

REPRODUCTIVE HEALTH SUPPLIES IN SIX COUNTRIES

THEMES AND ENTRY POINTS IN POLICIES, SYSTEMS AND FINANCING



BANGLADESH



GHANA



MEXICO



NICARAGUA



TANZANIA



UGANDA

POPULATION ACTION INTERNATIONAL

BY ELIZABETH LEAHY

JUNE 2009

COVER PHOTO CREDITS:

Front cover, top: Patients wait at a rural health clinic outside Mityana, Uganda.
(Elizabeth Leahy/PAI)

Supplies await distribution at the National Medical Stores in Ghana.
(Susan Anderson/PAI)

Back cover, top: A woman receives family planning counseling at an UMATI clinic in Dar es Salaam, Tanzania.
(IPPF /Sarah Shaw)

Back cover, bottom: Adolescent students and their parents attend a presentation on reproductive health and gender at a school in Malangala village in Uganda.
(Elizabeth Leahy/PAI)

Population Action
INTERNATIONAL
HEALTHY FAMILIES HEALTHY PLANET

Population Action International uses research and advocacy to improve access to family planning and reproductive health care across the world so women and families can prosper and live in balance with the earth. By ensuring couples are able to determine the size of their families, poverty and the depletion of natural resources are reduced, improving the lives of millions across the world.

TABLE OF CONTENTS

Acknowledgments	2
List of Acronyms	3
1 Key Findings	4
2 Country Context	14
3 The Policy Environment for Reproductive Health Supplies	18
4 The Public Sector Health System Structure	24
5 Financing of Reproductive Health Supplies	28
6 Forecasting, Procurement and Logistics Management	32
7 Development Partners and Civil Society	36
Appendix: Endnotes	41

ACKNOWLEDGMENTS

The six country case studies and this synthesis paper were prepared under the auspices of Project Resource Mobilization and Awareness (RMA), a partnership between Population Action International (PAI), the German Foundation for World Population (DSW) and the International Planned Parenthood Federation (IPPF). Funding for the project was awarded to PAI by the Bill & Melinda Gates Foundation.

The authors of the case studies are:

Bangladesh: Leslie Patykewich and Elizabeth Leahy

Ghana: Esther Akitobi, Elizabeth Leahy and Joana Nerquaye-Tetteh

Mexico: Carlos Manuel Indacochea

Nicaragua: Carlos Manuel Indacochea and Elizabeth Leahy

Tanzania: Elizabeth Leahy, Nel Druce, Esther Akitobi, Karen Hardee and Carolyn Gibb Vogel

Uganda: Elizabeth Leahy and Esther Akitobi

The case study research was guided by Jessica Bernstein, Suzanne Ehlers and Karen Hardee of PAI. Staff at each of the three Project RMA partner organizations, including Susan Anderson, Kristine Berzins, Amy Coen, Caroline Jane Kent, Matthew Lindley, Mercedes Mas de Xaxas, Ulrike Neubert, Sarah Shaw, Kate Tibone and Sabine Weber,

provided ongoing input and support. The reports were edited by Jennifer Johnson, and design and printing were led by Roberto Hinojosa.

The research was greatly facilitated by partner staff at the country and regional levels, including Maria Antonieta Alcalde, Victoria Fuentes, Elizabeth Guevara, Pierre Moon, Gilbert Mworira, Pradeep Patro, Lorena Santos, Claudio Sequeira and Gias Uddin. The directors and staff at IPPF member associations FPAB (Bangladesh), MEX-FAM (Mexico) and PROFAMILIA (Nicaragua) kindly hosted visitors and made the research trips to their countries very productive. Each of the interviewees listed in appendices to the individual case studies contributed to the reports by devoting time and energy to answering questions, clarifying issues and offering their well-informed assessments. Former project staff who were instrumental in the development of the case studies include Valerie de Fillipo, Pamela Foster and Joerg Maas. Thanks are also extended to Neil Datta, Sandra Jordan, Steve Kinzett, John Skibiak and Mimi Whitehouse.

Finally, the authors acknowledge Terri Bartlett, whose unwavering dedication and leadership in expanding access to reproductive health supplies has left a global legacy.

LIST OF ACRONYMS

ADD	Alliance for the Right to Choose (Mexico)	MEXFAM	Mexican Foundation for Family Planning
AIDS	Acquired immunodeficiency syndrome	MMAM	Primary Health Services Development Plan (Tanzania)
CPR	Contraceptive prevalence rate	MOHFW	Ministry of Health and Family Welfare (Bangladesh)
CSO	Civil society organization		
CSM	Coalition for the Health of Women (Mexico)	MTEF	Medium-Term Expenditure Framework
DAIA	Contraceptive security committee (Nicaragua)	NGO	Non-governmental organization
		NHIS	National Health Insurance Scheme
DGFP	Directorate General of Family Planning (Bangladesh)	PAI	Population Action International
		PAN	National Action Party (Mexico)
DSW	German Foundation for World Population	PEPFAR	President's Emergency Plan for AIDS Relief
EMP	Provisional medical enterprise (Nicaragua)	PPAG	Planned Parenthood Association of Ghana
FEMAP	Federation of Private Associations (Mexico)	PROFAMILIA	Pro Welfare of the Nicaraguan Family
FPAB	Family Planning Association of Bangladesh	RCHS	Reproductive and Child Health Section (Tanzania)
TFR	Total fertility rate	RH	Reproductive health
HIV	Human immunodeficiency virus	RHU	Reproductive Health Uganda
HNPSP	Health Nutrition Population Sector Program (Bangladesh)	RMA	Resource Mobilization and Awareness
ICC/CS	Interagency Coordination Committee for Commodity Security (Ghana)	SILAIS	Regional health agency (Nicaragua)
		STI	Sexually transmitted infection
ICPD	International Conference on Population and Development	SWAp	Sector-wide approach
		UMATI	Chama Cha Uzazi na Malezi Bora Tanzania
INSS	National Social Security Institute (Nicaragua)	UNFPA	United Nations Population Fund
IPPF	International Planned Parenthood Federation	USAID	United States Agency for International Development
LGA	Local government authority (Tanzania)		
MDGs	Millennium Development Goals		

1

KEY FINDINGS

The six case studies and this synthesis paper were prepared as part of Project Resource Mobilization and Awareness (RMA), whose goal is “to increase tangible financial and political commitment to sustainable reproductive health supplies through international coordination and support of national advocacy strategy development and implementation in developing countries.” The objectives of the project include:

- Promote a supportive political environment for reproductive health (RH) supplies by enabling civil society organizations (CSO) and networks to engage in advocacy at the international and regional levels in a comprehensive and coordinated manner.
- Create a supportive political and financial environment for improving access to RH supplies at the regional level.
- Strengthen national level advocacy on RH commodities supplies in six partner countries in the global south.

The definition of reproductive health supplies established by the Reproductive Health Supplies Coalition is: “any material or consumable needed to provide reproductive health services. This includes, but is not necessarily limited to contraceptives for family planning, drugs to treat sexually transmitted infections, and equipment such as that used for safe delivery.” Use of the term “reproductive health supplies” is intentionally broad in order to encompass the wide array of supplies necessary for quality reproductive health care, including and beyond family planning. The country case study research focuses on contraceptives and condoms because of the historical priority placed on these supplies, as well as the challenges in monitoring and tracking the full array of other products and medications. Contraceptives and condoms are the hallmark of many family planning and reproductive health programs and are the primary emphasis of many advocacy efforts at the national, regional and global levels, but the full range of reproductive health supplies extends well beyond the specific commodities discussed in this report.



Patients wait at a rural health clinic outside Mityana, Uganda. (Elizabeth Leahy/PAI)

Why RH Supplies?

Since early in this decade, advocates and researchers around the world have been building upon years of successful family planning programs by raising awareness of and promoting solutions to ongoing shortages of critical reproductive health supplies. Landmark global agreements such as the 1994 International Conference on Population and Development (ICPD) and the 2000 Millennium Development Goals (MDGs) have laid the foundation for these efforts by confirming the international community's commitment to achieving universal access to reproductive health, and the importance of reproductive health in advancing progress towards key health and development goals. Research has proven that secure access to RH supplies not only improves individual welfare, but also saves lives. For example, access to RH supplies could prevent unintended pregnancies and unsafe abortions and in turn avert hundreds of thousands of maternal deaths each year.¹

Noting that donor funding for contraceptives and condoms was declining in the late 1990s despite the ICPD commitments, in 2001 advocates organized a landmark meeting in Istanbul, Turkey. A “Call to Action” stemming from the Istanbul meeting identified strategies to address advocacy, donor coordination, financing and national capacity-building in support of RH supplies. The goal of ensuring “that people can choose, obtain and use a wide range of high-quality, affordable contraceptive methods and condoms for STI/HIV prevention” is also known as “contraceptive security.”² In the years following the Istanbul meeting, concentrated efforts on RH supplies led to a number of achievements, including the formation of a high-level donor coordination forum, the creation of the first web-based database to track funding of donated shipments of supplies, and steady growth in advocacy for supplies.

Donor funding for RH supplies has grown dramatically since 2000, the year before the Istanbul

meeting, reaching \$223 million in 2007, but these resources still fall well short of needs. Even discounting expenses for condoms for STI and HIV prevention, donor support for contraceptives and condoms in 2007 met just one-quarter of estimated costs.³ Although these deficits demonstrate that donors must continue to be a target of advocacy efforts to meet their own funding commitments, there are many routes needed for advocacy as the environment surrounding resources and policies for RH supplies has changed dramatically. While awareness is high at the global level, supplies often remain disconnected from other health and development issues, and at the facilities and outlets where commodities are most needed, women, men and young people are still met with shortages and stockouts.

For these reasons, advocacy efforts are increasingly focused on building capacity and support at the country level. Donors are shifting much of the authority and responsibility for development to national governments, in line with new principles of aid effectiveness. However, governments' technical knowledge and political commitment to reproductive health vary considerably, as does the experience of national advocacy groups. As explained in a Project RMA document, "developing countries must be mobilized to take ownership and be empowered to enter and impact the global

dialogue and action on supplies; and networks of NGOs [non-governmental organizations] must be mobilized to continue global support for sustainable solutions and financing."⁴

To provide an assessment of recent progress and challenges in improving access to RH supplies in national contexts, Population Action International completed in-depth case studies in six countries: Bangladesh, Ghana, Mexico, Nicaragua, Tanzania and Uganda. The findings regarding the policy environment, health system structure, financing, logistics, and organizational actors related to RH supplies in these countries, as synthesized in this summary paper, highlight a variety of overarching themes and a series of shared potential advocacy strategies. Although much progress has been made in winning government commitment and political and financial support, the goal of universal access to reproductive health supplies remains out of reach.

Policies on family planning and reproductive health supplies exist but are poorly implemented due to weak government commitment.

Official policy documents from the six countries indicate that governments recognize the importance of ensuring access to reproductive health supplies and improving the reach of family

Despite these commitments on paper, evidence has accumulated across all countries that access to reproductive health supplies lags behind as a government priority in policy implementation.

planning programs. In every country, poverty reduction and health sector plans as well as policies specific to reproductive health and contraceptive security reiterate the relationship between improved reproductive health indicators and broader measures of health, education, economic growth and countries' overall development. In every country, governments have set specific targets related to improving access to reproductive health supplies, such as increasing the contraceptive prevalence rate. In addition, reproductive health supplies are included to varying degrees in every country's List of Essential Medicines.⁵ Despite these commitments on paper, evidence has accumulated across all countries that access to reproductive health supplies lags behind as a government priority in policy implementation.

