The Global Programme to Enhance Reproductive Health Commodity Security

Annual Report 2012

Cover photo: Solange is a volunteer Community Health Worker in her village of Sablogo, Burkina Faso. Photo credit: UNFPA Burkina Faso/Ollivier Girard
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The sources of information in this report include (1) Special national surveys conducted with UNFPA support in GPRHCS Stream 1 countries; (2) Reports submitted by UNFPA Regional and Country Offices; (3) UNFPA's donor support report; (4) national data sources including Ministry of Health (MOH) data, Demographic and Health Surveys (DHS); Multiple Indicator Cluster Surveys (MICS), and Reproductive Health Surveys (RHS); (5) global sources including databases and technical publications by UNFPA, UNICEF and WHO.

This technical annual report was produced by Desmond Koroma, Technical Specialist for Planning, Monitoring and Reporting, and Susan Guthridge-Gould, writer and editor, with the guidance of Dr. Kechi Ogbuago and Jagdish Upadhyay of the Commodity Security Branch, Technical Division, UNFPA New York. Valuable input was provided by donors, partners and colleagues in UNFPA Regional and Country Offices engaged in the UNFPA flagship thematic fund, the Global Programme to Enhance Reproductive Health Commodity Security.

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FOREWORD

Universal access to reproductive health is a target that has been agreed to by world leaders, as part of the Millennium Development Goals, particularly the goal to improve maternal health. Family planning is at the heart of sexual and reproductive health, and is anchored on respect for human rights, for women's empowerment, for informed choice, for social justice and equality and for increased access to information, education, quality health care, and life-saving commodities, including reproductive health commodities.

In 2012, governments and partners in 46 developing countries took action to ensure that national health systems have the capacity and resources to provide a steady supply of quality, affordable reproductive health commodities. This symbolizes a strengthened commitment by countries with high unmet need for family planning so that all may exercise their right to voluntary quality family planning information and services. To date, some 220 million women and girls around the world have unmet need for family planning. As this 2012 annual report shows, UNFPA's support for providing essential supplies has proven to be a practical and cost-effective means to achieve the vision echoed at the London Summit on Family Planning, which has inspired momentum since last year to create a change in the lives of at least an additional 120 million women in the coming years.

With its 40 some years of experience and track record in sexual and reproductive health, and extensive geographical presence, UNFPA is proud to say that through our Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), we have enabled women, men and young people to make their own reproductive decisions within a framework of human rights. More broadly, the commitment expressed by many countries to RHCS has strengthened their health systems in ways that improve delivery of comprehensive sexual and reproductive health to their poorest and hardest-to-reach communities.

This report highlights how UNFPA translates the framework for reproductive health commodity security into practice. In Burkina Faso and Lao PDR, community-based distribution agents have expanded access to contraceptives in places with high demand and unmet need for family planning. In Niger and Côte d'Ivoire, men have learned how to become champions for reproductive health through initiatives known as Husbands' Schools. In Sierra Leone, independent monitoring by a community-based organization has dramatically improved supply security. In 2012, Ethiopia achieved the highest 'no stock-out' rate of the GPRHCS programme countries. Investments in computerized supply systems in Haiti and Madagascar have paid off with national-level increases in the use of modern methods of contraception. These and other results are reported here in the GPRHCS Annual Report 2012.

In spite of this progress in some focus countries, we also recognize that much more needs to be done. As we all know, making reproductive health commodity security more widely available requires more than increasing supply and quality of contraceptives. It requires building an enabling environment for women, men and young people, especially girls, to exercise their rights. This requires more efforts to build national capacity, to strengthen health systems, to ensure appropriate policies and legislation, and to ensure that resources are in place to achieve these goals. And it means raising awareness about the positive impact of reproductive health commodity security as the key to voluntary and accessible family planning, HIV/STI prevention and maternal health services, which are all critical elements to sustainable development.

With renewed – and unprecedented – support from donors, and with the renewed commitment of developing countries themselves to ensure reproductive health commodity security, UNFPA remains confident that it can deliver a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled. Progress in reproductive health commodity security is crucial to making this mission possible.

Dr. Babatunde Osotimehin
Executive Director of UNFPA

This traditional birth attendant received training to become an advocate for reproductive health as part of a Community Wellness Advocacy Group (CAG) in Sierra Leone. CAGs incorporate men's peer education, inspired by a study tour of the Husband's School project in Niger.

Photo: UNFPA Sierra Leone

OVERVIEW

A secure, steady and reliable supply of reproductive health commodities has an impact on teenagers too young to be mothers, couples seeking to space the births of their children, women whose lives could be saved by medication during childbirth, and people in need of protection from HIV and sexually transmitted infections. In 2007, UNFPA launched a thematic fund to strengthen country-driven efforts to provide essential supplies for their reproductive health programmes. In 2012, UNFPA continued to see real progress, and we are pleased to share good news especially at this exciting time of heightened global attention to issues of longstanding concern to UNFPA.

This remarkable year placed the UNFPA at the centre of an unprecedented global commitment by governments in the South and in the North, donors, civil society organizations and philanthropic foundations – everyone was on board for family planning. In-house, there was a sense of UNFPA rising to deliver and lead in family planning, starting from the Executive Director and emanating throughout UNFPA offices across the developing world.

The ground-breaking **London Summit on Family Planning** in July galvanized global support for the urgent acceleration of efforts to address the unmet family planning and reproductive health needs of an additional 120 million women and girls. UNFPA participated extensively with preparations starting early in the year, leadership at the event itself, and continued leadership in the initiative created to deliver on the commitments made at the Summit – a partnership called Family Planning 2020 or **FP2020** that is chaired by UNFPA and the Bill & Melinda Gates Foundation.

The launch of the **UN Commission on Life-Saving Commodities for Women and Children** signaled heightened attention to underutilized reproductive health commodities. It was created and is chaired by the UN Secretary-General, with Nigeria's President and Norway's Prime Minister as co-chairs. The Executive Directors of UNFPA and UNICEF are co-vice chairs. Under the auspices of the Every Woman Every Child movement, the Commission seeks to increase access to life-saving medicines and health supplies for the world's most vulnerable people. Working groups address market shaping, regulatory environment, and best practices and innovation.

Most directly affecting the programme was a **meeting of the 46 GPRHCS focus countries**, held in Cotonou, Benin, in November. The meeting provided an opportunity to share information on key drivers for UNFPA's integrated response to sexual and reproductive health and to finalize the design of the new programme. The GPRHCS 2013-2017 was launched at this event. The new programme, which aims to accelerate and consolidate the gains of the first five years, is introduced at the back of this publication.

Another important event for the GPRHCS was the **UNFPA Global Consultation on Family Planning**, held in Tanzania in June. The consultation gathered participants from the 18 countries of the Bill & Melinda Gates Foundation project 'Strengthening Transition Planning and Advocacy at UNFPA'. Most countries were also part of the GPRHCS and the event provided a forum for the exchange of lessons learned. The agenda also focused on planning for the consolidation of UNFPA's lead role in family planning through its reform process.

Throughout much of 2012, then finalized in early 2013, the GPRHCS team contributed to the development of the first corporate-wide **Family Planning Strategy 2012-2020**. The team was fully involved in the process of conceptualizing and drafting the strategy, which aims to accelerate access to information, exercise of rights, services and supplies in the

poorest countries where the need is greatest. The five measureable results areas are: enabled environments; increased demand; improved availability and reliable supply of quality contraceptives; improved services; and strengthened information systems for family planning. The GPRHCS is well-positioned to make a significant contribution to the strategy, working to maximize efficiency where objectives overlap.

This report captures the results of the final year of the programme 2007-2012, and in so doing shows progress over its five full years of operation. It also sets the stage for the new programme 2013-2017.

We are pleased to present our 2012 Annual Report and recommend several recent related publications including *Ten Good Practices in Essential Supplies*, the reports of the UNFPA Global Consultation on Family Planning and the Meeting of the 46 Countries of the Global Programme to Enhance Reproductive Health Commodity Security, and *Increasing Access to Reproductive Health*, the booklet showcasing key results over the past five years.

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

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EXECUTIVE SUMMARY

The Global Programme to Enhance Reproductive Health Security is the UNFPA flagship thematic fund to ensure access to a reliable supply of contraceptives, condoms, medicine and equipment for family planning, HIV/STI prevention and maternal health services. The Global Programme has mobilized approximately $565 million between its launch in mid-2007 and the conclusion of its first five years in 2012. Support to reproductive health commodities through the GPRHCS 2008-2012 included contraceptives worth 86 million couple years of protection.

UNFPA provided multi-year support to 12 Stream 1 countries and funded targeted initiatives in 34 Stream 2 countries through the Global Programme in 2012. Some additional *ad hoc* support was provided to Stream 3 countries. Total expenditure for 2012 was $129 million (provisional).

Selected results and country highlights 2012

Results from the 12 Stream 1 countries and 34 Stream 2 countries showed continuing progress in 2012:

1. Use of modern methods of family planning has continued its positive upwards trend. In Burkina Faso, the contraceptive prevalence rate has increased 11.5 per cent from 8.6 per cent in 2003 to 13.3 in 2006 to 20.1 per cent in 2012. Ethiopia has nearly doubled its CPR from 13.9 per cent in 2005 to 27.3 per cent in 2011. Haiti, recovering from a devastating earthquake, has improved its CPR by 6 percentage points from 24.8 per cent in 2006 to 31.3 per cent in 2012. CPR in Lao PDR has increased by 8 percentage points from 35 per cent in 2005 to 43 per cent in 2012. In Madagascar, CPR has increased 11.2 percentage points from 18 per cent in 2004 to 29.2 per cent in 2009. CPR in Sierra Leone has increased by 4 percentage points from 7 per cent in 2008 to 11 per cent in 2011.

2. Access to a choice of appropriate methods is improving. The benchmark for this indicator was achieved in 11 Stream 1 countries where more than 75 per cent of service delivery points (SDPs) offered at least three modern methods of contraception, with Nigeria close at 74.1 per cent. In eight of these countries, there was availability at more than 90 per cent of SDPs. Compared to 2011, the percentage has improved in Burkina Faso, Lao PDR, Madagascar, Mali, Niger and Sierra Leone.

3. Supplies are more reliable. Seven Stream 1 countries had no stock-outs in more than 60 per cent their service delivery points, up one from the previous year. Ethiopia, Madagascar and Niger experienced no stock-outs in more than 90 per cent of SDPs for all levels of SDPs (primary, secondary and tertiary).

4. National strategic plans for RHCS are in place and being implemented under government leadership and with the involvement of relevant stakeholders in 11 of 12 Stream 1 countries (excepting Haiti) and 32 of 34 Stream 2 countries, as last year.

5. All Stream 1 and 2 countries have functional coordinating mechanisms for RHCS, consistent with last year.

6. Essential medicines lists exist in all 46 countries. The lists in all countries include life-saving maternal health and reproductive health medicines, and contraceptives.

7. All 46 countries include RHCS in their national Poverty Reduction Strategies and national health sector plans as of 2012, ensuring its priority at the highest levels. RHCS issues are also integrated into the Sector Wide Approaches for health in 11

Stream 1 and 31 Stream 2 countries, where there was an increase of four countries over last year.

8. Budget lines for RH commodities, a strong indicator of government commitment, are present in 11 countries, excepting Haiti, consistent with the previous year. Budget allocations increased in 2012 in Ethiopia, Lao PDR, Mali, Mongolia and Mozambique. Budget lines for contraceptives in Stream 2 countries increased from 20 countries in 2011 to 25 countries in 2012.

9. National technical expertise for commodity forecasting and for managing procurement processes is being used in 10 out of 12 Stream 1 countries.

10. Six Stream 1 countries had seven life-saving medicines available in more than 70 per cent of SDPs in 2012. A revision in the indicator tracking life-saving maternal health drugs increased the medicines from five to seven, adding Magnesium Sulfate and Oxytocin to the list. For reference, 11 Stream 1 countries had five essential maternal health drugs available in more than 70 per cent of SDPs in 2011.

11. Based on demand from countries, expenditure on capacity development compared to commodity procurement approached 50:50 in the common pool of funds. In addition, an earmarked contribution from DFID was directed to commodity procurement.

12. Funding levels for the GPRHCS reached an all-time high of $181 million, up from the previous high of $145 million in 2011. From its launch in mid-2007 to its conclusion in 2012, the GPRHCS mobilized $565 million from donor that have included over the years: Australia, Canada, Denmark, European Commission, Finland, France, Ireland, Liechtenstein, Luxembourg, Netherlands, Spain, Spain (Catalonia), United Kingdom, and private and individual contributors.

Positive change in the face of complex global issues would be impossible alone, and in 2012 UNFPA continued to rely on and support a wide network of partnerships at global, regional, national and local levels. Nongovernmental organizations (NGOs) are among the many valued partners that engage with UNFPA through the Global Programme. These partners help national governments with advocacy, technical training, developing models, delivering services and exchanging information. The Global Programme procured supplies for many NGOs, and benefitted from close collaboration in many ways. Key partners in 2012 included International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), Population Services International (PSI), and the Universal Access to Female Condom Joint Programme.

Selected countries with increased CPR

Particularly strategic action in the priority countries receiving sustained UNFPA support through the Global Programme is moving an indicator at the national level, where it tends to be difficult to demonstrate progress. Increases in contraceptive prevalence rate (CPR) in the following five countries (all Stream 1), show increases in the number of women using modern methods of contraception. The indicator is linked not only to functional systems for RHCS but also to empowerment and the exercise of the right to reproductive health, including family planning.

In **Burkina Faso**, the contraceptive prevalence rate has increased 11.5 per cent from 8.6 per cent in 2003 to 20.1 per cent in 2012. In 2009, the government engaged civil society organizations in a partnership for

community-based distribution of contraceptives, with GPRHCS support. In addition, sustained commitment to a multi-media behaviour change communication campaign has reached up to 60 per cent of the population with information to inspire action for better reproductive health, including family planning. Other key data gathered by UNFPA tracked RHCS progress in 2012: The percentage of service delivery points offering at least three modern methods of contraception increased from 90.3 per cent in 2011 to 99.5 per cent in 2012. Only 24 per cent of SDPs had seven life-saving maternal/RH medicines available in 2012. The percentage of SDPs reporting 'no stock-out' of contraceptives increased from 12.8 per cent in 2011 to 25.1 per cent in 2012.

Ethiopia has nearly doubled its CPR from 13.9 per cent in 2005 to 27.3 per cent in 2011. One important contributor has been the country's investment in training Health Extension Workers, in particular focusing on the use of long-lasting contraceptive implants. Towards institutionalizing RHCS, the curriculum at the Public Health School and School of Pharmacy at Addis Ababa University has incorporated RHCS. In addition, five universities have launched training towards task shifting among middle-level health workers for maternal health. The GPRHCS has supported these and other efforts and tracked RHCS progress in 2012: National budget allocations for RH commodities increased in 2012. At least three modern contraceptive methods were available in 96.4 per cent of service delivery points. Seven life-saving maternal/RH medicines were available in 54.6 per cent of SDPs in 2012. In the six months prior to the survey, some 97.6 per cent of SDPs reported 'no stock-out' of contraceptives – the highest 'no stock-out' rate among Stream 1 countries. Ethiopia experienced no stock-outs in more than 90 per cent of SDPs for all levels of SDPs (primary, secondary and tertiary).

Haiti, recovering from a devastating earthquake, has improved its CPR by 6 percentage points from 24.8 per cent in 2006 to 31.3 per cent in 2012. The country has implemented CHANNEL for computerized supply management, created an RHCS technical committee, studied RHCS in Rwanda, and held workshops to address family planning and stock-outs at health facilities. A recent national survey on GPRHCS indicators at service delivery points found improvements in the availability of life-saving maternal health medicines and a more secure supply with fewer stock-outs. At least three modern contraceptive methods were available in 84.3 per cent of service delivery points. Seven life-saving maternal/RH medicines were available in 73.6 per cent of SDPs in 2012. The percentage of SDPs reporting 'no stock-out' of contraceptives in the six months prior to the survey increased from 26.4 per cent in 2011 to 42.6 per cent in 2012.

CPR in **Lao PDR** has increased by 8 percentage points from 35 per cent in 2005 to 43 per cent in 2012. With GPRHCS support, the country has accelerated its development of human resources for health and an integrated logistics management information system. Use of radio and community outreach activities promoting reproductive health, including village Health Days, has grown. The success of community-based distribution agents serving the most rural areas with family planning supplies and services has been credited to a culturally-sensitive approach that builds capacity among local health workers who speak the same ethnic language and share the same cultural background. National budget allocations for RH commodities increased in 2012. At least three modern contraceptive methods were available in 91.4 per cent of service delivery points. Seven life-saving maternal/RH medicines were available in 53.1 per cent of SDPs in 2012. In the six months prior to the survey, 71.1 per cent of SDPs reported 'no stock-out' of contraceptives.

In **Madagascar**, CPR has increased 11.2 percentage points from 18 per cent in 2004 to 29.2 per cent in 2009. The government's adoption of computerized supply management using the UNFPA-developed CHANNEL software has enabled significant progress. Training workshops have engaged directors, inspectors and staff at central, regional and district levels. Stock-outs are down, more pharmacies and warehouses are functional, coordinating committees are meeting regularly, more women are using contraception, and more youth-friendly health centres have opened to

provide access to this underserved population. The percentage of service delivery points offering at least three modern methods of contraception has increased steadily from 30.8 per cent in 2009 to 47.8 per cent in 2010 to 77.5 per cent in 2011 to 95 per cent in 2012. Madagascar experienced no stock-outs in more than 90 per cent of SDPs for all levels of SDPs (primary, secondary and tertiary). Seven life-saving maternal/RH medicines were available in 66.9 per cent of SDPs in 2012. In the six months prior to the survey, 88.9 per cent of SDPs reported 'no stock-out' of contraceptives.

CPR in **Sierra Leone** has increased by 4 percentage points from 7 per cent in 2008 to 11 per cent in 2011. This progress reflects a dynamic commitment to new approaches, such as managing contraceptives and other drugs and medical supplies through a contract with a civil society organization. The government has adopted a computerized supply management system using CHANNEL software, and has deployed monitors and community wellness advocates to see that essential supplies reach people who need them. Sierra Leone made its first budget allocation in 2011 for reproductive health commodities, a sign of commitment advocated by the GPRHCS. The number of service delivery points offering at least three modern methods of contraceptive increased from 80.5 per cent in 2011 to 89 per cent in 2012. Seven life-saving maternal/RH medicines were available in 71.7 per cent of SDPs in 2012. The percentage of SDPs reporting 'no stock-out' of contraceptives in the six months prior to the survey increased from 35.4 per cent in 2011 to 44 per cent in 2012.

All of the above countries have a national strategic plan in place for RHCS, engage relevant stakeholders, have functional coordinating mechanisms for RHCS, include contraceptives on their essential medicines list, fund national budget lines for RH commodities, and (with the exception of Lao PDR), use national technical expertise for commodity forecasting and for managing procurement processes.

Major events of the year

A number of events in 2012 reinforced the significance of RH commodity security and furthered UNFPA programming in this regard. The **London Summit on Family Planning** urged acceleration of efforts to address the unmet family planning and reproductive health needs of an additional 120 million women and girls. A newly created **UN Commission on Life-Saving Commodities for Women and Children** advocated at the highest levels for the increased availability, affordability and accessibility of essential but underutilized commodities for maternal and child health. The **UNFPA Global Consultation on Family Planning** reported on a Bill & Melinda Gates Foundation project and gathered many countries of the GPRHCS in Tanzania in June. In November, a **meeting of the 46 GPRHCS focus countries**, held in Cotonou, Benin, served to launch the new programme (2013-2018), which aims to accelerate and consolidate the gains of the first five years.

There are many stories of success and of challenges, many of them interlinked with complex issues of poverty and equality, many in countries requiring strategic support for years to come. A number of these success stories are featured throughout this report. With the generous support of donors and the invaluable collaboration of our partners, the Global Programme to Enhance Reproductive Health Commodity Security will continue to support countries in their efforts to meet the reproductive health needs of their populations, especially the poor and underserved.

INTRODUCTION

Reproductive health commodity security (RHCS) is achieved when all individuals can obtain and use affordable, quality reproductive health supplies of their choice whenever they need them. It has a pivotal and strategic role in accelerating progress towards the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals, especially MDG 5 to improve maternal health. UNFPA joins with a wide range of partners in governments, other agencies and civil society to work towards these goals.

Background

For decades, the international community had viewed supplies for reproductive health services in isolation from programming. Funding was sporadic, which meant procurement was ad hoc, leading to dangerous shortfalls at family planning clinics, maternity hospitals, pharmacies and other distribution points. In response, UNFPA developed a mechanism to advance the concept of reproductive health commodity security, providing a more comprehensive view of the problems and solutions. UNFPA launched the Global Programme to Enhance Reproductive Health Commodity Security in 2007 to provide a structure for moving beyond *ad hoc* responses to stock-outs towards more predictable, planned and sustainable country-driven approaches for securing essential supplies and ensuring their use.

Concluding its fifth full year of operation in 2012, the GPRHCS has provided support to countries for activities that have yielded measureable results. The GPRHCS has provided support in two key areas: (1) develop capacity to strengthen health systems; and (2) procure reproductive health commodities. This fund has been a catalyst for national efforts to build stronger health systems to procure essential supplies. It has provided a framework for assisting countries in planning for their own needs. At the request of governments, UNFPA has provided strategic and pivotal support seeking comprehensive RHCS by working with partners in several key areas:

- **Integrate RHCS in national policies, plans and programmes** through evidence-based advocacy with policy makers, parliamentarians, partners in government and many other valued partners in each country, seeking to catalyze political and financial commitment;
- **Strengthen the delivery system** to ensure a secure, steady and reliable supply through improved logistics management information systems, often with computer software and training, as well as RHCS mainstreaming in the national health system;
- **Provide training to build skills** at every step of the supply chain, developing the human resources capacity of national staff for forecasting and procurement, pharmacists, warehouse managers, and health workers charged with providing RH information and services, among others;
- **Procure contraceptives** and other essential reproductive health supplies and promote their use through various mechanisms such as community-based distribution and social marketing, seeking to increase timely access to a choice of quality, affordable reproductive health commodities;
- **Increase access and create demand** by working within a rights-based approach that empowers individual choices and dignity, sharing information through behaviour change communication, and going the last mile to ensure access for underserved and hard-to-reach populations.

The GPRHCS has supported countries through three funding streams in order to address the specific needs of each country.

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

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

Stream 3 has provided emergency funding for commodities in countries facing stock-outs for reasons such as poor planning, weak infrastructure and low in-country capacity. Stream 3 has also provided support for countries facing humanitarian situations, including natural or man-made disasters. In these settings, the GPRHCS has worked closely with UNFPA's Humanitarian Response Branch and the United Nations High Commissioner for Refugees.

The funding streams have helped to organize country selection criteria and the designation of the level of country support, though 'streams' will no longer be applied starting with the new programme in 2013.

2012 Stream 1 countries	2012 Stream 2 countries	
1. **Burkina Faso**	1. Benin	18. Lesotho
2. **Ethiopia**	2. Bolivia	19. Liberia
3. **Haiti**	3. Botswana	20. Malawi
4. **Lao PDR**	4. Burundi	21. Mauritania
5. **Madagascar**	5. Central African Republic	22. Namibia
6. **Mali**	6. Chad	23. Papua New Guinea
7. **Mongolia**	7. Congo	24. Sao Tome and Principe
8. **Mozambique**	8. Côte d'Ivoire	25. Senegal
9. **Nicaragua**	9. Democratic Republic of the Congo	26. South Sudan
10. **Niger**	10. Djibouti	27. Sudan
11. **Nigeria**	11. Ecuador	28. Swaziland
12. **Sierra Leone**	12. Eritrea	29. Timor Leste
	13. Gabon	30. Togo
	14. Gambia	31. Uganda
	15. Ghana	32. Yemen
	16. Guinea	33. Zambia
	17. Guinea-Bissau	34. Zimbabwe

Structure of this report

This report showcases results in the 46 countries of the UNFPA Global Programme to Enhance Reproductive Health Commodity Security, including 12 Stream 1 and 34 Stream 2 countries. The structure of the report follows the programme's Performance Monitoring Framework. The results framework is intrinsically linked to the UNFPA Strategic Plan and is therefore one of the key platforms for delivering on the UNFPA mandate.

- Goal: Universal access to reproductive health
- Outcome: Increased availability, access and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the GPRHCS focus countries
- Output 1: Country RHCS strategic plans developed, coordinated and implemented by government with their partners
- Output 2: Political and financial commitment for RHCS enhanced
- Output 3: Capacity and systems strengthened for RHCS
- Output 4: RHCS mainstreamed into UNFPA core business
- Programme management

At the **goal** and outcome level, there is the goal of universal access to reproductive health by 2015. The **outcome** level seeks increased availability, access and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in GPRHCS focus countries. The outcome indicators against which progress is monitored include contraceptive prevalence rate (CPR) and unmet need for family planning. At the **output** level GPRHCS activities are supported to achieve four results: (1) Country RHCS strategic plans developed, coordinated and implemented by government with their partners; (2) Political and financial commitment for RHCS enhanced; (3) Capacity and systems strengthened for RHCS; (4) RHCS mainstreamed into UNFPA core business.

