THE GLOBAL PROGRAMME TO ENHANCE REPRODUCTIVE HEALTH COMMODITY SECURITY

ANNUAL REPORT 2010

THE MISSION OF UNFPA

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect.

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Cover Photo: Portrait of a couple, Ethiopia.
Photo by Pholva Zimova/Panos Pictures

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LIST OF ACRONYMS

ABR	Adolescent birth rate
APRO	Asia and Pacific Region
BCC	Behaviour Change Communication
BKKBN	Indonesia's National Population and Family Planning Board
CARh	Coordinated Assistance for RH Supplies
CBDs	Community-based family planning distributors
CCA	Common Country Assessment
CCM	Country Commodity Manager
CCP	Comprehensive condom programming
CIES	Centro de Investigación y Estudios de la Salud
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPR	Contraceptive prevalence rate
CSB	Commodity Security Branch
CSO	Civil society organizations
CYP	Couple year protection
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
DHS	Demographic and Health Surveys
DRC	Democratic Republic of the Congo
EML	Essential Medicines List
EmOC	Emergency obstetric care
EmONC	Emergency Obstetric and Newborn Care
GPRHCS	UNFPA Global Programme to Enhance Reproductive Health Commodity Security
HEW	Health Extension Workers
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health management information system
HRB	Humanitarian Response Branch
ICPD	International Conference on Population and Development
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
LAC	Latin American countries
LMIS	Logistics Management and Information System
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MHTF	Maternal Health Thematic Fund
MMR	Maternal mortality ratio
MNCH	Maternal, Newborn and Child Health

MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSI	Marie Stopes International
NA	Not Available
NGO	Non-governmental organization
OC	Oral contraceptive
OECD	Organisation for Economic Co-operation and Development
PDR	Peoples' Democratic Republic
PMNCH	Partnership for Maternal, Newborn and Child Health
PPMR	Procurement Planning and Monitoring Report
PRISMA	Asociación Benéfica PRISMA
PRSP	Poverty Reduction Strategy Papers
PSB	Procurement Services Branch
PSM	Procurement and supply management
QA	Quality Assurance
RBM	Results-based management
REC's	Regional Economic Communities
RH	Reproductive health
RHCS	Reproductive health commodity security
RO	Regional Office
SDP	Service delivery point
SRH	Sexual Reproductive Health
STI	Sexually transmitted infections
SWAps	Sector-wide approaches
TD	Technical Division
TOR	Terms of Reference
UBW	Unified Budget and Workplan
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAHO	West African Health Organisation
WHO	World Health Organization

FOREWORD

by Werner Haug – Director, Technical Division, UNFPA

More than 100 countries worldwide have eliminated or nearly eliminated maternal mortality as a public health problem. In spite of this, there are still approximately 350,000 maternal deaths and over 1 million newborn deaths yearly in the world. For every woman who dies in childbirth, at least 20 more suffer injuries, infections or disabilities.

This reality could be averted with highly cost-effective and feasible interventions to prevent maternal and newborn mortality and morbidity. These interventions include general access to reproductive health (including family planning), a skilled birth attendant present at every delivery, access to emergency obstetric and newborn care when needed and HIV prevention. When adopted and scaled up with a rights-based and equity-driven approach, these have led to tremendous gains, proving that rapid progress is indeed possible.

UNFPA supports developing countries that are most in need of assistance — and furthest from achieving MDG 5 and universal access to reproductive health by 2015 — through two important initiatives: the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) and the Maternal Health Thematic Fund (MHTF). Both initiatives, working together, are well-positioned to support the UN Secretary-General's Global Strategy for Women's and Children's Health, an unprecedented global-level commitment to advance the well-being of women and children. The many achievements, outlined in this report, provide ample evidence that strong political commitment, adequate investments and partnerships are critical to achieving MDG 5 and universal access to reproductive health.

UNFPA launched the GPRHCS in 2007 to address the urgent and ongoing need for a reliable supply of contraceptives, condoms, medicines and equipment in developing countries. Reproductive health commodity security is achieved when all individuals can obtain and use affordable, quality reproductive health commodities of their choice whenever they need them. Commodity security underpins UNFPA programming and is critical to accelerating progress towards internationally agreed development goals. The Global Programme is already yielding measurable results through a framework for assisting countries in planning for their own needs, with a focus on commodities as well as capacity development to strengthen health systems.

Momentum is building around achieving MDG 5 and we face an unprecedented opportunity to tackle maternal mortality and morbidities head on. While much progress has been made, in many countries there is still a far way to go. I would like to take this opportunity to thank countries, donors, other partner organizations and all colleagues for the continued collaboration to reaching our shared goal.

Werner Haug
Director, Technical Division
UNFPA

EXECUTIVE SUMMARY

The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) provided sustained multi-year support to 11 Stream 1 countries and funded targeted initiatives in 34 Stream 2 countries. In total, the Global Programme focused on 45 countries, a deliberately tighter focus than the previous year. Some additional ***ad hoc*** support was provided to Stream 3 countries. Expenditures (provisional) totaled $93,551,586 in 2010, up from $87,089,805 in 2009. Of that amount, $61,771,480 (66 percent) went to reproductive health commodities and $31,780,105 (34 percent) went to capacity development.

Within UNFPA, the GPRHCS worked in collaboration with the Maternal Health Thematic Fund to provide programmatic support to ensure that life-saving maternal health drugs and supplies were available in all facilities. The GPRHCS also worked closely with the HIV/AIDS branch to increase the availability of contraceptives in countries with high HIV prevalence and among vulnerable populations. Selected results and country highlights from 2010 include the following:

1. Contraceptive prevalence rate (CPR) increased substantially in several Stream 1 countries (Ethiopia, Mozambique and Niger), continuing to build on notable increases in 2009;
2. In 10 out of 11 Stream 1 countries, three modern methods of contraceptives were available in at least 80 percent of service delivery points;
3. Nine out of 11 Stream 1 countries had the five essential maternal health drugs available in more than 60 percent of service delivery points;
4. There was a clear increase in the number of facilities without stock-outs of contraceptives in 5 out of 11 Stream 1 countries. Also, six Stream 1 countries had no stock-outs in more than 76 percent their service delivery points;
5. Ten out of 11 Stream 1 countries and 26 Stream 2 countries have national strategic plans in place for RHCS under government leadership and with the involvement of relevant stakeholders;
6. Functional coordinating mechanisms for RHCS exist in 10 out of 11 Stream 1 and most Stream 2 countries;
7. Essential medicines lists include reproductive health commodities in all Stream 1 and 26 Stream 2 countries as of 2010, with both life-saving medicines and modern methods of contraception, though not every list includes every method;
8. Ten out of 11 Stream 1 countries and 15 Stream 2 countries include RHCS within national Poverty Reduction Strategies, ensuring its priority at the highest levels;
9. Budget lines for RH commodities, a strong indicator of government commitment, are present in 10 out of 11 Stream 1 countries and at least 16 Stream 2 countries; allocations actually increased in Mongolia, Mozambique and Niger in 2010;
10. National technical expertise for commodity forecasting and for managing procurement processes is being used in 8 out of 11 Stream 1 countries, up from six countries in 2009;
11. Based on demand from countries, expenditure on capacity development increased from 19.3 percent in 2009 to 34 percent in 2010, reflecting intensified efforts to build capacity and strengthen systems;
12. Funding levels for the GPRHCS reached an all-time high of almost $100 million in 2010.

Information used for the preparation of this report comes from a variety of sources. The main sources of information are reports submitted by UNFPA Country Offices in collaboration with country partners, and data analysed from the country reporting questionnaire. Information from other published and unpublished sources provides further explanation to make the discussion more meaningful.

In 2010, implementation reached new levels in Stream 1 and 2 countries, and the added value of the Global Programme was demonstrated in many ways and captured in 'results'. Using the GPRHCS monitoring and evaluation framework, the programme was able to track progress and achievements much more comprehensively. This improved understanding of progress is also contributing substantially to currently ongoing discussions both within and outside the organization on the future directions of the programme.

The GPRHCS will continue to work with governments and partners to improve RHCS in a focused manner within the Stream 1 and Stream 2 countries receiving support. The focus will be on continuing to develop sustainable approaches to RHCS as part of overall health sector reform, and in building a stronger foundation for more permanent and lasting solutions to RHCS. Results-based management, lessons learned and monitoring will strengthen future efforts. Support to a few Stream 3 countries will continue to be necessary due to the unexpected and devastating nature of so many humanitarian situations and natural disasters, and the weak infrastructure in many countries. However, some Stream 3 countries are building up their capacity to achieve RHCS and may be selected for Stream 2 in the coming years. At the same time, however, the GPRHCS will finalize its gradual exit strategy for countries as they no longer need targeted support and become ready to graduate. Ensuring the availability and utilization of family planning information and services has always been a priority for UNFPA and continues to be a priority through the GPRHCS. In this regard, UNFPA has pledged to contribute to the HANDtoHAND Campaign of the Reproductive Health Supplies Coalition, supporting Stream 1 and Stream 2 countries to attain at least 2 percentage points increase in CPR per year.

Evidence of increasing government commitment to RHCS is being seen in many countries and, it is hoped, will continue to rise so that the reliance on external funding can lessen. However, additional funding will continue to be required for the foreseeable future. The need for expanding the GPRHCS donor base remains a key priority and efforts in this regard will intensify in 2011. Substantial results of achievements from counties with the support of the GPRHCS will be documented and widely shared.

The GPRHCS continues in line with UNFPA's Strategic Plan to ensure access to and use of quality reproductive health commodities, supplies and medicines, as part of the overall effort to reduce the number of maternal and newborn deaths, halt the spread of HIV/AIDS and improve the sexual and reproductive health and rights of women, men and young people – particularly within countries most in need.

INTRODUCTION

The urgent and ongoing need for a reliable supply of contraceptives, condoms, medicines and equipment in developing countries is the challenge addressed by UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). Reproductive health commodity security is of critical importance to reproductive health, and the critical importance of reproductive health to development is expressed in the Millennium Development Goals (MDGs), where universal access to reproductive health is a target for 2015, and in the International Conference on Population and Development (ICPD) Programme of Action. Without a secure, reliable supply of contraceptives and other essentials, countries will not be able achieve these goals.

UNFPA established the Global Programme as a framework for assisting countries in planning for their own needs. At the request of governments, UNFPA helps to:

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

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

Since 1990, UNFPA has been considered to be the largest multilateral supplier of contraceptives and condoms, and the lead United Nations agency for reproductive health commodity security (RHCS). However, funding shortages and a tendency to look at reproductive health commodities in isolation from other issues meant that support in this area was often substantial but ad hoc. UNFPA launched the Global Programme to Enhance Reproductive Health Commodity Security in 2007 to provide a structure for moving beyond ***ad hoc*** responses to stock-outs towards more predictable, planned and sustainable country-driven approaches for securing essential supplies and ensuring their use. In only a few years, it is already yielding measureable results.

Reporting on results

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

This report looks at the results (goal, outcome and output) and associated indicators that are used to measure progress in the Global Programme to Enhance RHCS. The results-based approach is based on the GPRHCS Monitoring and Evaluation Framework and the UNFPA Results and Resources Framework. Both aggregate data and specific examples to highlight achievements in 2010 are presented in this report.

Section One states the main goal: UNFPA works at the request of governments to achieve universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life. It also presents the programme's main outcome: The Global Programme seeks results in increased availability, access and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the focus countries.

Section Two looks at the programme's four outputs: (1) Country RHCS strategic plans developed, coordinated and implemented by government with their partners; (2) Political and financial commitment for RHCS enhanced; (3) Capacity and systems strengthened for RHCS; (4) RHCS mainstreamed into UNFPA core business.

Section Three presents selected areas of achievement and Section Four presents examples of activities in support of several 'key issues'. Section Five summarizes the allocation of funds for commodities in 2010, and Section Six provides the financial overview. The report concludes with challenges, lessons learned and suggestions for next steps.

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

Funding streams

GPRHCS supports countries through three funding streams in order to address the specific needs of each country:

Stream 1 provides multi-year funding to a relatively small number of countries. These predictable and flexible funds are used to help countries develop more sustainable, human rights-based approaches to RHCS, thereby ensuring the reliable supply of reproductive health commodities and the concerted enhancement of national capacities and systems.

Stream 2 funding supports initiatives to strengthen several targeted elements of RHCS, based on the country context.

Stream 3 is emergency funding for commodities in countries facing stock-outs for reasons such as poor planning, weak infrastructure and low in-country capacity. Stream 3 also provides support for countries facing humanitarian situations, including natural or man-made disasters. In these settings, the GPRHCS works closely with UNFPA's Humanitarian Response Branch (HRB) and United Nations High Commissioner for Refugees (UNHCR) to deliver much-needed commodities in times of emergency. All funding through this stream is used for the provision of commodities.

2010 Stream 1 countries

1. Burkina Faso
2. Ethiopia
3. Haiti
4. Lao PDR
5. Madagascar
6. Mali
7. Mongolia
8. Mozambique
9. Nicaragua
10. Niger
11. Sierra Leone

2010 Stream 2 countries

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

SECTION ONE

GOAL AND OUTCOME

Young woman in Chad.
Photo by Giacomo Pirozzi/Panos Pictures

Driving progress towards one global goal, UNFPA applies a strategic and structured framework[1] for assisting countries establish a secure, reliable supply of contraceptives and other essential supplies. Each year, more countries are establishing RHCS as an integral part of their overall health sector plan and a key strategy in reducing maternal and newborn death and preventing the spread of HIV. In 2010, UNFPA worked in targeted ways through the Global Programme to Enhance Reproductive Health Commodity Security to contribute to progress towards this goal and the outcome against which progress is measured.

> **Goal:** Universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life.
>
> **Outcome:** Increased availability, access and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the Global Programme to Enhance RHCS focus countries.

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

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

This goal of the Global Programme is derived from the UNFPA Strategic Plan 2008-2012. The indicators associated with this goal – adolescent birth rate, maternal mortality ratio and youth HIV prevalence rate – are used globally to measure progress in achieving MDG 5 to improve maternal health. Monitoring of progress by means of the goal and outcome indicators draws on quantitative data sources. In many countries these are often not readily and consistently available, thus making it difficult to demonstrate progress and adequately compare change among the countries. In spite of this, however, some progress has been made. The data presented here on progress should not be attributed as the achievement to GPRHCS alone, or indeed to UNFPA alone, but should be seen as outcomes of concerted efforts by all partners to address the development challenges in each country.

1.1.1 Adolescent birth rate

Adolescent birth rate (ABR) is a measurement of the number of births to women 15 to 19 years of age per 1,000 women in that age group. It represents the risk of childbearing. The indicator measures the incidence of childbirth among young people, which has implications for prevalence of unprotected sex, early marriage, early childbearing, teenage pregnancy and disruption of schooling among adolescents.

In the Global Programme's Steam 1 countries, adolescent birth rates (ABR) range from 18.5 per 1,000 women (15-19) in Mongolia to 199 per 1,000 women (15-19) in Niger. With the exception of Mongolia and Haiti, the Stream 1 countries have adolescent birth rates of more than 100 per 1,000 women.

In Stream 2 countries, adolescent birth rates are within the same range as in Stream 1 countries. Among the Stream 2 countries only Ecuador has an ABR of less than 100 (see Annex 3). The 21 Stream 2 countries with an ABR of more than 110 are all in Africa.

[1] See the annex for the Global Performance Monitoring Framework

Table 1: Adolescent birth rate and percentage of women aged 15 to 19 years who had children or were currently pregnant at the time of various surveys for GPRHCS Stream 1 countries

	Adolescent birth rate*		Percentage who had childrena or are currently pregnant**	
Country	Year	Per 1,000 women 15-19	Survey and year	Percent
Burkina Faso	2001	131.0	DHS 2003	23.3
Ethiopia	2003	109.1	DHS 2005	16.6
Haiti	2003	68.6	DHS 2005-06	14.0
Lao PDR	2005	110.0	-	N/A
Madagascar	2008	148.0	DHS 1992	29.0
Mali	2004	190.0	DHS 1995-96	41.5
Mongolia	2007	18.5	-	N/A
Mozambique	2001	185.0	DHS 2003	41.0
Nicaragua	2005	108.5	DHS 2006	25.2
Niger	2004	198.9	DHS 1992	36.2
Sierra Leone	2006	143.0	DHS 2008	34.0

Source: * Population and Development Branch, Have we progressed on MDG4b? The empirical evidence in advancing Universal Access to Reproductive Health, Technical Division, UNFPA New York, June 2010.
** Data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

Available data for Stream 1 countries indicate that the percentages of young women aged 15 to 19 years who had children or were currently pregnant at the time of various DHS surveys, were as high as 41 percent in Mozambique and 34 percent in Sierra Leone. Table 2 shows that the incidence of pregnancy and motherhood among women aged 15 to 19 years in all the countries was higher for young women in poor households, and lower for households with the highest wealth index. In Mozambique, while 60.5 percent of females 15 to 19 years in the lowest wealth quintile had children or were pregnant, only 24.6 percent of their counterparts in the highest wealth quintile had children or were pregnant at the time of the survey.

Table 2: Percentage of females aged 15 to 19 years who had children or were currently pregnant at the time of the survey by household wealth quintile for selected GPRHCS Stream 1 countries

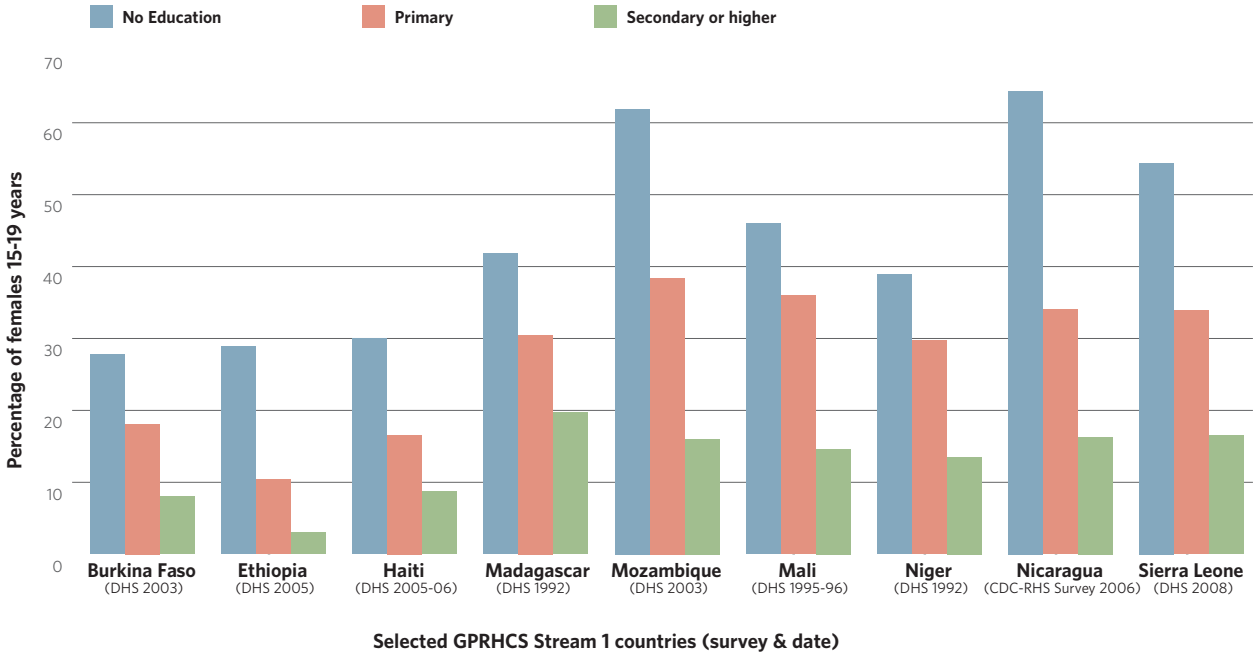
Household wealth index	Burkina Faso (DHS 2003)	Ethiopia (DHS 2005)	Haiti (DHS 2005-06)	Mozambique (DHS 2003)	Sierra Leone (DHS 2008)
Lowest	26.0	23.8	21.5	60.5	49.4
Second	31.8	20.8	15.6	48.9	46.8
Middle	27.2	19.8	17.6	44.6	43.4
Fourth	26.8	18.3	13.4	42.0	31.6
Highest	12.2	8.2	7.1	24.6	16.1

Source: Data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

Pregnancy and motherhood among women aged 15 to 19 years, as shown in Figure 1, was found to be significantly lower among young girls with secondary or higher education than their counterparts with no education. In Ethiopia, the figure was 28.9 percent for women with no education, compared to only 3 percent for women with secondary education. For Nicaragua, the percentage for women with no education (64.2 percent) is nearly twice as high as for women with primary education (34 percent).

Reproductive health commodity security remains a key strategy for meeting young people's reproductive health needs, including family planning. UNFPA works in many ways, including RHCS, to support countries in their efforts to address the problems associated with pregnancy and motherhood among young women, for preventing unwanted pregnancy, and for making maternal health safe.

Figure 1: Percentage of females aged 15 to 19 years who had children or were currently pregnant at the time of the survey by highest educational level for selected GPRHCS Stream 1 countries



Source: Demographic and Health Surveys (DHS) data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

1.1.2 Maternal mortality ratio

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

With the exception of Sao Tome and Principe, for which data is not available, recent UN estimates[2] show that MMR for GPRHCS Stream 1 countries range from 65 maternal deaths per 100,000 live births for Mongolia to 970 for Sierra Leone. The GPRHCs country with the highest MMR is Chad, with 1,200 maternal deaths per 100,000 live births. Only three countries (Ecuador, Mongolia and Nicaragua) have MMR of 100 or less. In contrast, 33 out of the 44 Stream 1 and 2 countries that submitted reports have MMR of more than 300 maternal deaths per 100,000 live births.

Most maternal deaths are preventable using well-known, cost-effective strategies including the provision life-saving maternal health medicines; ensuring skilled health workers are at hand to assist at every delivery; providing access to essential obstetric care, especially when complications arise; and providing family planning information and services to prevent unwanted pregnancies and unsafe abortions. Activities of the Global Programme to Enhance RHCS directly support efforts to reduce maternal deaths, which require the provision of contraceptives to prevent unwanted pregnancy and life-saving maternal health medicines to make pregnancy and childbirth safer.

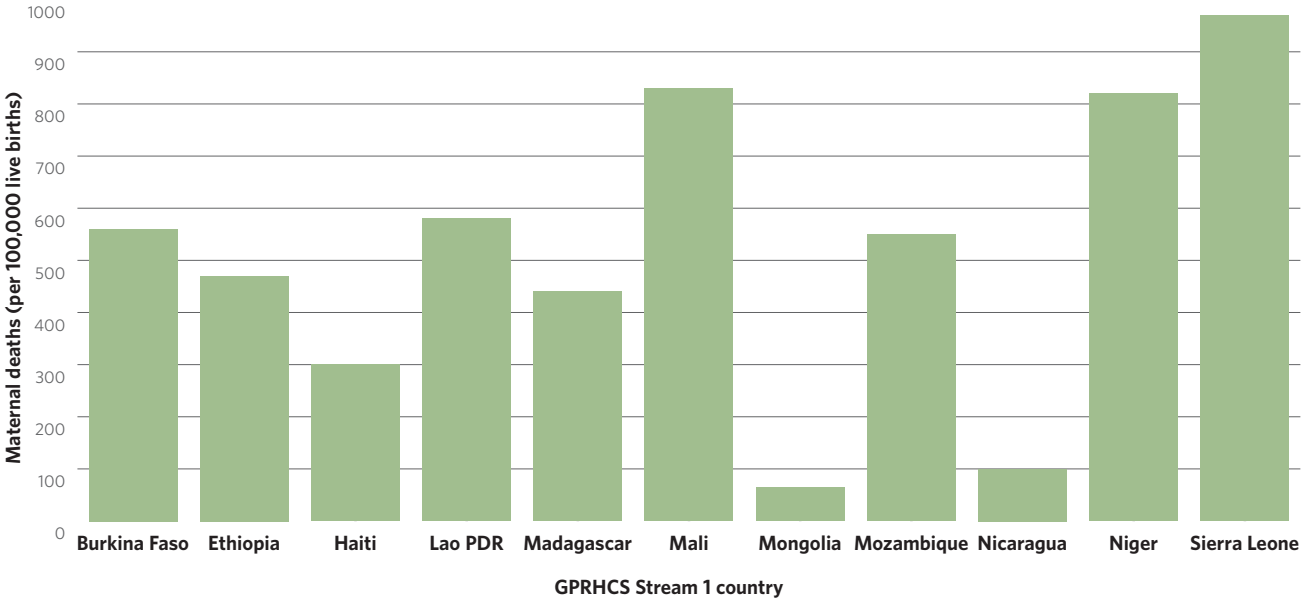
2 Trends in Maternal Mortality: 1990 to 2008; Estimates developed by WHO, UNICEF, UNFPA and the World Bank; WHO 2010

Table 3: Maternal mortality ratio for GPRHCS Stream 1 countries

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

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

Figure 2: Maternal mortality ratio for GPRHCS Stream 1 countries

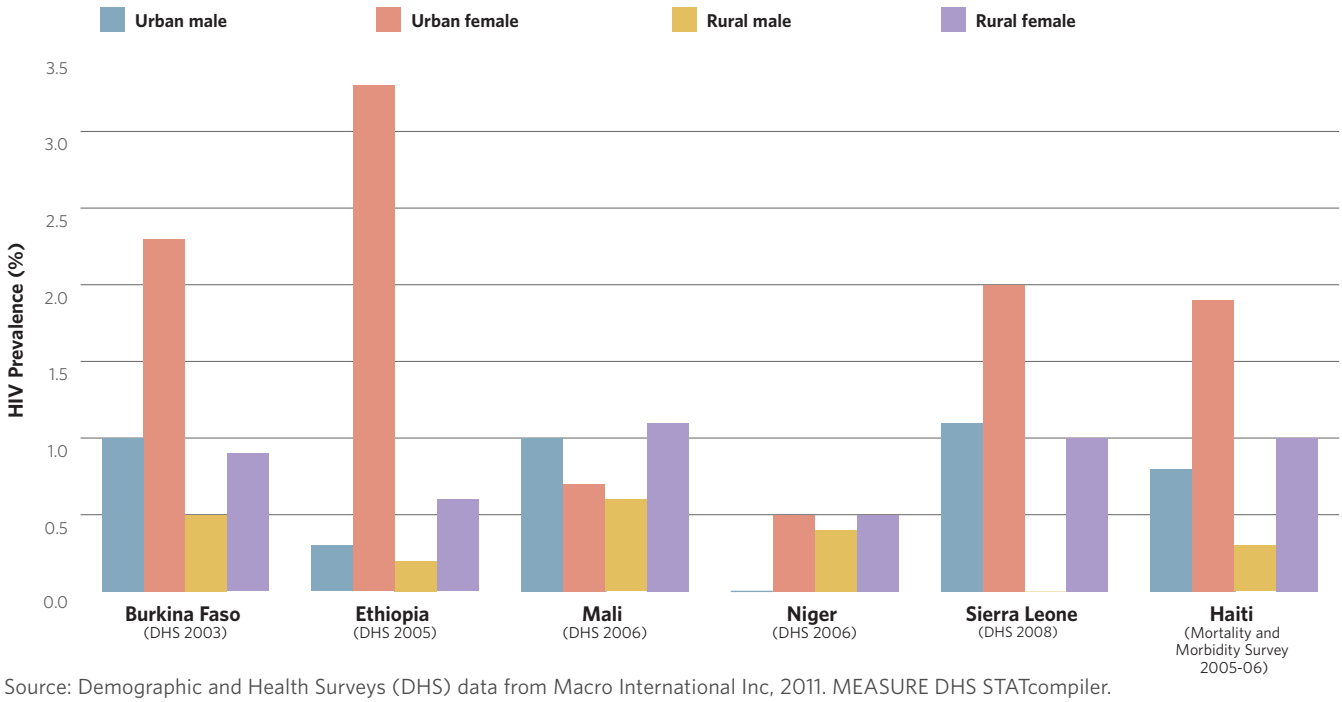


Source: Trends in Maternal Mortality: 1990 to 2008; Estimates developed by WHO, UNICEF, UNFPA, World Bank; Annex 1, page 23

1.1.3 Youth HIV prevalence rate

The percentage of young people aged 15-24 who are living with HIV out of total population in this age group is one of the Millennium Development Goal indicators that seeks to measure the incidence of the HIV epidemic among young people. This indicator gives the potential effect of the disease on the youth population, which has current and future development implications. Available data for this indicator, sourced from national survey results, show that HIV/AIDS is more prevalent among young females than young males.

Figure 3: HIV prevalence among young people aged 15 to 24 years for selected GPRHCS Stream 1 countries



Source: Demographic and Health Surveys (DHS) data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

Figure 3 shows that HIV/AIDS prevalence is often higher among urban females than rural females. In most of the countries represented in the figure, HIV prevalence among young females is twice as high when compared to their male counterparts. HIV prevalence among young people is higher in southern African countries than elsewhere. In Swaziland (DHS 2006-07) the prevalence among young people was 5.9 percent for male and 22.7 percent for female and in Zimbabwe (DHS 2005-06) the prevalence among young males 15 to 19 years was 4.2 percent compared to 11.0 percent for young females 15 to 19 years.

The urban-rural disparities, the differences observed between the sexes, and the high prevalence in southern Africa call for focused strategies to scale up interventions, including comprehensive condom programming. There is also the important need to address the vulnerability of young women to HIV infection. In recognition of this need, a cluster of countries in southern Africa are supported by the GPRHCS within the Stream 2 funding modality and targeted support is provided particularly for HIV/AIDS prevention and comprehensive condom programming.

