartum.

The strategy aims to accelerate the fight against morbidity and maternal and neonatal mortality for the achievement of MDGs 4 and 5 in particular. It seeks to promote an increase in the use of reproductive health information and services, including family planning and to increase the involvement of local and private sector partners. Challenges include compliance with selection criteria to identify women community leaders, responding to the increasing demand for RH services, and coordination among partners.

UNFPA has provided technical and financial support to the *Banjenu Gox* iniative:

- supporting the programme's formulation and test, including the definition of criteria for selecting and training women leaders for the first *Bajenu Gox* training;
- mobilizing community stakeholders including NGOs and women's associations;
- documenting of the process of implementation in three regions of Kolda, St. Louis and Matam;
- increasing the supply of RH information services (in particular family planning) through advocacy, securing contraceptive supplies, producing equipment, and training of health personnel with a focus on long-acting methods of modern contraception;

- improving acceptance of the programme, in particular among men, by focusing on the choice of women leaders in each community at the start of implementation;
- building capacity of the *Bajenu Gox* (1,236 trained in the three regions at the time of the study) on reproductive health including family planning, to enhance the dissemination of messages and minimize misconceptions;
- mobilizing additional technical and financial partners;
- mobilizing political commitment at all levels to a community initiative based on social values;

This programme is set to increase demand and use of RH services, including family planning, services, and contribute strengthening the health system by providing qualified personnel through a suitable technical platform. The programme aims to address the high rate of maternal and neonatal mortality and the challenges of achieving MDGs 4 and 5. The acceptances and success of this innovative approach is linked to local social values and the selection by peers of women recognized as leaders in their communities to receive training in topics rarely discussed in the open, yet at the heart of women's health.

6.5 UN High Level Meeting on Reproductive Health Commodity Security

Left: Mrs. Sia Nyama Koroma, First Lady of Sierra Leone. Panel: Mrs. Helen Onma Mark, spouse of Senate President of Nigeria; Mrs. Sia Nyama Koroma; UNFPA Executive Director Dr. Babatunde Osotimehin; Ms. Julia Bunting, Leader of the AIDS and Reproductive Health Team, DFID. Right: Mrs. Helen Onma Mark. *Credit: UNFPA*

First ladies, ministers of health and parliamentarians numbered among the 80 people present at the first High Level Meeting on Reproductive Health Commodity Security, 7 and 8 September 2011 in New York. It provided an opportunity to share experiences among 12 priority countries in the UNFPA Global Programme to Enhance Reproductive Health Commodity Security. Panel discussions focused how to mobilize political and financial resources, how integrate supply management in national health systems, and how to provide access to family planning services for underserved communities. In opening remarks, Dr. Babatunde Osotimehin, Executive Director, UNFPA, called on the countries to put resources in their budget to meet the needs of their women and girls.

A report to the UNFPA Executive Board was presented by H.E. Zainab Hawa Bangura, Minister of Health and Sanitation in Sierra Leone. "As countries, we shared our experiences and reported on what we have achieved, especially in the four years since the Global Programme was launched. Countries reported unprecedented progress in the use of modern methods of contraception, with CPR (contraceptive prevalence rate) often increasing by as much as 4 or 5 percentage points per year on the average. This has helped to reduce rates of maternal death and prevent HIV infections," she said.

"We are achieving notable successes by directing sustained, multi-year funding towards underserved populations and by building the capacity of our health systems. Many of us described how our integrated supply management systems are reducing costs, making effective use of resources, and reducing wastage," she continued.

Participants attended from Burkina Faso, Ethiopia, Haiti, Lao People's Democratic Republic, Mali, Madagascar, Mongolia, Mozambique, Nicaragua, Niger, Nigeria and Sierra Leone. In a Call to Action, (see Annex 5) the distinguished group declared: **"Comprehensive sexual and reproductive health services including for voluntary family planning, ensured by a secure supply of reproductive health commodities, is a national priority for saving women's lives, improving maternal health and preventing HIV."**

CHAPTER SEVEN

By the Numbers

Much of this report has focused on programme results., The management of the GPRHCS is also closely monitored and reported with specific reference to 10 indicators in the monitoring and evaluation framework. These indicators are focused on adherence to programme guidelines, timely completion of tasks and tracking regional and headquarters implementation of activities. They provide a way of gauging how well the programme has been managed during the year.

7.1 Programme management

Table 37 shows the performance levels relating to the 10 management indicators. The average implementation rate for the GPRHCS countries was 89 per cent in 2011, almost the same as in 2010 (88 per cent). The average implementation rate for Stream 1 countries in 2011 was 88 per cent and for Stream 2 countries it was 92 per cent.

About 74 per cent of the countries submitted budgeted work plans to their respective regional offices compared to 90 per cent in 2010. The reduction was due to unexpected cancellation of the annual review process. Most of the work plans submitted were reviewed and finalized by February 2012. As was the case in 2010, all the 12 GPRHCS Stream 1 countries submitted midyear progress reports in 2011. The reports were discussed, peer-reviewed and experiences shared in a mid-year review meeting held in Addis Ababa in June 2011.

For 2011, about 76 per cent of GPRHCS countries submitted both programme report for review by the regional offices with copies to CSB by December compared to over 90 per cent in 2010. The countries finalized the reports based on advice and comments given by both Regional Offices and CSB. However due to the fact that financial closure does not end until end of March and there was need to ensure financial report was aligned to the AWP which would facilitate reporting on the linkage between results and resources, most countries were not able to submit finalized financial reports by the set deadline.

A community-based distribution agent visited this Cameroon family.
Credit: Alain Sibenaler/UNFPA

As is the case for country offices, Regional Offices are also required to submit midyear reports. In this respect, 5 out of the 7 ROs prepared and submitted annual work plans for funding by CSB by mid-January 2011 same as in 2010. The reports were also part of the mid-year review discussions held in Addis Ababa in June 2011.

The 2011 work plans were peer reviewed by CSB, ROs and other COs at regional meetings organized in Dakar (for countries in western and central Africa), Johannesburg (for countries in eastern and southern Africa, and the Arab states region) and Bangkok (for countries in Latin America, Asia and the Pacific, and Eastern Europe and Central Asia). The work plan review meetings also served as experience sharing sessions which made possible an organized presentation in three regional meetings jointly reviewed by CSB and regional offices.

Because the annual planning meetings did not take place in 2011, countries held bilateral work plan review teleconferences with their respective Regional Offices. The ROs provide support for the revision of the work plans before they were submitted to CSB. The revised work plans were further reviewed by CSB and approvals were made for funding of agreed upon work plans. By March 2012, about 76 per cent of countries had their work plans approved. For the other countries, approval was pending due reasons such as the need to submit AWPs in the correct format; and, the need to finalize and submit previous year's narrative and financial report.