Progress towards the outcome on increasing availability, access and use is measured from several perspectives: For situational context, **national data** (mostly DHS or HMIS) is used to report on unmet need for family planning and contraceptive prevalence rate. National data sources include Ministry of Health (MOH) data, Demographic and Health Surveys (DHS); Multiple Indicator Cluster Surveys (MICS), and Reproductive Health Surveys (RHS).

Country-level progress for RHCS is measured using data from **special national surveys conducted every year with UNFPA support** for GPRHCS Stream 1 countries where such data is not otherwise available. The surveys look at representative samples of service delivery points (SDPs) that provide contraceptive methods or medicines. Reports are also submitted by UNFPA Regional and Country Offices.

Progress is also measured by tracking donor resources available for contraceptives including condoms, with data from UNFPA's donor support report published by the Commodity Security Branch based on donor databases. Other global sources include databases and technical publications by the United Nations, including by UNFPA, UNICEF and WHO, and by international development partners including Marie Stopes, IPPF and RH Supplies coalition and members of FP2020.

CHAPTER ONE:
TOWARDS UNIVERSAL ACCESS AND USE

Members of a civil society group monitor and load RH supplies in Bo, Sierra Leone. Photo: UNFPA Sierra Leone

UNFPA supports interventions that catalyze country-driven efforts towards a steady, secure and reliable supply of essential reproductive health commodities. The aim is to help countries achieve RHCS outcomes as an integral part of their overall health sector interventions. UNFPA is contributing towards the Millennium Development Goals, notably the MDG 5 target to achieve, by 2015, universal access to reproductive health.

Goal and context

Strategic interventions in commodity security have been catalytic for the implementation of sexual and reproductive health interventions, including family planning, maternal health and HIV prevention. Action in this area contributes to the achievement of universal access to reproductive health – which is the highest-level goal in the framework of the Global Programme to Enhance Reproductive Health Commodity Security. Since goal-level results are contributed to by all actors,

presentation of progress here should not be attributed alone to the GPRHCS or indeed UNFPA. This section is meant to provide information on current levels of achievement and place in context some of UNFPA support through its flagship thematic fund for reproductive health commodity security.

Goal:
Universal access to reproductive health by 2015

At the top of the Global Programme's Performance Monitoring Framework is the goal of universal access to reproductive health. At this 'goal level' progress is measured through three indicators: adolescent birth rate, maternal mortality ratio and youth HIV prevalence rate. These indicators also are used globally to measure progress in achieving MDG 5.

1.1 Adolescent birth rate

The adolescent birth rate (ABR) is a measurement of the number of births to women 15 to 19 years of age per 1,000 women in that age group. It relates to assessing the impact of various interventions being implemented to address the incidence of childbearing among adolescent women. The levels and trends of ABR could represent measures of success in addressing early marriage and early childbearing, family planning for young girls, and sexuality education and awareness raising interventions for young people to make informed choices. All of these have implications for the well-being of adolescent girls.

In most countries, including GPRHCS Stream 1 countries, adolescent birth rate (ABR) remains very high. According to the Millennium Development Goals Report 2011, sub-Saharan Africa has the highest adolescent birth rate – which has barely changed from 124 per 1,000 women 15-19 in 1990 to 122 in 2008.[1] GPRHCS Stream 1 countries in sub-Saharan Africa have higher ABR than the countries from other regions (Table 1). ABR is highest in Niger at 198.9 per 1,000 women 15-19, followed by Mozambique at 193 per 1,000 women 15-19 and Mali at 189 per 1,000 women 15-19. Globally, the number of women aged 15 to 19 will reach 300 million very soon and most of them will be in developing countries, especially sub-Saharan Africa, according to population estimates.

The GPRHCS provides a platform for helping countries design and implement family planning and maternal health programmes that address the special needs of adolescents. Specific activities implemented in 2012 will be presented in appropriate sections of this report.

Table 1: Adolescent birth rate for GPRHCS Stream 1 countries

Country	Year	Per 1,000 women 15-19
Burkina Faso	2009	130
Ethiopia	2010	79
Haiti	2003	68.6
Lao PDR	2005	110
Madagascar	2006	147.1
Mali	2004	189.6
Mongolia	2008	19.8
Mozambique	2007	193
Nicaragua	2005	108.5
Niger	2003	198.9
Nigeria	2006	123
Sierra Leone	2006	113

http://mdgs.un.org/unsd/mdg/SeriesDetail.aspx?srid=761 as on 20th March 2013

1 United Nations, The Millennium Development Goals Report 2011, UN, New York 2011, p.31

1.2 Maternal mortality ratio

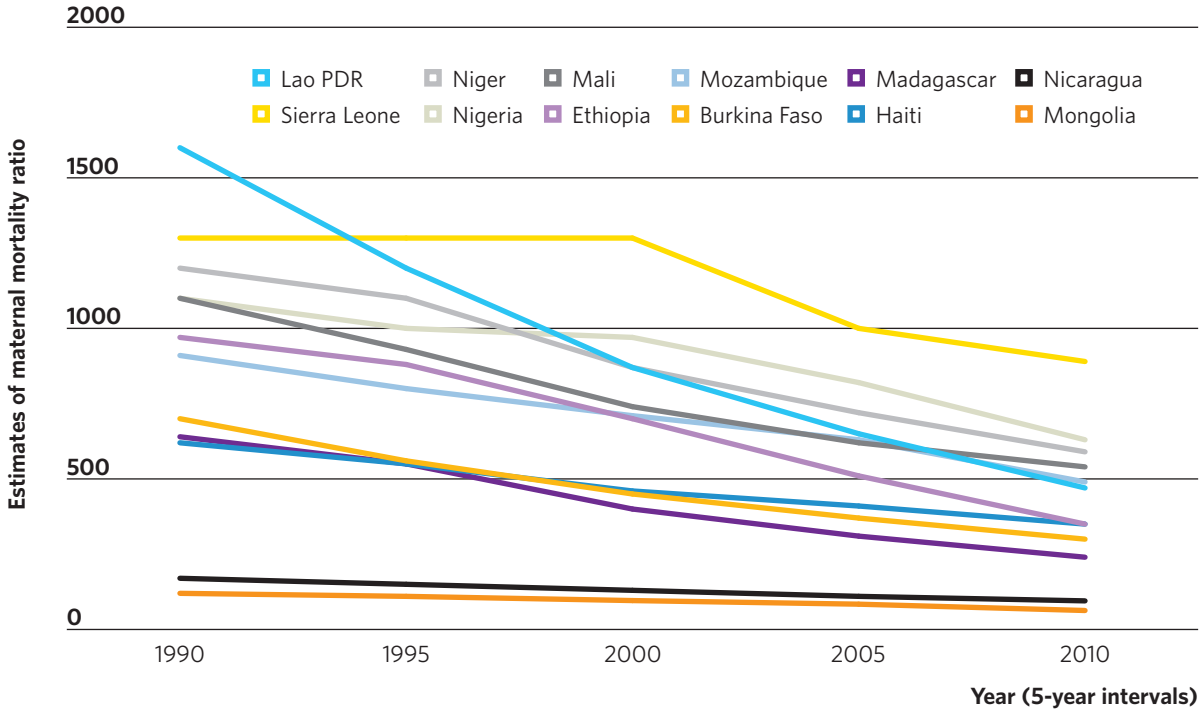
Maternal mortality ratio (MMR) refers to the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births. Pregnancy remains a major health risk for women in most countries despite evidence of proven interventions that could prevent disability and death related to pregnancy, according to the *Millennium Development Goals Report 2011.*

Maternal mortality has declined globally from 400 maternal deaths per 100,000 live births in 1990 to 210 maternal deaths per 100,000 live births in 2010,[2] recent maternal mortality ratio estimates show. Among countries of the GPRHCS, Mongolia and Nicaragua had the lowest MMR estimates among the GPRHCS Stream 1 countries 2009 to 2010 (Figure 1). Generally, MMR has declined in all the Stream 1 countries. The rate declined faster in Lao PDR than all the other countries: MMR in Lao PDR declined from an estimated 1,600 maternal deaths per 100,000 live births in 1990 to 470 maternal deaths per 100,000 live births in 2010. Although there has been improvement, MMR estimates for Sierra Leone continue to be the highest among the Stream 1 countries.

The GPRHCS serves as one of the main channels through which UNFPA works with countries to provide health care services and information for prevention and management of pregnancy-related complications. Specific interventions include the provision life-saving maternal health medicines, supporting the distribution mechanisms so that medicines and supplies are available at service delivery points and stock-outs are averted, training of skilled birth attendants, and provision of family planning information and services to prevent unwanted pregnancies and unsafe abortions. Other critical interventions such as provision of essential obstetric care are supported largely through the other strategic funding mechanisms.

2 Trends in Maternal Mortality: 1990 to 2010; Estimates developed by WHO, UNICEF, UNFPA and the World Bank; WHO 2012

Figure 1: Trends in estimates of maternal mortality ratio (per 100,000 live births) by 5 year intervals 1990 to 2010



Source: Trends in Maternal Mortality: 1990 to 2010; Estimates Developed by WHO, UNICEF, UNFPA, World Bank; See Annex.

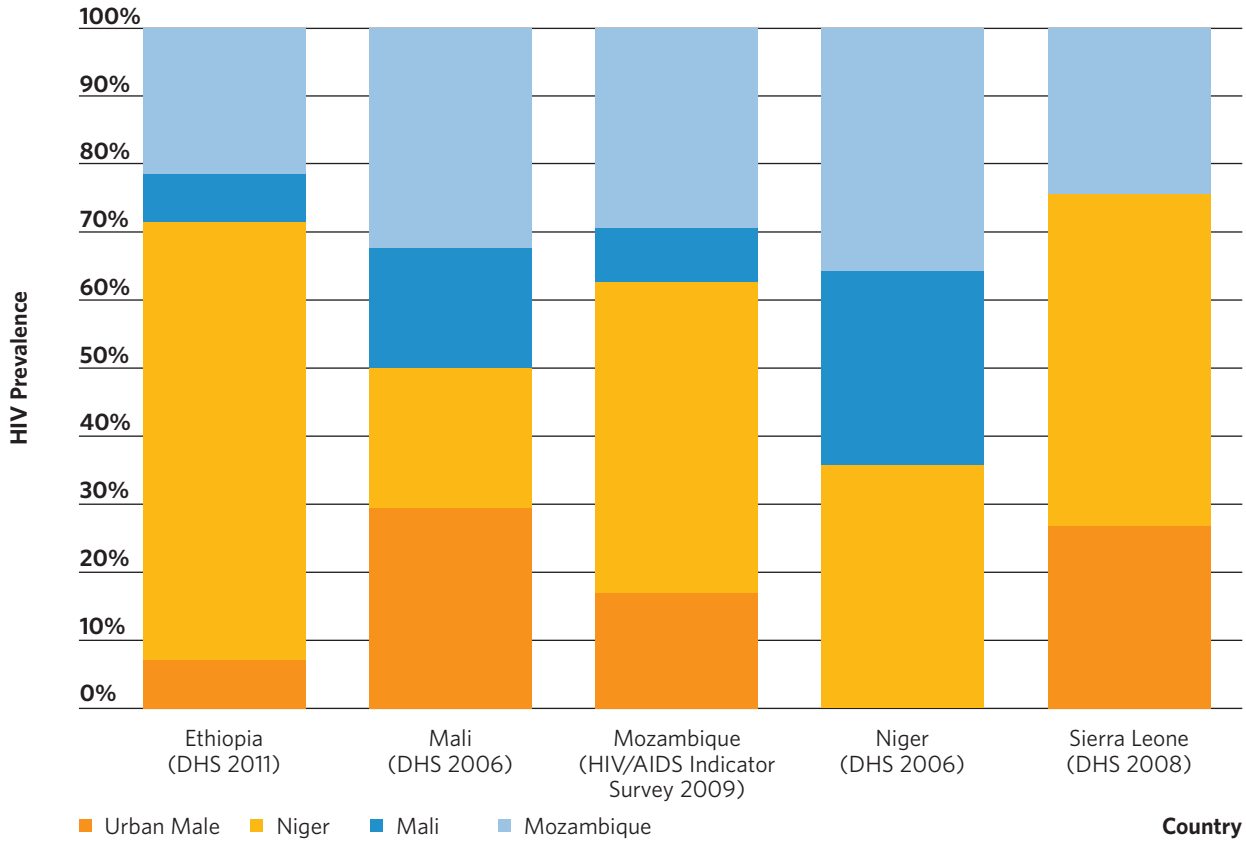
1.3 Youth HIV prevalence rate

The percentage of young people aged 15 to 24 years who are living with HIV out of total population in that age group provides a measure of the effect of HIV among young people and its ramifications for socio-economic development, and the impacts of interventions.

Globally, nearly 23 per cent of all people living with HIV are under the age of 25 and young people 15 to 24 account for 41 per cent of new infections among those aged 15 or older, according to the *Millennium Development Goals Report 2011*. HIV prevalence in most of the Stream 1 countries is higher in urban areas than in rural settings. In Ethiopia (DHS 2011), young people living in urban areas accounted for 75 per cent of the total HIV prevalence among young people 15 to 24 years compared to 25 per cent for rural residence. The pattern was the same in Sierra Leone (DHS 2008), where HIV prevalence among young people in urban areas accounted for 73 per cent of the total prevalence for that age group compared to 27 per cent for rural residence.

In almost all the countries, HIV is more prevalent among young women in urban areas than for males in urban or rural areas or females in rural areas (Figure 2). The surveys consistently show a higher prevalence among females. HIV prevalence is disproportionately higher among young women in both rural and urban settings than their male counterparts in rural and urban settings. Young women aged 15 to 24 years accounted for 85 per cent of the HIV prevalence among young people in that age group in Ethiopia; 75 per cent in Mozambique and 52 per cent in Mali.

Figure 2: HIV prevalence among young people aged 15–24 in selected GPRHCS Stream 1 countries by urban and rural residence



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

Generally, HIV prevalence has fallen by more than 25 per cent among young people in 15 of the most severely affected countries, mostly in sub-Saharan Africa, as they continue to adopted safer sexual practices – and progress in this direction is urgently needed.

To address the HIV prevalence among young people, GPRHCS has worked with governments and other partners to implement strategies such as comprehensive condom programming and supporting integrated sexual and reproductive health services delivery at country level.

Linking HIV responses with these services is an overarching strategy for reaching more people cost-effectively and moving towards universal access to prevention, treatment, care and support – including wider access for people living with HIV. As one of ten co-sponsors of UNAIDS, UNFPA works to intensify and scale up HIV prevention efforts using rights-based and evidence-informed strategies, including attention to the gender inequalities that add fuel to the epidemic. Reproductive health commodity security supports the strengthening of efforts to prevent HIV.

1.4 Unmet need and CPR

Unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour. Contraceptive prevalence rate (CPR) refers to the use of modern methods of contraception. Together, these national-level indicators provides context about the situation as reported at the national level by national sources. Both indicators are directly related to an outcome of the GPRHCS: increased availability, access and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the GPRHCS focus countries.

Outcome:

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

1.4.1 Unmet need for family planning

Women with unmet need are fecund and sexually active women who are not using any method of contraception, and who report not wanting any more children or wanting to delay the birth of their next child. The updated information on unmet need for family planning for 2012 is presented in Table 2.[3] The information has been updated for Burkina Faso, Haiti, Lao PDR, Mali, Mozambique, Niger, Nigeria and Sierra Leone. Unmet need has remained fairly constant in most of the countries, the exceptions being Lao PDR where it decreased from 27.3 per cent in 2005 to 20 per cent in 2012, and Mozambique where it increased from 18.4 per cent in 2003 to 22.3 per cent in 2011.

Through the GPRHCS, UNFPA works with governments to addressing unmet need for family planning. This is done through the broader framework of sexual reproductive health but specifically in the context of commodity security. Specific actions include the provision of commodities, advocacy for an enabling environment for family planning, logistics management, training of staff, raising awareness and generating demand and working to address barriers women have in accessing family planning services.

3 For unmet need and CPR, data are sourced from national survey results (mostly DHS) or from national HMIS where available. Since surveys are conducted infrequently updates for these indicators are presented when they are available.

Table 2: Unmet need for family planning for GPRHCS Stream 1 countries, percentage

Country	Baseline (2008)	2009	2010	2011	2012	Target (2013)
Burkina Faso	31.3 (MOH)	28.8 (MOH)	28.8 (MOH)	28.8 (MOH)	24.5 (DHS 2010)	NA
Ethiopia	34 (DHS 2005)	34 (DHS 2005)	34 (DHS 2005)	25 (DHS 2011)	25 (DHS 2011)	Less than 10%
Haiti	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	37.5 (DHS 2005-06)	38 (DHS 2012)	NA
Lao PDR	27.3 (LRHS 2005)	27.3 (LRHS 2005)	27.3 (LRHS 2005)	27.3 (LRHS 2005)	20 (Social Indicator Survey 2012)	NA (CPR target is set in MNCH Strategy rather than unmet need
Madagascar	24 (DHS 2004)	19 (MOH)	19 (MOH)	19 (DHS 2009)	19 (DHS 2009)	NA
Mali	31.2 (DHS 2006)	31.2 (DHS 2006)	31.2 (DHS 2006)	31.2 (DHS 2006)	32 (MICS 2009/2010)	NA
Mongolia	14.4 (RHS 2008)	14.4 (RHS 2008)	14.4 (RHS 2008)	14.4 (RHS 2008)	14.4 (RHS 2008)	10%
Mozambique	18.4 (DHS 2003)	18.4 (DHS 2003)	18.4 (DHS 2003)	18.4 (DHS 2003)	22.3 (DHS 2011 Preliminary)	NA
Nicaragua	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	10.7 (DHS 2006-07)	8%
Niger	22 (MOH 2007)	NA	NA	NA	20 (DHS 2012 Prelim)	NA
Nigeria				20 (DHS 2008)	18.9 (MICS 2011)	
Sierra Leone	28 (DHS 2008)	28 (DHS 2008)	28 (DHS 2008)	28 (DHS 2008)	27.4 (MICS 2011)	40% reduction

Source: Compiled from various sources as indicated in the table

1.4.2 Contraceptive prevalence rate - modern methods

Contraceptive prevalence rate (CPR) is a very important measure of the outcome of family planning interventions. With respect to modern methods, this measure refers to the proportion of women aged 15-49 who are using, or whose sexual partners are using, any modern method of contraception. The measure provides an indication of progress made in improving family planning and meeting the needs of women. For a better understanding of progress, the measure can be disaggregated to show

prevalence for different areas of the country, different age groups, background characteristics such as household wealth and level of education.

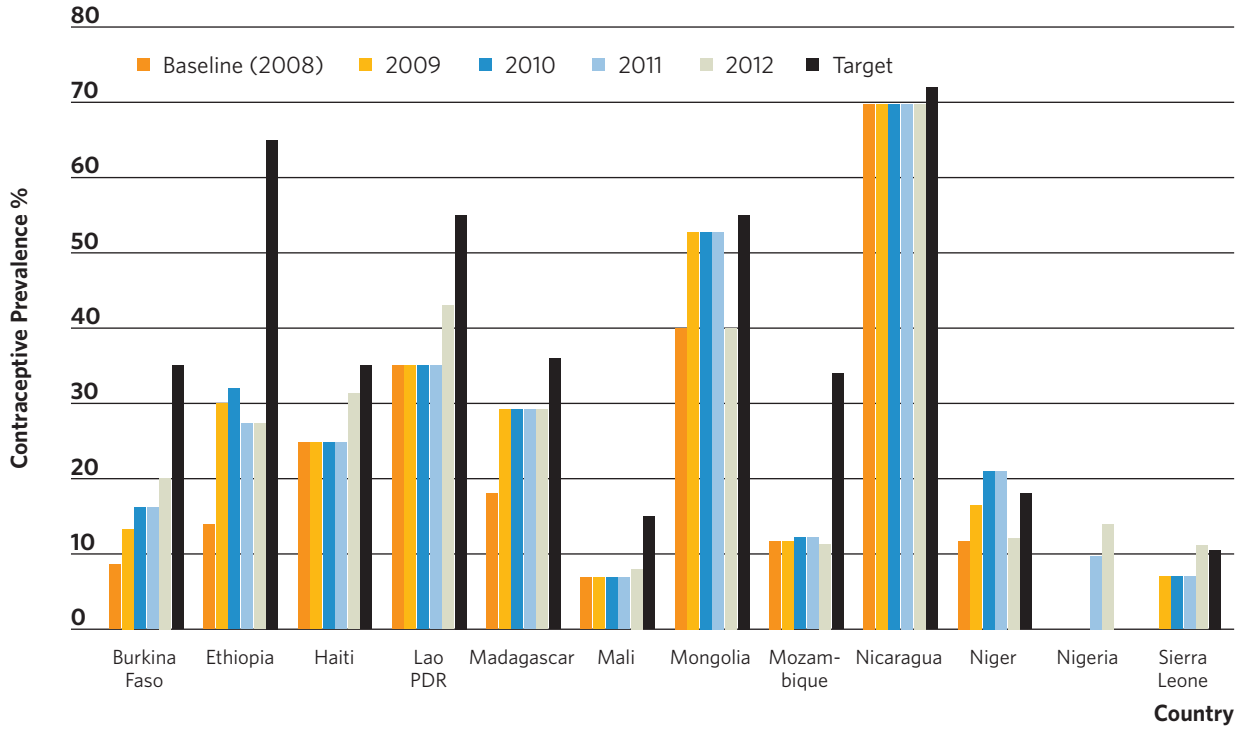
The updates provided in Table 3 and Figure 3 show that CPR has increased in Lao PDR, by 8 percentage points from 35 per cent in 2005 to 43 per cent in 2012; in Haiti by more than 6 percentage points from 24.8 per cent in 2005-2006 to 31.3 per cent in 2012; in Nigeria by 4 percentage points from 9.7 per cent in 2008 to 14.0 per cent in 2011; and in Sierra Leone by four percentage point from 7 per cent in 2008 to 11 per cent in 2011. Preliminary results of a KAP study conducted in Burkina Faso showed that CPR has increased by 5 percentage points over last to 20.1 per cent in 2012.

Table 3: Contraceptive prevalence rate (modern methods): Stream 1 countries, percentage

Country	Baseline	2009	2010	2011	2012	Target
Burkina Faso	8.6 (DHS 2003)	13.3 (MICS 2006)	16.2 (DHS 2010)	16.2 (DHS 2010)	20.1 (KAP 2012 Preliminary)	35% (2013)
Ethiopia	13.9 (DHS 2005)	30 (MOHS)	32 (MOHS)	27.3 (DHS 2011)	27.3 (DHS 2011)	65% (2015)
Haiti	24.8 (DHS 2005-06)	24.8 (DHS 2005-06)	24.8 (DHS 2005-06)	24.8 (DHS 2005-06)	31.3 (DHS 2012)	35% (2013)
Lao PDR	35 (LRHS 2005)	35 (LRHS 2005)	35 (LRHS 2005)	35 (LRHS 2005)	43 (Social Indicator Survey 2012)	55% (2015)
Madagascar	18 (DHS 2004)	29.2 (MOHS)	29.2 (DHS 2008-09)	29.2 (DHS 2008-09)	29.2 (DHS 2008-09)	36% (2012)
Mali	6.9 (DHS 2006)	6.9 (DHS 2006)	6.9 (DHS 2006)	6.9 (DHS 2006)	8 (MICS 2009/2010)	15% (2013)
Mongolia	40 (RHS 2008)	40 (RHS 2008)	40 (RHS 2008)	40 (RHS 2008)	40 (RHS 2008)	55% (2012)
Mozambique	11.7 (DHS 2003)	11.7 (DHS 2003)	12.2 (MOH)	12.2 (MOH)	11.3 (DHS 2011 Preliminary)	34% (2015)
Nicaragua	69.8 (DHS 2007)	69.8 (DHS 2007)	69.8 (DHS 2007)	69.8 (DHS 2007)	69.8 (DHS 2007)	72% (2013)
Niger	11.7 (DHS 2006)	16.5 (MOH)	21 (HMIS)	21 (HMIS)	12.1 (DHS 2012 Preliminary)	18% (2012)
Nigeria	-	-	-	9.7 (DHS 2008)	14 (MICS 2011)	-
Sierra Leone	-	7 (DHS 2008)	7 (DHS 2008)	7 (DHS 2008)	11.1 (MICS 2011)	10.5% (2013)

Source: Compiled from various sources as indicated in the table

Figure 3: Contraceptive prevalence rate (modern methods) for GPRHCS Stream 1 countries



Even with improvements in CPR, disparities in contraceptive use among women based on education levels, household income and urban rural location continue to exist. CPR is disproportionately higher among married women in the highest wealth quintile than those in lower wealth quintiles. In all GPRHCS countries, the percentage of women who are current users of contraceptives increases with the level of education of the women.