This lack of attention to implementation has serious implications for meeting the reproductive health needs of women and men. Even as donor support becomes increasingly fragile, governments continue to rely on external resources to fund contraceptives and condoms, either directly or in budget and sector support, even as they allocate internally-generated revenue to other health line items. Governments have neglected to include reproductive health supplies in new programs, such as Tanzania's primary health plan and Ghana's national insurance scheme. Through decentralization, governments have absolved themselves of any enforcement power to ensure that supplies are delivered effectively at lower levels of the health system, as in Mexico's transference of all procurement responsibilities to individual states. There has been a lack of foresight in the long-term planning needed to maintain ready access to supplies, as in Bangladesh's delayed response to an impending stockout of implants. Bangladesh also demonstrates that capacity to support reproductive health supplies can weaken when technical experts and experienced health workers retire or are otherwise unavailable.

There are a number of reasons that may explain the diminished attention paid to reproductive health supplies when policies are evaluated against rhetoric and funding allocations. In some cases, family planning has been eclipsed by other pressing development needs that may draw more external funding, especially as the global community has made vast investments in specific diseases. Countries can be challenged to absorb and report on their work for these large disease-specific initiatives, and neglect the much smaller amount of resources available for reproductive health. In other cases, reproductive health supplies appear to have simply fallen off the agenda as governments perceive that population issues are no longer a pressing priority. In Tanzania, some officials have expressed doubt that the country needs any support for family planning; in Mexico, ensuring access to contraceptives and condoms is no longer treated as a matter of "national security," as are vaccines. Reproductive health supplies are also sometimes subject to hostility from political leaders. This has been most evident in Nicaragua, where the government has recently closed clinics and suspended contracts with reproductive health service providers as part of a broader campaign against civil society. In Uganda, leaders have stated that continuing population growth will bring economic prosperity and have emphasized abstinence in the prevention of HIV/AIDS; in Mexico, the government repeatedly delayed release of its population and family planning policies.

Funding for reproductive health supplies from country governments is increasingly fragile in both the short- and long-term as donors withdraw support.

The landscape for population assistance has changed dramatically in the 15 years since the International Conference on Population and Development (ICPD) in Cairo, when donors agreed to meet one-third of the costs of achieving

universal access to reproductive health by 2015. In a series of reforms culminating in the Paris Declaration on Aid Effectiveness in 2005, donors committed to improve the results of their foreign assistance by increasing country ownership, allowing aid-recipient countries to take leadership over their own development.⁶ Over the same period, there has been a general decrease in the share of population assistance awarded to family planning and reproductive health in favor of HIV/AIDS. After stagnating for three years, donor support for contraceptives and condoms has increased by four to five percent in each of the past two years, but still only meets one-quarter of global need.⁷

These changes, as well as the decisions of some donors to target their assistance to certain countries and regions, have meant that country governments are assuming an increasing share of allocation decisions for reproductive health supplies and related programs. In many cases, the quantity of external funding available is in rapid decline. While Mexico is the only country that has been entirely “graduated” from donor financial support for family planning, Nicaragua is only a few years away from a complete withdrawal of donor funding for contraceptives and condoms, and two of the other countries are experiencing declines in the total amount of available donor funding for reproductive health.

Budget line items for reproductive health supplies are often drawn from pooled health sector or general budget funds, or remain largely underspent, and do not necessarily indicate a dedication on the part of the government to use its own resources for reproductive health supplies.

In response to changes in donor support, and as a sign of domestic commitment to reproductive health, each country provides some degree of budgetary support at the central level for supplies. Some governments have signed financial sustainability plans with donors guaranteeing that

their support for reproductive health supplies will increase, but it remains to be seen whether government funding will rise at the same pace as donor support withdraws. Ghana, for example, is expected to assume funding for 80 percent of total need by 2011, and Nicaragua has committed to being totally self-sufficient for funding of reproductive health supplies by 2012. Given recent trends, countries cannot expect a rebound in donor support for reproductive health supplies, and must plan to fully assume the mantle of ownership for this critical aspect of their development.

All countries profiled in this series have implemented some type of budget line item to finance RH supplies with government funds, although Mexico has decentralized public sector health spending to the state level. These line items are often drawn not only from internally generated revenue such as taxes, but also from pooled funds whose contributions come in large part from donors. The direction of such funds is at the government’s discretion, and any allocation to RH supplies, even if ultimately drawn indirectly from donor sources, is a positive step. However, in many cases these budget line items are redirected to other areas or remain vastly underspent, as has occurred in Bangladesh and Uganda. Because domestic commitment to reproductive health is showing signs of waning, as outlined above, governments may require motivation, especially from internal civil society organizations, to ensure that the potential gaps in funding for supplies are closed.

Countries have made major improvements in their reproductive health supplies logistics systems in recent years, thanks in part to external technical assistance, and have taken on a greater share of the management of regular forecasting and smooth procurement.

In every country except Mexico, governments chair a contraceptive coordination committee at



A pharmacy in Dhaka, Bangladesh, sells many products, including socially marketed condoms. (Elizabeth Leahy/PAI)

the central level with representation from donors and NGO service providers. Regular meetings of such committees help avoid disruptions in supply by forecasting annual needs, developing long-term financing plans, and advocating for financial commitments from both donors and country governments. In most cases, procurement responsibilities have been transferred to government agencies by donors, and contraceptives have been integrated into logistics management systems with other essential medicines. These steps have been very effective in improving the delivery and availability of reproductive health supplies at the higher levels of the system, as noted in various logistics assessments. However, periodic stockouts at the facility level still occur, as discussed below. In addition to the challenges in delivering supplies to lower levels, governments sometimes demonstrate a lack of capacity in long-term planning, for example when certain contraceptive brands are discontinued.

The security of reproductive health supplies is most precarious at the district and facility level, in some cases compounded by decentralization.

The progress that has been achieved in procurement and forecasting has not always been replicated throughout the health system, especially in districts and individual facilities. Stockouts remain frequent, and although they occur throughout the supply chain, they are most common below the central level. This is due to a variety of impediments, such as human resource capacity and limited training, budgetary regulations, transportation and infrastructure challenges and delays in the transfer of supplies from governments to NGO service providers. Availability of supplies can be further compromised by shifts in brand or method availability, unfavorable pricing when high-volume discounts are unavailable, shipment delays and changes in regulatory

Civil society organizations have also successfully highlighted the need for effective coordination to ensure smoother distribution of supplies and to help avoid stockouts.

guidelines. When countries have policies in place to push all available commodities to the facility level in case of limited supplies, as Bangladesh has done during the current stockout of implants, shortages can be somewhat alleviated, albeit for a limited time.

In some cases, the welcome efforts at decentralization—transferring authority for health budgeting to the state or local level—have in fact created fragmentation and compounded stockouts and shortages in supplies. For example, in countries such as Tanzania and Uganda, funding for supplies can be allocated by both central ministries and local councils or districts, creating multiple financing streams but also requiring advocacy to encourage local authorities to begin spending their own funds on RH supplies rather than relying on federal financing. In Mexico, each state is responsible for procuring its own reproductive health supplies, and most do so separately, with no oversight authority from the government.

Advocacy on reproductive health supplies is a new issue for many civil society organizations, who are often viewed as governments by service providers, despite their advocacy capacity.

NGOs and civil society organizations are well-positioned to direct advocacy in support of reproductive health supplies, but their relatively short tenures as advocates have gone somewhat unrecognized by governments and development partners. With networks of clinics around the country, service provider NGOs have a thorough understanding of the improvements needed to increase access to reproductive health supplies both at a national level and among specific regions and groups of the population. Although these NGOs

generally work closely with country governments, and in some cases depend on them as a source of supplies, their relatively low market share in service delivery and their nascent role as advocates seem to have created a perception that NGOs are small-scale partners for governments, not yet important political pressure points. Civil society organizations, especially if they are not service providers, are often not offered a seat at the table in coordination and planning forums with country governments and donors and instead have to insist to be included. In some countries, such as Mexico and Nicaragua, reproductive health and feminist advocacy groups that are not service providers are more entrenched, with a history of efforts monitoring budget line items for reproductive health and promoting abortion rights, among other issues, but may have less experience focusing on RH supplies.

Potential advocates have been identified among civil society organizations that are new to the reproductive health field, but whose interests overlap, such as youth organizations, rural women's clubs, religious leaders, trade unions, neighborhood or municipal groups, and professional associations. While this creates opportunity for collective action, in many cases there is also coalition fatigue, or a tendency toward repeated discussions with little motivation for follow-up actions. Advocacy for RH supplies is strengthened by a planning process that maps potential partners, action steps and target audiences.

Support of civil society advocacy is key to promote and monitor the necessary increases in commitments from national governments.



Coordinated action to effect change is underway, but needs continued investments to keep growing. A number of strategies for reproductive health supplies advocacy are already in progress, and others have been identified through case study research. Through Project RMA, advocates in each of the six countries have garnered major achievements toward the goal of increasing political and financial commitment for RH supplies.

On the policy front, advocates have been involved in drafting national contraceptive security strategies, such as that of Uganda. Civil society organizations have also highlighted the absence of a full range of reproductive health supplies on essential medicines list, and pressed for the inclusion of a complete range of commodities in line with international standards. In Ghana, advocates have worked with researchers and politicians to promote the addition of family planning to the National Health Insurance Scheme.

Given ongoing decentralization processes and the changing funding environment, advocates have focused much of their effort to increase funding for RH supplies at lower levels of the health system. In Mexico, civil society helped secure a state-level declaration of commitment to increased funding for supplies. In Tanzania,

advocates are transforming existing networks into district contraceptive security committees, and are participating in district health budget reviews. Advocates in Uganda secured commitments from multiple district leaders to allocate health budget funds to RH supplies.

Civil society organizations have also successfully highlighted the need for effective coordination to ensure smoother distribution of supplies and to help avoid stockouts. In Bangladesh, NGO staff were essential in reviving the national contraceptive coordination committee, which had been dormant for three years. In some cases, civil society organizations have provided trainings to national health sector staff to build their capacity for procurement and logistics in the face of waning external technical assistance.

Civil society has worked to spark media interest in reproductive health supplies issues, and has been successful in some cases, such as a front-page newspaper article in Bangladesh that brought a quick response from the highest levels of government, and media briefings and radio programs with parliamentarians in Uganda. These achievements are far from comprehensive, and advocates regularly initiate additional strategies based on their own capacities, knowledge and

Supplies await distribution at the National Medical Stores in Ghana. (Susan Anderson/PAI)

target audiences. Advocacy environments are ever-changing, and their constant evolution demands adaptability, flexibility and a keen attention to specific contexts. The following list includes some of the entry points for advocacy that emerged in the course of country research.