Only the midyear review meeting was organized in 2011 for Stream 1 countries and Regional Offices. The annual joint planning meeting could not be held because of the need to realign the thematic funds planning process with the cluster system that emerged as the agencies strategy for programme

Table 37: Programme management indicators, 2011

SN°	Programme management Indicator	Achievement for 2010		Achievement for 2011	
		Number of countries	Percentage	Number of countries	Percentage
1	Number of countries achieving at least 60% of work plan outputs	40 out of 45 countries (11 Stream 1 countries) (29 Stream 2 countries)	88.9% 100% 85.3%	45 out of 46 countries (12 Stream 1 countries) (33 Stream 2 countries)	98% 100% 97%
2	Number of Country Offices with completed and budgeted annual work plan by end of December each year	42 out of 45 countries (11 Stream 1 countries) (31 Stream 2 countries)	93.3% 100% 91.2%	34 out of 46 countries (9 Stream 1 countries) (25 Stream 2 countries)	74% 75% 74%
3	Number of Country Offices submitting mid-year progress report to respective regional offices by 15 June each year	11 out of 11 Stream 1 countries	100%	12 out of 12 Stream 1 countries	100%
4	Number of Country Offices submitting completed annual narrative programme report to respective Regional Offices by 15 December	42 out of 45 countries (11 Stream 1 countries) (31 Stream 2 countries)	93.3% 100% 91.3%	35 out of 46 countries (10 Stream 1 countries) (25 Stream 2 countries)	76% 83% 74%
5	Number of Country Offices submitting completed financial report to respective Regional Offices by 15 December	5 out of 45 countries	10.0%	10 out of 46 countries	22%
6	Number of Regional Offices submitting reviewed AWPs to Technical Division/HQ by mid-January	5 out of 7 regional offices	71.4%	5 out of 7 regional offices	71%
7	Number of Regional Offices submitting mid-year report by mid-July and annual report by mid-January to Technical Division/HQ	5 out of 7 regional offices	71.4%	5 out of 7 regional offices	71%
8	Country work plans reviewed and allocation made by HQ by 1st week of March	37 out of 45 countries (10 Stream 1 countries) (27 Stream 2 countries)	82.2% 90.9% 79.4%	35 out of 46 countries (11 Stream 1 countries) (24 Stream 2 countries	76% 92% 71%
9	Semi-annual and annual progress review/planning meeting organized for all GPRHCS Stream 1 counties by CSB/TD	2 meetings held	100%	1 meetings held	50%
10	Consolidated annual GPRHCS report (programmatic and financial) prepared by end of March of following year by HQ	1 consolidated annual report prepared	100%	1 consolidated annual report prepared	100%

delivery and for implementing the Executive Director's Business Plan. In the face of this development, arrangements were made by various regional offices to review the country AWPs and make recommendations for further consideration by CSB. The final stage of the reviews included holding teleconferences, first with the Regional Offices and where necessary with the Country Offices to have a common understanding of issues to be funded for 2012.

The GPRHCS Annual Report 2011 (programmatic and financial) was prepared in line with the results and indicators in the GPRHCS Monitoring and Evaluation Framework and key strategic activities that were implemented during the year and that have significant bearing on reproductive and maternal health including family planning in general and RHCS in particular.

7.2 Commodity purchases and benefits

One principal component of the assistance to countries has been for the procurement of reproductive health commodities. These include contraceptives, condoms, maternal health medicines and RH kits.

Allocation of funds for commodity purchases

Provision of commodities to countries goes through several steps to ensure that procurement and delivery is done according to laid down procedures and that all parties are involved and in agreement with the basic specifications of each order. Generally, the first step taken is for staff in the UNFPA staff CO to work with the Ministry of Health and other partners to determine the type and quantities of supplies required. This forms the basis of the request, which is then submitted to GPRHCS. All the country requests are analyzed, discussed and validated to determine how to best allocate the funds available to meet the needs of the countries. The validation process involves staff at UNFPA's Country Offices, Regional Advisors, Procurement Services Branch, and other branches at headquarters; Ministry of Health officials and officials from other public health offices.

At the next phase, the Global Programme coordinates UNFPA's response to each country requests with those of other major donors, including USAID, World Bank and the Reprodctive Health Supplies Coalition to share information and avoid duplications. These activities are thoroughly carried out, always mindful of the necessity for a speedy response to calls for help from governments to avert shortfalls of medical supplies.

Contraceptives and condoms

In 2011, the total units of commodities are shown in Table 38 (for contraceptives) and Table 39 (for male and female condoms). The two tables show that commodities are being provided to all streams but proportionately more to Stream 1 countries. Details of specific commodities provided to each country are in the annex.

Benefits of commodities supplied

There are several ways to measure the direct impact of the provision of commodities, including increased contraceptive prevalence rate (CPR), reduced stock-outs, and increased couple years of protection (CYP).

CYP is the number of couples protected from unwanted pregnancy for one year. In its years of operation

What kind of 'commodities' are provided?
Reproductive health commodities and life-saving maternal medicines and devices include:

Modern method contraceptives: Condom, Pills (CCP-combined contraceptive pills, ECP-emergency contraceptive pills, and Phasics), Injectables (3 monthly, 2 monthly, monthly), IUDs and Implants, Essential supplies/commodities for male and female sterilization

Essential life-saving maternal/RH medicines: Magnesium Sulfate, Oxytocin, Ergometrine, Iron/Folate, Amoxicillin, Azithromycin, Clotrimazole, Metronidazole, Benzathine Benzylpenicillin, Cefixime (this list of UNFPA priority medicines is being revised and updated with WHO)

Emergency RH Kits for conflict, post conflict and emergency situations

Medical devices/equipment and supplies on case by case basis
Medical supplies related to EMONC such as autoclave, sterilizer, OT table and lights, anesthesia machine, etc. (refer to the Interagency List of Essential Medical Devices for RH and the H4 list for Medical Devices)

Table 38: Contraceptives provided to all countries in 2011

Stream	Contraceptives				
	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency Oral (doses)	Implant (pieces)
Stream 1	11,198,107	155,200	6,816,946	47,000	117,492
Stream 2	3,655,700	888,650	5,440,525	267,100	169,528
Stream 3	115,800	60,500	1,659,279	1,800	20,524
Total	**14,969,607**	**1,104,350**	**13,916,750**	**315,900**	**307,544**

Table 39: Male and female condoms provided to all countries in 2011

Stream	Pieces of condoms	
	Male condom (pieces)	Female condom (pieces)
Stream 1	89,257,728	1,140,000
Stream 2	156,444,672	2,322,000
Stream 3	7,653,600	81,000
Total	**253,356,000**	**3,543,000**

Table 40: Contraceptives provided to Stream 1 countries in 2011

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency Oral (doses)	Implant (pieces)
Burkina Faso	362,800		698,400		
Ethiopia	6,823,000	50,000	0		
Haiti	408,000		201,000		
Lao PDR	300,000		800,000		
Madagascar	987,600		270,000		41,680
Mali		36,500			51,200
Mongolia	80,000	5,000	100,002	5,000	
Mozambique	768,000	13,500	2,724,480		
Nicaragua	653,000	200	575,000		
Niger	304,200	2,500			2,512
Nigeria	416,507	21,500	759,000		8,100
Sierra Leone	95,000	26,000	689,064	42,000	14,000
Total	**11,198,107**	**155,200**	**6,816,946**	**47,000**	**117,492**

2008-2011, the GPRHCS has provided contraceptives worth 56 million couple years of protection. In 2011, the contraceptives purchased with the monies from the GPRHCS provided about 11.45 million CYP. Refer to the Appendix for detailed data for contraceptives provided to Stream 2 and 3 countries.

The IUD offers the most years of protection, followed by the three-month injectable, implants and the male condom. It is worth noting that, in terms of use, IUDs are still one of the least used methods. Factors include myths and misconceptions on the part of both clients and providers. GPRHCS is working with countries to improve the acceptability of this cost-effective method.

7.3 Finance

GPRHCS contributions and expenditures[6]

The total of funds available in 2011 was $188 million. This included carry over funds from 2010 amounting to $43 million the contributions received by GPRHCS from donors in 2011 amounting to $144.9 million. The

[6] Since the financial closure for 2011 has not been finalized, all financial figures in this report should be seen as *provisional* until actual expenditure is reflected in the certified financial report. All figures are in US dollars.