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

A measureable outcome enables UNFPA to measure progress towards the global goal. The outcome is measured using the following indicators:

Two outcome indicators of the GPRHCS are derived from the UNFPA Strategic Plan 2008-2012. They are also indicators for MDG 5, improve maternal health:

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

In addition, the GPRHCS monitors the following three outcome indicators to measure progress for commodity security:

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

Achieving reproductive health commodity security is manifested in the availability of contraceptive commodities and life-saving and essential maternal health medicines within service delivery points where clients, irrespective of background, could have access to them. It is with this in mind that the GPRHCS supports countries in addressing shortfalls and stock-outs of essential medicines and contraceptives. GPRHCS is engaged in the actual procurement and delivery of these commodities to the countries and, significantly, the programme assists in strengthening storage, distribution and service provision systems in support of family planning and maternal and neonatal health.

The GPRHCS provides funds for an annual survey in Stream 1 countries to obtain data for three important outcome indicators specific to the programme. In situations where the health management information system (HMIS) is regularly updated, data for these indicators could be easily obtained. However, as a result of the weak statistical systems in all the GPRHCS countries, data for three additional GPRHCS outcome indicators have to be sourced from special surveys. The 2010 surveys in Stream 1 countries were carried out according to a standardized methodology and survey guidelines. The guideline recommended a framework for choosing representative sample of service delivery points (SDPs) that provide modern contraceptive methods and maternal/reproductive health (RH) services in each country. The service delivery points of the countries were categorized into primary Level SDPs (health posts and health centres); secondary level SDPs (rural, zonal and regional hospitals/general hospitals); tertiary level SDPs (referral/specialized hospitals); or as defined by national protocols.

In practice, the ability to compare figures for 2010 and previous years is limited by the fact that ccountries adopted methods that not only varied widely but also differed from the standardized methodology adopted for 2010.

1.2.1 Unmet need for family planning

This indicator is measured by the percentage of women currently married, or in a consensual union, aged 15-49 who want to stop having children or to postpone the next pregnancy for at least two years, but who are not using contraception.

As a result of lack of recent DHS survey data, most countries have not reported any change in unmet need for family planning. Table 4 shows that unmet need for family planning in Stream 1 countries ranges from 10.7 percent for Nicaragua to 34 percent in Ethiopia. With the exception of Lao PDR in Southeast Asia, all the Stream 1 countries with unmet need higher than 25 percent are in Africa. For Stream 2 countries, unmet need ranges from 3.8 percent for Timor Leste to 40.3 percent for Uganda (see Annex 3). Unmet need is higher than 25 percent for 22 programme countries, and this includes five of the 11 Stream 1 countries.

High unmet need for family planning is an indication of the existence of barriers, including social, economic and physical barriers that limit women's access to and utilization of family planning services, and limit quality of care. This carries attendant risk of unintended pregnancies and early childbearing. Barriers are also related to quality of care. Support is required for country-led family planning efforts-through the provision of commodities; strengthening health systems; removing social, economic and physical barriers; scaling up demand creation efforts; and improving quality of care—all necessary for reducing unmet need and improving contraceptive use.

Table 4: Unmet need for family planning for GPRHCS Stream 1 countries, percentage

Country	Baseline (2008)	2009	2010	Target (2013)
Burkina Faso	31.3 (MOH)	28.0 (MOH)	28.8 (MOH)	NA
Ethiopia	34.0 (DHS 2005)	34.0 (DHS 2005)	34.0 (DHS 2005)	Less than 10%
Haiti	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	NA
Lao PDR	27.3 (LRHS 2005)	27.3 (LRHS 2005)	27.3 (LRHS 2005)	NA (CPR target is set in MNCH Strategy rather than unmet need)
Madagascar	24.0 (DHS 2004)	19.0 (MOH)	19.0 (MOH)	NA
Mali	31.2 (DHS 2006)	31.2 (DHS 2006)	31.2 (DHS 2006)	NA
Mongolia	14.4 (ENDSA 2008)	14.4 (ENDSA 2008)	14.4 (ENDSA 2008)	10%
Mozambique	18.4 (DHS 2003)	18.4 (DHS 2003)	18.4 (DHS 2003)	NA
Nicaragua	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	8%
Niger	22.0 (MOH 2007)	NA	NA	NA
Sierra Leone	28.0 (DHS 2008)	28.0 (DHS 2008)	28.0 (DHS 2008)	40% reduction

Source: Compiled from 2010 GPRHCS country reports and related documents

1.2.2 Contraceptive prevalence rate - modern methods

Contraceptive prevalence rate (CPR) - modern methods - refers to the proportion of women aged 15-49 who are using, or whose sexual partners are using, any modern method of contraception. The indicator is useful in tracking progress towards health, gender and poverty goals. It also serves as a proxy measure of access to reproductive health services. Though new data for CPR for 2010 was not available for most of the Stream 1 countries, the conclusions made about improvement in CPR in 2009 still remains valid; that is nine original Stream 1 countries have a CPR greater than 10 percent and seven countries have a CPR of 25 percent or higher. Over 70 percent of the Stream 1 countries are within 10 percentage points of their target CPR for 2013 or 2015 as set in their national health strategies. In the new Stream 1 countries (Mali and Sierra Leone), the baseline CPR was established at 7 percent in 2009.

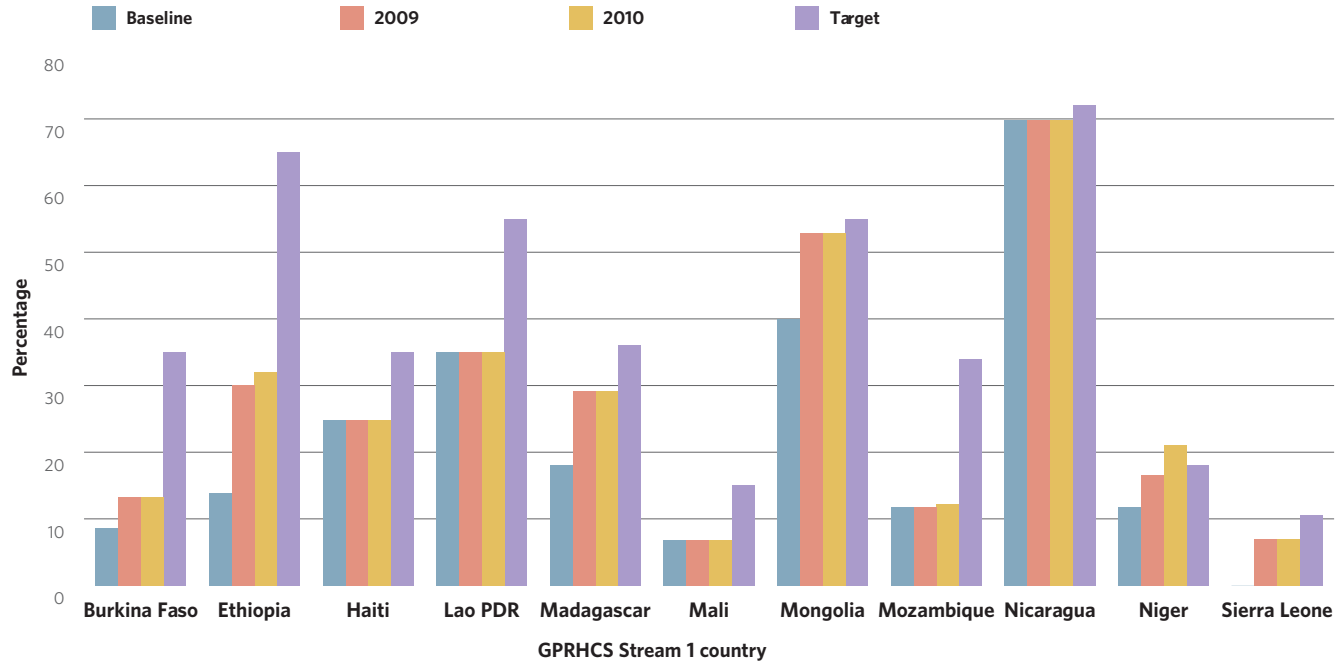
While CPR continued to increase in 2010 in countries supported by the Global Programme, analysis of disaggregated data revealed that in all Stream 1 countries, current use of contraception was higher in urban areas and amongst those with higher education, and also increased with higher wealth quintiles. This finding is consistent with the longstanding situation in developing countries regarding use, access, availability, affordability and other factors that help or hinder the use of modern methods of contraception. A focus on those most in need in poor and rural areas is called for, along with efforts to enhance awareness and knowledge to generate demand.

Table 5: Contraceptive prevalence rate (modern methods): Stream 1 countries, percentage

Country	Baseline	2009	2010	Target
Burkina Faso	8.6 (DHS 2003)	13.3 (MICS 2006)	13.3 (MICS 2006)	35% (2013)
Ethiopia	13.9 (DHS 2005)	30.0 (MOHS)	32.0 (MOHS)	65% (2015)
Haiti	24.8 (DHS 2005-06)	24.8 (DHS 2005-06)	24.8 (DHS 2006)	35% (2013)
Lao PDR	35.0 (LRHS 2005)	35.0 (LRHS 2005)	35.0 (LRHS 2005)	55% (2015)
Madagascar	18.0 (DHS 2004)	29.2 (MOHS)	29.2 (DHS 2008-09)	36% (2012)
Mali	6.9 (DHS 2006)	6.9 (DHS 2006)	6.9 (DHS 2006)	15% (2013)
Mongolia	40.0 (RHS)	52.8 (RHS 2008)	52.8 (RHS 2008)	55% (2012)
Mozambique	11.7 (DHS 2003)	11.7 (DHS 2003)	12.2 (MOH)	34% (2015)
Nicaragua	69.8 (DHS 2007)	69.8 (DHS 2007)	69.8 (DHS 2007)	72% (2013)
Niger	11.7 (DHS 2006)	16.5 (MOH)	21.0 (National Health Information System)	18% (2012)
Sierra Leone	-	7.0 (DHS 2008)	7.0 (DHS 2008)	10.5% (2013)

Source: Compiled from 2010 GPRHCS country reports and related documents

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

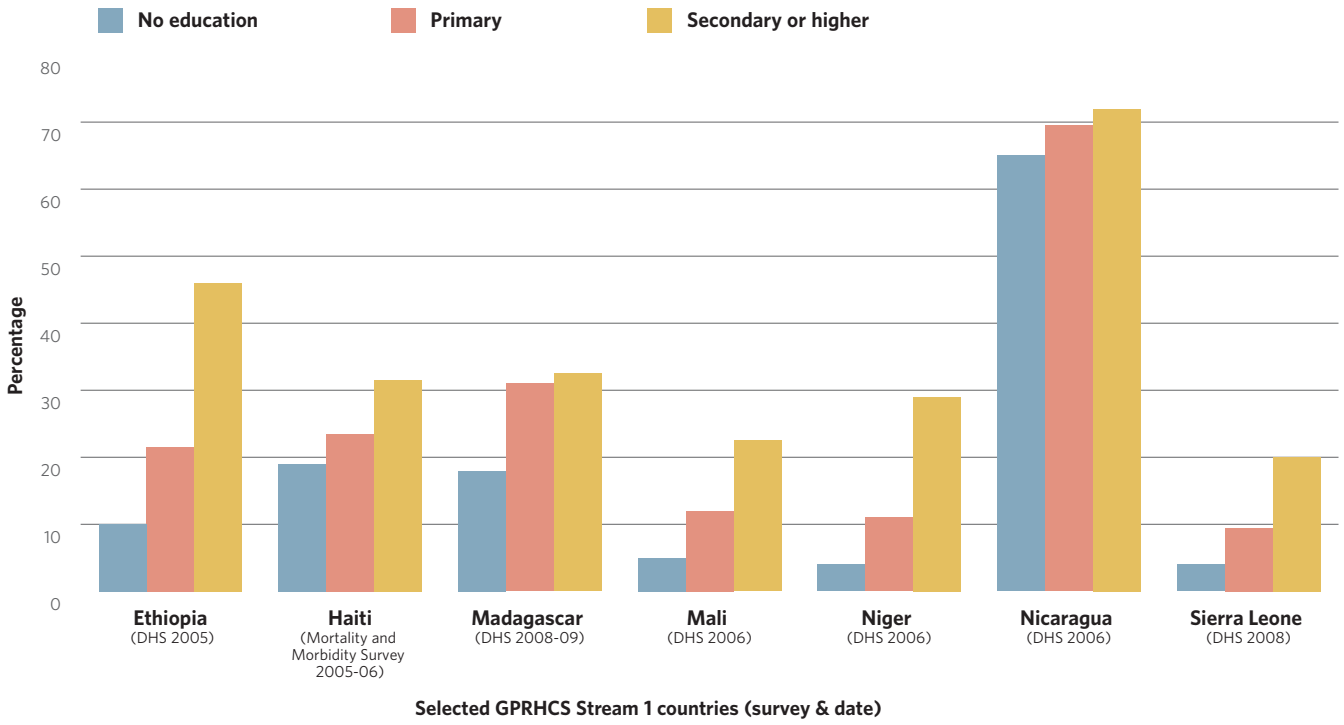


Source: Compiled from 2010 GPRHCS country reports and related documents

Figure 4 shows that the significant increase in CPR witnessed in 2009 in several Stream 1 countries (Ethiopia, Mozambique and Niger) continued in 2010. Specifically for Niger, the target set for 2012 in the country's national health strategy has already been surpassed. Figures from Mongolia and Nicaragua indicate that the targets are close to being achieved.

Disaggregated data compiled from various DHS and other national surveys conducted in Stream 1 countries give insight into the disparities that exist in use of contraceptives. As shown in Figure 5, current use of contraceptives is higher among women with secondary or higher levels of education in all the countries. In Nicaragua, the difference between respondents with no education and those with secondary or higher level is narrower than for the other countries.

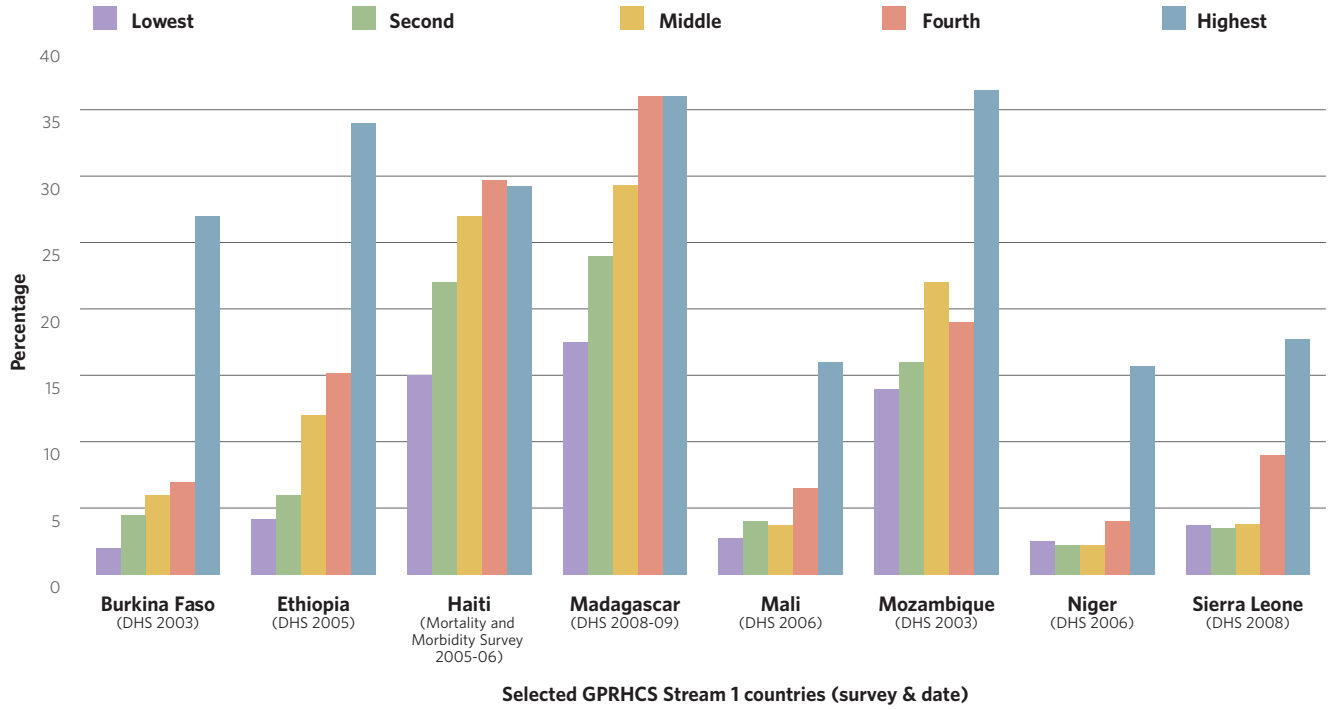
Figure 5: Current use of contraception by highest educational level for selected GPRHCS Stream 1 countries



Source: Demographic and Health Surveys (DHS) data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

Current use of contraceptives is also highly related to household wealth index. Data presented in Figure 5 shows that for most of the countries, the percentage of current users of contraceptives are disproportionately higher among married women in the highest wealth quintile. In the case of Burkina Faso, Ethiopia, Mali, Niger and Sierra Leone, the percentage of women who are current users of contraceptives in the highest wealth quintile is higher than all the other categories put together. Haiti appears to have the least disparity between the poorest and the richest quintiles. Information provided by this disaggregated data will be used by countries and partners in targeting the underserved and devising strategies to better address their needs.

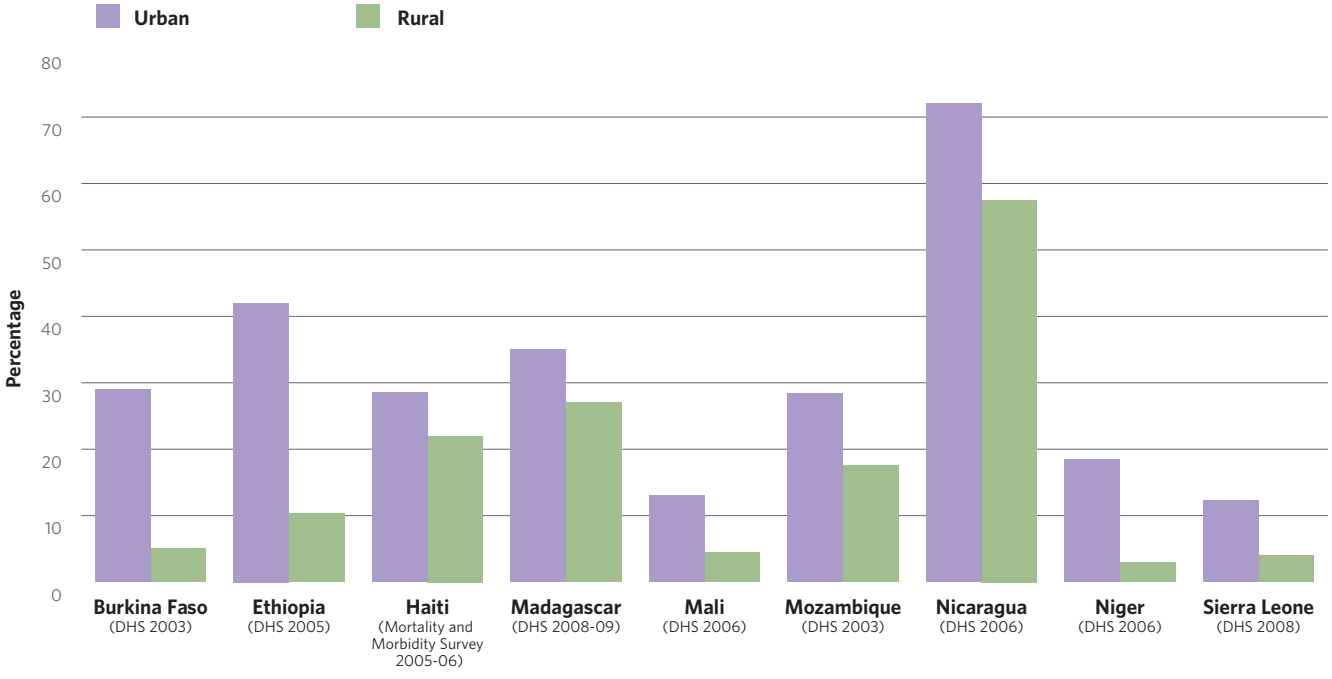
Figure 6: Current use of contraception by household wealth index for selected GPRHCS Stream 1 countries



Source: Demographic and Health Surveys (DHS) data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

Figure 7 shows that the percentage of contraceptive users in all the countries shown appears to be higher for urban dwellers than for rural dwellers. In the case of Burkina Faso, Ethiopia, Mali, Niger and Sierra Leone, there appears to be four times more current users in urban centres than in rural areas.

Figure 7: Current use of contraception by urban/rural residence for selected GPRHCS Stream 1 countries



Source: Demographic and Health Surveys (DHS) data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

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

This indicator assesses the percentage of service delivery points (SDPs) that report the availability of at least three types of modern methods of contraceptives. It allows a country to better understand the extent to which quality contraceptive services are being made available and accessible to their population, which will impact CPR in the long run. Ensuring the availability of contraceptives and choice of methods at every facility that offers health services is the foundation for improving reproductive health and rights. As had been mentioned before, to ensure standardisation and comparability among countries, a standardised methodology was designed for the conduct of this survey in the 11 Stream 1 countries for 2010. Summaries of data from the individual survey reports, as shown in Table 6 show that the number of service delivery points (SDPs) offering at least three modern contraceptive methods varied from country to country – but had shown a steady increase in 2010 for all Stream 1 countries (except Sierra Leone where the survey the year before had been on availability of two rather than three modern methods of contraception).

Table 6: Percentage of service delivery points (SDPs) offering at least three modern methods of contraception in GPRHCS Stream 1 countries

Country	Baseline	2009	2010	Target (2013)
Burkina Faso	NA	80.4 (2009)	93.5	100 (2012)
Ethiopia	60.0 (2006)	90.0	98.0	100 (2010)
Haiti	0	NA	93.0	90.0 (2013)
Laos	96.0 (2006)	91.0	93.0	100 (2012)
Madagascar	-	30.8	47.8	100 (2012)
Mali	-	100	97.0	NA
Mongolia	98.0	NA	93.5	100
Mozambique	95.7 (HIS 2008)	NA	96.5	100
Nicaragua	66.6 (2008)	92.0	99.5	100
Niger	56.0 (2008)	NA	80.9	90.0
Sierra Leone	-	88.0*	87.2	100

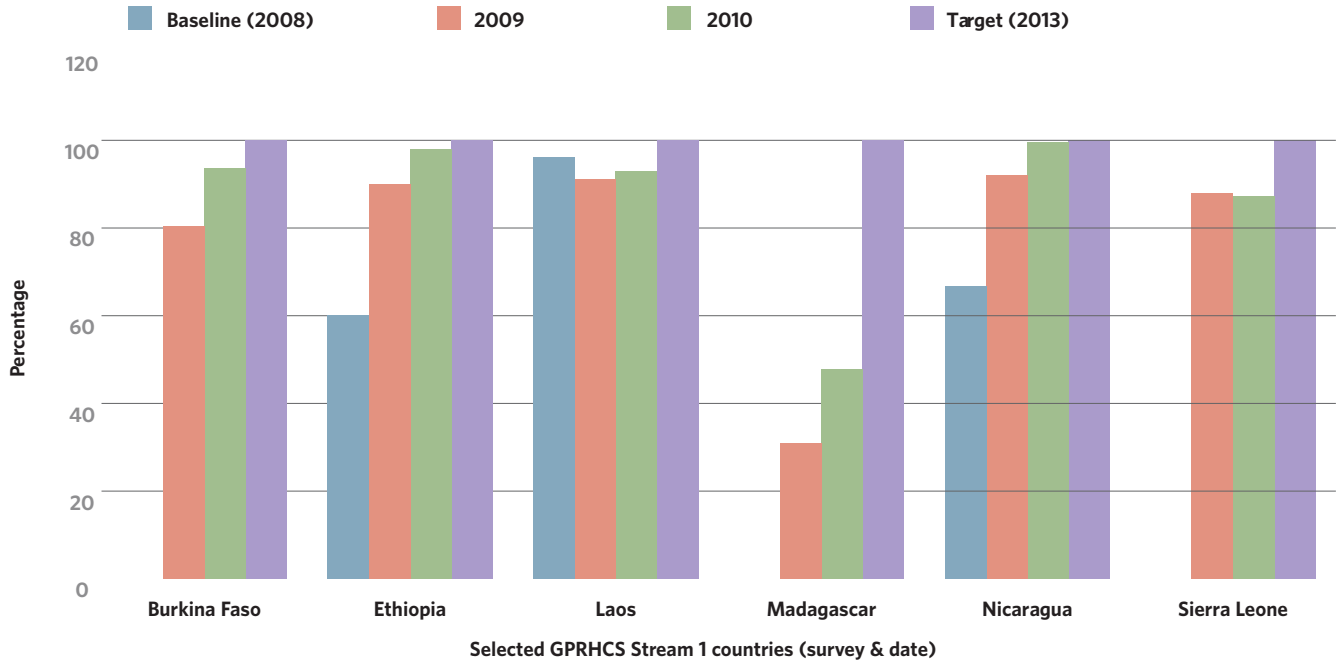
Source: GPRHCS 2010 country and related sample survey reports
Note: 2010 data from sample surveys reports of each country conducted using standardized methodology
* Proportion with at least two modern methods available

Three modern contraceptive methods were available in more that 80 percent of primary-level SDPs surveyed in Stream 1 countries, the disaggregated data revealed. The exceptions were Madagascar and Sierra Leone (50 and 70 percent, respectively) as shown in Table 7. In Ethiopia, Mongolia and Mozambique, three modern methods of contraceptives were available in 100 percent of the tertiary-level SDPs. In general higher level facilities appear to be better stocked with contraceptives than the lower level facilities.

The Haiti survey report indicates that male condoms, pills and injectables were offered in more than 90 percent of SDPs but female condom, vasectomy and the IUD were provided in less than 35 percent of SDPs. In the south-east, north, north-west and west of Haiti, over 10 percent of SDPs offer less than three methods. Public SDPs offer more contraceptives in Haiti than private SDPs. The same can be said about SDPs located in urban areas which provide far more methods than those located in rural area.

[3] The modern methods under consideration are i) Male condoms, ii) Female Condoms , iii) Oral Pills , iv) Injectables , v) IUDs , vi) Implants, vii) Sterilisation for Females and viii) Sterilisation for Male

Figure 8: Percentage of SDPs offering at least three modern methods of contraception in GPRHCS selected Stream 1 countries



Source: GPRHCS 2010 country and related sample survey reports

Table 7: Percentage of sampled SDPs by type of facility, offering at least three modern methods of contraception in GPRHCS Stream 1 countries in 2010

Country	Primary	Secondary	Tertiary
Burkina Faso	92	100	100
Ethiopia	97.6	98.4	100
Haiti	91.0	94.0	93.0
Laos	89.0	95.0	94.0
Madagascar	50.0	50.6	61.8
Mali	88.0	88.0	73.0
Mongolia	92.0	100	100
Mozambique	96.7	95.0	100
Nicaragua	99.5	100	-
Niger	80.0	100	100
Sierra Leone	70.0	76.0	78.0

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

1.2.4 Number of GPRHCS Stream 1 countries where 5 life-saving maternal/RH medicines[4] from the list of UNFPA priority medicines are available in all facilities providing delivery services

Reducing the maternal mortality ratio (MMR) is a key goal for all Stream 1 countries supported by the GPRHCS. High rates of maternal mortality continue to plague most of the Stream 1 countries. Women, particularly in rural areas, die in high numbers from lack of access to quality maternal health services. Situation analyses such as national Emergency Obstetric and Newborn Care (EmONC) needs assessments often reveal that facilities which provide delivery services are not adequately stocked with the necessary supplies and medicines to save a woman's life during childbirth.

UNFPA, in collaboration with WHO and other partners, has identified 10 priority and essential medicines that must be available in all facilities where births take place, to decrease the number of maternal and infant deaths. The GPRHCS is working to ensure that these medicines are routinely available in adequate quantities and quality at all maternal health facilities. This indicator is a measure of the functionality of the health system, and the ability of countries to forecast their needs and then procure and manage commodities to efficiently meet those needs. Given the inherent difficulty in tracking all 10 essential medicines, the number of medicines has been restricted to five in this indicator.

Table 8 shows the results of the survey conducted in 2010 on the availability of five life-saving maternal/RH medicines (including three UNFPA priority medicines) in GPRHCS Stream 1 countries. The results show that most Stream 1 countries (10 out of 11) had these medicines available in 50 percent or more of facilities. Availability was low in Lao PDR (13%), probably because for Lao PDR the sample contained a disproportionate number of health centres that did not have these medicines available. For the other Stream 1 countries, the percentage ranged from 51.4 percent in Burkina Faso to 99.5 percent in Nicaragua – showing that Nicaragua has already achieved the target set for 2011.