1.4.3 Family planning demand satisfied

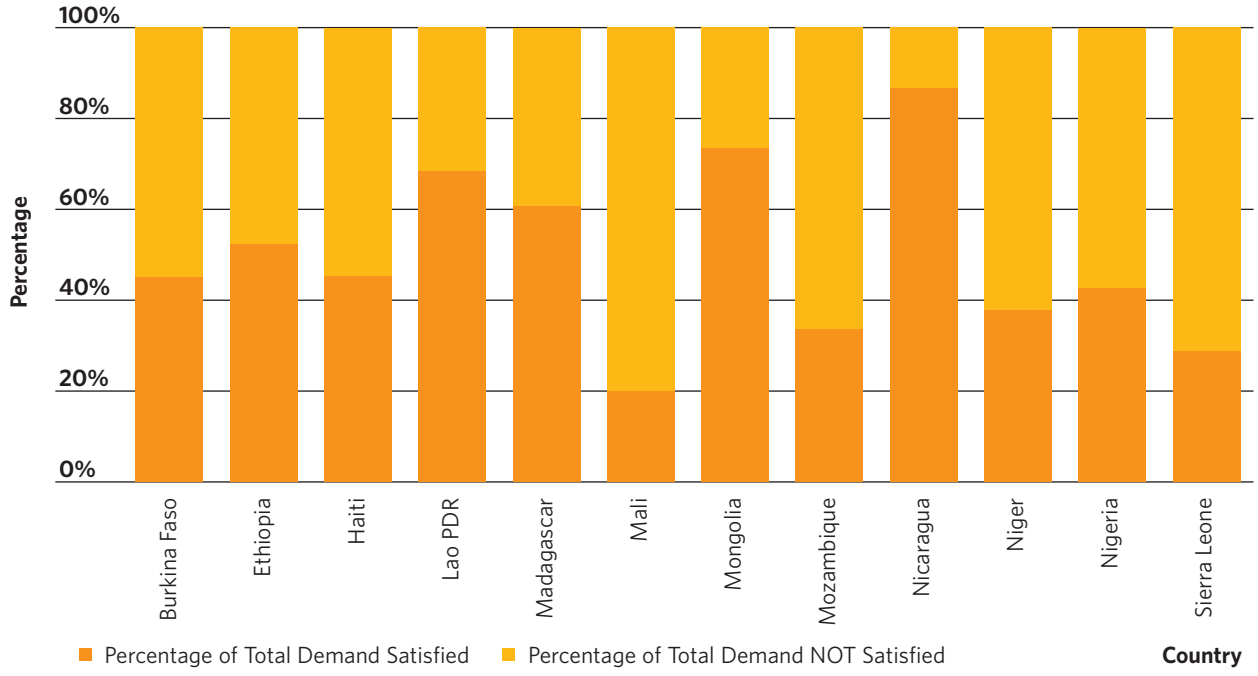
Computation of 'total demand for family planning' uses data for CPR and unmet need for family planning. The total demand for family planning constitutes those who are currently using a family planning method and those who need family planning but are not currently using any family planning method. The percentage of family planning demand satisfied is arrived at by computing contraceptive prevalence rate as a percentage of total demand for family planning – % of demand satisfied = [(CPR Ð (CPR + Unmet Need)) x100]. Based on the updated information, shown in Tables 4 and Figure 4, the percentage of demand satisfied is highest in Nicaragua (86.7 per cent) followed by Mongolia (73.5 per cent) and Lao PDR (68.3 per cent); it is lowest in Sierra Leone (28.8 per cent).

Total demand satisfied has increased from 2011 to 2012 in Lao PDR from 56.2 per cent to 68.3 per cent, Burkina Faso from 36 per cent to 45 per cent, Haiti from 39.8 per cent to 45 per cent and Sierra Leone from 20 per cent to 28.8 per cent (Table 4).

Table 4: Family planning demand satisfied in GPRHCS Stream 1 countries

Country	Unmet need	CPR	Total demand for FP	Percentage of total demand satisfied	Percentage of total demand NOT satisfied
Burkina Faso	24.5	20.1	44.6	45.1	54.9
Ethiopia	25	27.3	52.3	52.2	47.8
Haiti	38	31.3	69.3	45.2	54.8
Lao PDR	20	43	63.	68.3	31.7
Madagascar	19	29.2	48.2	60.6	39.4
Mali	32	8	40	20	80
Mongolia	14.4	40	54.4	73.5	26.5
Mozambique	22.3	11.3	33.6	33.6	66.4
Nicaragua	10.7	69.8	80.5	86.7	13.3
Niger	20	12.1	32.1	37.7	62.3
Nigeria	18.9	14	32.9	42.6	57.4
Sierra Leone	27.4	11.1	38.5	28.8	71.2

Figure 4: Family planning demand satisfied in GPRHCS Stream 1 countries



1.5 Family planning method mix

Family planning method mix is used to look at whether users of family planning are concentrated on a few methods or are fairly spread among a number of methods. One way of assessing this is by computing the difference in prevalence between the most prevalent modern method in a country and the third-most prevalent method and dividing it by the total CPR for modern methods.[4] Countries with high method mix scores are said to have even spread of users among the methods – which could be conducive for contraceptive security. On the other hand, countries with low scores may have high concentrations of users on limited methods – a scenario that is though not to be conducive for contraceptive security. Table 5 shows data for four countries with two recent surveys for which method mix scores are presented.

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

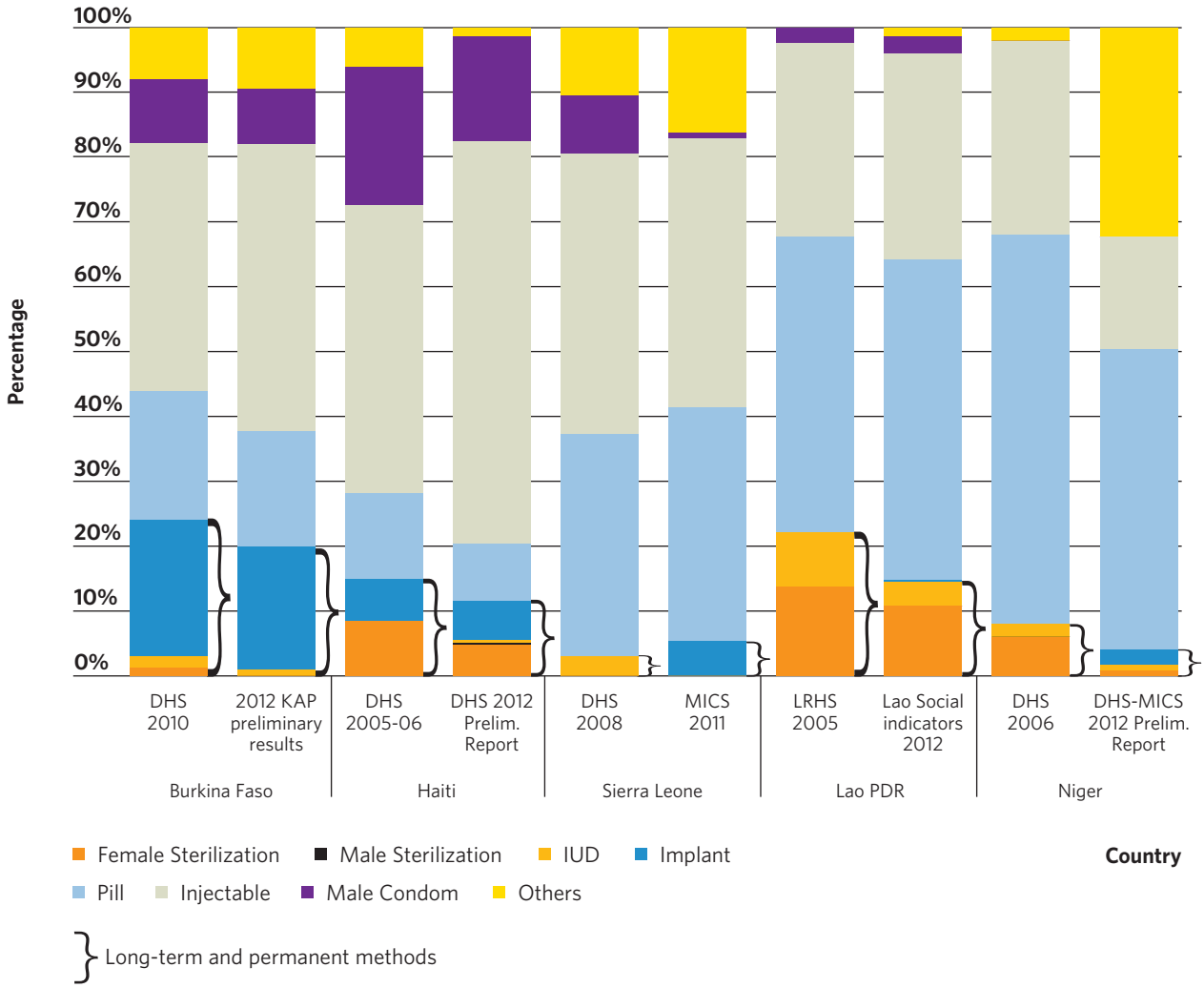
Table 5: Per cent distribution of currently married women age 15-49 by contraceptive method currently used for selected GPRHCS Stream 1 countries

	Burkina Faso		Haiti		Sierra Leone		Lao PDR		Niger	
Modern FP Method	DHS 2010	2012 KAP preliminary results	DHS 2005-06	DHS 2012 Preliminary report	DHS 2008	MICS 2011	LRHS 2005	Lao Social indicator Survey 2012	DHS 2006	Preliminary DHS-MICS 2012
Female Sterilization	0.2	0.0	2.1	1.5	0.0	0.0	4.6	4.6	0.3	0.1
Male Sterilization	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
IUD	0.3	0.2	0.0	0.1	0.2	0.0	2.8	1.6	0.1	0.1
Implant	3.4	3.8	1.6	1.9	0.0	0.6	0.0	0.1	0.0	0.3
Pill	3.2	3.6	3.3	2.8	2.3	4.0	15.2	21.2	3.0	5.6
Injectable	6.2	8.9	11.0	19.4	2.9	4.6	10	13.6	1.5	2.1
Male Condom	1.6	1.7	5.3	5.1	0.6	0.1	0.8	1.1	0.0	0.0
Others	1.3	1.9	1.5	0.4	0.7	1.8	0.0	0.6	0.1	3.9
Total for Modern FP Methods	16.2	20.1	24.8	31.3	6.7	11.1	33.4	42.8	5.0	12.1
Method Mix Score on a 10-point scale	8.1	7.4	6.9	4.7	6.7	7.5	6.8	6.1	4.6	7.1

In Burkina Faso, the three methods with the highest prevalence accounted for 79 per cent of modern CPR in 2010, which increased slightly to 81.1 per cent in 2012. Similarly in Haiti, the three methods with the highest prevalence accounted for 79 per cent of modern CPR in 2005-2006 and increased to 87.3 per cent in 2012. For Lao PDR, the concentration of users on limited methods increased from 67.7 per cent in 2005 to 92.1 per cent of users in 2012. For Niger, even with improvement in method mix score, the concentration on the three most prevalent methods has remained very high at around 96 per cent. In the case of Sierra Leone, even with a slight improvement in method mix score, the three most prevalent methods accounted for 93.7 per cent of CPR in 2011 compared to 88.1 per cent in 2008. The injectable is the most popular method in Haiti (61.9 per cent of CPR in 2012) and Sierra Leone (41.4 per cent of CPR in 2011); and the pill is the most popular method in Niger (49.5 per cent of CPR in 2012) and Lao PDR (46.3 per cent of CPR in 2012).

Preference for long-term and permanent methods

Figure 5: Per cent distribution of currently married women age 15–49 by contraceptive method currently used for selected GPRHCS Stream 1 countries



For the new set of countries with updated data, the prevalence of long-term and permanent methods (e.g. sterilization, IUD and implants) decreased in Burkina Faso from 24 per cent to 19 per cent of CPR, decreased in Haiti from 14.9 per cent to 11.5 per cent of CPR, decreased in Lao PDR from 22.2 per cent to 14.7 per cent of CPR and decreased in Niger from 8 per cent to 4.1 per cent of CPR (Figure 5). In contrast, for Sierra Leone, prevalence of long term and permanent methods increased from 3 per cent to 5.4 per cent of CPR. While the implant is the most popular long-term permanent method in Haiti, Niger and Sierra Leone, in Lao PDR the most popular method is female sterilization.

Box 1:
Procure contraceptives and promote their use

The Global Programme to Enhance RHCS works to procure contraceptives and other essential reproductive health supplies and promote their use through various mechanisms such as community-based distribution and social marketing, seeking to increase timely access to a choice of quality, affordable reproductive health commodities.

Burkina Faso's community-based distribution

The predominantly rural country of Burkina Faso has initiated an innovative approach to community-based distribution of condoms and contraceptives, as well as health information, in a project spearheaded by UNFPA and involving a wide range of partners, from volunteer health workers and community-based organizations to government ministries.

Although Solange Lamoussa Sawadogo (pictured at right) has no medical training, the 28-year-old mother of two is fondly called 'loctoré' – doctor in English – in her village 200 kilometres east of Ouagadougou.

With the nearest health centre in Moaga, eight kilometres away, Solange, a volunteer Community Health Worker, promotes reproductive health, encourages couples to seek family planning counselling – something rather new in this traditional community – and dispenses condoms and some contraceptives. Well respected by both the men and women of Sablogo, she seizes every opportunity to talk to people wherever she finds them – by the well,

on the farm, in the market place, at places of worship, and attending village events.

"Here, women are willing to use contraceptive pills," says Solange. Some are also starting to use longer-acting injectables, such as Norplant, but an increasing number prefer pills, she says.

After going to the Health and Social Promotion Centre in Moaga, women can buy contraceptive supplies from Solange, upon presentation of the booklet given them by a health worker, to whom they must return on a quarterly basis for a check-up. Solange also makes it a point to encourage men to take an active role in their wives' pregnancies, including by going with them to the clinic for antenatal consultations. And she is getting results: In this village, about 20 men have already accompanied their pregnant wives at least once to the Moaga health clinic, something virtually unheard of in the past. The community-based distribution system has increased family planning: The Moaga health centre was able to increase the contraceptive prevalence rate from 11 per cent in 2009 to 30 per cent in 2011 among the 7,000 people it serves in six villages. Source: UNFPA news story by Boureima Sanga

Community-based distribution of contraceptives in Burkina Faso was launched in 2009 as a partnership of government, civil society and UNFPA's GPRHCS involving outsourcing for efficiency. Agents have served 94 per cent of health districts including more than 1,000 health facilities. Women accounted for nearly half of the 1,443 facilitators and 4,954 distributors trained from 2009 to 2011. In 2012, contraceptives distributed provided 8,184 couple years of protection from unwanted pregnancy. Progress in the country is moving forward on several fronts, including training of staff at more than 200 service delivery points, developing capacity for forecasting and procurement and, specifically, training of district health practitioners in every region on the use of computerized logistics management information system to avoid supply stock-outs. Also, an extensive multi-media public outreach campaign using film, radio and theatre has reached an estimated audience of 60 per cent of the population with family planning messages since 2008.

Reaching rural and ethnic women in Lao PDR

In Lao People's Democratic Republic (Lao PDR), specially trained 'community-based distribution agents' are the reason why more hard-to-reach women are using modern methods of contraception and why local family planning services are providing better care and serving more clients. In areas where they work, family planning uptake has increased from 12 per cent in 2007 to 45 per cent in 2011. Developing the capacity of community service providers to deliver culturally appropriate services has demonstrated positive results. In some districts, the level or extent of family planning services provided by special family planning providers now exceeds that of district hospitals. At the national level, the contraceptive prevalence rate has increased in Lao PDR by 8 percentage points from 35 per cent in 2005 to 43 per cent in 2012.

Community Wellness Advocacy Groups launched in Sierra Leone

Traditional Birth Attendants have become a powerful force for family planning community advocacy at community level. They have received training and formed Community Wellness Advocacy Groups (CAGs) to address public gatherings at markets, meetings and move from door to door. The CAGs programme was officially launched in 2012 in Sierra Leone.

CAGs conduct various outreach activities, such as mobilizing and referring pregnant women for antenatal care, accompanying women and girls for reproductive health services including family planning services, making sure that women benefit from the Free Health Care Initiative and dispelling the wide spread myths and misconceptions that hamper access to RH/FP services. Of particular importance in the community advocacy programme is the inclusion of Men's Peer Educator Networks (MPENs) that were established as an adaptation of the Husband schools in Niger, following a study tour to that country.

CAGs aim to reach individuals like Fatmata Kamara, a young mother of three, whose husband does not know that his wife takes contraceptive pils. "After our third kid, I told him I do not want any more kids, and asked him to use a condom but he wouldn't listen to me," she says. Asked if she'd like to know more about long-acting implants, she voices a concern:, "I have heard of it, but my friends are saying that if I take them, I will develop a bad sickness and will eventually bleed to death". Addressing misconceptions is a frequent task for the CAGs.

Marian Foday, a Community Wellness Advocate in Bo, says this case is not an exception: "There are many women like Ms. Kamara who want to practice long term family planning methods but are afraid to use methods like implants due to the local myths and misconceptions associated with them". She believes that attitudes are changing. "With the support received from UNFPA and other partners I hope we can continue to change attitudes in the community and I am confident that soon young women like Ms. Kamara will voluntarily access long-term methods like implants". Source: Annual UNFPA country report to GPRHCS

More country examples

The Condomize Campaign reached thousands of participants at two events in **Ethiopia** in 2012: the 13th World Congress on Public Health in April attended by 168 countries and a family planning symposium in November. UNFPA supported the National Family Planning Symposium attended by 500 high-level government officials, policy advisers, and representatives from development partners and community service organizations.

Nigeria, which moved from Stream 2 to Stream 1 in 2011, committed $3 million and signed an MOU with UNFPA to procure contraceptives in 2012. The Government also enacted a policy to dispense contraceptives in public health facilities free of charge.

Community-based provision of family planning information, services and supplies expanded to two additional districts in **Rwanda** in 2012, Karongi and Rubavu, accompanied by training at the village level

of 2,172 community health workers. Expansion to Nyamasheke district in early 2013 included training for another 1,206 community health workers. For more information, view this video: http://youtu.be/EiKeHOttLeo.

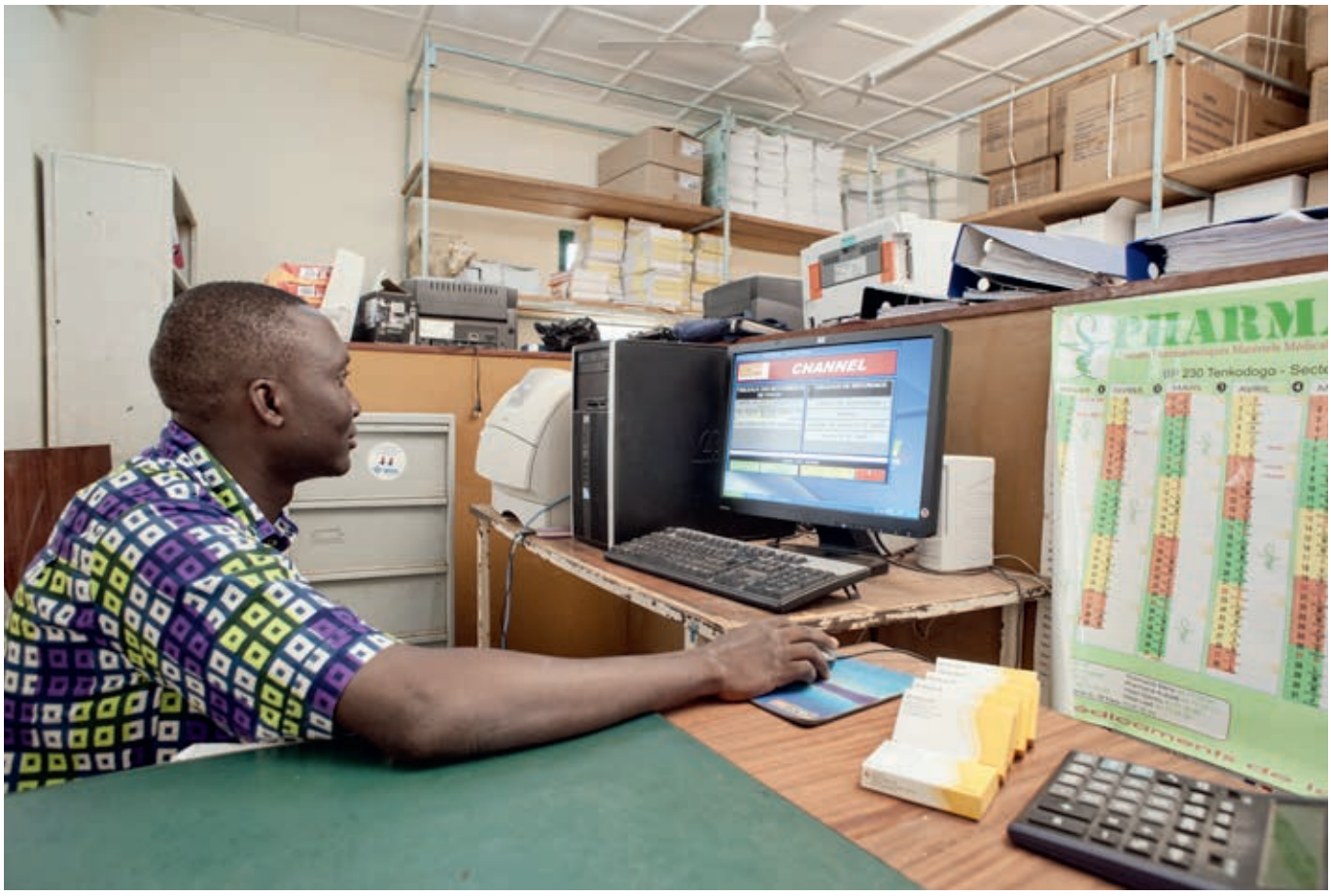
In **Cameroon** in 2012, monitoring was conducted for the implementation of the pilot project on pre-placement of obstetric kits for safer birth and Caesarian sections. After 10 months of implementation, the number of women delivering in the participating health facilities had increased by 70 per cent. The Government initiated the scale-up of the strategy to other health districts using its own funds. For the first time, Cameroon's Ministry of Health included a budget line for the procurement of contraceptives in its budget, as of 2013.

A pilot plan to introduce modern methods of contraception in **Peru** increased use of injectables and implants right from the start: in the first month, use increased from zero to 341 implants and 679 monthly injectables across five pilot sites. For many years, the mix of contraceptive has been limited to only four alternatives and has not reached the neediest populations. The Government and UNFPA are committed to expanding access to and choice of methods.

In **Bolivia**, a proposal was submitted to the Ministry of Health and Sports to amend the legal framework of the bid process for reproductive health commodities and drugs. Presently, CEASS (the national distribution centre for health supplies) is at a legal disadvantage in the process of bidding on against private entities for such supplies; the proposed amendment would level the playing field. CEASS has also undertaken negotiations for purchase of reproductive health commodities and drugs including contraceptives from other countries including Canada, Cuba and India.

Although **South Sudan** is a new nation, the government with UNFPA support distributed over 911,600 condoms in 2012 through a network of partners in the country and as part of the emergency programme response through the distribution of RH kits. UNFPA South Sudan and the Ministry of Health also participated in the UNFPA-funded workshop in Rwanda on strengthening comprehensive condom programming. Staff members and MoH focal point came back with increased knowledge and skills to strengthen condom programming in the country.

CHAPTER TWO: MEASURING AVAILABILITY AT THE COUNTRY LEVEL



A warehouse dispatcher in Tenkodogo, Burkina Faso, uses CHANNEL computer soft ware to track stocks of reproductive health supplies. Photo: Ollivier Girard/ UNFPA Burkina Faso

Reporting on results

The GPRHCS is able to demonstrate specific achievements in this report because UNFPA uses results-based management (RBM) - an approach for more effective and efficient ways of working. The results-based approach applies the GPRHCS Performance Monitoring Framework and the UNFPA Results and Resources Framework. The robust Performance Monitoring Framework enables the GPRHCS to measure progress and report results. Reviewed extensively in 2009 in a collaborative effort by UNFPA Country Offices, Regional Offices, donors and partners, the framework focuses on valuable data about RHCS progress and results at the national, regional and global levels.

Headings represent the framework's indicators. Sources of data in the remainder of the report include national surveys conducted with UNFPA support in GPRHCS Stream 1 countries, reports submitted by UNFPA Regional and Country Offices, and UNFPA's donor support report.

2.1 Number of GPRHCS Stream 1 countries with service delivery points (SDPs) offering at least 3 modern methods of contraceptives[5]

This outcome indicator is a measure of the efficiency of commodity distribution networks in a country and the ability of government and its partners to sustain achievements made in making services available to clients. Since 2010, information for this indicator is derived from annual surveys conducted in all GPRHCS Stream 1 countries using a special tool designed for the purpose.

Recent survey results shown in Table 6 and Figure 6 track the percentage of service delivery points (SDPs) offering at least three modern contraceptive methods. The benchmark for this indicator has been achieved in all Stream 1 countries where more than 75 per cent of SDPs offered at least three modern contraceptives. Eight out of the 12 Stream 1 countries had at least three modern contraceptive methods available in more than 90 per cent of SDPs as per national protocols and guidelines. The percentage was highest in Burkina Faso (99.5 per cent). Compared to 2011, the percentage has improved in five countries (Burkina Faso, Lao PDR, Madagascar, Mali, Niger and Sierra Leone).