Figure 33: Couple years of protection (CYPs) of contraceptive methods provided in 2011

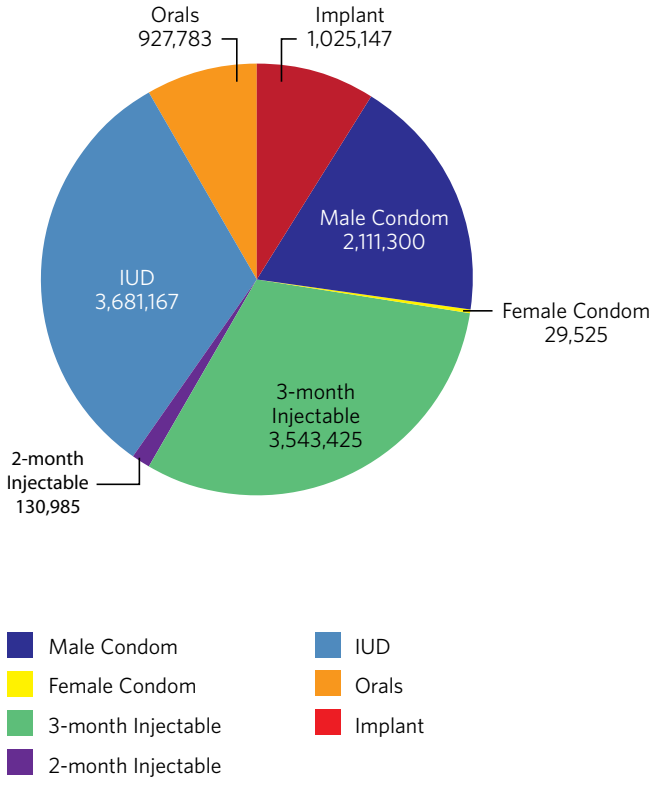


Table 41: Sources of GPRHCS contributions available in 2011

Donors/description	Total amount programmed in 2011	Contributions received in the last quarter of 2011 to be expended in 2012	Total contributions received in 2011
Carry over 2010 funds	43,751,515.86		43,751,515.86
Australians	10,893,246.19		10,893,246.19
Luxembourg	569,800.57		569,800.57
DFID (UK)	20,559,210.53	19,623,233.91	40,182,444.44
DFID (UK)		55,910,543.13	55,910,543.13
Denmark		3,586,157.00	3,586,157.00
Netherlands	29,935,810.00	3,847,973.00	33,783,783.00
Total	**105,709,583.15**	**82,967,907.04**	**188,677,490.19**

donors included Australia, Denmark, Luxembourg, the Netherlands and the United Kingdom (DFID). The UNFPA Global Programme to Enhance Reproductive Health Commodity Security, as always, remains indebted to the generous contributions from its donors.

Of the funds available during the year, $105,709,582 was programmed for expenditure during the year and the remaining carried over to 2012. The carry over included contributions received during the last quarter from three donors. Reporting on the use of the amount carried over will be reflected in next year's report. Table 42 shows that total expenditure for 2011 was $76.3 million, which amounts to an expenditure rate of about 72 per cent.

Of the total amount available for 2011, $32 million was used for the provision of commodities and $44 million for funding capacity development. A comparison of expenditure trends for commodities and capacity for the three years under consideration reveals a steady increase in capacity building but a sharp decline in expenditure for commodities in 2011. This was a result of several factors. Major amongst these was the increasing importance being given by the programme to countries' capacity building efforts, in order to ensure sustainability and system strengthening. Early in the year, priority was therefore given to the release of funds in support of capacity building priorities as articulated by the countries themselves, so as to enable maximum implementation of country annual work plans. Remaining funds were then programmed for commodity purchases. The

Table 42: Breakdown of total expenditure for GPRHCS, 2009 to 2011

Component	Amount per component per year (US$)					
	2009		2010		2011	
Countries	Amount	Per cent	Amount	Per cent	Amount	Per cent
Commodity	70,259,604	80.7	61,771,480	66.0	32,442,226	42.5
Capacity building	16,830,201	19.3	31,780,105	34.0	43,818,543	57.5
Total	**87,089,805**	**100.0**	**93,551,585**	**100.0**	**76,260,769**	**100.0**

Table 43: Breakdown of capacity building expenditure, 2009 to 2011

Region or component	Capacity building expenditure (amount in US$ and percentage)					
	2009		2010		2011	
Countries	Amount	Per cent	Amount	Per cent	Amount	Per cent
Africa Regional Offices	875,589.00	5.2	1,523,808.00	4.8	948,147.00	2.2
Arab States	99,593.00	0.6	104,651.00	0.3	421,032.00	1.0
Asia and Pacific	756,783.00	4.5	805,949.00	2.5	1,126,588.00	2.6
Eastern Europe	180,316.00	1.1	310,573.00	1.0	342,937.00	0.8
Latin America and the Caribbean	640,754.00	3.8	1,482,512.00	4.7	1,065,740.00	2.4
Country level	12,482,476.00	74.2	23,946,158.00	75.3	26,604,000.00	60.7
Global level	775,388.00	4.6	1,783,722.00	5.6	6,546,483.00	14.9
Prequalification and AccessRH	1,019,302.00	6.1	1,822,731.00	5.7	6,763,616.00	15.4
Total	**16,830,201.00**	**100**	**31,780,104.00**	**100**	**43,818,543.00**	**100**

limited availability of funds for commodity purchases was made known to partners and was partly responsible for the relatively large amount of funds provided by some donors, such as DFID, specifically for the purchase of commodities, towards the later part of the year. Although these funds were received too late in the year to be used for the 2011 commodity needs, they were rapidly utilized to address country commodity needs for 2012 and GPRHCS can report that in the first three months of 2012, the programme has spent $86 million for commodity purchases.

Of the $44 million expended on capacity building, about $27 million (61 per cent) was spent at the country level.[7] About 9 per cent of the capacity building resources were expended at the regional level; 15 per cent at the global level; and the remaining 15 per cent expended on Prequalification, procurement related activities and the AccessRH project.

About 58 per cent of the expenditures were for capacity development and 42 per cent for the provision of commodities. Capacity building expenditures have increased from 19.3 per cent of funds utilized in 2009 to 34 per cent of funds utilized in 2010 to 58 per cent of funds utilized in 2011.

Trends in commodity provision and capacity development

According to Figure 34, the relative percentage expenditures show that where as more resources were spent on commodities in 2009, the situation has been gradually reversed with a higher percentage of funds being spent on capacity building in 2011.

There was a decline in total GPRHCS expenditures on commodities from $70.3 million in 2009 to $32.4 million in 2011. Within the same period total expenditures capacity building have increased steadily from $16.8 million in 2009 to $44 million in 2011.

The general trend in expenditures for commodities and capacity building is a reflection of the support provided to the countries. There has been a general disposition for

[7] Capacity building expenditures go towards meeting the needs of countries in areas such as human capacity building including training; institutional capacity building; national plans and policies; supply chain management; family planning demand creation, awareness raising and advocacy; support for reproductive health service delivery; surveys and documentation; partnerships; and and programme management, supervision and monitoring.