- NGOs with experience in service delivery can utilize their expertise to highlight the relevance of coordination, funding and prioritization to government officials who often move to different job posts. Given that other health issues may have taken precedence over reproductive health at the national level, this could take the form of a large-scale communications campaign to motivate both government officials and public opinion, as is currently being developed in Uganda.
- Working through contraceptive coordination committees or other forums, advocates can provide quantification and projections of need, as well as linkages between reproductive health and broader development issues, to justify the commitment of sufficient financial resources for supplies on the part of governments. Even if the Ministry of Health understands the importance of ensuring access to supplies, the Ministry of Finance or other powerful government bodies will, in most cases, benefit from further education.
- Advocates can also link directly into government, where supporters offer unique access. In Uganda, a network of female parliamentarians promoting improved maternal health serves as the most prominent champion of reproductive health supplies. In Bangladesh, advocates' strategic decision to recruit former top-level government officials with decades of experience as consultants and advisors gained civil society entry with senior decision-makers.
- Particularly in the context of fragile funding as outlined above, advocates can play a key role in adding relevant indicators to policies and planning documents, monitoring budgets and promoting transparency to ensure that promised funding is actually disbursed.
- Advocates can demonstrate that reproductive health supplies should not be set in a "silo" separate from other health issues, such as maternal mortality or HIV/AIDS. With support from national advocates, nine country governments recently submitted proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria that integrated reproductive health, including supplies, with HIV/AIDS prevention, treatment and care, resulting in the successful mobilization of tens of millions of dollars. National health insurance schemes under development in various countries provide another important opportunity for integration.
- In order to address challenges of procurement and logistics as technical assistance eventually phases out, advocates should ensure that broader efforts to strengthen health systems emphasize sustainability of the supply chain for contraceptives and condoms, and promote mechanisms to improve coordination within and between higher and lower levels.
- Civil society organizations are often active at the regional and local levels in areas far from national capitals. This degree of entrenchment in decentralized environments is well-suited to advocacy for budget oversight, community sensitization and coordination to ensure that supplies reach the poorest and most underserved populations.
- Global-level commitments such as the Millennium Development Goals and the Paris Declaration on Aid Effectiveness can serve as strong motivators for both country governments and donors. Such commitments can serve as accountability monitors for policymakers, and are also useful when working in a regional or cross-country context.

METHODOLOGY

The six countries were selected across three world regions based on the “need and readiness for supply advocacy, existence of civil society networks and convergence of other complementary work on the supply issue.”⁸ The group of countries offers insight into the opportunities and challenges of increasing commitment to reproductive health supplies in settings that differ geographically, and in a myriad of other respects.

Research was conducted between September 2007 and March 2009. The methodology included evaluations of each country’s context and policy documents. The research team conducted in-country interviews with key stakeholders, including government officials, civil society organizations and bilateral and multilateral donors. Research and writing followed a standard template, with six main areas of focus, as reflected in the narrative structure of this synthesis paper and each country report.

Research centered on the funding, structure and logistics of reproductive health care provided by the public sector in each country, although services offered by NGOs and social marketing organizations are also discussed. Assessments of reproductive health supplies in the public sector, although an incomplete picture, provide a simple measure of the access to services presumably available to a country’s entire population, including the poorest and most vulnerable. Still, it is important to note that use of the public sector as a source of supplies for contraceptives and condoms varies considerably. In Mexico, Nicaragua and Tanzania, two-thirds or more of women obtain modern contraceptive methods through the public sector; in Ghana and Uganda, the share drops to 35 or 40 percent.

2 COUNTRY CONTEXT

The six focus countries range from a population of five million to the seventh most populous country in the world. In general, a geographic divide distinguishes Ghana, Tanzania and Uganda from the other three countries in terms of access to and measurements of reproductive health. In each of the three African countries, 20 percent or fewer of married women of reproductive age are using a modern contraceptive method, according to the most recent survey data. In Mexico and Nicaragua, contraceptive prevalence stands above 60 percent, while Bangladesh falls in the middle. Unmet need for family planning is also highest in the African countries, although there is a wider range. In Uganda, nearly 41 percent of women would like to delay or prevent their next pregnancy but are not using an effective contraceptive method; in Nicaragua and Mexico, this rate, although still significant, is much lower at eight and 12 percent. In the case of another indicator of reproductive health, the maternal mortality ratio, Bangladesh, Ghana and Uganda have similarly high levels. Tanzania's maternal mortality ratio of 950 deaths per 100,000 live births is extremely high. A wider range of demographic indicators is presented in each individual country case study.

Bangladesh is noted for its long history of family planning program success, dating from the 1970s. In a 2007 survey, although the country's fertility rate declined to 2.7 children per woman, contraceptive prevalence using modern methods was measured at 47.5 percent, unchanged for the past three years, and unmet need for family planning at 17.1 percent, an increase from 11 percent in 2004. The government of Bangladesh described population growth as the main barrier to the country's development over 30 years ago in 1976. Family planning efforts have remained distinct and segregated from broader health services, with the division emphasized by a bureaucratic structure of separate directorates within the Ministry

of Health and Family Welfare (MOHFW). The government has set a target of reaching a total contraceptive prevalence rate (CPR) of 73.2 percent (modern and traditional methods) by 2010; meanwhile, the number of women of reproductive age is projected to increase by 23 percent—assuming continued fertility declines—by 2025.

The government of Ghana has been active in reproductive health issues for decades; its 1969 population policy was the third such document published in Africa.⁹ In the 1980s, the introduction of a social marketing program and strengthened commitment on the part of government officials contributed to significant results in family planning, with fertility falling by two children per woman in a decade. Between 1998 and 2003, however, Ghana's fertility rate remained stagnant at over four children per woman (though this is among the lower fertility rates in sub-Saharan Africa). Contraceptive use is very low, with fewer than 20 percent of married women using a modern method, and another one-third of married women of reproductive age are estimated to have an unmet need for family planning. As in indicators of family planning use and demand, Ghana fares better than its West African neighbors in its maternal mortality ratio (560 deaths per 100,000 live births), but this level is still quite high on a global scale.

Mexico's family planning program was not formally initiated until the 1970s, but it achieved results very quickly. Mexico has the lowest fertility rate among the six countries, at 2.1 children per woman, which is also "replacement level fertility," the rate needed to sustain a population at a stable level. Young people face greater barriers and challenges to accessing reproductive health services in Mexico, which has a high adolescent fertility rate. Sixty percent of adolescent girls do not use contraceptives. The level of unmet need

TABLE 1. SELECTED DEMOGRAPHIC INDICATORS

	Bangladesh¹⁰	Ghana¹¹	Mexico¹²	Nicaragua¹³	Tanzania¹⁴	Uganda¹⁵
Total population, millions (2005)	153	22	105	6	39	29
Projected total population, millions (medium-fertility variant, 2025)	195	32	123	7	67	53
Total fertility rate (TFR)	2.7 (2007)	4.4 (2003)	2.1 (2006)	2.7 (2006/2007)	5.7 (2004)	6.7 (2006)
Contraceptive prevalence rate (CPR) (percent of women ages 15-49 married or in union, modern methods)	47.5 (2007)	18.7 (2003)	62.8 (2006)	69.8 (2006/2007)	20.0 (2004)	17.9 (2006)
Unmet need for family planning (percent of women ages 15-49 married or in union)	17.1 (2007)	34.0 (2003)	12 (2006)	7.5 (2006/2007)	21.8 (2004)	40.6 (2006)
Maternal mortality ratio (deaths per 100,000 live births, 2005)	570	560	60	170	950	550

for family planning among teenagers ages 15 to 19 is three times higher than that for women of reproductive age as a whole. Contraceptive use is also much lower among rural women and those of indigenous origin.

Nicaragua's fertility rate has been steadily declining, from 3.6 children per woman in 1998 to 2.7 in 2006, and use of modern contraceptive methods is very high, at 70 percent. However, differences in family planning indicators are vast among different income groups. While the wealthiest 40 percent of Nicaraguan women have families of fewer than two children on average, women in the poorest income group have nearly five children. Adolescent fertility has decreased by one-third since the 1990s, but nearly one-third of

girls are mothers by the age of 18. Nicaragua has the lowest level of unmet need for family planning among the six countries at eight percent among all married women.

Tanzania has had a static fertility rate, now measured at 5.7 children per woman, and equally unchanging level of unmet need for family planning since the mid-1990s. Unmet need, at 22 percent among married women, is actually higher than use of modern methods of family planning, which stands at 20 percent. Although contraceptive use has increased by 50 percent since 1996, it remains very low, and most women and men report a desired family size of at least five children. Tanzania also has a very high maternal mortality ratio, at 950 per 100,000 live births. This means

that almost one percent of mothers die due to pregnancy-related causes for each successive birth, and given Tanzania's high fertility rate, the life-time risk of death due to maternal health reasons is one in 24.

Uganda has the highest fertility rate (6.7 children per woman), lowest contraceptive prevalence rate (18 percent), and highest level of unmet need for family planning (41 percent) among the six countries included in this series. Indeed, unmet need for contraceptives in Uganda is the third highest rate in the world. Knowledge of family planning methods is high, but fewer than 20 percent of

married women are currently using a modern contraceptive method. Although there has been an active family planning program (initiated in the NGO sector) since the 1950s, government support and the attention paid to these challenges will be a key determinant of the future of reproductive health in Uganda.



A MEXFAM youth promoter speaks to a class of teenage girls in Mexico City about contraceptive options. (Maia Bradley)



A range of contraceptive methods at an UMATI clinic in Tanzania. (IPPF/Sarah Shaw)



Boxes of oral contraceptives at a regional warehouse in Bangladesh. (Elizabeth Leahy/PAI)



A truck at a Central Medical Stores warehouse in Ghana. (Jessica Bernstein/PAI)

3

THE POLICY ENVIRONMENT FOR REPRODUCTIVE HEALTH SUPPLIES

All six countries have multiple policies that acknowledge the importance of reproductive health, including family planning. Each country has also set a specific target for improving contraceptive prevalence rates. In most countries, the policy environment is quite favorable, with a range of documents that explicitly address the government's commitment to improving access to reproductive health supplies. Bangladesh, Ghana and Uganda have developed policies that are exclusively devoted to achieving contraceptive security. All countries except Nicaragua have published population policies, though some have not been updated for over 15 years, and all but Bangladesh have dedicated reproductive health policies. Reproductive health services are addressed in the national development/poverty reduction plans of all countries except Mexico. The comprehensiveness of essential medicine lists varies; all countries include contraceptives to some extent, though the lists for Ghana and Tanzania include only a single method. Despite this generally positive framework, it is important to consider that development policies are often heavily influenced by donors, and in most countries, stakeholders report that implementation of the government's policy commitments lags behind. The motivation and support of top-level leaders for reproductive health, or lack thereof, can also affect the strength of policy implementation, as is most evident in Nicaragua and Uganda.

Bangladesh

Although there have been dramatic declines in fertility and increases in contraceptive use in the past 30 years, the government of Bangladesh continues to recognize population as a top priority, and this is reflected in multiple national policies. The updated National Health Policy, in draft form in August 2008, indicates that "family planning needs to be identified as a primary national problem." Both this policy and the 2004 National Population Policy set a target of achieving a net reproduction rate (average number of

daughters born to each woman) of one by 2010, which has been a goal since 1985 and is widely acknowledged among stakeholders interviewed to be unfeasible. Although the National Maternal Health Policy and the Health Nutrition Population Sector Program (HNPS) (the sector-wide plan for health), set a target for contraceptive prevalence rate, the National Population Policy and draft National Health Policy lack specific targets for CPR, unmet need, reduction of stockouts or other measures of contraceptive availability. Bangladesh's Essential Medicines List was updated in 2008 for the first time since 1982 and now includes oral contraceptives and condoms, but not a full range of RH supplies. Government staff in the Directorate General of Family Planning seemed unaware of this missed opportunity.

Ghana

Ghana's policy environment is quite favorable for reproductive health supplies. Based on policy language, the government recognizes the links between population and other areas of development, such as education and health. Nearly all published policies highlight the need to strengthen family planning services, including access to reproductive health supplies. Ghana has a formal policy on "Repositioning Family Planning" covering a three-year period; its strategies are intended to result in clear targets for contraceptive prevalence, total fertility, population growth rate and maternal mortality. However, the Essential Medicines List only contains a single method, injectables, identified for contraceptive use.

