Moving in the Right Direction: Results of a Global Survey of Activities and Processes to Meet Contraceptive Commodity Needs

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CONTENTS

ABBREVIATIONS

ABPF	Benin Association for Family Welfare
ANE	Asia and the Near East
CHPS	Community-based Health and Planning Services
CLMS	Contraceptive Logistics Management System
CS	contraceptive security
CSR	contraceptive self-reliance
DfID	Department for International Development (United Kingdom)
DRC	Democratic Republic of Congo
DRH	Division of Reproductive Health
E&E	Europe and Eurasia
FP	family planning
GHS	Ghana Health Service
HIV	human immunodeficiency virus
HSAF	Health and Social Aid Foundation
ICC/CS	Interagency Coordinating Committee for Contraceptive Security
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
INSS	Nicaraguan Social Security Institute
IUD	intrauterine device
KIDOG	Turkish Network for Women
LAC	Latin America and the Caribbean
LGU	local government unit
MCH	maternal and child health
MIS	Management Information System
MOF	Ministry of Finance
MOH	Ministry of Health
MOHF	Ministry of Health and Family
MOHP	Ministry of Health and Population
MOU	memorandum of understanding
NGO	nongovernmental organization
NHIH	National Health Insurance House
PRODESS	Program for Health and Social Development
PRSP	Poverty Reduction Strategy Paper
RAPID	Resources for the Awareness of Population Impacts on Development
RH	reproductive health
RHAP	Reproductive Health Action Plan
RHCS	reproductive health commodity security
RHSC	Reproductive Health Supplies Coalition
SMC	Social Marketing Corporation
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SSA	sub-Saharan Africa
STI	sexually transmitted infection
SWAp	sector-wide approach
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

INTRODUCTION

In May 2004, the World Bank chaired a two-day meeting of key stakeholders on the subject of contraceptive security (CS) and commodities, which resulted in the formation of the Reproductive Health Supplies Coalition (RHSC). The coalition includes members from governments, bilateral donors, multilateral organizations, private foundations, private sector organizations, and industries.

The coalition serves as a forum to share priorities and perspectives and devise joint strategies and activities to move toward a full supply of reproductive health (RH) commodities. The initial focus is on contraceptives and condoms for STI prevention in developing and transition countries.

The efforts of the RHSC fit into a larger set of activities addressing contraceptive security, including the Supply Initiative, the RHInterchange, UNFPA's Countries at Risk, and activities undertaken by other donor organizations, including the United States Agency for International Development (USAID), the Gates Foundation, the European Community, and the Department for International Development (DfID/United Kingdom).

The RHSC identified several priorities for immediate attention. The first priority is to expand and strengthen awareness-raising, advocacy, and policy dialogue efforts to ensure RH commodities are addressed in national budgets, aid mechanisms such as sector wide approaches (SWAps) and poverty reduction strategy papers (PRSPs), strategic plans and policies, and other country processes (see Appendix 1 for a review of the PRSPs of countries included in this report).

To learn more about how countries have been addressing RH—and family planning (FP) in particular—commodities and where significant advocacy efforts have occurred, the POLICY Project, the International Planned Parenthood Federation (IPPF), and United Nations Population Fund (UNFPA) undertook a global survey of local and international, nongovernmental organizations (NGOs) and public officials. The survey's goal was to gather information on countries' processes and activities aimed at meeting current and future contraceptive commodity needs. This report focuses principally on the results of the survey; however, it also includes complementary findings from additional research on recent and current CS activities.

BACKGROUND

This survey comprised 171 interviews from 47 countries. Respondents included staff from POLICY Project offices, IPPF affiliates, UNFPA offices, NGOs, and the public sector. The majority of the interviews were conducted in sub-Saharan Africa, with 97 surveys returned. The table below lists participating countries; the number of interviews for each country is shown in parentheses. Appendix 2 lists the titles and affiliations of survey respondents.

Participating Countries						
Contraceptive Security Index Scores						
Above 60	55 to 59	50 to 54	45 to 49	40 to 44	Below 40	Not in Index
SSA South Africa (4) **LAC** Jamaica (4) Mexico (3) Peru (1) **ANE** Jordan (1)	**LAC** Ecuador (2) Honduras (3) Nicaragua (1) El Salvador (4) **ANE** Bangladesh (4) Egypt (4) Indonesia (1) Nepal (6) Vietnam (5)	**SSA** Kenya (7) **LAC** Bolivia (1) Guatemala (4)	**SSA** Ghana (5) Malawi (8) Senegal (1) Togo (5) Tanzania (4) Zimbabwe (4) **LAC** Haiti (5) **ANE** Cambodia (3)	**SSA** Benin (5) Eritrea (1) Guinea (1) Mali (4) Mozambique (5) Nigeria (5) Zambia (4)	**SSA** Ethiopa (6) Madagascar (1) Rwanda (1) Uganda (3)	**SSA** Botswana (4) D.R. Congo (1) Lesotho (2) Niger (2) Swaziland (5) **LAC** St.Lucia (3) Trinidad& Tobago (2) **E&E** Romania* Tajikistan (3) Turkey (4) Ukraine (6)

* No interviews were conducted in this country, but some information on its CS activities was available from existing POLICY Project documents.

This report is organized according to the countries' Contraceptive Security Index Scores, which is a composite indicator based on five programmatic areas: supply chain, finance, health and social environment, access to services, and use of services. (More information about the index is available from USAID, the POLICY Project, and the DELIVER Project.) The higher a country's index score, the more effectively it has addressed the five programmatic areas and the closer it should be to achieving contraceptive security. The highest CS index score a country can have is 100; Brazil has the highest index, with a score of 68.1. Index scores are not available for several countries included in the assessment; however, the lack of an index score does not mean that the country is or is not effectively addressing contraceptive security.

Each section of the report includes a matrix on national strategy and funding issues, along with a brief description of each country's CS activities, which is based on input from interview respondents. In general, the matrix is self-explanatory. However, the following brief explanation of abbreviations and symbols will help guide the reader.

Abbreviations and Symbols Used in Tables

A—Country is actively addressing contraceptive security, and advocacy efforts have achieved significant results in making progress toward contraceptive security.
B—Country is addressing contraceptive security, but advocacy efforts have not yet yielded significant results.
C—Country has begun to address contraceptive security, but the issue does not appear to be a priority as relatively little movement is taking place.
Y—Yes
N—No
D—In the process of being developed
?—Based on the interviews, the status of the issue is unclear. When possible we attempted to resolve these uncertainties; however, in many cases, it was not possible to do so.
Y(?) and **N(?)**—appears that response is yes/no, but respondents gave contradictory or inconsistent responses and we were not able to state definitively what the correct response is.
RH policy—National Reproductive Health Policy
Pop policy—National Population Policy
PRSP—Poverty Reduction Strategy Paper
+ These types of linkages are of interest to other ministries.
– These types of linkages did not increase the interest of other ministries.

During the interviews, to help respondents gain a common understanding of awareness raising, advocacy, and policy dialogue, the following standard explanations were provided:

Awareness raising *draws attention to reproductive health commodity security* and sets the stage for policy dialogue and advocacy. It provides stakeholders and policymakers with relevant information of key issues to help them be effective participants in policy dialogue and planning processes. Examples of awareness-raising efforts include information, education, and communication (IEC) and media campaigns to inform the public about the need for the government to help finance contraceptives.

Advocacy is a set of *systematic, targeted actions directed at specific stakeholders and decisionmakers* to promote attention to a policy issue and to influence policy decisions, funding streams, or programs. As a natural complement to awareness-raising activities, advocacy moves issues onto the national policy agenda by building commitment among decisionmakers who, in turn, provide leadership and guidance. For example, civil society organizations or NGOs may develop a strategy to advocate among specific stakeholders, such as the ministers of health and finance, for the establishment of a budget line item for contraceptives.

Policy dialogue *brings together groups of stakeholders* to reach consensus for taking action to improve the availability of RH supplies and to define and debate the merits of policies that emerge from the dialogue. It also builds ownership and commitment within a Ministry of Health, more broadly within government, and even more broadly within society, including the private sector. An example of policy dialogue includes stakeholder roundtable meetings to discuss reproductive health commodity security (RHCS).

The survey was divided into five sections:

National strategies. Questions on the existence of an RHCS strategy and a coordinating committee were included to find out how the country is currently addressing CS issues or whether they are even being addressed. It is presumed that countries with strategies are generally better equipped to begin to procure their own contraceptives because they are thinking about the complexity of the issues.

Funding decisions. Interviewers asked questions about funding—for example, at which level financial allocations are made—to learn about how contraceptives currently fit into health budgets and funding streams. This information elucidates where the decisions are made and how much emphasis CS is given.

Examples of activities to raise awareness, advocate, or stimulate policy dialogue on contraceptive security. Interviewers asked respondents to provide information about awareness-raising, advocacy, and policy dialogue activities, such as the target audience, issues addressed, and when the activity took place. In most cases, respondents gave partial information, usually about the issues addressed and the organizations involved. When respondents did not include activities in their interviews, it is noted in this report. A discussion of activities is included for a few countries that did not participate in the survey; this information was obtained through additional research so the report could include a wider range of activities in each region.

Linkages between CS activities and other health sector issues (including poverty alleviation). Interviewers asked about the inclusion of contraceptive commodities in different strategy documents—national population policies, national RH plans, PRSPs, and SWAps. Addressing the issue of commodity availability in these documents could help establish contraceptive security as a priority for the country. The questions about linking CS activities with efforts to address vulnerable groups, poverty, HIV, and maternal health were included to find out whether the links that might interest a country's Ministry of Finance (MOF) are actually being made. As countries begin to reposition family planning, making these types of links helps to build the case for additional support. (Appendix 3 lists selected FP and RH indicators for the countries surveyed.)

Funding requirements for contraceptives. Interviewers asked respondents if funding requirements for contraceptives had even been estimated for the country. As follow-up questions, interviewers asked about the process through which government resources for family planning are approved, disbursed, and actually spent.

All of this information helps donors understand a country's situation in relation to CS, and consequently, offers insight into how long it will be before countries are able to finance their own contraceptive needs.

SURVEY LIMITATIONS

As with all surveys, this one had limitations:

- Interviewers were not trained on the specific meaning of questions; therefore, they likely interpreted them differently. Furthermore, in some cases, consultants conducted the interviews who may not have fully understood the relevant CS issues.
- Consultants may have had more time than staff employees to spend on this activity, thus eliciting greater detail.
- The survey was lengthy and resulted in time constraints, possibly forcing the interviewers to leave the last questions unanswered or not give them adequate attention.
- Interviews elicited inconsistent answers from respondents in the same country. The survey process unearthed a widespread, fundamental lack of communication in countries. Inconsistencies on the first question about policies demonstrated that people lack full knowledge about the policy environment in their countries. To help resolve these inconsistencies, country experts reviewed and analyzed the data. They made their best attempt to discern what respondents meant and how their answers fit into the larger picture.
- Respondents had different levels of knowledge and expertise on the issues. At times, respondents gave information that was overstated, inaccurate, or not fully informed.

- Respondents appeared to have trouble linking the activities to advocacy. They may have been hesitant to state that an activity led to a specific result. Similarly, they may not have been aware that an activity was developed with specific advocacy messages. Compiling case studies would be an effective way to learn more about the results of specific activities aimed at achieving contraceptive security.

CS INDEX: 60 AND ABOVE

Five countries included in the survey fall into this highest category. **Jamaica** continues to receive donor support for contraceptives but amounts are decreasing. Between 1992 and 1999, contraceptive donations to **Mexico** were phased out. The process occurred over several years and involved the public and private sectors. Now, Mexico is responsible for procuring and distributing contraceptives to its citizens. **Peru**'s Ministry of Health (MOH) contributed 70 percent of the funds for contraceptives in 2003, and in 2005, the MOH contributed 100 percent of funding for commodities. However, funding was insufficient to meet the demand for MOH services. **Jordan** is also moving toward the phaseout of donations. The government has recently begun procuring contraceptives; a CS plan is in place. Between 2004 and 2005, **South Africa** received less than $4,000 in condom donations. This small amount reflects the ability of the government to provide contraceptives using its own resources, as well as the ability of the private sector to fulfill demand. However, due to significant efforts to respond to the high prevalence of HIV in South Africa, relatively little attention is given to family planning.