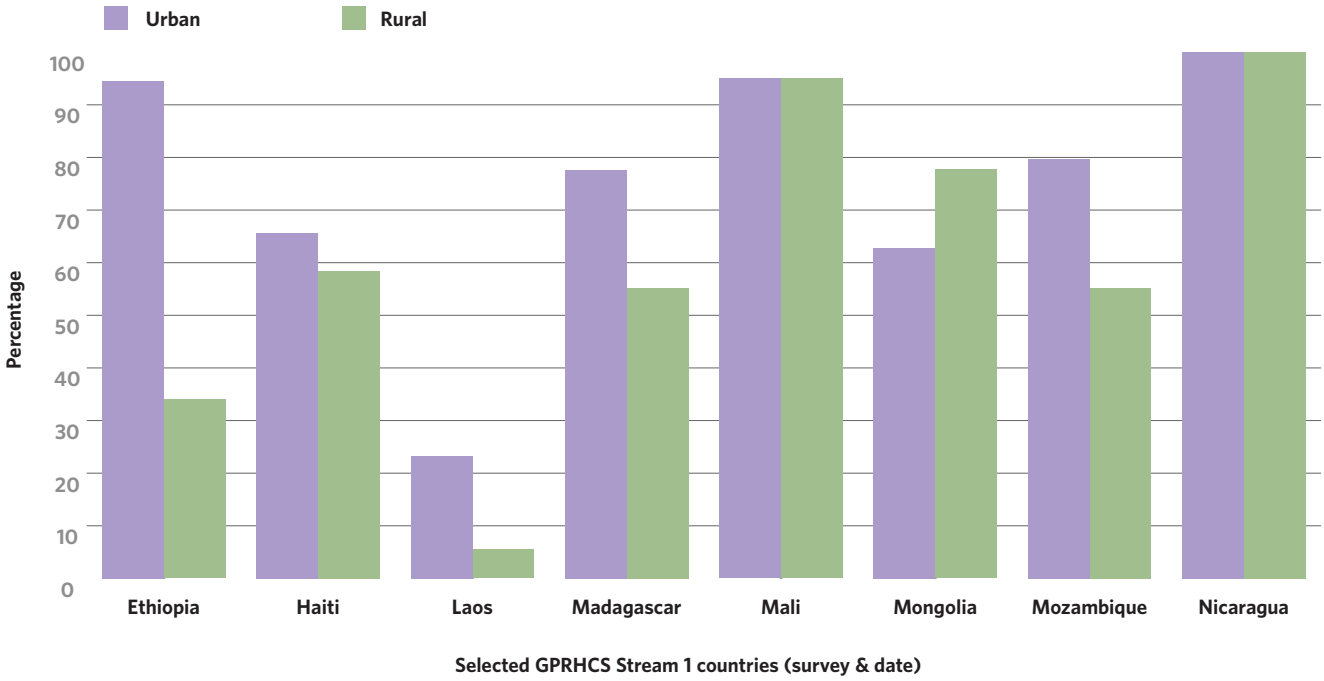
Table 8: Percentage of SDPs with five life-saving maternal/RH medicines (including three UNFPA priority medicines) available in GPRHCS Stream 1 countries

Country	2010*	Target (2013)
Burkina Faso	51.4	Y**
Ethiopia	76.1	100
Haiti	60.8	NA
Lao PDR	13.0	Y**
Madagascar	66.6	100
Mali	92.0	NA
Mongolia	76.8	98.0
Mozambique	68.4	NA
Nicaragua	99.5	100
Niger	60.6	100
Sierra Leone	75.5	100

*Source: GPRHCS 2010 country and related sample survey reports
** National average 80%, Prov: 100%, Dist: 90% HC: 30%

4 The 10 UNFPA Priority medicines are i) Amoxicillin , ii) Azithromycine, iii) Benzathine Penicillin, iv) Cefexime, v) Clotrimazole, vi) Ergometrine, vii) Iron/Folate, viii) Magnesium Sulfate, ix) Metronidazole and x) Oxytocine

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



Source: GPRHCS 2010 country and related sample survey reports

In terms of urban and rural disparities, the results of the survey as shown in the Figure 9 indicate that in Mongolia more rural SDPs had the required life-saving maternal health medicines available than in urban areas. The opposite is the case in Ethiopia, Haiti, Lao PDR, Madagascar and Mozambique, where more SDPs in urban areas had the required medicines than those in the rural areas. The disparity was found to be higher in Ethiopia with 93.9 percent of urban SDPs compared to 45 percent of rural SDPs having available 5 life-saving maternal/RH medicines (including three UNFPA priority medicines.

1.2.5 Number of Stream 1 countries with service delivery points with 'no stock-outs' of contraceptives within last 6 months

The GPRHCS supports governments in making sure that reproductive health commodities and services are available on a consistent and reliable basis with no stock-outs. These efforts involve the timely response to reproductive health commodity requirements to avert shortfalls; capacity development to improve procurement and management systems for reproductive health. For many countries, supply management systems are still not fully functional at every level of the health system. The number of stock-outs experienced in a country reflects the level of functioning of the Logistics Management System (LMS) at central and district levels.

Table 9 indicates that 'no stock-out' rates improved for most Stream 1 countries. In 2010, 'no stock-out' rates higher than 80 percent were reported for Nicaragua (99.7%), Ethiopia (99.2%), Niger (99.1%), Mongolia (97.6%) and Burkina Faso (81.3%). On the other hand, four countries experienced 'no stock out' rates of less than 50% in the six months preceding the survey. These were Mozambique (24.1%), Lao PDR (36%), Sierra Leone (41.4%) and Mali (46%).

In terms of types of service delivery points, and in Lao PDR, 100 percent of the national hospitals and 80 percent of the provincial hospitals and MCH clinics, all of which are urban-based, had stocks of all contraceptives at the time of the survey. About 72 percent of SDPs at district level had at least three modern contraceptive methods. For Ethiopia, in the six months prior to the survey, no stock-outs of modern contraceptive methods were reported in all of the primary and tertiary level SDPs, and only 3.2 percent of secondary level SDPs experienced stock-out. Regarding urban rural stock status, only 2.6 percent of rural

SDPs experienced stock-out of any modern contraceptive method in the six months prior to the survey. In Sierra Leone, two districts – the Western Urban Area (where the capital Freetown is located) and Bombali district – experienced no stock-out of any contraceptive commodity or service that they offer in the six months prior to the survey. This was said to be attributable to the fact that these two geographic subdivisions of the country were the model districts for UNFPA reproductive health interventions for the Country Programme (2007-2010). In addition, female and male condoms, followed by IUDs were the methods most regularly in stock. Injectables and female sterilization techniques experiences the most stock-outs. In Mozambique, 64.8 percent of primary level SDPs had no stock-out of male condoms; 53.8 percent had no stock-out of oral pills; 46.2 percent had no stock-out of IUDs; 54.9 percent had no stock-out of injectables; and, 39.6 percent had no stock-out of female condoms.

The most frequently cited reasons for stock-out were inadequate logistics management (e.g. shortage of supply, delay in placing orders and delivery of commodities), and the lack of resources to procure commodities. For certain contraceptive methods like IUDs, there were limited numbers of trained personnel to provide this service in some SDPs.

On the whole, the steady reduction in the number of facilities experiencing stock-outs of contraceptive commodities amongst the Stream 1 countries is very encouraging, and attests to system improvements which in the long run will contribute to the availability and accessibility of commodities in many of these countries.

Table 9: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months in GPRHCS Stream 1 countries

Country	Baseline	2009	2010****	Target (2013)
Burkina Faso	NA	29.2 (2009)	81.3	100 (2012)
Ethiopia	60.0 (2006)	90.0 (2009)	99.2	100 (2010)
Haiti	NA	NA	52.5	NA
Lao PDR	NA	20.0*	36.0	80.0
Madagascar	63.3 (2008)	74.4(2009)	79.6	96.0 (2012)
Mali	-	100	46.6	NA
Mongolia	100	100	97.6**	100
Mozambique	NA	NA	24.1	NA
Nicaragua	66.6 (2008)	81.0 (2009)	99.7	92.0
Niger	0	100 (2009)	99.1***	100 (2012)
Sierra Leone	-	77.0	41.4	100

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

1.2.6 Funding available for contraceptives including condoms

Funding available globally for contraceptives and condoms is shown Table 10 (figures for 2010 were still being calculated at the time this report was finalized). This indicator, which focuses on trends in commodity support among major donors, measures the level of external assistance to countries and the availability of donor funds for procurement of contraceptives, including condoms.

UNFPA has been tracking donor support for contraceptives and condoms for STI/HIV prevention since 1997. From its donor database, the UNFPA Commodity Security Branch publishes an annual report with information on the trends and gaps between estimated needs and actual donor support.

This report highlights trends in support from bi-lateral donors, multi-lateral donors and social marketing organizations. The report is intended mainly for use in planning contraceptive supply, advocacy and resource mobilization. The 'value added' by publishing this annual document is its significant impact on issues related to RHCS in the areas of policy dialogue, advocacy, contribution to advancing the MDGs and interagency work.

Table 10: Trends in donor expenditure by commodities, 2005-2009

	Expenditure, in millions of US$				
Donors	2005	2006	2007	2008	2009
USAID	68.8	62.8	80.9	68.9	87.5
UNFPA	82.6	74.4	63.9	89.3	81.1
PSI	28.8	30.6	24.9	14.1	17.9
BMZ/KFW	13.1	23.6	24.6	15.5	16.2
DFID	4.6	12.1	22.5	11.1	13.0
Others*	9.6	5.1	6.4	14.9	23.0
Total	**207.5**	**208.6**	**223.2**	**213.7**	**238.8**

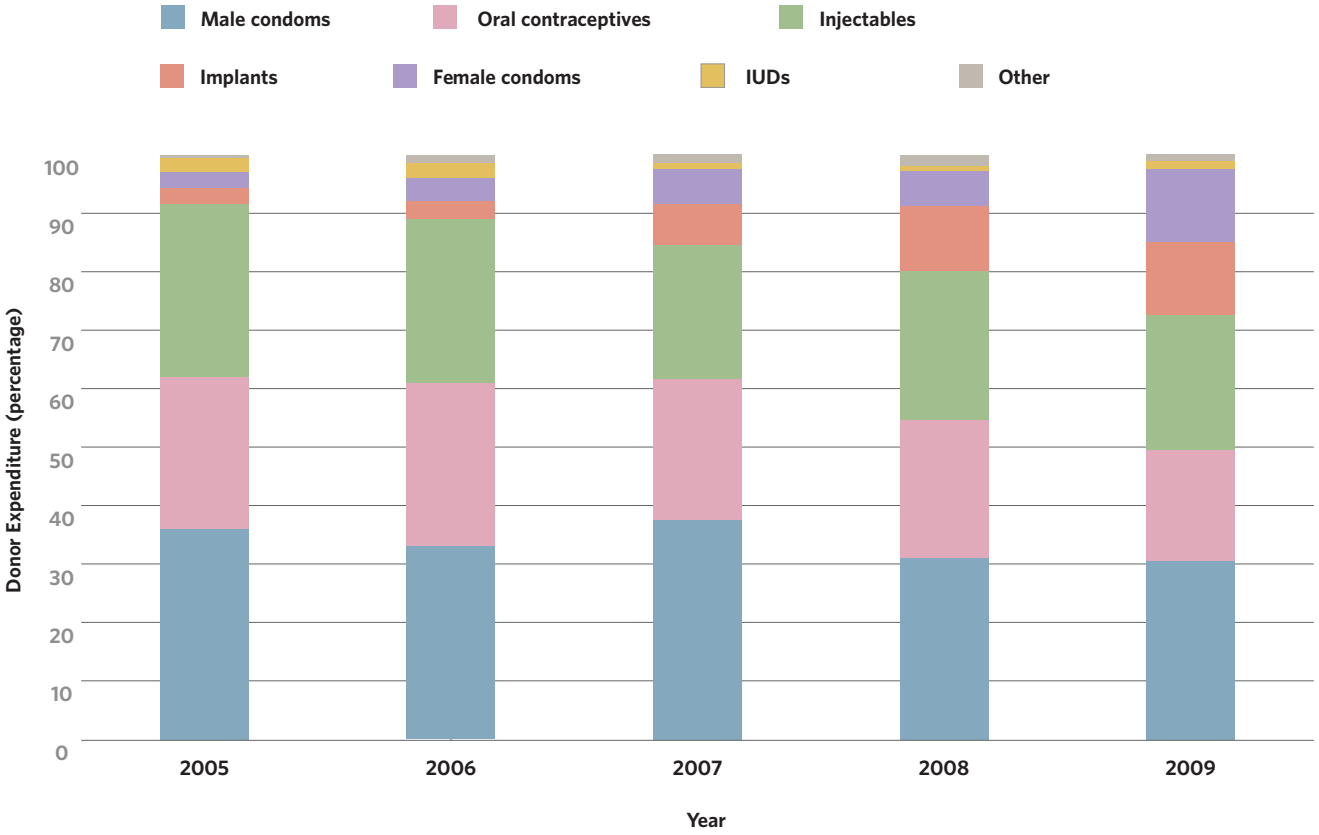
* Includes IPPF, MSI, Japan, Netherlands, and others

Table 11: Trends in commodity support among major donors, 2005-2009

	Expenditure, in millions of US$				
Method	2005	2006	2007	2008	2009
Male condoms	75.7	68.9	83.5	65.7	72.6
Oral contraceptives	55.9	58.2	52.3	52.8	45.8
Injectables	58.9	58.4	53.3	53.2	52.6
Implants	5.5	7.2	16.2	23.3	33.4
Female condoms	5.3	9.0	12.8	14.3	29.2
IUDs	4.3	4.0	2.5	1.7	3.2
Other*	1.8	2.8	2.6	2.7	2.1
Total	**207.5**	**208.6**	**223.2**	**213.7**	**238.8**

*Includes emergency contraceptives, vaginal tablets, foams/jellies, and sampling/testing

Figure 10: Donor expenditure by commodities, 2005-2009



Tables 10 and 11 illustrate trends in commodity expenditures among major donors from 2000 to 2009. Together, USAID and UNFPA account for about 70 percent of overall donor support for contraceptives and condoms for STI/HIV. Some highlights of the 2009 donor report include:

- Donor support in 2009 was $238.8 million, approximately an 11 percent increase from 2008;
- There was a more diversified commodity mix in 2009. Male condoms led (30%), followed by injectables (22%), oral contraceptives (19%), implants (14%), and female condoms (12%). By comparison in 2008, 80 percent of donor support was allocated to only three types of commodities (male condoms, oral contraceptives and injectables);
- Donor support for female condoms more than doubled (from 14 million in 2008 to 29 million in 2009), while there were notable increases for IUDs and implants;
- Donor share requirements would nearly need to double in order to meet projected contraceptive need (estimated at $408 million) in 2015.

Although funding is increasing, it still has not met the need that exists. At least 215 million women in the developing world want to delay or avoid pregnancy but are not using family planning. The demand for modern contraception continues to far outstrip supply. It is estimated that to meet current unmet need and keep pace with population growth, numbers of contraceptive users will increase by over 30 per cent during the next 15 years.

SECTION TWO

OUTPUT-LEVEL RESULTS

Health worker keeps records in Niger.
Photo by Giacomo Pirozzi/Panos Pictures

Section Two looks at the programme's four outputs: (1) Country RHCS strategic plans developed, coordinated and implemented by government with their partners; (2) Political and financial commitment for RHCS enhanced; (3) Capacity and systems strengthened for RHCS; (4) RHCS mainstreamed into UNFPA core business.

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

Supporting government-led processes to formulate and implement RHCS activities as an integral part of health sector interventions, and putting in place structures that will institutionalize such processes are key strategies of the GPRHCS, especially in Stream 1 countries. The GPRHCS therefore helps government to prepare and implement RHCS strategies and action plans, and to integrate RHCS issues into key sectoral strategies. It also helps to establish functional coordinating bodies under the leadership of government and with the participation of key stakeholders as per country requirement. These bodies help to ensure resource mobilization and implementation of activities, as well as their government's recognition of the need to put RHCS high on the national agenda. Essential in all this is to strive to include RH commodities, including contraceptives, on the Essential Medicines List (EML) of each country.

2.1.1 Number of countries where RHCS strategy is integrated with national RH/SRH,HIV/AIDS, Gender & Reproductive Rights strategies

This indicator seeks to assess the holistic approach adopted by each country (Streams 1 and 2) in implementing RHCS and other closely related and complementary interventions in the areas of RH health, HIV/AIDS and gender. The indicator assesses the existence of the three thematic strategies and most importantly the inclusion of appropriate RHCS issues in each of the thematic strategies.

Table 12: RHCS strategy integrated into sectoral strategies in Stream 1 countries

	Sectoral strategies		
Countries	RH/SRH	HIV/AIDS	Gender
Burkina Faso	Y	Y	Y
Haiti	Y	Y	N
Ethiopia	Y	Y	Y
Lao PDR	Y	Y	N
Madagascar	Y	Y	N
Mali	Y	Y	Y
Mongolia	Y	Y	Y
Mozambique	Y	Y	Y
Nicaragua	Y	N	N
Niger	Y	Y	Y
Sierra Leone	Y	Y	Y
Total for 'Yes'	**11**	**10**	**7**

Source: * Population and Development Branch, Have we progressed on MDG4b? The empirical evidence in advancing Universal Access
to Reproductive Health, Technical Division, UNFPA New York, June 2010.
** Data from Macro International Inc, 2011. MEASURE DHS STATcompiler. http://www.measuredhs.com, March 16 2011

All of the Stream 1 countries have RHCS integrated into RH/SRH Strategies. Ten out the 11 Stream 1 countries have RHCS issues integrated into HIV/AIDS strategies, and only seven of them have RHCS key issues integrated into gender strategies.

For the Stream 2 countries, with the exception of Djibouti, all the other countries have integrated GPRHCS key issues into at least one of the three sectoral strategies. Among Stream 2 countries, 23 indicated that they have integrated RHCS key issues into HIV/AIDS strategies, while in the case of the gender strategy 14 had done so.

Table 13: RHCS strategy integrated into sectoral strategies in Stream 2 countries

	Sectoral strategies		
Countries	RH/SRH	HIV/AIDS	Gender
Benin	Y	Y	N
Bolivia	Y	Y	N
Botswana	Y	Y	Y
Burundi	Y	Y	N
Central African Republic	Y	Y	Y
Chad	Y	Y	NA
Congo	Y	Y	Y
Côte d'Ivoire	Y	Y	Y
Democratic Republic of the Congo	Y	Y	Y
Djibouti	N	N	N
Ecuador	Y	Y	Y
Eritrea	Y	Y	Y
Gabon	Y	Y	Y
Gambia	Y	Y	NA
Ghana	N	Y	Y
Guinea	Y	N	N
Guinea-Bissau	Y	N	N
Lesotho	Y	Y	N
Liberia	Y	Y	N
Malawi	Y	Y	N
Mauritania	Y	Y	Y
Namibia	Y	Y	Y
Nigeria	Y	NA	Y
Sao Tome and Principe	N	N	N
Senegal	Y	Y	Y
Swaziland	Y	Y	N
Uganda	Y	Y	Y
Zambia	Y	Y	N
Zimbabwe	Y	N	N
Total for 'Yes'	**26**	**23**	**14**

There are several reasons why RHCS issues are not integrated in sectoral strategies, including the absence of such a strategies (Chad, Liberia and Swaziland indicated that there was no gender mainstreaming strategy); lack of resources or funds as indicated by Benin; the need to revise an existing strategy often regarded as obsolete in Burundi and Djibouti; and, limited human capacity as noted by Democratic Republic of Congo, Malawi and Namibia.

2.1.2 Number of countries with strategy implemented (National strategy/action plan for RHCS implemented)

In addition to ascertaining the existence of a RHCS strategy, this indicator seeks to determine whether actions were taken during the year to implement aspects of the strategies and action plans especially in the GPRHCS Stream 1 and 2 countries.

The number of Stream 1 countries that have developed RHCS strategies or action plans increased to 10 out of 11 countries in 2010, compared to 9 out of 11 countries in 2009. Mali now has an RHCS strategy/plan but Haiti has not yet developed one. Regarding implementation, RHCS strategies/action plans were implemented in 10 countries in 2010, up from seven in 2009, as shown in Table 14.

Table 14: RHCS strategies/action plans and coordinating committees in Stream 1 countries

	Have RHCS strategy/ action plan		If yes, elements being implemented		National country coordinating mechanism exists		If yes, RHCS issues included in institutional mechanism	If yes, does mechanism have TOR
Countries	2009	2010	2009	2010	2009	2010		
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y	Y	Y
Haiti	N	N	N	N	N	N	N	N
Lao PDR	Y	Y	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y	Y	Y
Mali	N	Y	N	Y	Y*	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	N	Y	Y	Y	Y	Y
Nicaragua	Y	Y	N	Y	Y	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y	Y	Y
Sierra Leone	Y	Y	Y	Y	Y	Y	Y	Y
2010 Total for 'Yes'	-	10	-	10	10	10	10	10
2009 Total for 'Yes'	9	-	7	-	9	-	-	-

** For contraceptives only

Table 15 shows that an RHCS strategy/action plan exists in 26 Stream 2 countries. With the exception of two countries (Uganda and Côte d'Ivoire) all the other countries reported the implementation of RHCS strategies/action plans. The focus in 2011 is to support the formulation and implementation of RHCS strategies in Stream 2 countries such as Congo, Gambia, Lesotho, Liberia, Mauritania and Zambia, where in some cases though plans exist, they are to a larger extent not being implemented.

Table 15: RHCS strategies/action plans and coordinating committees in Stream 2 countries

Countries	Have RHCS strategy/ action plan	If yes, elements being implemented	National country coordinating mechanism exists	If yes, RHCS issues included in institutional mechanism	If yes, does mechanism have TOR
Benin	Y	Y	Y	Y	N
Botswana	Y	Y	Y	Y	Y
Burundi	Y	Y	N	-	-
Central Africa Republic	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y
Congo	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	N	Y	Y	Y
DRC	Y	Y	Y	Y	Y
Djibouti	Y	Y	N	N	N
Eritrea	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y
Ghana	Y	Y	Y	Y	Y
Guinea	Y	Y	N	N	N
Guinea Bissau	Y	Y	Y	Y	-
Lesotho	Y	N	Y	N	Y
Liberia	N	NA	Y	Y	Y
Malawi	Y	Y	Y	Y	Y
Mauritania	N	NA	Y	Y	Y
Namibia	Y	Y	Y	Y	-
Nigeria	Y	Y	Y	Y	Y
Sao Tome and Principe	Y	Y	N	N	N
Senegal	Y	Y	Y	N	N
Swaziland	Y	Y	Y	Y	Y
Gambia	N	NA	Y	Y	N
Uganda	Y	Y	Y	Y	N
Zambia	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y
Bolivia	Y	Y	Y	Y	Y
Ecuador	Y	Y	Y	Y	Y
Total for 'Yes'	**26**	**24**	**25**	**23**	**20**

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

This indicator determines the existence of a coordinating mechanism and also assesses the existence and the effectiveness of the mechanism used to bring country-level partners together to work on RHCS issues. It provides an indication of GPRHCS countries with bodies or entities that facilitate the interaction of stakeholders and oversees joint planning and decision making on RHCS issues.

Ten of the 11 Stream 1 countries have mechanisms in place for coordinating RHCS issues with terms of references and with broad-based memberships (see Table 14). Haiti does not have such a mechanism. At least four meetings were held in the countries, with the exception of Burkina Faso where no meetings were held and Mali where only one meeting was held in 2010. This is an improvement compared to 2009, when three out of the 11 Stream 1 countries had no functional coordinating mechanisms on RHCS or had RHCS issues included in a broader coordination mechanism.

For the Stream 2 countries, Table 15 further shows that national country coordinating mechanisms are reported to exist, with RHCS issues included as part of their core business, in 25 countries. However, two countries (Benin and Gambia) indicated that these committees have no terms of reference (TOR). Also, in 11 of the Stream 2 countries with coordination mechanisms, no meetings have been held. The lack of TORs and meetings not being held indicate that the committees are less functional.

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

The indicator provides a measure for the progress made by GPRHCS countries in establishing an essential medicines list (EML) and, most importantly, in ensuring that all the modern contraceptives and the 10 priority reproductive health medicines are included on the EML for each country.

Essential medicines lists exist in all the Stream 1 countries and the lists contain all UNFPA and WHO essential and life-saving maternal health medicines. Two countries, Mozambique and Nicaragua, reported that the EMLs do not contain all the modern contraceptive methods. This is because in the case of Nicaragua, female condoms are not included on the list and in the case of Mozambique the list does not include implants.

All of the Stream 2 countries that provided reports (26 countries), indicated the existence of an EML, and that the list contained essential life-saving maternal health medicines. Namibia reported it does not have an EML. Only four countries (Congo, DRC, Djibouti and Gambia) reported that the list did not contain all the modern contraceptive methods.

2.2 Output 2: Political and financial commitment for RHCS enhanced

In moving towards a more sustainable approach, progress can be measured by several indicators that symbolize the commitment of national governments to support and finance RHCS. This second GPRHCS output seeks to measure the political and financial commitment particularly of the national governments to RHCS issues at the country level. The GPRHCS strongly supports countries that are implementing broad-based efforts to reform and improve health systems and services, and advocates for the mainstreaming of RHCS into such processes. Inclusion of RHCS in the national planning process is an important step in ensuring that reproductive health issues are national priorities and budgeted for accordingly.

Key indicators identified to gauge the achievement of this output include availability of funding for GPRHCS through multi-year pledges, signing of MOUs with Stream 1 country governments, mainstreaming of RHCS issues in policies and strategies at the regional level, inclusion of RHCS priorities in national and sectoral policies and plans, and the maintenance of allocation within SRH/RHCs budget line for contraceptives at country level. While the establishment of a budget line for RH commodities is considered to be a powerful indication of the fact that a government has chosen to prioritize RHCS, maintaining the funds allocated within the budget is an indication of sustained commitment particularly during this period of global economic downturn.

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

This indicator provides information on actual resources mobilized from pledges made by donors for the implementation of the GPRHCS. It ascertains the results of resource mobilization efforts undertaken by UNFPA Commodity Security Branch to support countries for the implementation of the GPRHCS.

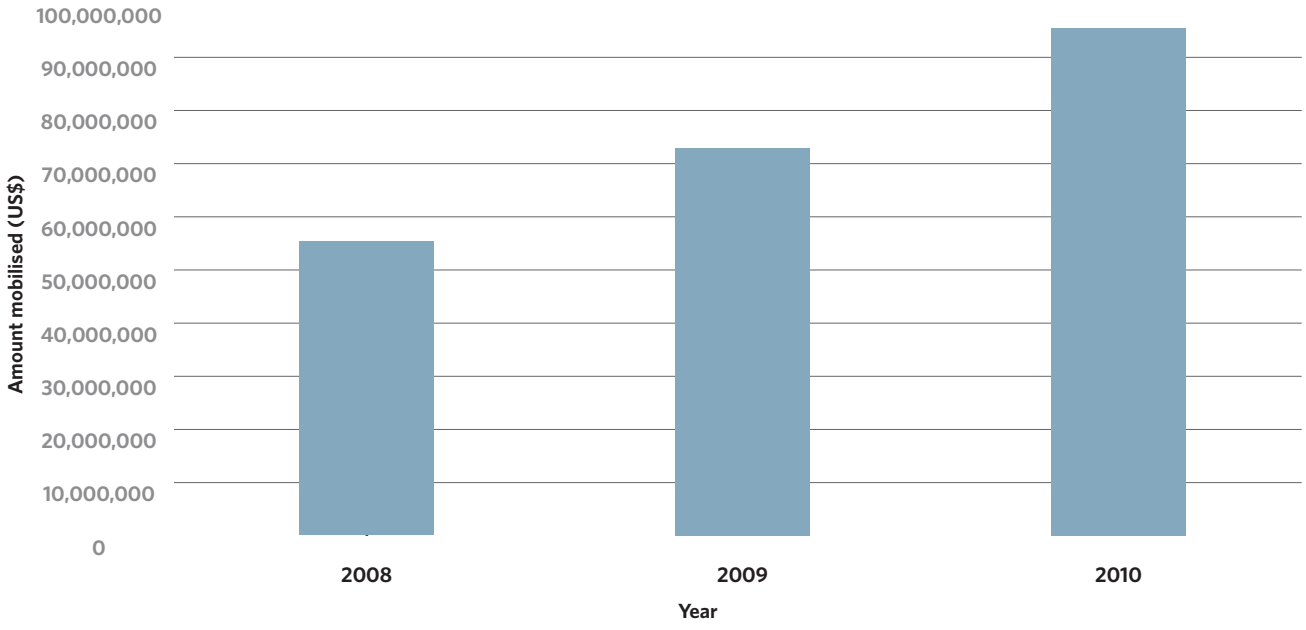
Since 2008, over $223 million has been mobilized by UNFPA from various donors. As shown in Figure 11, this amount has increased steadily from $55.3 million in 2008 to $95.5 million in 2010.

The amount mobilized for 2010 was from six donors countries; with the Netherlands and the United Kingdom accounting for nearly 82 percent of the resources mobilized for the year. Although there has been a significant increase in recent years, prospects for the future funding of the GPRHCS, in line with other aid/donor dependent funds, is likely to decrease in spite of the encouraging results being clearly documented in this and other reports. This is a largely attributable to the global financial crisis, which has limited the ability of many funding governments to commit resources to aid as used to be the case. The GPRHCS is fully aware of this and efforts are being intensified in 2011 to expand the donor base, demonstrate and disseminate results, and also secure the interest of non-traditional partners in order to ensure that support to countries, particularly those in most need, continues uninterrupted.