After a shift in power in early 2009 following the presidential election, supporters of reproductive health are assessing the interest and commitment to such issues within the new government. Stakeholders generally agree that the challenge for Ghana's policy environment is to translate strong commitments on paper into equally strong political prioritization, as family planning has been eclipsed by other health issues on many

In most countries, the policy environment is quite favorable, with a range of documents that explicitly address the government's commitment to improving access to reproductive health supplies.

policy-makers' agendas. Although reams of government policy documents demonstrate an official understanding of and commitment to reproductive health and family planning in Ghana, some observers feel that such programs are in decline, due to overshadowing focus on other health issues such as HIV/AIDS and a decline in donor financial support. Unmet demand for family planning in Ghana remains very high, and missed opportunities, such as the exclusion of contraceptives from the National Health Insurance Scheme, will only reduce needed access to reproductive health supplies, not expand it.

Mexico

Mexico's original 1974 population policy was strongly supported by the single ruling party for 35 years, and when political leadership changed in 2000, there was little concern that support for family planning would wane. However, many observers feel that family planning efforts have faltered in this decade, suffering from declining expenditures on the part of state governments. Unmet need for family planning has remained stagnant, and contraceptive prevalence did not reach the goal set in the National Population Program 2001-2006.

The major development policies produced by the government of Mexico are re-written at the beginning of each new presidential administration. The ruling party, Partido de Acción Nacional (PAN), which was re-elected in 2006, did not release its National Population Program until late 2008 and only after pressure from advocates. However, the

document does not appear to have shifted from previous policy, and it emphasizes the importance of ensuring access to sexual and reproductive health services among marginalized and vulnerable groups. The government also belatedly released a Program of Action for Family Planning and Contraception, which sets actions designed to improve contraceptive security and targets for CPR and unmet need for family planning. Although the National Health Program 2007-2012 focuses on the reproductive health needs of young people, neither the National Development Plan nor the Social Development Program reference family planning. On a positive note, the government recently published Mexico's first action plan on sexual and reproductive health for adolescents.

Still, given the delay in releasing key documents, the conservative political orientation of the PAN, its alliance with traditional Catholic hierarchy, and a statement by a cabinet secretary in the previous administration that Mexico now needs to repopulate the country, interviewed stakeholders speculate that political support for family planning has weakened considerably. Political leaders at the federal level in recent years have treated the issues with disdain or hostility, and access to reproductive health services in less developed regions and among vulnerable groups—where unmet need for family planning is highest—remains limited, despite positive recent policies and action plans. Conservative groups have begun to frame reproductive health in strictly aggregate demographic terms, positing that population issues are no longer important since the country

TABLE 2. REPRODUCTIVE HEALTH SUPPLIES IN NATIONAL POLICIES

	Bangladesh	Ghana	Mexico
Population Policy	Published 2004. Highlights importance of contraceptive supply system. Discusses need to raise CPR and lower TFR.	Published 1994. Highlights availability and affordability of family planning supplies. Sets targets for CPR, TFR and birth spacing.	Published 2008. Emphasizes need to provide sexual and RH services to adolescents, the poor, indigenous groups and those in hard-to-reach areas.
Reproductive Health Policy	None.	Published 2003. States necessity of access to a full range of contraceptive methods. Describes minimum accepted level of program performance.	Program of Action: Family Planning and Contraception (2007-2012): Identifies insufficient contraceptive supplies as a problem, with three sets of actions. Sets targets for CPR and unmet need for family planning.
Contraceptive Security Strategy	Published 2002. Focuses on long-term/permanent methods, public-private partnerships and supply chain management.	Covers 2004-2010. Five-pillared framework: financing, partnerships, efficiency, quality, and monitoring and evaluation.	None, although substantially addressed in Program of Action: Family Planning and Contraception (above).
Health Sector-Wide Approach (SWAp)	Health, Nutrition and Population Sector Program (2003-2011): Highlights ensuring availability of contraceptive supplies. Sets targets for CPR, TFR and adoption of specific methods.	Health Sector Programme of Work (2007-2011): Repositioning family planning and ensuring contraceptive security are activities to support an objective of strengthened reproductive and sexual health.	National Health Program (2007-2012): Includes a line of action for family planning. Sets a target for CPR and adolescent fertility.
Poverty Reduction Strategy Paper (PRSP)	PRSP (2005-2008): Sets indicators for adequate supply and efficient distribution of drugs, and for CPR and TFR. New PRSP approved late 2008.	Growth and Poverty Reduction Strategy (2006-2009): Includes a section on population management. Promotion of family planning services is a program priority.	Social Development Program (2007-2012): Objectives include ending gender-based discrimination and promoting development of young people. No discussion of family planning or reproductive health.
Essential Medicines List	Updated 2008. Includes condoms and oral contraceptives.	Published 2004. Includes injectables as only drug in “contraceptive” class. 2008 revision delayed.	Updated 2007. Lists 20 items in the “family planning” group, including oral contraceptives, injectables and implants.
Other policies addressing RH supplies	National Health Policy; National Maternal Health Policy; Adolescent Reproductive Health Strategy	A Roadmap for Repositioning Family Planning in Ghana 2006-2010	National Development Plan 2007-2012; Program of Action: Sexual and Reproductive Health for Adolescents 2007-2012

Nicaragua	Tanzania	Uganda
None.	Published 1992. Discusses family planning only in the context of maternal and child mortality; does not discuss RH supplies.	Published 2008. Includes an objective on reducing unmet need for FP with a strategy to promote RH commodity security.
Published 2008. Contraceptive security is one of eight objective areas; refers to need to offer "accessible and high-quality family planning services." Sets targets for CPR and unmet need.	Covers the period 2005-2010. Sets targets for increasing CPR. Highlights unmet need for family planning and provision of essential supplies.	Covers the period 2005-2010. Sets target for lowering maternal mortality ratio; repeatedly addresses need to improve contraceptive security and reduce stockouts.
None.	None.	First CS strategy, covering 2009-2014 with eight strategic objectives, to be published in 2009.
National Health Plan (2004-2015): Includes the elimination of unmet need for family planning as a performance indicator.	Second Health Sector Strategic Plan (2003-2008): Mentions the need for a continuous supply of contraceptives and highlights the low CPR.	HSSP II (2005/06-2009/10): Includes targets for increasing CPR; achieving universal access to condoms; improving availability of emergency contraception; and lowering the drug stockout rate, including for injectables.
National Development Plan (2005): Sets targets for reducing unmet need and improving access to FP.	National Strategy for Growth and Reduction of Poverty (2005): Contains a strategy to promote reproductive health, including access to family planning services.	Poverty Eradication Action Plan (2004/05-2007/08): Links reproductive health to poverty. Indicators include lowering the drug stockout rate, including for one injectable brand; and reducing unmet demand for family planning.
Updated 2005. Includes oral contraceptives, injectables, IUDs, condoms and sterilization and vasectomy supplies. Separate social security list includes oral contraceptives, injectables and IUDs.	Published 1997. Includes oral contraceptives.	Published 2001. Includes oral contraceptives, implants and injectables.
Strategy for the Prevention of Pregnancy in Adolescence; National Sexual and Reproductive Health Program; Framework for a Model of Family and Community Health; National Plan on Maternal Mortality; Short-Term Institutional Plan	National Package of Essential Reproductive and Child Health Interventions; Roadmap for Maternal, Newborn and Child Health	National Family Planning Advocacy Strategy; National Advocacy Strategy in Support of RH, Population and Development Programmes; Adolescent Health Policy; Roadmap for Reduction of Maternal and Neonatal Mortality

has achieved replacement-level fertility, and have conflated family planning and abortion.

Nicaragua

Nicaragua has a large set of policy frameworks that relate to reproductive health supplies, supported by constitutionally mandated rights to reproductive health and universal access to health care. The array of official documents that specifically address improving access to reproductive health services and/or reducing unmet need for contraception include the National Strategy for Sexual and Reproductive Health (2008), the Short-Term Institutional Plan Aimed at Results (2008), the Conceptual Framework for the Model of Family and Community Health (2007), the National Plan on Maternal Mortality (2007), the National Development Plan (2005), the National Health Plan (2004) and the Strategy and Basic Guidelines for the Prevention of Pregnancy in Adolescence (2003). The sexual and reproductive health strategy released in 2008 includes a strong component on the need to improve access to services and supplies among adolescents.

Despite this seemingly favorable policy environment, the political atmosphere in Nicaragua has changed dramatically since the election of former Sandinista president Daniel Ortega in 2006, with generally negative repercussions for supporters of reproductive health. The president has allied himself with Nicaragua's Catholic hierarchy and promoted a bill banning abortion in 2006. Following disputed municipal elections in November 2008, organizations that had advocated in favor of reversing the abortion ban were threatened with legal action. Pro-Welfare of the Nicaraguan Family (PROFAMILIA), the national IPPF affiliate, unexpectedly had the operational licenses for two of its clinics withdrawn by the government, and its services contract with the social security agency rescinded. The political situation continues to evolve, but given new hostilities from the highest levels, combined with the ongoing phaseout of

contraceptive donations from major donors, access to reproductive health supplies is likely to be endangered under the current government.

Tanzania

Tanzania has a full range of policies that address reproductive health and the need to secure access to contraceptives and condoms, though its population policy has not been updated since 1992 and does not reference RH supplies. Reproductive and child health is one of five major components of the National Essential Health Package, and has its own set of essential interventions that include the need to provide comprehensive family planning services ranging at all levels and the government's responsibility to provide reproductive health supplies, education and counseling. Tanzania's poverty reduction plan includes a strategy devoted to the promotion and protection of reproductive health, and the Roadmap for Maternal, Newborn and Child Health, launched in 2007, calls for increased funding and availability of contraceptives. However, the policy environment calls for some improvements. Tanzania has no official strategy on contraceptive security, and an earlier attempt to draft one stalled. The Essential Drug List only includes varieties of a single contraceptive method, oral contraceptives, while the Primary Health Services Development Plan (MMAM) does not address family planning as a method to reduce maternal mortality. Although a renewed emphasis on maternal health provides an entry point for linking with reproductive health, the fact that family planning was entirely omitted from the MMAM demonstrates that some officials do not consider it an integral component of the health system. In addition, the Roadmap for Maternal, Newborn and Child Health is not widely known at the district level, and its secretariat remains inactive.

Uganda

Since the mid-1990s, when family planning in Uganda was only available to married women

with their husband's permission and the country had yet to produce a population policy, a number of comprehensive policies have been introduced. These include a recently revised National Population Policy that includes a strategy on promoting RH commodity security; a Strategy to Improve Reproductive Health in Uganda that repeatedly references contraceptive security and the need to reduce stockouts; and distinct advocacy strategies for both family planning and reproductive health. In early 2009, the Ministry of Health was preparing to release the country's first Reproductive Health Commodities Security Strategic Plan. A draft of this plan reviewed by the authors contained eight objectives ranging from policies to monitoring and evaluation, each with a proposed budget. Each of these documents, and others, directly address the need to improve access to and availability of reproductive health supplies. Still, the Population Secretariat, a government body, sometimes reiterates the president's argument that Uganda's fast-growing population will be a major driver for economic growth. The newly instated minister of state who supervises the Secretariat recently stated that Uganda's population growth is driven by electricity shortages and thus infrastructure improvements, not family planning, are needed to address the issue.¹⁶

Like other countries, Uganda has a favorable policy environment based on the frequency with which population and family planning are addressed in official documents and the repeated identification of unmet need to family planning and insufficient access to contraceptives and condoms as barriers to health and development. However, also similar to other countries, the implementation of these policies is lacking. Political leaders, including the president, have been vocal about the perceived benefits of population growth, and this contributes to a lack of motivation among reproductive health program managers, even though they are often individually committed. Efforts are needed to ensure that population and reproductive health are mainstreamed and prioritized in revisions to existing policies, such as the forthcoming National Development Plan. Meanwhile, the pro-natalist rhetoric offered by some government leaders is extremely counterproductive in reducing the country's very high rate of unmet need for family planning. Advocacy is needed to promote the fact that access to reproductive health supplies is a right so that community mobilization can create pressure on local and national leaders to provide access to the supplies that their policies repeatedly guarantee.