CS Index: 60 and Above

	Question	Jamaica	Jordan	Mexico	Peru	South Africa
Location	Region	LAC	ANE	LAC	LAC	SSA
Expert Ranking	Grade	A	A	A	A	C
National coordination	National strategy for RHCS	Y	Y	Y	D	N
	Coordinating committee for RHCS	N (?)	Y	N	Y	
Funding mechanisms	Level of allocation decisions	Central, Regional	Central	State	Central	National, Regional, Local
	Country budget including contraceptives	National/ MOH, Regional, National FP Board	National/ MOH	National/ MOH, Regional	National/ MOH	MOH/ National
	Line item for contraceptives	Y	Y	Y	Y	Y
	Pharmaceuticals/ supplies budget includes contraceptives	?	Y	?	N	Y
	List of essential drugs includes contraceptives	?	N	Y	Y	Y
	Document(s) that include funding for contraceptives	Pop. policy, RH policy	Pop. policy, RH policy	RH policy (?)	RH policy	None
Contraceptive security activities	Focus on most vulnerable populations	Y	Y	Y	N	N
	Linkage between CS and poverty reduction	Y+	Y+	Y+	N	N
	Linkage between CS and HIV/AIDS	Y+	Y+	N		Y

CS Index: 60 and Above						
	Question	**Jamaica**	**Jordan**	**Mexico**	**Peru**	**South Africa**
	Linkage between CS and maternal mortality	Y+	Y+	Y+	N	Y
Funding levels	Estimated funds to meet national need for contraceptives	Y	$500,000	Y	Y	N
	Approved funds		All donor funds (with exception of $30K)	Y	$2.8m (2003)	
	Disbursed funds		In progress	Y	$2.8m (2003)	
	Spent funds		In progress	Y	$2.8m (2003)	

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

ACTIVITIES

Jamaica

Marketing campaign for contraceptives. A donor agency in Jamaica sponsored a marketing campaign aimed at physicians, pharmacists, and the general public focusing on the use of all contraceptive methods. This activity examined people's willingness to pay for private sector services, which would reduce the burden on the public sector. As a result, fewer people rely on the public sector and the government is better able to serve those most in need.

Cost recovery and procurement. As donor support for commodities has dwindled, policy dialogue was undertaken to address cost recovery and procurement. As a result, a cost recovery mechanism was approved and the number of clients purchasing contraceptives from public health facilities has increased.

Procurement of condoms. Economies of scale have been maximized by integrating procurement of condoms for family planning and the prevention of sexually transmitted infections (STIs). This resulted in achieving support for funding and the systematic distribution of condoms by one agency to health facilities nationally.

Increasing access to contraception. Advocacy and policy dialogue activities have been implemented to increase access to low dose oral and emergency contraception. These activities addressed the ability to pay for contraceptives, especially by adolescents, along with the need for public facilities to estimate the quantity of commodities to distribute free of charge. As a result, pills were reclassified to allow them to be branded and sold in the private sector without a prescription.

Jordan

RH strategy and allocated funds. Jordan reported implementing policy dialogue and awareness-raising activities to create a Reproductive Health Action Plan (RHAP) to achieve the sustainability of finance and respond to donor phaseout. After adopting the plan, the government allocated funds to implement the plan's activities.

CS workshop. The Higher Population Council held an awareness-raising workshop on contraceptive security to discuss financial requirements, logistics, and potential financing mechanisms. This workshop initiated work around the phaseout strategy and the formation of a CS working group that included representation from the private sector. The working group developed and costed a CS strategy and implementation plan.

Procurement of Depo-Provera. The Supplies Directorate, which handles procurement for the government of Jordan, procured Depo-Provera in 2005 as its first trial procurement of contraceptives. In addition, the Supplies Directorate linked with the MOH's Logistics Unit that has a high-quality management information system (MIS), which will give the Supplies Directorate data for forecasting and program management.

Procurement of condoms. The procurement of Depo-Provera went smoothly; therefore, the Supplies Directorate is expanding its procurement in 2006 to include condoms.

Peru

Goals and activities of the CS plan. In 2004, Peru's CS Committee identified short- and long-term goals and activities in its action plan. They include the following activities that are not reflected in the matrix:

- Continuing to encourage support for FP/RH throughout the country
    - Holding a CS committee meeting with regional presidents to introduce them to CS objectives and a regional plan
    - Forming advocacy groups at the national and regional levels
- Encouraging a more rationally segmented market
    - Conceptualizing and beginning to implement a study on targeting FP resources
- Working with NGOs and the commercial sector (including private insurance) to begin increasing market shares

Mexico

Budgeting for contraceptive commodities. Activities in Mexico have focused on the Annual Operative Programming Workshop to help budget for the purchase of contraceptive commodities within states. Because state resources are budgeted for specific program activities, it is important that budgets explicitly include contraceptive commodities. In the workshop, program-specific budget proposals were introduced as the appropriate methodology for ensuring that all categories of expenses are covered. As a result of this activity, states and localities have estimated the need for contraceptive commodities and included funding in appropriate budgets.

Policy dialogue leads to coordinated buying. Mexican states have coordinated their procurement to obtain a larger volume of contraceptives at a lower price on the international market. Participating states use their own resources to finance the contraceptives. Policy dialogue has led to including NGOs in the procurement process, enabling them to procure contraceptives at a lower price.

South Africa

South Africa did not report activities, and this information was not found through subsequent research.

CS Index: 55 to 59

Nine countries included in the survey fall into this second-highest category. In **Ecuador**, phaseout of donor support occurred abruptly and the public and private sectors had little time to prepare for the transition to procuring commodities on their own. **El Salvador** covered 100 percent of the total annual cost of contraceptives in 2005. In 2003, the **Honduran** MOH contributed 23 percent of the funds that were available for contraceptives. **Nicaragua** is entirely dependent on contraceptive donations. **Bangladesh** has been successfully addressing CS issues, as has **Indonesia**. USAID is scheduled to phase out commodity donations to **Egypt** in 2009, and Egypt is already procuring a portion of its contraceptives. In **Nepal**, capacity for conducting in-country forecasts of commodity needs is increasing. Little is known about the current CS situation in the **Philippines**. The CS initiatives are moving slowly, although USAID still plans to phase out commodity support in 2007.

CS Index: 55 to 59

	Question	Ecuador	El Salvador	Honduras	Nicaragua
Location	Region	LAC	LAC	LAC	LAC
Expert Ranking	Grade	A-	A	B	B+
National coordination	National strategy for RHCS	N	Y	D	D
	Coordinating committee for RHCS	N	Y	Y	Y
Funding mechanisms	Level of allocation decisions	?	Central, Local	Central	None
	Country budget including contraceptives	National/ MOH	National/ MOH, Local	National/ MOH	None
	Line item for contraceptives	?	N	N	N
	Pharmaceuticals/ supplies budget includes contraceptives	Y	Y	Y	N
	List of essential drugs includes contraceptives	Y	Y	Y	Y
	Document(s) that include funding for contraceptives	Pop. policy, PRSP, RH policy(?)	RH policy	Pop. policy, RH policy, PRSP	None
Contraceptive security activities	Focus on most vulnerable populations	N	Y(?)	N	N
	Linkage between CS and poverty reduction	N	N	N	Y+
	Linkage between CS and HIV/AIDS	N	?	N	Y+
	Linkage between CS and maternal mortality	N	Y-	Y+(?)	Y+

CS Index: 55 to 59

	Question	Ecuador	El Salvador	Honduras	Nicaragua
Funding levels	Estimated funds to meet national need for contraceptives	N	$4–4.5m	$921,789 (2004)	Y
	Approved funds	N	$1.8m(?)	Y	N (all donor funds)
	Disbursed funds	N	Y	Y	
	Spent funds	N	90%	$1.3m:donors, $223,000:MOH, $100,000:NGO (2003)	

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

CS Index: 55 to 59

	Question	Bangladesh	Egypt	Indonesia	Nepal	Vietnam
Location	Region	ANE	ANE	ANE	ANE	ANE
Expert Ranking	Grade	A	A	A	B+	B-
National coordination	National strategy for RHCS	Y	D	Y	D	N
	Coordinating committee for RHCS	Y	Y	Y	Y	N
Funding mechanisms	Level of allocation decisions	Central	Central	Central, District	Central	Central, Local
	Country budget including contraceptives	National/ MOH	National/ MOH	National/ MOH	National/ MOH	National/ MOH, Regional/ Provincial
	Line item for contraceptives	N	N	N	N	N
	Pharmaceuticals/ supplies budget includes contraceptives	Y	Y	N	N	?
	List of essential drugs includes contraceptives	?	N	N	N	N
	Document(s) that include funding for contraceptives	?	RH policy (?)	Pop. policy, RH policy	None	?
Contraceptive security activities	Focus on most vulnerable populations	Y	Y (?)		Y	Y
	Linkage between CS and poverty reduction	Y+	Y+ (?)		Y+	?

CS Index: 55 to 59						
	Question	**Bangladesh**	**Egypt**	**Indonesia**	**Nepal**	**Vietnam**
	Linkage between CS and HIV/AIDS	Y+	Y+		Y+	?
	Linkage between CS and maternal mortality	Y+	Y+		Y+	?
Funding levels	Estimated funds to meet national need for contraceptives	$24.73m	Y		$18.2 (2004–2008); $6.23m (2005)	Y
	Approved funds	$16m	Y		All donor funds	Y
	Disbursed funds	Y	In progress			Y
	Spent funds	Y	In progress			Y

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

ACTIVITIES

Bangladesh

SWAp and contraceptive procurement. The government of Bangladesh and donors have entered into a SWAp arrangement for funding contraceptive commodities, among other supplies needed for the health sector. As a result, funding from the government and the World Bank has been used for the procurement of contraceptives.

Donor meetings to discuss CS issues. The most concrete steps toward achieving CS were those efforts made by the Social Marketing Corporation (SMC) to devise a strategic plan that more actively involves the private sector in delivering FP services. Based on a market segmentation analysis, SMC's efforts are aimed at shifting wealthier users away from the public sector so that resources can be better used to provide services for the poor. An international NGO's efforts have sparked improved coordination among the public, commercial, and NGO sectors (CS committee) and improved the logistics management and forecasting systems. In addition, the SMC was able to purchase condoms from the government until 2006; negotiations are underway for future procurement.

Ecuador

CS action plan activities. Ecuador was not a part of the survey; however, CS action plan activities have been identified and documented. In 2004, the CS Committee of Ecuador planned the following activities:

- Develop enhanced political commitment and leadership with CS
  - Organize a CS committee
  - Initiate and promote a regional CS agenda
  - Develop local participation
  - Organize meetings with providers within the health sector
- Realize market segmentation and plan for targeting resources
  - Solicit and coordinate technical assistance from cooperating agencies and others
  - Project contraceptive needs

    - Identify market niches and opportunities for targeting FP supplies
- Initiate dialogue between institutions around the financing and procurement of contraceptives
    - Formulate a budget to meet contraceptive needs
    - Integrate sources of funding
    - Design a plan for centralized procurement

El Salvador

Awareness raising and policy dialogue among donors and the Ministry of Public Health. El Salvador's CS activities have included awareness raising and policy dialogue. Policy dialogue between donors and the Ministry of Public Health has focused on the need for the government to increase funding for family planning. This dialogue addressed the withdrawal of donor support for contraceptive commodities and the need for the government to take responsibility for purchasing contraceptives. As a result, decisionmakers and technical staff became aware of the need to address CS at national and local levels in the appropriate budgets. In addition, there was an increase in the percentage of the health budget allocated to purchasing contraceptives, an agreement with a donor agency for purchasing contraceptives with MOH funds, and the establishment of a logistics system for contraceptives.

Pharmaceuticals procurement plan. The CS committee has worked with the MOH to raise awareness about the need to include contraceptive purchases within the pharmaceuticals purchase procurement plan.

Market segmentation. An international NGO analyzed data to understand the mix of users according to socioeconomic quintiles so that provider organizations can better coordinate efforts and meet the needs of a broader portion of the population. This information will help to better direct funds to the poor and have wealthier people use the private sector.

CS action plan activities. In late 2004, additional activities for working toward contraceptive security were identified but are not reflected in the matrix:

- Elevate the visibility of the CS committee
    - Collect and prepare briefs that link contraceptive security with maternal and perinatal mortality reduction
    - Establish strategic partnerships with international organizations and national governmental and nongovernmental institutions
- Negotiate with the National Treasury to assign a line item for RH/contraceptives
    - Prepare evidence-based arguments and/or an historical analysis of stockouts of contraceptive commodities and their effects on health
    - Analyze the health budget to identify the percentage allocated to RH commodities and services and advocate for a specific line item for contraceptives
    - Solicit technical assistance to learn about successful experiences in other countries
    - Hold CS meetings with high-level government officials
- Create and plan advocacy campaigns around reproductive health.