Table 16: Amount mobilized from donor countries in US$

Funding Source	2008	2009	2010	Total
Canada	-	1,996,805	-	1,996,805
Finland	2,590,674	-	-	2,590,674
France	-	-	272,109	272,109
Ireland	1,557,632	-	-	1,557,632
Luxembourg	557,103	591,716	544,218	1,693,037
Netherland	34,114,379	45,831,976	39,807,880	119,754,235
Spain	7,772,021	7,396,450	-	15,168,471
Spain (Catalonia)	-	563,471	420,168	983,639
UK	8,695,652	16,474,465	54,464,816	79,634,933
Total	**55,287,461**	**72,854,883**	**95,509,191**	**223,651,535**

Figure 11: Total Resources for the GPRHCS (2008 to 2010)



2.2.2 UNFPA signed MOUs with Stream 1 country governments

The indicator assesses the existence of an agreement between government and UNFPA on the implementation of GPRHCS. The MOU spells out the expectations of each party and therefore provides a formal basis for cooperation and commitment for the achievement of the GPRHCS goals in Stream 1 countries.

All the 11 Stream 1 countries indicated that an MOU has been signed between UNFPA and government. The signing of MOUs provides a formal basis for ensuring governments' commitment to the implementation of GPRHC. LOUs/MOUs have also been formalized with many Stream 2 countries in 2010. Experiences with Stream 1 countries have shown that this serves to formalize the arrangement and commit governments to prioritizing programmes in this area and, indeed, committing their domestic resources towards the achievement of identified common goals and objectives.

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

The indicator assesses the outcome of efforts made by UNFPA, especially at the regional level to infuse RHCS issues into the policies, plans and activities of global, bilateral and regional organizations/partners. It also focuses on the role of UNFPA through the GPRHCS in building RHCS capacities in for instance regional economic communities or commissions.

Partners such as the **Regional Economic Communities (RECs)** are making RHCS their own by including it in policies and strategies at the regional level. For several years, the GPRHCS has been working very closely with the following institutions: West African Health Organisation (WAHO), East African Community (EAC), the Intergovernmental Authority on Development (IGAD), and the South African Development Community Parliament (SADC/PF). Most have established their regional and strategic action plans for RHCS and SRH. Examples include the West African RHCS Strategy developed and implemented by WAHO, the East Africa RHCS/SRH strategic plan being developed by EAC, and the RHCS/SRH plan developed by IGAD. This collaboration has continued, as in the examples below from 2010.

In Johannesburg in May 2010, a joint planning meeting of the Regional Economic Communities led to development of joint action plans, which were agreed upon and will be implemented in 2011. In a formal Communiqué signed by the RECs, various actions points were agreed upon at regional and sub-regional levels, among which were need for UNFPA to support with capacity building and evidence based data; promoting the production and utilisation of data for evidence based sub regional interventions; promoting and/or conducting regular inter REC-fora for exchange and sharing of experiences.

Representatives of IGAD, a regional development organization in East Africa, and EAC, a regional intergovernmental organization, held a meeting with UNFPA management to discuss future areas of collaboration with UNFPA. The GPRHCS also provided significant support to IGAD in support of their work with vulnerable populations in IGAD hot spots, including support to service providers on SRH/HIV with training and provision of RH kits.

UNFPA provided technical support for WAHO for developing comprehensive and harmonized RH Action Plans in ECOWAS member states, and welcomed WAHO staff to a training-of-trainers session on LMIS and computer software.

Support was provided in 2010 to the SADC Executive Secretariat for developing regional guidelines for sustained access, availability, acceptability and use of condoms – along with development of an inter-agency roster of consultants for comprehensive condom programming (CCP). The work is related to a grant received by SADC from the African Development Bank.

2.2.4 Number of countries that have included RHCS priorities in; a) PRSP and b) Health sector policy and plan and SWAPs

For RHCS issues to be given priority in plans programmes and budgets, stakeholders should advocate for and work towards their inclusion in key country level strategic planning documents, including Poverty Reduction Strategy Papers (PRSPs); national health sector policies and plans; and health sector wide approaches for the health sector. The level of inclusion of RHCS issues in these documents provides a clue about the level of commitment and importance attached to RHCS issues in the country.

In 2010, RHCS issues were integrated into PRSPs in 10 Stream 1 countries (with the exception of Mozambique), compared to eight Stream 1 countries in 2009. For Stream 2 countries, only 12 out of the 27 countries have RHCS issues integrated into PRSPs or national development plans.

As mentioned before, inclusion of RHCS in the national planning process is an important step in ensuring that reproductive health issues are national priorities and budgeted for accordingly. Inclusion within the PRSPs and processes is of particular strategic importance given that this is at the highest level of national planning. This is often difficult to achieve, however, and opportunities to intervene in this national process come but once every five years. It is therefore of singular interest to note the progress made amongst Stream 1 countries in this area in 2010. Two additional Stream 1 countries (Ethiopia and Nicaragua) succeeded in having RHCS included in their PRSPs. In the case of Stream 2 countries, 14 have RHCS issues integrated in their PRSPs.

Table 17: RHCS issues included in PRSPs, health policies and SWAps in Stream 1 countries

Countries	RHCS issues in PRSP	RHCS issues in health policy & plan	RHCS issues in SWAp (for health)
Burkina Faso	Y	Y	Y
Ethiopia	Y	Y	Y
Haiti	Y	Y	N
Laos	Y	Y	Y
Madagascar	Y	Y	Y
Mali	Y	Y	Y
Mongolia	Y	Y	Y
Mozambique	N	Y	N
Nicaragua	Y	Y	Y
Niger	Y	Y	Y
Sierra Leone	Y	Y	N
2010 Total for 'Yes'	**10**	**11**	**8**

Reasons why RHCS issues are not integrated into PRSPs include the nonexistence of PRSPs in some countries (as indicated by Benin, Mauritania and Zambia), and the minimal involvement of RHCS technical experts in the formulation of PRSPs as indicated by Malawi and Nigeria.

Table 17 shows that in 2010, all Stream 1 countries, as was the case in 2010, have RHCS issues included in health policies and plans; eight countries responded that RHCS issues were included in sector-wide approaches (SWAp) in health. Haiti, Mozambique and Sierra Leone reported the nonexistence of a SWAP for the health sector.

All Stream 2 countries have RHCS key issues included in their health sector policies and plans, with the exception of Burundi, Djibouti and Namibia. Also, 21 Stream 2 countries have RHCS issues in their SWAps, as shown in Table 18.

Table 18: RHCS issues included in PRSPs health policies and SWAPs in Stream 2 countries

Countries	RHCS issues in PRSP	RHCS issues in health policy & plan	RHCS issues in SWAP (for health)
Benin	N	Y	Y
Bolivia	N	Y	Y
Botswana	Y	Y	Y
Burundi	N	Y	N
Central Africa Republic	Y	Y	Y
Chad	Y	Y	-
Congo	Y	Y	-
Côte d'Ivoire	N	Y	Y
Democratic Republic of Congo	Y	Y	Y
Djibouti	N	N	N
Ecuador	Y	Y	Y
Eritrea	Y	Y	Y
Gabon	Y	Y	Y
Gambia	N	Y	Y
Ghana	Y	Y	Y
Guinea	N	Y	Y
Guinea Bissau	N	Y	Y
Lesotho	N	Y	Y
Liberia	N	Y	N
Malawi	N	Y	Y
Mauritania	N	Y	N
Namibia	-	-	-
Nigeria	N	Y	Y
Sao Tome and Principe	Y	Y	Y
Senegal	Y	Y	Y
Swaziland	Y	Y	-
Uganda	Y	Y	Y
Zambia	Y	Y	Y
Zimbabwe	Y	Y	Y
Total for 'Yes'	**15**	**27**	**21**

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

This indicator is used to assess the willingness of governments to consistently allocate resources for the procurement of contraceptives. Analysis is mindful of the fact that the inclusion of RHCS issues into key national planning documents alone is not the only requirement for actions to be taken to address RHCS concerns, and that a budgetary allocation for the procurement of RHCS including contraceptives is also a strong indication of government commitment.

Ten Stream 1 countries indicated that their government budget contains line item for the procurement of contraceptives, the exception being Sierra Leone. The amount allocated was reported to have increased, compared to last year, in Mozambique, Mongolia and Niger; it was said to have decreased in Burkina Faso, Mali and Nicaragua. For Ethiopia, Lao PDR and Madagascar the amount was said to have remained unchanged. For Stream 2 countries, 17 countries have contraceptives included in the in national budget line. Six Stream 2 countries (Guinea Bissau, Liberia, Mauritania, Swaziland, Uganda and Zambia) reported that the budget line increased. The amount allocated remained same in nine countries and decreased for two countries (Central African Republic and Botswana) compared to last year.

2.3 Output 3: Capacity and systems strengthened for RHCS

It is only by strengthening country capacity that reproductive health commodity security can be assured. Building in-country capacity allows for sustainable progress and helps ensure that commodities procured can be distributed in an efficient and effective manner. It also helps to ensure that issues of demand and equity are given due cognizance in the provision of services. It is for this reason that GPRHCS funds country efforts to train staff and strengthen systems and institutions. The achievement of this output is measured by examining efforts relating to strengthened forecasting and procurement systems as well as the existence of a well-adapted and functioning logistics management information system within GPRHCS countries.

2.3.1 Number of countries using AccessRH for procurement of RHCs

The indicator measures the extent to which AccessRH has been adopted by countries for the procurement of RHCs and the extent to which this has reduced the lead time by 20 percent (time between ordering the commodity and its arrival in the country). It therefore assesses the effectiveness of the new procurement modality that is expected to address delays in procurement.

AccessRH, is an innovative procurement mechanism supported by key global partners working in the area of procurement. The GPRHCS provided $6 million for this initiative in 2010. AccessRH is expected to commence support to countries and partners in April 2011. Since the initiative is yet to be functional, no country reported using AccessRH for the procurement of reproductive health commodity supplies.

The AccessRH project, aims to improve access to quality, affordable reproductive health commodities and enhance delivery performance for low- and middle-income public sector entities and NGO clients. It also aims to increase information sharing and supply chain visibility for all reproductive health stakeholders. UNFPA was selected by the Reproductive Health Supplies Coaltion to implement this initiative as part of the operations of the Procurement Services Branch (PSB), and donors provided funding to cover 2010-2013.

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

The indicator measures the efforts of UNFPA-WHO partnership for ensuring quality supplies of IUDs and condoms from a set of prequalified and re-qualified manufactures. This exercise, carried out on a continuous basis, provides countries with a certified list of manufacturers for the procurement of the two commodities.

To support national and global efforts to increase access and availability of reproductive health commodities, GPRHCS in collaboration with UNFPA's Procurement Service Branch continued to ensure that RH commodities meet international quality standards at all times. Based on evaluation of products and equipment previously delivered, PSB with support from the GPRHCS, in the last few years has worked at strengthening quality assurance procedures in collaboration with major partners and stakeholder such as WHO, UNICEF, Global Fund and Family Health International.. UNFPA continues to ensure reproductive health commodity security by the prequalification process for manufacturers of IUDs and condoms in line with WHO's prequalification standards. By the end of 2010, 23 manufactures of condoms and eight manufacturers of IUDs had been assessed and services retained for use by UNFPA and partners.

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

This indicator assesses the extent to which countries effectively prepare procurement plans for their RH commodity needs at the beginning of the year such that no requests are made outside the plans (except for humanitarian situations). When countries are able to make good annual procurement plans and, most importantly, carry out actual procurement according to the plan , RH commodities will be expected to be always available for provision of services to clients (except in the case of humanitarian situations). Therefore, as countries are assisted to strengthen national systems for commodity security, one of the key expected results is the occurrence of 'no stock-out' for RH commodities, including contraceptives.

Eight Stream 1 countries made no ***ad hoc*** requests for commodities; only Haiti, Mali and Mongolia reported that they made requests for RHCs in 2010. These three countries further indicated that steps such as training of government staff in procurement, putting in place and implementing procurement and distribution plans have helped to reduce the ***ad hoc*** requests they made during the year.

Seventeen Stream 2 countries made no ***ad hoc*** requests for commodities in 2010, and about 24 countries have taken measures during 2010 to reduce ***ad hoc*** requests for RH commodities. Gabon indicated that stock-outs are averted by ensuring that there is a national budget line for the medicines and that estimation of three years needs for RH products are prepared. In Ghana, medium-term forecasting for three years; annual forecasting for each year, bi- annual review meetings and regular pipeline monitoring are carried out to avert stock-outs. In Liberia, Burundi, Central African Republic and Congo the measures taken to avert stock-out includes strengthening of forecasting, procurement and distribution systems for RH commodities.

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

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

Of the 11 Stream 1 countries, seven indicated that they had national technical expertise in the Ministry of Health or in other government agency for forecasting RH commodities for the respective countries. The following four countries did not indicate the existence of a national expert for forecasting for RH commodities: Lao PDR, Mongolia, Mozambique and Niger.

Table 19: Stream 1 countries using national technical experts for forecasting and procurement of RH commodities

Countries	Expertise forecasting in MOH	Expertise for procurement of RH commodities	
	2010	2009	2010
Burkina Faso	Y	Y	Y
Ethiopia	Y	Y	Y
Haiti	Y	N	N
Lao PDR	N	N	Y
Madagascar	Y	Y	Y
Mali	Y	N	Y
Mongolia	Y	N	Y
Mozambique	N	N	N
Nicaragua	Y	Y	Y
Niger	N	Y	Y
Sierra Leone	Y	Y	Y
Total for 'Yes'	**7**	**6**	**8**

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

For each Stream 1 country, the indicator ascertains the existence of nationals responsible for procurement of RH commodities in a government agency. The indicator contributes to ascertaining the extent to which capacities of nationals have been built for managing procurement. This use of national for managing procurement processes is a key step to ensuring sustainability and country ownership and institutionalization of skills and capacities for RHCS.

Nine Stream 1 countries reported that national technical expertise was present in the Ministry of Health or in another government agency for procurement of RH commodities in 2010. Two countries (Haiti and Mozambique) indicated that they did not have national technical experts for managing procurement. This was an improvement from 2009 when only six countries indicated that there was national technical expert for managing procurement processes for RH commodities.

2.3.6 Number of Stream 1 countries with functioning LMIS

The Global Programme to Enhance RHCS provides capacity building support to countries for the strengthening of logistics management information systems (LMIS) for managing procurement and distribution of RH commodities. The indicator therefore measures the effectiveness of the LMIS in providing relevant information about the procurement and distribution of the RH commodities in terms of the ability of the system to provide data on current and up-to-date stock levels; data on distribution of essential life-saving medicines; data on distribution of modern contraceptives; number of users for each modern contraceptive method; and, product particulars including expiry date.

Seven out of the 11 Stream 1 countries indicated that they had functioning LMIS. The seven countries indicated that the LMIS can provide figures on distribution of contraceptives, while five countries (Haiti, Ethiopia, Nicaragua, Niger and Sierra Leone) indicated that the system was capable of provide figures on distribution of essential life-saving medicines.

Furthermore, four of the countries (Lao PDR, Madagascar, Mali and Nicaragua) with functional LMIS indicated that the system is capable of providing inventory and monthly consumption data. Five Stream 1 countries reported that the system can readily provide information on stock at all levels, five can readily provide information on the expiry dates of all products, and, two can readily provide information on number of users of each product.

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

The indicator assesses the existence of a unified procurement and distribution system for health supplies that includes RH commodities, including modern methods of contraception and priority medicines. In many countries, contraceptive commodity logistic systems were largely parallel systems in response to donor demands and to the need for timely data for addressing logistic needs. To ensure efficiency and sustainability, there is a need for unified procurement and distribution systems that would cater for all commodities within the health system. The indicator therefore assesses the existence of such a unified mechanism for managing all health supply systems that takes into account the procurement and distribution of RH commodities.

The responses provided by the countries indicated that six out of the 11 Stream 1 countries have coordinated and integrated health supplies management system; five countries do not (Burkina Faso, Haiti, Lao PDR, Monoglia and Mozambique). In five out of the six countries with a coordinated and integrated health supplies management system, the system contains (a) an ***integrated procurement mechanism*** for contraceptives and RH medicines and (b) an ***integrated supply/distribution mechanism*** for contraceptives and RH medicines (Ethiopia, Madagascar, Nicaragua and Niger). For Sierra Leone, the system contains an integrated supply/distribution mechanism for contraceptives and RH medicines only.

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

Adopting or adapting a health supply chain management information tool into the national system is critical for the achievement of RH commodity security. The GPRHCS promotes computer-based logistics management information systems. Various types of computer software are in use, and the indicator assesses the existence of a computerized health supply chain management information system in the country through the use of any relevant software, including CHANNEL or PIPELINE, for example.

All Stream 1 countries have adapted or adopted a computerized tool. CHANNEL software continues to be the most popular tool for adaption and, in some countries, use is being made of its web version.

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

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

2.4.1 Expenditure of UNFPA/CSB core resources for RHCS increased

In addition to mobilizing resources from donors, UNFPA provides support to the branch that manages its commodity security functions. The indicator therefore provides information on the amount that UNFPA provides from core resources for implementing RHCS functions and activities

Each year, UNFPA allocates core resources to its Commodity Security Branch principally as matching fund for the management and implementation of the GPRHCS. The amount increased from $1.33 million in 2008 to $2.12 million in 2009 and decreased slightly to $2.10 million in 2010. The slight decrease was due to reduction in resources mobilized as core funds as a result of the global financial downturn.

2.4.2 GPRHCS planning takes into account lessons learned in RHCS mainstreaming

To improve the implementation of programme activities, lessons learned must be taken into account so as to ensure efficient use of resources for the achievement of outputs. This indicator assesses whether countries make use of key lessons learned for the previous year in the implementation of activities for the present year.

In addition to all the Stream 1 countries, 17 out of the 27 responding Stream 2 countries indicated that they took into account lessons learned in 2009 for GPRHCS planning in 2010.

Examples of lessons learned in Stream 1 countries include the following: In, Burkina Faso, some facilities has been found to lack sufficient life-saving maternal medicines in 2010 and, therefore, steps are being taken in 2011 to strengthen the capacity for procurement and distribution of essential maternal medicines. In Nicaragua, review of the previous year's implementation revealed that adequate oversight was not being provided by existing coordination mechanisms and, in response, Nicaragua is establishing and strengthening coordination mechanisms, including at the sub-national level. In Niger, because of the low uptake of services by communities in the hard-to-reach areas, NGOs are being used to create demand for family planning and maternal health services within these areas.

Similarly, lessons learned are being used in Stream 2 countries to improve on programme results. For example; to address the persistent commodity stock out situations in Central Africa Republic, surveillance mechanisms are being put in place to gather data and monitor stock levels and movement of commodities from warehouses to service delivery points. In the Gambia, where accurate forecasting of contraceptive

needs remain a persistent problem, plans are being made to build the capacity of government staff to carry out forecasting and procurement functions more effectively.

The lessons learned by each country are important for selecting activities to include in the work plans and for ensuring continuity in GPRHCS planning and programme implementation. The results achieved in the implementation of these activities are expected to strengthen the contribution of RHCS interventions towards the achievement of RH outcomes.

2.4.3 Number of countries with RHCS priorities included in: a) CCA, b) UNDAF, c) CPD and d) CPAP

This indicator gauges extent to which UNFPA Country Offices have been able to have RHCS issues included in country programming frameworks and hence provide a platform within the UN for leveraging resources and advocating with government and other partners to advance RHCS at country level.

Table 20: Stream 1 countries with RHCS priorities included in: a) CCA, b) UNDAF, c) CPD, d) CPAP and e) AWP

Country	RHCS included in CCA	RHCS included in UNDAF	RHCS included in CPD	RHCS included in CPAP	RHCS included in AWP
Burkina Faso	Y	Y	Y	Y	Y
Ethiopia	N	Y	Y	Y	Y
Haiti	N	Y	Y	Y	Y
Lao PDR	N	Y	Y	Y	Y
Madagascar	N	Y	Y	Y	Y
Mali	Y	N	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y
Mozambique	N	Y	Y	Y	Y
Nicaragua	N	Y	Y	Y	Y
Niger	N	Y	Y	Y	Y
Sierra Leone	N	Y	Y	Y	Y
Total for 'Yes'	**3**	**10**	**11**	**11**	**11**

Table 20 shows that only three Stream 1 countries (Burkina Faso, Mali and Mongolia) stated that RHCS issues were included in CCA documents. With the exception of Mali, all the other Stream 1 countries indicated that they have included RHCS issues in the UNDAF. Most importantly, all the 11 GPRHCS Stream 1 countries have included RHCS issues in their CPD, CPAP and AWP documents.

Table 21 shows that among the Stream 2 countries, 21 have included RHCS in CCAs, 25 in UNDAF, 25 in CPDs, and 29 in CPAPs and AWPs documents of their country.

The results show that efforts have been made by the country offices to include RHCS issues into core planning documents especially those documents for which the country offices take direct responsibility in working with governments to formulate i.e. CPD, CPAP and AWPs.

Table 21: Stream 2 countries with RHCS priorities included in: a) CCA, b) UNDAF, c) CPD, d) CPAP and e) AWP

Country	RHCS included in CCA	RHCS included in UNDAF	RHCS included in CPD	RHCS included in CPAP	RHCS included in AWP
Benin	Y	Y	N	Y	Y
Bolivia	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y
Burundi	N	N	N	Y	Y
Central Africa Republic	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y
Congo	N	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y
DRC	Y	Y	Y	Y	Y
Djibouti	Y	Y	Y	Y	Y
Ecuador	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y
Gambia	Y	N	N	Y	Y
Ghana	Y	Y	Y	Y	Y
Guinea	N	Y	Y	Y	Y
Guinea Bissau	N	Y	Y	Y	Y
Lesotho	Y	Y	Y	Y	Y
Liberia	Y	Y	Y	Y	Y
Malawi	Y	Y	Y	Y	Y
Mauritania	N	Y	Y	Y	Y
Namibia	N	N	N	Y	Y
Nigeria	Y	Y	Y	Y	Y
Sao Tome and Principe	N	Y	Y	Y	Y
Senegal	Y	Y	Y	Y	Y
Swaziland	Y	Y	Y	Y	Y
Uganda	Y	Y	Y	Y	Y
Zambia	N	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y
Total for 'Yes'	**21**	**25**	**25**	**29**	**29**

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

Each country office is expected to allocate, and even mobilize additional resources for the programme, in addition to resources provided for the implementation of RHCS-related activities. The indicator therefore assesses the extent to which countries have been supporting the implementation of RHCS activities with additional resources.

Ten Stream 1 countries reported an increase in country office allocation for RHCS in 2010. In the case of Haiti, the amount allocated was the same as the previous year. Of the Stream 2 countries, 19 increased their allocation for RHCS, six country offices indicated a decrease in their funding for RHCS in 2010, and three maintained the same level of funding for RHCS.

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

In situations where joint UN programmes are formulated for the health sector, especially on sexual and reproductive health and maternal and newborn health, it is important to ensure that RHCS issues are part of the joint programmes. This enables the provision of support to make available maternal health medicines, including contraceptives, and to build capacities and strengthen systems for improved maternal health. The indicator assesses the extent to which UNFPA Country Offices, with joint UN Programmes, have been able to have RHCS issues included in relevant thematic programmes.

The six Stream 1 countries that have a UN Joint Programme on SRH or MNH, indicated that they have key RHCS issues included in the programmes (Burkina Faso, Ethiopia, Madagascar, Mali, Niger and Sierra Leone). Also, 14 Stream 2 countries indicated that RHCS key issues are included in their UN Joint Programmes.

2.4.6 Number of national/regional institutions providing quality technical assistance on RHCS in the areas of Training and Workshops

In addition to providing support for country-level interventions, the GPRHCS also provide support for building capacities of regional organizations so that they can offer technical assistance for GPRHCS in each of the UNFPA geographic regions. This is done in support of the regionalization and capacity building strategies of UNFPA.

The UNFPA sub-regional office in Johannesburg conducted a capacity building activity on computerized LMIS for 36 programme managers and logisticians from 13 countries in the eastern and southern part of Africa in collaboration with the Mauritius Institute of Health. The capacity of the Mauritius Institute of Health was strengthened to provide annual courses in supply chain management for national health systems of African countries. The need to develop capacity for sub-regional institutions to provide integrated programmatic and technical support for RHCS prompted the UNFPA sub-regional office in Johannesburg to identify seven consultants in the field of RHCS and provided training on UNFPA programming and strategies.

The UNFPA Asia and Pacific Regional Office (APRO) has been providing technical support to the BKKBN in order to strengthen the technical capacity of its faculty, and support the periodic review, revision and update of the training curriculum. In 2010 APRO conducted a training of trainers from the faculty at BKKBN (including selected UNFPA CO staff) for the international training programme on RHCS; and to guide the follow-up actions aimed at ensuring a qualitative improvement in the content and presentation of the training programme. In support of south-south cooperation, APRO also facilitated the participation of two trainers from BKKBN, Indonesia and one trainer from ICOMP, Malaysia in the training of trainers in the Mauritius Institute of Health.

In Latin America and the Caribbean, the Global Programme provided evidence-based information for advocacy, policy development, incorporation of RH drugs at public health services, and medical protocol development. In addition, the GPRHCS contributed to the establishment of regional strategic alliances between the Latin American Federation of. Obstetrics and Gynaecology Societies (FLASOG) and a range of organizations including IPAS, Latin American Consortium against Unsafe Abortion (CLACAI) and the Consortium on Emergency Contraception (CLAE). UNFPA continued to strengthen the Sexual and Reproductive Rights FLASOG Committee and to work with this regional group in a number of ways, from training programmes to strategic alliance to reduce unsafe abortion and improve access to emergency contraception to development of SRH content for university medical curricula (see section 4.4 for additional information about activities in the region in 2010).

Alliances with FLASOG and with the Legal Advisory Committee of Emergency Contraception served to reach new audiences such as health professionals and lawyers, and to identify advocacy strategies to reach the young and the poor. The GPRHCS supported collaboration with the CLAE for the promotion of emergency contraceptives in the countries of Latin America and the Caribbean. It also supported development of CLAE's Index, a tool which is an indicator on the status of the availability of emergency contraceptives in each LAC country. UNFPA also worked with civil society representatives to develop a paper on misoprostol with the CLACAI that was presented in regional fora and used in advocacy efforts.

Also in Latin America, UNFPA expanded partnership and networking with two nongovernmental organizations, CIES (Centro de Investigación y Estudios de la Salud) and PRISMA, in the area of commodity security to produce south-south cooperation between academic and technical institutions to provide technical assistance to countries, develop research, enhance training options, and extend knowledge sharing best practices in the region. The PRISMA CIES programme has directly contributed to strengthening the capacities of professionals working in commodity security from public and private sector in Argentina, Dominican Republic, Nicaragua, Panama, Peru, Uruguay and other countries.

2.5 Cluster achievements

Some countries that are in need of assistance but are too small to be considered for individual support have been grouped, or clustered, to receive support. The Global Programme provides support, largely technical and not RH commodities, through their respective regional office. The countries jointly report to the GPRHCS. They include the Pacific Island countries, Eastern European and Central Asian countries, and countries of the Caribbean.

2.5.1 Pacific Island countries

The specific needs of small island states were reflected in 2010 RHCS training in FSM, Kiribati, Tuvalu, Tonga and Vanuatu. Within months of the training, there were no stock-outs reported by any facility and the entire medicines supply system was running better. For Vanuatu and Papua New Guinea, the development of RHCS supply management training materials for first referral health facilities included a competency map for RHCS and the wider medicine supply. The materials will be used a course, and University of Canberra will award a certificate to participants who complete the course.

In Fiji in August, senior staff (including many pharmacists) attended a training session aimed at improving skills in higher-level procurement.

Wastage and overstocking of RH supplies were linked to an inconsistent flow of data in Vanuatu and Papua New Guinea, where a 2010 mission studied the need for more accurate forecasting. A baseline against which to measure progress in Vanuatu was one result of the RH commodity availability mission.

Also in 2010, training for health service providers focused on long-lasting implants and non-scalpel vasectomy. In Micronesia, the Government endorsed evidence-based service guidelines and draft policy guidelines on family planning. High-level representatives from five countries attended the Asia and Pacific Regional Family Planning Advocacy Workshop, which received technical support from UNFPA Pacific Sub-regional Office. The focus was on re-positioning family planning in the development agenda, which was also promoted in national advocacy with parliamentarians in 2010. There was progress for maternal health as eight Pacific Island countries finalized and updated RHCS Strategic Plans (Cook Islands, Micronesia, Kiribati, Nauru, Niue, Tuvalu, Tonga and Vanuatu). UNFPA provided support for RHCS focal points to coordinate and integrate RHCS within existing supply systems (Micronesia, Papua New Guinea, Samoa, Solomon Islands, Tuvalu and Vanuatu). In the Solomon Islands, the inter-agency RH Supplies Coalition conducted an RHCS assessment.

2.5.2 Eastern Europe and Central Asian countries

These countries belong to a cluster of Central Asian countries where CPR ranges from 26.4 in Tajikistan to 59.3 in Uzbekistan. Tajikistan has highest unmet need of 25 percent and for others it is around 10 percent; however, data from Turkmenistan is not available.

All of these countries, except Kazakhstan, has a national strategy on reproductive health where RHCS issues have been included and has a national coordination mechanism coordinated largely by the MOH. In 2010, three out of five of these countries made ***ad hoc*** requests for contraceptives.

In 2010, these countries received modest amount of contraceptive supply. All the countries received oral pills, and requests were made for IUDs, implants and female condoms. All four countries reported that they

have well-developed LMIS. UNFPA's software CHANNEL and Country Commodity Manager (CCM) have been in use in their systems. In Kazakhstan, 50 staff members from healthcare facilities from six districts were trained to assess family planning needs and 20 were trained on logistics management including use of the CHANNEL software. A strong LMIS in Tajikistan has helped keep even district-level warehouse with stable and reliable supplies and distribution.