Figure 34: GPRHCS expenditure on commodities and capacity building, 2009 to 2010

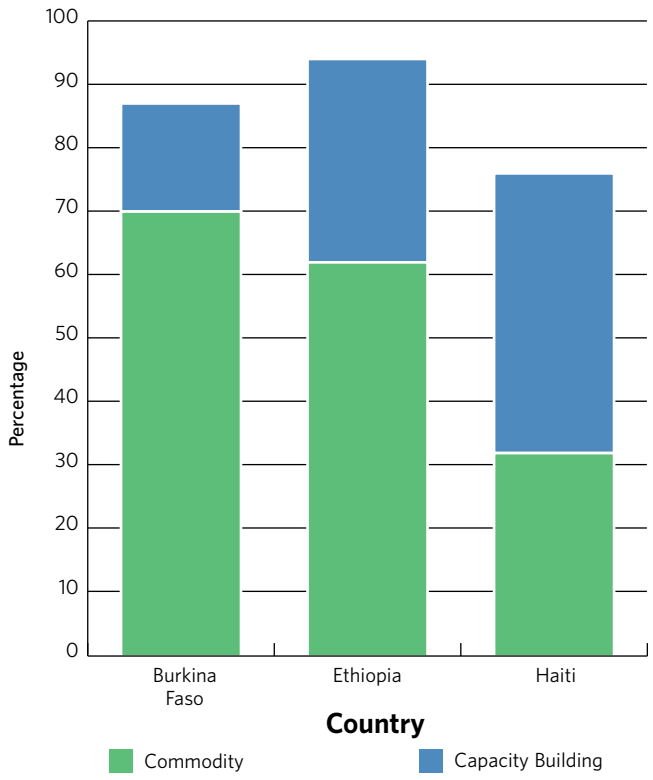
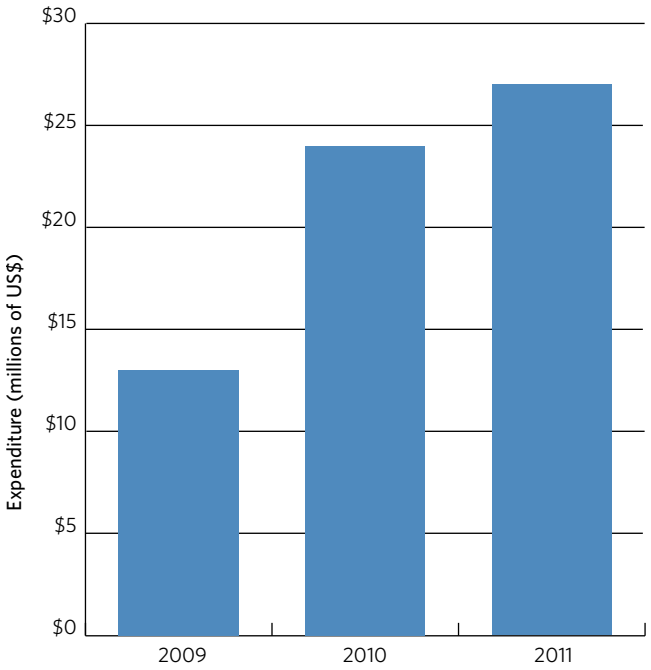


Figure 36: Trend of country-level capacity development expenditure, 2009 to 2011



providing increased support for capacity building activities and less for commodity support. The results achieved through this strategic intervention are reflected in the discussions for the various GPRHCS outputs and related indicators in previous chapters of this report.

Linking resources to results

The adoption of Monitoring and Evaluation Frame work in 2010 made it possible to strengthen results-based programming. One important step in this direction is the ability to link results of the framework with the resources spent on activities related to each output. The reporting on results and resources has been done through the use of a specially designed reporting tool. The analysis looked at the 'output' level results in the GPRHCS Performance Monitoring Framework, for the four outputs:

1. Country RHCS strategic plans developed, coordinated and implemented by governments with their partners;
2. Political and financial commitment for RHCS enhanced;
3. Capacity and systems strengthened for RHCS;
4. RHCS mainstreamed into UNFPA core business.

Figure 37 shows a similar situation observed in 2010; that more resources were spent on Output 3 (capacity building and systems strengthened for RHCS) followed by Output 2 (political and financial commitment for RHCS enhanced).

Activities related to Output 3 include, for example, improving the skills of nationals in important logistics functions such as forecasting, procurement and LMIS – which forms the foundation of capacity building for sustainable country-driven systems for the distribution and management of RH commodities. In second place is expenditure on Output 1, country RHCS strategies, which would reflect the expenditures made on assessing country situation, jointly develop national strategic plans for coordination, and setting up and maintaining national committees.

Output 2, on political and fiscal commitments enhanced, involves activities such as resource mobilization, advocating for inclusion of RHCS within national strategies and plans, and advocacy for budget lines for RH commodities. These activities may not be frequent or cost-intensive. Not surprisingly, the least amount of funds were spent on Output 4, as many of the activities are integral to UNFPA and UN processes and do not need additional funding, example.g. activities such as participating in UN joint processes at country level such as UNDAF and CCA and developing country programmes.

Figure 35: Trends for total GPRHCS expenditure for commodity and capacity building, 2009 to 2011