Egypt

Contraceptive security study. In 2003, an international NGO took the lead in raising awareness of a CS study's findings through a series of dissemination activities. A summary was produced, discussed, and presented to the Head of the Ministry of Health and Population (MOHP/PS).

Forecasting of contraceptive commodities. In 2004, an international NGO supported the MOHP's efforts to address CS by assisting a task force charged with discussing and assessing the MOHP's optimal source

mix and by assisting the MOHP/PS/Logistics Unit with preparing relevant materials and conducting a workshop to forecast contraceptive commodities.

Policy dialogue through a workshop. To prepare for the 2004 CS workshop, titled "Contraceptive Security in Egypt: Basic Issues, the Contraceptive Security Working Group held a series of meetings to discuss the findings of a CS Diagnostic Survey. Under the patronage of the Minister of Health and Population, an international NGO collaborated with the MOHP/PS on the workshop, which aimed to raise awareness of and gain support for contraceptive security through assessing the current country situation and projecting future needs for FP services and contraceptive commodities. The workshop also focused on defining policy issues associated with the strategic framework for contraceptive commodity security and building consensus among stakeholders on priority issues and strategies to address the issues. A report on the outcomes of the CS workshop was presented to the Minister of Health and Population for further action.

Honduras

CS committee activities. The Honduran CS Committee planned the following three activities to be conducted in 2005:

- Create and sustain a budget allotment specifically for contraceptives as a way to ensure funding for commodities
    - Hold a CS committee meeting to examine possible financing and administrative mechanisms
    - Update and identify the contraceptive needs and costs for 2005–2008
    - Investigate procurement mechanisms, prices, and administrative processes for purchasing contraceptives (via international NGOs, donors, and local providers)
- Develop a national plan for the gradual and progressive purchase of contraceptives from 2005–2008
    - Determine how much is in the national budget for 2005 for the purchase of contraceptives and locate the remaining funds necessary to meet the total demand
    - Share the funding plan developed principally by USAID and the MOH with other donors
    - Hold monthly CS committee meetings
- Develop advocacy arguments for high-level officials of the ministries of health and finance, Comisión Nacional de Salud de Congreso, and civil society groups
    - Prepare a financial argument (cost-benefit analysis) for investing in FP programs
    - Jointly implement the CS plan with the Consejo Nacional de la Salud
    - Expand the CS committee to include members of Social Security, the Inter-American Development Bank, and women's groups
    - Discuss the CS plan with el CONCOMI (Consejo Consultivo Ministerial)

Indonesia

Advocacy for an RHCS policy. Activities in Indonesia have focused more on contraceptive distribution and FP services for poor and underserved people than specifically on contraceptive security. However, one advocacy effort succeeded in convincing the government to establish a policy that addresses RHCS needs.

Decentralized CS plans. An international NGO's efforts contributed to the creation of CS plans at the district level. A roll-out process, in which districts provided technical assistance to other districts, was used to implement the plans.

Elimination of taxes on imported contraceptives. Another activity advocated for the local production of contraceptives and a reduction in taxes on imported contraceptives; it is unclear what results have come from this activity.

Nicaragua

CS committee goals and activities. In 2004, the Nicaraguan CS Committee worked on a set of goals and activities for 2005 to move its CS agenda forward:

- Ensure that the MOH guarantees financing for contraceptive procurement and that the Nicaraguan Social Security Institute (INSS) fulfills its promise to offer FP methods to its insured population
    - Produce an executive document that outlines for health sector officials the MOH's financial and supply situation for the next few years
    - Encourage the monitoring of FP services offered to those insured by INSS
- Strengthen political commitment toward more rational market segmentation and the targeting of resources
    - Strengthen the CS committee and look for strategic alliances
    - Incorporate civil society groups in the implementation of the CS strategy
    - Propose an incentive plan for private and NGO sectors to increase their roles in providing FP services
    - Create a revolving fund for NGOs
- Identify procurement mechanisms that are appropriate for economies of scale

Nepal

Increased attention on contraceptive security. Efforts in Nepal appear to be moving toward addressing contraceptive security. Donors and cooperating agencies are highly active in supporting the FP program and have facilitated efforts to begin addressing CS. A market segmentation study has been conducted, revealing that the wealthy access public services at a higher rate than the poor. As a result, increasing attention is being paid to the roles the commercial and NGO sectors can play in providing services to the wealthy so that more resources can be targeted to those unable to pay.

Capacity building leads to results. In Nepal, a donor agency advocated for the government to fund contraceptives and mobilize resources to purchase commodities on the international market. The donor agency also sponsored advocacy training for NGOs and government officials, focusing on increasing public funding for contraceptives. As a result of these activities, the government now provides some funding. The donor also assisted the government in establishing an FP subcommittee as one of the highest level subcommittees within the RH Committee. It addresses contraceptive commodity issues—such as supply, monitoring, finance, and stocks—to ensure that every health facility has a sufficient supply and that contraceptives are distributed.

Annual CS advocacy campaign. The Health Journalist Association of Nepal advocates for the needs and importance of contraceptive security once a year with an advocacy campaign aimed at policymakers and high-level MOH officials. CS and related issues are discussed in local newspapers and journals.

Contraceptive forecasting. A contraceptive forecasting activity began in 1996 and continues as a key part of advocacy for contraceptive funding in Nepal. However, in light of government financial constraints, advocacy efforts have focused on donors instead of the government, resulting in a commitment to provide

continued support for contraceptives from both donor agencies and the government for the next eight years.

Government funding for contraceptives. Policy dialogue on the current CS situation, future needs, and shortfall with the MOH, Ministry of Finance, and donors started in 1995 and is ongoing. This dialogue resulted in the government funding contraceptive purchases for the first time and an initial analysis of contraceptive needs and sources.

Vietnam

Vietnam did not report activities, and no additional information was found through subsequent research.

CS INDEX: 50 TO 54

Three countries for which data are available fall into this group. **Guatemala** is expected to contribute 40 percent of funds required to meet contraceptive needs by 2006. Although **Bolivia**'s MOH does not provide funding for contraceptives, SUMI (Maternal Child Health Insurance) provides funding to municipalities to purchase contraceptives. Contraceptive prevalence in **Kenya** has leveled off, and efforts are being made to reposition family planning that has become a lower priority because of the HIV epidemic.

CS Index: 50 to 54

	Question	Bolivia	Guatemala	Kenya
Location	Region	LAC	LAC	SSA
Expert Ranking	Grade	B	B+	A-
National coordination	National strategy for RHCS	N	Y	Y
	Coordinating committee for RHCS	Y	N	Y
Funding mechanisms	Level of allocation decisions	Central	Central (?)	Central
	Country budget including contraceptives	Municipal	National/MOH, Guatemalan Social Security Institute	National/ MOH(?)
	Line item for contraceptives	N	N	N
	Pharmaceuticals/ supplies budget includes contraceptives	N	?	?
	List of essential drugs includes contraceptives	Y	?	N
	Document(s) that include funding for contraceptives	RH policy	Pop. policy, RH policy (?)	N
Contraceptive security activities	Focus on most vulnerable populations	N	N(?)	Y
	Linkage between CS and poverty reduction	Y-	N(?)	Y+
	Linkage between CS and HIV/AIDS	N	Y(?)	Y+
	Linkage between CS and maternal mortality	Y+	Y+	Y+
Funding levels	Estimated funds to meet national need for contraceptives	$300,000 (2005)	$1.5m (2005)	$43.3m for 2003–2006

CS Index: 50 to 54				
	Question	**Bolivia**	**Guatemala**	**Kenya**
	Approved funds	N (all donor funds)	$450,000(?) (2005)	$9.6m (?)
	Disbursed funds		Y	?
	Spent funds		Y	
D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries				

ACTIVITIES

Bolivia

CS action plan. While survey respondents did not describe CS activities in Bolivia, the CS Committee's action plan outlines key activities to be undertaken in 2005:

- Expand the CS committee and elevate its visibility to increase awareness of CS objectives and enhance political capital
  - Invite additional key players from agencies, institutions, and sectors
  - Invite a higher level MOH official to preside over the committee
- Strengthen legal and financing mechanisms to support contraceptive security
  - Establish a legal framework to secure financing for contraceptives
  - Strengthen mechanisms for procurement (various sources) for contraceptives with participation from municipal governments
- Undertake further analysis of the DHS and disseminate findings to increase awareness of and advocate for contraceptive security
  - Execute an in-depth market segmentation analysis to target support to vulnerable groups
  - Disseminate findings to local, regional, and national political leaders

Guatemala

MOH and women's groups in policy dialogue. In 2004, policy dialogue occurred during meetings and forums for women from civil society organizations and the MOH's National Program on Reproductive Health. Participants discussed the program's workplans and securing economic and budget support for FP/RH services. The MOH has collaborated with women's groups as a way of lobbying for an increase in RH funds.

CS action plan activities. In 2004, the following CS activities were proposed for 2005 but are not reflected in the matrix:

- Strengthen the government of Guatemala's political commitment for reproductive health and contraceptive security
  - Form a CS committee
  - Develop a workplan for the CS committee
  - Draft the official language for operationalizing the decree of law 2504 (a tax on cigarettes and alcoholic beverages, 15% of which is directed to the MOH's RH programs)
- Secure the financing and procurement of contraceptives
  - Include contraceptives as strategic commodities on the essential drugs list, giving them a higher priority for procurement

- Standardize methodology for forecasting contraceptive supply needs at the national level
- Design a legal framework that would allow the assigning of specific line items in the national budget

Kenya

Advocacy for creating a line item and its funding. In Kenya, advocacy has occurred for creating a budget line item for reproductive health (contraceptives) and funding the line item within the MOH to enable the government to purchase contraceptives. While there has been no direct result yet, advocates are hopeful.

Contraceptive Commodities Procurement Plan 2003–2006. Advocacy and awareness raising resulted in the creation of the Contraceptive Commodities Procurement Plan 2003–2006. It includes projections of the contraception requirement for this time period, projections and calculations of the total financial requirements, the role of national supply agencies in procurement and logistics, and the financial cycles of both the government and development partners. This plan resulted in an improved organizational structure for managing the procurement and distribution of contraceptives within the MOH Division of Reproductive Health (DRH), along with better organization for lobbying for contraceptive commodities. It also includes placement of a point person for contraceptives in the DRH and calls for improved monitoring of contraceptive security.

National advocacy strategy for repositioning family planning. The MOH/DRH has initiated the joint development of the national advocacy strategy for repositioning family planning and the attainment of contraceptive security. This strategy includes the need to budget for RH programs within the MOH to enable the government to purchase contraceptives.

CS INDEX: 45 TO 49

Eight countries participating in the survey had relatively low CS index scores between 45 and 49. The government of **Ghana**, despite receiving several million dollars in commodity donations, is purchasing some commodities on its own. **Malawi** and **Tanzania** have been focused on HIV issues, with relatively little attention given to family planning and contraceptive security. CS-related activities in **Senegal** and **Togo** have begun, focusing mainly on regional training activities. **Cambodia** has begun CS advocacy efforts, linking CS issues to other health sector issues. Funds for contraceptive procurement in **Zimbabwe** were included in the national 2005 budget. Though still entirely dependent on contraceptive donations, **Haiti** has also taken steps to begin addressing CS issues.