In Turkmenistan in 2010, GPRHCS support is strengthened national RH commodity security through annual procurement of contraceptives, training of the RH care providers on family planning and IEC activities to raise awareness about family planning. The new LMIS system was initially piloted in the selected regions of Uzbekistan.

2.5.3 Caribbean countries

UNFPA undertook a number of activities and advocacy for RHCS integration, co-financing, harmonized procurement processes, and implementation of computerized LMIS. Workshops in four regions provided CHANNEL training. Posters, pamphlets, TV sports and other IEC materials on RHCS, including family planning, were produced for nine Caribbean countries jointly with the Caribbean Family Planning Affiliation and IPPF. Brochures on RHCS were translated into Dutch. Belize developed audio visuals on the use of male and female condoms as part of their awareness programme to reduce HIV infections and unwanted pregnancies.

Humanitarian response and RHCS was the focus of training with the MOH and NGOs in Barbados, Grenada and Surinam, with a stronger focus on issues of gender-based violence in a workshop in Trinidad. Preparations were made in Jamaica to establish an RHCS coordinating committee.

To support the re-positioning of family planning as a development and rights issue in countries especially Guyana and Suriname, funding from the RHCS programme supported two workshops with 93 participants to strengthen family planning programme delivery.

2.6 Programme management

To assess key aspects of the management of the GPRHCS ten indicators are included in the monitoring and evaluation framework. These indicators help to assess the adherence to programme guidelines, timely completion of tasks and also support the tracking of activities in regions. The Table shows the performance levels relating to the ten management indicators.

For 2010 the GPRHCS countries achieved an overall implementation rate of 88 percent, with stream one countries reaching 98 percent.

By mid-December 2010, over 90 percent of the countries submitted budgeted work plans to their respective regional offices. Most of these work plans were reviewed and finalized by January/February 2011. Also, all the 11 GPRHCS Stream 1 countries submitted midyear progress reports. The reports were discussed, peer-reviewed and experiences shared in a midyear review meeting held in Addis Ababa in June 2010. Stream 2 countries are expected to provide midyear reports for 2011.

By December 2010, over 90 percent of GPRHCS countries submitted both programme report for review by the regional offices with copies to CSB. The countries finalized the reports based on advice given by both ROs and CSB on the joint reporting format to use, alignment of report with the year's work plan, and the need to report on results rather than activities. Most countries were unable to submit financial reports in mid-December due to the fact that financial closure continues until the end of March. The deadline for this indicator will therefore be reviewed accordingly.

By mid-January 2010, GPRHCS focal points in five out of the seven regional offices prepared and submitted budgeted annual work plans for by CSB. As is the case for country offices, regional offices are also required to submit midyear reports. The reports submitted were discussed and reviewed at the midyear review meeting held in Addis Ababa in June 2010.

Table 22: Programme management indicators, 2010

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

The 2010 work plans submitted by countries were reviewed by both CSB and regional offices. The review process included telephone discussions and emails. By 1st week of March, over 80 countries had their work plans approved. For the other countries, approval was pending due to various reasons including the need to submit AWPs in the correct format; and, the need to finalize and submit previous year's narrative and financial report.

In 2010, CSB organized two meetings – a joint planning meeting at the beginning of the year and a progress review at mid-year. The joint planning meeting in 2010 was jointly organized in January 2010 by the Thematic Trust funds of the Technical Division: GPRHCS, MHTF (including Fistula and Midwifery and UBW). Participation was therefore broader in scope, to include countries supported by the MTHF. The 11 Stream 1 countries and the regional offices participated at the mid-year review meeting organized in Addis Ababa in July 2010. In addition to focusing on the peer review of planning and reporting documents, the meetings encouraged south-south exchange of ideas and good practices, identification of technical assistance needs of countries, and the formulation of joint actions.

This consolidated Annual GPRHCS 2010 Report (programmatic and financial) responds to the last indicator in this section. In addition to being aligned to the GPRHCS Monitoring and Evaluation Framework, the report provides information on other areas of intervention including capacity development, partnerships, family planning, and resource mobilization and allocation for capacity development and procurement of commodities. It also addresses the challenges, lessons learned and way forward for the GPRHCS in the coming years.

SECTION THREE

SELECTED AREAS OF ACHIEVEMENT

Outreach worker in Ethiopia talks to young women.
Photo by Peter Barker/Panos Pictures

3.1 Prequalification and Quality Assurance policy / WHO

Quality assurance of reproductive health commodities, technical cooperation with relevant stakeholders and building national capacity have been key features of work on behalf of RHCS in 2010.

Quality assurance efforts were undertaken to help maintain and increase the supplier base for male condom and IUD manufacturers who meet the quality standards as set out by the WHO Prequalification standards and guidelines. Thirteen male condom and seven IUD factories were re-inspected in 2010. As of 31 December, 25 male condom and eight IUD factories are on the UNFPA 'prequalified' list of manufacturers. This list serves as a resource for all UN agencies, NGOs and government institutions procuring male condoms and IUDs that meet requirements for international quality standards. The factories are re-inspected every three years to maintain their prequalification status and all orders purchased by UNFPA are pre-shipment tested.

Currently there is only one female condom factory that is prequalified. As a result, the price of the female condom has remained high, due to one manufacturer being the sole source for procurement. A lot of work in 2010 has been towards addressing this issue by initiating the development of specifications and guidelines for other female condom designs to come on to the market. A successful workshop was conducted with manufacturers interested in taking part in female condom production, researchers, technical experts and other public sector and social marketing procurers. Generally, there is great support and interest from manufacturers for the development of this market. Work is in progress to finalize the specifications and guidelines and support the technical review process to identify other female condom factories to be approved for public sector procurement. This work has been in collaboration with WHO.

In the area of policy, a quality assurance policy was developed in collaboration with WHO, UNICEF and other agencies involved in procurement of medicines, The QA Policy for pharmaceuticals is to guide PSB on procurement of contraceptives and other medicines that meet international quality standards. The policy outlines quality assurance activities that support procurement of contraceptives and other reproductive health medicines from manufacturers who adhere to good manufacturing practices in accordance with international standards.

Technical cooperation and collaborations with key partners (WHO Depts. of Medicines, Quality Assurance and Safety; Reproductive Health and Research, FHI, UNICEF, other NGOs) and relevant stakeholders to strengthen partnerships continued in 2010 with special focus on strategic areas. This included quality assurance, development of guidelines and tools, capacity building of national entities involved in commodity security, for example, national quality control laboratories, regulatory authorities and manufacturers.

In the area of national capacity building, there was a need to respond to the increasing number of countries undertaking post-shipment quality testing of reproductive health commodities. Guidance and harmonization is required in this area. The aim is to promote the use of international specifications, guidelines, procedures and testing protocols to prevent rejection of acceptable batches. Use of inappropriate testing standards, equipment and procedures has contributed greatly to increasing shortages of reproductive health products at country level when product release is delayed or products are destroyed. Workshops in collaboration with WHO and FHI in the Latin American and Caribbean region were conducted with laboratories that perform post-shipment testing to encourage use of international guidelines, techniques and decision processes. Similar work is envisioned for Africa in 2011.

3.2 Partnership for Maternal, Newborn and Child Health (PMNCH)

UNFPA's Commodity Security Branch was co-chair with UNICEF in Priority Action 3 of PMNCH, which focuses on essential commodities for maternal, newborn and child health. In 2010 a number of key activities were carried out. A resource library on MNCH commodity research and information was developed for the Partnership's website.

A mapping exercise conducted on the available MNCH-related procurement and supply management (PSM) tools helped to identify publicly available PSM tools and to develop an exhaustive list of these tools. These MNCH related procurement and supply management tools will be added to the PMNCH Knowledge Gateway portal. Tools are defined as software, spreadsheets, websites, fact sheets, guides, guidelines, manuals, standard operating procedures, databases, check lists, price lists, catalogues and training course material.

Also in 2010, a draft list of priority/essential MNH commodities (medicines including contraceptives) was developed in line with existing WHO guidance. A survey conducted in 2010 will contribute to a publication on existing funding sources for MNCH commodity security.

3.3 National capacity on procurement

Building national capacity in the sphere of procurement focused on three main areas: materials development, human resources and strategies.

In materials development, the training package was translated to Mongolian and adapted for two training sessions, one at the central level in May and one at the aimag (province) level in November. In the case of the latter, an audience of pharmacists performing procurement for the hospitals in the regions. In the same manner, materials were adapted for the Pacific Island Countries, 14 in total who attended training in Fiji, to a mixed audience of pharmacists, logisticians, procurement officers, programme and RH coordinators, and central medical store managers. Africa was again hesitant to receive similar trainings and come forward in 2010. However, current indications show growing improvement. To address this challenge and promote more interest, a marketing brochure was developed that highlights the benefits such as economic gains, reduction in stock-outs and quality products. Finally, in seeking to assist country offices with the human resource challenge of preparing this activity, Terms of Reference have been prepared for consultants to undertake the assessment process at two levels, be it for Situation Analysis for which to build strategies, or for Fact Finding assessment in advance of the training workshops.

In terms of human resources, the strategy from the outset has been not to train unless the option to train trainers has been agreed upon. Securing transfer of knowledge is essential to strengthening systems and the progress in this regard has been steady. Some 70 participants and 15 trainers have received training during the year, with additional trainers in the case of Mongolia, co-facilitating in a second session as a result of the first. Mongolia established an MOU with the University of Health Science School of Pharmacy faculty. The education unit of the MOH acknowledged the training's worth by accrediting it through their development programme. Finally, the outcome of the November training produced numerous recommendations from the pharmacists to the MOH in remedying flaws in the current system. Using examples of what they had learned and pointing to better solutions from the tools and templates of the training, they succeeded in making a case to convince the MOH to review the current documents and laws.

In total some 85 individuals were trained in 2010, 15 of which were trained as trainers though this number could be seen as greater considering additional contributions from government personnel in Mongolia and one interpreter-turned-trainer. Activities developed national capacity in 15 countries and produced numerous additional requests ranging from quality assurance technical assistance to developing tailor-made workshops, training and operational manuals.

3.4 Reproductive Health Supplies Coalition

UNFPA fully supports and collaborates with the Reproductive Health Supplies Coalition. Since 2004, this innovative and effective partnership forum has worked towards building global coordination among

different stakeholders to enhance RHCS. Three innovative mechanisms have already been adopted and they are contributing effectively. Although the Coalition does advocate for more money, it is not always "more money" but "better money" through these innovative mechanisms that help international development. The three innovative mechanisms are: CARh, AccessRH and Pledge Guarantee. UNFPA is operating AccessRH and is fully involved in the other two.

UNFPA together with other partners support the HANDtoHAND campaign in support of the UN Secretary-General's Global Strategy for Women's and Children's Health. The campaign aims at achieving 100 million new users of modern contraception by 2015 – meeting the needs of 80 percent of women in low- and middle-income countries.. UNFPA would like to contribute through RHCS to enhance CPR in Stream 1 and Stream 2 countries by 2 percentage points per year more.

The Reproductive Health Supplies Coalition is a global partnership of some 125 public, private, and non-governmental organizations dedicated to ensuring that all people in low- and middle-income countries can access and use affordable, high-quality supplies to ensure their better reproductive health. The Coalition brings together diverse agencies and groups with critical roles in providing contraceptives and other reproductive health supplies. These include multilateral and bilateral organizations, private foundations, governments, civil society, and private-sector representatives.

3.5 Coordinated Assistance for RH Supplies (CARh)

Members of CARh include the UNFPA Commodity Security Branch, UNFPA Procurement Services Branch, USAID, the RH Interchange Secretariat, and the USAID | DELIVER Project. Other members participate on an ***ad hoc*** basis according to need, including the World Bank, KfW, the UN Foundation (Pledge Guarantee for Health staff), the Reproductive Health Supplies Coalition Secretariat, and Marie Stopes International.

The group focuses on contraceptives and condoms in countries on the verge of a shortage or stock-out. The main objective of CARh is to coordinate the efforts and response of the global donor community during a commodity crisis[5]. CARh holds a monthly meeting where key global-level partners for the funding and procurement of contraceptives meet to share the latest information. The group seeks to identify shortages and their causes, to seek solutions, and to coordinate action. As of September 2010, CARh has provided data on 21 countries. The main source of data is the monthly Procurement Planning and Monitoring Report (PPMR) produced by USAID.

Between October 2009 and September 2010, the CARhs group addressed 184 distinct commodity issues, of which 103 required action (the remaining required information). Most of the group's work is directed towards averting future stock-outs. Other areas of activity include addressing existing stock-outs or handling existing overstocks. CARhs also assists countries in creating new shipments or expediting existing shipments. The group has found that female condoms and progestin-only pills have been most prone to stock-out, whereas emergency contraception and combined oral pills have been least likely to stock-out. More specifically, between October 2009 and September 2010, in both Kenya and Ghana, six contraceptive methods provided by the public sector faced multiple or recurrent stock crises. Two or more products faced stock crises for multiple months in Bangladesh, Liberia, Mali, Mozambique and Tanzania.

CARhs is seeking to streamline the process now that data is making contraceptive supply challenges ever more visible. Future challenges for CARhs include expanding the available supply of data, assuring the involvement of more stakeholders, and streamlining and automating processes. CARhs also seeks greater impact on policy issues affecting reproductive health commodity security.

3.6 Emergency/humanitarian response

Reproductive health kits for disasters and conflicts areas were provided by GPRHCS. To reduce reproductive health mortality and morbidity, particularly among women during the disaster situation, UNFPA has assembled the essential drugs, equipment and supplies into a set of pre-packaged kits specifically designed

[5] The group changed its name in May 2010 from Countries-At-Risk (CAR) to Coordinated Assistance for Reproductive Health Supplies (CARh).

for these purposes – 'Reproductive Health Kits'. Under the GPRHCS programme during 2010, RH kits were procured and delivered to Ethiopia, Haiti, Kenya, Djibouti, Sudan, Somalia, Uganda and Afghanistan to meet the needs for vulnerable populations, displaced persons and refugees. The total expenditure for RH kits was $1.9 million which is part of the total $61.7 million .

In addition kits were provided as part of the collaborative activities with the Intergovernmental Authority on Development (IGAD) in eastern Africa in support of SRH activities targeted at their 'hotspots' and cross-border populations.

The UNFPA-UNHCR Commodities Initiative provided male and female condoms, RH Kits and other essential RH commodities for refugees and displaced populations in 26 conflict and post-conflict countries, in collaboration between CSB, Humanitarian Response Branch and Procurement Services Branch.

3.7 UNFPA and WHO collaboration

The UNFPA-WHO Collaborative Initiative on Critical Life-saving Medicines was launched in 2008 to review access to a core set of critical, life-saving maternal/RH medicines. Joint fact finding missions have been carried out in selected countries during 2008, 2009 and 2010 (Lao PDR, Mongolia, Nepal, Philippines, the Democratic People's Republic of Korea and Solomon Islands). Suggestions were then made by the joint team on the basis of country specific findings, many of which are being implemented by the governments with the technical assistance from UNFPA and other in-country key stakeholders. In 2010, a UNFPA-WHO joint mission was conducted in the Solomon Islands. Also during 2010, countries implementing some of the key recommendations from these fact-finding studies benefited from specific follow up actions; two are Stream 1 countries (Mongolia and Lao PDR) and one (Solomon Islands) falls within the South Pacific Cluster of Stream 2 countries.

3.8 Collaboration with MSI and IPPF

Partnership makes progress possible, and the GPRCHS values its collaboration with many important partners at the local, national, regional and global level who are working together to achieve shared goals. The Global Programme provides commodities to two leading non-governmental organizations and, beyond products, engages in ongoing collaboration to promote efficiency and effectiveness in programming and to make the most of limited resources. A brief overview of the successful partnerships with Marie Stopes International (MSI) and the International Planned Parenthood Federation (IPPF) is provided below.

The GPRHCS and MSI, one of the largest international family planning organizations in the world, are partners with an MoU. MSI provides high-quality family planning and sexual healthcare in more than 40 countries. In 2010, UNFPA supported MSI country programmes in Africa, Asia, Latin America and the Middle East by providing family planning commodities worth $2,500,000 over the period 1 October 2009 to 30 September 2010. In total, 28 MSI country programmes have benefitted from UNFPA commodities to avoid shortages, increase their service delivery or remove price barriers for poor clients. MSI is using the contraceptive supplies to provide women and men, in particular from poor and underserved communities, with access to much needed quality, family planning services. The largest amounts were for 19.3 million male condoms followed by nearly 1.2 million oral contraceptive cycles.

The GPRHCS also works closely with IPPF, the leading international non-governmental organization dealing with sexual and reproductive health and rights, and another MoU partner. In September 2010, UNFPA approved the donation of commodities worth $2,000,000 to support IPPF in the delivery of family planning and reproductive health programmes across the world. Oral contraceptives, injectables, IUDs, female condoms, male condoms and implants were among the RH commodities delivered to IPPF's warehouse in the UK and distributed by IPPF to recipient countries. The support helped to enable IPPF Member Associations to avoid some of the commodity security problems that have, in the past, undermined their ability to deliver effective family planning and reproductive health programmes. It also provided an opportunity for IPPF to promote long-acting methods to Member Associations who are more reliant on short-term methods of contraception, which IPPF considers an important area of growth for the Federation.

SECTION FOUR

KEY ISSUES IN RHCS

Teenagers in Madagascar at a talk about safer sex practice.
Photo by Piers Benatar/Panos Pictures

This section showcases examples of 2010 activities related to four 'key issues' of importance to the Global Programme to Enhance RHCS: Comprehensive condom programming, family planning, building capacity for logistics management, and advocacy and resource mobilization. This is not a systematic analysis of action, but a collection of examples from country reports where some detail was provided. The aim is to suggest the range and scope of activity associated with the GPRHCS.

4.1 Support to family planning

The need for voluntary family planning is growing fast, and it is estimated that the 'unmet need' will grow by 40 percent during the next 15 years. UNFPA is committed to closing the gap between the number of individuals who use contraceptives and those who would like to space or limit their families.

UNFPA supports family planning services that:

- offer a wide selection of methods
- reflect high standards of medical practice
- are sensitive to cultural practices
- provide sufficient information about proper use or possible side effects
- address women's other reproductive health needs

The Husbands' School: Where men learn about reproductive health

Groups of men are learning about reproductive health in "Husbands' Schools" and taking the lessons home. Increases are being seen in the use of family planning and the numbers of antenatal consultations, skilled health workers at births, and vaccinations. The innovative initiative was developed and carried out in Niger's Zinder region. Cited as a 'best practice' it is now being scaled up in Niger and in the sub-region.

The aim of the Husbands' School initiative is to improve the involvement of men in the promotion of reproductive health. In villages where it has been implemented, use of family planning has increased dramatically and antenatal consultations have tripled within three years. It has given communities responsibility for improving the supply of services, from building a delivery room to building housing for a midwife.

Following the establishment of a Husbands' School in Bandé, several indicators related to the use of reproductive health services illustrate the level of results experienced in the initiative. From 2006 to 2010, family planning use increased from 1.7 percent to 17.20 percent; antenatal consultation increased from 28.62 percent to 87.30 percent; delivery with qualified person present increased from 8.39 percent to 25.02 percent and vaccination increased from 45.6 percent to 107 percent. "Before [the project], we feared motherhood like people fear death. Now, we are enthusiastic about it," said a woman in Bandé.

The Global Programme supports government efforts to implement a comprehensive approach to reproductive health commodity security. Such an approach not only delivers supplies but addresses related needs such as demand generation, innovative financing mechanisms, consideration for market segments, and outreach to vulnerable populations – with due attention to the reproductive rights of individuals. Progress at the level of the two main indicators of results in this area (unmet need and CPR) takes time. Small changes in these indicators can reflect progress and impact, and in countries where leadership and focused support are provided, significant progress can be made. A number of examples have been selected from country reports to illustrate the range of family planning activities in 2010.

Community outreach activities were scaled up in **Benin**, reaching 28,818 adolescents and young people through person-to-person interviews and educational sessions led by community volunteers and community nurse counsellors. With partners including PSI, training sessions for leaders of social promotion centre leaders were organized, with a focus on men's involvement in family planning.

Photo: Broadcasting the benefits of family planning in a community theatre performance.

A campaign in **Burkina Faso** conveyed the benefits of family planning to communities via IEC/BCC activities using mass, interpersonal and social media. Thirteen activities in 2010 helped to raise awareness, including a mobile media service, forum theatres, radio and TV advertisements, radio and TV broadcasts in local languages ("Burkina variétés"), film screenings and the distribution of posters and leaflets. Grassroots communication activities reached many people, in particular through 450 theatre performances that carried messages about the benefits of family planning, existing methods and the location of family planning service providers. Performances in local villages directly involved some 366,705 individuals, including 142,567 women, 108,386 men and 115,752 young people. Tribal leaders were extensively involved in these performances. In addition, 100 film screenings followed by discussions about the benefits of family planning were organised in villages by local partners, reaching more than 150,000 men, women and young people.

In response to rising demand for family planning in **Mongolia**, an extensive training and re-training programme on family planning was implemented in 2010 in collaboration with the University of Mongolia. The training programme involved 223 primary health care providers from urban and rural health facilities. The Global Programme supported a 'demand creation' campaign focused on preventing unwanted pregnancy among young people, and also provided reproductive health commodities that helped to fill the gap in contraceptive supply in a country where stock-outs are a challenge. Also in 2010, a social marketing initiative was implemented by Mongol Em Impex Company (MEIC) and MSI Mongolia. The latter also partnered with UNFPA to train trainers from NGOs working with sex workers on female condom use.

Photo: Women in Niger's Maradi region listen to 'The Adventures of Foula' on a Lifeline radio.

Community radio in **Niger** broadcasts reproductive health information in a series of short sketches called "The Adventures of Foula." Named for a brand of condoms, Foula, the campaign was launched last year by Niger's former first Lady Mrs. Laraba Tandja.

In 2010 it expanded not only in coverage but also in partnerships. Radio is crucial in a country with a 15 percent literacy rate for women. Five-minute sketches with themese, stories and characters from the lives of the local population address reproductive health topics such as family planning, prevention of unwanted pregnancy, female genital cutting/mutilation, sexually transmitted infections and HIV/AIDS. The sketches are broadcast in several languages on radio throughout the country. A local social marketing organization, Animas Sutura, produces the IEC/BCC campaign with the involvement of UNFPA, World Bank and the Global Fund. With UNFPA funding, coverage rose from 140 villages to 197 villages and neighbourhoods in the Maradi region, with 1,764 broadcasts of these sketches on community radio. The broadcasts reached around 72,000 people, including 5,400 women and 1,800 men in discussion sessions led by 180 women. Communication activities that began in 2008 have contributed to significant results, including increased use of contraception.

Photo: Participants at an RHCS training in Madagascar.

In **Madagascar**, a rapid results strategy known as 'Quick Wins' was adopted by MINSANP to improve reproductive health indicators in six of the poorest regions by improving provision of reproductive health commodities and services, including family planning, to communities. A strategy guide was produced to standardise the implementation of outreach work, and Behaviour Change Communication (BCC) activities were carried out.

In **Chad**, GPRHCS supported the effort to increase access and availability of long-term family planning methods such as implants. In 2010, some 20 health workers participated in training on how to properly insert implants, going on to provide this service to 165 women within a three-month period.

Photo: This woman in Mali chose an implant, now covered by a patch, as a long-term method.

A first in family planning in **Mali** was the training of clinicians from the Army's Central Health Services Directorate (ASDAP) in 2010. ASDAP organised training for 23 army clinicians from the eight military regions of Mali in contraceptive technology. Reaching another audience, a meeting involving 80 imams in Tombouctou, and meetings involving leaders of Muslim women's associations and imams in Bamako, demonstrated that Islamic leaders are interested in family planning. Mali moved forward on family planning on several fronts. More than 5,000 people were reached through 147 IEC sessions carried out by MSI Mali with UNFPA support. Of this number, 899 were referred for reproductive health services. Four major events of 2010 included mass demonstrations on the themes of birth spacing and family planning in Fana, Kangaba, Koulikoro and Kati. In some areas of Mali, use of modern methods of contraception by married women is very low. From July through November 2010, with support from UNFPA and MSI Mali, two mobile teams provided 2,347 women with a long-term method of family planning (implant or IUD) in partner community health centres (CSCOMs) where these methods had not been previously available. In the Koulikoro region, 38 partner CSCOMs are now offering these services. In April, 110 qualified services providers participated in a training session on long-term contraceptive technology.

Many women in **Ethiopia** would like to avoid or delay pregnancy. A key role is played by the country's Health Extension Workers (HEWs), who bring family planning information and services closer to communities. They are contributing to the increase in the contraceptive prevalence rate (CPR) from 13.9 percent in 2005 to 30 percent in 2009 (as indicated by the L10K baseline in 2009) in the four most populous regions. Ethiopia's Ministry of Health has responded to a growing demand for long-acting methods of contraception by expanding access to voluntary family planning methods such as Implanon. UNFPA's Global Programme to Enhance Reproductive Health Commodity Security has contributed by providing RH commodities and allocating funds for advocacy and for capacity building of the HEWs. Since the start of the initiative, 15,000 Health Extension Workers have been trained on Implanon insertion procedures. In 2010, more than 400 HEWs were trained on Implanon insertion and 200,000 sets of Implanon and consumables were procured and delivered to the Federal Ministry of Health. An estimated 1.7 million mothers (clients) have benefited from the programme thus far. The GPRHCS has contributed more than 60 percent of commodities and covered 25 percent of training costs. Ethiopian women have, on average, more than five children, but more than a third say they would like to avoid or delay pregnancy, according to the Demographic and Health Survey (2005).

Community-based distribution is a successful model for reaching the most vulnerable and remote communities of **Lao PDR** with family planning services, finds a 2010 evaluation study. MCHC, with technical and financial support from UNFPA, is implementing a community-based family planning service provision programme in eight provinces in Lao PDR. The study finds an overall increase in the number of family planning clients in remote and ethnic communities. The data further shows significant increase in CPR in the catchment areas of community-based family planning distributors (CBDs), from 12 percent baseline (2005 LRHS) to 41.2 percent in 2010. The study shows CBDs to be a highly cost-effective channel for delivering quality services and family planning products such as condoms, oral contraceptive pills and injectable to remote populations. Through engaging and investing in the capacity building of local community members, this CBD model is proving to be an effective intervention for increasing knowledge, access, availability, and

demand for FP products and services. The findings of the CDB evaluation were overwhelmingly positive and evaluators recommended further scaling up of the community-based distribution model to deliver selected MNCH services, such as micronutrients and health messages, thus making them as CBD+. On the basis of this evaluation, the Government of Lao PDR has agreed with UNFPA and World Bank to expand the scope and coverage of this programme to the maximum possible nationwide.

Photo: Participants at an RH and family planning training session, 2010.

In **Sierra Leone**, access has increased and service uptake has trebled in some cases following a major commitment to reproductive health services. The key was the launch of the Sierra Leone section of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). This kicked off the roll out of demand creation activities including mass media campaigns promoting the use of reproductive health services including family planning. Next, in April 2010, there was the launch of free health care services for pregnant women, lactating mothers and children under 5 years, by His Excellency the President of Sierra Leone. UNFPA made substantive and timely support to both the preparations and launch of the Free Health Care Initiative, which the President of Sierra Leone acknowledged in a national radio interview. At community level, 400 community members (TBAs, traditional and religious leaders) were empowered through training on RH, family planning promotion, prevention of teenage pregnancy and fistula in order to raise awareness and demand for RH services.

In coordination with **Bolivia's** Ministry of Health, 10 intermediate 'Centers for Reproductive Health Training' were selected. UNFPA is helping to upgrade these facilities by providing technical assistance to review printed materials and procuring furniture, medical equipment and anatomical models. Training of health nurses and doctors has started in two Centers for Reproductive Health Training (Trinidad and Tarija), giving priority to health providers coming from rural areas.

The Government of **Ecuador** committed in 2010 to guarantee effective access to information, counselling, and quality reproductive health services that include modern family planning methods based on Constitutional norms. The Ministry of Health worked with UNFPA in a consultative process to develop Ecuador's first national family planning strategy. UNFPA also assisted the MoH to develop a RHCS plan that includes procurement of modern family planning methods through GPRHCS and procurement of anatomic and pelvic models for training in obstetric care, and intrauterine aspiration kits. UNFPA also helped to procure contraceptives third party. Training on norms, protocols, quality standards and other issues for family planning providers was carried out with 150 national facilitators and providers from the MoH. Also, at the request of the Ministry, it was agreed that studies will be conducted on family planning and maternal health costs, and demographic and social impact.

Religious and political leaders in **Mauritania** are using an advocacy tool called 'Islam and Family Planning/ Birth Spacing' to help increase knowledge and use of family planning among the Mauritian population. It

was created by the Mauritanian Ulama Association with UNFPA and other partners. First used in 2010, the strategy includes identifying 'champions' to act as trainers, especially of Imams in Mosques. More than 100 imams were involved in Nouakchott and Nouadhibou, using their Friday sermons to raise awareness of family planning.

Three studies in **Nigeria** will help to guide government decisions about funding for contraceptives. UNFPA provided a forum for coordination of the studies, which focused on RCHS issues such as willingness to pay for contraceptives by clients, ability to pay, and supply chain cost assessment.

In **Sao Tome and Principe**, new distribution points expanded access to RH commodities, including male and female condoms. Booklets, posters and other materials promoted the female condom. Services providers received training in logistics management information systems.

In **Senegal**, 727 new ASBC were trained and equipped to offer reproductive health services including family planning and another 55 midwives were trained to provide long-lasting modern methods of contraception such as implants and IUDs. Training in CHANNEL also increased capacity for procurement.