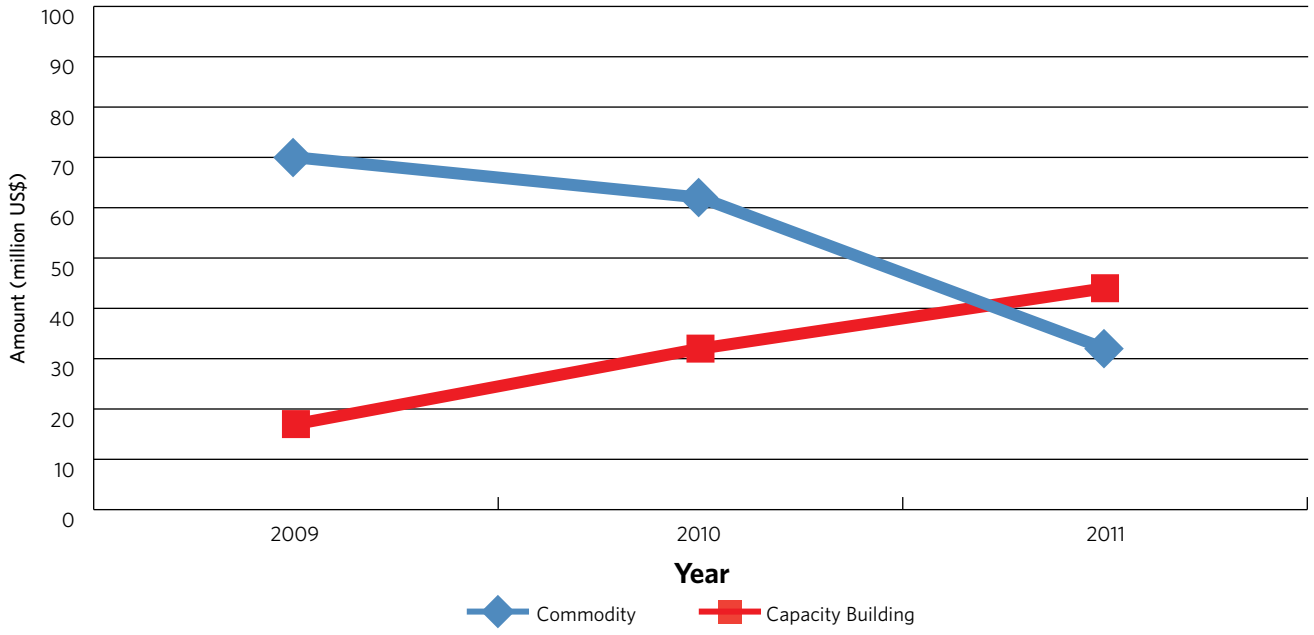


Figure 37: GPRHCS resources expended by output and by Stream for 2011

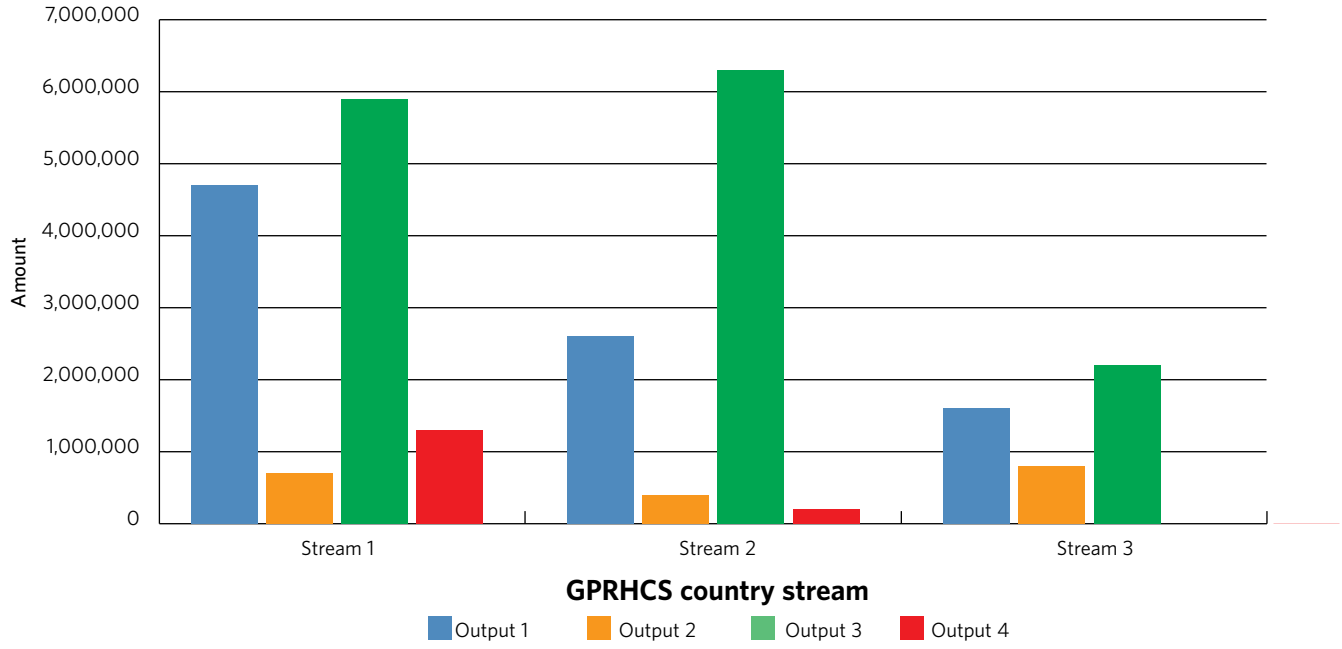
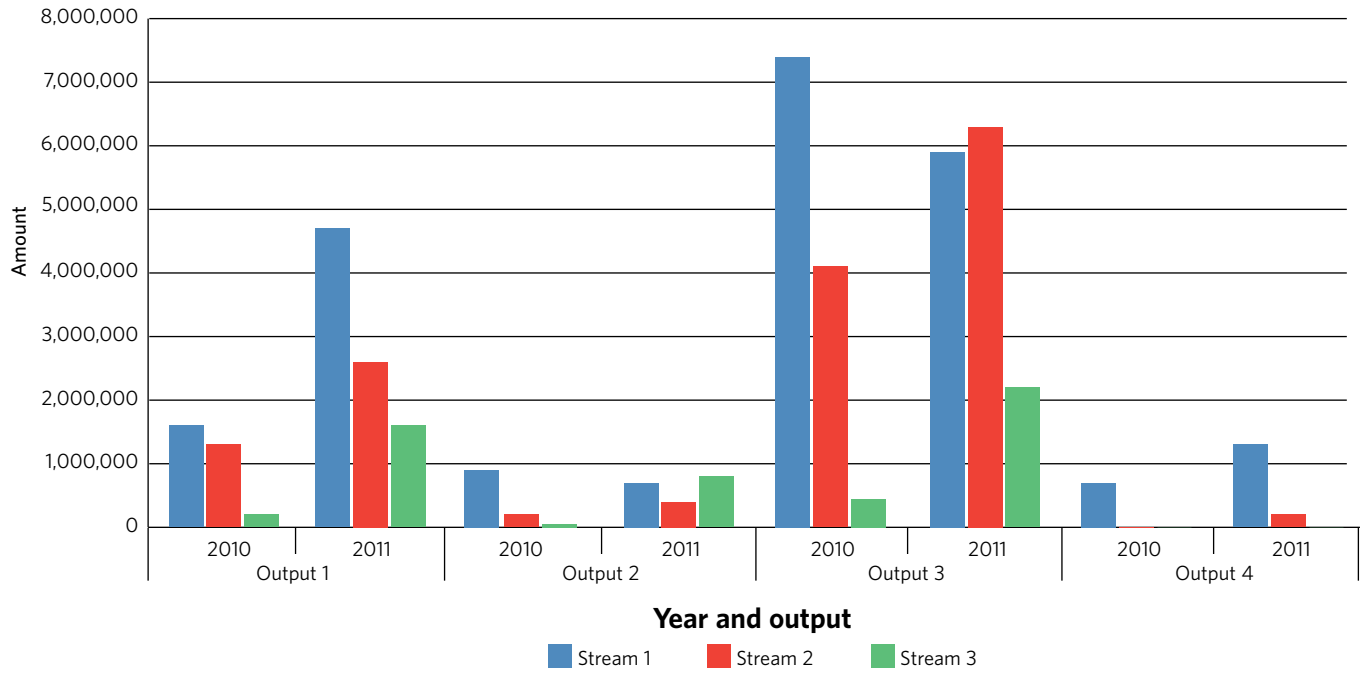


Figure 38: GPRHCS resources expended by output, 2010 and 2011



CHAPTER EIGHT

Conclusion & Way Forward

This year was remarkable in many ways for the Global Programme and for UNFPA as a whole. The beginning of 2011 witnessed the passing of the baton to a new UNFPA Executive Director, Dr. Babatunde Osotimehin. Dr Osotimehin attended the 2011 GPRHCS Stock Taking Meeting held in Barcelona and promised not only an organizational commitment to the issues of RHCS and family planning but eloquently pledged his personal commitment to supporting efforts of UNFPA and partners in this regard.

There were also major changes in the way UNFPA does business. Most significant in 2011 were the mid-term review of the UNFPA Strategic Plan and the Executive Director's new Business Plan. Both processes sharpened, refocused and revitalized the functions of the organization with the objective of making UNFPA more efficient and responsive to country needs. Important results of the processes include the redefined Strategic Plan Outcomes and Outputs through which the Commodity Security Branch/GPRHCS was given greater responsibility in ensuring that family planning will be effectively addressed by the organization and partners. An equally important development was the Cluster Approach of the Executive Director's Business Plan, which defined two major target groups for support and created a medium for ensuring that various units within the organization worked more closely in an integrated and effective manner in responding to country needs.

It was a year of change and reflection – and a year in which even greater progress was achieved in both the GPRHCS Stream 1 and 2 countries. Many of the achievements have been described in great detail in this report, with highlights elaborated in the Executive Summary. An independent review conducted in 2011 confirmed the success and achievement of the GPRHCS. The review

A young peer educator in Burundi explains how to use a female condom. *Credit: Yolande Magonyagi/UNFPA*

was conducted approximately half-way through the 2007-2013 programme. The report[8] synthesized findings from 14 country case studies.[9] It found that "the Global

[8] Synthesis Report, UNFPA Global Programme to Enhance Reproductive Health Commodity Security Mid-Term Review, January 2012, Authors: Adrienne Chattoe-Brown, Olivier Weil and Meg Braddock, www.hlsp.org

[9] Stream One: Mongolia, Sierra Leone, Madagascar, Ethiopia, Burkina Faso, Lao PDR and Nicaragua. Stream Two: Ghana, Zambia, Lesotho, Benin, Liberia, Nigeria and Uganda

Programme has successfully set up country-level building blocks for reproductive health commodity security":

- Coordination committees are in place in most countries and function reasonably well, particularly on operational issues;
- RHCS is embedded in key national strategies such as health sector strategies, poverty reduction strategies, and STI/HIV/AIDS strategies. In several countries it is also included in gender mainstreaming strategies;
- RHCS strategies are in place in most countries, and are being implemented;
- With only three exceptions countries have made no *ad hoc* requests for supplies during 2010;
- Logistics management information systems (LMIS) are being developed everywhere;
- Essential reproductive health commodities are included on essential medicines lists, with only a few commodities omitted in some countries.