CS Index: 45 to 49

	Question	Ghana	Malawi	Tanzania	Togo
Location	Region	SSA	SSA	SSA	SSA
Expert Ranking	Grade	A-	C+	C+	B-
National coordination	National strategy for RHCS	Y	D (?)	?	D
	Coordinating committee for RHCS	Y	?	Y	Y
Funding mechanisms	Level of allocation decisions	Central	Central	Central	Central, regional, local
	Country budget including contraceptives	National/ MOH	National/ MOH	National/ MOH	Local (?)
	Line item for contraceptives	?	N	?	N
	Pharmaceuticals/ supplies budget includes contraceptives	Y	N	N	N
	List of essential drugs includes contraceptives	Y	Y	Y	N
	Document(s) that include funding for contraceptives	Pop. policy (maybe RH), PRSP	N	Pop. policy, RH policy	N
Contraceptive security activities	Focus on most vulnerable populations	Y	N	N	Y
	Linkage between CS and poverty reduction	Y+	N	N	N
	Linkage between CS and HIV/AIDS	Y+	Y+	Y-	Y+
	Linkage between CS and maternal mortality	Y+	Y-	Y+	Y+

CS Index: 45 to 49

	Question	Ghana	Malawi	Tanzania	Togo
Funding levels	Estimated funds to meet national need for contraceptives	6.4m(2004), $7m (2005), $8.2m (2006)	Y	$11–$15m (2004/5)	$260,000
	Approved funds	Y		$3.6m (2004/05)	N
	Disbursed funds	MOH: $240,000 (2003), $280,000 (GOG), $1.5 million (SWAp-Donors)		Y	
	Spent funds	Y		Y	

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

CS Index: 45 to 49

	Question	Cambodia	Haiti	Senegal	Zimbabwe
Location	Region	ANE	LAC	SSA	SSA
Expert Ranking	Grade	B	B-	C+	B+
National coordination	National strategy for RHCS	N	Y (?)	N	Y
	Coordinating committee for RHCS	Y	Y (?)	N, admin of contraceptive provision and inventory?	Y
Funding mechanisms	Level of allocation decisions	Central	Central	Central	Central
	Country budget including contraceptives	None	National/ MOH	National/MOH	National/ MOH
	Line item for contraceptives	N	N (?)	Y	Y (sub item?)
	Pharmaceuticals/ supplies budget includes contraceptives	N	N (?)	Y	N
	List of essential drugs includes contraceptives	?	Y	Y	N
	Document(s) that include funding for contraceptives	None	None (?)	RH policy	?
Contraceptive security activities	Focus on most vulnerable populations	N	Y(?)		Y
	Linkage between CS and poverty reduction	Y+	?		Y+
	Linkage between CS and HIV/AIDS	Y+	Y+(?)		Y+

CS Index: 45 to 49					
	Question	**Cambodia**	**Haiti**	**Senegal**	**Zimbabwe**
	Linkage between CS and maternal mortality	Y+	Y+(?)		Y+
Funding levels	Estimated funds to meet national need for contraceptives	Y	Y		$820,627
	Approved funds	All donor funds	?		Y (but noted accepted from donors)
	Disbursed funds		?		Y
	Spent funds		?		Y

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

ACTIVITIES

Cambodia

Separate budget line item for RHCS. Cambodia has proposed a separate budget line item for RHCS. In addition, they are looking at alternative funding sources, along with stopgap measures to ensure continuity of supply. There has been no reported impact yet.

Ghana

CS workshop led to the formation of a coordinating committee. In 2002, the MOH and Ghana Health Service (GHS), with assistance from an international NGO and donors, organized a CS workshop that addressed funding levels, pricing of contraceptives, coordination of donor/counterpart funding, national health sector support, and the maternal health sector budget. This activity resulted in the formation of the Interagency Coordinating Committee for Contraceptive Security (ICC/CS), which includes representatives of government agencies, donors, and NGOs. This committee discusses forecasting, procurement, budgets, and pricing. Overall, its work is contributing to the eventual inclusion of funds for contraceptives in the MOH budget.

Development of a national CS strategy. The ICC/CS and Reproductive and Child Health Unit initiated policy dialogue with the MOH/GHS, leading to the development of a national CS strategy. The ICC/CS Core Technical Working Group drafted the final Contraceptive Security Strategy 2004–2010 and, at a 2004 workshop, presented it to the MOH/GHS and development partners for adoption and to gain the necessary policy commitment and financial support. The issues addressed include the identification of needs, funding gaps, the government's commitment to contraceptive security, and the need to increase government funding as donor contributions is declining.

The CS strategy includes the following activities:

- Involve the Community-based Health Planning and Services (CHPS) initiative and integrate its community mobilization efforts in the CS advocacy strategy, which is directed toward the District Assemblies and the District Health Management Teams
- Direct advocacy efforts toward the Ministry of Finance and Economic Planning and other ministries

- Create a public/private forum to facilitate the greater involvement of the private/commercial sectors
- Hold a conference to present the CS strategy to policymakers
- Increase and sustain the participation of partners in the ICC/CS
- Advocate for widespread financial support across sectors

Pricing structure study. To support the policy dialogue process, an international NGO conducted a pricing structure study, looking at the willingness and ability of consumers/clients to pay for contraceptives.

MOH workshops on contraceptive funding. The MOH has held workshops to examine scenarios for funding contraceptives. Discussions focused on funding levels from various sources, such as the government and donors. Participants committed themselves to ensuring that there be sufficient and sustainable funding for commodities.

Haiti

National strategic RH plan. Awareness-raising and advocacy efforts for establishing a national policy agenda on family planning have led to the approval of a national strategic RH plan. Although not specifically related to contraceptive security, this plan will help raise awareness of the need to allocate funds for contraceptive commodities.

Policy dialogue with the MOH. Donors have undertaken policy dialogue to strengthen the national capacity to estimate contraceptive and condom needs (demand, supply, service delivery, supportive environment), which has resulted in the availability and willingness of MOH staff to address the issue.

Malawi

Malawi did not report activities, and no additional information was found through subsequent research.

Senegal

Policy dialogue within the National Committee on Contraceptive Management. In Senegal, an important activity to garner support for contraceptive security has been policy dialogue with the National Committee on Contraceptive Management. This ongoing dialogue has helped to identify contraceptive needs and made possible the conducting of advocacy for continued financing of contraceptive products from partners in development. As a result of this dialogue, there have been improvements in access to products in health facilities, improvements in product management and data collection, and regular supervision of all service delivery points.

Regional workshop on family planning and contraceptive security. Representatives from Senegal—including the media, FP program technical staff, and parliamentarians—attended a regional workshop in May 2005 designed to raise awareness of FP and CS issues. The workshop was organized by an international NGO and included participants from five countries.

Regional workshop on strategic planning for contraceptive security. Representatives from Benin attended a regional workshop in September 2004 on developing a CS plan. The workshop was organized by an international NGO and included participants from six countries.

Tanzania

Policy dialogue on the cost of contraceptives. The MOH in Tanzania has had discussions with the MOF, the president's office, regional administration, and local government about the cost of addressing contraceptive needs. Topics have included the cost of contraceptives, procurement procedures, national capacity for procurement, and local distribution costs.

Integration of forecasting into budget and planning tools. The Commodity Task Force has forecasted contraceptive needs and consumption patterns and presented the information to health sector policymakers and planners. This awareness-raising effort resulted in the integration of this information into the health sector's budget and planning tools.

Zimbabwe

Lobbying resulted in funding. Activities in Zimbabwe have primarily focused on lobbying the MOH and MOF to provide funding for family planning. One result is the inclusion of funds for contraceptive procurement in the 2005 national budget.

CS INDEX: 40 TO 44

The seven countries with CS index scores between 40 and 44 are all from sub-Saharan Africa. **Benin** and **Mali** have both participated in regional CS workshops and are beginning to develop strategies. **Mozambique** has used SWAp funding to fund contraceptives. **Nigeria** has been addressing CS issues for several years and has a strategic plan for reproductive health commodities. Information on contraceptive security in **Eritrea, Guinea,** and **Zambia** is limited.

CS Index: 40 to 44

	Question	Benin	Eritrea	Guinea	Mali	Mozambique	Nigeria	Zambia
Location	Region	SSA	SSA	SSA	SSA	SSA	SSA	SSA
Expert Rankings	Grade	B	B-	B-	B	B	B+	B-
National coordination	National strategy for RHCS	D	Y	D	Y	?	Y	D
	Coordinating committee for RHCS	N	Y	N	Y	?	Y	Y
Funding mechanisms	Level of allocation decisions	None	Central	Central	Central	Central, Regional, Local	Central	Central
	Country budget including contraceptives	None	National/ MOH	None	None	National/ MOH	National/ MOH	National/ MOH
	Line item for contraceptives	N	N	N	N	N	under maternal mortality line item	Y
	Pharmaceuticals/ supplies budget includes contraceptives	N	Y	Y	?	Y	N	Y
	List of essential drugs includes contraceptives	Y	Y	Y	Y	?	Y	Y
	Document(s) that include funding for contraceptives	None	None	Pop. policy, RH policy	Pop. policy, RH policy	Pop. policy, RH policy	Pop. Policy (no budget), RH policy	Pop. policy, RH policy
Contraceptive security activities	Focus on most vulnerable populations	Y		N	Y	Y	Y	Y
	Linkage between CS and poverty reduction	Y-		N	Y+	Y+	Y+	Y+
	Linkage between CS and HIV/AIDS	Y-		Y+	Y+	Y+	Y+	Y+
	Linkage between CS and maternal mortality	Y-		Y+	Y+	Y+	Y+	Y+
Funding levels	Estimated funds to meet national need for contraceptives	Y		N	$1.5m (each year)	$1–$1.3 m	$7 million, $19.8m for 2002–2006	Y
	Approved funds	Y			All donor funds	Y	Y	Y

CS Index: 40 to 44								
	Question	**Benin**	**Eritrea**	**Guinea**	**Mali**	**Mozambique**	**Nigeria**	**Zambia**
	Disbursed funds	N				$1m (includes donor funds)	$29,000	Y
	Spent funds					$800,000	Y	Y
D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries								

ACTIVITIES

Benin

National CS policy workshop. A workshop on national CS policy was held in Benin for donors, partners in development, and Ministry of Public Health officials. Donors conducted the workshop, which focused on financing contraceptives.

Regional workshop on strategic planning for contraceptive security. Representatives from Benin attended a regional workshop in September 2004 on developing a CS plan. The workshop was organized by an international NGO and included participants from six countries.

Forecasting and CS workshop. In 2005, an international NGO forecasted contraceptive commodity needs, hold a CS workshop, and provide participants with skills for carrying out advocacy and awareness-raising activities.

Guinea and Eritrea

Guinea and Eritrea did not report activities, and no additional information was found through subsequent research.

Mali

Advocacy campaign for a line item in the health budget. Since 2003, there has been an active advocacy campaign aimed at Parliament, focusing on securing contraceptive commodities. Organized by the Health Ministry and Directorate for Reproductive Health, meetings have been held with the MOH, MOF, Ministry of Foreign Affairs, and partner organizations. This ongoing campaign has resulted in the request for a line item in the health budget, allowing for the purchase of contraceptives.

Widespread awareness-raising campaign. In 2004, an NGO initiated days of reflection, which consisted of advocating for contraceptive security. After a workshop to advocate to technical and financial partners of the Program for Health and Social Development (PRODESS), various ministries and the national assembly have increased their involvement in addressing CS issues. In addition, an awareness-raising campaign in the media focused on contraceptive use.

Regional workshop on family planning and contraceptive security. Representatives from Côte d'Ivoire—including the media, FP program technical staff, and parliamentarians—attended a regional workshop in May 2005 designed to raise awareness of FP and CS issues. The workshop was organized by an international NGO and included participants from five countries.

Regional workshop on strategic planning for contraceptive security. Representatives from Mali attended a regional workshop in September 2004 on developing a CS plan. The workshop was organized by an international NGO and included participants from six countries.

Mozambique

Contraceptive funding through SWAps. A donor has undertaken advocacy and awareness raising to ensure funds for contraceptives, especially to improve logistics and supplies of RH commodities and forecasting within the Strategic Plan of Health Sector and SWAp context. As a result, donors have been allocating funds to the MOH through SWAps. It is the responsibility of the ministry to decide how to use the funds according to priorities.

Advocacy and policy dialogue on condoms. The Ministry of Planning and Finance, in coordination with other sectors, also carries out advocacy and policy dialogue activities to ensure funds for contraceptives, particularly condoms. Its message focuses on the use of condoms in preventing STIs and pregnancy. Donor funds have risen as a result of these activities.

Nigeria

National Strategic Plan for RHCS. In 2002, there was a Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) Strategy Workshop in Nigeria. An international NGO provided technical assistance to the Department of Community Development and Population Activities of the MOH in support of the SPARHCS process, which was directed toward achieving national RHCS. After disseminating a draft National Strategic Plan for RHCS to all stakeholders and incorporating the comments for a final review meeting, the plan was finalized and adopted. The plan received the Minister of Health's endorsement and was published and formally launched in 2004.

Adoption and dissemination of the revised Contraceptives Logistics Management System. In 2004, an international NGO participated in the Stakeholders' Contraceptive Logistics Management System (CLMS) Re-Design Workshop. During the meeting, the revised CLMS was adopted and the roll-out plan was approved for implementation at the national, state, and local levels. The new guidelines were endorsed by the Honorable Minister of Health, and copies were disseminated to stakeholders at the National Reproductive Health Summit to serve as a basis for awareness-raising and policy dialogue.

Capacity building on revised national guidelines. A donor agency reported conducting advocacy directed at key policymakers in the Federal Ministry of Health on the need to meet the funding gap for contraceptive supplies, along with the need for capacity building on implementing the revised national guidelines for the states and Federal Capital Territory. As a result, the ministry provided funds for training states on the revised national guidelines in 2004.

Zambia

Monthly policy dialogue meetings. In Zambia, during monthly committee meetings, the MOH and central Board of Health engaged in policy dialogue with donors about the purchase of Norplant, which resulted in its purchase by the MOH.