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

Table 6: Percentage of service delivery points (SDPs) offering at least three modern methods of contraception in GPRHCS Stream 1 countries, 2008 to 2012

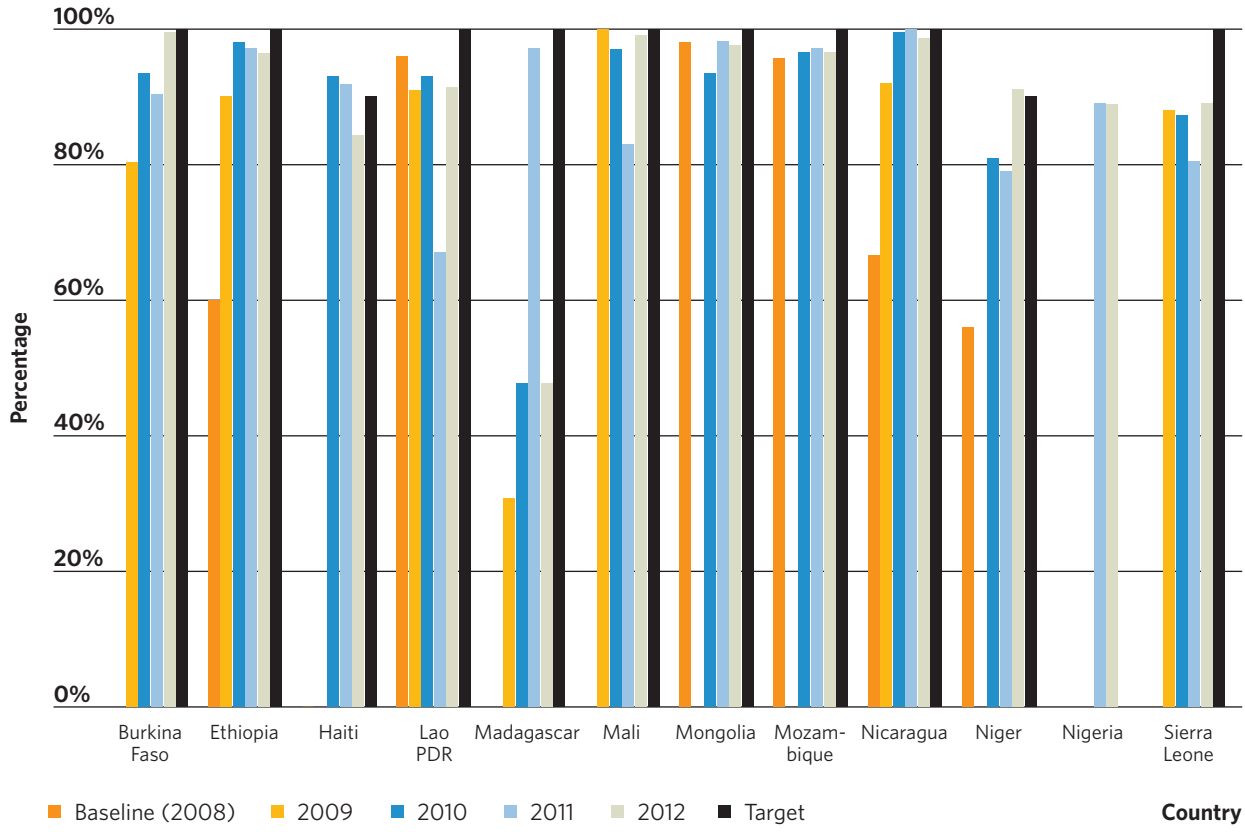
Country	Baseline (2008)	2009	2010	2011	2012	Target (2013)
Burkina Faso	NA	80.4 (2009)	93.5	90.3	99.5	100 (2012)
Ethiopia	60 (2006)	90	98	97.2	96.4	100 (2010)
Haiti	-	NA	93	91.8	84.3	90 (2013)
Lao PDR	96 (2006)	91	93	67	91.4	100 (2012)
Madagascar	-	30.8	47.8	77.5	95	100 (2012)
Mali	-	100	97	83	99	NA
Mongolia	98	NA	93.5	98.2	97.6	100
Mozambique	95.7 (HIS 2008)	NA	96.5	97.1	96.6	100
Nicaragua	66.6 (2008)	92	99.5	100	98.6	100
Niger	56 (2008)	NA	80.9	79	91.1	90
Nigeria				89	88.9	NA
Sierra Leone	-	88*	87.2	80.5	89	100

Source: GPRHCS 2010 country and related sample survey reports

Note: 2010 to 2012 data from sample surveys reports of each country conducted using standardized methodology

* Proportion with at least two modern methods available

Figure 6: Percentage of service delivery points (SDPs) offering at least three modern methods of contraception in GPRHCS Stream 1 countries, 2008 to 2012



In 2012, five countries, (Burkina Faso, Lao PDR, Madagascar, Mali, and Niger) showed improvements in the availability of contraceptives at the primary SDP level (Table 7) and nine countries showed improvements at secondary level.

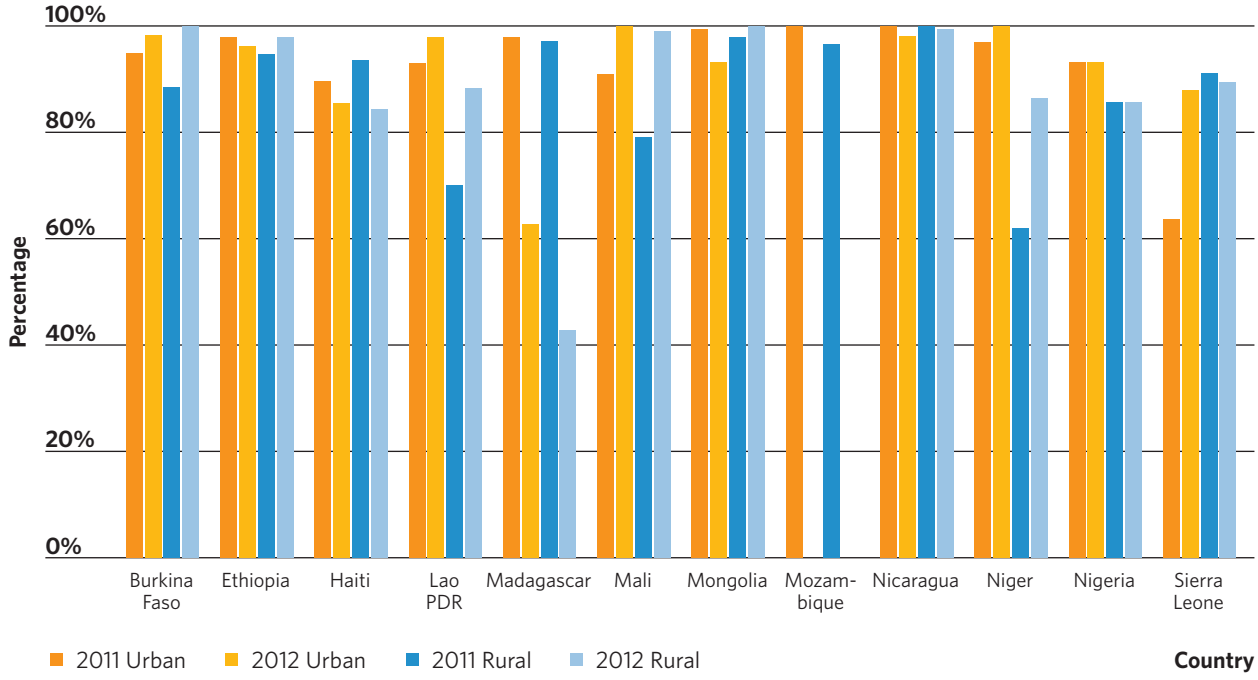
Table 7: Percentage of sampled SDPs by type of facility, offering at least three modern methods of contraception in GPRHCS Stream 1 countries, 2010 to 2012

	Primary			Secondary			Tertiary		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Burkina Faso	92	89.6	100	100	92.7	96.8	100	100	100
Ethiopia	97.6	96.4	95.8	98.4	98.4	96.6	100	100	100
Haiti	91	90.9	80.2	94	93.5	91.2	93	100	100
Lao PDR	89	67	87.1	95	92	97.9	94	93	94.3
Madagascar	50	78.5	95	50.6	45.3	96.3	61.8	45.5	100.0
Mali	88	77	99	88	95	100	73	82	100
Mongolia	92	98.2	96	100	97.8	100	100	100	100
Mozambique	96.7	98.9	95.5	95	92.1	97.4	100	100	100
Nicaragua	99.5	100	98.5	100	100	100	-	-	100
Niger	80	78	90.7	100	97.0	100	100	100	100
Nigeria	-	84	83.3	-	94.3	96	-	97.1	100
Sierra Leone	70	90.2	88.9	76	58.2	86.4	78	50	100

Source: GPRHCS 2010 to 2012 country and related sample survey reports

In line with their national protocols and guidelines, 100 per cent rural SDPs in Mali and Niger had at least three modern methods of contraceptives available; while in Burkina Faso and Mongolia, 100 per cent of urban SDPs had at least 3 modern methods available (Figure 7).

Figure 7: Percentage of sampled SDPs by location offering at least three modern methods of contraception in GPRHCS Stream 1 countries, 2011 and 2012*



Survey reports cited several factors that could account for SDPs not offering three modern methods of contraceptives. In Sierra Leone, for example, the lack of trained staff and equipment limited the provision of long-term and permanent methods. In Mozambique, delays in transportation systems made it difficult for some SDPs to offer three modern methods. In Lao PDR, there was a lack of appropriately trained staff to provide services such as IUD insertion and male and female sterilization; in addition, the capacity of the supply chain system was too limited to ensure a constant flow of supplies to all facilities. In Mali, infrequent demand by clients was cited as the reason why some methods, including female condoms and male sterilization, were not available in SDPs.

2.2 Number of GPRHCS Stream 1 countries with seven life-saving maternal/RH medicines (including magnesium sulfate and oxytocin) available

The list of priority life-saving medicines for women and children was revised in 2012, directly affecting this indicator on maternal health medicines[6]. Two changes occurred: The number of life-saving maternal health medicines increased from five to seven, and inclusion of two medicines was specified. The revision requires that magnesium sulfate and oxytocin must be among the seven, subject to the provisions of national protocols and guidelines regarding the level of SDPs and their mandates to provide certain medicines.

In 2012, six out of the 12 Stream 1 countries had seven life-saving medicines (including magnesium sulfate and oxytocin) available in more than 70 per cent of SDPs (Table 8 and Figure 8). The survey results of 2012 are not comparable to the other years.

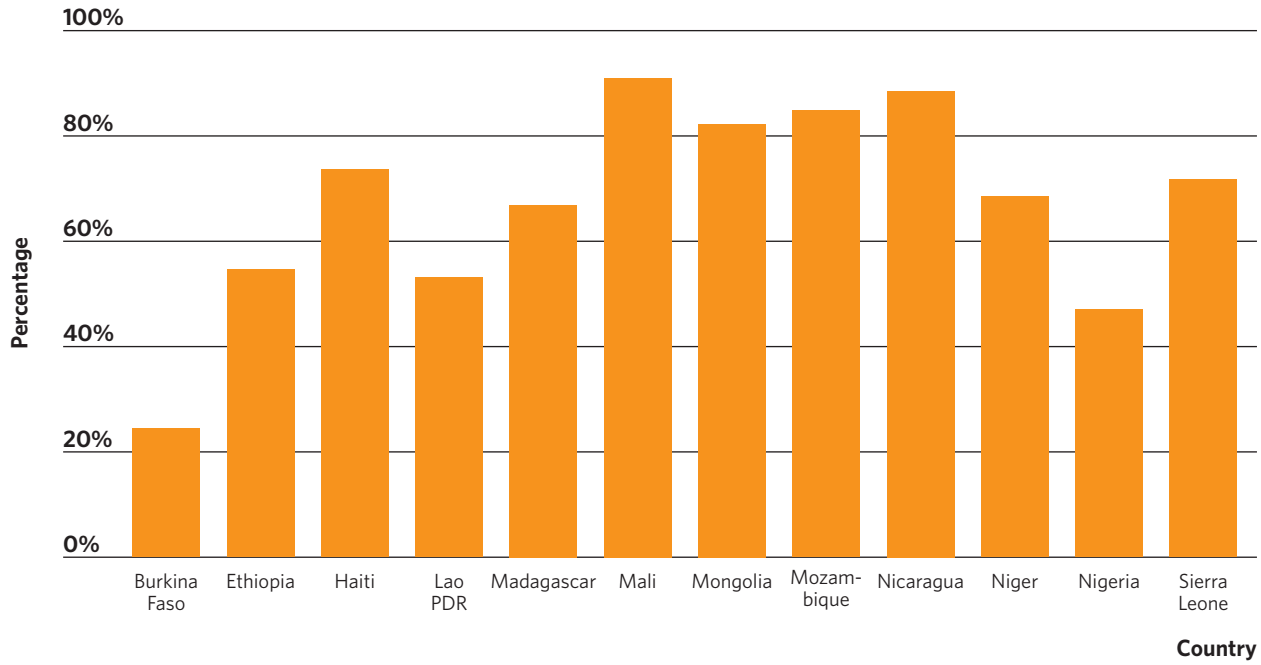
6 According to the WHO Priority life-saving medicines, for women and children, 2012; the priority medicines are: i) Oxytocin, ii) Misoprostol, iii) Sodium chloride, iv) Sodium lactate compound solution, v) Magnesium sulphate, vi) Calcium gluconate, vii) Hydralazine, viii) Methyldopa, ix) Ampicillin, x) Gentamicin, xi) Metronidazole, xii) Mifepristone, xiii) Azithromycin, xiv) Cefixime, xv) Benzathine Benzylpenicillin, xvi) Nifedipine, xvii) Dexamethasone, xviii) Betamethasone, and ixx) Tetanus toxoid. For further information please see to the updated list at http://apps.who.int/iris/bitstream/10665/75154/1/WHO_EMP_MAR_2012.1_eng.pdf. Please note that for this survey a) Sodium chloride and Sodium lactate compound solution are alternates; and that b) Dexamethasone is an alternate to Betamethasone

Table 8: Percentage of SDPs with seven life-saving maternal/RH medicines (including magnesium sulfate and oxytocin) available in GPRHCS Stream 1 countries in 2012

Country	Percentage	Country	Percentage
Burkina Faso	24.4	Mongolia	82.3
Ethiopia	54.6	Mozambique	84.8
Haiti	73.6	Nicaragua	88.5
Lao PDR	53.1	Niger	68.5
Madagascar	66.9	Nigeria	47.0
Mali	91.0	Sierra Leone	71.7

*Source: GPRHCS 2012 Survey reports of GPRHCS Stream 1 countries

Figure 8: Percentage of SDPs with sevel life-saving maternal/RH medicines (which includes magnesium sulfate and oxytocin) available in GPRHCS Stream 1 countries in 2012



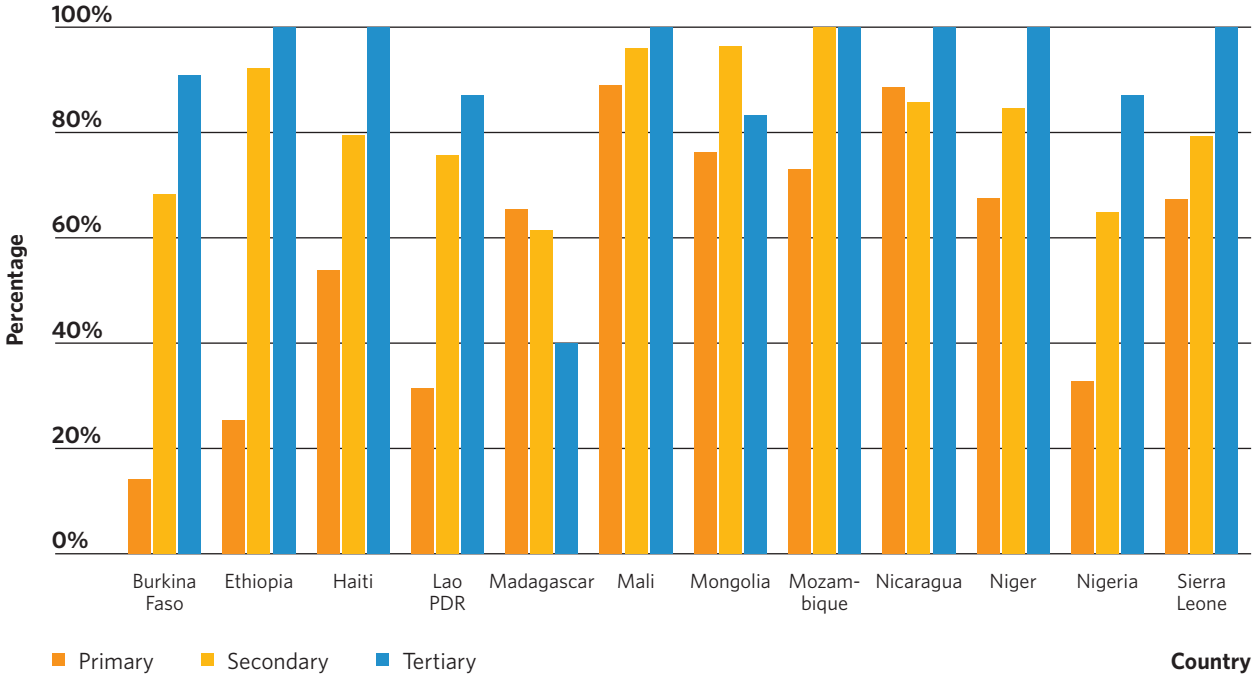
The percentage of SDPs with seven life-saving maternal health medicines (including magnesium sulfate and oxytocin) was higher in tertiary SDPs than for secondary SDPs in 10 countries (except in Madagascar and Mongolia). Also in Burkina Faso, Lao PDR, and Sierra Leone less than 35 per cent of primary SDPs had the seven life-saving medicines available in 2012.

Table 9: Percentage of SDPs by type with seven life-saving maternal/RH medicines (including magnesium sulfate and oxytocin) available in GPRHCS Stream 1 countries in 2012

Country	By type of SDP		
	Primary	Secondary	Tertiary
Burkina Faso	14.2	68.3	90.9
Ethiopia	25.4	92.2	100
Haiti	53.8	79.4	100
Lao PDR	31.4	75.7	87.1
Madagascar	65.4	61.5	40.0
Mali	89.0	96.0	100
Mongolia	76.2	96.3	83.3
Mozambique	73.0	100	100
Nicaragua	88.5	85.7	100
Niger	67.6	84.6	100
Nigeria	32.7	64.8	87.0
Sierra Leone	67.4	79.2	100

*Source: GPRHCS 2012 Survey reports of GPRHCS Stream 1 countries

Figure 9: Percentage of SDPs with seven life-saving maternal/RH medicines (including magnesium sulfate and oxytocin) available in GPRHCS Stream 1 countries in 2012



The challenges of providing the full range of maternal health medicines varied from country to country in 2012. In Lao PDR, some SDPs did not meet the requirements of this indicator because some medicines were not included on the facility's drug list, and also because they lacked refrigerators or proper storage systems. In Mongolia, the main reason for not offering oxytocin or magnesium sulfate was because SDPs had limited or no supply of these commodities. Medicines such as clotrimazol and metronidazole were prescribed by doctors but clients were required to buy them at drug stores. For Haiti, medicines were not readily available because of weakness in the supply chain system, which was in some cases plagued by delays.

There is an ongoing need to address the challenges faced by countries as they strive to maintain quality of care and deliver services closer to the people. One step is building the capacity of the health authorities of SDPs. It also is important to ensure that at least some methods are provided when needed, which calls for improvement in storage, transportation and inventory management to improve availability of maternal health medicines especially in hard to reach areas. Overall, effective planning and monitoring systems are essential in order to ensure the consistent supply of medicines.

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

The aim is to ensure that service delivery points always have contraceptives in stock to serve clients, in line with national protocols. UNFPA supports countries to procure and distribute contraceptives and train staff to make the methods available to women who need them. Averting shortfalls or 'stock-outs' entails making logistics management systems fully functional. It also requires addressing issues related to policies, building infrastructure and in some cases ensuring political stability.

Seven out of 12 countries (Ethiopia, Lao PDR, Madagascar, Mongolia, Mozambique, Nicaragua and Niger) experienced no stock-out of contraceptives in 60 per cent or more SDPs in 2012 (Table 10). This is an increase of one country from 2011. Ethiopia (97.6 per cent), Niger (97.1 per cent) and Madagascar (88.9 per cent) have very high 'no stock-out' rates.

Table 10: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months in GPRHCS Stream 1 countries, 2008 to 2012

Country	Baseline (2008)	2009	2010****	2011****	2012****	Target (2013)
Burkina Faso	NA	29.2 (2009)	81.3	12.8	25.1	100% (2012)
Ethiopia	60 (2006)	90 (2009)	99.2	98.8	97.6	100% (2012)
Haiti	NA	NA	52.5	26.4	42.6	NA
Lao PDR	NA	20*	36	84	71.1	80%
Madagascar	63.3 (2008)	74.4 (2009)	79.6	90.3	88.9	96% (2012)
Mali	-	NA	46	31	57	NA
Mongolia	100	100	97.6**	37.7	64.4	100%
Mozambique	NA	NA	24.1	81	64.7	NA
Nicaragua	66 (2008)	81 (2009)	99.7	64.5	63.1	92%
Niger	0	100 (2009)	99.1***	85	97.3	100% (2012)
Nigeria				44	67.4	NA
Sierra Leone	-	77.0	41.4	35.4	44	100%

* For Lao PDR, the break down were as follows in 2009; national = 20%, provincial hospitals = 50% district hospitals = 19% and health centre = 15%
** 100% in both tertiary and secondary facilities but 92% in primary facilities
*** 100% for tertiary institutions and 95.2% for secondary and 99.3% for primary
****GPRHCS 2010, 2011 and 2012 country and related sample survey reports

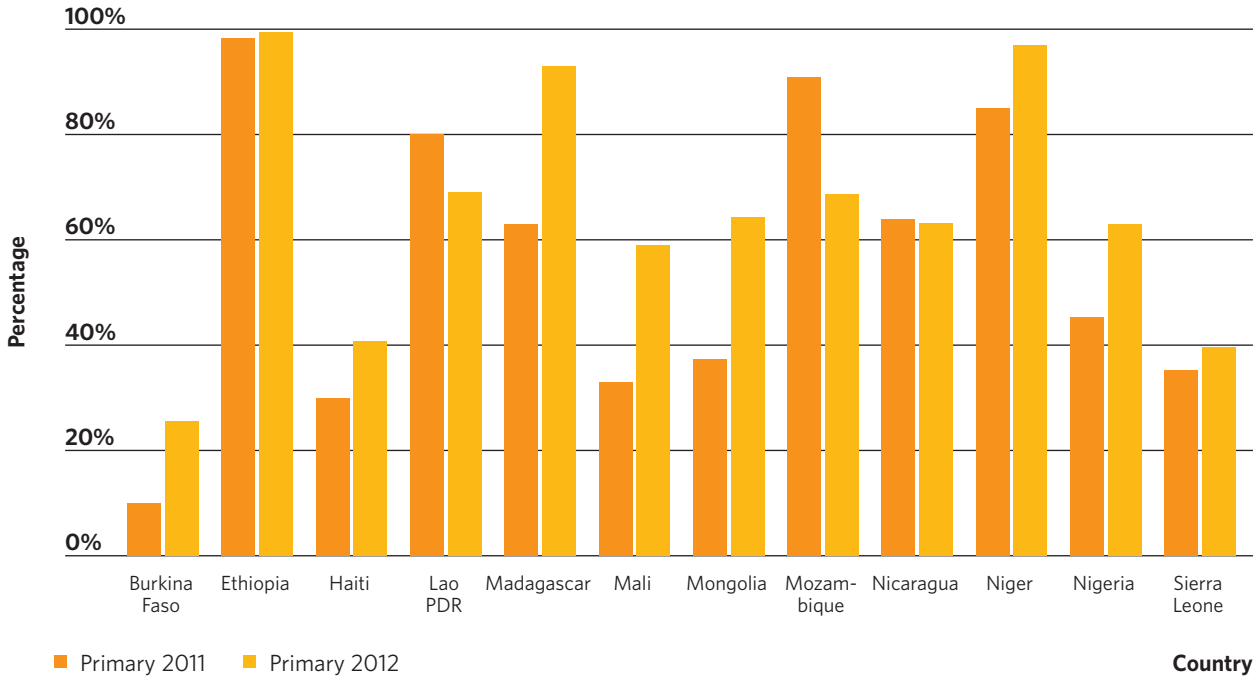
Ethiopia, Madagascar and Niger experienced no stock-outs in more than 90 per cent of SDPs for all levels of SDPs (primary, secondary and tertiary). This was accomplished in Ethiopia in 2011 and in 2012.