The review also commented on other areas of progress. In some countries the programme has successfully advocated for increased government funding for reproductive health commodities. The programme has mobilized considerable and increasing donor funds for reproductive health commodity security. Reports against the monitoring framework indicate that integration into UNFPA and the wider United Nations is proceeding well. The Commodity Security Branch in New York has designed a programme which has good country reach and enough flexibility to enable many country priorities to be addressed. Programme management systems are in place, Country and Regional Offices have staff who are committed to RHCS, and a monitoring framework has been developed. And, at global level, there is active engagement with key partners on RHCS. UNFPA has established itself as a global and country level player in RHCS.

The building blocks are indeed in place and yet a great deal remains to be done. The review also asked for "more" in some areas including awareness-raising about RHCS activities, efforts to encourage governments to spend their own money on commodities, investing more on the sub-national levels, attention to the non-state sector, and analysis of appropriate contraceptive method mix, amongst others.

As the first five years of the GPRHCS come to an end, and the key elements of the new phase are articulated, discussed and agreed upon, the many positive achievements noted by the review will be continued and strengthened, and the less positive recommendations addressed. Looking ahead, the GPRHCS plans to continue in line with UNFPA's Strategic Plan to ensure access to and use of quality reproductive health commodities, supplies and medicines, as part of the overall effort to reduce the number of maternal and newborn deaths, halt the spread of HIV/AIDS and improve the overall sexual and reproductive health and rights of women, men and young people—particularly within the countries most in need. The GPRHCS will continue to work with governments and partners to improve RHCS in a focused manner in Stream 1 and 2 countries receiving support. The focus will be on continuing to develop sustainable approaches to RHCS as part of overall health sector reform, and on building a stronger foundation for more permanent and lasting solutions to RHCS. Evidence of increasing government commitment to RHCS is being seen in many countries and this is in the right direction for reducing reliance on external funding. Efforts to strengthen results-based management and reporting will continue. In line with this work, the GPRHCS Performance Monitoring Framework will soon be revised to make it even more comprehensive. Lessons learned since the Global Programme's inception in 2007 will continue to be used to improve its effectiveness and efficiency and, even more importantly, to design the new programme expected to commence in 2014.

Funding in support of activities in-country and globally remains crucial in two regards. The present programme has a no-cost extension until 2013. Thus, in reality, funding from most major donors has either ceased in 2011 or will do so in 2012, making the need for interim funding commitments in 2013 urgent, so as to ensure that countries continue to receive support prior to the start of the new programme. In addition, we are witnessing an unprecedented surge of global and national commitment towards addressing the unacceptable levels of unmet need for family planning. This global commitment provides a singular and unique opportunity for traditional and new partners to make a transformational difference — by working with tried and tested programmes such as the GPRHCS. This will ensure that resources both financial and technical reach the countries and communities most in need in a lasting and sustainable manner.

Table 44: Contraceptives provided to Stream 1 countries in 2011

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency oral (doses)	Implant (pieces)
Burkina Faso	362,800		698,400		
Ethiopia	6,823,000	50,000	0		
Haiti	408,000		201,000		
Lao PDR	300,000		800,000		
Madagascar	987,600		270,000		41,680
Mali		36,500			51,200
Mongolia	80,000	5,000	100,002	5,000	
Mozambique	768,000	13,500	2,724,480		
Nicaragua	653,000	200	575,000		
Niger	304,200	2,500			2,512
Nigeria	416,507	21,500	759,000		8,100
Sierra Leone	95,000	26,000	689,064	42,000	14,000
Total	**11,198,107**	**155,200**	**6,816,946**	**47,000**	**117,492**

Table 46: Contraceptives provided to Stream 3 countries in 2011

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency oral (doses)	Implant (pieces)
Cape Verde	73,000	500	323,001		2,000
Comoros	26,800				1,024
Iraq			675,000		
Moldova	4,000	30,000	339,276		
Occupied Palestinian Territories	12,000	30,000	309,000		
Sri Lanka					10,000
Tanzania					
Total	**115,800**	**60,500**	**1,646,277**	**0**	**13,024**

Table 45: Contraceptives provided to Stream 2 countries in 2011

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Oral (doses)	Implant (pieces)
Benin		15,000			30,000
Bolivia	500,000	35,000	210,000	15,000	
Burundi	496,000		20,001		40,000
Caribbean	108,000	6,150	146,000	4,000	500
Central African Republic	45,000		59,000		500
Chad	200,000			180,000	15,000
Congo, Democratic Republic	300,000	11,000	392,502	22,000	8,500
Congo Republic	25,000	500	162,000		
Côte d'Ivoire	43,000		37,887		5,000
Djibouti	50,000	1,500			
Eritrea	100,000	5,500	53,004	9,000	5,100
Gabon	9,000	500	100,001		100
Gambia	110,000	500	300,003		100
Guinea	60,000	1,000	200,000		1,000
Guinea-Bissau	6,000	10,000	5,100		5,000
Kazakhstan	4,000	52,500	75,400	5,000	
Kyrgyzstan		160,000			
Lesotho			63,000		2,000
Liberia	50,000				3,000
Malawi	724,400			30,600	
Mauritania	9,500	5,500	400,000	1,500	3,600
Namibia	44,600				328
Sao Tome and Principe	20,000		45,435		
Senegal	200,000		300,000		10,000
Sudan, North	31,600	2,000	813,639		500
Swaziland	69,200				24,300
Tajikistan	100,000	150,000			5,000
Togo			13,002	1,800	7,500
Turkmenistan	20,400	50,000	71,250		
Uganda			26,301		
Uzbekistan		350,000	360,000		
Yemen	320,000	30,000	1,600,002		5,000
Zimbabwe	10,000	2,000			5,000
Total	**3,655,700**	**888,650**	**5,453,527**	**268,900**	**177,028**

Table 47: Male and female condoms provided to Stream 1 countries in 2011

Countries	Male Condom (pieces)	Female Condom (pieces)
Ethiopia	3,000,000	
Haiti	10,080,000	
Laos	450,000	
Madagascar	1,000,080	100,000
Mongolia	1,440,000	10,000
Mozambique	68,018,400	1,000,000
Nicaragua	1,026,000	
Nigeria		30,000
Sierra Leone	4,243,248	
Total	**89,257,728**	**1,140,000**

Table 48: Male and female condoms provided to Stream 2 countries in 2011

Countries	Male Condom (pieces)	Female Condom (pieces)
Bolivia	1,100,016	15,000
Burundi		200,000
Caribbean	2,452,464	253,000
Central African Republic	6,000,048	13,000
Chad	1,500,048	50,000
Congo, Democratic Republic	9,999,936	200,000
Congo, Republic	6,000,048	90,000
Côte d'Ivoire	8,000,064	250,000
Djibouti	570,240	20,000
Eritrea	7,200,000	100,000
Gabon	6,102,432	140,000
Gambia	1,584,000	1,000
Guinea	3,000,000	100,000
Guinea-Bissau	1,440,000	5,000
Kazakhstan	1,051,200	
Kyrgyzstan	1,872,000	
Lesotho		50,000
Liberia	1,500,048	60,000
Mauritania	3,600,000	20,000
Namibia		150,000
Sao Tome and Principe	1,880,064	5,000
Sudan, North	651,024	
Swaziland	5,000,112	
Tajikistan	3,600,000	
Togo	2,016,000	7,000
Turkmenistan	2,000,000	
Uganda	68,340,928	
Zambia	12,000,000	600,000
Total	**158,460,672**	**2,329,000**

Table 49: Male and female condoms provided to Stream 3 countries in 2011

Countries	Male Condom (pieces)	Female Condom (pieces)
Cape Verde	108,000	9,000
Comoros	1,008,000	
Iran		15,000
Moldova	2,016,000	
Occupied Palestinian Territories	2,505,600	
Peru		50,000
Total	**5,637,600**	**74,000**