CS INDEX: BELOW 40

Four countries participating in the survey had CS index scores below 40. However, respondents from all the countries reported some CS activities.

CS Index: Below 40

	Question	Ethiopia	Madagascar	Rwanda	Uganda
Location	Region	SSA	SSA	SSA	SSA
Expert Ranking	Grade	B-	A	B+	B+
National coordination	National strategy for RHCS	D	D	Y	?
	Coordinating committee for RHCS	Y	Y	Y	Y
Funding mechanisms	Level of allocation decisions	Central, Regional	Central	Central	Central, local
	Country budget including contraceptives	Regional/ Provincial	National	National/ MOH	National/ MOH, District
	Line item for contraceptives	N (national) Y (some regions)	N	N	Y
	Pharmaceuticals/ supplies budget includes contraceptives	N	Y	Y	?
	List of essential drugs includes contraceptives	Y	Y	Y	Y
	Document(s) that include funding for contraceptives	None	MOU—donors and GOM	Pop. policy, RH policy	None
Contraceptive security activities	Focus on most vulnerable populations	N	N		Y
	Linkage between CS and poverty reduction	Y-	Y	Y-	Y+
	Linkage between CS and HIV/AIDS	Y-	Y	Y-	Y+
	Linkage between CS and maternal mortality	Y	Y	Y-	Y+
Funding levels	Estimated funds to meet national need for contraceptives	$9.6–$21.9m (2005)	Y	N	$848,896
	Approved funds	$11.1m		All donor funds	Y
	Disbursed funds				Y
	Spent funds				

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

ACTIVITIES

Ethiopia

Policy dialogue on CS. Donors, international NGOs, and the National Office of Population took part in a national dialogue on contraceptive security in 2003. Participants discussed a proposed government budget allocation. They also discussed the need for a contraceptive framework, a strategic planning process, market segmentation and the role of the private sector, and the government's share in the supply of contraceptive commodities. This dialogue resulted in the forecasting of contraceptive needs and the creation of a national RH strategy.

Task force policy dialogue. The contraceptive logistics task force has initiated policy dialogue, including how to purchase contraceptives through government funding and how to redistribute available contraceptives.

National dialogue. During a policy dialogue meeting, an advisory committee was established to oversee the formation of the Family Planning Committee under the National RH Task Force. Based on the results from the national dialogue, two international NGOs will begin working at the national and subregional levels on CS issues. Donors and NGOs will work together to develop a strategy to complement other FP activities with advocacy for the expansion of FP services and to implement the recommendations of the national dialogue.

Madagascar

Contraceptive procurement plan 2005–2008. International NGOs worked with Madagascar's MOH and partners to finalize the three-year contraceptive procurement plan for 2005–2008. The procurement plan was presented to MOH decisionmakers and donors to confirm their respective commitment in financing commodities procurement. An FP association has been active in disseminating the procurement plan to donors so that all the partners have a clearer understanding of their roles in the process.

National FP/CS workshop. An NGO led activities to design a "technical note" and a related workplan for finalizing the National Strategy for Contraceptive Security—the focus of a national conference on family planning in 2004. The MOH, in coordination with two other donor-funded NGOs, organized preparatory workshops for the conference. The Stock Status Report was shared with the MOH and donors, and the report findings were presented in a national FP/CS workshop.

Policy dialogue resulting from a willingness-to-pay (WTP) study. An international NGO analyzed data and completed a report on a contraceptive WTP study, which provides information on public sector contraceptive users as well as potential users willing to pay for FP commodities. Preliminary results were presented to the donor agency. This information was combined with a market segmentation analysis (a capacity-to-pay study), conducted when the family planning results of the DHS became available to guide MOH leaders in making policy and programmatic decisions. This information served as a basis for policy dialogue that led to decisions, including the sale price of contraceptives and the sources of FP services and commodities for various segments of the population.

Rwanda

Workshop for devising a national FP sub-strategy and building advocacy skills for CS. In May 2005, an international organization facilitated a workshop designed to help stakeholders write the National FP Sub-

strategy (part of the larger National Reproductive Health Strategy). The workshop also included training on advocacy skills to promote commodity security, so that participants will be better able to advocate to high-level government officials for the funding of commodities.

Resources for the Awareness of Population Impacts on Development (RAPID) model. An international NGO is working on a RAPID presentation to help raise awareness among high-level government officials of the benefits of family planning and the importance of government funding for commodities.

Uganda

Policy dialogue resulted in reviving the RHCS committee. Uganda's Population Secretariat initiated policy dialogue with policymakers in health, RH program managers, development partners, and academia. This dialogue included discussions on increasing funding for contraceptives and increasing capacity for handling contraceptive logistics. As a result of the dialogue, the RHCS committee became highly active again.

Awareness-raising study tour. In 2003, a national FP association undertook an awareness-raising study tour for Danish parliamentarians to increase their knowledge on the RH needs of individuals in the developing world and to take practical measures to support RH programs on financial, institutional, and public relations levels. The tour resulted in a pledge of $348,628 to provide contraceptives to vulnerable populations in a certain district.

NOT IN CS INDEX

Information on 10 countries with unavailable CS index scores is included in the survey. These countries represent a wide range of economic and geographic settings. Because of the variety, it is not possible to make any generalizations about how they are addressing CS issues.

Sub-Saharan Africa: **Botswana** received minimal commodity donations from UNFPA following USAID's phaseout. However, Botswana receives commodity donations (mainly condoms) through the U.S. President's Emergency Plan for AIDS Relief and other sources. **Niger** and the **Democratic Republic of Congo** (DRC) receive extensive support, albeit from a different mix of donors. IPPF is the main source for Niger, while the DRC has a larger number of sources. **Lesotho** and **Swaziland** receive extensive commodity donations, but with the main intent being to prevent the spread of HIV/AIDS.

Caribbean: **Trinidad and Tobago** and **St. Lucia** receive very small amounts of contraceptive donations. St. Lucia receives funding from the Caribbean Regional Program, which includes an HIV/AIDS reduction component.

Eastern Europe and Eurasia: **Turkey** was one of the first countries to address CS issues and now procures and funds contraceptives. Because **Ukraine** does not receive contraceptive donations and the government does not procure contraceptives, its citizens depend on the private sector for contraceptive commodities. **Tajikistan** is the only country in the region receiving donor support for contraceptives and other FP activities and is starting to address CS issues.

Not in CS Index

	Question	Botswana	D.R. Congo	Lesotho	Niger	Swaziland
Location	Region	SSA	SSA	SSA	SSA	SSA
Expert Ranking	Grade	B	C+	C-	C+	B+
National coordination	National strategy for RHCS	Y	Y	N	N	N
	Coordinating committee for RHCS	Y	Y	N	N	?
Funding mechanisms	Level of allocation decisions	Central	Central	Central	Central	Central
	Country budget including contraceptives	National/ MOH	National/ MOH	National/ MOH	National/ MOH	National/ MOH
	Line item for contraceptives	?	N	Y	Y	N
	Pharmaceuticals/ supplies budget includes contraceptives	Y	Y	N	?	Y
	List of essential drugs includes contraceptives	Y	Y	Y	Y	Y
	Document(s) that include funding for contraceptives	None	RH policy	RH policy	Pop. policy, PRSP (RH policy?)	RH policy (?)

Not in CS Index

	Question	Botswana	D.R. Congo	Lesotho	Niger	Swaziland
Contraceptive security activities	Focus on most vulnerable populations	Y	N	N	Y	Y
	Linkage between CS and poverty reduction	Y+	N	N	N	Y+
	Linkage between CS and HIV/AIDS	Y+	Y-	Y+	Y	Y+
	Linkage between CS and maternal mortality	Y+	Y-	Y+	Y-	Y+
Funding levels	Estimated funds to meet national need for contraceptives		$4.03m (2004), $4.59m (2005), $5.18m (2006)	N	N	Y
	Approved funds		N		Y	Y
	Disbursed funds		N			Y
	Spent funds		?			Y

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

Not in CS Index

	Question	St. Lucia	Tajikistan	Trinidad & Tobago	Turkey	Ukraine
Location	Region	LAC	E&E	LAC	E&E	E&E
Expert Ranking	Grade	A	B+	A	A-	B+
National coordination	National strategy for RHCS	N	Y	Y	Y	N
	Coordinating committee for RHCS	Y (?)	Y	Y	N	N
Funding mechanisms	Level of allocation decisions	Central (?)	Central, Regional, Local (?)	Central	Central, Local	Central, Regional, Local (?)
	Country budget including contraceptives	National/ MOH	National/ MOH, Regional/ Provincial, Local (?)	National/ MOH	National/ MOH, Social Security Authority (SSK)	National/MOH, Regional/ Provincial, District (?)
	Line item for contraceptives	N	N	N	Y	N
	Pharmaceuticals/ supplies budget includes contraceptives	Y	Y	Y	Y	N(?)
	List of essential drugs includes contraceptives	Y (?)	Y	Y	N	Y

Not in CS Index						
	Question	**St. Lucia**	**Tajikistan**	**Trinidad & Tobago**	**Turkey**	**Ukraine**
	Document(s) that include funding for contraceptives	RH policy(?)	Pop. policy, RH Policy, PRSP	Pop. policy, RH policy	Pop. policy, RH Policy	None
Contraceptive security activities	Focus on most vulnerable populations	N	Y	Y	Y	Y
	Linkage between CS and poverty reduction	?	Y	?	N	N
	Linkage between CS and HIV/AIDS	Y+	Y	?	N	N
	Linkage between CS and maternal mortality	N	Y	?	N	N
Funding levels	Estimated funds to meet national need for contraceptives	N	Y	?	$3–4m	N(?)
	Approved funds		Local $16,170 (2003) National $2,679 (2003)	?	$2.5–3m	
	Disbursed funds			?	$2.5m	
	Spent funds			?	$1.8m	

D: Developing ?: Unclear Blank: Left blank in questionnaire +/-: Of interest/disinterest to ministries

ACTIVITIES

Botswana

Policy dialogue between the MOH and an NGO. The Botswana Family Welfare Association has held roundtable meetings with the MOH to discuss funding for RH services, particularly for youth, and has received free supplies as a result. This is an ongoing activity.

Lesotho

Awareness raising for improved contraceptive planning. The MOH and other groups in Lesotho have undertaken an awareness-raising activity, with an emphasis on improved contraceptive planning and reporting among public and NGO health facilities.

Democratic Republic of Congo

Repositioning FP conference. The MOH and an NGO organized a national conference on repositioning family planning in 2004. This event has been the only large awareness-raising and advocacy activity oriented toward resource allocation for contraceptives from the public sector. This conference included a

wide range of stakeholders, including journalists, religious leaders, NGO leaders, and MOH officials. The conference resulted in higher allocations made to the health sector in the national budget.

Niger

Establishment of a committee on contraceptives. In Niger, the Ministry of Public Health has held meetings with other partners—donors and UN agencies—to discuss how to ensure continuous contraceptive coverage for the country. These meetings resulted in establishing a committee in charge of adding contraceptives into the MEG (essential generic drugs) and financing.

National policy. Policy dialogue meetings have also included discussions to define the national policy on the provision and distribution of contraceptives.

Romania

Because interviews were not conducted in Romania, the following activities for working toward contraceptive security were identified in a review of existing POLICY documentation and are not reflected in the matrix.

Coverage of generic contraceptive formularies by the health insurance system. An international NGO worked with the Ministry of Health and Family (MOHF) and key stakeholders to advocate for contraceptive coverage by the national insurance system, as health insurance was seen as one of the main financing options for contraceptive security. NGO advisors engaged in policy dialogue with leaders of the MOHF, National Health Insurance House (NHIH), and College of Physicians. NGO staff analyzed cost data, which was used by the minister to propose that NHIH include contraceptives on the list of drugs compensated under health insurance. Data from a field study that assessed the implementation of new contraceptive security policies were used in drafting the minister's memorandum to the Committee on Transparency, a joint MOHF-NHIH committee that reviews all proposals for social health insurance funding. As a result, the NHIH approved the inclusion of generic formularies for oral contraceptives and injectables in the List of Compensated Drugs in 2002.

Increased government budgetary allocation for free distribution of contraceptives. In 2002, the MOHF and NGO staff helped advocate for increasing government resources for contraceptives. NGO-sponsored research was used by the MOHF and other National Family Planning Program partners, including the Information, Education, and Communication Working Group of the RH Committee (composed of MOHF staff), local agencies from the public and private sectors, donors (UNFPA and USAID), other cooperating agencies, FP/RH advocacy networks, and private commercial sector entities. As a result of this advocacy, the MOHF increased the earmarked funding for contraceptives from $250,000 in 2001 to $333,000 in 2002.