The political atmosphere in Nicaragua has changed dramatically since the election of former Sandinista president Daniel Ortega in 2006, with generally negative repercussions for supporters of reproductive health.

4

THE PUBLIC SECTOR HEALTH SYSTEM STRUCTURE

The six countries are alike in that family planning services are managed by a dedicated government unit, though names of such units vary from family planning to reproductive health to maternal health. Other than this similarity, the public health system structure in each country presents unique advantages and obstacles. In Mexico and Nicaragua, health systems follow the common Latin American model, with care divided between social security systems for formal workers, public sector systems for the poor and informally employed, and a small private sector. In Nicaragua, the recent policy decision to offer universal free health care, including of medicines such as contraceptives and condoms, has been overwhelmingly popular, but has strained the health system. In Bangladesh, family planning remains rigidly separate from primary health care, while in Tanzania, the unit for reproductive health has a lower hierarchical position in the government bureaucracy than that for HIV/AIDS. In Ghana, the introduction of a national health insurance system has been a barrier rather than an opportunity for reproductive health, as contraceptives were excluded from the group of services covered under the program.

Bangladesh

The major investments of financial and human resources devoted to the family planning program by the government of Bangladesh in the 1970s appear to have languished. Staffing in the Directorate General of Family Planning (DGFP) has shifted in favor of career civil servants with little technical expertise and often short tenures. For example, the DGFP has been headed by approximately ten different individuals in the past six years. While limited terms and knowledge inhibit decision-making and leadership at the bureaucratic levels, the human resource challenges of Bangladesh's family planning program are compounded by a severe and growing shortage of health service delivery workers. The waves of family welfare visitors and assistants who provide front-line

reproductive health services in communities around the country were largely hired more than two decades ago, and as they retire, recruitment and training of replacements is lagging behind. There has been resistance to the integration of the Directorates General of Family Planning and Health within the Ministry of Health and Family Welfare (MOHFW), although this may change under the current government. Coordination committees for both health and family planning exist at the district level, but coordination remains weak at the central level. The committee created to coordinate supplies under the leadership of the DGFP did not meet regularly until recently, when motivated by the Family Planning Association of Bangladesh (FPAB). The integration of a new administration following recent elections has also somewhat delayed program implementation, as program managers wait to observe shifting political winds.

Ghana

Health sector reform, with decision-making shifting from central to district levels, is ongoing in Ghana. Family planning and maternal health services are overseen by the Family Health Unit, located within the Public Health division of the Ghana Health Service. Community health centers are intended to be the main service delivery point for family planning methods. In 2003, the government created the National Health Insurance Scheme (NHIS), with a goal of reaching universal coverage by 2010. Users pay a sliding-scale fee to enroll in the program and are then eligible for services at any government or accredited facility. However, contraceptives were intentionally not included in the list of services covered by the NHIS, under the assumption that family planning is available at no cost in public sector clinics. In practice, users are often charged fees for contraceptives, and their exclusion from the insurance scheme renders family planning a seemingly low priority.



Patients wait at a rural health clinic outside Mityana, Uganda. (Elizabeth Leahy/PAI)

Mexico

Mexico's health system historically divided the population into groups with access to the separate social security network of facilities and those whose access was limited to public sector care. The social security network, available to private sector and government workers, covered slightly half of the population, with others limited to public facilities jointly operated by the federal and state governments or to the poorly-regulated private sector. Family planning services have been available for free at both social security and public facilities since the mid-1970s.

In 2000, a major reform of the health system began and the government established the People's Health Insurance program. Operation of public sector facilities, together with a large share of the federal health budget, was shifted to the

Secretariats of Health in the 32 states, who have authority to allocate funding based on their own assessments of local needs and priorities. Only vaccines, which are considered a matter of national security, are exempt from this decentralization. Reproductive health supplies were once also classified as a matter of national security due to their importance in achieving the National Population Policy, but are no longer. Meanwhile, the social security health system, which is the primary source of contraceptives, is facing financial challenges and patients are less likely to receive the free medications to which they are entitled.

Nicaragua

As in Mexico and many other Latin American countries, the Nicaraguan health system is divided into a social security sub-system for most formal workers, a network of public sector facilities for

the poor and informally employed, and a small private sector that primarily serves the very wealthy. However, this system has been complicated by a previous hiatus in the operations of the Social Security Institute (INSS) and its recent restructuring by the current administration which has left the agency rather disjointed and covering only a portion of the formally employed segment of the population it is intended to support. Health services within the social security system are provided by private provisional medical enterprises (EMPs) operating within facilities. These EMPs may or may not offer family planning services, and they have recently been directed to purchase their own reproductive health supplies rather than using those supplied by the central government. The right to family planning methods should be explicitly guaranteed for those who receive health care through the social security system, which should also be encouraged to revise its separate list of essential medicines to match the more comprehensive official version of the Ministry of Health.

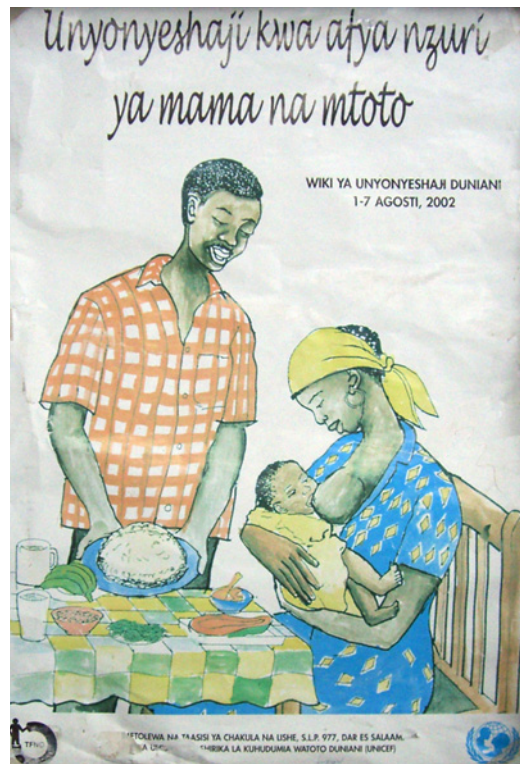
Meanwhile, the public sector health care offered by the Ministry of Health has been undergoing reform for several years. Health agencies (SILAIS) intended to administer management, planning, technical and logistical support were established in each regional department. In most cases,

the SILAIS have maintained decision-making responsibilities at the regional level rather than passing authority on to the municipal level, which is responsible for service delivery. During this time, the government was only able to provide selected medications at no cost, and individuals had to pay user fees for care received. Upon assuming office, President Ortega announced a policy of universal free health care, extending to medicines. Stakeholders report that the increased demand for health care since this policy change was enacted has taxed the system's capacity, and patients are still sometimes asked to pay for their own medications, including contraceptives. Throughout the health system, "free health care" is increasingly considered a goal rather than an achievement.¹⁷

Tanzania

Tanzania's health system is decentralized, with a number of key federal agencies regulating policy, financing and logistics, while authority for facility operations and local health plans rests at the district level with local government authorities (LGAs). At the central level, the Reproductive and Child Health Section of the Ministry of Health and Social Welfare is not a separate directorate but a vertical program with its own financing and procurement. Forecasting and logistics are managed by the Pharmaceutical Support Unit, while

Advocacy targeting officials at all levels of government has the potential to make major inroads in Tanzania.



Left: A poster displays contraceptive methods at a MEXFAM clinic. (Christine Bixiones/PAI)

Right: A poster in the reproductive health unit at Selian Lutheran Hospital in Tanzania promotes breastfeeding for maternal and child health. (Elizabeth Leahy/PAI)

procurement and distribution (including international tender for contraceptives) occurs through the Medical Stores Department. At the district level, local budgets and health plans, which may include RH supplies, are designed and implemented by 122 councils through the LGAs following broad guidelines issued at the central level. Councils have authority to direct funding in their districts through their own health baskets, with total funds available allocated at the central level. An external evaluation of the health sector found that shortages of supplies and workers combined with poor infrastructure inhibit effective service delivery.

Advocacy targeting officials at all levels of government has the potential to make major inroads in Tanzania. Some parliamentarians have reportedly questioned whether the country still needs external assistance for family planning, and the Reproductive and Child Health Section occupies a lower position in the bureaucratic hierarchy than offices devoted to other health issues, which weakens the ability of its staff to champion their issues.

Uganda

Uganda's political structure includes a Population Secretariat, housed in the Ministry of Finance, Planning and Economic Development. The Secretariat is responsible for coordinating the implementation of population policies across the various levels of government. Within the Ministry of Health, family planning, safe motherhood and related programs are administered by the Reproductive Health Division. Procurement and distribution of reproductive health supplies and other medicines are the responsibility of the National Medical Stores, while the regulatory functions provided by the National Drug Authority include testing imported condoms. Decentralization means that district health services are responsible for translating central-level policies into health outcomes at the community level. However, ties between facilities, districts and national authorities are weak, and districts are not yet prioritizing RH supplies in their health plans or budgets.

5

FINANCING OF REPRODUCTIVE HEALTH SUPPLIES

Other than uncertainty, no single pattern of reproductive health supplies financing exists among the countries profiled in this study. In Bangladesh and Uganda, little concern for the long-term future of reproductive health supplies funding is evident. Although the shift to sector and budget support has allowed governments to claim more ownership of their own financing needs, most countries are still reliant on donor aid for their reproductive health programs, even if such support is now drawn from pooled funding. However, Mexico no longer receives donor support for RH supplies, and Nicaragua's donor funding will end soon.

Budget line items for reproductive health supplies are in place in all countries, though decentralization makes funding difficult to track in Mexico, where support for reproductive health supplies is determined by individual states, with no binding targets at the federal level aside from that for the social security system. In Ghana and Nicaragua, governments have signed on to ambitious financing plans with donors that will require the share of reproductive health financing generated internally to rise dramatically, or become universal, in the very near future. In the case of Ghana, serious funding gaps are already evident; in Nicaragua, government commitment to exceeding its share of funding has been promising, but recent events are likely to jeopardize the security of this funding.

Bangladesh

Bangladesh is atypical in that stakeholders are broadly confident in the long-term financial sustainability of the family planning program through external funding. So far, although the government has directed its own funding to other essential medicines, it has relied exclusively on World Bank loans and credits, as well as contributions from a small number of other bilateral and multilateral donors, to support reproductive health supplies. Although the government has allocated internal funding for contraceptives, in

most cases staff have determined that sufficient resources are available from other sources, and government funds have been reallocated. In the 2008/2009 fiscal year, a local manufacturer was unable to provide the necessary quantity of condoms, resulting in another reallocation of government funds.

Health sector funds are provided through a pool of contributions from the government of Bangladesh and donors. Financing limitations have not been an issue for the health sector pool; in fact, the government periodically has trouble spending all of the funds available. Unfortunately, unanticipated interruptions in the availability of funding can have lasting repercussions. During the transition between successive health sector development plans in 2005-06, insufficient quantities of buffer stock resulted in significant contraceptive stock-outs when the release of new funding was delayed. Although stakeholders are confident about the financing of contraceptives and condoms, they should be cognizant of the implications of ongoing withdrawals in direct support from donors, as well as potential expectations of development partners that the government will improve the efficiency of its use of funds.