Photo: Training participants in Tsévié - Maritime Region

Training in **Togo** in 2010 reached 60 service providers with learning on contraceptive technology, organized into three sessions lasting 21 days each. Also, 79 service providers participated in week-long workshops to learn how to insert and remove Implanon. A practical introduction used anatomical models and a second phase took the training to selected clinics. A study in Togo found that mobile strategies for family planning are cost-effective compared to the administration of contraception at fixed facilities. Also in 2010, two worshops explored audio materials for broadcasts about maternal health and family planning. Four broadcasts were produced in the 12 most widely-spoken languages in Togo.

Photo: Training participant in Uruguay.

In **Uruguay**, training of 113 health professionals supported the country's decree on comprehensive sexual and reproductive health services. The training, carried out by the MoH with the GPRHCS support, helped to build institutional capacity.

4.2 Support to condom programming

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

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

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

Table 23: Male and female condoms provided to Stream 1 countries in 2010

Countries	Male Condoms	Female Condoms
Burkina Faso	7,294,032	-
Haiti	5,760,000	-
Lao PDR	1,000,080	
Mali	4,268,600	135,500
Mongolia	3,636,000	-
Mozambique	30,780,000	1,500,000
Nicaragua	965,000	-
Niger	-	525,256
Sierra Leone	7,200,000	400,000
Total	**60,903,712**	**2,560,756**

See Annex for Stream 2 and 3 countries

In UNFPA, support for CCP is provided by the HIV/AIDS Branch, in close collaboration with the GPRHCS, the Humanitarian and Procurement Services Branches. These four entities have distinct but complementary roles and responsibilities to have a maximum impact at country level. UNFPA plays a key role in the Global Condom Initiative. The Initiative was launched in 2005 and works in 74 countries to increase both demand for, and supply of, condoms at the national level. CCP activities include support for governments of low- and middle-income countries to advocate for the removal of laws and policies that prevent condom access and utilization by key populations, such as young people, men who have sex with men, to establish a budget line for male and female condoms, and to allocate adequate national financial and human resources to procure and programme these commodities. This includes motivating users, strengthening service providers and developing educational materials to promote consistent and correct condom use. In 2010, UNFPA's Global Programme on RHCS continued to contribute to this initiative. The following activities are selected examples of support to condom programming.

In **Lesotho**, findings of a comprehensive condom programming needs assessment were presented to stakeholders for use in developing a CCP strategy. UNFPA also teamed up with PSI to produce 93,000 packages containing three female condoms each – a response to research showing that women who use female condoms at least three times are more likely to continue using them than women who use them only once. With support from UNFPA, PSI printed 20,000 leaflets for insertion into free-issue male condom packages, to increase knowledge about male condom use.

Photo: Students at Jimma University, Ethiopia, attending an educational event on reproductive health

In **Ethiopia**, the nationwide 'Wise Up' Programme continued to promote condom use to prevent HIV and other STIs among commercial sex workers, their clients and at-risk groups. They are reached day and night by outreach workers bringing information about the proper and consistent use of condoms. Peer education, mass campaigns and other IEC/BCC activities amplify the safer-sex message. Ethiopia is also reaching university students with new condom kiosks at five schools, a documentary film titled 'Accessing Condoms in Higher Education Institutions', and an FAQ booklet for young people.

To reduce teen pregnancy and STIs in **Nicaragua**, workshops engaged 617 adolescents and young people in nine of the country's 17 local health systems (SILAIS) in learning about the prevention of dangerously early pregnancy, prevention of STIs including HIV, and violence. On the national level, the MOH added indicators for adolescent fertility rate sexual and 'actions' of sexual and reproductive health targeting adolescents and young people into its 2011-2015 plan, along with inclusion of an indicator on the HIV prevalence rate among people 15 to 24 years old. Sensitization workshops developed with 'Voz Joven' on issues of adolescent SRH targeted mayors and personnel from 43 city halls. Also a logistics study on young people's access to modern methods of contraception was carried out with partners PRISMA and CIES. Condom programming to combat HIV infection, which has tripled in the last six years especially among women, included a donation of male condoms to the MoH, technical and financial support to the national sex workers' network, and inclusion of antiretroviral drugs and HIV rapid texts in the logistics system, SIGLIM.

Demand for the female condom increased dramatically in **Mozambique** following expanded and higher-quality training, promotional events, and the close collaboration of the National Aids Council, UNFPA and other partners. Female condom programming was initiated for the first time in 2009. In 2010, training was expanded to district providers and civil society organizations (including networks of women's group, men's engagement, and youth and adolescents). Some 1150 female and 600 male anatomical models were acquired to improve training. Female condoms featured in events throughout the year, e.g. international Days, openings of new health facilities, activities of Ministries, sporting and school events, and at youth centres.

In **Sierra Leone**, 27 trainers attended a workshop on condom programming and will next undertake cascade training for staff; 25 parliamentarians attended an event designed to gain their support for inclusion of condom promotion in secondary schools; and 38 focal points were nominated at ministry development agencies to promote CCP.

Photo: Condom kiosk at the World Cup, South Africa.

In **South Africa**, UNFPA's support to condom programming assisted the Government of South Africa to close the shortfall of female condoms during the 2010 World Cup, including 3.5 million female condoms, which provided women with an additional tool to negotiate protected sex. The GPRHCS provided technical support for the distribution and management of condoms, and the HIV/AIDS Branch provided funding for the procurement of female condoms. The major focus in South Africa's condom programming was related to a special event: Millions of soccer fans attended the FIFA World Cup. South Africa's National Department of Health launched the Condom Distribution Project, focusing on the sporting events in June and July. "This was a period of festivities," explain UNFPA staff in South Africa, "and an increase in unprotected and casual sex with the risk of HIV infection was anticipated." The aim was to maximize the national distribution of male and female condom commodities around the World Cup, together with HIV counseling and education. Youth Ambassadors specially trained to distribute condoms and health information helped to make the project a success, along with local volunteers, cleaning staff at the sporting venue and mobile health clinics. Photo: Condom kiosk at the World Cup, South Africa.

Capacity development in **Botswana** focused on developing a National Condom Strategy with an operational plan, working closely with the Ministry of Health and partners such as PSI. Supply and demand issues were considered, as well as the need for social marketing, partnership and capacity building, especially regarding the female condom. Training for health service providers and members of the media emphasized the dual protection offered by female condoms, especially for prevention of sexually transmitted infections including HIV/AIDS. Development of a Comprehensive Condom Programming (CCP) Training manual was also initiated.

In **Burkina Faso**, 420 young people participated in training in adolescent reproductive health and other capacity-building activities related to life skills, IEC for HIV prevention, and the ARH response of youth organization in times of humanitarian crisis. About 420 young people, half young women and half young men, participated.

In **Burundi**, the introduction of the CHANNEL software module in the national reproductive health programme (PNSR) facilitated needs assessment for male and female condom programming. One of the challenges is the lack of self-sufficiency in terms of stockpiling. The Ministry of Health and other partners are being approached to find a sustainable solution, in particular through the mobilization of funds to extend the central drug and medical supplies purchasing agency (CAMEBU).

In **Congo**, the Comprehensive Condom Programming committee has been set up and is preparing to carry out an analysis of the existing situation and draw up a strategic Comprehensive Condom Programming plan for 2011.

Media and arts professionals in **Côte d'Ivoire** joined UNFPA in a strong effort to raise awareness and share information about the benefits of condom use. UNFPA signed a memorandum of understanding with the Network of Media and Arts Professionals against AIDS (Réseau des Professionnels des Medias et des arts contre le sida, REPMASCI). The MoU is a commitment to build capacity amongst the network's members

to communicate and raise awareness about reproductive health problems and to increase understanding of UNFPA's mandate. Female condoms were promoted in 18 messages to be used in awareness raising, in a collaborative process with the MoH, Ministry for Combatting Aids, and other civil society partners including young people, sex worker and social marketing experts. A total of 1,996 radio advertisements were broadcast compared with the 935 planned, and three different radio programmes were produced. In addition, a training programme for 25 press, radio and television journalists on reproductive health lead to a competition for the best article or best radio or television programme on a reproductive health topic. Eleven news articles were written: the most frequent topic covered was female condoms, followed by family planning. A TV report and nine radio reports were produced, with articles and broadcasts covering family planning the prevention of sexually transmitted infections, including HIV. In addition to a strong emphasis on raising awareness, CCP activities in Côte d'Ivoire included a review of CCP in preparation for a scale-up, training for service providers, and an 18-month forecast of contraceptive product needs, including condoms.

In **Ecuador**, UNFPA continued to assist the MoH to design strategies related to a comprehensive condom programming initiative that includes overcoming social and cultural barriers in the access and use, design and implement a communications strategy aimed at addressing condom use barriers. Ecuador is in the process of elaborating a national strategy and related sensitization, including information materials and anatomical models for use in training and education.

Regional Health workers in the **Gambia** were trained on RHCS and comprehensive condom programming at a training funded by GPHCS, with personnel from National AIDS Secretariat National AIDS Control Programme.

Procuring and distributing condoms has been a challenge in **Madagascar**. In May 2010, it was confirmed that the National AIDS Programme, a department within the new ministerial structure, will be responsible for managing condoms. UNFPA will provide assistance to improve comprehensive condom programming in 2011.

In **Malawi**, male involvement programmes continued in to 2010 to engage former perpetrators of violence in activities related to SRH in general, and to condom programming in particular. New activities are spinning off, and men are now engaging in the social marketing of female condoms and educating fellow men on issues of masculinity and their role in gender-based violence and SRH. Men's travelling conferences around The 16 Days of Violence campaign spurred increased interest in condom use. A group of men developed interactive media tools (CD Rom) for engaging men in these issues.

Building on established groups, **Mozambique** embarked on the process of compiling best practices through the nationally-led Prevention Reference Group and continued to look to the Multi-Sectorial Condom Working Group for leadership, partnership and coordination of condom programming in the country. Very good coordination was noted between the Condom Programming Coordination Group (CPCG) and the RHCS Task Force.

The development of a condom strategy by **Namibia's** government received financial and technical support from UNFPA in 2010. The process was strengthened by South-South cooperation. The strategy complements existing strategies and is aimed at increasing both the availability of, and the demand for condoms in the Namibia. It outlines the strategic priorities and key interventions needed to ensure the availability of and access to male and female condoms for all in Namibia.

2010 marked the second year that the **Mongolian** Government allocated money in the national budget for procurement of contraceptives, including condoms, and UNFPA supported procurement, provision, and distribution of 9,000 female and 24,856 male condoms.

In **Tajikistan**, interviews were conducted to determine if condom programming would benefit specific groups. In a country where it is generally socially and culturally unacceptable for a woman to acquire condoms outside of a health clinic, only 3.4 percent of women and their partners use condoms. Interviews were conducted with health professionals and staff in private pharmacies, pointing to the importance of privacy, confidentiality and convenience to men when acquiring condoms.

UNFPA strengthened the capacity of CCP Focal Points from 15 **African countries** to integrate CCP and reproductive health commodity security, resulting in the development of national integrated plans in Benin, Burkina Faso and Côte d'Ivoire; the implementation of a situation analysis to inform strategic plan development in Equatorial Guinea and Guinea; and the establishment of a National Condom Task Team in the Republic of Congo.

UNFPA supported mapping of organizations in the **Caribbean** region involved in condom programming that revealed the need for greater investment and partnerships to address supply management of condoms.

Female condom programming was focus in **Uganda**, where orders have increased from 100,000 in 2007, to 200,000 in 2009 and to 600,000 female condoms ordered in December 2010 for procurement by UNFPA. Partnerships have been established, and trainings conducted with anatomical models also procured by UNFPA.

There is much more to do in CCP to ensure that sexually active people feel free to demand for and access the means to protect themselves. Motivating users; strengthening service providers; and developing information, education and other promotional materials are actions needed in addition to the commodities themselves. Promotion is key to creating demand for male and female condoms, along with the design of attractive packages, sensitive messages, awareness campaigns, and efforts to engage the media. Promotion is often costly, however, and funds are limited.

4.3 Building capacity for logistics management

Ensuring access to essential reproductive health supplies is a complex process. An effective logistics management information system (LMIS) can collect data about how much of each commodity has been used (consumption) and how much is left at each level of the supply chain (stock status). This data can be used to forecast future needs, determine financing requirements, procure supplies in a timely manner, and manage their distribution in order to avoid shortages.

The GPRHCS promotes good logistics management information systems that are computerized. Various types of computer software are in use, including CHANNEL, a user-friendly software developed by UNFPA with the active participation of local governments. CHANNEL helps countries to manage their RH supplies through the public health distribution system by allowing individual warehouses to track their supply stock as soon as commodities enter or leave storage, and to generate simple reports and requests. Tracking and forecasting supplies is the key to avoiding shortages.

Typically, use of CHANNEL starts at one location and expands to other regions or districts. After two or three years, users may wish to customize it to the country context or to advance to a more extensive program. Countries that have successfully launched this software at home often send trainers to neighboring countries to share skills. In deploying CHANNEL, UNFPA seeks to engage partners and local institutions and to use South-South collaboration for greater sustainability.

The installation of CHANNEL software in 50 percent of **Benin's** health care delivery points served to kick-start the computerisation of contraceptive supply management. It was an opportunity to build the capacities of a number of individuals responsible for RHCS management, set up RHCS-related databases and ensure the logistics management of these supplies such as to secure their availability. Training on RHCS, including LMIS, was conducted for 32 trainers, 240 service providers, 16 staff form the central medicine purchasing agency; 53 trainers trained in CHANNEL then provided software training to 56 service providers. Donor updates, monitoring visits and other activities accompanied the CHANNEL rollout.

Botswana encountered obstacles to improving LMIS and the supply chain in 2010, due in part to restructuring at the MoH. Three training-of-trainer sessions and sensitization activities set the stage for improvements in 2011.

In **Burkina Faso**, the aim in 2010 was to build the competencies of grassroots actors and improve quality monitoring of data input. CHANNEL software is now in the final stages of rollout across all of Burkina Faso's

health regions and districts and regional and national hospitals. Development of an LMIS training module supported training of 174 pharmacists and health workers in the use of CHANNEL software, which was installed in 63 health districts, nine regional hospitals, two university hospitals – adding the 13 regional health services equipped last year. Assessment visits and a review of data collection practice helped to ensure quality and planning throughout.

Collaboration with UNFPA's partner KfW is considered a 'best practice' in the rollout of CHANNEL software to manage essential RH supplies in **Burundi**. UNFPA covered all contraceptive and life-saving maternal medicines/drugs needs over a period of two years, while KfW supplied computing equipment to the country's 45 Ministry of Health districts. Thematic funds then enabled individuals responsible for the management of medicines and contraceptives at health district level to be initiated in system software and the use of CHANNEL. CHANNEL, which is fast becoming the standard programme for the management of all medicines, has been installed in the office of the KfW focal point to monitor RH commodity supply management at the national reproductive health programme warehouse, the central warehouse, and in 36 health district warehouses.

Training for pharmacists and national procurement supervisors in **Côte d'Ivoire**, an LMIS training-of-trainers workshop, contributed to efforts to scale up the use of CHANNEL and improve LMIS.

In **Eritrea**, efforts to improve the referral system for emergency obstetric care (EmOC) include upgrading and installing CHANNEL and CCM in 10 hospitals and six zonal medical stores, on-the-job training and refresher courses, procurement of 17 printers, development of a software stock catalogue for pharmaceuticals, and several visits for monitoring and evaluation.

Stock-outs in the **Gambia** brought the need for better logistics systems to the forefront in 2010. Efforts to assess and quantify supplies and systems energized the commitment to RH commodity security. The supply chain management of contraceptives and other RH supplies is being merged into the CMS system. Participants from all health regions attended a workshop on RHCS and the effective use of the logistics management information system.

Hands-on training and a university course enhance LMIS

These before-and-after photos show a warehouse in Ethiopia that was reorganized following training for store managers and pharmacists working on the distribution and supply of RH commodities. In Ethiopia in 2010, UNFPA and SNNPR, with technical support from USAID/DELIVER, organized three training sessions for a total of 107 health professionals. Also, automating LMIS record-keeping was initiated. UNFPA also worked with the School of Public Health at Addis Ababa University to institutionalize RHCS, successfully creating a two-credit training course for postgraduate students. Topics for course, planned to start in early 2011, will include logistics management, assessing stock status, quantification, inventory control systems and warehousing.

Procurement of quality products in Mongolia

Training has become a central feature of RHCS action in Mongolia, a country committed to RHCS with a national strategy and a budget line, yet faced with problems related to its market for illegal and poor-quality medicines, weaknesses in procurement laws and practices and even, occasionally, stock-outs. The country is addressing these problems by equipping pharmacists in the aimags (provinces) with training, and the tools and systems they need to ensure a safe and secure supply of reproductive health commodities.

Through GPRHCS in May and November 2010, more than 50 procurement personnel, pharmacists and NGO partners received training along with trainers to carry the initiative forward. The initiative was institutionalized with the University of Health Science, School of Pharmacy faculty. Trainers trained in May helped to facilitate the November training session, thereby strengthening ownership and continuity. The training sessions addressed solutions through pre-qualification, quality verification, exclusion of manufacturers not meeting criteria, tendering, evaluating and pricing strategies as well as other effective and efficient approaches. The institutionalization of the training was further guarded through recognition by the Ministry of Health's Education Unit, which granted certified credits to health procurement personnel attending the training. Implementation of the good practices in their entirety is currently being undertaken through the editing of official tendering and evaluation documents.

Following training in 2009 and 2010, health professionals in **Kazakhstan** are more prepared to assess contraceptive needs and use the CHANNEL software. This knowledge will support efforts to advocate for the procurement of RH commodities in the near future, as existing supplies come to an end.

Building the capacity of reproductive health and family planning institutions is important in **Kyrgyzstan**, where specific needs include updating the LMIS, establishing a RHCS Committee, and developing an effective RHCS national strategy and programme. In 2010, UNFPA assisted with training programmes, technical support and improvement of the reporting system. Collaboration with the Republican Medical Information Centre strengthened forecasting, distribution and evaluation.

Lao PDR undertook the design of a pilot unified logistics system for the health sector through the Medical Products and Supplies Centre, which also received GPRHCS support to conduct a survey on stock availability.

In **Madagascar**, UNFPA signed an MOU with the Department for Information Systems with regard to maintaining the computers using CHANNEL in the health districts and regions, conducted to workshops to asses RH commodity needs, and designed a software interface to facilitate data transfer.

In **Malawi**, LMIS training improved the data-capturing skills of 172 health staff, including members of the District Management Health Team. The role of LMIS as a system for data for use in decision making,

for capturing data, and for supply chain management was emphasized. The training contributed to the improved quality of data at district level, with an increase from a 45 percent reporting rate to an average of 80 percent. Also, training on CHANNEL and approval by the MoH of its installation in seven central warehouses and several other key locations are expected to improve data for RHCS.

Conditions at **Mozambique's** central warehouse in Maputo have improved with UNFPA support, removing one constraint in a country with weak capacity to procure RH supplies. The LMIS at the warehouse is functioning, and its expansion to others is planned for 2010. For the first time, Mozambique is undertaking a survey on the availability of modern methods of contraception. Tools provided by the GPRHCS were translated into Portuguese by UNFPA and Eduardo Mondlane University, which is leading the survey.

A total of 293 Ministry of Health staff in **Nicaragua** participated in LMIS training in 2010, for implementation of PASIGLIM software. At service delivery points, the LMIS implementation has helped to reduce stock-outs, increase the availability of medicines, and enhanced monitoring. Also in 2010, a strategic plan for medical supplies was developed and approved by the MoH with UNFPA and many partners. A number of training programmes further strengthened quality control, forecasting and supply chain management.

In **Nigeria**, a total of 634 health managers and providers received training on logistics management information systems in an effort to develop human resources capacity. Sessions were held in Abuja and the six states of Abia, Adamawa, Akwa Ibom, Benue, FCT, Kebbi and Lagos.

Photo: A workshop on logistics management information systems in Panama

Numerous activities were undertaken in **Panama** to manage the distribution of supplies, taking steps to fulfill recommendations of an assessment of the logistics management information system by PRISMA. The advocacy, leadership, collaboration and involvement of the MOH staff provided better inputs to understand the situation, identify scenarios and provide recommendations to decision makers. Areas of activity included: (1) technical assistance for the implementation of two workshops addressed to 45 health professionals on Logistics Management and Monitoring and Evaluation the LMIS; (2) technical assistance to create a RHCS Technical Group at central level responsible of training, supervising monitoring and evaluating regional and local levels; and (3) participation in regional training on RHCS and costing, including international workshops on estimating supply needs and monitoring and evaluation for strengthening the chain of health supplies.

Swaziland prepared for a 2011 pilot of CHANNEL in cooperation with the Central Medical Stores, with support in 2010 to develop capacity in reproductive health commodity security, particularly logistics management information systems using CCM and CHANNEL. At the regional level, the systems and software were introduced to the Health Directorate and nurse managers of health facilities. Also, a pool of LMIS trainers was developed.

Photo: CHANNEL training in Sierra Leone.

Leakages in **Sierra Leone's** commodity supply and distribution system were drastically reduced through a collaborative effort of UNFPA and civil society organizations (CSOs), focusing on monitoring from the port to the end users. CSO monitors at the national, district and community level are present as supply and distribution points and, frequently, submit reports to the Anti-Corruption Commission for further action. The initiative is contributing to strengthening accountability in the use of health commodities. Also in 2010, Sierra Leone engaged in the revision of its national procurement and supply management (PSM) system, with the Government working in collaboration with UNFPA, UNICEF and other development partners. With CHANNEL implemented as the national inventory control and management software, three training sessions prepared 94 participants for a series of cascade trainings. Training on results-based management was organized for 30 implementing partners. Also, 50 computers and 30 printers were supplied to district medical stores and to hospitals.

Photo: Warehouse in Tajikistan.

In 2010 in **Tajikistan**, monitoring visits to Khamadoni, Vose and Muminabad districts found that the top RH facilities are well-informed and trained on the LMIS system, and knowledgeable about RHCS and tasks such as registration and distribution of contraceptives to patients, maintenance of log books, patients' cards. However, rural health centers and health houses require urgent measures and attention on these matters. The monitoring visits also suggest that CHANNEL software would provide substantial benefits at all Oblast- and Rayon- level facilities, yet the system has not been supported to reach its potential.

Gaps and challenges in LMIS in **Zambia** were identified through visits to 14 pharmacies and facilities, with support from GPRHCS. Ministry of Health staff participated in a regional training of trainers on LMIS and CHANNEL software. As a result of the reviews, available stocks were assessed, procurement plans were developed, and commitments from partners were sought.

Photo (left): A truck was procured to address problems in distribution of RH commodities.
Photo (right): In Zimbabwe, warehousing for storage of RH commodities like these anaesthetic machines, was secured in 2010.

In **Zimbabwe**, UNFPA procured a lorry to facilitate distribution of RH commodities to the service delivery points. Warehousing for storage of commodities was also secured. A logistics assistant was recruited to strengthen logistics and supply chain management of RH commodities.

4.4 Capacity development of institutions for technical assistance

The Mauritius Institute of Health undertakes training and research in the health sector under the aegis of the Government's Ministry of Health & Quality of Life. In 2010, UNFPA and MIH organized a 10-day regional training of trainers workshop on RHCS with 30 delegates from 11 African and Asian countries: Cameroon, Egypt, Ethiopia, Indonesia, Kenya, Lebanon, Madagascar, Mauritius, Morocco, Nepal and Senegal. The aim of the workshop was to improve capacity in RHCS so that each country can forecast, finance, procure and distribute quality reproductive health commodities such as contraceptives, maternal health drugs and HIV commodities. Collaboration between UNFPA and MIH dates back to 1982; as many as 1,200 health professionals from the sub-Saharan region have since been trained in reproductive health.

A 10-day training of trainers workshop on RHCS was carried out in 2010 for senior officials of Bhutan, Lao PDR, Mongolia, Myanmar, Timor Leste and Yemen as a joint effort of BKKBN's Centre for International Training and Collaboration, the UNFPA Country Office in Indonesia, and the UNFPA Asia Pacific Regional Office. APRO has been providing technical support to the BKKBN in order to strengthen the technical capacity of its faculty, as also in the periodic review, revision and update of the training curriculum. BKKBN is the Government of Indonesia's National Family Planning Coordination Board. The Indonesian family planning program is internationally recognized for its success in lowering average family size, increasing contraceptive use, and improving the health of women and children.

Photo: PRISMA facilitators assisting in small group work.

Developing institutional capacity in Latin America

The Latin American Federation of Obstetrics and Gynaecology Societies (FLASOG) is a key implementing partner of the UNFPA Regional Office in Latin America and the Caribbean. In 2010, UNFPA supported the training of 10 trainers and some 100 health professionals in sexual and reproductive health and rights, as well as promoting a proposal for SRH contents in university curricula. A specialized FLASOG team received training on how to improve access to emergency contraception. With support from UNFPA, FLASOG also produced a publication on studies and intervention to prevent sexual violence, and supported the development of a document on misoprostol for use in advocacy with governments for the drugs incorporation into public health systems.

GPRHCS also supported activities in 2010 with the Consortium on Emergency Contraception (CLAE), enabling the group to enhance strategic alliances, develop tools to monitor the supply of emergency contraception, and to produce an advocacy kit. Also in 2010, UNFPA supported activities by REPROLATINA, an SRH NGO based in Brazil, to continue to promote family planning guidelines and tools developed by WHO and UNFPA in the past two years as part of a regional initiative. A training programme for family planning from Social Security Institutes was implemented, with an emphasis on quality counselling and services.

South-south cooperation between academic and technical institutions was promoted through UNFPA's partnership with CIES and PRISMA. Training programmes in 2010 included a series of week-long courses, each with 15 to 27 participations from at least five countries, on topics including RHCS principles and practice, strengthening the supply chain through monitoring and evaluation, and forecasting and procurement planning.

The UNFPA Sub Regional Office for the **Caribbean** carried out advocacy and sensitization activities to promote RHCS as part of the development agenda at the Caribbean Community and Common Market (CARICOM), the Organisation of Eastern Caribbean States (OECS), Ministers of Health, chief procurement officers at Pharmaceutical Procurement Services (PPS), and among local leaders including NGOs and health providers. In 2010, UNFPA worked in partnership with PSI, IPPF, CFPA affiliates, USAID, local NGOs and government to ensure sustainable work in RHCS and increase the demand for RH commodities through social marketing at the community level and a wider appreciation of the supply needs by the Government and the local NGOs. CFPA produced brochures, television spots and other IEC materials for use throughout the sub region. The GPRHCS also supported three brochures on RHCS contributions to the MDGs as well as the benefits of family planning. Training workshops to build capacity focused on RH in disaster response, RHCS and contraceptive technology, HIV/AIDS prevention, and legal and ethical aspects of RH and emergency contraception.

4.5 Advocacy and resource mobilization

A more sustainable approach to funding for reproductive health commodities is a GPRHCS priority (see section 2.2 on Output 2). Such funding in most countries has long depended on aid from external partners. GPRHCS strongly supports countries that are implementing broad-based efforts to reform and improve health systems and services, and advocates for the mainstreaming of RHCS into such processes – especially into the national budget line. The establishment of a national budget line is a clear sign that the government has chosen to prioritize RHCS, demonstrating that reproductive health issues are national priorities and budgeted for accordingly. Other steps that symbolize the commitment of national governments to support and finance RHCS is the inclusion of RHCS in national planning and policy documents related to the overall health sector programme, and in key strategies such as the Poverty Reduction Strategy Papers (PRSP).

The following examples suggest the range of activities undertaken with the support of the GPRHCS in 2010 to advocate for RHCS and to mobilize resources.

Several countries reported high-level support in 2010. The President of **Niger** announced a formal commitment to the United Nations Secretary-General's maternal and child health initiative, and met with the UNFPA Executive Director. **Sierra Leone's** President visited district hospitals and medial stores in all 13 districts of the country, accompanied by UNFPA and UNICEF, to promote reproductive and child health services. Sierra Leone's First Lady supported the new Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), on the theme 'repositioning family planning'.

The Ministry of Health can also show support for RHCS. **Niger's** Minister of Public Health met with the Director of UNFPA's Technical Division and Head of the Commodity Security Branch. Commitments were made to a budget line for the purchase of contraceptives and a system of storage and distribution. **Burkina Faso's** Minister of Health chaired a national consensus workshop on the country's strategic plan for RHCS, an event attended by directors of central and regional directorates, technical and financial partners, civil society partners and the media.

From conferences to workshops, events can lead to concrete action and raise RHCS higher as a national priority. **Mongolia** welcomed over 500 participants to its sixth conference on national policy and essential medicines, with a focus on RHCS and the private sector. In **Burkina Faso**, a national consensus workshop featured a new RHCS strategic plan was held in March, chaired by the Minister of Health, brought together family planning stakeholders (directors of central and regional directorates, technical and financial partners, partner civil society organizations, media representatives and other actors. In **Bolivia**, eight workshops lead to the development of eight departmental plans for sexual and reproductive health, which facilitated resource mobilization from other sources and the participation of diverse stakeholders. Advocacy on behalf of Bolivia's indigenous populations also continued in 2010, with requests for further training.

A round-table discussion in **Chad** continued lobby efforts for a specific budget line for RH commodities, meanwhile opening a dedicated account. Chad's national RHCS strategic plan is integrated in its National Road Map for reducing maternal, neonatal and infant mortality; the roundtable discussion has enabled the mobilization of resources necessary for its implementation.