Table 11: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months by type of SDP in GPRHCS Stream 1 countries, 2011 and 2012

Country	Primary 2011	Primary 2012	Secondary 2011	Secondary 2012	Tertiary 2011	Tertiary 2012
Burkina Faso	10	25.5	23.7	22.6	10	27.3
Ethiopia	98.2	99.4	100	91.9	100	100
Haiti	29.9	40.7	19.4	50	0	0
Lao PDR	80	69.1	89	76.8	94	65.7
Madagascar	62.9	92.9	74.4	94.1	69.5	94.1
Mali	33	59	28	57	36	0
Mongolia	37.3	64.2	44.4	67.5	20	50
Mozambique	90.9	68.6	78.9	61.5	100	50
Nicaragua	63.9	63.2	73.9	57.9	NA	100
Niger	85	96.9	85	100	100	100
Nigeria	45.2	63	39.8	72.8	58.3	78.3
Sierra Leone	35.2	39.5	30.7	57.1	29.2	0

*Source: GPRHCS 2011 and 2012 Survey reports of GPRHCS Stream 1 countries

Figure 10: Percentage of rural SDPs reporting 'no stock-out' of contraceptives within the last six months in GPRHCS Stream 1 countries, 2011 and 2012



'No stock-out' rates at primary SDPs have improved since last year in many countries, with the exception of Lao PDR, Mozambique and Nicaragua (Figure 10). The 'no stock-out' rate at the primary level remained above 60 per cent for 2011 and 2012 in six countries: Ethiopia, Lao PDR, Madagascar, Mozambique, Nicaragua and Niger.

'No stock-out' rates for 2012 were higher in rural areas in 9 of the 12 Stream 1 countries (Burkina Faso, Ethiopia, Lao PDR, Madagascar, Mali, Mongolia, Nicaragua, Nigeria and Sierra Leone) than in urban areas (Table 12). In contrast, for Haiti, Niger and Nigeria the 'no stock-out' rates are higher in urban areas.

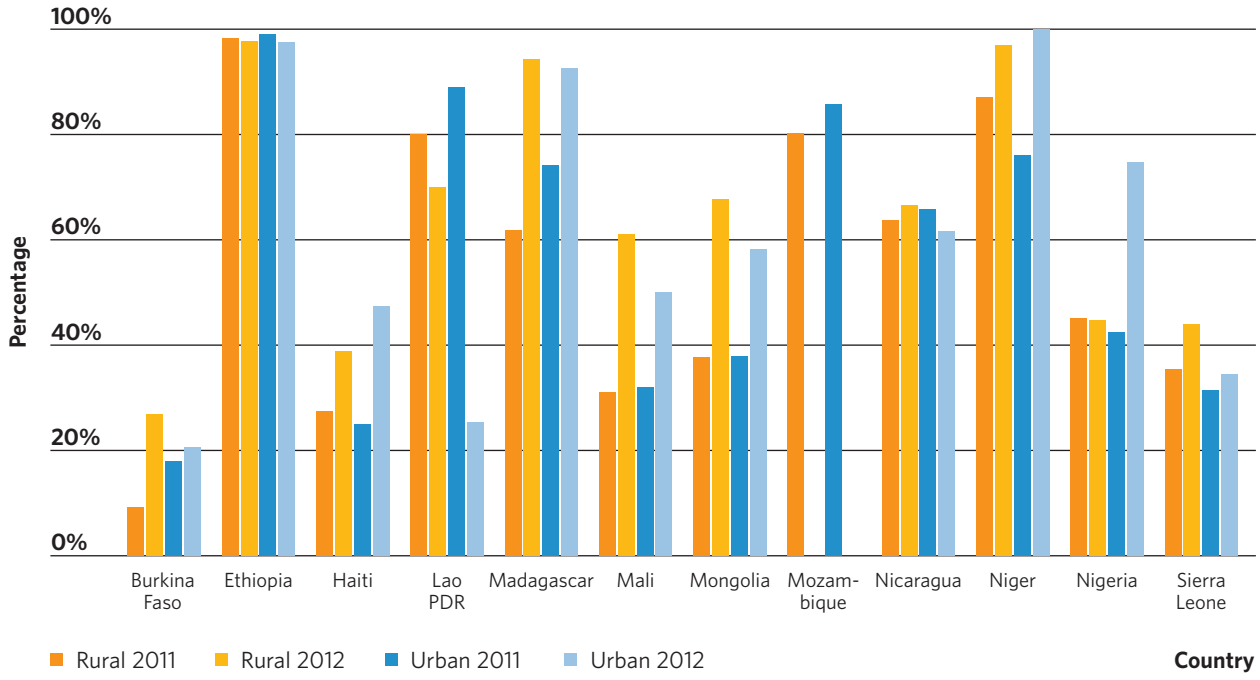
Table 12: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months by location of SDP in GPRHCS Stream 1 countries, 2011 and 2012

Country	Rural		Urban	
	2011	2012	2011	2012
Burkina Faso	9.3	26.8	17.9	20.6
Ethiopia	98.2	97.8	99	97.6
Haiti	27.4	38.8	25	47.3
Lao PDR	80	69.9	89	25.4
Madagascar	61.8	94.2	74.2	92.6
Mali	31	61.0	32	50.0
Mongolia	37.7	67.7	37.8	58.3
Mozambique	80.2		85.7	
Nicaragua	63.7	66.6	65.8	61.7
Niger	87	96.9	76	100
Nigeria	45.1	58.4	42.5	79.8
Sierra Leone	35.5	44	31.5	34.4

*Source: GPRHCS 2011 and 2012 Survey reports of GPRHCS Stream 1 countries

'No stock-out' rates improved in SDPs in urban and rural areas from 2011 to 2012 (Figure 11). Rural rates improved in 8 of the 12 GPRHCS Stream 1 countries (Burkina Faso, Haiti, Madagascar, Mali, Mongolia, Nicaragua, Niger and Sierra Leone). Urban rates also improved in 8 of the 12 Stream 1 countries (Burkina Faso, Haiti, Madagascar, Mali, Mongolia, Niger, Nigeria and Sierra Leone).

Figure 11: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months by location of SDP in GPRHCS Stream 1 countries, 2011 and 2012



The stock-out situation has improved in the Stream 1 countries, yet many challenges still persist. In Sierra Leone, for example, weakness in the supply and distribution system affects the availability of all the methods. Lack of trained staff and equipment contributed to the stock-out level of long-term and permanent methods such as IUDs, implants and sterilization (male and female). In Mongolia, shortage of supply due to weak distribution systems contributed to the stock-out level for male condoms, oral pills, IUDs and emergency pills. In Burkina Faso, demand exceeded the limited quantity of supplies and caused stock-outs for male and female condoms, pills and injectables. Also, due to errors in inventory management, some SDPs were not able to predict the occurrence of stock-outs and could not order for replenishment in time.

Results of the annual surveys conducted as part of the GPRHCS show that capacity development challenges, including problems associated with national supply chain systems, continue to impede the effective functioning of the health system at all levels. The stock-outs experienced in the countries continue to reflect the level of functioning of the logistics management system from central to district levels.

2.4 Funding available for contraceptives including condoms

The indicator tracks the donor resources available for contraceptives, including condoms, as another way of measuring progress towards RHCS. The source of the data for this indicator is the *UNFPA Report on Donor Support for Contraceptives and Condoms*, a report compiled from donor databases and published annually by the Commodity Security Branch. In 2012, data was only available for DFID, Global Fund, IPPF, MSI, PSI, UNFPA and USAID but not for DKT and KFW, a change from 2011. The report will be posted on the UNFPA website as soon as it becomes available at www.unfpa.org.

Box 2: Increase access and create demand

Countries are increasing access and creating demand by working within a human rights-based approach that empowers individual choices and dignity, sharing information through behaviour change communication, and going the last mile to ensure access for underserved and hard-to-reach populations.

Four new Husbands' Schools in Côte d'Ivoire

Men can learn to become champions for reproductive health and help to reduce maternal mortality: This is the idea behind the School for Husbands (École des Maris), a project that started in Zinder, Niger, and with UNFPA support is expanding in that country and others, including Burkina Faso and Côte d'Ivoire in 2012.

In Côte d'Ivoire, men from four pilot Schools for Husbands are talking about change. "Now, I am happy to help my wife with the loads on our way back from the field. Something has changed because everybody in the village is doing so," says a man from Djangomenou who joined the new school in his village. His neighbor admits: "I cannot stand seeing my wife go to the hospital alone; that's why I always go with her." A man from Ousso says the husbands put their new knowledge to work. "Upon our return from training, we cleaned the whole village to make it healthy because we now know that dirt gives us a lot of diseases," he said.

Members of the Schools are becoming role models in their communities. The Chief of Sakassou is trusted for advice by more young people, he says: "Young people in my village now easily come to see me when they have problems in their homes (couple) because I give them good advice since the School for Husbands was put in place. I feel closer to them."

Côte d'Ivoire's Ministry of Health and AIDS is working with UNFPA on many fronts to accelerate progress towards the Millennium Development Goals, including a strategy to boost the use of reproductive health services in the district of Toumodi by involving men and boys. The action responds to high rates of maternal mortality and unmet need for family planning.

In August 2012, the partners established four pilot sites for the School for Husbands in the Health District of Toumodi, with a total population of 22,775. Each school is run by 10 to 12 people, for a total of 45 members, eight Coaches or Community Agents, and four health workers (all nurses). Monthly reports of activities at the Schools are reported to the health center supervisor, then transmitted to the district level, where they are compiled using health information management software.

Results in the first six months of the pilot phase show promising progress. Four health centers, one in each of the four villages where a School for Husbands operates, report increased use of reproductive health services between 2011 and the six months of 2012 following project implementation in August 2012:

- Use of key reproductive health services increased at all four health facilities, including maternal health and family planning;
- New users of family planning increased by five times;
- Assisted delivery at birth increased.

Men's involvement contributed to a substantial increase in attendance and use of maternal as well as child health services. The pilot phase has demonstrated that men's involvement of men promotes access to information and services for family

planning and other aspects of reproductive health, removes barriers, and improves awareness among families and communities. Further, the involvement of administrative, political and community leaders enhances success and local ownership, especially when traditional village chiefs are themselves participants in the schools. Early results from this experience also confirm a high level of interest in modern contraception by women, consistent with high unmet need across the country. Requests are already coming in from neighboring villages to start schools of their own.

Schools for Husbands and demand generation through behaviour change in Niger

In **Niger**, where the Schools for Husbands initiative originated, the number of schools has grown from 11 test schools in 2007 in the Zinder region to a total of 284 schools in four regions as of 2012, including Dosso, Maradi, Tahoua and Zinder. As of 2012, an estimated 3,250 men are participating. Traditional leaders (*chefs traditionnels*) expressed their support for efforts to sensitize the public about the importance of family planning in the "Déclaration de Niamey" issued 24 November 2012. Documented results include behaviour changes in men in favour of reproductive health, improvements in RH indicators such as more post-natal consultations, and dramatic increases in the use of family planning.

Also in **Niger** and expanding with GPRHCS support, an NGO-led radio programme called 'The Adventures of Foula' has reached hundreds of villages with thousands of broadcasts and discussions sessions reaching tens of thousands of women and men. This IEC/BCC campaign continues today, reporting 7,884 dramatic sketches, 3,300 discussion session, creation of committees and training on family planning – all for community-level initiatives on sexual and reproductive health.

More country examples

In **Mali**, demand creation activities and supply of RH commodities were at the heart of implementation, particularly in response to the 2012 socio-political and humanitarian crisis marked by a coup in March. A collaborative forecasting activity was instrumental in developing an emergency procurement plan for contraceptives. 'Mobile Teams' in rural areas fostered demand for long-acting contraceptive methods and built understanding of the importance of birth spacing, messages echoed in media spots, sketches and radio shows.

A youth-led organization, Y.E.S. Salone, is the driver of a multi-sectoral programme launched nationally in **Sierra Leone** in 2012 by UNFPA, five Ministries, UN agencies and NGOs. The acronym stands for 'Young, Empowered and Safe'. The programme provides a single framework for all partners, including the Strategic Planning Unit in the President's Office; during Parliament's opening session in December, the President himself announced a new programme on teenage pregnancy. The programme aims to scale up demand for family planning and sexual and reproductive health services for adolescents and youth. Activities this year included development of minimum standards for services; a mobile minibus 'Poda Poda' campaign with music, drama sketches, debates and discussion; and roll-out of a

peer-to-peer grassroots education programme in 13 districts.

Adolescent health was also a priority for GPRHCS-supported action in **Nicaragua**, including development and validation of a National Comprehensive Adolescent Health and Development Strategy, advocacy with government and donors to launch an inter-sectorial approach to prevent adolescent pregnancy, dissemination of youth care guidelines, and information and awareness campaigns in 43 municipalities. The number of youth-friendly service delivery points increased from three in 2011 to 10 in 2012 working with PROFAMILIA and AMNLAE. The national budget line for contraceptives in Nicaragua has increased from $321,935 in 2010 to $1,669,042 in 2012.

Youth-friendly services, including access to contraceptives, were the focus of a Ministry of Health training course for 70 health professionals in **Uruguay**. Also, UNFPA partner Reprolatina developed an action research project with adolescents to link SRH and HIV services and sexuality education in schools.

In **Mozambique**, demand creation activities for long-acting contraceptive implants increased significantly in 2012, with emphasis on the use of implants overall and, more specifically, promotion of the IUD during National Health Week in Nampula Province.

In **Lao PDR**, repositioning of family planning included messages that show positive health benefits to

mothers and children by better birth spacing and delaying onset of first pregnancy. With GPRHCS funds, UNFPA supported national and sub-national awareness raising using TV and radio spots, posters, leaflets and other materials in local language, plus production, training and dissemination of IEC/BCC materials to promote increased use of modern family planning and attendance at births by a professional midwife. New in 2012 was condom promotion for dual protection among young people.

As a strategy to reach remote communities in Lao PDR, UNFPA supports the Government and other stakeholders to conduct regular Health Promotion Days. In each event, doctors, midwives and nurses provide free family planning services, nutrition counseling and antenatal care check-ups to the villagers from the surrounding areas. Advocacy efforts encourage each village to make an action plan to assist women with transportation if complications occur in childbirth.

CPR in **Rwanda** increased from 10 per cent in 2005 to 45 per cent in 2010, accompanied by improvement in maternal health. HIV prevalence has remained constant at 3 per cent, however, and in 2012 UNFPA

increased its support to partners to increase HIV awareness and prevention measure, and to ensure condoms are widely available at hot spots where people meet.

In **Ghana**, advocacy work in 2012 seeking governmental support for contraceptive procurement led to the Minister of Health declaring a free family planning service. UNFPA and its stakeholders undertook advocacy work to win government support for contraceptive procurement. The modalities for implementing this initiative are presently under consideration.

In **Benin**, five advocacy campaigns were organized aimed at the involvement of men and youth, local elected officials and opinion leaders in the promotion of family planning. This helped to foster and reinforce membership and engagement around family planning. The strong involvement of men and youth in the social mobilization campaigns helps to facilitate free access to family planning services in rural health districts.

Togo has also emphasized the critical role of men as Champions of Reproductive Health, forming committees of men throughout the country in 2012 to discuss family relationships and support women's access to reproductive health services.

In **Namibia**, information, education and communication family planning materials which had been developed during 2011 for demand creation were translated and aired on nation and community radios in 2012.

The **Republic of the Congo** (Brazzaville) embarked on a unique programme for distribution of female condoms in 2012 through hairdressers, clothing stores, and other places where women gather. The results of these innovative efforts will be tallied in 2013. In the Congo, UNFPA also developed non-traditional private-sector partnerships, including those with Total EP, la Congolese Industrielle du Bois, and the Rotary Club International, to mobilize financial and human resources to advance family planning and reproductive health programme goals.

Gabon intensified its efforts to increase demand for contraceptive supplies in 2012, particularly among the youth and adolescents who comprise more than 60 per cent of the population. Large-scale information display boards on the central highways around Libreville (home of over 50 per cent of the population of the country) and radio and television spots have been targeted to reach young people, and will continue on through 2013. Leaders of each of Gabon's religious communities also entered into a resolution in 2012 to promote reproductive health.

CHAPTER THREE: CATALYZING NATIONAL POLITICAL AND FINANCIAL COMMITMENT

Young women in Ecuador, where evidence-based advocacy garnered high-level support for RHCS. Credit: UNFPA Ecuador

Many countries are taking action to mobilize political will and financial resources for RHCS. Vigorous and committed support at the highest national levels is an important factor in achieving sustainable results. Reproductive health commodity security is a powerful platform for reducing unmet need and achieving reproductive rights, but it is largely dependent on donors at the present time.

Outputs that speak to political and financial commitment to RHCS are presented in this section: (1) Country RHCS strategic plans developed, coordinated and implemented by government with their partners; (2) Political and financial commitment for RHCS enhanced.

Output 1:

Country RHCS strategic plans developed, coordinated and implemented by government with their partners

The GPRHCS provides support to countries to formulate and implement RHCS strategies, and to integrate those strategies into health sector interventions, providing evidence-based advocacy and assistance to ensure that RHCS strategies in place. This process includes ensuring country ownership and country leadership in the area of RHCS and family planning. Countries are assisted to formulate and implement RHCS strategies and action plans; integrate RHCS issues into key sectoral strategies; establish functional coordinating bodies under the leadership of government; and ensure RH commodities, including contraceptives, are included in the Essential Medicines List (EML) of each country. Both Stream 1 and 2 countries made progress in these areas in 2012.

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

Many countries have successfully integrated RHCS issues into national sectoral strategies for reproductive health or sexual and reproductive health (RH/SRH), HIV/AIDS and gender strategies (Table 13 and Figure 12). All Stream 1 countries have integrated reproductive health commodity security into their RH/SRH strategies and HIV/AIDS strategies. Eleven of the 12 countries have integrated RHCS issues into their gender strategy, the exception being Nicaragua where a gender strategy does not exist.

Table 13: RHCS strategy integrated into sectoral strategies in Stream 1 countries, 2010 to 2012

Countries	RH/SRH			HIV/AIDS			Gender		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y	Y
Haiti	Y	Y	Y	Y	Y	Y	N	N	Y
Ethiopia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lao PDR	Y	Y	Y	Y	Y	Y	N	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y	N	N	Y
Mali	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nicaragua	Y	Y	Y	N	Y	Y	N	N	NA
Niger	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria*	NA	Y	Y	NA	Y	Y	NA	Y	Y
Sierra Leone	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	11	12	12	10	12	12	7	9	11

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

Figure 12: RHCS strategy integrated into sectoral strategies in Stream 1 countries, 2010 to 2012

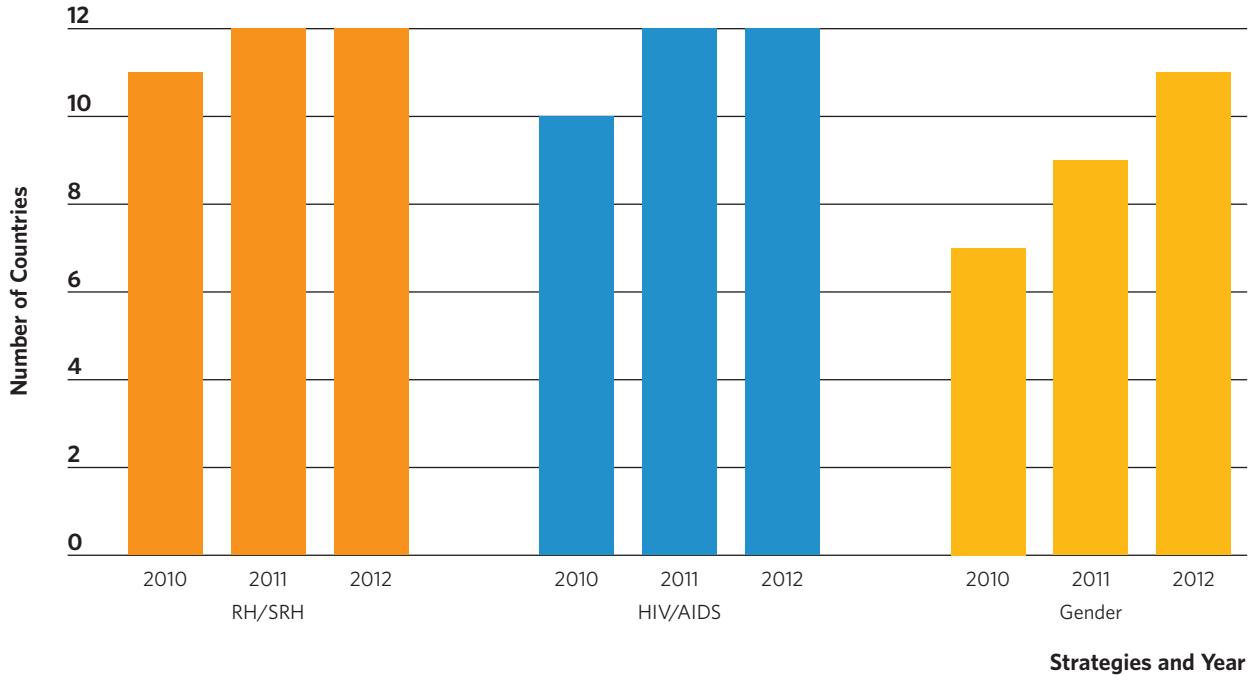


Figure 13: RHCS strategy integrated into sectoral strategies in Stream 2 countries, 2010 to 2012

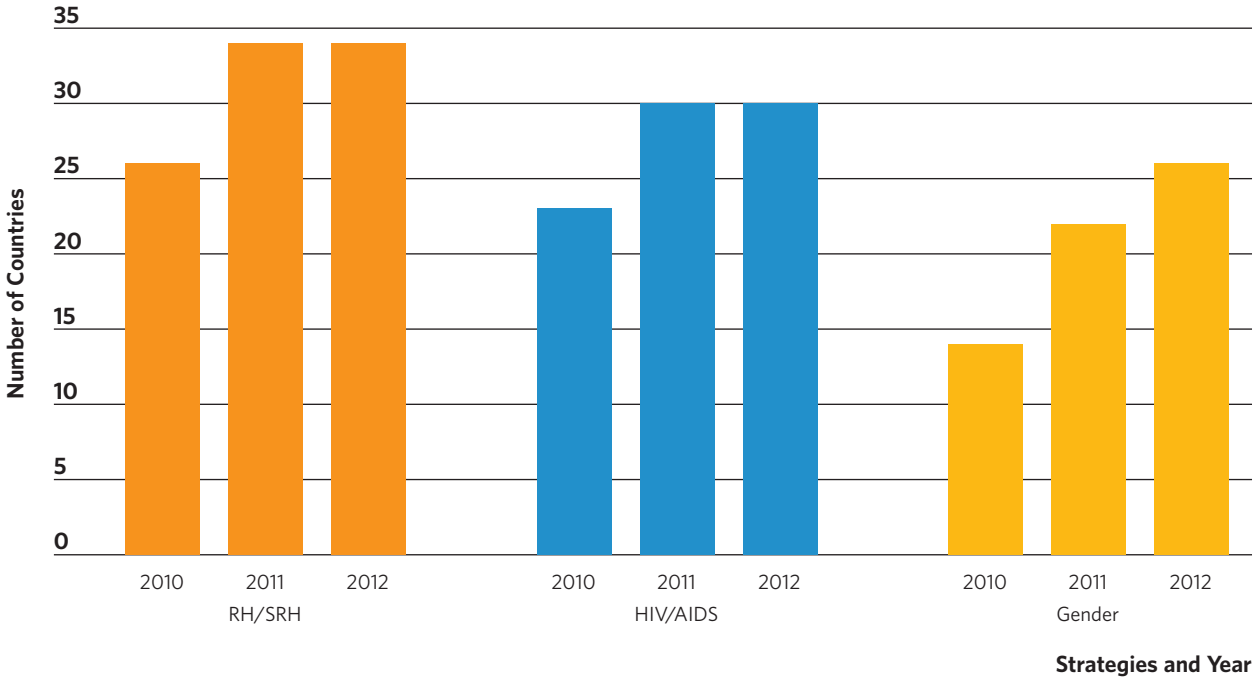


Table 14: RHCS strategy integrated into sectoral strategies in Stream 2 countries, 2010 to 2012

Countries	RH/SRH			HIV/AIDS			Gender		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Benin	Y	Y	Y	Y	Y	Y	N	Y	Y
Bolivia	Y	Y	Y	Y	Y	Y	N	Y	Y
Botswana	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burundi	Y	Y	Y	Y	Y	Y	N	Y	Y
Central African Republic	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y	N	N	N
Congo	Y	Y	Y	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	Y	Y	Y	Y
Democratic Republic of the Congo	Y	Y	Y	Y	Y	Y	Y	Y	Y
Djibouti	N	Y	Y	N	Y	Y	N	Y	Y
Ecuador	Y	Y	Y	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gambia	Y	Y	Y	Y	Y	Y	N	N	N
Ghana	N	Y	Y	Y	Y	Y	Y	Y	Y
Guinea	Y	Y	Y	N	Y	Y	N	N	N
Guinea-Bissau	Y	Y	Y	N	Y	Y	N	N	N
Lesotho	Y	Y	Y	Y	Y	Y	N	N	N
Liberia	Y	Y	Y	Y	Y	Y	N	Y	Y
Malawi	Y	Y	Y	Y	Y	Y	N	Y	Y
Mauritania	Y	Y	Y	Y	Y	Y	Y	Y	Y
Namibia	Y	Y	Y	Y	Y	Y	Y	Y	Y

Countries	RH/SRH			HIV/AIDS			Gender		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Nigeria*	Y	NA	NA	N	NA	NA	Y	NA	NA
Papua New Guinea	N	Y	Y	N	Y	Y	N	N	Y
Sao Tome and Principe	N	Y	Y	N	N	N	N	N	Y
Senegal	Y	Y	Y	Y	Y	Y	Y	Y	Y
South Sudan	-	Y	Y	-	N	Y	-	N	N
Sudan	N	Y	Y	N	N	N	N	N	N
Swaziland	Y	Y	Y	Y	Y	Y	N	N	N
Timor Leste	N	Y	Y	N	Y	Y	N	N	Y
Togo	N	Y	Y	N	Y	Y	N	Y	Y
Uganda	Y	Y	Y	Y	Y	Y	Y	Y	Y
Yemen	N	Y	Y	N	N	N	N	N	Y
Zambia	Y	Y	Y	Y	Y	Y	N	Y	Y
Zimbabwe	Y	Y	Y	N	Y	Y	N	Y	Y
Total for 'Yes'	26	34	34	23	30	30	14	22	26

* Nigeria was designated as a Stream 1 Country in 2011, thus updates for 2011 and 2012 are in the Stream 1 Table

The number of GPRHCS Stream 2 countries where RHCS issues were integrated into sexual and reproductive health strategies was 32 out of 34, remaining the same in 2011 and 2012 (Table 14 and Figure 13). Likewise, the number of countries with RHCS issues integrated into the sectoral strategy on HIV/AIDS remained at 30. The number of countries with RHCS issues integrated into the sectoral strategy on Gender increased from 22 countries in 2011 to 26 countries in 2011.