Ghana

As in other countries, donors are shifting away from vertical program funding and in-kind contributions toward sectoral and general budget support in Ghana. The U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) continue to provide direct funding for family planning programs, with a few budget earmarks also offered by some European bilateral donors. Health sector basket funding through a sector-wide approach (SWAp) has been an aid modality in Ghana for a decade, but is increasingly shifting to multi-donor budget support. Under this system, Ministry of Health staff must compete for pooled funding against other sectors, with final funding decisions made

TABLE 3. RECENT TRENDS IN FINANCING FOR REPRODUCTIVE HEALTH SUPPLIES

All funds in US\$ millions	Bangladesh ¹⁸	Ghana ¹⁹	Nicaragua ²⁰	Tanzania ^{21*}	Uganda ²²
2005	\$27.7	\$3.9	n/a	\$9.0	\$5.7
2006	\$10.6	\$5.1	\$1.3	\$8.8	\$4.2
2007	\$33.9	\$6.3	\$1.0	\$6.3	\$4.2
2008	\$34.5	\$5.4	\$1.7	n/a	\$5.8

*Fiscal year ending in specified calendar year.

Note: The most recent data on cumulative expenditures on contraceptives in Mexico's public sector date from 2004.

by the Ministry of Finance under the guidelines of the Medium-Term Expenditure Framework (MTEF). With increasing ownership over its own budget, the government is unlikely to prioritize family planning unless it is included in key guidelines such as the MTEF.

In a positive sign of its new authority over development financing, the government of Ghana has successfully instituted and funded an annual budget line item for contraceptives since 2003, which draws on resources from the pooled funds of the health SWAp. The value of the disbursed funding from the government's line item, which has also drawn on funding from tax revenue and World Bank credits, has lagged behind allocated amounts and varied in the range of \$1-2 million in recent years. In 2007, the Ministry of Health agreed to a contraceptive sustainability plan with donors. The plan rapidly increases the share of total contraceptive need funded by the government as donors simultaneously phase out their support. The Ministry's share of the total contraceptive budget would rise from 13 percent in 2006 to 80 percent by 2011.²³

At the same time that the government is quickly assuming responsibility for funding much of Ghana's needs for reproductive health supplies, a growing gap in funding is emerging. The gaps in funding identified for 2006 and 2007 were filled by donors, who made direct donations of contraceptives beyond what they had planned. However, the gap is expected to grow—by one estimate, the cumulative unaddressed funding for the three years between 2008 and 2010 would reach \$22 million.²⁴ In response to this situation, USAID has altered plans to phase out its support for contraceptives.²⁵ Although the government is on record promising to pick up the financial needs where donors leave off, these needs are growing and have already reached well beyond the scale of existing government support. The contraceptive financing gap for 2008 was more than double the level of any previous year. Financing will clearly be a key priority for the Ghanaian government's current and future support of reproductive health.

Mexico

Prior to the process of health sector reform and decentralization, reproductive health supplies were

consistently included as a line item in the federal budget. Now, the funding needs and availability for reproductive health supplies are determined separately by each Mexican state, resulting in 32 separate budget processes. Targets are proposed at the federal level at an annual meeting of all state secretaries of health and the Council of Health Prevention and Promotion, and later shared with the Secretariat of the Treasury. However, these expenditures are not labeled as budget line items and are not binding to the states. Although annual funding reports are published, the most recent data available date from 2004, estimating that total public sector expenditures on contraceptives were \$241 million.²⁶ Allocation of funds for the family planning services provided through the social security system is still done centrally, but financial difficulties are turning a greater share of the responsibility for purchasing contraceptives to the system affiliates.

The federal budget for “women’s issues,” which does not include reproductive health supplies, recently won an historic increase in the lower house of parliament, targeted by an advocacy network of NGOs.

Nicaragua

In recent years, Nicaragua’s Ministry of Health has relied on an increasing proportion of donor funds while reducing the government’s own contribution to health costs. Meanwhile, political leaders have requested that donations be made to the health sector or general budget, rather than through vertical direct funding. However, Nicaragua’s aid situation has become more precarious, both due to pre-planned phaseouts of support as well as negative responses by donors to the current administration’s authoritarian actions. Following the disputed elections in November, the U.S. announced a freeze in its support to Nicaragua through the Millennium Challenge Corporation, while other key donors such as the European Union and the Netherlands also suspended aid.

These political developments further undermine the financial security of reproductive health supplies, which was already in question. The government only introduced a budget line item for reproductive health supplies in 2006, and its funding levels for the first two years were quite small. Meanwhile, USAID and UNFPA both announced that their contraceptive donations would phase out, those from USAID in 2009 and from UNFPA in approximately 2012. Although technical assistance will continue for a few years, USAID plans to completely graduate Nicaragua from aid related to reproductive health supplies by 2012. This process was met by a full assurance on the part of the Nicaraguan government to meet the country’s contraceptive needs; in 2008, internal funding exceeded the government’s commitment and reached 40 percent of total need. However, the government contribution will need to roughly triple from 2008 levels by 2010, and the suspension of aid in both project and sector support following the electoral machinations of last year, even if only temporary, is likely to present major challenges in achieving this target.

Tanzania

The shift toward health sector and general budget support for donor funding is well underway in Tanzania, and the government has simultaneously instituted and successfully funded a budget line item for contraceptives. Overarching funding priorities are guided by the Medium Term Expenditure Framework, which combines internal and external sources, and the Joint Assistance Strategy, which is designed to align donor financing with government priorities. Reproductive health supplies are among a group of commodities whose budgets are managed separately through vertical programs. The government of Tanzania first allocated a budget line item for contraceptives in 2002, and began including its own internally generated funding in the line item in 2005. The line item represented more than half of the total budget for reproductive health supplies in



A rural health clinic in eastern Bangladesh. (Elizabeth Leahy/PAI)

2006-07, and the government is now procuring four contraceptive methods. USAID is the only donor that continues to provide in-kind donations of contraceptives, though its contributions are declining. Meanwhile, local authorities have the authority to program additional funding for RH supplies through the share of health sector basket funds allocated to districts, but monitoring the disbursements of more than 100 councils is challenging.

The relatively rigid central budgeting process, with competition for resources among ministries and a long delay between allocation of funds and receiving supplies, does not allow for the needed flexibility to adapt financial allotments to changing or rising needs. The use of up-to-date forecasting data demonstrating future need, as well as survey results showing stagnancy in indicators of family planning use and demand, has been successful in obtaining needed funds for reproductive health supplies in recent years, and these advocacy tools could be expanded to other ministries. At the district level, advocates could be more involved in the process of allocating funds in council block grants.

Uganda

Although funding for reproductive health in general is difficult to track, the government of Uganda supports a budget line item for contraceptives, with funds drawn from the Poverty Action Fund, the pooled resources to support implementation of the Poverty Eradication Action Plan. However, the funds allocated to the contraceptive line item are often shifted elsewhere or remain unspent. Two donors, USAID and UNFPA, are responsible for the majority of funding for RH supplies, and a major funding gap between demand and committed resources is already evident. Meanwhile, contraceptives are distributed at no charge through the public sector, and no districts are yet using their own budgets to support the purchase of supplies. Existing pressure from parliamentarians to demand accountability for the government's support of reproductive health provides an advocacy entry point, as does the stalled progress toward achieving the Abuja target of 15 percent of budget resources devoted to health.

6

FORECASTING, PROCUREMENT AND LOGISTICS MANAGEMENT

While some country governments have assumed full responsibility for their own logistics systems and delivery of reproductive health supplies, others are very dependent on external technical assistance. In all countries except Uganda, donors have transferred responsibility for the procurement of donated supplies to government agencies. All countries except Mexico have a contraceptive coordination committee operating at the national level to help forecast future needs and develop financial sustainability plans. Unfortunately, stockouts remain a regular occurrence, especially in individual facilities, as the delivery of supplies below the central level remains challenging. The current stockout of implants in Bangladesh highlights the difficulties of long-term planning for changes in methods and brands, which has also been an issue in other countries. Mexico, meanwhile, illustrates the high degree of fragmentation that can occur when logistics and procurement responsibilities are fully decentralized.

Bangladesh

In partnership with the USAID | DELIVER Project, the government of Bangladesh has implemented a state-of-the-art web-based logistics management system for contraceptives and condoms. The system provides automatic warnings of low supplies that, together with forecasting data, should support the foundation for a secure availability of reproductive health supplies. Unfortunately, limited long-term planning, challenges in procurement and the failure to update forecasting data on an annual basis are major impediments. Country ownership has become a tangible reality in Bangladesh. The government is privy to timely and regular information about the stock status of reproductive health supplies through its management of procurement and logistics, but a failure to act on this information has led to serious stockouts.

The Directorate General of Family Planning has held responsibility for procurement of contracep-

tives for several years. Although a Procurement Coordination Committee meets regularly and the Logistics Coordination Forum was recently revived, procurement-related delays have been identified as contributing causes to shortfalls or stockouts of three contraceptive methods in the past two years. In early 2009, a major stockout occurred as the government prepared for the transition between two different brands of implants. Although the logistics management system had provided advance warning of the impending shortfall, an emergency procurement by a donor was necessary, and backup supplies were not expected to arrive until implants had been stocked out at the central level for approximately three months. Questions remain about the capacity of DGFP staff to address ongoing procurement challenges when external technical assistance is no longer available.

Ghana

Ghana has recently transitioned to an integrated logistics management system, which joins the storage and distribution of contraceptives with other drugs and turns responsibility for procurement from donors to the government. Deliveries are scheduled to process through three main stages of the supply chain, with ordering and issuing of reproductive health supplies managed by Central Medical Stores. Ministry of Health staff conduct regular forecasting exercises with quarterly reviews. Outside technical assistance needed for the forecasting process is minimal, and the regular reviews have successfully identified current and projected funding gaps. A logistics assessment in 2006 found that 21 percent of facilities were out of stock for contraceptives on the day of the visit, a rate somewhat better than that of other essential medicines.

Coordination is handled through the Interagency Coordination Committee for Commodity Security (ICC/CS), which was formed in 2002. It is convened quarterly by the Ghana Health Service



Entrance to Central Medical Stores warehouse in Ghana. (Jessica Bernstein/PAI)

with membership drawn from government agencies, donors and NGOs. The committee drove the publication of Ghana's Contraceptive Security Strategy, and has successfully advocated for funds from donors to meet projected resource gaps, as well as identifying internal funding resources to the government. The preparation of annual forecasting tables and their subsequent quarterly review by the ICC/CS has been an instrumental component of its coordination function.