So that more people know and understand the benefits of reproductive health, outreach takes many forms. In **Mali**, information and awareness-raising sessions on were organized in three of the eight regions to explain and clarify national and international commitments and laws related to reproductive health, family planning, HIV/AIDS and free caesarean sections. Elected representatives attended trainings. Religious groups organized related events including a meeting of 80 imams in Tombouctou to discuss family planning and Islam, and another of imams and preachers in Bamako. One hundred women's associations met in Bamako.

Advocacy can yield results, as in the case of **Mozambique's** first budget line for contraceptives, approved in 2010 by the MOH, which also added the allocation to its indicators for monitoring and evaluating the Mozambican Family Planning Strategy. Advocacy in **Botswana** made an impact through participation in the development of documents such as the national condom strategy, a training manual on maternal and

newborn health, service standards and protocols for the health sector and more. Members of the media in Botswana, along with MOH public relations officers, were encouraged through training sessions to become advocates for the female condom. In **El Salvador**, advocacy activities were conducted with key officials of the Ministry in the finance and procurement management for purposes of obtaining support for increased government funding for the purchase of contraceptives, resulting in increased allocation of funds to purchase 2010.

Resource mobilization can also mean asking for assistance when it is urgently needed. In **Madagascar**, a 'pledging document' was jointly produced by United Nations agencies to ask for donor support in a time of political crisis that has weakened the health system. A joint project was also set up to procure the country's health supplies and an RHCS survey was conducted by UNFPA and UNICEF. In light of the socio-political crisis in **Guinea** and **Cote d'Ivoire**, an assessment was undertaken of the humanitarian situation in the border region between the two countries.

Coordinating bodies can play a key role in maintaining advocacy impact. Democratic Republic of **Congo** introduced a coordination framework that includes the CCP Committee and RHCS committee, and strengthened the leadership of RHCS with national partners in purchasing, social marketing and family planning. A coordination group for technical and financial partners in the health field was set up this year by a Ministerial Order in Côte d'Ivoire. In **Sierra Leone**, the RHCS National Committee actively promoted the campaign and coordinated a GPRHCS survey on contraceptives and life-saving drugs that helped mobilize additional funds by showing results. A large number of partners joined together in 2010 to create a a regional coordination body for RHCS, the **Latin American and Caribbean Forum** of the Reproductive Health Supplies Coalition (LAC RHSC), which cross-cuts Coalition working groups.

SECTION FIVE

COMMODITIES

Pharmacists at a maternal health clinic in Darfur, Sudan.
Photo by Sven Torfinn/Panos Pictures

Making commodities available to the people who need and want them (reproductive health supplies, including contraceptives) is a cornerstone of reproductive health programming. However, Resources for contraceptive commodities continue to be largely donor-dependent. One of our objectives is to encourage and support countries to become less dependent on global donors. This is beginning to yield results, as many countries are creating budget lines and allocating resources for RH commodities. Yet many continue to depend on external support, and we continue to provide support to meet their commodity needs. Responding to the commodity requests from countries is one of the major activities of the Global Programme.

5.1 Allocation of funds for commodity purchases

The process of allocating funds for commodity purchases involves several steps. First, UNFPA staff in the country work with the Ministry of Health to determine the type and quantities of supplies required. A request is then submitted to GPRHCS. A systematic process is used for accumulating, analyzing, and validating country requests in determining how to best allocate the funds available to the GPRHCS. It is a process that involves UNFPA's Country Offices, Regional Advisors, Procurement Services Branch, and experts at headquarters in several branches – all working in collaboration with the Ministry of Health and officials from other public health offices. Part of the process of validation also includes discussing requests with other partners.

The Global Programme coordinates the UNFPA response with those of other major donors, including USAID, World Bank, and the RH Supplies Coalition. It may involve obtaining further clarification from government health officials. These activities are thoroughly carried out, always mindful of the necessity for a speedy response to calls for help from governments to avert shortfalls of medical supplies.

What kind of 'commodities' are provided?

Reproductive health commodities and life-saving maternal medicines and devices include:

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

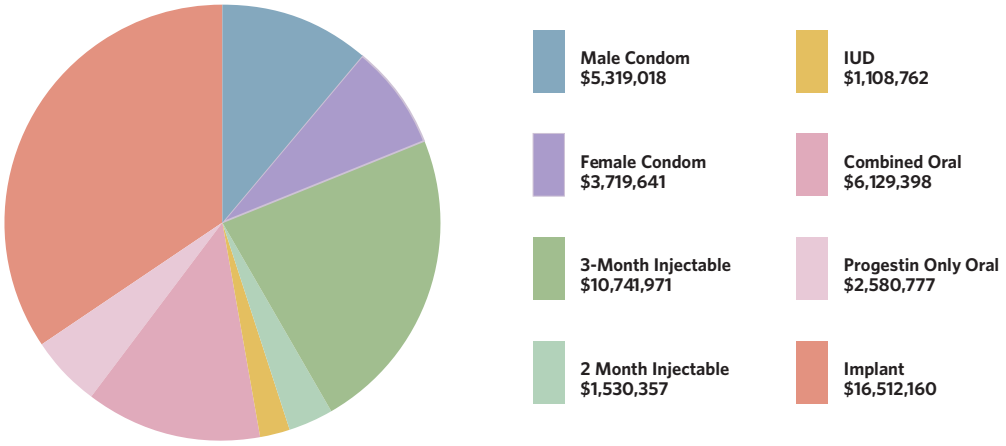
Essential life-saving maternal/RH medicines: Magnesium Sulfate, Oxytocin, Ergometrine, Iron/ Folate, Amoxicillin, Azithromycin, Clotrimazole, Metronidazole, Benzathine Benzylpenicillin, Cefixime (this list of UNFPA priority medicines is being revised and updated with WHO)

Emergency RH Kits for conflict, post conflict and emergency situations

Medical devices/equipment and supplies on case by case basis

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

Figure 12: Expenditure by method, 2010



5.2 Contraceptives and condoms

Contraceptives and condoms account for nearly all of the GPRHCS expenditures for commodities. Table 24 shows the number of contraceptives supplied to Stream 1 countries. This supply depends on several factors: requests from countries based on the needs of their clients, the funds available to GPRHCS, and information about the needs being met by other partners within the country.

The GPRHCS funded $61.7 million in commodities in 2010, of which $59.8 million was for contraceptives and medical devices and $1.9 million was for RH kits. A total of $22,246,515 went to the procurement of contraceptives for 11 Stream 1 countries.

In 2010, the Global Programme provided only implants to Ethiopia, while Sierra Leone and Mali received a wide variety of contraceptive commodities, including implants. Ethiopia had the highest amount of support followed by Madagascar, Mozambique, Mali and Sierra Leone, in that order. The least number of supplies went to Lao PDR, Haiti and Mongolia, though Haiti received a large number of RH Kits to meet humanitarian needs. A table on contraceptives provided and cost per country for Stream 2 and 3 are included in Annex 1.

Table 24: Contraceptives provided to Stream 1 countries in 2010

Countries	Male Condom (pieces)	Female condom (pieces)	Injectable (vials)	IUD (pieces)	Combined oral (cycles)	Progestin oral (cycles)	Implant (pieces)	Cost
Burkina Faso	7,294,032	-	-	8,500	962,664	-	47,631	$1,751,079
Ethiopia	-	-	-	-	-	-	260,000	$6,240,000
Haiti	5,760,000	-	33,478	-	33,048	-	-	$213,117
Lao PDR	1,000,080	-	-	-	-	250,000	-	$166,802
Madagascar	-	-	2,546,346	29,500	3,062,778	95,043	36,800	$4,769,694
Mali	4,268,600	135,500	576,100	19,150	900	9,900	59,900	$2,266,034
Mongolia	3,636,000	-	105,000	25,000	80,000	-	-	$258,197
Mozambique	30,780,000	1,500,000	-	3,367	192,000	1,452,436	-	$2,848,565
Nicaragua	965,000	-	400,000	4,600	350,000	-	-	$576,552
Niger	-	525,256	109,697	-	-	412,445	9,260	$938,669
Sierra Leone	7,200,000	400,000	352,245	15,445	525,645	180,531	43,500	$2,217,806
Total	-	-	-	-	-	-	-	**$22,246,515**

The largest amount was spent on implants, followed by 3-month injectables, followed by combined oral pill and male condoms and female condoms. Though the unit cost compared to the period of protection of female condoms is high, the GPRHCS provides this commodity to countries to give women access to this important female-controlled method and because it offers an option for prevention of HIV infection.

5.3 Benefits of commodities supplied

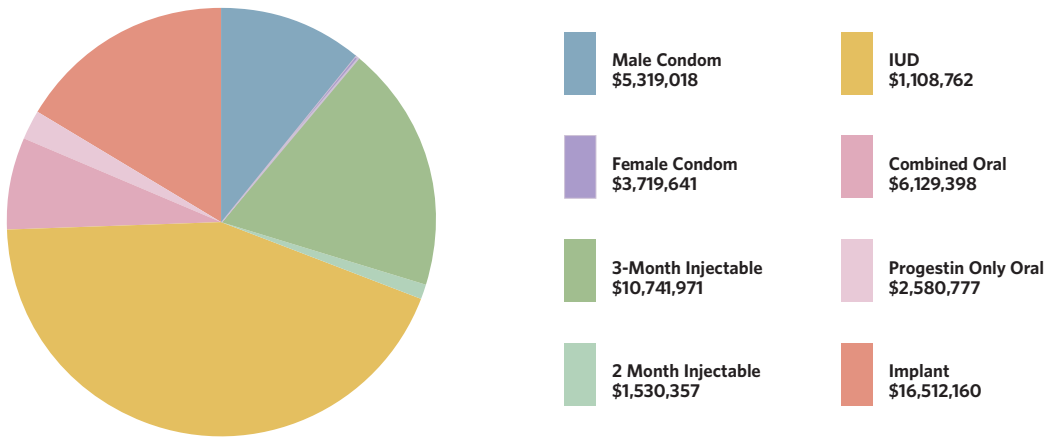
There are several ways to measure the direct impact of the provision of commodities, including increased contraceptive prevalence rate (CPR), reduced stock-outs, and increased couple years of protection (CYP). CYP is the number of couples protected from unwanted pregnancy for one year. In 2010, the contraceptives purchased with the monies from the GPRHCS provided protection to 17 million couples. In its three years of operation, the GPRHCS has provided a total of 45 million CYP. Refer to the Appendix for detailed data for contraceptives provided to Stream 2 and 3 countries.

Table 25: Couple years of protection (CYP) provided to Stream 1 countries in 2010

Countries	CYP
Burkina Faso	312,065
Ethiopia	866,667
Haiti	58,573
Lao PDR	25,001
Madagascar	1,068,108
Mali	443,871
Mongolia	145,217
Mozambique	389,852
Nicaragua	146,708
Niger	90,164
Sierra Leone	394,956
Total	**3,941,181**

The IUD offers the most years of protection, followed by the 3-month injectable, implants and the male condom. It is worth noting that, in terms of use, IUDs are still one of the least used methods. Factors include myths and misconceptions on the part of both clients and providers. GPRHCS is working with countries to improve the acceptability of this cost-effective method.

Figure 13: Couple years of protecion (CYP) by method, 2010



SECTION SIX

FINANCE

Father with sons and motherless nephew in Sierra Leone.
Photo by Aubrey Wade/Panos Pictures

6.1 GPRHCS contributions and expenditures

In 2010, the Global Programme to Enhance Reproductive Health Commodity Security had total funds available of $136,961,434. This includes total contributions received by the GPRHCS in 2010 ($95,509,190.54) and the carry over funds from 2009 ($41,452,244). The 2009 carryover amount of $41.4 million resulted from the receipt of contributions totaling $25 million from Luxembourg, the United Kingdom and Spain. The remaining $16.4 million is the rolled-over commodities purchase orders and the interest income from 2009.

In 2010, major funding came from the United Kingdom and the Netherlands, along with Luxembourg, Spain and France. The GPRHCS remains indebted to these generous donors, yet acknowledges that the total donor base remains quite small. Efforts will be intensified in 2011 to increase the number of donors, especially in light of the challenging global economic situation.

Table 26: Total funds available in 2010

Donor	Total (US $)
Carry over 2009 funds	41,452,244.20
Spain (Catalonia)	420,168.07
Netherlands	39,807,880.00
UK (DFID)	54,464,815.94
Luxembourg	544,217.69
France	272,108.84
TOTAL	**136,961,434.20**

The total expenditure for 2010 was $93,551,586. The expenditure rate was around 69 percent for the year, due in part to the fact that funds from three donors were not received until September 2010 (those expenditures will be reflected in 2011).

Of the funds spent, $61,771,481 was used for the provision of commodities and $31,780,105 was used for capacity development. Thus approximately 66 percent was spent for the provision of commodities and 34 percent was spent for capacity development at country, regional and global levels.

Table 27: Commodity and capacity development expenditures 2009-2010 (US$)

Donor	2009	Percent	2010	Percent
Total Expenditure	87,089,805	-	93,551,586	-
Commodity	70,259,604	80.7%	61,771,480	66%
Capacity	16,830,201	19.3%	31,780,105	34%

*Since the financial closure is still in process, all financial figures in this report should be seen as provisional until actual expenditure is reflected in the certified financial report.

6.2 Expenditure on capacity development

Capacity development is understood as the process whereby people, organizations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time, stated the OECD/DAC definition adopted by UNDG. The ultimate goal is to reach a level of capacity development whereby countries are able to own, lead, manage, achieve and account for their national development priorities, especially those related to the ICPD-goals and corresponding MDG-targets.

In the context of the GPRHCS, capacity development involves everything done to help the country develop, manage and maintain RHCS in a sustainable manner. In effect, it involves all support provided at all levels, excluding actual RH commodities. The objective of capacity development is to achieve RHCS at the country level.

Table 28: Breakdown of capacity development expenditures 2009-2010 (US$)

Description	2009	Percent	2010	Percent
Africa Regional Office	875,589	5.2%	1,523,808	4.8%
Arab States Regional Office	99,593	0.6%	104,651	0.3%
Asia and the Pacific Regional Office	756,783	4.5%	805,949	2.5%
Eastern Europe and Central Asia Regional Office	180,316	1.1%	310,573	1.0%
Latin America and the Caribbean Regional Office	640,754	3.8%	1,482,512	4.7%
Country level	12.482,476	74.2%	23,946,158	75.4%
Global level	775,388	4.6%	1,783,722	5.6%
Prequalification and Access RH project	1,019,302	6.1%	1,822,731	5.7%
TOTAL	**16,830,201**	**-**	**31,780,105**	**-**

*Figures are provisional

Of the roughly $32 million expended on capacity development, the majority 75 percent was spent at the country level. Country-level support was directed to strengthening their distribution systems, advocating for resources, creating demand and other activities.

Some 13 percent was expended at the regional level, largely for building the capacity of institutions to provide technical assistance. This was the case in Latin America and the Caribbean, where with CIES and PRISMA and others, RH was institutionalized within institutions and within various curricula.

The 6 percent of funds expended at the global level were largely for the in-depth studies conducted in nine UNFPA Category A countries, Access RH, and the prequalification activities of the Procurement Services Branch in Copenhagen. The GPRHCS allocated a total of $6 million in 2010 to Access RH. However, this is only partially reflected in the table; most of this expenditure will be rolled over to 2011.

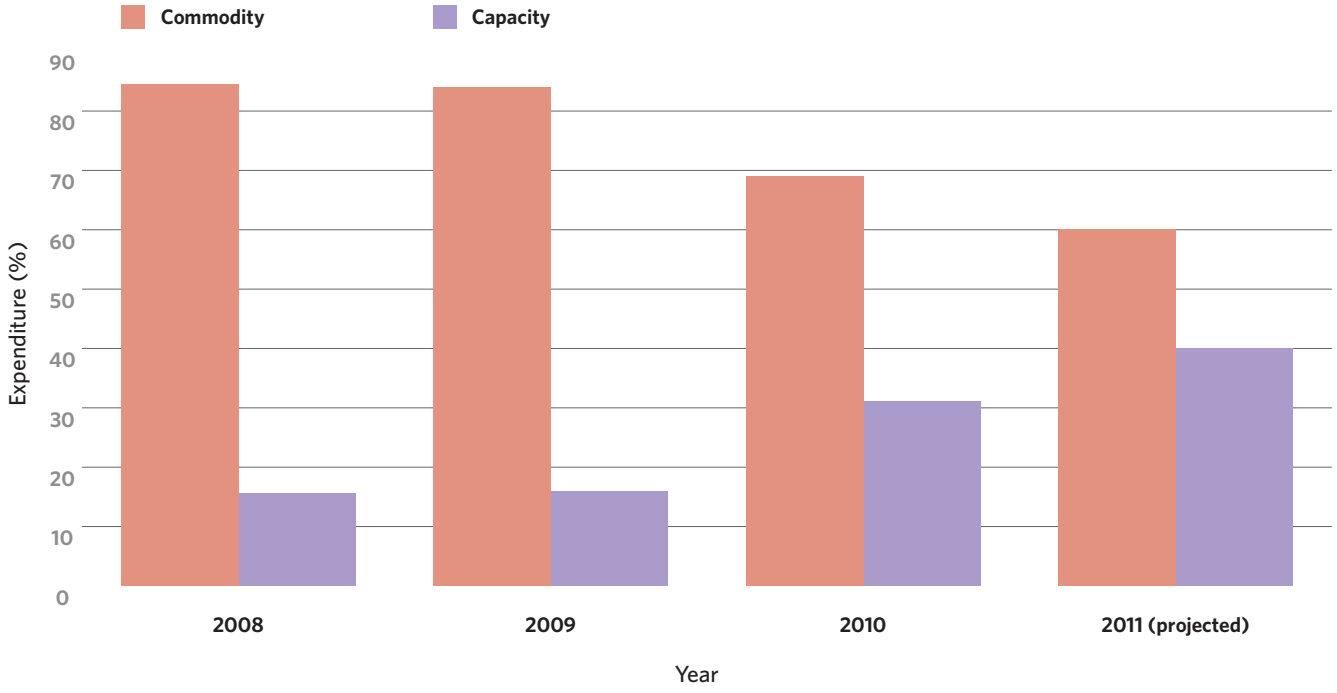
Table 27 compares expenditures in 2009 to expenditures in 2010. Expenditure on capacity development nearly doubled from 19.3 percent in 2009 to 34 percent in 2010. (At the same time, expenditure on commodities provision decreased by 13 percent from 70 million in 2009 to 61 million in 2010.)

6.3 Trends in commodity provision and capacity development

Given the importance of supporting countries to lead, manage and achieve their RHCS systems in a sustainable manner, capacity development is a major priority of the GPRHCS. From budget lines in the national level to logistics management information systems, GPRHCS has been encouraging countries to emphasize and building to lessen dependence on donors and to build their own sustainable system,. In view of that, a review of expenditures has been undertaken in light of capacity development. A major goal of the GPRHCS is to support countries in their efforts to build sustainable systems of their own, and not only to depend on the global donor community for the provision of commodities.

In each of the last three years of the GPRHCS, the percentage of funds used for the purchase of commodities has decreased (see Figure 14). Conversely, the percentage of funds for capacity building activities, including training on RH supplies forecasting and training on advocacy efforts for local fundraising, has increased. Until it is economically viable for countries to sustain the provision of these supplies with their own or local resources, however, a major contribution to the success of countries' family planning, maternal health, and other RH-related initiatives is the direct supply of contraceptives and other medicines.

Figure 14: Percentage of funds spent on commodity versus capacity



A detailed look at commodity vs capacity development expenditure by Streams also showed a clear increase inammount spent on capacity development in Streams 1, 2 and 3 (see Figures 14, 15 and 16).

Overall spending on commodities decreased in 2010 while there was a significant increase in spending for capacity development in 2010, across all Streams. This trend is due to several factors:

- More countries have strategic plans in place that call for capacity development activities;
- Countries are making more requests for capacity support, so with GPRHCS's limited resoruces, there is less avaible for commodities;
- Countries are documenting less commodity stock-outs, suggesting that despite our reduced expenditure on commodities, they have adequate commodity supplies and are able to mobilize resources for commodities from their national budget or from other partnters. Improvements of country capacity to mobilize partners in support of their RHCS agenda is good news.

The figures below illustrate the changes from 2008 to 2010 in commodity and capacity expenditure in the Stream 1, 2 and 3 countries respectively. Stream 1 countries, expenditure for capacity development has also increased since 2008 and similarly for Stream 2 countries. The commodities expenditures decreased starting 2009 to 2010. The expenditure indicated in the following graphs derives solely for stream 1,2, and 3 countries only (without regional offices).

It should be noted that the total expenditures are derived from the annual RHCS financial data submitted by Streams 1, 2 and 3 countries between the months of December 2010 and February 2011. During this period financial closure is in process and the figures were not fully stable yet. Therefore, the data should be seen in the light of this situation.

Figure 15: Trends in Streams 1, 2 and 3 of expenditure related to provision of commodities and capacity development activities from 2008 to projected 2011

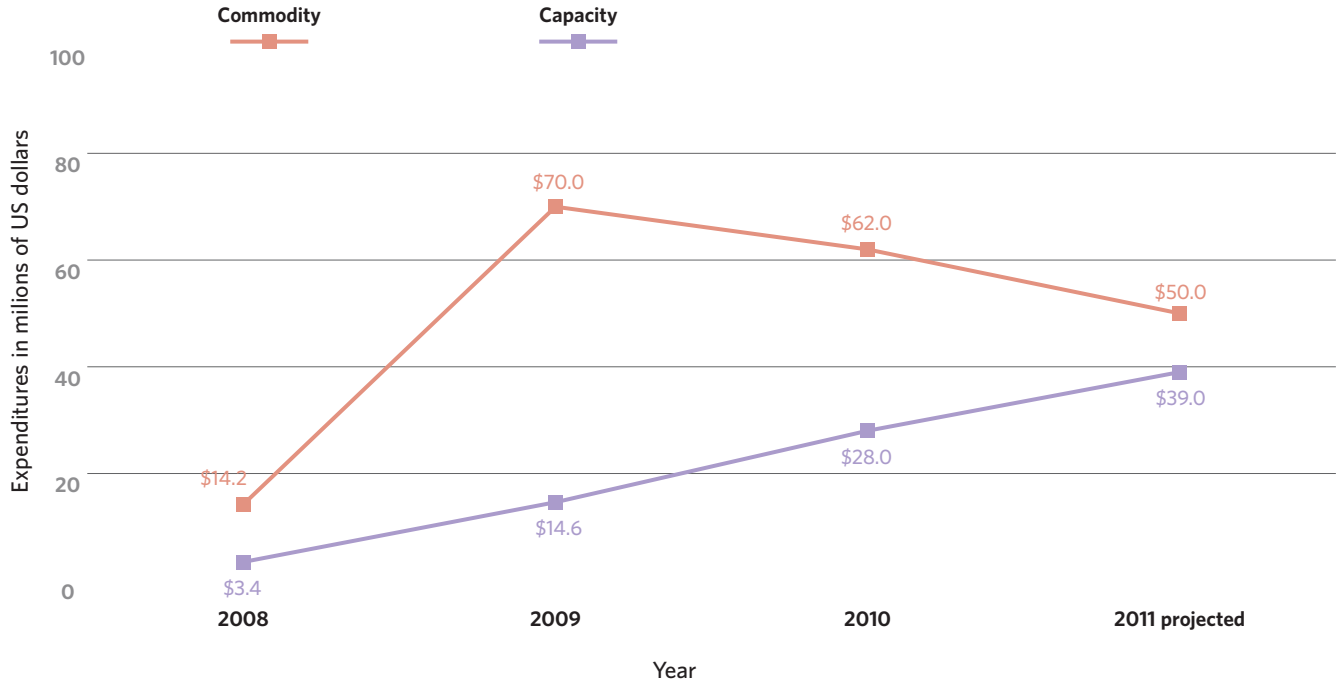


Figure 16: Trends in Stream 1 countries of expenditure related to provision of commodities and capacity development activities from 2008 to projected 2011

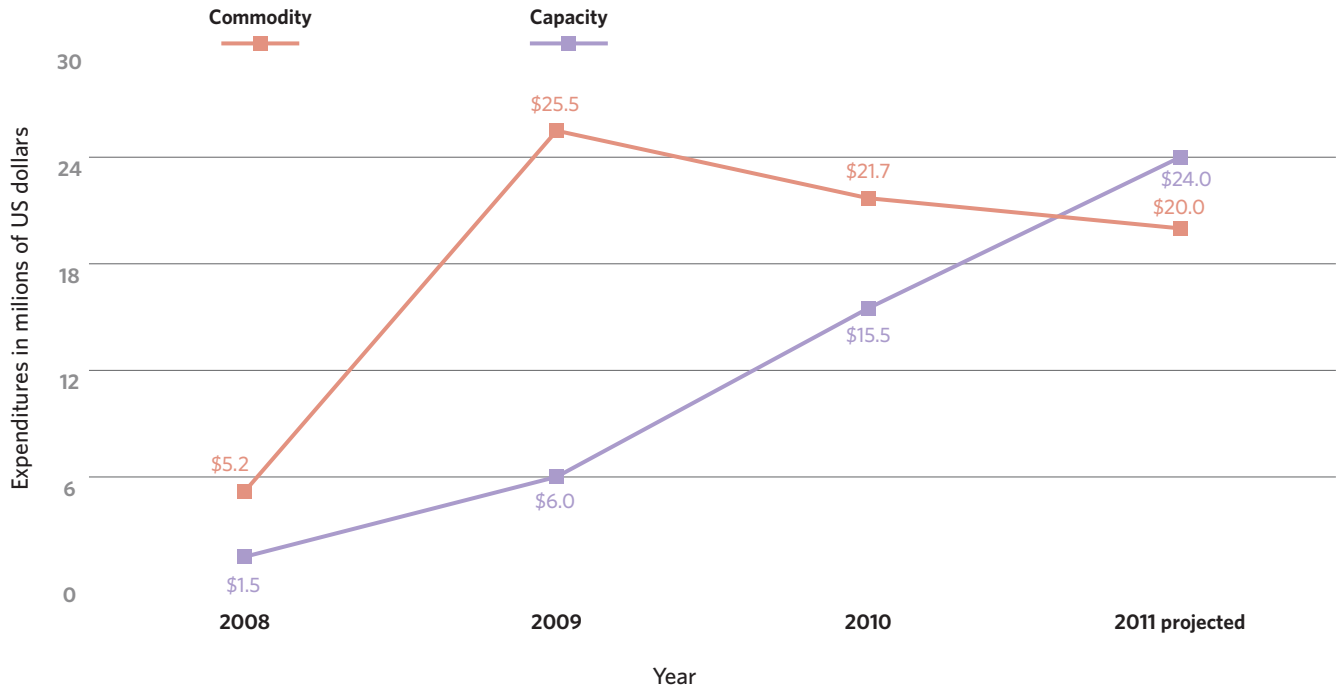


Figure 17: Trends in Stream 2 countries of commodity provision and capacity expenditure

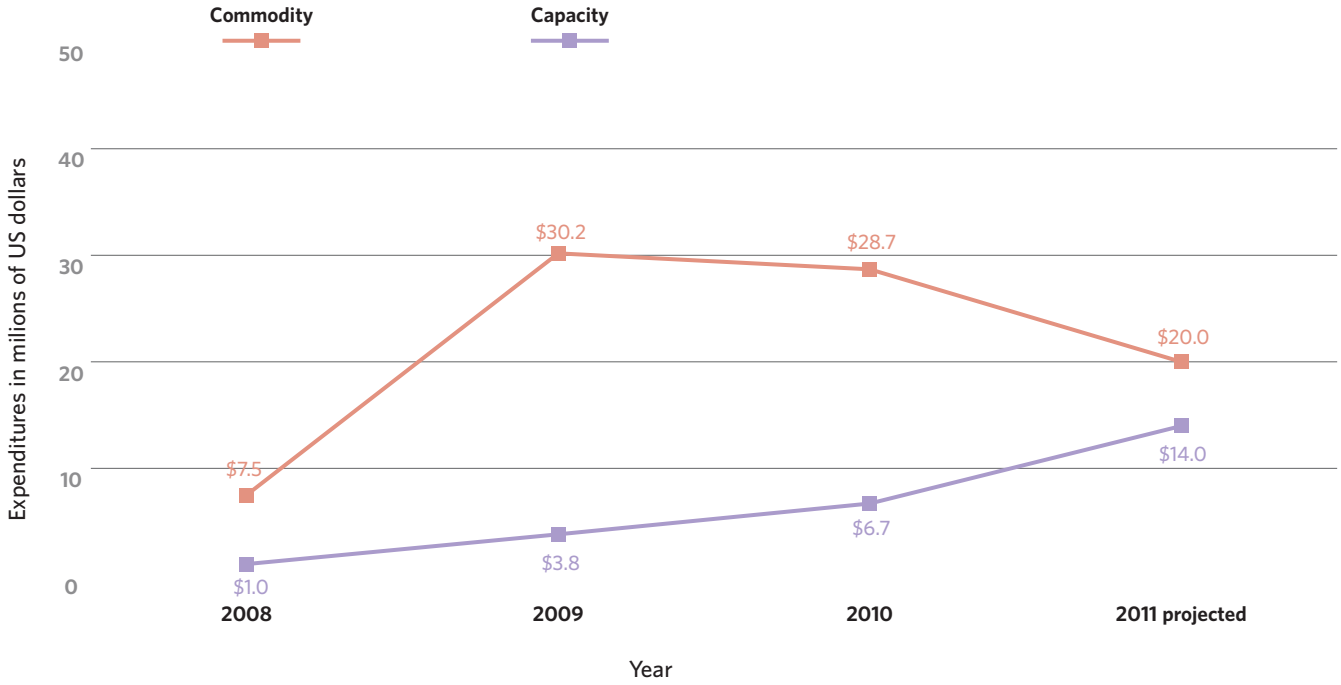
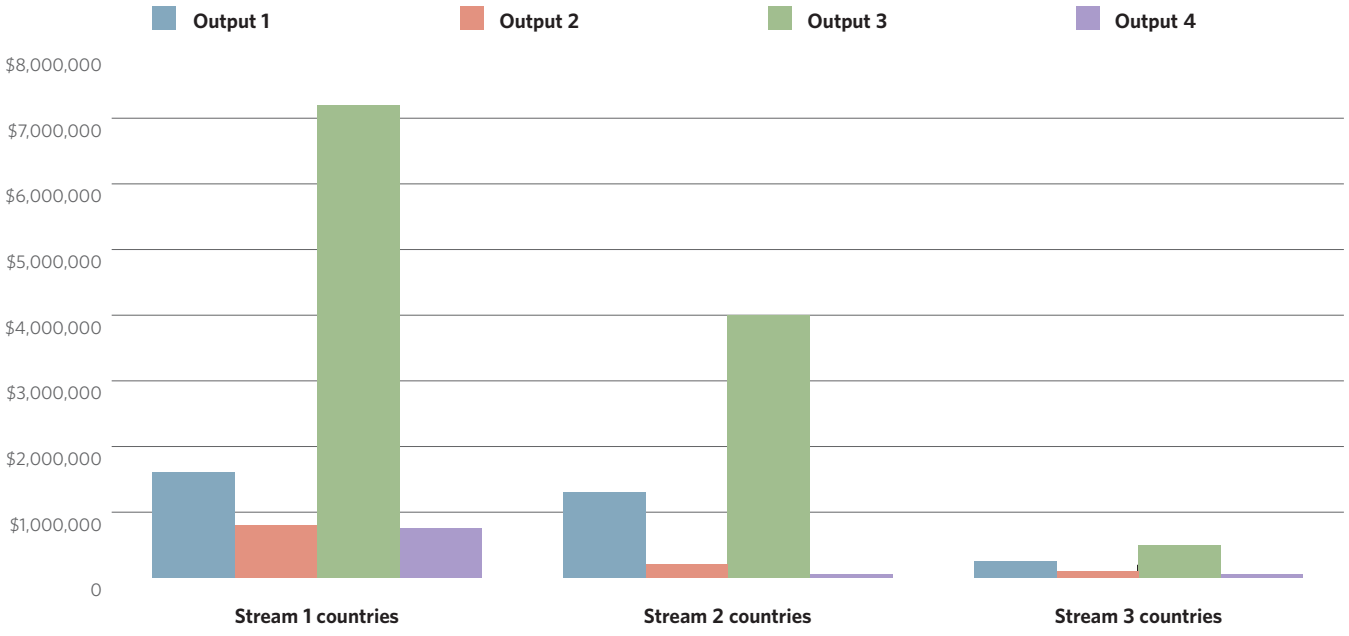


Figure 18: Linking results and resources by GPRHCS outputs



*Figures are provisional

6.4 Linking resources to results

UNFPA places great priority on results-based programming. A results-based framework was developed for the GPRHCS. But what remained a challenge in the past two years was to understand the relationship between the results being documented and the funds being expended. In this regard, a template was developed that asked countries to show how activities contributed to achieved outputs and results, along with the cost of those activities. This information was carefully analysed for 2010 and is presented here. The analysis was conducted separately for funding streams 1, 2 and 3. The analysis looked at the 'output' level results in the GPRHCS Performance Monitoring Framework, for the four outputs:

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

By far, most funds were linked to results in Output 3, Capacity and Systems strengthened by RHCS. This was so in all streams, and particularly in Stream 1. Activities related to Output 3 include, for example, improving the skills of nationals in important logistics functions such as forecasting, procurement and LMIS – which forms the foundation of capacity building for sustainable country-driven systems for the distribution and management of RH commodities.