There are several reasons why RHCS issues are not integrated in some sectoral strategies. In some cases, no comprehensive strategies exist, which means that implementation is usually ad hoc. Another reason is that existing strategies are very old and yet to be revised, which is the case of in Chad, Gambia, Guinea and Sudan, where actions are not guided by updated protocols and guidelines.

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

The GPRHCS assists countries in the implementation of their RHCS action plans. Table 15 shows progress made in implementing RHCS strategies/action plans in the GPRHCS Stream 1 countries from 2009 to 2012. As was the case in 2011, only Haiti did not have an action plan for RHCS in 2012. The number of countries implementing elements of RHCS strategy and action plan increased from 7 in 2009 to 11 in 2011 and 2012 (Figure 14). In Lao PDR, the plan is implemented as part of an integrated MNCH strategic and planning framework of the Ministry of Health.

Thirty two of the 34 GPRHCS Stream 2 countries have action plans for reproductive health commodity security and are implementing aspects of the plan. Papua New Guinea and Sudan do not have an action plan for implementation (Table 16 and Figure 15).

Table 15: RHCS strategies/action plans being implemented in Stream 1 countries, 2009 to 2012

Country	Have RHCS strategy/action plan				If yes, elements being implemented			
	2009	2010	2011	2012	2009	2010	2011	2012
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y	Y	Y
Haiti	N	N	N	N	N	N	N	N
Lao PDR	Y	Y	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y	Y	Y
Mali	N	Y	Y	Y	N	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y	N	Y	Y	Y
Nicaragua	Y	Y	Y	Y	N	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria*	-	-	Y	Y	-	-	Y	Y
Sierra Leone	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	9	10	11	11	7	10	11	11

* Nigeria was designated as a Stream 1 Country in 2011, thus information for 2010 are in the Stream 2 Table

Figure 14: Number of Stream 1 countries with RHCS strategy being implemented

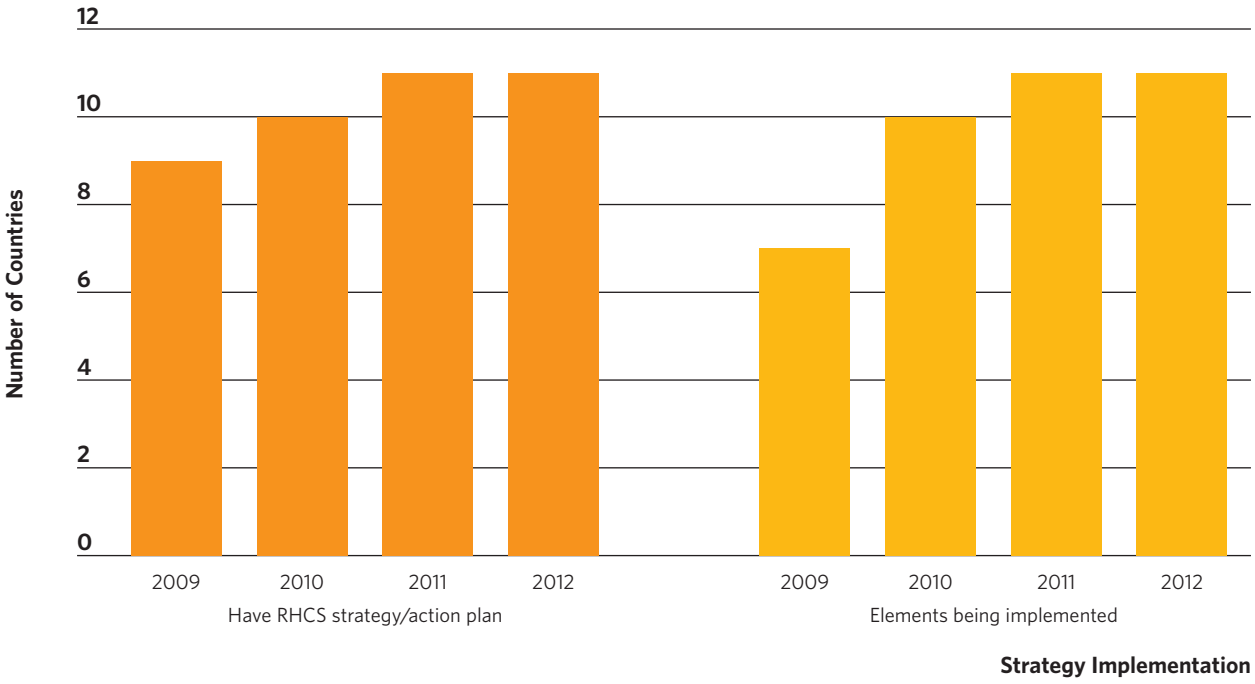


Figure 15: Number of Stream 2 countries with RHCS strategy being implemented

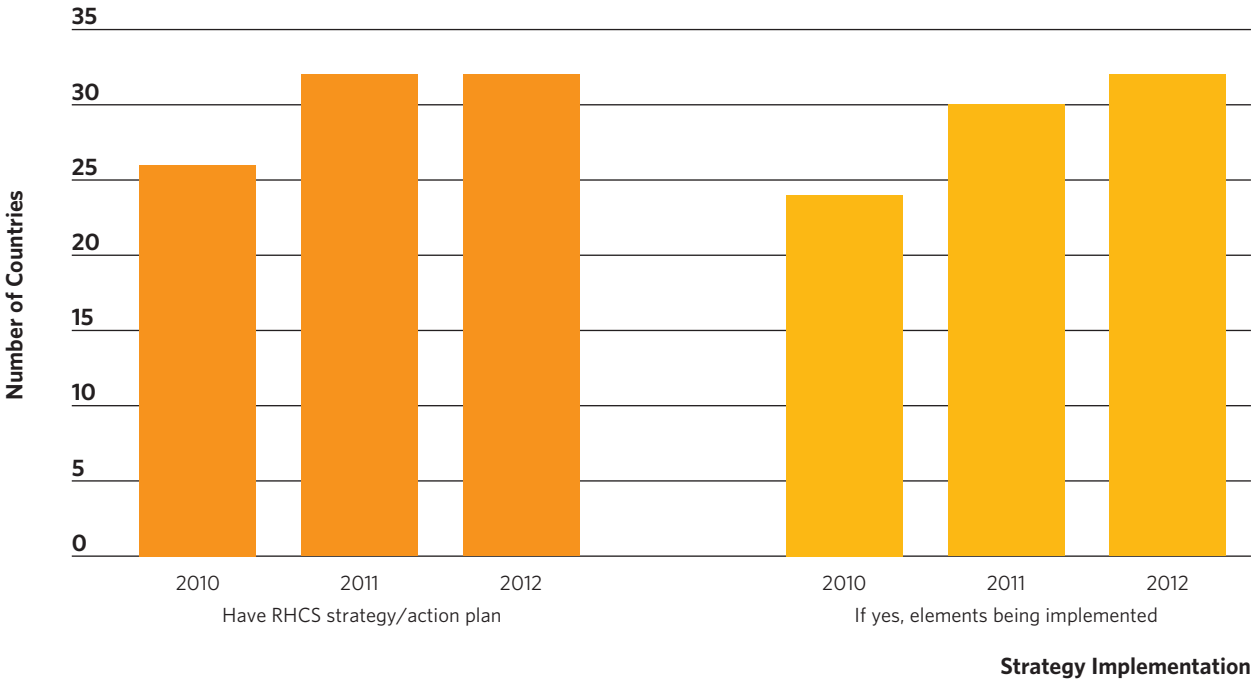


Table 16: RHCS strategies/action plans implemented in Stream 2 countries, 2010 to 2012

Countries	Have RHCS strategy/action plan			If yes, elements being implemented		
	2010	2011	2012	2010	2011	2012
Benin	Y	Y	Y	Y	Y	Y
Bolivia	Y	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y
Burundi	Y	Y	Y	Y	Y	Y
Central Africa Republic	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y
Congo	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	N	Y	Y
DRC	Y	Y	Y	Y	Y	Y
Djibouti	Y	Y	Y	Y	Y	Y
Ecuador	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y
Ghana	Y	Y	Y	Y	Y	Y
Guinea	Y	Y	Y	Y	Y	Y
Guinea Bissau	Y	Y	Y	Y	Y	Y
Lesotho	Y	Y	Y	N	Y	Y
Liberia	N	Y	Y	N	N	Y
Malawi	Y	Y	Y	Y	Y	Y
Mauritania	N	Y	Y	N	Y	Y
Namibia	Y	Y	Y	Y	Y	Y
Nigeria*	Y	NA	NA	Y	NA	NA

Countries	Have RHCS strategy/action plan			If yes, elements being implemented		
	2010	2011	2012	2010	2011	2012
Papua New Guinea	N	N	N	N	N	N
Sao Tome and Principe	Y	Y	Y	Y	Y	Y
Senegal	Y	Y	Y	Y	Y	Y
South Sudan	-	Y	Y	-	Y	Y
Sudan	N	N	N	N	N	N
Swaziland	Y	Y	Y	Y	Y	Y
Timor Leste	N	Y	Y	N	Y	Y
Togo	N	Y	Y	N	Y	Y
Gambia	N	Y	Y	N	Y	Y
Uganda	Y	Y	Y	Y	Y	Y
Yemen	N	Y	Y	N	N	Y
Zambia	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y
Total for 'Yes'	26	32	32	24	30	32

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

3.3 Number of countries with functional co-ordination mechanism for RHCS, or RHCS is included in broader coordination mechanism

All the GPRHCS Stream 1 countries had a coordination mechanism in place that included RHCS issues and had Terms of Reference in 2012, as in the previous year. Efforts in this area aimed to bring partners together for joint decision making and action on RHCS under the leadership of government.

All of the 34 Stream 2 countries reported that they have coordinating committees which include RHCS in their frameworks (Table 18 and Figure 16). More specifically, these mechanisms have Terms of Reference (TORs) in 33 countries, up from 32 in 2011, with Senegal being the country where action was taken. The TORs address country-specific issues that need to be coordinated and the modality to do so.

Table 17: RHCS coordinating mechanism in place in Stream 1 countries, 2009 to 2012

Country	National country coordinating mechanism exists				If yes, RHCS issues included in institutional mechanism			If yes, does mechanism have TOR		
	2009	2010	2011	2012	2010	2011	2012	2010	2011	2012
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Haiti	N	N	Y	Y	N	Y	Y	N	Y	Y
Lao PDR	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mali	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nicaragua	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria*	-	-	Y	Y	-	Y	Y	-	Y	Y
Sierra Leone	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**10**	**10**	**12**	**12**	**10**	**12**	**12**	**10**	**12**	**12**

* Nigeria was designated as a Stream 1 Country in 2011, thus information for 2010 are in the Stream 2 Table

** For contraceptives only

Figure 16: Number of Stream 1 countries with national coordinating mechanisms

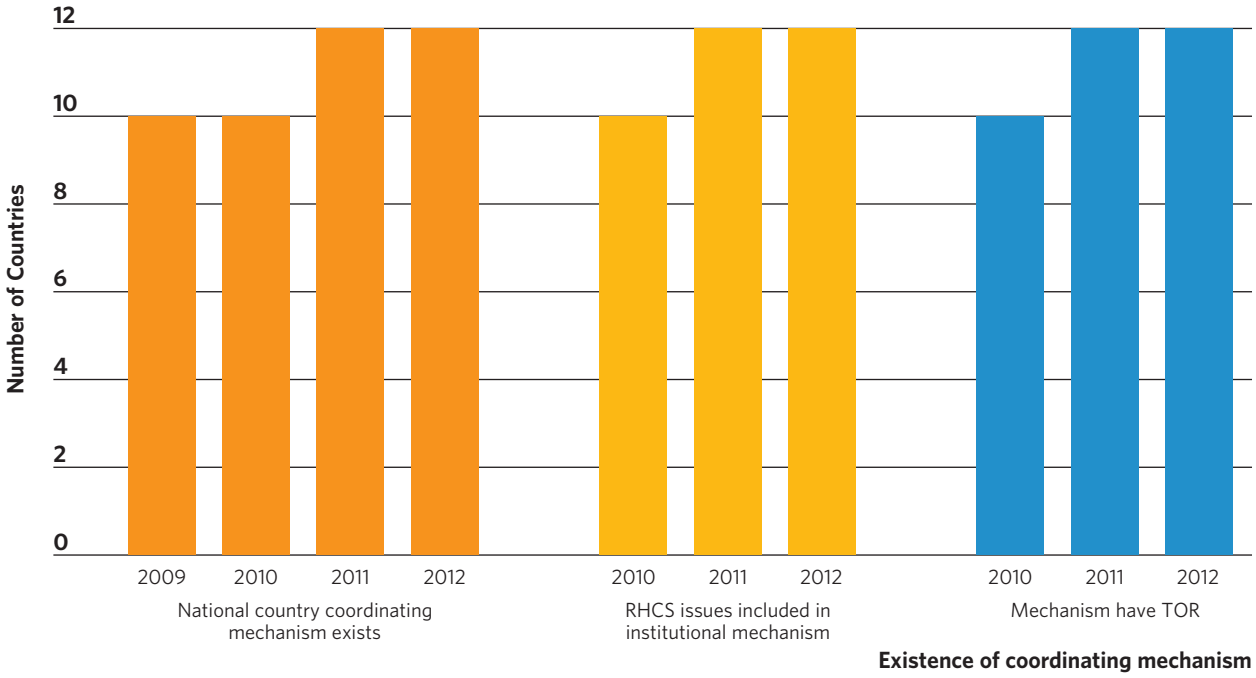


Figure 17: Number of Stream 2 countries with national coordinating mechanisms

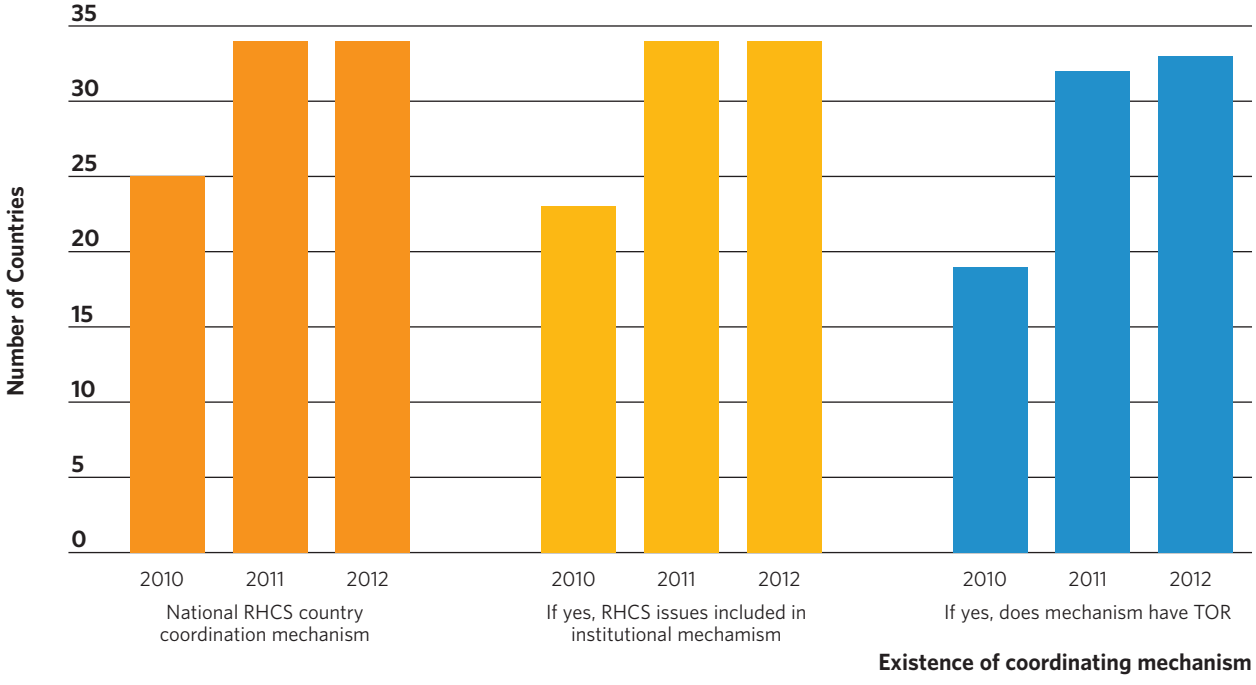


Table 18: RHCS coordinating committees in Stream 2 countries, 2010 to 2012

Country	National country coordinating mechanism exists			If yes, RHCS issues included in institutional mechanism			If yes, does mechanism have TOR		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Benin	Y	Y	Y	Y	Y	Y	N	Y	Y
Bolivia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burundi	N	Y	Y	N	Y	Y	N	Y	Y
Central Africa Republic	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y	Y	Y	Y
Congo	Y	Y	Y	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	Y	Y	Y	Y
DRC	Y	Y	Y	Y	Y	Y	Y	Y	Y
Djibouti	N	Y	Y	N	N	N	N	Y	Y
Ecuador	Y	Y	Y	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gambia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ghana	Y	Y	Y	Y	Y	Y	Y	Y	Y
Guinea	N	Y	Y	N	Y	Y	N	Y	Y
Guinea Bissau	Y	Y	Y	Y	Y	Y	N	Y	Y
Lesotho	Y	Y	Y	N	Y	Y	Y	Y	Y
Liberia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Malawi	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mauritania	Y	Y	Y	Y	Y	Y	Y	Y	Y

Country	National country coordinating mechanism exists			If yes, RHCS issues included in institutional mechanism			If yes, does mechanism have TOR		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Namibia	Y	Y	Y	Y	Y	Y	N	Y	Y
Nigeria*	Y	NA	NA	Y	NA	NA	Y	NA	NA
Papua New Guinea	N	Y	Y	N	Y	Y	N	Y	Y
Sao Tome and Principe	N	Y	Y	N	Y	Y	N	N	N
Senegal	Y	Y	Y	N	Y	Y	N	N	Y
South Sudan	-	Y	Y	-	Y	Y	-	Y	Y
Sudan	N	Y	Y	N	Y	Y	N	Y	Y
Swaziland	Y	Y	Y	Y	Y	Y	Y	Y	Y
Timor Leste	N	Y	Y	N	Y	Y	N	Y	Y
Togo	N	Y	Y	N	Y	Y	N	Y	Y
Uganda	Y	Y	Y	Y	Y	Y	N	Y	Y
Yemen	N	Y	Y	N	Y	Y	N	Y	Y
Zambia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	25	34	34	23	34	34	19	32	33

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

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

All Stream 1 countries had Essential Medicines Lists (EML) in place as of 2012, and all of these lists contained the UNFPA and WHO essential and life-saving maternal health medicines. Also, all the Stream 1 countries reported that their EMLs have maternal health medicines and contraceptives (Table 19 and Figure 18).

Among Stream 2 countries, all had EMLs in place, with contraceptives included on the list for 32 countries in 2012, up from 30 in 2011 (Table 20). The number of Stream 2 countries with maternal health medicines included in the EML increased from 32 countries in 2011 to 34 countries in 2012 (Figure 19).

Table 19: Stream 1 countries with essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML, 2011 and 2012

Country	EML exists in the country		If yes, does EML contains contraceptives		If yes, does EML contains maternal drugs	
	2011	2012	2011	2012	2011	2012
Burkina Faso	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y
Haiti	Y	Y	Y	Y	Y	Y
Lao PDR	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y
Mali	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y	Y	Y
Nicaragua	Y	Y	Y	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y
Nigeria	Y	Y	Y	Y	Y	Y
Sierra Leone	Y	Y	Y	Y	Y	Y
Total for 'Yes'	12	12	12	12	12	12

Figure 18: Stream 1 countries with essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML, 2011 and 2012

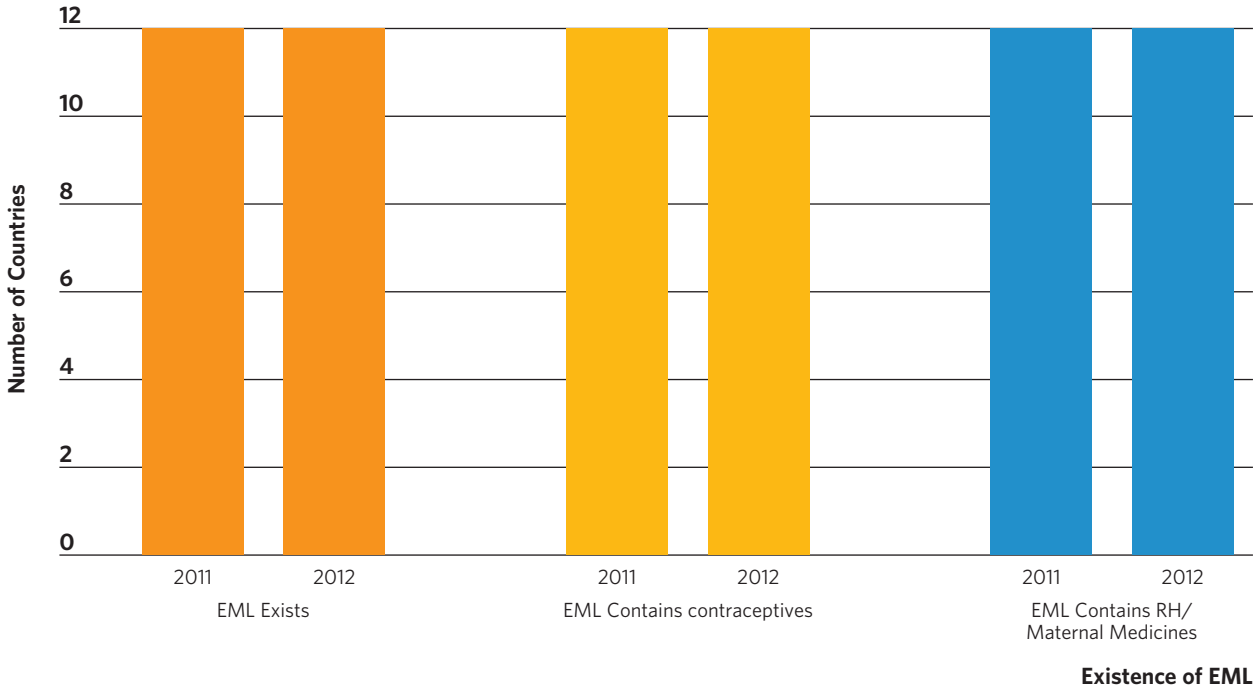


Figure 19: Stream 2 countries with essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML, 2011 and 2012

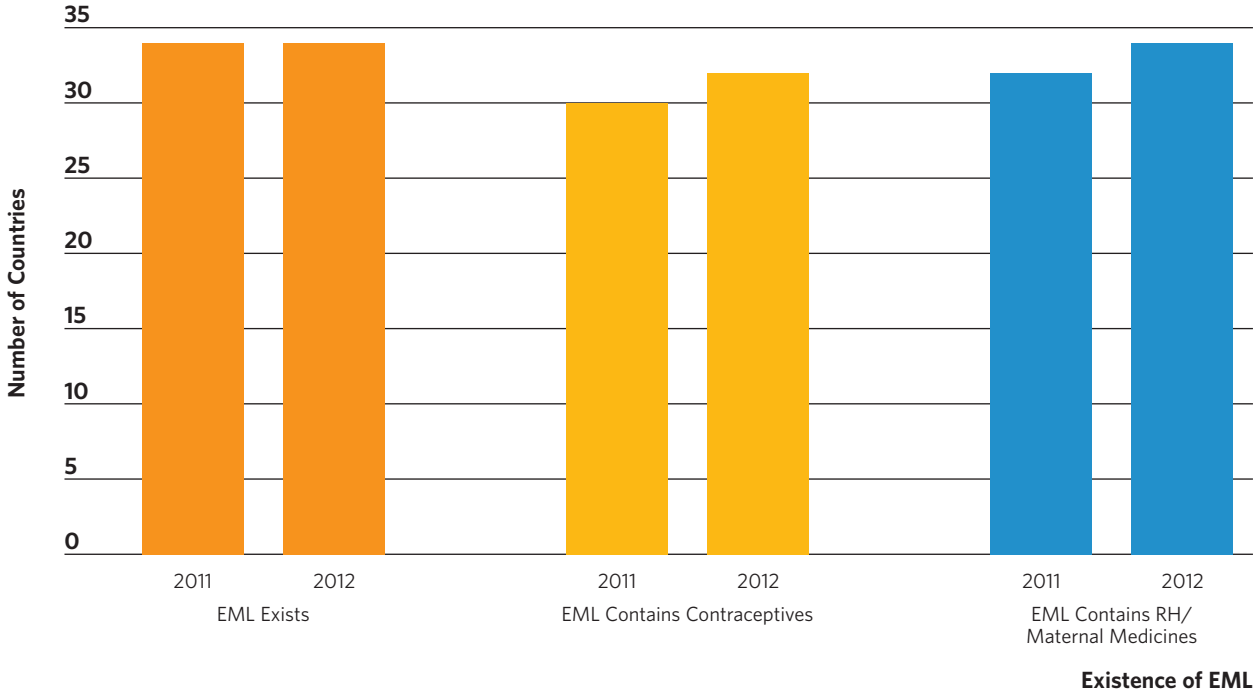


Table 20: Stream 2 countries with essential RH commodities (contraceptives and life-saving maternal/RH medicines) in EML, 2011 and 2012

	EML exists in the country		If yes, does EML contains contraceptives		If yes, does EML contains maternal drugs	
Country	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Benin	Y	Y	Y	Y	Y	Y
Bolivia	Y	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y
Burundi	Y	Y	Y	Y	Y	Y
Central Africa Republic	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y
Congo	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	Y
Democratic Republic of Congo	Y	Y	Y	Y	Y	Y
Djibouti	Y	Y	Y	Y	Y	Y
Ecuador	Y	Y	N	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y
Gambia	Y	Y	Y	Y	Y	Y
Ghana	Y	Y	N	Y	Y	Y
Guinea	Y	Y	Y	Y	Y	Y
Guinea Bissau	Y	Y	Y	Y	Y	Y
Lesotho	Y	Y	Y	Y	N	Y
Liberia	Y	Y	Y	Y	Y	Y
Malawi	Y	Y	N	N	Y	Y
Mauritania	Y	Y	Y	Y	Y	Y

	EML exists in the country		If yes, does EML contains contraceptives		If yes, does EML contains maternal drugs	
Country	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Namibia	Y	Y	N	N	Y	Y
Nigeria*	NA	NA	NA	NA	NA	NA
Papua New Guinea	Y	Y	Y	Y	Y	Y
Sao Tome et Principe	Y	Y	Y	Y	Y	Y
Senegal	Y	Y	Y	Y	Y	Y
South Sudan	Y	Y	Y	Y	Y	Y
Sudan	Y	Y	Y	Y	Y	Y
Swaziland	Y	Y	Y	Y	Y	Y
Timor Leste	Y	Y	Y	Y	Y	Y
Togo	Y	Y	Y	Y	N	Y
Uganda	Y	Y	Y	Y	Y	Y
Yemen	Y	Y	Y	Y	Y	Y
Zambia	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y
Total for 'Yes'	34	34	30	32	32	34

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

Output 2:
Political and financial commitment for RHCS enhanced

Ensuring RHCS requires commitment country, regional and global from governments and their partners. It is for this reason that the GPRHCS supports country initiatives to advocate for commitments from both donors and governments. Under this output evidence of commitments are gauged by the availability of funding for the GPRHCS through multi-year donor pledges, signing of MOUs with Stream 1 country governments, mainstreaming of RHCS issues in policies and strategies in the work of global and regional organizations and partners, inclusion of RHCS priorities in national and sectoral policies and plans, and the allocation of resources within SRH/RHCs budget line for contraceptives at country level.