Mexico

After the phaseout of donor support for reproductive health supplies in the 1990s, the government assumed responsibility relatively seamlessly, and health facilities could rely on a tested and fine-tuned logistics system. During the process of decentralization, the federal government planned to contract with UNFPA to serve as a procurement agent for each of the 32 states now allocating their own funding. However, only half of the states signed on to the agreement with UNFPA, and the remaining 16 elected to handle their own procurement. Individual states' procurement

occurs through public bidding available to local manufacturers, international pharmaceutical companies, pharmacy chains and an array of distributors. Each state also maintains its own network of warehouses and distribution mechanisms. Due to delays in the public sector funding process, at least four states that originally joined the UNFPA procurement have since withdrawn. The social security agencies also procure contraceptives independently, but use an integrated supply chain within their own system. Although the federal Directorate of Family Planning conducts a joint forecasting exercise with the states and visits their facilities, it lacks enforcement powers.²⁸

According to many stakeholders, the fragmented logistics system in operation in Mexico has resulted in unnecessarily high prices paid for supplies by state governments, which in turn results in insufficient quantities and eventual stockouts.²⁹ Decentralization, despite its laudable goal of increasing local authority, has transformed a system with relatively stable and secure access to reproductive health supplies into instability and

Adolescent students and their parents attend a presentation on reproductive health and gender at a school in Malangala village in Uganda. (Elizabeth Leahy/PAI)



fragmentation. Meanwhile, although population is still considered a matter of national security by law, contraceptives have not been afforded the protection of vaccines in retaining federal oversight to ensure their availability at the state level. The efforts of the Mexican Foundation for Family Planning (MEXFAM) to create a shadow contraceptive committee at the state level is a movement toward much-needed coordination.

Nicaragua

The contraceptive logistics system in Nicaragua has improved significantly in recent years, in large part thanks to estimation of need based on consumption and inventory data and the integration of the contraceptive logistics system with those of other medicines. Current logistics barriers include delays in using local distributors for procurement (no contraceptives are manufactured locally in Nicaragua), balancing stock levels in facilities to meet increased demand under the new universal health care policy, and finding a replacement brand for an oral contraceptive product that has been discontinued. Ministry of Health staff still work together with the USAID | DELIVER Project for technical assistance with procurement, and the re-staffing of the government agency following the change in administration in 2006 required extensive new training.

A contraceptive security committee (DAIA) was formed in Nicaragua in 2003, coordinated by the Director of Reproductive Health in the Ministry of Health with membership drawn from the two major donors, NGOs and a social marketing organization. The DAIA was instrumental in developing a financial sustainability plan following the announcement of USAID's planned withdrawal of contraceptive support. However, after the 2006 presidential election, the Ministry of Health did not convene the DAIA for the first 18 months of the new administration. Meetings were renewed in mid-2008, although representation by the social security agency was delayed. The committee is continuing to focus on issues of government financing for reproductive health supplies.

Tanzania

Forecasting of contraceptive needs is managed by the Medical Stores Department in collaboration with the USAID | DELIVER Project. Projections of future need determined through the forecasting process are used by the Reproductive and Child Health Section (RCHS) to advocate for funds in the annual budget negotiation process. Tanzania has gradually been shifting to an integrated logistics system, joining more than a dozen parallel supply chains and shifting to a "pull" approach wherein orders are generated by local program

coordinators. Although government capacity to carry out forecasting, procurement and logistics functions is improving, stakeholders report that external technical assistance remains critical. A Contraceptive Security Working Group has been active since 2004, chaired by the RCHS and joined by donors and NGOs. It meets quarterly and has focused on various issues, including long-term financing and sustainability. Still, a 2005 assessment found periodic contraceptive stockouts in more than half of surveyed facilities.³⁰ Advocates are already working to form contraceptive coordination committees in certain districts; the expansion of these efforts across the country could make significant progress in reducing stockouts.

Uganda

The main challenges to Uganda's logistics system for reproductive health supplies lie in the delivery of commodities at the district level and below, as well as weak human resource capacity. Coordination of financing and logistics is addressed at the central level, primarily by the Reproductive Health Commodity Security coordination com-

mittee, chaired by the Reproductive Health Division in the Ministry of Health with membership from donors and NGOs. Forecasting is conducted annually by the Ministry of Health with technical assistance provided by the USAID | DELIVER Project. Procurement is handled individually by each funder, whether the Ministry of Health (using health sector pooled funds) or donors such as IPPF, UNFPA and USAID. Distribution occurs in a pull system, with facilities ordering stocks of reproductive health supplies from the National Medical Stores.

Although a tracking survey found that contraceptives were in stock at 80 percent of Ministry of Health facilities and 60 percent of NGO facilities on the day of visit,³¹ Uganda has had severe problems maintaining a stable stock of reproductive health supplies at the facility level in recent years. Coordination between the central level and district Drug and Therapeutic Committees could help identify the barriers preventing effective channeling of supplies to district level.

Uganda has had severe problems maintaining a stable stock of reproductive health supplies at the facility level in recent years.

7

DEVELOPMENT PARTNERS AND CIVIL SOCIETY

Most countries are experiencing some degree of decline in donor support for reproductive health supplies together with greater autonomy in funding decisions on the part of the government. This major shift away from decades of in-kind donations is already complete in Mexico and is underway in Bangladesh, Nicaragua and Tanzania. Only in Uganda has direct support for contraceptives and condoms remained stable at historic levels. Still, the level of donor commitment still greatly affects access to RH supplies in all countries, although to a much lesser degree in Mexico.

Meanwhile, NGOs have historically focused on service delivery in most countries, and have maintained a relatively small market share in the provision of reproductive health supplies. Most NGOs report a positive working relationship with the government, though in some cases they are also dependent on the government as a source of their reproductive health supplies. The relative experience of NGOs in fulfilling an advocacy role varies among the countries. In Bangladesh, Ghana and Tanzania, NGOs active in reproductive health are still newly developing their voice and strategies, while civil society advocacy in this arena is more advanced in Mexico and Uganda. In Nicaragua, recent political upheaval has left CSOs, especially those active in reproductive health and women's empowerment, under fire from a hostile government.

Bangladesh

Bangladesh is experiencing a decline in in-kind contraceptive donations from development partners. USAID no longer provides contraceptive donations to the government and is phasing out its support to the private Social Marketing Company. UNFPA, which has donated contraceptives with its own funds and served as a procurement agent for funding supplied by the Canadian International Development Agency, is shifting its focus away from funding and procurement to policy ad-

vocacy and capacity-building under the umbrella of reproductive health commodity security.

Meanwhile, NGOs, which represent about five percent of the market share for contraceptives and condoms, generally receive their reproductive health supplies from the government. Some NGOs have reported that despite a policy of equal access, the government sometimes prioritizes distribution of supplies to its own facilities when stocks are low. Within the field of reproductive health, NGOs in Bangladesh are often perceived by donors as service providers only, without a joint role as advocates. Because NGOs rely on the government as the source of supplies for their programs, they are in a delicate situation as political activists. Still, NGOs report their relationship with the government to be positive and based on mutual partnership.

As reported in the case study, “The legacy of family planning success in Bangladesh is now confronted with the challenges of weakened government capacity to carry out essential functions, which provides ripe opportunities for advocacy... although NGOs and other potential advocacy partners readily prioritize problematic policies and practices, there does not appear to be a history of coordinated action by the family planning community to effect change.”³² The “watchdog” role is still nascent, but growing, and advocates such as FPAB are benefiting from the advice and expertise of former government officials with the knowledge and access to pressure for change at high levels.

Ghana

Effective coordination among donors, government and NGOs has been a hallmark of Ghana's family planning program and is likely to continue under the auspices of the Interagency Coordination Committee for Commodity Security. However, some donors that support reproductive

Although their share of service delivery is small, reproductive health advocacy is relatively advanced in Mexican civil society.

health in Ghana are shifting to health sector or multi-donor budget support while the funding provided by others has been erratic. USAID is focusing its work on 30 districts in the southern region of the country where access to health services is low and poverty is high. Although USAID, together with UNFPA, has historically been able to respond to unexpected contraceptive needs by providing emergency shipments at short notice, the financial sustainability plan indicates that an increasing share of need must be met by the government of Ghana.

The two largest local NGOs historically active in reproductive health in Ghana have both faced funding challenges in recent years. The Planned Parenthood Association of Ghana (PPAG), which is almost entirely dependent on donor funding, lost approximately one-third of its budget when the organization refused to sign the Mexico City Policy (Global Gag Rule) in 2003.³³ This funding supported a community-based service program that trained local men and women to sell contraceptives and condoms for small fees and offer basic reproductive health education in their communities. The Ghana Social Marketing Foundation, which once held a market share of nearly two-thirds of all condom sales, lost its contract with USAID in 2005. Among the private sector, 80 percent of all facilities are owned by the National Catholic Secretariat, making the distribution of contraceptives a challenge in this market.

Government and NGO agencies are already well-engaged with each other in Ghana, and as the role of donors diminishes, opportunities for collaboration between the public sector and civil society should increase. Through forums such as the ICC/CS, advocates must be proactive in the planning process and press the government early on to develop strategies for filling current and future funding gaps.

Mexico

With strong political support from the single ruling party, the end of donations of reproductive health supplies in the mid-1990s resulted in a diminished role for donors, as the government took the lead on reproductive health issues. USAID and its cooperating agencies have not been active in family planning in Mexico, although they continue to support HIV/AIDS activities. UNFPA, in contrast, has remained involved in technical assistance, implementing procurement for the group of states that have signed on with the agency. By its own estimates, joint procurement through UNFPA has saved Mexican states \$40 million due to economies of scale.

Most NGOs active in reproductive health in Mexico do not offer family planning services, as such programs were historically well-entrenched in the public sector. The major exception is MEXFAM, which maintains a network of clinics and operates smaller-scale community projects in 18 states. The Federation of Private Associations (FEMAP)

also provides contraceptives in poor communities and operates a social marketing organization.

Although their share of service delivery is small, reproductive health advocacy is relatively advanced in Mexican civil society. The Alliance for the Right to Choose (ADD) and the Coalition for the Health of Women (CSM) include organizations focusing on a comprehensive range of reproductive health issues, such as abortion rights, gender-based violence and access among young people. NGOs are heavily involved in political advocacy, including earmarking funds for contraceptives, monitoring state and federal budgets and lobbying Congressional committees. In recent years, this advocacy has resulted in notable victories, including the decriminalization of abortion in Mexico City, the approval and implementation of emergency contraception and the publication of a new action plan on adolescent sexual and reproductive health. Moving forward, advocates are in need of nuanced strategies that protect their focus on individual reproductive rights while also effectively communicating the vital importance of access to reproductive health supplies as a national priority. Advocates' existing role in monitoring federal and state budgets should be expanded to addressing political platforms and parties, in order to build a base of support among policymakers and assure continuity despite high turnover in legislative bodies.

Nicaragua

Nicaragua's main donors in the reproductive health field have been USAID and UNFPA, though other bilateral and multilateral donors are active through pooled health sector funding. Historically, 60 percent of the government's need for contraceptive supplies was fulfilled by USAID, and the remaining 40 percent by UNFPA.³⁴ USAID plans to end its contraceptive donations this year, with final shipments comprised only of injectables. The agency plans three additional years of continuing technical assistance through

the USAID | DELIVER Project before graduation is complete in 2012. UNFPA's contraceptive donations have not begun to decline, though the agency projects a complete phase out by approximately 2012, and it serves as the procurement agent for the government.

Various NGOs provide family planning and reproductive health services in Nicaragua, of which the largest is PROFAMILIA. PROFAMILIA maintains a network of 900 distribution posts and 17 clinics, two of which had their operational licenses abruptly suspended in late 2008 during the post-election political turmoil. The operating environment for NGOs in general is now strained by the government's desire to consolidate services in the public sector, and is compounded for organizations working in sexual and reproductive health by political battles, especially around abortion.

Despite a solid foundation in official policies, achievement of a financial commitment on the part of the government last year, and major improvements in the logistics system, the situation surrounding reproductive health supplies in Nicaragua has become ambiguous. The rapid execution of the total ban on abortion demonstrates that reproductive health has become "an expendable bargaining chip"³⁵ under the current government. Civil society organizations operate in an increasingly unfriendly environment, with political leaders demonstrating no hesitation to take stringent legal actions against those whose activities are deemed offensive. Despite this climate, advocates may be able to take a long-term view and work towards those current and future policymakers whose perspectives are more sympathetic. One legislator suggested that basic information on the connections between population and development, such as those available in the Resources for the Awareness of Population Impacts on Development (RAPID) model funded by USAID, would be illuminating for his peers.