In second place is expenditure on Output 1, country RHCS strategies, which would reflect the expenditures made on assessing country situation, jointly develop national strategic plans for coordination, and setting up and maintaining national committees.

Output 2, on political and fiscal commitments enhanced, involves activities such as resource mobilization, advocating for inclusion of RHCFS within national strategies and plans, advocacy for budget lines for RH commodities. These activities may not be frequent or cost-intensive.

Not surprisingly, the least amount of funds were spent on Output 2, as many of the activities are integral to UNFPA and UN process and do not need additional funding. For example, activities such as participating in UN joint processes at country level such as UNDAF and CCA and developing country programmes.

SECTION SEVEN

CHALLENGES AND LESSONS LEARNED

Fatimata, 20, waters vegetables in Burkina Faso.
Photo by Aubrey Wade/Panos Pictures.

Results achieved in RHCS in 2010 are strong, yet in many countries the systems remain weak and many challenges stand in the way of a secure, reliable supply of reproductive health commodities sufficient to support national goals for reproductive health.

An important activity of the GPRHCS is to advocate with policy makers, parliamentarians and partners in government for the integration of RHCS in national policies, strategies and plans; for the establishment of budget lines for reproductive health commodities; and for the inclusion of RH commodities within essential medicines' lists. Progress in mobilizing resources in 2010 was hindered by the global financial and economic crisis. Even in countries where budget lines exist, funds were restricted as in Burkina Faso, where the total allocated was revised downwards. Overall, there were less funds available to commit to previous pledges or commitments. Also, donor resources were not available early in the year in some cases, meaning that late contributions cannot be used but have to be programmed for the next year. On the Global Programme's part, the late release of funds for some of the countries in 2010 was exacerbated by the delay in submission of new joint workplans with UNFPA's Maternal Health Thematic Trust Fund, and delays in the submission of country financial reports. These issues have however been addressed in 2011. For the future, some countries expressed concern that fewer resources may be available to RHCS as governments move towards free maternal and child health services, a concern noted by Lao PDR, Madagascar, Mongolia and Sierra Leone.

Humanitarian and natural disasters affected several countries in the Global Programme. The earthquake that struck Haiti in January 2010 reduced much of the capital to rubble and claimed more than 300,000 lives, according to government estimates. Also, severe weather seriously affected Mongolia, with weeks of freezing temperatures leading to a humanitarian emergency. Countries as diverse as Madagascar, Nicaragua and Niger reported obstacles related to political upheaval, citing a need to respond to changes in staffing and in national policies.

The Global Programme continued to work to strengthen the delivery system to ensure reliable supply including community-based distribution, logistics information and management. However, many national health systems remain week and fragmented and are unable to provide routine data that would support monitoring of interventions in the country. For this reason, the GPRHCS funded surveys in all Stream 1 countries. Mozambique, Lao PDR and Sierra Leone noted challenges related to the ongoing efforts to unify supply systems for more unified RHCS logistics. Many governments continued this process of establishing comprehensive, integrated commodity logistics systems – a resource-intensive process requiring sufficient capacity to ensure effective coordination of all stakeholders – though in some cases such systems are still in the early stages. Requests for RH commodities continued to exceed GPRHCS resources, but more investment had to be made in capacity development since this is an investment in building sustainable national systems that rely less on external international assistance.

In terms of procurement, much was accomplished through efforts to procure and purchase contraceptives and other essential supplies and promote their use through social marketing. Yet there were delays related to procurement. Delays and weaknesses in national procurement processes were cited by several countries as reasons for stock-outs. GPRHCS supported the efforts of governments to identify their procurement capacity needs, and provided capacity development assistance. Overall, distribution of RH commodities at the district and sub-district levels continued to pose a serious challenge for many countries, compounded by difficult terrain or poor physical infrastructure.

The shortage of qualified professional staff – human resources capacity – was another major constraint in the management of supplies and the delivery of services. High turnover in government staff, lack of backstopping at decentralized levels, and staff shortages in ministries of health are among the challenges. The GPRHCS continued to support training to build skills at every step, from forecasting need to providing quality information and services in family planning and maternal health, and to support demand generation activities.

RHCS coordination bodies, which play a key role in linking governments and partners, continued to need more sustainable mechanisms to support their work. Such committees or groups enable harmonization of aid and synergy with other initiatives in reproductive health, yet support for their important activities has proven difficult in resource-constrained settings.

A number of countries intensified their outreach to poor and vulnerable populations, including young people, with activities targeted towards their high unmet need for family planning. This vast endeavor remains, like the need to improve monitoring and evaluation, an ongoing priority. Effective monitoring and evaluations is critical for tracking the results of interventions and for deriving lessons learned for future programming. In 2010, a deliberate emphasis on the GPRHCS results-based framework has helped to identify and elaborate real achievements by countries in the Global Programme this year.

CONCLUSION

MOVING FORWARD

Mother in Mongolia breastfeeding her baby.
Photo by Giacomo Pirozzi/Panos Pictures

This was a landmark year for the GPRHCS – a year in which implementation reached unprecedented levels in both the Stream 1 and 2 countries; a year in which the value added of this support to countries has been very clearly demonstrated; and a year in which the programme was able to track progress and achievements much more comprehensively using the finalized GPRHCS monitoring and evaluation framework.

With a clearer accounting of results, an improved understanding of progress is also contributing substantially to currently ongoing discussions both within and outside the organization on the future directions of the programme, including priorities which need to be addressed between now and the end of the GPRHCS in 2013, and key elements which may need to be part of the programme's new generation.

The GPRHCS will continue to work with governments and partners to improve RHCS in a focused manner within the Streams 1 and 2 countries receiving support. The focus will be on continuing to develop sustainable approaches to RHCS as part of overall health sector reform, and in building a stronger foundation for more permanent and lasting solutions to RHCS. Efforts at results based management and reporting will continue and lessons learnt within the past two years will be used to improve management. Interventions within the focus countries will continue to be closely monitored and in collaboration with other partners, support will be provided where necessary. Efforts within countries to ensure more effective distribution below the district to the community level will be intensified.

Support to a few Stream 3 countries will continue to be necessary due to the unexpected and devastating nature of so many humanitarian situations and natural disasters, and the weak infrastructure in many countries. However, some Stream 3 countries are building up their capacity to achieve RHCS and may be selected for Stream 2 in the coming years. At the same time, however, the GPRHCS will finalize its gradual exit strategy for countries as they no longer need targeted support and become ready to graduate.

Ensuring the availability and utilization of family planning information and services has always been a priority for UNFPA and continues to be a priority for the GPRHCS. In this regard, UNFPA's pledge to contribute to the global HANDtoHAND campaign remains and will involve supporting Streams 1 and 2 countries to attain at least 2 percentage points increase in CPR per year. We will also continue to work with partners such as the H4, particularly UNICEF, to support country efforts at putting in place integrated commodity supply systems.

Evidence of increasing government commitment to RHCS is being seen in many countries and hopefully will continue to rise so that the reliance on external funding can lessen. In the interim however, additional funding will continue to be required for the foreseeable future. The need for expanding the GPRHCS donor base remains a key priority and efforts in this regard will intensify in 2011. In support of this, the substantial results of achievements from counties with the support of the GPRHCS will be documented and widely shared.

In conclusion, the GPRHCS plans to continue in line with UNFPA's Strategic Plan to ensure access to and use of quality reproductive health commodities, supplies and medicines, as part of the overall effort to reduce the number of maternal and newborn deaths, halt the spread of HIV/AIDS and improve the overall sexual and reproductive health and rights of women, men and young people particularly within the countries most in need.

Annex 1: Contraceptives provided to Stream 2 and 3 countries

Table 29: Contraceptives provided to Stream 2 countries in 2010

Description	Male condom (pieces)	Female condom (pieces)	Injectable (vials)	IUD (pieces)	Combined oral (cycles)	Progestin Oral (cycles)	Implant (pieces)	Cost (US$)
Benin			6,000	3,200	48,600	300	27,832	700,538
Bolivia	912,754		427,763	27,948	174,568			545,465
Burundi	2,901,600	200,000					60,000	1,667,566
Caribbean			51,000	2,500	78,603			91,280
Central African Republic	2,317,440	170,000	170,000	5,477	452,700	28,243		663,054
Chad	3,000,000	4,000	6,500				1,000	122,904
Republic of the Congo			23,000	1,000	162,285	40,572	500	124,392
Democratic Republic of the Congo	30,672,000		1,230,000			40,600		2,184,005
Côte d'Ivoire	10,000,000	300,000	211,483	4,000	105,000	32,000	7,795	1,106,474
Ecuador	8,640,000	20,000		112,500	2,100,000	600,000	20,000	1,998,732
Eritrea	3,600,000		30,000	3,000	30,000		1,000	171,960
Gambia	1,000,080		80,000		200,001	200,000	100	303,843
Ghana		100,000	800,000				10,000	1,272,000
Guinea	600,000	100,000	150,000	1,700	310,000	120,000	1,000	458,220
Guinea-Bissau	2,880,000	5,000	20,000	20,000	19,982	14,003	7,500	314,586
Jamaica			100,000		50,000		1,500	157,200
Kyrgyzstan		20,000		90,000	30,000	30,000		97,200
Lesotho			200,000		178,000			274,224
Liberia			48,000				1,000	72,384
Malawi		800,000	1,700,000		625,700			2,544,886
Mauritania	2,160,000	15,000	11,200	7,000	281,000	291,000	4,000	461,774
Namibia		200,000	183,400					331,478
Nigeria	36,000,000	206,700	350,000	30,000			8,214	2,022,360
Sao Tome	2,872,080		6,158		7,728			92,076
Senegal			800,000	5,100			3,700	898,260
Sudan		5,000	7,000		33,000	23,000		36,816
Swaziland	4,500,000	120,945		2,260			2,600	280,436
Tajikistan			223,230		932,400	197,400	17,750	1,170,720
Timor Leste				3,000	15,000	10,002		13,441
Turkmenistan		10,000			35,000	15,000		29,760
Uganda	15,000,000	200,000		56,700	750,000		47,000	2,044,020
Uzbekistan	3,675,916		409,859	1,529,377	784,877	336,376		1,942,540
Yemen	147,888		214,812	22,000	1,863,150	1,195,533	3,251	1,732,113
Zambia		950,000						684,000
Zimbabwe			18,000	1,800			8,750	229,224
Total								**$26,839,931**

Table 30: Contraceptives provided to Stream 3 countries in 2010

Description	Male condom (pieces)	Female condom (pieces)	Injectable (vials)	IUD (pieces)	Combined oral (cycles)	Progestin Oral (cycles)	Implant (pieces)	Cost (US$)
Algeria				30,000				18,000
Cameroon	7,200,000	100,000	200,000	5,500	500,000		10,000	928,260
Cape Verde	100,000	9,000	70,000	1,000	150,000	20,000		152,760
Comoros	462,240		41,400		30,000			99,079
Dominican Republic			220,000		500,000		3,000	497,760
Equatorial Guinea	1,000,000	10,000	10,000	1,500	10,000	10,000	625	75,420
Honduras	11,000,000		600,000	12,000	650,000			1,194,000
Iraq					600,000			244,800
Kazakhstan	144,000		9,000	20,000	10,000			29,299
Kenya			327,000	92,000	570,000		70,000	2,297,376
Kosov	1,000,080		15,000		100,000			84,722
Mauritius	1,400,000	20,000			130,000		400	117,360
Myanmar	936,000		250,000	10,000	295,002			405,318
Peru		20,000						14,400
Rwanda	6,599,952							190,079
Sri Lanka		50,000					15,000	396,000
Tanzania			400,000				30,000	1,123,200
Togo		3,000	80,000	11,400	8,010	6,000	5,000	216,220
Total								**$8,084,053**

Annex 2: Male and female condoms provided to Stream 2 and 3 countries

Table 31: Male and female condoms provided to Stream 2 countries in 2010

Countries	Male Condoms	Female Condoms
Cameroon	7,200,000	100,000
Cape Verde	100,000	9,000
Comoros	462,240	-
Equatorial Guinea	1,000,000	10,000
Honduras	11,000,000	-
Kazakhstan	144,000	-
Kosova	1,000,080	-
Mauritius	1,400,000	20,000
Myanmar	936,000	-
Peru	-	20,000
Rwanda	6,599,952	-
Sri Lanka	-	50,000
Togo	-	3,000
Total	**29,842,272**	**212,000**

Table 32: Contraceptives provided to Stream 3 countries in 2010

Countries	Male Condoms	Female Condoms
Cameroon	7,200,000	100,000
Cape Verde	100,000	9,000
Comoros	462,240	-
Equatorial Guinea	1,000,000	10,000
Honduras	11,000,000	-
Kazakhstan	144,000	-
Kosova	1,000,080	-
Mauritius	1,400,000	20,000
Myanmar	936,000	-
Peru	-	20,000
Rwanda	6,599,952	-
Sri Lanka	-	50,000
Togo	-	3,000
Total	**29,842,272**	**212,000**

Annex 3: Estimates for ABR, MMR, CPR and unmet need

Table 33: Estimates for adolescent birth rate, maternal mortality ratio, contraceptive prevalence rate and unmet need for family planning

	Country	Adolescent birth* rate		Maternal mortality ratio**		Contraceptive prevalence rate*			Unmet need*			
		Year	Per 1,000 women 15-19	Year	Per 100,000 live births	Year	Any method (%)	Modern method (%)	Year	Total (%)	Spacing (%)	Limiting (%)
1	**Burkina Faso**	2001	131.0	2008	560	2006	17.4	13.3	2003	28.8	21.8	7.0
2	**Ethiopia**	2003	109.1	2008	470	2005	14.7	13.7	2005	33.8	20.1	13.7
3	**Haiti**	2003	68.6	2008	300	2006	32.0	23.6	2006	37.5	17.0	20.4
4	**Lao PDR**	2005	110.0	2008	580	2000	32.2	28.9	2000	39.5	10.5	29.0
5	**Madagascar**	2008	148.0	2008	440	2009	39.9	28.2	2004	23.6	11.3	12.3
6	**Mali**	2004	190.0	2008	830	2006	8.2	6.3	2006	31.2	21.4	9.8
7	**Mongolia**	2007	18.5	2008	65	2005	66.0	60.6	2003	4.6	2.0	2.6
8	**Mozambique**	2001	185.0	2008	550	2004	16.5	11.8	2004	18.4	10.8	7.5
9	**Nicaragua**	2005	108.5	2008	100	2007	72.4	68.8	2007	7.5	-	-
10	**Niger**	2004	198.9	2008	820	2006	11.2	5.0	2006	15.8	13.3	2.5
11	**Sierra Leone**	2006	143.0	2008	970	2008	8.2	6.0	2008	27.6	16.4	11.2
12	**Benin**	2004	114.0	2008	410	2006	17.0	5.9	2006	29.9	17.6	12.3
13	**Bolivia**	2006	89.0	2008	180	2008	60.6	33.8	2008	20.2	6.4	13.8
14	**Botswana**	2006	51.0	2008	190	2000	44.4	42.1	-	-	-	-
15	**Burundi**	2001	30.0	2008	970	2006	9.1	7.5	2002	29.0	-	-
16	**Central African Republic**	2003	132.9	2008	850	2006	19.0	8.6	1995	16.2	11.6	4.6
17	**Chad**	2002	193.0	2008	1200	2004	2.8	1.7	2004	23.3	19.2	4.1
18	**Congo**	2003	131.5	2008	850	2005	44.3	12.7	2005	16.2	13.0	3.2
19	**Côte d'Ivoire**	2006	111.1	2008	470	2006	12.9	8.0	1999	27.7	20.0	7.6
20	**DRC**	2005	127.0	2008	690	2007	20.6	5.8	2007	24.4	19.4	5.0
21	**Djibouti**	2000	27.0	2008	300	2006	17.8	17.1	-	-	-	-
22	**Ecuador**	2002	100.0	2008	140	2004	72.7	58.0	2004	7.4	-	-
23	**Eritrea**	2000	85.0	2008	280	2002	8.0	5.1	2002	27.0	21.0	6.0
24	**Gabon**	1998	144.0	2008	260	2000	32.7	11.8	2000	28.0	19.9	8.0
25	**Gambia**	2000	103.9	2008	400	2001	17.5	12.7	-	-	-	-
26	**Ghana**	2006	70.0	2008	350	2008	23.5	16.6	2008	35.3	22.5	12.9
27	**Guinea**	2003	153.0	2008	680	2005	9.1	4.0	2005	21.2	13.1	8.1
28	**Guinea-Bissau**	2000	170.0	2008	1000	2006	10.3	6.1	-	-	-	-
29	**Lesotho**	2003	98.0	2008	530	2005	37.3	35.2	2005	30.9	10.9	20.0

(continued)

(Table 33 continued)

	Country	Adolescent birth* rate		Maternal mortality ratio**		Contraceptive prevalence rate*			Unmet need*			
		Year	Per 1,000 women 15-19	Year	Per 100,000 live births	Year	Any method (%)	Modern method (%)	Year	Total (%)	Spacing (%)	Limiting (%)
30	**Liberia**	2007	177.0	2008	990	2007	11.4	10.3	2007	35.6	24.6	11.0
31	**Malawi**	2005	178.0	2008	510	2006	41.0	38.4	2004	27.6	17.2	10.4
32	**Mali**	2004	190.0	2008	830	2006	8.2	6.3	2006	31.2	21.4	9.8
33	**Mauritania**	2002	88.0	2008	550	2007	9.3	8.0	2001	31.6	22.9	8.6
34	**Namibia**	2004	74.0	2008	180	2007	55.1	53.5	2007	6.7	3.8	2.9
35	**Nigeria**	2006	123.0	2008	840	2008	14.6	8.1	2008	20.2	15.0	5.2
36	**Papua New Guinea**	2000	70.0	2008	250	1996	25.9	19.6	-	-	-	-
37	**Sao Tome and Principe**	2001	91.0	2008		2000	29.3	27.4	-	-	-	-
38	**Senegal**	2007	96.0	2008	410	2005	11.8	10.0	2005	31.6	24.3	7.3
39	**Sudan**	1997	72.0	2008	750	2006	7.6	5.7	1993	26.0	-	-
40	**Swaziland**	2004	111.0	2008	420	2007	50.6	46.8	2007	24.0	7.4	16.7
41	**Timor-Leste**	2004	59.2	2008	370	2003	10.0	7.0	2003	3.8	3.7	0.1
42	**Uganda**	2004	159.0	2008	430	2006	23.7	17.9	2006	40.6	24.5	16.1
43	**Yemen**	2005	80.0	2008	210	2006	27.7	19.2	1997	38.6	17.2	21.4
44	**Zambia**	2005	151.0	2008	470	2007	40.8	26.5	2007	26.5	17.1	9.4
45	**Zimbabwe**	2003	101.3	2008	790	2006	60.2	57.9	2006	12.8	7.7	5.1

* Population and Development Branch, Have we progressed on MDG4b? The empirical evidence in advancing Universal Access to Reproductive Health Technical Division, UNFPA New York, June 2010

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

Annex 4: GPRHCS Global Performance Monitoring Framework

Commodity Security Branch, Technical Division, UNFPA

Global Programme to Enhance RHCS 2008-2013: Global Performance Monitoring Framework

	Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data	Milestone(s) (data/end 2010)	Target (data/end 2013)	Source of data
Goal[1] : Universal access to Reproductive Health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life						
	Adolescent birth rate					
	Maternal mortality rate					
	Youth HIV prevalence rate					
Outcome indicators						
1.	Average unmet need for family planning (45 countries)					
2.	Average Contraceptive prevalence rate of modern methods (45 countries)					
3.	No. of Stream 1 countries with Service Delivery Points (SDPs) offering at least three modern methods of contraceptives					
4.	No. of stream 1 countries where 5 life-saving maternal /RH medicines from UNFPA list[2] are available in all facilities providing delivery services					
5.	No. of Stream 1 countries with Service Delivery Points with 'no stock outs' of contraceptives within last 6 months[3]					
6.	Funding available globally for contraceptives / condoms					

1 Goal and Goal indicators, and Outcome indicators 1, 2 and 3 are from UNFPA Development Results Framework (DRF) 2008-2013

2 UNFPA list for life-saving maternal/RH medicines list contains 10 UNFPA medicines

3 Number of FP service delivery points in GPRHCS stream 1 countries that experienced 'no stock out' of one or more of the modern methods of contraceptives expected to be provided by that point at any time during the last 6 months. To meet this indicator at least 60% of the service delivery points at each level should have "no stock outs" in last 6 months. The analysis will include the geographically disaggregated data from central, provincial, and up to the district level SDPs (or country specific distribution of equivalent levels.)

(Global Programme to Enhance RHCS 2008-2013: Global Performance Monitoring Framework continued)

	Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data	Milestone(s) (data/end 2010)	Target (data/end 2013)	Source of data
Output 1: Country RHCS strategic plans developed, co-ordinated and implemented by government with their partners						
1.	Number of countries where RHCS strategy is integrated with national RH/SRH, HIV/AIDS, Gender, & Reproductive Rights strategies (45 countries)					
2.	Number of countries with strategy implemented (National strategy/action plan for RHCS implemented) (45 countries)					
3.	Number of countries with functional coordination mechanism on RHCS or RHCS is included in broader coordination mechanism (45 countries)					
4.	Number of countries with essential RH commodities in EML (Contraceptives and life saving maternal/RH medicines in EML) (45 countries)					
1.	Funding mobilised for GPRHCS on a reliable basis (e.g. multi-year pledges)					
2.	UNFPA signed MOUs with Stream 1 country governments					
3.	RHCS mainstreamed in regional policies and strategies through UNFPA work with global, bilateral and regional organizations/ partners (Regional Economic Communities)					
4.	Number of countries included RHCS priorities (45 countries) in a. PRS b. Health sector policy and plan					
5.	Number of countries maintaining allocation within SRH/RHCs budget line for contraceptives (45 countries)					
Output 3: Capacity and systems strengthened for RHCS						
1.	Number of countries using AccessRH[4] for procurement of RHCS resulting 20% reduction in lead time (45 countries)					
2.	Number of pre-qualified suppliers of IUDs and condoms for use by UNFPA and partners					
3.	Number of Stream 1 countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian)					

[4] AccessRH initiative will offer: a. affordable, high quality RHCs to meet public sector needs, b. improve delivery times to clients needs, c. contraceptive order and shipment information available to countries. By decreasing the lead time and ensuring quality with competitive lower prices will have 'value for money' to the clients

(Global Programme to Enhance RHCS 2008-2013: Global Performance Monitoring Framework continued)

	Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data	Milestone(s) (data/end 2010)	Target (data/end 2013)	Source of data
Output 3: Capacity and systems strengthened for RHCS						
4.	Number of Stream 1 countries forecasting for RHCS using national technical expertise					
5.	Number of Stream 1 countries managing procurement process with national technical expertise					
6.	No of Stream 1 countries with functioning Logistics Management Information System (LMIS)					
7.	Number of Stream 1 countries with coordinated approach towards integrated health supplies management system					
8,	Number of stream 1 countries adopting/ adapting a Health Supply Chain Management information tool (e.g. CHANNEL, PIPELINE) into national system					
Output 4: RHCs mainstreamed into UNFPA core business (UN reform environment)						
1.	Expenditure of UNFPA /CSB core resources for RHCS increased					
2.	GPRHCS planning takes into account lessons learned in RHCS mainstreaming (45 countries)					
3.	Number of countries with RHCS priorities included in (45 countries): a. CCA[5] b. UNDAF[5] c. CPD d. CPAP					
4.	Number of UNFPA Country Offices with increasing funds allocated to RHCS (45 countries)					
5.	Number of countries with all the relevant joint UN programmes for SRH and MNH that include RHCS (45 countries)					
6.	Number of national/regional institutions providing quality technical assistance on RHCS in the areas of Training and Workshops, Advocacy, Monitoring & Progress Reviews, and Programme Development with countries (1 in each of 5 regions)					

[5] Note that CCA and UNDAF are renewed every five years. Some of the target countries may not be doing their next CCA and UNDAF in this phase (particularly CCA). However, the targets would be 100% of those countries doing CCAs and UNDAFs during this phase.

(Global Programme to Enhance RHCS 2008-2013: Global Performance Monitoring Framework continued)

	Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data	Milestone(s) (data/end 2010)	Target (data/end 2013)	Source of data
	Advocacy, Monitoring & Progress Reviews, and Programme Development with countries (1 in each of 5 regions)					
Programme Management[6]						
1.	Number of countries achieving at least 60% of workplan outputs (45 countries)					
2.	Number of Country Offices with completed and budgeted Annual Workplan by end of December each year (45 countries)					
3.	Number of Country Offices submitting mid-year progress report to respective regional offices by 15 June each year (45 countries)					
4.	Number of Country Offices submitting completed annual narrative program report to respective Regional Offices by 15 December (45 countries)					
5.	Number of Country Offices submitting completed financial report to respective Regional Offices by 15 December (45 countries)					
6.	Number of Regional Offices submitting reviewed AWPs to Technical Division/ HQ by mid January (5 Regional Offices)					
7.	Number of Regional Offices submitting mid-year report by mid July and annual report of mid January to Technical Division/HQ (5 Regional Offices)					
8.	Country work plans reviewed and allocation made by HQ by 1st week of March[7]					
9.	Semi annual and annual progress review/planning meeting organized for all GPRHCS Stream 1 counties by CSB/TD					
10.	Consolidated annual GPRHCS report (programmatic and financial) prepared by end of March of following year by HQ					

6 This section monitors the completeness and timeliness of management oversight activities

7 At least 80% of all Annual Work Plans will be reviewed and funds will be allocated to meet this indicator

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