Simplified certification requirements for the poor to access free contraceptives. In 2003, advocacy efforts led to a new policy approving the self-certification of poverty status as a requirement to access free contraceptives in Romania. An NGO study on the implementation of the August 2000 policies that approved free contraceptive distribution to vulnerable population sectors reported that clients without official documentation or proof of poverty status could not obtain free contraceptives.

Swaziland

Policy dialogue for MOH contraceptive funding. An NGO in Swaziland reported undertaking policy dialogue activities with stakeholders to convince parliamentarians of the importance of allocating funding

for the procurement of contraceptives. This activity was successful, with the allocation of funds being approved and contraceptives purchased through the MOH budget.

Tajikistan

CS working group formed and raising awareness. The CS committee has focused its attention on the results of the analysis of the contraceptive security situation in the Republic of Tajikistan, seminars on contraceptive security, and strategic planning. An intersectoral working group was formed and has held meetings with stakeholders on contraceptive security. It has conducted a CS assessment and is preparing a workplan. At one of its meetings, a booklet on contraceptive security in Tajikistan in 2004 served as the basis for discussion of priorities and joint actions to be taken. The working group will focus on raising awareness by disseminating data to decisionmakers. Policy dialogue will be fostered through national- and oblast-level policy workshops for key stakeholders. An expected result of this process will be the development of a CS strategic plan.

Turkey

The following activities illustrate the pathway used in Turkey to address donor phaseout.

Commodity procurement mapping workshop. This 1996 workshop generated an understanding of the contraceptive procurement process and alternatives to the existing procedures in Turkey and established key linkages among actors and stakeholders. This workshop was the first time different units of the MOH worked on an interrelated issue and recognized the need to improve the commodity procurement process.

Market segmentation analysis and public-private partnership workshop. In 1997, an international NGO conducted a quantitative analysis that described the structure of the FP market in Turkey, assessed the degree to which MOH commodities were targeted toward "high-need" groups, and examined commercial sector market niches and their potential growth. The analysis was the centerpiece of discussion at the Public–Private Partnership Workshop. The workshop opened policy dialogue to a range of public, private, and NGO audiences, resulting in a consensus about the potential of increasing the sustainability of the public sector by focusing resources on the poor and the ability of the private sector to absorb clients not targeted for subsidy. The General Directorate for Maternal and Child Health/Family Planning (MCH/FP) committed to more clearly defining its high-priority target populations.

KIDOG informational meetings and the Contraceptive Self-Reliance (CSR) Campaign. In 1998, a Turkish Network for Women, KIDOG, created and implemented a CSR campaign to alert policymakers of a potential FP program crisis and to influence public officials to allocate and use resources to purchase contraceptives. An international NGO facilitated the policy dialogue process with technical information and assistance. KIDOG met with the president of Turkey and received his support for the purchase of contraceptives. After the meeting, the president sent a letter to the prime minister asking for a budget increase and to take the necessary action to purchase contraceptives.

Creation of a budget line item. In 1999, a new Financing Plan for Contraceptive Commodities was presented, which led to the MOH and MOF making joint decisions about commodity financing. The MOF decided to transfer additional funds to the MOH for the procurement of contraceptive commodities and to create a budget line item with an earmark. The MOF also decided to establish a way for the MOH to collect contributions from clients who could afford to pay for contraceptives.

Pilot study and national policy dialogue meeting. In 2000/2001, the MOH and an international NGO prepared a plan for implementing the targeting strategy (based on a multi-tiered donation policy) and designed and garnered consensus for a pilot study. The findings and outcomes of the pilot study, along

with recommendations on scaling up, donation prices and retention levels, and administrative procedures, were documented and presented to a key group of policymakers, including provincial health directors, their deputies, MCH/FP Unit heads of all provinces, the Health and Social Aid Foundation (HSAF) provincial branch accountants, and the HSAF General Director and his deputy. The policy dialogue facilitated the growing consensus among key stakeholders for accepting the targeting strategy in the pilot test provinces, as well as other provinces.

National CS workshop. The Turkish MOH and an NGO conducted a national workshop, Pathways to Contraceptive Security, in 2001. Forty-four policymakers and leaders from the health sector participated, including representatives from the MCH/FP, provincial health directorates, local branches of the HSAF, NGOs, and the commercial pharmaceutical industry. Participants convened to

- review progress to date toward achieving contraceptive self-reliance and identify challenges for completing the process; and
- identify challenges for achieving full contraceptive security and establish strategies and responsibilities.

A joint action plan was developed with contributions from all stakeholders.

Ukraine

National RH Program (NRHP) for 2006–2010. Ukraine's MOH and Policy Development Group are including contraceptive security as a component of the new National RH Program for 2006–2010. An international NGO has assisted with the CS initiative and introduced the SPARHCS framework to the MOH. After the MOH conducted a SPARHCS assessment of the current RH situation, a multisectoral workshop was held with stakeholders, including representatives from various ministries, the NGO sector, the commercial sector, public and private health care providers, universities, foundations, UN organizations, and the Ukraine RH Network. It had the following objectives:

- Achieve a common understanding of contraceptive security
- Understand the use of SPARHCS as a tool in the strategic planning process and disseminate the findings from the MOH's assessment
- Identify CS issues in Ukraine
- Identify next steps for CS planning and advocacy
- Understand the components included in a financing model and the opportunities for using the model as a planning tool for the NRHP

Small grants to support CS advocacy efforts. An international NGO funded small grants to four NGOs of the Ukraine RH Network. All four NGOs successfully met the objective of their advocacy strategies—to increase funding for FP planning at the local level.

Current and upcoming activities. Planned activities include a national public hearing on current RH program implementation and advocacy for approval of a separate line item in local budgets to finance the RH program.

LESSONS LEARNED

Global experiences addressing contraceptive security are extremely varied. In some countries, efforts are only now beginning as the health sector recognizes the importance of long-term sustainability. In other countries, years of dedication and hard work have led to effectively addressing commodity issues—one of the key elements of contraceptive security.

The lessons learned about moving toward commodity security and sustainability can be grouped into two thematic issues: framing contraceptive security as an international concern with a local solution and illustrating how different policy mechanisms can contribute to achieving commodity security.

CONTRACEPTIVE SECURITY: FINDING A LOCAL SOLUTION

Frame the issue appropriately. The way that contraceptive security is framed affects how a country addresses it. In most countries where CS issues have been addressed, efforts have been in response to the phasing out of donor support for contraceptives. On one level, the need to think about sustainability has contributed to the RH sector's willingness to take on the issue. Yet the ways that the issue has been addressed has varied based on the strength of the country's RH program. In some cases—especially the countries where phaseout has already occurred because of the strength of the FP program and the country's level of economic development—efforts were spearheaded by national institutions. In other countries—including many of those documented in this report—the effort has been a joint collaboration between national and international institutions.

Mexico provides an example of efforts being spearheaded by national institutions. Although facilitated by USAID, the efforts with the public and private sectors were handled largely in separate, parallel planning processes. Spurred on by donor phaseout over several years, local institutions found alternative ways of reaching sustainability. For the public sector, finding the most cost-effective procurement mechanism and pooling resources played a major role. For the private sector, diversifying services and finding alternative sources of revenue was part of the solution.

While a national effort, the movement toward sustainability has also involved a high level of involvement by international organizations. Because the RH sector in most countries is less developed, international organizations have played an important role in facilitating the process toward sustainability. The collaboration between national and international organizations has, in general, been successful. International organizations, with technical assistance from projects like POLICY and DELIVER, have provided expertise in developing strategies and workplans. An advantage of these national/international collaborations is that international organizations are able to draw on the experiences of other countries and bring specific attention to issues related to commodity security in a way that national organizations, with their competing priorities, may not be able to do.

Employ policy champions to increase awareness. Although most countries have a national FP program, the attention that the program receives is often linked to the level of attention given to contraceptive security. A critical factor contributing to the success of both FP programs and commodity security efforts is having well-positioned policy champions capable of drawing attention to the benefits of family planning, and consequently to the importance of a sustainable FP program. Two illustrative examples are Jordan and Egypt, where the respective heads of state are in favor of FP efforts. In Jordan, King Abdullah II saw the advantages of family planning and reduced population growth on national economic development and became a champion for the national FP program. Similarly, President Hosni Mubarek of Egypt spoke of the benefits of family planning, thus establishing it as a national priority. Neither leader

has explicitly mentioned the importance of commodity security, but through their ongoing support of family planning in general, FP remains a priority within the ministries of health, and, consequently, attention has been given to commodity security.

Gain the appropriate political commitment. An additional factor contributing to the success of contraceptive security is political commitment. For CS efforts to be successful, the Ministry of Health must recognize the importance of contraceptive security and take a leadership role in working to achieve it. Although achieving contraceptive security is a long-term goal and requires the involvement of all RH sector stakeholders, without MOH leadership, CS efforts are not likely to be successful. The timing of donor phaseout and internal political processes, such as elections, may temporarily challenge CS efforts. For example, during the months prior to elections in many countries, public sector activities come to a stand still. CS issues may receive little attention during those months prior to and after an election because incumbents do not want their endeavors to be too closely linked with their political party, which might cause a new government from an opposition party to ignore the issues. These instances, however, highlight the importance of framing contraceptive security in a way that transcends being associated with a specific political party.

Use country-specific approaches. Finally, for contraceptive security to be considered a national issue, it must be framed as a national issue. Materials and messages must be written or translated into local languages and with country-specific data for leaders to take on CS as a priority. When reading and hearing a message in their local language, stakeholders are more likely to understand it and not see it as a copy of something that was developed for another country. Furthermore, valuable tools for preparing national CS messages have been the SPECTRUM models, especially RAPID and FamPlan. In Rwanda, for example, an important tool for gaining political support for contraceptive security was an analysis of national data using the RAPID model in order to illustrate the effects of rapid population growth on health, education, agriculture, urbanization, the national economy, and the environment. By using the most current national data, the RAPID model presents scenarios likely to occur if contraceptive security is not effectively addressed. Moreover, developing these types of materials in local languages helps frame contraceptive security as a local issue—but of global importance—with solutions to be found at the local level.

POLICY MECHANISMS USED IN ADDRESSING CONTRACEPTIVE SECURITY

As part of the solution to achieve commodity security, a range of policy mechanisms have been used. Some of the policy approaches address how the market for FP services and products is segmented, normally leading to a reduction in the role of the public sector and an increase in the role of the private sector. An additional policy mechanism that has proved effective is the creation of a line item in the national or sub-national budget for the purchase of contraceptive commodities. Often related to this policy approach is including contraceptives in the country's list of essential drugs.

Coordinating committee. Preparing a national CS strategy and forming a coordinating body are critical mechanisms for addressing contraceptive security. The CS committee, which is a multisectoral coordinating group, is charged with preparing and implementing strategies related to FP sustainability. Often with assistance from donors and international organizations, the committee develops a CS strategy that serves as a road map for how the country will address various issues. The development of the strategy requires involving a wide range of public, commercial, social marketing, and NGO stakeholders, with each group having a role in implementing the strategies. Having a representative of the Ministry of Finance on the CS Committee has proved helpful for implementing some strategies related to increasing funding from the government for commodities or other strategies to guarantee sufficient funds for contraceptives.

Market segmentation and private sector involvement. While most CS committees normally include the leading private sector players, such as NGOs and IPPF affiliates, involving the commercial sector is an important—and at times challenging—part of a CS strategy. In most countries, a critical challenge for achieving CS is to reduce the use of public sector services by the wealthier segments of the population, shifting them to the commercial sector. Thus, positioning the commercial and private sectors to provide services to more people requires that they be aware of this effort and have an active voice in the process.

Means testing. The challenge of shifting wealthier clients to using private sector services normally requires specific policy initiatives. Through means testing and targeting public resources, governments are able to focus their limited resources on the poor, while the non-poor either find alternative sources of services or pay for public sector services. An approach implemented in Romania used means testing to target free public sector FP services to the poor. To be eligible for those services, a person must qualify as poor according to local government standards and obtain a certificate indicating their poverty status; students were also eligible to receive free services. In using such an approach, the non-poor had the choice to pay for services from the public sector or rely on the private sector. A less rigorous approach was used in Turkey, where people could declare themselves to be poor and receive free family planning services. Those people who could afford to pay generally chose to do so.

Budget line item for contraceptives. Another strategy that CS committees have implemented is the creation of a protected line item for contraceptives in the national or MOH budget. Having a separate line item encourages policymakers to view supplying contraceptive commodities as an integral part of the health program. With a protected line item, funds for contraceptives have high visibility; however, if the funds are not spent, the likelihood of being funded at the same level during the following year is greatly reduced. Thus, when a protected line item is in place, having a well-designed procurement system that will spend the funds in a timely way is also important.