3.5 Funding mobilized for GPRHCS on a reliable basis

The purpose of this indicator is to track and report on resource mobilization efforts undertaken by UNFPA for the implementation of the GPRHCS, in particular on multi-year pledges. Funds mobilized in 2012 came from five sources (European Commission, UK, Netherlands, Liechtenstein and from donations received from private individuals) amounting to $181.4 million (Table 23). Although the European Union has supported RHCS interventions implemented by UNFPA in the past, the 2012 contribution of $34.6 million from the European Commission was the first such donation to the GPRHCS.

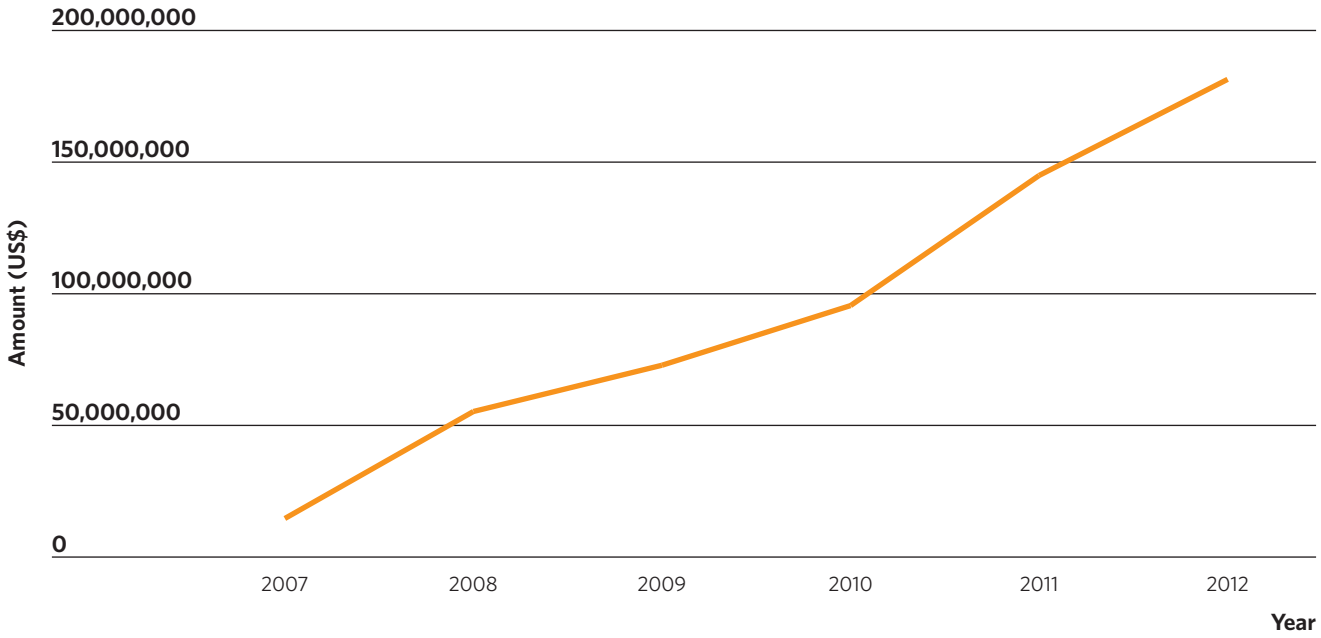
The 46 countries of the GPRHCS were represented at a November 2012 meeting in Cotonou, Benin. Photo: UNFPA Benin

Table 21: Amount mobilized from donor countries in US$ for GPRHCS, 2007 to 2012

Donor partner	2007	2008	2009	2010	2011	2012	Total
Australia	0	0	0	0	10,893,246	0	10,893,246
Canada	0	0	1,996,805	0	0	0	1,996,805
Denmark	0	0	0	0	3,586,157	0	3,586,157
European Commission	0	0	0	0	0	34,598,541	34,598,541
Finland	0	2,590,674	0	0	0	0	2,590,674
France	0	0	0	272,109	0	0	272,109
Ireland	1,440,922	1,557,632	0	0	0	0	1,557,632
Liechtenstein	0	0	0	0	0	32,002	32,002
Luxembourg	544,959	557,103	591,716	544,218	569,800	0	2,262,837
Netherland	6,024,096	34,114,379	45,831,976	39,807,880	33,783,783	39,596,300	193,134,318
Spain	6,637,168	7,772,021	7,396,450	0	0	0	15,168,471
Spain (Catalonia)	0	0	563,471	420,168	0	0	983,639
UK	0	8,695,652	16,474,465	54,464,816	96,092,987	107,215,048	282,942,968
Private/ Individual Contributors	0	0	0	0	3,949	3,284	7,233
Total	**14,647,145**	**55,287,461**	**72,854,883**	**95,509,191**	**144,929,922**	**181,445,175**	**564,673,777**

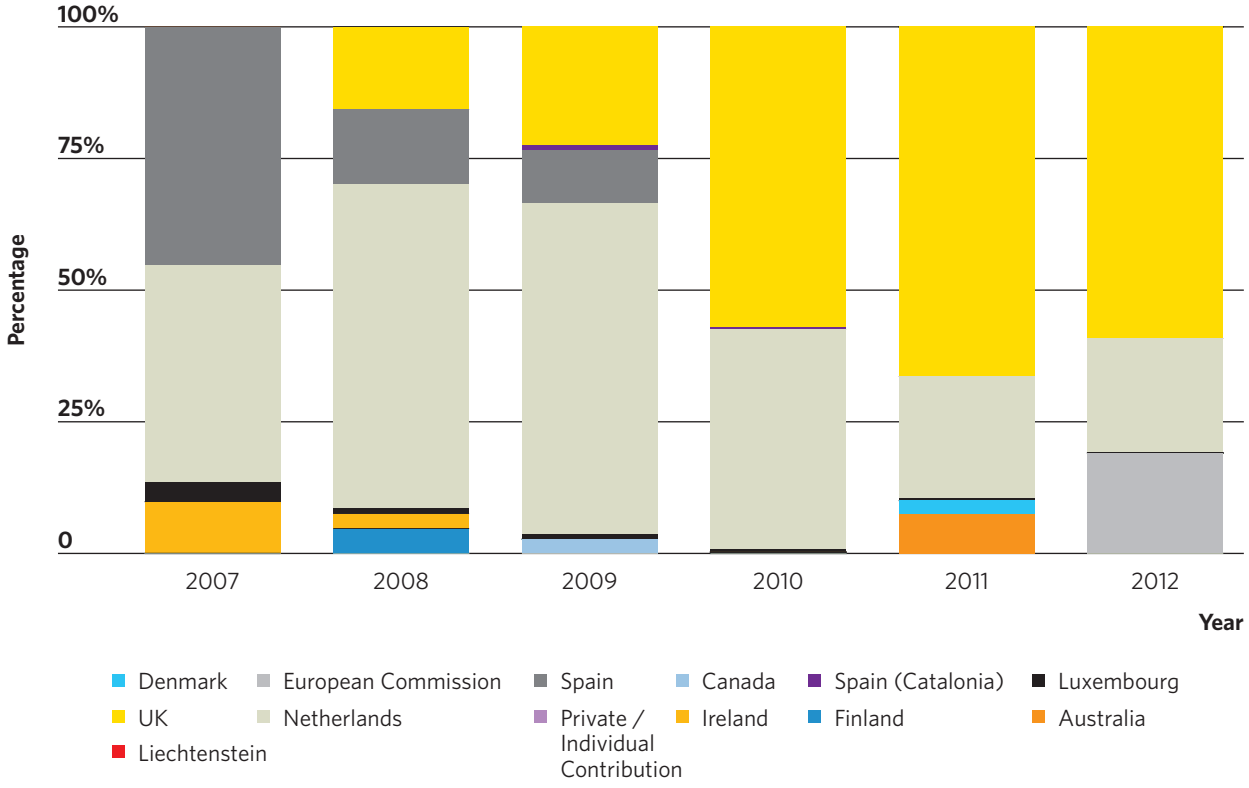
The total contribution received from donors, as shown in Figure 20, increased by about 25 per cent; from $144.9 million in 2011 to $181.4 million in 2012. The total contribution received from the launch of the programme in mid-2007 to 2012 was **$564.7 million**. (In comparison, the same table in the 2011 annual report, p.40, shows a total of $365 million for a shorter timespan).

Figure 20: Resources mobilized for GPRHCS, 2007 to 2012



Two donors continued to be the two highest contributors to the GPRHCS: the UK accounted for 59.1 per cent and The Netherlands accounted for 21.8 per cent. Together, the two contributed 80.9 per cent of the resources in 2012. The other major contribution to the GPRHCS in 2012, amounting to 19 per cent of the resources, was from the European Commission.

Figure 21: Resources contributed by donors to GPRHCS, 2007 to 2012



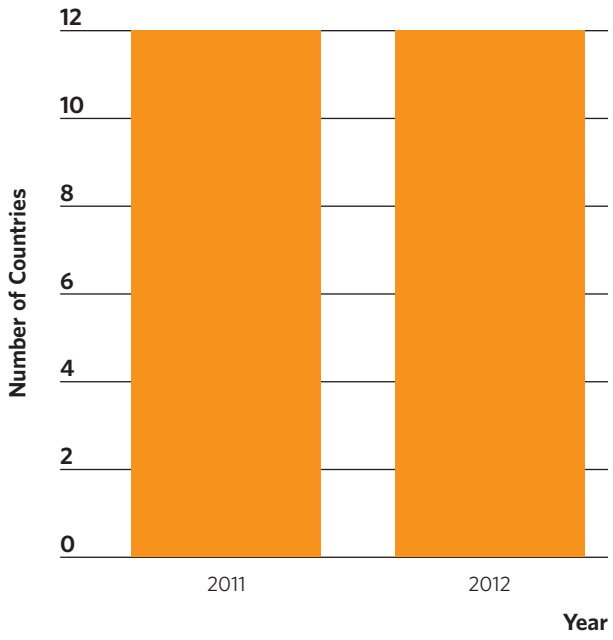
3.6 MOU signed with UNFPA and Stream 1 country governments

UNFPA Country Offices in the Stream 1 countries sign a Memorandum of Understanding with their respective governments to ensure each party understands the actions that are to be taken and the commitments that must be met to ensure successful programme implementation. All Stream 1 countries had signed MOUs as a basis of cooperation and partnership in the implementation of the GPRHCS as of 2012 (Table 24 and Figure 22). Although it is not compulsory for Stream 2 countries to sign MOUs with their respective governments, the country offices are encouraged explore the possibility of doing so, in order to formalize the working relationship around GPRHCS interventions.

Table 22: Stream 1 countries with signed MOU between Government and UNFPA for GPRHCS implementation, 2011 and 2012

Country	2011	2012
Burkina Faso	Y	Y
Ethiopia	Y	Y
Haiti	Y	Y
Lao PDR	Y	Y
Madagascar	Y	Y
Mali	Y	Y
Mongolia	Y	Y
Mozambique	Y	Y
Nicaragua	Y	Y
Niger	Y	Y
Nigeria	Y	Y
Sierra Leone	Y	Y
Total for 'Yes'	**12**	**12**

Figure 22: Government has signed MOU for GPRHCS implementation



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

UNFPA, through its regional offices, works with global, bilateral and regional organizations/partners to build capacities and ensure their policies, plans and activities reflect RHCS key issues. Over the years, UNFPA has worked with different regional economic communities or commissions; providing support through the GPRHCS for the institutions to scale up actions relating to RHCS.

In 2012, capacity assessments were conducted with the Intergovernmental Authority on Development (IGAD) as part of technical assistance provided by UNFPA Regional Offices with support from the GPRHCS. The assessments identified specific strategic areas for sexual and reproductive health and RHCS programming within the various mandates of IGAD Member States. Capacity assessments were undertaken using the guidelines of the UNFPA Policies and Procedures Manual (PPM). The assessments provided evidence regarding areas of strengths and weaknesses as well as opportunities for UNFPA collaboration. Letters of Understanding

(LOUs) were subsequently signed, with partnership arrangements established and areas of technical collaboration agreed. The assessments focused on contextual issues, institutional commitment to RHCS coordination mechanisms, clientele of the institutions and implementation capacity of the institutions.

Also this year, IGAD Member States nominated a senior programme staff member to serve as the IGAD-RHCS focal point within the departments of reproductive health to support the IGAD UNFPA RHCS initiative. (This action followed a recommendation made at the 2011 regional meeting of RH experts at the IGAD secretariat.) IGAD countries received support to implement family planning demand creation/generation, training of family planning service providers, building national capacity for procurement.

Efforts were made to integrate family planning with PMTCT interventions for cross-border and mobile populations, and to integrate sexual and reproductive health into existing HIV/AIDS services for these populations and surrounding communities in selected hot spots in IGAD countries.

3.8 Number of countries that have included RHCS priorities in PRSP and Health sector policy and plan and SWAPs

This indicator tracks results achieved in working with governments and other partners to ensure that RHCS issues are part of national planning and country programming processes – specifically within documents such as Poverty Reduction Strategy Papers (PRSPs); national health sector policies and plans; and sector wide approaches for the health sector.

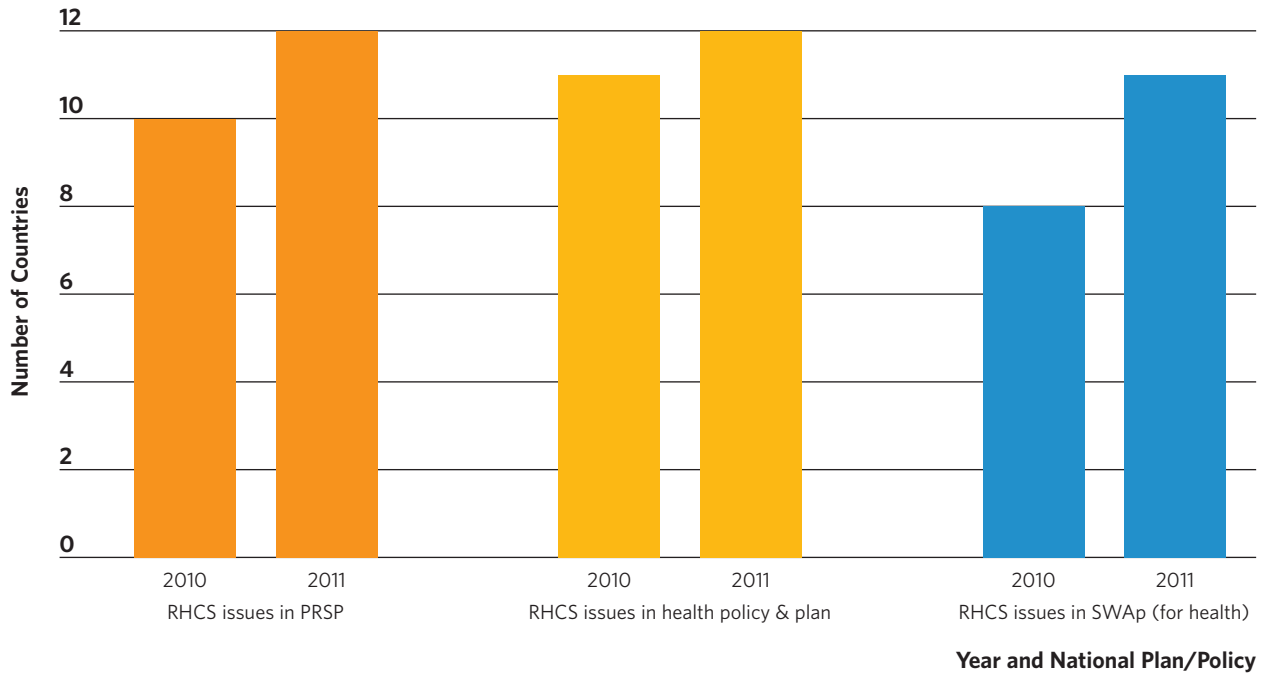
Table 23: RHCS issues included in PRSPs, health policies and SWAPs in Stream 1 countries, 2010 to 2012

Countries	RHCS issues in PRSP			RHCS issues in health policy & plan			RHCS issues in SWAP (for health)		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Haiti	Y	Y	Y	Y	Y	Y	N	N	N
Laos	Y	Y	Y	Y	Y	Y	Y	Y	Y
Madagascar	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mali	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	N	Y	Y	Y	Y	Y	N	Y	Y
Nicaragua	Y	Y	Y	Y	Y	Y	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria	-	Y	Y	-	Y	Y	-	Y	Y
Sierra Leone	Y	Y	Y	Y	Y	Y	N	Y	Y
Total for 'Yes'	**10**	**12**	**12**	**11**	**12**	**12**	**8**	**11**	**11**

* Nigeria was designated as a Stream 1 Country in 2011, thus information for 2010 are in the Stream 2 Table

As of 2012, RHCS issues were integrated in the PRSPs and national development strategies of all the Stream 1 countries (Table 23 and Figure 23). RHCS issues were also integrated in their existing health sector policies. RHCS issues were integrated in the Sector-Wide Approaches for the health sector in 11 Stream 1 countries, the exception being Haiti, as in 2011.

Figure 23: RHCS issues included in PRSPs; health policies & plans; and SWAp in Stream 1 countries, 2010 to 2012



Among Stream 2 countries, RHCS issues were integrated in the PRSPs, national development plans, and health sector policies and plans of all 34 countries as of 2012, as in 2011 (Table 24 and Figure 29). The number of Stream 2 countries that have integrated RHCS issues into their Sector-Wide Approaches for the health sector increased from 21 in 2010 to 27 in 2011 to 31 in 2012. The integration of RHCS issues into key national development strategies and plans indicated commitment and desire to prioritize RHCS at country level.

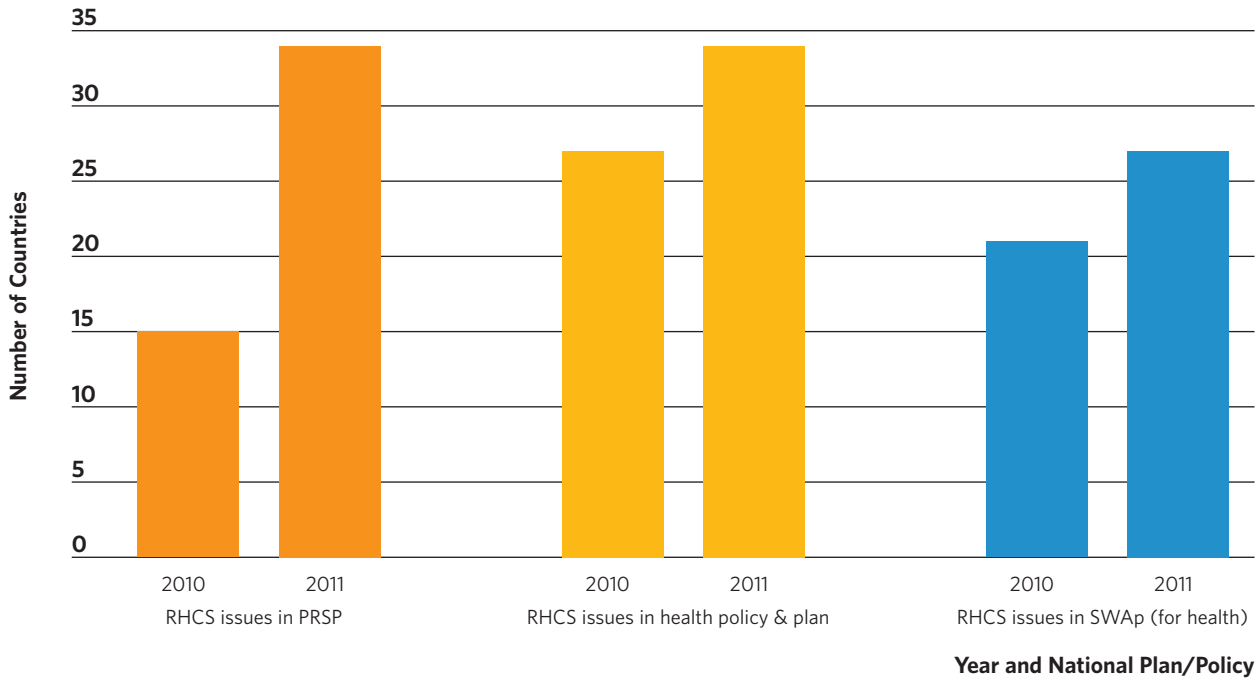
Table 24: RHCS issues included in PRSPs, health policies and SWAPs in Stream 2 countries, 2010 to 2012

	RHCS issues in PRSP			RHCS issues in health policy & plan			RHCS issues in SWAP (for health)		
Countries	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**
Benin	N	Y	Y	Y	Y	Y	Y	Y	Y
Bolivia	N	Y	Y	Y	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burundi	N	Y	Y	Y	Y	Y	N	Y	Y
Central Africa Republic	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y	-	N	Y
Congo	Y	Y	Y	Y	Y	Y	-	Y	Y
Côte d'Ivoire	N	Y	Y	Y	Y	Y	Y	Y	Y
Democratic Republic of Congo	Y	Y	Y	Y	Y	Y	Y	Y	Y
Djibouti	N	Y	Y	N	Y	Y	N	N	N
Ecuador	Y	Y	Y	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gambia	N	Y	Y	Y	Y	Y	Y	Y	Y
Ghana	Y	Y	Y	Y	Y	Y	Y	Y	Y
Guinea	N	Y	Y	Y	Y	Y	Y	Y	Y
Guinea Bissau	N	Y	Y	Y	Y	Y	Y	Y	Y
Lesotho	N	Y	Y	Y	Y	Y	Y	Y	Y

	RHCS issues in PRSP			RHCS issues in health policy & plan			RHCS issues in SWAP (for health)		
Countries	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**
Liberia	N	Y	Y	Y	Y	Y	N	Y	Y
Malawi	N	Y	Y	Y	Y	Y	Y	Y	Y
Mauritania	N	Y	Y	Y	Y	Y	N	Y	Y
Namibia	-	Y	Y	-	Y	Y	-	Y	Y
Nigeria	N	-	-	Y	-	-	Y	-	-
Papua New Guinea	-	Y	Y	-	Y	Y	-	Y	Y
Sao Tome and Principe	Y	Y	Y	Y	Y	Y	Y	Y	Y
Senegal	Y	Y	Y	Y	Y	Y	Y	Y	Y
South Sudan	-	Y	Y	-	Y	Y	-	N	Y
Sudan	-	Y	Y	-	Y	Y	-	N	N
Swaziland	Y	Y	Y	Y	Y	Y	-	N	Y
Timor Leste	-	Y	Y	-	Y	Y	-	Y	Y
Togo	-	Y	Y	-	Y	Y	-	N	N
Uganda	Y	Y	Y	Y	Y	Y	Y	Y	Y
Yemen	-	Y	Y	-	Y	Y	-	N	Y
Zambia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**15**	**34**	**34**	**27**	**34**	**34**	**21**	**27**	**31**

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

Figure 24: RHCS issues included in PRSPs; health policies & plans; and SWAp in Stream 2 countries, 2010 to 2012



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

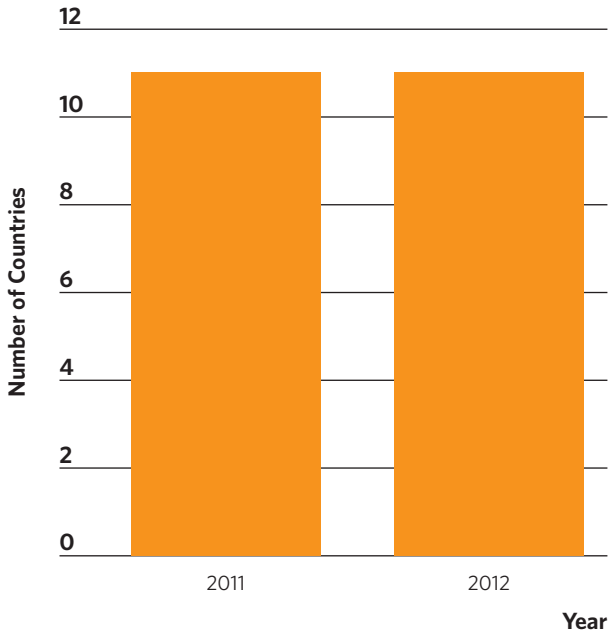
This indicator assesses the commitment to RHCS by the willingness of governments to allocate resources for the procurement of contraceptives and to fund family planning and maternal health interventions, with or without assistance from donors.