Table 50: CYP from contraceptives provided to Stream 1 countries in 2011

Countries	3-month injectable CYP	2-month injectable CYP	IUD CYP	Oral CYP	Implant CYP	Total contraceptive CYP
Burkina Faso	90,700			46,560		137,260
Ethiopia	1,705,750		166,667			1,872,417
Haiti	102,000			13,400		115,400
Lao PDR	75,000			53,333		128,333
Madagascar	246,900			18,000	138,933	403,833
Mali			121,667		170,667	292,333
Mongolia	20,000		16,667	6,667		43,333
Mozambique	192,000		45,000	181,632		418,632
Nicaragua	127,750	23,667	667	38,333		190,417
Niger	76,050		8,333		8,373	92,757
Nigeria	63,275	27,235	71,667	50,600	27,000	239,776
Sierra Leone	23,750		86,667	45,938	46,667	203,021
Total	**2,723,175**	**50,901**	**517,333**	**454,463**	**391,640**	**4,137,513**

Table 52: CYP from contraceptives provided to Stream 3 countries in 2011

Countries	3-month injectable CYP	2-month injectable CYP	IUD CYP	Oral CYP	Implant CYP	Total contraceptive CYP
Cape Verde	18,250		1,667	21,533	6,667	48,117
Comoros		4,467			3,413	7,880
Iraq				45,000		45,000
Moldova	1,000		100,000	22,618		123,618
Occupied Palestinian Territories	3,000		100,000	20,600		123,600
Sri Lanka					33,333	33,333
Total	**22,250**	**4,467**	**201,667**	**109,752**	**43,413**	**381,548**

Table 51: CYP from contraceptives provided to Stream 2 countries in 2011

Countries	3-month injectable CYP	2-month injectable CYP	IUD CYP	Oral CYP	Implant CYP	Total contraceptive CYP
Benin			50,000		100,000	150,000
Bolivia	125,000		116,667	14,000		255,667
Burundi	124,000			1,333	133,333	258,667
Caribbean	25,500	1,000	20,500	9,733	1,667	58,400
Central African Republic	11,250			3,933	1,667	16,850
Chad	37,500	8,333			50,000	95,833
Congo, Democratic Republic		50,000	36,667	26,167	28,333	141,167
Congo, Republic	6,250		1,667	10,800		18,717
Côte D'Ivoire	10,750			2,526	16,667	29,942
Djibouti	12,500		5,000			17,500
Eritrea	25,000		18,333	3,534	17,000	63,867
Gabon	2,250		1,667	6,667	333	10,917
Gambia	25,000		1,667	20,000	333	47,000
Guinea	15,000		3,333	13,333	3,333	35,000
Guinea-Bissau	1,500		33,333	340	16,667	51,840
Kazakhstan	1,000		175,000	5,027		181,027
Kyrgyzstan			533,333			533,333
Lesotho				4,200	6,667	10,867
Liberia	12,500				10,000	22,500
Malawi	181,100					181,100
Mauritania	1,500	583	18,333	26,667	12,000	59,083
Namibia	4,900	4,167			1,093	10,160
Sao Tome and Principe	5,000			3,029		8,029
Senegal	50,000			20,000	33,333	103,333
Sudan, North	7,900		6,667	54,243	1,667	70,476
Swaziland		11,533			81,000	92,533
Tajikistan	25,000		500,000		16,667	541,667
Togo				867	25,000	25,867
Turkmenistan	5,100		166,667	4,750		176,517
Uganda				1,753		1,753
Uzbekistan			1,166,667	24,000		1,190,667
Yemen	80,000		100,000	106,667	16,667	303,333
Zimbabwe	2,500		6,667		16,667	25,833
Total	**798,000**	**75,617**	**2,962,167**	**363,568**	**590,093**	**4,789,445**

Table 53: CYP from male and female condoms provided to Stream 1 countries in 2011

Countries	Male condom CYP	Female condom CYP	Total condom CYP
Ethiopia	25,000		25,000
Haiti	84,000		84,000
Lao PDR	3,750		3,750
Madagascar	8,334	833	9,167
Mongolia	12,000	83	12,083
Mozambique	566,820	8,333	575,153
Nicaragua	8,550		8,550
Nigeria		250	250
Sierra Leone	35,360		35,360
Total	**743,814**	**9,500**	**753,314**

Table 55: CYP from male and female condoms provided to Stream 3 countries in 2011

Countries	Male condom CYP	Female condom CYP	Total condom CYP
Cape Verde	900	75	975
Comoros	8,400		8,400
Iran		125	125
Moldova	16,800		16,800
Occupied Palestinian Territories	20,880		20,880
Peru		417	417
Total	**46,980**	**617**	**47,597**

Table 54: CYP from male and female condoms provided to Stream 2 countries in 2011

Countries	Male condom CYP	Female condom CYP	Total condom CYP
Bolivia	9,167	125	9,292
Burundi		1,667	1,667
Caribbean	20,437	2,108	22,546
Central African Republic	50,000	108	50,109
Chad	12,500	417	12,917
Congo, Democratic Republic	83,333	1,667	84,999
Congo, Republic	50,000	750	50,750
Côte d'Ivoire	66,667	2,083	68,751
Djibouti	4,752	167	4,919
Eritrea	60,000	833	60,833
Gabon	50,854	1,167	52,020
Gambia	13,200	8	13,208
Guinea	25,000	833	25,833
Guinea-Bissau	12,000	42	12,042
Kazakhstan	8,760		8,760
Kyrgyzstan	15,600		15,600
Lesotho		417	417
Liberia	12,500	500	13,000
Mauritania	30,000	167	30,167
Namibia		1,250	1,250
Sao Tome and Principe	15,667	42	15,709
Sudan, North	5,425		5,425
Swaziland	41,668		41,668
Tajikistan	30,000		30,000
Togo	16,800	58	16,858
Turkmenistan	16,667		16,667
Uganda	569,508		569,508
Zambia	100,000	5,000	105,000
Total	**1,320,506**	**19,408**	**1,339,914**

Call to Action

Enhancing Reproductive Health Commodity Security

New York, 7-8 September 2011

WE, the participants of the High-Level Meeting on Enhancing Reproductive Health Commodity Security held in New York on 7-8 September 2011,

WELCOME PROGRESS made in recent decades in ensuring that more individuals worldwide are now able to exercise their right to reproductive health, including the right to plan and space their families, and the results achieved in increasing the use of modern methods of contraception and reducing maternal death and HIV infections;

REAFFIRM our commitment to achieving the Millennium Development Goals and to the principles of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, and commend the high-level political commitment by our Heads of State and Governments to sexual, reproductive, maternal, newborn and child health and to scaling up efforts to meet demand for reproductive health commodities;

CONCERNED that despite progress disparities persist in access to sexual and reproductive health information, services and essential supplies, and that the poor and other vulnerable groups, including young people, continue to be underserved and suffer high unmet need;

AWARE that spending for sexual and reproductive health programmes, including for maternal and family planning services, is not sufficient to meet current and future needs, we acknowledge that there is global consensus that family planning is a cost-effective investment in human development, especially important given the global economic crisis;

AFFIRM that comprehensive sexual and reproductive health services including for voluntary family planning, ensured by a secure supply of reproductive health commodities, is a national priority for saving women's lives, improving maternal health and preventing HIV;

RECOGNIZE that reproductive health commodity security, with its strong family planning focus, provides a powerful platform for governments to align efforts according to national priorities and to accelerate the reduction of unmet need for family planning and so allow women, men and young people throughout the world to exercise their right to reproductive health;

WE, FIRST LADIES, PARLIAMENTARIANS, MINISTERS, HEREBY INDIVIDUALLY AND COLLECTIVELY CALL ON countries and national stakeholders, including civil society and the private sector—according to their respective roles and responsibilities—to partner and collaborate to:

1. Reinforce existing political and financial commitments for reproductive health commodity security:

a) Provide political leadership to bring about sustainability in reproductive health commodity security by: developing and expanding social protection mechanisms; strengthening partnership and coordination; leveraging, allocating and using resources equitably at all levels; demonstrating results to mobilize support; and scaling up successful country-driven initiatives;

b) Take concerted action to demonstrate that the primary responsibility for the achievement of reproductive health commodity security lies with national government and ensure increased resource allocation for reproductive health in line with global and regional commitments.