Contraceptives included on the list of essential drugs. Including contraceptives on a country's list of essential drugs has also been a policy mechanism to draw greater attention to contraceptive security, especially in places where a budget line item is not feasible. Although being included on the list does not guarantee that sufficient quantities will be procured, most drugs included on the list are higher priorities for public sector facilities and the likelihood of stock outs is lower.

EXPERIENCE SUGGESTS…

Two additional lessons have been learned about policies addressing contraceptive security:

1. Decisionmaking and policy implementation occurs at multiple levels. CS-related policies may be addressed at the national level, where strategies, goals, and objectives are developed, but implementation takes place at several levels, including at districts and municipalities. In countries where the health sector is decentralized, decisions are made at numerous levels, increasing the requirement for coordination. Coordinating policy implementation that involves both the public and private sectors may require greater effort.

2. The existence of CS policies does not necessarily translate into desired results. The policy development phase represent good intentions and well-designed action plans, but it can lack sufficient guidance for implementation or the needed levels of political will. Budget shortfalls, changes in government, and social and economic crises can all affect the successful implementation of public policies.

CONCLUSION

Results from the global survey indicate that there are many diverse CS-related activities taking place. In some countries, where family planning has received little attention, activities that increase attention to family planning also contribute to making it more sustainable. In other areas where it is well established, efforts tended to be directed more toward addressing phaseout and finding ways to support local procurement and financing of commodities. In addition, these countries were also addressing greater involvement of the private sector.

With that said, it is difficult to find well-defined trends or draw generalizations from this survey. Even within regions, because countries vary in many different ways, it is difficult to make generalizations. However, there are a few patterns that can be discerned. It is evident that countries with national RHCS strategies tend to have national coordinating committees.

LAC countries are the closest to having their own sustainable contraceptive systems, as they have experienced more donor phaseout than sub-Saharan Africa, Asia and the Near East, or Europe and Eurasia. Because many LAC countries have decentralized their health sector, financial allocation decisions are often made at many levels.

On the whole, survey respondents were unclear on which documents actually address funding for contraceptives. Answers varied widely across regions and even within countries. It is clear that even if documents exist, they are not being widely distributed. As a result, individuals are unlikely to have a clear understanding of how countries are addressing CS issues.

Most countries had estimates for the amount of funding needed to meet their contraceptive needs. However, most respondents could not provide detail on the exact estimates or if funds had actually been approved, dispersed, or spent. This type of information may be difficult to obtain, but is critical to developing a CS strategy.

Across regions, it appears that when making links between contraceptive use and other themes related to improving health status (poverty reduction, HIV reduction, maternal health), poverty reduction is the least popular. This was particularly true in the LAC region. There, most of the activities focused on the connection between contraceptive use and maternal health. While respondents from sub-Saharan Africa indicated that many different types of advocacy activities had taken place, most of them focused on condom use related to reducing HIV.

In many of the countries that have begun to address CS issues, international NGOs have played an important role in getting the CS topic on the public sector agenda. The countries appear to understand that donor phaseout is planned, but often do not know how to put themselves on the course to becoming self-reliant. The role of international organizations in providing technical assistance and helping to foster public/private partnerships has contributed to CS efforts.

While it is evident that NGOs, government agencies, and donors are active in advocacy, policy dialogue, and awareness-raising efforts to increase support for contraceptive security, these activities are not well evaluated. Many respondents noted that it is difficult to say what kind of impact their projects or activities have had because they have not been evaluated.

The activity data in this report gives us a sense of what is being done within countries to achieve contraceptive security. However, donors undertook some of the reported activities. When activities are

not initiated by government agencies or local NGOs, it is unlikely that they are fully engaged in taking the necessary steps to achieve contraceptive security.

Contraceptive security is a long-term initiative that requires a concerted effort by the public and private sectors, donors, and international organizations. While few countries have achieved contraceptive security, many—if not most—have now heard the term and are aware of the need to move toward it. Many countries are moving in the right direction, but will need to make substantial efforts to move beyond donor dependence and ensure that women and men have access to the contraceptive methods they desire.

APPENDICES

Appendix 1. PRSP Analysis

In 2004, the POLICY Project conducted a desk review of 45 Poverty Reduction Strategy Papers (PRSPs), with the aim of learning how these strategic documents addressed family planning and/or reproductive health (FP/RH) finance, logistics systems, commodities, and quality of service. More specifically, the aim was to determine whether these PRSPs included a budget line item for family planning and/or reproductive health. Out of the 45 countries (25 in SSA, four in LAC, nine in ANE, seven in E&E), only five countries had a line item dedicated to family planning and/or reproductive health. In general, the lack of funding set aside for FP/RH programs suggests that they are not considered to be an essential poverty reduction strategy.

This review revealed that PRSPs are general documents and tend not to address specific topics such as FP/RH commodities. They are meant to serve as a framework to bring together several sectors and discuss long-term, results-focused plans. For example, the PRSPs contain a range of information, from unemployment alleviation to water and sanitation programs. The health section alone includes a plethora of issues, varying from infectious diseases to sexually transmitted diseases. FP/RH programs are a small section of the health or population management sections. Generally, these PRSPs acknowledged there is a link between poverty and large family size. The majority mentioned improving the performance of the RH programs, and there were general goals of increasing prenatal care, decreasing maternal mortality and morbidity, and improving access to essential services. However, these goals were rarely quantified.

The following discussion focuses only on countries for which we have PRSP information and from which we obtained interview data.

Sub-Saharan Africa: All 25 PRSPs mentioned family planning, reproductive health, or maternal and child health. Ghana included a budget line for FP or RH programs in its 2003 PRSP. Ghana's two-pronged approach to FP/RH includes:

- Decentralization of service delivery—"decentralization of counseling services and sale of contraceptives through greater use of community agents, including maternity homes and field workers"
- Institution of a major national campaign—"a comprehensive and systematic culturally sensitive information, education, and communication (IEC) [campaign] on family will be undertaken nationwide"

(Ghana PRSP, 2003, page 108)

Latin America and the Caribbean: Of the LAC PRSPs (Honduras, Nicaragua, and Bolivia,), only Honduras had a budget line for FP and RH services. The line item called for $25 million to be allocated between 2002 and 2005. Honduras' 2001 PRSP mentioned reducing maternal mortality by increasing contraceptive prevalence, as well as increasing the availability of FP and RH services. Nicaragua's 2003 PRSP mentions improving access to and the quality of FP/RH services. Its broad objectives include:

- "Increase access to reproductive healthcare services to individuals of all ages by 2015"

(Nicaragua PRSP, 2003, page 87)

Bolivia's 2001 PRSP mentions increasing access to RH services, encouraging birth spacing, and preventing adolescent pregnancies, although neither family planning nor contraceptives are explicitly mentioned. Bolivia's brief reference to reproductive health programs states:

"Sexual and reproductive health programs will be continued to ensure longer birth spacing, so as to avoid frequent pregnancies that increase the likelihood of a mother's having low birth weight babies." *(Bolivia PRSP, 2001, page 95)*

Asia and the Near East: Only Pakistan and Nepal had budget lines for FP/RH programs. Nepal's 2003 PRSP made reference to a population management strategy that included increasing access to FP services by rural populations. It states "Management of the growing population by enhancing the accessibility of rural population to family planning services….Given the inadequate staffing and quality of health facilities in rural areas, the government will make recruitment and transfer process of health facilities in rural areas…"*(Nepal PRSP, 2003, page 55).* The PRSP projected a total budget of 1.97 billion Rs. for 2004/2005 for basic health and family planning.

Pakistan's 2001 PRSP has detailed information on FP/RH programs in the Population Planning section. It includes a thorough description regarding service delivery infrastructure, areas of improvement, and financing.

Vietnam's 2004 PRSP acknowledged the correlation between large families and poverty, and described how to improve the quality of FP/RH services, without including specific funding related to contraceptives. The reference made to their population strategy follows:

"Consider implementation of family planning and the reduction of the birth rate to be one of the important steps to poverty reduction. Attach special attention to publicize family planning to couples of high fertility age…" *(Viet Nam PRSP, 2004, page 106)*

Europe and Eurasia: Tajikistan's 2004 PRSP referenced family planning as a component of a poverty reduction strategy and included a budget line for FP/RH programs. $585,000 was allotted for the promotion of family planning and reproductive healthcare, which includes the following actions:

- To increase level of knowledge on family planning and the healthy way of life
- Provision of contraceptive means to population
- Rehabilitation of buildings provision of resources

(Tajikistan PRSP, 2004, Annex page 9)

Appendix 2. Survey Respondents

Country	No. of Respondents	Respondent's Affiliation
Sub-Saharan Africa		
Benin	5	1. Director of Programs & Procurement, Benin Association for Family Welfare (ABPF); 2. Head of Social Marketing, ABPF; 3. Director of National Budget, MOH; 4. Director of Family Health, Division of Family Planning & Logistics, MOH; 5. Head of Reproductive Health Programme, UNFPA
Botswana	4	1. Country Representative & National Program Officer, UNFPA; 2. Executive Director & Clinical Service Provider, Botswana Family Welfare Association; 3. Acting Reproductive Health Manager, Family Health Department, MOH; 4. Chief Pharmacist and Chief Central Medical Stores, MOH
D.R. Congo	1	Association for Family Welfare and Planned Pregnancy (ABEF-ND)
Eritrea	1	Family and Reproductive Health Unit Head, MOH
Ethiopia	6	1. National Program Officer for Reproductive Health, UNFPA; 2. Senior Technical Advisor, POLICY Project; 3. Head, National Office of Population; 4. Executive Director, Family Guidance Association of Ethiopia; 5. Advocacy and Networking Officer, Consortium of Reproductive Health Associations (CORHA); 6. Family Planning Expert, MOH
Ghana	5	1. Resident Advisor, JSI/DELIVER; 2. Executive Director, Ghana Social Marketing Foundation (GSMF); 3. Head, Policy, Planning & Budget Unit, MOH; 4. Senior Program Advisor, POLICY Project; 5. National Family Planning Coordinator, Ghana Health Services
Guinea	1	Executive Director, Guinean Association for Family Welfare-IPPF affiliate (AGBEF)
Kenya	7	1. Assistant Deputy Director, National Council for Population and Development; 2. Program Manager, Family Planning, MOH; 3. Head, Division of Reproductive Health, MOH; 4. Program Director, Family Planning Association of Kenya; 5. Director of Medical Services, MOH; 6. Director, National Council for Population and Development (NCPD); 7. Family Planning/Reproductive Health co-coordinator, POLICY Project
Lesotho	2	1. Program Director, Lesotho Planned Parenthood Association; 2. Assistant, Population Services International (PSI)
Madagascar	1	Executive Director, Fianakaviana Sambatra – IPPF affiliate (FISA)
Malawi	8	1. Program Officer for Reproductive Health, UNFPA; 2. Sexual Reproductive Health Development Officer, Reproductive Health Unit-MOH; 3. PHN (Population, Nutrition, Health) Officer, USAID/Malawi; 4. Senior Deputy Budget Director, Funding & Operations, MOF; 5. Program Coordinator, Family Planning Association of Malawi; 6. Chief Stores Officer, Central Medical Stores-MOH; 7. Health Planning Technical Assistant, Sector Wide Approaches Secretariat; 8. Acting Resident Logistics Advisor, JSI/DELIVER
Mali	4	1. General Pharmacist & Director of CAG, Central D'Achat des generiques; 2. Doctor & Medical Assistant, DNS (Direction Nationale de la Sante)/ DSR (Direction de la Sante de la Reproduction); 3. Resident Advisor, DPM (Division de la Pharmacie et des Medicaments)/DELIVER; 4. Health Program Management Specialist, USAID Mali