A poster in Uganda promotes family planning for family welfare. (Jennifer Johnson/PAI)

Tanzania

As evidenced by the regular meetings of the Contraceptive Security Working Group, donor coordination has been strong in Tanzania. However, with only a single donor (USAID) still providing in-kind donations of reproductive health supplies as other development partners transition to sector and budget support, coordination among the government and donors is evolving. In addition to the Contraceptive Security Working Group, many donors participate in the Reproductive and Child Health technical working group for health sector basket partners. Although USAID's vertical support for contraceptives has been stable in recent years, some stakeholders observed that the agency has been overwhelmed managing the huge disbursement of HIV/AIDS funding through the President's Emergency Plan for AIDS Relief (PEPFAR), leaving other health sector issues, such as family planning, relatively neglected.

Although various NGOs are active in reproductive health service delivery, the advocacy voice of civil society on these issues is still burgeon-

ing. Chama Cha Uzazi na Malezi Bora Tanzania (UMATI), the local affiliate of the International Planned Parenthood Federation, suffered from funding cuts earlier this decade but has been focusing on expanding its reach at district level, for example by promoting the inclusion of RH supplies in local budgets. Other potential advocates for reproductive health supplies include faith-based organizations, groups focused on maternal health, professional associations and youth organizations. At the community level, the attention of many civil society organizations, along with district government committees, has turned to HIV/AIDS issues, which draw upon significantly greater financial resources.

Uganda

Direct donations of contraceptives (other than condoms) in Uganda are largely funded by two donors, UNFPA and USAID. Other bilateral and multilateral agencies provide health sector and general budget support. The private sector, specifically private hospitals and clinics, provide an especially integral part of the reproductive health



A vehicle advertises the Vive condom brand marketed by PASMO in Nicaragua. (Elizabeth Leahy/PAI)

supplies system in Uganda, where just 35 percent of women rely on the public sector as their source of supplies.³⁶ Within the private sector, Reproductive Health Uganda (RHU), the national member association of the International Planned Parenthood Federation, and Marie Stopes Uganda each run networks of clinics. Uganda is also home to NGOs dedicated to advocacy in support of reproductive health, including supplies, while parliamentarians are some of the most vocal champions of RH issues. Still, many stakeholders report that the disinterest in family planning at the highest levels—which is sometimes manifested in outright opposition—has created a climate of fatigue around the issue, and new advocacy voices are very much needed.

While financing is not a major challenge in Uganda, logistics issues create regular stockouts at facility level. Strengthening these broken delivery systems must be a high priority, but so should reframing the broader social rhetoric and political climate. Some of the greatest advocacy challenges and opportunities in Uganda lie in clearly demonstrating the importance of access to reproductive health supplies and shaping the political climate and public opinion.

ENDNOTES

For a complete list of the individuals with whom PAI staff met during the case study research process, please see the individual country reports' appendices.

- 1 United Nations. 2007. *The Millennium Development Goals Report 2007*. New York: United Nations.
- 2 DELIVER and Task Order I of the USAID | Health Policy Initiative. 2006. *Contraceptive Security Index 2006: A Tool for Priority Setting and Planning*. Arlington, Virginia: DELIVER, for the U.S. Agency for International Development.
- 3 UNFPA. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2007*. New York: UNFPA.
- 4 Project RMA Proposal (unpublished), September 2006.
- 5 Essential medicines, as defined by the World Health Organization, are “those that satisfy the priority needs of the population.” National Essential Medicines Lists identify the medicines that are intended to be available throughout the health system in adequate supply, at good quality, and at affordable prices.
- 6 For further information on reforms in aid architecture and their relevance to reproductive health, see: Dennis, S. 2009. *Aid Effectiveness: Its Implications on Financing for Family Planning and Reproductive Health*. PAI Working Paper. Washington, DC: Population Action International.
- 7 UNFPA. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2007*. New York: UNFPA.
- 8 Project RMA Year 1 Report (unpublished), October 2007.
- 9 Essandoh, E., S. Wright and L. Schaefer. 2007. *Population and Reproductive Health Program: Program Assessment*. USAID/Ghana, p. 12.
- 10 United Nations Population Division. 2009. *World Population Prospects: The 2008 Revision*. New York: United Nations Population Division; National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ORC Macro. 2007. *Bangladesh Demographic and Health Survey 2007: Preliminary Report*. Dhaka, Bangladesh and Calverton, Maryland [USA]: National Institute of Population Research and Training, Mitra and Associates, and ORC Macro; World Health Organization (WHO). 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva: WHO.
- 11 United Nations Population Division. 2009. *World Population Prospects: The 2008 Revision*. New York: United Nations Population Division; Ghana Statistical Service (GSS), Noguchi Memorial Institute for Medical Research (NMIMR), and ORC Macro. 2004. *Ghana Demographic and Health Survey 2003*. Calverton, Maryland: GSS, NMIMR, and ORC Macro; World Health Organization (WHO). 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva: WHO.
- 12 United Nations Population Division. 2009. *World Population Prospects: The 2008 Revision*. New York: United Nations Population Division; Consejo Nacional de Población (CONAPO). 2006. *La situación demográfica de México, 2006*. Mexico City: CONAPO; World Health Organization (WHO). 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva: WHO.
- 13 United Nations Population Division. 2009. *World Population Prospects: The 2008 Revision*. New York: United Nations Population Division; Instituto Nacional de Información de Desarrollo (INIDE). 2008. *Encuesta Nicaragüense de Demografía y Salud ENDESA 2006/07*. Managua, Nicaragua and Atlanta, Georgia [USA]: INIDE and U.S. Centers for Disease Control and Prevention (CDC); World Health Organization (WHO). 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva: WHO.
- 14 United Nations Population Division. 2009. *World Population Prospects: The 2008 Revision*. New York: United Nations Population Division; National

- Bureau of Statistics (NBS) [Tanzania] and ORC Macro. 2005. *Tanzania Demographic and Health Survey 2004-05*. Dar es Salaam, Tanzania: NBS and ORC Macro; World Health Organization (WHO). 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva: WHO.
- 15 United Nations Population Division. 2009. *World Population Prospects: The 2008 Revision*. New York: United Nations Population Division; Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007. *Uganda Demographic and Health Survey 2006*. Kampala, Uganda and Calverton, Maryland [USA]: UBOS and Macro International Inc; World Health Organization (WHO). 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva: WHO.
 - 16 Khan, S., S.E.K. Bradley, J. Fishel, and V. Mishra. 2008. *Unmet Need and the Demand for Family Planning in Uganda: Further Analysis of the Uganda Demographic and Health Surveys, 1995-2006*. Calverton, Maryland: Macro International Inc; Baguma, R. and J. Ogwang. 2009. "Electricity shortage causing high population—Kamuntu." *The New Vision*, 10 March, p. 3.
 - 17 Indacochea, C.M. and E. Leahy. 2009. *A Case Study of Reproductive Health Supplies in Nicaragua*. Washington, DC: Population Action International, p. 17.
 - 18 RHInterchange. Available at rhi.rhsupplies.org; last accessed 31 March 2009. These data reflect dates of shipment, which do not necessarily correspond to when funding was disbursed or when supplies were received.
 - 19 DELIVER 2007, p. 18; Ghana Ministry of Health 2008, pp. 7-8; RHInterchange (for UNFPA and USAID). RHInterchange totals reflect dates of shipment, not of funding allocations or when products were received.
 - 20 Information provided by DAIA, UNFPA, USAID.
 - 21 DELIVER. 2007. *Tanzania: Final Country Report*. Arlington, VA: DELIVER, for the U.S. Agency for International Development, p. 18. These figures do not include condoms, nor contributions from the African Development Bank maternal mortality project.
 - 22 RHInterchange. Available at rhi.rhsupplies.org; last accessed 9 April 2009. These data reflect dates of shipment, which do not necessarily correspond to when funding was disbursed or when supplies were received, and do not include procurements by the Ministry of Health.
 - 23 DELIVER. 2007. *Ghana: Final Country Report*. Arlington, VA: DELIVER, for the U.S. Agency for International Development, pp. 18-19, 20-21; Ministry of Health. 2008. Draft: The Ghana National Financial Sustainability Plan for Contraceptives 2008-2011.
 - 24 Essandoh et al., p. 22.
 - 25 Essandoh et al., p. 21.
 - 26 Instituto Nacional de Salud Pública, Secretaría de Salud (SSA) 2005. *Cuentas nacionales de salud reproductiva y equidad de género 2004*. Our conversion at 1490 pesos per U.S. dollar.
 - 27 DELIVER. 2007. *Ghana: Final Country Report*. Arlington, VA: DELIVER, for the U.S. Agency for International Development., pp. 12-13.
 - 28 Díaz Echevarría, D. 2008. "Diagnóstico de financiamiento y gasto en métodos anticonceptivos a nivel federal para población abierta: quien decide la ruta de financiamiento," Mexico City: MEXFAM.
 - 29 The 2002 and some of the 2003 stockouts of medications, including contraceptives, were reported in *Prácticas de abastecimiento y distribución de medicamentos, encuesta a secretarías de salud estatales*.
 - 30 Patykewich, L., M. Tien, E. Mielke and T. Rosche. 2007. *Tanzania: Contraceptive Security Assessment*. Arlington, VA: USAID | DELIVER Project and New York: The ACQUIRE Project.
 - 31 DELIVER. 2007. *Uganda: Final Country Report*. Arlington, Virginia: DELIVER, for the U.S. Agency for International Development.
 - 32 Patykewich, L. and E. Leahy. 2009. *A Case Study of Reproductive Health Supplies in Bangladesh*. Washington, DC: Population Action International, p. 34.

- 33 This policy, reinstated under the administration of George W. Bush, mandates that no U.S. family planning assistance can be directed to foreign NGOs that use funding from any other source to provide abortions, counsel clients about abortion, or advocate for the legalization of abortion. It was termed the “Global Gag Rule” because it stifles free speech and public debate on abortion issues and impeded delivery of the family planning and reproductive health that help women avoid unwanted pregnancy in the first place.
- 34 Taylor, PA, C Arauz, G Subiria, C Cisek, JA Merdrano, D Fuentes, D Sarley, L Patykewich and A Karim. 2004. *Nicaragua: Contraceptive Security Assessment, February 2-13, 2004*. Arlington, Virginia: John Snow, Inc./DELIVER, and Washington, DC: Futures Group Inc./POLICY II, for the U.S. Agency for International Development (USAID).
- 35 Indacochea and Leahy, p. 28.
- 36 Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007. *Uganda Demographic and Health Survey 2006*. Kampala, Uganda and Calverton, Maryland [USA]: UBOS and Macro International Inc.



BANGLADESH



GHANA



MEXICO



NICARAGUA



TANZANIA



UGANDA



1300 19th Street, NW, Second Floor
Washington, DC 20036 USA

Tel: 202-557-3400

Fax: 202-728-4177

www.populationaction.org

Email: pai@popact.org

Order publication online at

www.populationaction.org/order

View report online www.populationaction.org

© Population Action International, 2009.

Contents from this and accompanying materials may be reproduced provided Population Action International is acknowledged as the source.

Population Action
INTERNATIONAL
HEALTHY FAMILIES HEALTHY PLANET