2. Invest in stronger supply chain management systems for reproductive health commodities:

a) Establish integrated supply management systems for health to improve efficiency including functional logistics management information systems using modern information and communication technology in order to ensure consistent, reliable supply of quality-assured reproductive health commodities;

b) Establish a sustainable national mechanism for human resource development to strengthen capacity to deliver reproductive health commodity security.

3. Ensure expanded and equitable access to services:

a) Ensure that under-served and hard-to-reach groups (with a focus on protecting adolescent girls) can exercise their right to informed choice and can access and use sexual and reproductive health information and care, including voluntary family planning;

b) Increase partnership, collaboration and coordination among all stakeholders and at all levels and strengthen the capacity of civil society and parliamentarians to represent the grassroots and to hold governments accountable for their commitments to reproductive health commodity security.

This Call to Action was issued at a meeting organized by the United Nations Population Fund and attended by senior representatives of 12 Stream 1 countries of the UNFPA-initiated *Global Programme to Enhance Reproductive Health Commodity Security*. The countries represented were: **Burkina Faso, Ethiopia, Haiti, Lao People's Democratic Republic, Mali, Madagascar, Mongolia, Mozambique, Nicaragua, Niger, Nigeria and Sierra Leone.**

ANNEX 5: CALL TO ACTION PARTICIPANTS

Burkina Faso

H.E. Rock Marc Christian Kabore, Chairman of the National Assembly

H.E. Michel Kafando, Ambassador Extraordinary and Plenipotentiary Permanent Representative

H.E. Paul Robert Tiendrebeogo, Ambassador Extraordinary and Plenipotentiary Deputy Permanent Representative

Dr. Souleymane Sanou, Permanent Secretary of the Ministry of Health

Ms. Françoise Ouedraogo, Assistant Parlementaire

Ms. Françoise Beremwoudougou, Attaché

Ethiopia

H.E. Tekeda Alemu, Ambassador Extraordinary and Plenipotentiary Permanent Representative

Haiti

H.E. Dr. Bertrand Sinal, Health Commission President of the Chamber of Deputies

H.E. Uder Autoire, President, Health Committee

Dr. Marie Lamercie Florence Duperval, Member of the Technical Advisory Group of the Presidency

Lao People's Democratic Republic

H.E. Dr. Bounkhuang Phichit, Vice Minister, Mother and Child Health Center

Dr. Kaisone Chounramany, Director, Mother and Child Health Center

Ms. Keobounkhong Vidavone, Third Secretary

Madagascar

H.E. Médecin Général de Brigade Pascal Jacques Rajaonarison, Minister of Public Health

H.E. Zina Andrianarivelo-Razafy, Ambassador Extraordinary and Plenipotentiary Permanent Representative

Mali

H.E. Diallo Madeleine Ba, Minister of Health

H.E. Oumar Dau, Ambassador Extraordinary and Plenipotentiary Permanent Representative

Dr. Ibrahim Coulibaly, Technical Adviser to the Minister

Mongolia

H.E. Lambaa Sambuu, Minister of Health and Member of Parliament

Ms. Jargalsaikhan Dondog, Director of the Information, Monitoring and Evaluation Department at the Ministry of Health

Mozambique

Dr. Aida Libombo, Minister of Health's Special Advisor for MDG 4 & 5

Nicaragua

H.E. Yamileth Bonilla, Parliamentarian

H.E. Elias Guevara, Vice-Minister of Health

H.E. Maria Rubiales de Chamorro, Ambassador Extraordinary and Plenipotentiary Permanent Representative

Niger

H.E. Soumana Sanda, Minister of Health

H.E. Dr. Maikibi Kadidiatou Dandobi, Minister of Population and Social Affairs

H.E. Aboubacar Ibrahim Abani, Ambassador Extraordinary and Plenipotentiary Permanent Representative

Mrs. Halimatou Djibo Saddy, First Counsellor

Nigeria

H.E. Helen Onma Mark, Spouse of the Senate President of the Federal Republic of Nigeria

H.E. Ambassador Nkojo Toyo, Member of the Nigerian House of Representatives

H.E. Prof U. Joy Ogwu, Ambassador Extraordinary and Plenipotentiary Permanent Representative to the Nigerian Mission to the UN

Mr Linus Awute, Permanent Secretary of the Federal Minister of Health

Mrs. Tumini Akogun, Wife of the Leader of the Nigerian House of Representatives

Dr. Nnenna Ogbualafor, Technical Assistant to the Minister of Health on Maternal and Child Health

Mrs. Hafsatu Garba-Abdulkadir, Second Secretary, Permanent Mission

Mr. Umar Abdullahi, Personal Assistant

Sierra Leone

H.E. Sia Nyama Koroma, First Lady of the Republic of Sierra Leone

H.E. Zainab Hawa Bangura, Minister of Health and Sanitation

H.E. Elizabeth Alpha-Lavalie, Chairperson, Sierra Leone Parliamentarian Action Group on Population and Development

H.E. Leroy Kanu, Minister Plenipotentiary

H.E. Rasie Kargbo, Deputy Permanent Representative for Political Affairs

Ms. Florence Katta, Project Coordinator, Women's Initiative for Safer Health Project (WISH)

Mrs. Musu Matturi Dao, Personal Assistant to the First Lady

Mr. Saidu Nallo, Counsellor

Lt. Col. Ronnie Harleston, Military Attaché

ANNEX 6: LIST OF ACRONYMS

ABR	Adolescent Birth Rate
AIDS	Acquired Immune Deficiency Syndrome
APRO	Asia and Pacific Region
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
CARh	Coordinated Assistance for RH Supplies
CBDs	Community-Based Distributors
CBO	Community Based Organization
CCA	Common Country Assessment
CCM	Country Commodity Manager
CCP	Comprehensive Condom Programming
CO	Country Office
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPR	Contraceptive Prevalence Rate
CSB	Commodity Security Branch
CSO	Civil Society Organization
CYP	Couple Years of Protection
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
DMT	Decision-Making Tool for Family Planning Clients and Providers
DRC	Democratic Republic of Congo
EML	Essential Medicines List
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
EU	European Union
GPRHCS	UNFPA Global Programme to Enhance Reproductive Health Commodity Security
HEW	Health Extension Workers
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HRB	Humanitarian Response Branch
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
LAC	Latin America and the Caribbean
LMIS	Logistics Management and Information System
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MHTF	Maternal Health Thematic Fund
MIC	Middle-Income Country
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSI	Marie Stopes International
NA	Not Available
NDF	National Development Framework
NGO	Non-Governmental Organization
OC	Oral Contraceptive
OECD	Organisation for Economic Co-operation and Development
OPT	Occupied Palestinian Territories
PDR	Peoples' Democratic Republic (Lao PDR)
PMNCH	Partnership for Maternal, Newborn and Child Health
PMT	Programme Management Team
PPMR	Procurement Planning and Monitoring Report
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Papers
PSB	Procurement Services Branch
PSM	Procurement and Supply Management
QA	Quality Assurance
RBM	Results-Based Management
RC	Resident Coordinator
RECs	Regional Economic Communities
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RO	Regional Office
SDP	Service Dvelivery Point
SRH	Sexual and Reproductive Health and Reproductive Rights
SRO	Sub Regional Office
STI	Sexually Transmitted Infection
SWAp	Sector-wide Approach
TD	Technical Division
TOR	Terms of Reference
UBW	Unified Budget and Workplan
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WAHO	West African Health Organisation
WHO	World Health Organization

United Nations Population Fund
605 Third Avenue
New York, NY 10158
USA
www.unfpa.org