Mozambique	5	1. Director, Mozambican Association for Family Development (AMODEFA); 2. Community Health Director, MOH; 3. PHN Specialist, USAID; 4. Assistant Representative, UNFPA; 5. Technical Advisor on Population, Ministry of Finance and Planning
Niger	2	1. Technical Director, Project Reproductive Health; 2. President/Midwife, Dimol (Reproductive Health NGO)
Nigeria	5	1. Assistant Director, Department of Community Development & Population Activities, MOH; 2. Assistant Representative for Reproductive Health, UNFPA; 3. Executive Director, Planned Parenthood Foundation of Nigeria; 4. Senior Program Manager for Reproductive Health, USAID; 5. Desk Officer, MOF
Rwanda	1	Health Care Officer, UNFPA
Senegal	1	National Program Officer, Senegalese Association for Family Welfare (ASBEF)–IPPF Affiliate
South Africa	4	1. Senior Advisor for AIDS & Reproductive Health, USAID; 2. Assistant Director, Department of Health (Maternal, Child, and Women's Health); 3. Program Associate, Population Council; 4. CEO, Planned Parenthood Association of South Africa
Swaziland	5	1. Supplies Coordinator, Family Life Association of Swaziland; 2. Program Manager, Sexual & Reproductive Health, Ministry of Health & Social Welfare; 3. Acting Director of Budget & Economic Affairs, MOF; 4. HIV/AIDS Program Coordinator, US Embassy; 5. Program Manager, PSI Swaziland
Tanzania	4	1. Assistant Representative, UNFPA; 2. Procurement and Supplies Manager, Tanzanian Family Planning Association (UMATI) –IPPF Affiliate; 3. Principle Finance Net Officer, MOH; 4. Head of Reproductive and Child Health Section, MOH
Togo	5	1. Executive Director, Togoese Association for Family Welfare-IPPF Affiliate (ATBEF); 2. Director, Division of Family Health, MOH; 3. Country Representative, PSI Togo; 4. Head of MOH Accounting Department, MOH/MOF
Uganda	3	1. Head of Family Health Department, Population Secretariat (POPSEC)-Ministry of Finance; 2. National Programme Manager, Family Planning Association of Uganda (FPAU); 3. Principal Medical Officer, MOH
Zambia	4	1. Advocacy Advisor, POLICY Project; 2. Adolescent and Reproductive Health Specialist, MOH; 3. Health Advisor for Systems & Reproductive Health, USAID; 4. Director of Programs, Planned Parenthood Association of Zambia
Zimbabwe	4	1. Director, Office of Health, USAID; 2. Director of Finance, Ministry of Health and Child Welfare; 3. Former Executive Director, Zimbabwe National Family Planning Council; 4. Administration and Procurement Manager, PSI
Latin America and the Caribbean		
Bolivia	1	Executive Director, Center of Investigation, Education, and Services (CIES)-IPPF affiliate
Ecuador	2	1. Executive Director, Medical Center for Orientation and Family Planning-CEMOPLAF (NGO); 2. Director of Normatization of the National Health System, MOH

El Salvador	4	1. Assistant Representative, UNFPA; 2. National Family Planning Program Coordinator, MOH; 3. Reproductive Health Specialist, USAID; 4. Executive Director, Salvadoran Demographic Association -IPPF affiliate
Guatemala	4	1. Coordinator National Program for Reproductive Health, Ministry of Public Health and Social Assistance (MSPS); 2. Director of Strategic Planning, MSPS; 3. Expert in Family Planning; 4. Director of Mother & Child Section, Guatemalan Social Security Institute (IGSS)
Haiti	5	1. Chief of Party of Management for Science & Health's USAID-funded Haiti Health Systems 2004 project; 2. Expert, UNFPA; 3. Director of Reproductive Health Program, Reproductive Health Division of MOH; 4. Country Director, POLICY Project; 5. Director of Private Sector Assistance Association
Honduras	3	1. Reproductive Health officer, UNFPA; 2. Director of Maternal & Child Health/Family Health, MOH; 3. Population advisor, USAID
Jamaica	4	1. Former Executive Director of National Family Planning Board; 2. Executive Director of National Family Planning Board; 3. UNFPA; 4. Senior Policy Analyst, Office of Prime Minister
Mexico	3	1. Director General National Center for Gender Equity and Reproductive Health; 2. Reproductive Health Coordinator, Mexican Social Security Institute; 3. Commercial Director., DKT International (Social Marketing Organization)
Nicaragua	1	Director of Women and Adolescent Services, MOH
Peru	1	Country Director, POLICY Project
St. Lucia	3	1. Project Coordinator, OPEC Fund/UNFPA/GOSL HIV/AIDS Prevention Project; 2. Medical Supplies Officer, MOH; 3. Administrative Assistant, St. Lucia Planned Parenthood Association
Trinidad/Tobago	2	1. Manager/Senior Pharmacist, MOH; 2. Health Promotion Advisor, PAHO/WHO
Asia and the Near East		
Bangladesh	4	1. Chief of Party, JSI/DELIVER; 2. PHN, Team Leader, USAID; 3. Social Marketing Company; 4. Director of Planning, Population Bhaban, Directorate of Family Planning
Cambodia	3	1. Assistant Representative, UNFPA; 2. Deputy Director of Finance and Budget Department, MOH; 3. Reproductive Health Coordinator, National Maternal and Child Health Center
Egypt	4	1. General Manager- National Budget Sector, MOF; 2. Head of Egyptian Family Planning Association; 3. Head of Population and Family Planning Sector, Ministry of Health & Population; 4. Deputy Director of POLICY Project
Indonesia	1	Head of Reproductive Health Services, Indonesian Planned Parenthood Association
Jordan	1	1. Country Manager, POLICY Project; 2. USAID PHN officer; 3. Head of MCH, MOH; 4. Director of MOH budget, MOF
Nepal	6	1. Managing Director, Nepal CRS Company (Social Marketing Company); 2. Assistant Representative, UNFPA; 3. Team leader, Nepal Family Health Project; 4. Senior Demographer, Family Health Department, MOH; 5.

		Program Director, Family Planning Association of Nepal; 6. Reproductive Health Specialist, USAID
Pakistan	1	Director General of Monitoring and Statistics, Ministry of Population & Welfare
Vietnam	5	1. Vice President of Vietnam Family Planning Association; 2. Deputy of Administrative Financing Department, MOF; 2. Country Director, POLICY Project; 3. National Program Officer of Reproductive Health Program, UNFPA; 4. Head of Population Department, National Committee for Population, Family, and Children (NCPFC)
Europe and Eurasia		
Tajikistan	3	1. Director National Reproductive Health Center for Republic of Tajikistan; 2. Project Manager "Gender & Development" NGO; 3. Chief Specialist of Budget Department, MOF
Turkey	4	1. Executive Director, Family Planning Organization of Turkey; 2. Assistant Representative & Reproductive Health Program Coordinator, UNFPA; 3. Unit Director of Family Planning & Maternal Health Services in the Mother-Child Unit of General Directorate of MOH; 4. Former Country Manager, POLICY Project
Ukraine	6	1. PHN Officer, USAID; 2. Head of Humanitarian Development Department, Ministry of Economy; 3. Board Member, Ukraine Family Planning Association; 4. Head of Department for Obstetrical care, MOH; 5. Country Director, POLICY; 6. Deputy Director, Mother & Child Health Project

Appendix 3. Selected FP and RH Indicators for Countries Included in Analysis

Africa				Percent Usage of Modern Methods, Married Women						
	% Unmet need	HIV Prevalence*	CPR	Any Modern Method	Pill	IUD	Injections	Other	Condom	Female sterilization
Benin 2001	27.2	1.9	19	7.2	1.8	.8	2.1	.4	1.3	.3
Botswana*	NA	37.3	40	39	14.3	1.7	8.1	1.1	15.5	1.2
Burkina Faso 2003	28.8	1.8	13.8	8.6	2.2	.4	2.5	1.2	2.1	.1
Congo, D.R. *	NA	4.2	31	4	.4	.1	.4	.6	.5	.2
Eritrea 2002	27	2.7	8	5.1	1.4	.4	2.6	0	.6	.2
Ethiopia 2000	35.8	4.4	8.1	6.3	2.5	.1	3.1	0	.3	.3
Ghana 2003	34	2.2	25.2	18.7	5.5	.9	5.4	.6	3.1	1.9
Guinea 1999	24.2	3.2	6.2	4.2	2.1	.2	1	0	.6	.3
Kenya 2003	24.5	6.7	64.2	55.1	32.3	7.9	33.2	4.2	10.2	4.3
Lesotho*	NA	28.9	30	30	9.4	2.6	13.9	.3	1.8	1.3
Madagascar 1997	25.6	1.7	19.4	9.7	2.4	.5	4.7	.5	.7	1
Malawi 2000	29.7	14.2	30.6	26.1	2.7	.1	16.4	.2	1.6	4.7
Mali 2001	28.5	1.9	8.1	7	2.8	.2	2.1	.1	.3	.3
Mozambique 1997	22.5	12.2	5.6	5.1	1.4	.3	2.3	0	.3	.7
Niger 1998	16.6	1.2	8.2	4.6	2.8	.1	1.5	.1	0	.1
Nigeria 2003	16.9	5.4	12.6	8.2	1.8	.7	2	.1	1.9	.2
Rwanda 2000	35.6	5.1	13.2	5.7	1	.1	1.9	.1	.4	.8
Senegal 1999	34.8	.8	10.5	8.2	3.2	.9	2.3	.5	.7	.5
South Africa 1998	15	21.5	56.3	55.1	10.6	1.8	23.2	2.1	1.7	15.8
Swaziland*	NA	38.8	28	26						
Tanzania 1999	21.8	8.8	25.4	16.9	5.3	.4	6.3	.1	2.7	2
Togo 1998	32.3	4.1	23.5	7	1.2	1	2.1	.9	1.5	.4
Uganda 2000/01	34.6	4.1	22.8	18.2	3.2	.2	6.4	.3	1.9	2
Zambia 2001/02	27.4	16.5	34.2	22.6	11.9	.1	4.5	.4	3.8	2
Zimbabwe 1999	12.9	24.6	53.5	50.4	35.5	.9	8.1	.6	1.8	2.6

Source: DHS data
*Data from Population Reference Bureau Data Finder

LAC				Percent Usage of Modern Methods, Married Women						
	% Unmet need	HIV Prevalence*	CPR	Any Modern Method	Pill	IUD	Injections	Other	Condom	Female sterilization
Bolivia 2003	22.7	.1	58.4	34.9	3.6	10.2	8	.2	3.9	6.5
Ecuador*	No data	.3	66	50	11.1	10.1	3.5	.2	2.7	22.5
El Salvador*	No data	.7	67	54.1	8.1	1.5	8.9	.7	2.5	32.4
Guatemala 1998/99	23.1	1.1	38.2	30.9	5	2.2	3.9	.8	2.3	16.7
Haiti 2000	39.8	5.6	28.1	22.8	2.3	.1	11.8	2.4	2.9	2.8
Honduras*	No data	1.8	62	51	9.9	8.5	0	0	3.2	18.1
Jamaica*	No data	1.2	66	63	21.2	1	10.9	.4	17	12.3
Mexico*	No data	.3	68	59	6.9	14.2	3.2	1.4	3.8	30.6
Nicaragua 2001	14.6	.2	68.6	66.1	14.6	6.4	14.3	.5	3.3	25.3
Peru 2000	10.2	.5	68.9	50.4	6.7	9.1	14.8	1.7	5.6	12.3
St. Lucia*	No data									
Trinidad/Tobago*	No data	3.2	No data							

Source: DHS data
*Data from Population Reference Bureau Data Finder

Asia				Percent Usage of Modern Methods, Married Women						
	% Unmet need	HIV Prevalence*	CPR	Any Modern Method	Pill	IUD	Injections	Other	Condom	Female sterilization
Bangladesh 1999/00	15.3	No data	54.3	44	23.3	1.3	7.3	1	4.3	6.8
Cambodia 2000	29.7	2.6	23.8	18.8	4.5	1.3	7.4	.3	.9	1.5
Egypt 2003	9.5	.05	60	56.6	9.3	36.7	7.9	1	.9	.9
Indonesia 2002	8.6	.1	60.3	56.7	13.2	6.2	27.8	4.7	.9	3.7
Jordan 2002	11	.05	55.8	41.2	7.5	23.6	.9	.3	3.4	2.9
Nepal 2001	27.8	.5	39.3	35.4	1.6	.4	8.4	6.9	2.9	15
Pakistan*	31.8	.1	28	20	1.9	3.5	2.6	.05	5.5	6.9
Vietnam 2002	4.8	.4	78.5	56.7	6.3	37.7	.4	.5	5.8	5.9

Source: DHS data
*Data from Population Reference Bureau Data Finder

Eurasia				Percent Usage of Modern Methods, Married Women						
	% Unmet need	HIV Prevalence*	CPR	Any Modern Method	Pill	IUD	Injections	Other	Condom	Female sterilization
Tajikistan*	No data	.05	34	27	.6	25.1	.9	.1	.4	.2
Turkey 1998	10.1	0	63.9	37.7	4.4	19.8	.5	.6	8.2	4.2
Ukraine*	No data	1.4	68	38	3	18.6	0	1.1	13.5	1.4

Source: DHS data
*Data from Population Reference Bureau Data Finder