Budget lines for contraceptives were present in 11 out of 12 Stream 1 countries in 2012, excepting Haiti. The amount allocated increased from 2011 to 2012 in Ethiopia, Lao PDR, Mali, Mongolia and Mozambique. The allocated remained the same in Burkina Faso, Nigeria and Sierra Leone. Resources decreased from 2011 to 2012 in Madagascar, Nicaragua and Niger.

Table 25: Existence of line item for contraceptives in national budget for GPRHCS Stream 1 countries, 2011 and 2012

Country	2011	2012
Burkina Faso	Y	Y
Ethiopia	Y	Y
Haiti	N	N
Lao PDR	Y	Y
Madagascar	Y	Y
Mali	Y	Y
Mongolia	Y	Y
Mozambique	Y	Y
Nicaragua	Y	Y
Niger	Y	Y
Nigeria*	Y	Y
Sierra Leone	Y	Y
Total for 'Yes'	**11**	**11**

Figure 25: Existence of line item for contraceptives in national budget for GPRHCS Stream 1 countries, 2011 and 2012

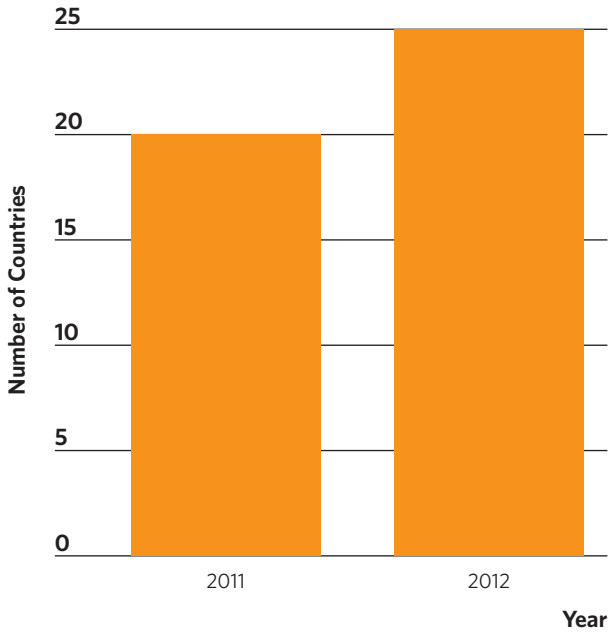


The number of Stream 2 countries with line items in the national budget for the procurement of contraceptives increased from 20 in 2011 to 25 in 2012 (Table 26 and Figure 26).

Table 26: Existence of line item for contraceptives in national budget for GPRHCS Stream 2 countries, 2011 and 2012

Country	2011	2012
Benin	Y	Y
Bolivia	Y	Y
Botswana	Y	Y
Burundi	Y	Y
Central Africa Republic	Y	Y
Chad	N	N
Congo	Y	Y
Côte d'Ivoire	N	N
Democratic Republic of Congo	N	N
Djibouti	N	N
Ecuador	Y	Y
Eritrea	Y	Y
Gabon	N	Y
Gambia	Y	Y
Ghana	N	Y
Guinea	Y	Y
Guinea Bissau	N	Y
Lesotho	Y	Y
Liberia	Y	Y
Malawi	N	Y
Mauritania	N	N
Namibia	N	Y
Papua New Guinea	Y	Y
Sao Tome and Principe	Y	Y
Senegal	Y	Y
South Sudan	N	N
Sudan	N	N
Swaziland	Y	Y
Timor Leste	N	N
Togo	Y	Y
Uganda	Y	Y
Yemen	N	N
Zambia	Y	Y
Zimbabwe	Y	Y
Total for 'Yes'	**20**	**25**

Figure 26: Existence of line item for contraceptives in national budget for GPRHCS Stream 2 countries, 2011 and 2012



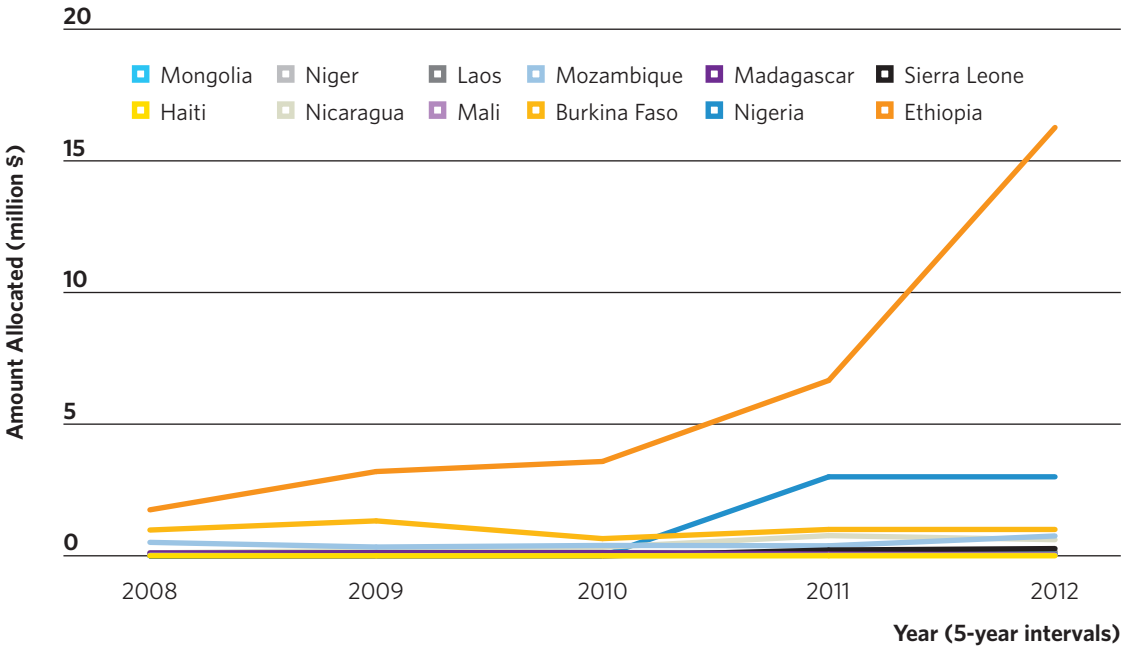
Resources allocated in Ethiopia increased from $6.7 million in 2011 to $16.3 in 2012 (Table 27 and Figure 27). The allocation remained the same as last year in Nigeria at $3 million, Burkina Faso at $1 million, Mozambique at $753,523 and Sierra Leone at $165,000.

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

Country	Amount allocated in US$				
	2008	2009	2010	2011	2012
Burkina Faso	978,261	1,326,087	652,174	1,000,000	1,000,000
Ethiopia	1,745,213	3,200,000	3,581,849	6,659,500	16,267,585
Haiti	0	0	0	0	0
Laos	18,500	0	0	18,750	25,000
Madagascar	109,524	119,168	121,126	68,501	47,273
Mali	0	0	0	218,917	274,081
Mongolia	0	47,000	41188	55,000	57,095
Mozambique	510,000	333,079	392,913	379,962	753,523
Nicaragua	110,158	208,723	321,935	765,940	611,320
Niger	103,734	103,734	122,222	122,222	108,481
Nigeria	0	0	0	3,000,000	3,000,000
Sierra Leone	0	0	0	165,0000	165,0000

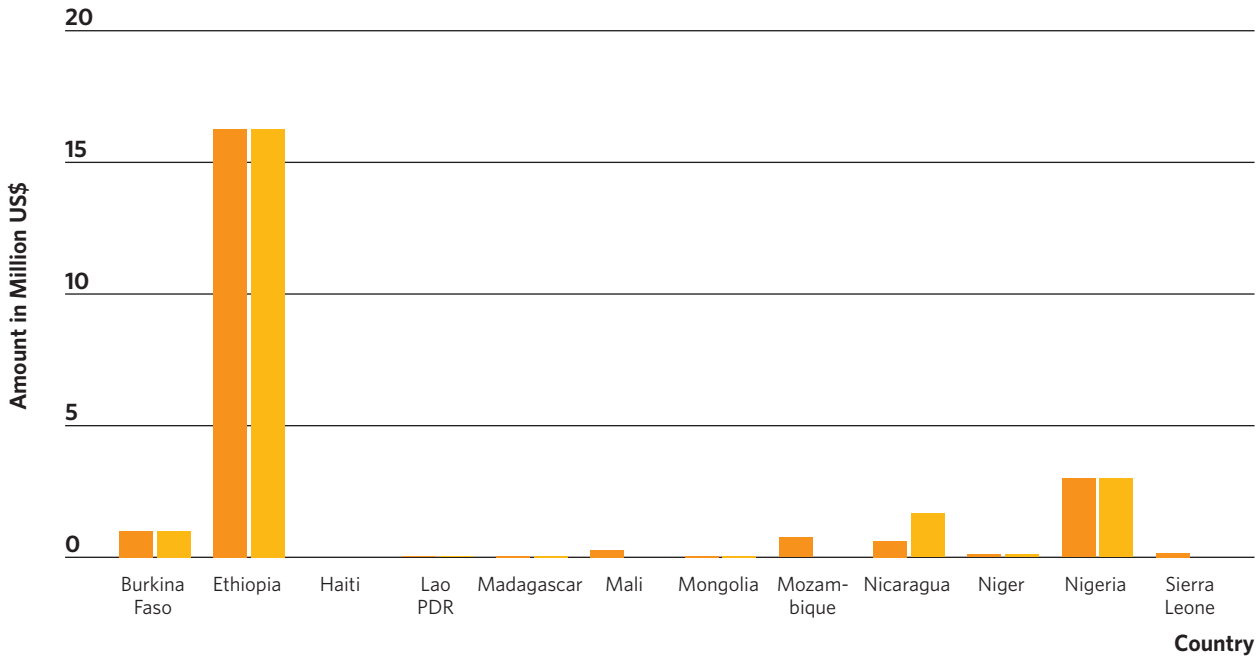
Source: Data provided by UNFPA CO in Stream 1 countries from information obtained from the Ministries of Health of their respective countries, March 2012

Figure 27: Government budget allocation for contraceptives in GPRHCS Stream 1 countries, 2008 to 2012



Regarding allocations by programme country governments, Nicaragua spent more on contraceptives than it allocated in its national budget line (with the exception of 2010); expenditures were more than double allocations in 2011 and 2012 (Figure 28 and Table 28). Seven countries (Burkina Faso, Ethiopia, Lao PDR, Madagascar, Mongolia, Niger and Nigeria) spent 100 per cent of their allocated resources for the procurement of contraceptives in 2012. In Mali, the amount allocated was not spent due to the conflict situation in the country. Mozambique is the only country reporting that the amount allocated was not spent for any of the years 2008 to 2012. Also, no allocations were made in Haiti from 2008 to 2012.

Figure 28: Government budget allocated and spent for procurement of contraceptives in GPRHCS Stream 1 countries in 2012



Source: Data provided by UNFPA CO in Stream 1 countries from information obtained from the Ministries of Health of their respective countries, April 2013.

Table 28: Government budget allocated and spent for procurement of contraceptives in GPRHCS Stream 1 to 2012

Country	2008			2009			2010			2011			2012		
	Amount Allocated	Amount Spent	%age spent	Amount Allocated	Amount Spent	%age spent	Amount Allocated	Amount Spent	%age spent	Amount Allocated	Amount Spent	%age spent	Amount Allocated	Amount Spent	%age spent
Burkina Faso	978,261	937,051	95.8	1,326,087	1,543,161	116.4	652,174	652,173	100.0	1,000,000	1,000,000	100.0	1,000,000	1,000,000	100.0
Ethiopia	1,745,213	1,745,213	100.0	3,200,000	3,200,000	100.0	3,581,849	3,581,849	100.0	6,659,500	6,659,500	100.0	16,267,585	16,267,585	100.0
Haiti	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lao PDR	18,500	16,300	88.1	-	-	-	-	-	-	18,750	18,396	98.1	25,000	25,000	100.0
Madagascar	109,524	109,524	100.0	119,168	75,805	63.6	121,126	121,126	100.0	68,501	68,501	100.0	47272	47272	100.0
Mali	-	-	-	-	-	-	-	-	-	218,917	218,917	100.0	274,081	0	0.0
Mongolia	0	0	-	47,000	46,022	97.9	41,188	41,188	100.0	55,000	52,337	95.2	57,095	57,095	100.0
Mozambique	510,000	0	0.0	333,079	0	0.0	392,913	0	0.0	379,962	0.00	0.0	753,523		
Nicaragua	110,158	591,665	537.1	208,723	227,500	109.0	321,935	321,935	100.0	765,940	2,025,891	264.5	611,320	1,669,042	273.0
Niger	103,734	103,734	100.0	103,734	103,734	100.0	122,222	122,222	100.0	122,222	122,222	100.0	108,481	108,481	100.0
Nigeria	-	-	-	-	-	-	-	-	-	3,000,000	3,000,000	100.0	3,000,000	3,000,000	100.0
Sierra Leone	-	-	-	-	-	-	-	-	-	165,000	165,000	100.0	165,000	-	-

Source: Data provided by UNFPA CO in Stream 1 countries from information obtained from the Ministries of Health of their respective countries, April 2013.

Box 3: Integrating RHCS in national policies, plans and programmes

Integrating RHCS into national policies, plans and programmes has been a process of fostering commitment at all levels. Advocacy with partners in government, parliamentarians and other policy makers has helped to ensure national ownership and sustainability. Many countries have taken action to mobilize political will and financial resources for RHCS, both international donors and the governments of developing countries. New national budget lines and allocations for contraceptives are striking signs of commitment when limited resources are further strained by the global economic crisis.

High-level support in Ecuador

Evidence-based advocacy in Ecuador won high-level support for the national family planning strategy, along with Government support of $8 million for the strategy plus $7 million to procure modern contraceptives through UNFPA in 2011. The country also centralized the procurement of reproductive health commodities for a more efficient system. With catalytic funding of $700,000 over three years, results were achieved through the process of building understanding and technical capacity among government health staff at the national and regional level. Results of national and local dialogue processes were presented at a special committee meeting of the Latin American Economic Commission (CEPAL) and UNFPA in July. At the Ministry of Health's request, UNFPA developed training for health staff nationwide, holding the first session in September for 100 health providers on contraceptives and other RH issues. In 2012, evidence-based advocacy and policy dialogue continued to engage government and civil society, influencing rights and norms.

Institutionalizing RHCS training in Ethiopia and Mongolia

In Ethiopia, a curriculum on reproductive health commodity security has evolved over time, from orientation and training, to an ongoing collaboration with the Public Health School and School of Pharmacy. Health Extension Workers have received training to deliver RH and family planning to rural communities. GPRHCS commodity procurement supported the government's plan to make long-lasting contraceptive implants widely available throughout the country to women who want to delay pregnancy. One sign of improved RHCS, the percentage of service delivery points offering at least three modern methods of contraception increased from 60 per cent in 2006 to 96.4 in 2012, and uptake in the use of long-lasting implants is increasing significantly.

In seeking to build a sustainable system for RHCS in Mongolia, UNFPA focused on institutional capacity building rather than short- term training. The strategy helped to build national ownership while ensuring UNFPAs eventual exit from the process. Hundreds of pharmacists graduate each year in Mongolia with special training in family planning services and supplies. In addition to quality of care, they learn how to manage a computerized supply chain for a steady flow of essential supplies from warehouses to the couples who need them. Training in reproductive health commodity security is now part of the curriculum at Health Sciences University of Mongolia's School of Pharmacy. Previously, a lack of know-how caused shortfalls in essential supplies. The government and UNFPA started by training 12 health professionals in 2008 and quickly expanded to 150 in 2009, 222 in 2010 and 367 in 2011. In 2012, the School of Pharmacy in collaboration with department of obstetrics and gynaecology conducted refresher training on RHCS for RH managers of all provinces. Even in remote rural areas, access to contraceptives and the availability of a choice of methods are improving. RHCS indicators for contraceptive method choice and availability of life-saving medicines have improved consistently to reach high levels. The commitment of the MOH and the university, and dedication of the faculty of the School of Pharmacy played a major role in the success. The availability of a web-based CHANNEL programme in Mongolian language was also useful in the training.

More country examples

Institutionalizing RH indicators in **Nicaragua** in three spheres of commitment – an RHCS committee, sector-wide cooperation agreement, and the Common Basket Fund – has fostered a positive environment for increased RH commodities access. Change came through development of an advocacy strategy, with GPRHS support, which helped win inclusion of RHCS indicators in the national health plan and recognition of adolescents and youth as a priority group in RH, particularly for pregnancy prevention. The percentage of service delivery points in Nicaragua offering at least three modern methods of contraception increased from 66.6 per cent in 2008 to 98.6 in 2012.

Mozambique's leaders affirmed commitments made at the London Summit on Family Planning in July 2012, with the overall goal of increasing the Mozambican population's utilization of family planning services and contraception. The Government provides free integrated sexual and reproductive health services and commodities in all health facilities, and committed to increasing funding for contraceptive procurement. The Minister of Health again pledged the country's commitment at a National Workshop on Family Planning in November 2012, noting the need to explore new innovative approaches and partnerships to improve universal access to family planning and increase CPR in Mozambique. More than 150 young people participated in a workshop for dialogue and discussion prior to the national workshop.

The RHCS Technical Working Group expanded its scope in **Nigeria** in 2012, ensuring RHCS as national, state and community levels. Led by the Federal Ministry of Health, the Group inaugurated a Procurement Supply Management (PSM) sub-committee in January 2012 for monitoring, tracking and problem-solving with meetings every two weeks. Procurement lead time was reduced from nine months to 3.5 months, social marketing continued to grow, and the total market for contraceptives increased in 2012. The cumulative effect of the advocacy efforts, resource mobilization and implementation of RHCS Strategic Plan led to a three-fold increase in CYP for contraceptives provided to States based on requests made between 2011 and 2012.

Demonstrating its commitment to family planning, **Rwanda** pledged nearly $1 million ($909,685) to

procure contraceptives in 2012. The President of Rwanda delivered a speech at the family planning summit in London in November.

With UNFPA partner PRISMA in **Uruguay**, a new RHCS committee was established in 2012 with two delegates from each member of the Health Public Providers Comprehensive Network (RIEPS), with the government and UNFPA as part of the team. The committee analyzed the logistics system and initiated training. The percentage of health institutions in Uruguay with a Sexual and Reproductive Health Coordinator Team increased from 40 per cent in 2011 to 78 per cent in 2012. Also this year, the National Observatory on Gender and Sexual and Reproductive Health received UNFPA GPRHCS support to track progress and produce reports for advocacy in policy and planning. The tool includes a database and indicators and has produced status reports on SRH standards, a study on health human resources, and a study in 2012 on the sexual and reproductive health of women and men 15 to 49 years old.

Kyrgyzstan's decision in 2012 to include contraceptives in the list of medicines and supplies under the Additional Drug Benefit List financed by the Mandatory Health Insurance Fund was an important step towards meeting the family planning requirement of women in poor and vulnerable groups. Kyrgyzstan also revised its EML this year so that contraceptives, IUD and condoms are now included in the national list. In other progress this year, a budget line for contraceptives was also created as a first step in a wider strategy to meet demand for RH commodities. The country has already installed and introduced Country Commodity Manager (CCM) and the CHANNEL software programme to strengthen supply management.

An in-depth analysis of access to reproductive health services in **Tajikistan**, led by the MoH with UNFPA support, has contributed data for evidence-based advocacy. Data from five regions will support the integration of reproductive health into health services and other RHCS goals. The process has included reporting back to local health authorities,

Students of the national medical university attend a family planning training course. Photo: UNFPA/Parviz Boboev

institutions and the MOH on indicators, obstacles and recommendations. It involved staff of regional RH centres to improve transparency while building capacity in monitoring and assessment. As a result, health care authorities demonstrate increased sensitivity to reproductive health and family planning, given them higher priority at the primary care level, increased method choice and availability, reorganized and improved access to RH commodities at primary health care level, and introduced a top-up system to stock contraceptives at facilities.

Ecuador has taken action to mobilize political support and resources for RHCS on both international and local levels. In 2012, UNFPA facilitated dialogue between authorities from the Ministries of Health of Ecuador and Uruguay in regard to comprehensive sexual and reproductive health care which resulted in an exchange of experiences between the two Ministries. This led to the initiation of South-South development cooperation to strengthen sexual and reproductive health services by level of health care and complexity. A partnership between UNFPA and the Municipality of Quito has strengthened other medium and small municipalities within the country regarding reproductive health programmes and access to family planning services. Youth, civil society, and citizenship participation, and educational and communicational strategies have established the creation of zone dialogue spaces to improve reproductive health service delivery.

The Government of **South Sudan** adopted its first UNFPA Country Programme in April 2012. South Sudan continued work already started in 2011 by ensuring that RHCS was integrated in the family planning policy and strategy which was revised in 2012. This document integrated key issues related to RHCS, midwifery and maternal health. The Ministry of Health strengthened capacity for managing RH commodities through participation of key staff in several meetings related to RHCS and condom programming including the Intergovernmental Authority on Development (IGAD) meeting on RHCS in Djibouti. The Ministry of Health also led the nation-wide Reproductive Health Coordination Forum in holding six working sessions with 15 partners to enhance the political and social environment for sexual and reproductive health through the engagement of civil society.

In **Djibouti**, the Ministry of Health initiated a series of activities with UNFPA in 2012 to implement the national strategy for reproductive health commodity security. A thematic group has been established within the Ministry to coordinate RHCS activities.

Senegal created a line in the national budget for contraceptive acquisition. Senegal is mid-way through implementation of a 2011-2015 Strategic Plan for Reproductive Health Commodity Security, acting on its government's commitment to ensure that every person can chose, obtain and use high-quality contraception and reproductive health supplies. In 2012, youth training sessions prepared peer educators to share accurate information about modern family planning.

CHAPTER FOUR: STRENGTHENING HEALTH SYSTEMS: INTEGRATION, LOGISTICS AND MAINSTREAMING

An outsourcing strategy through contracting is part of the government's plan to secure RH supplies in Burkina Faso. Photo: UNFPA/Ollivier Girard

Strengthening national health systems through capacity building continued to a priority for countries participating in the GPRHCS in 2012. This work encompassed diverse aspects of reproductive health commodity security, including the procurement and distribution of RH commodities, training of staff in a wide range of positions from pharmacists to warehouse managers, addressing institutional capacity, improving the delivery of health services, and ensuring a functional logistics management information system.

Output 3:

Capacity and systems strengthened for RHCS

4.1 Number of countries using AccessRH for procurement of RHCS

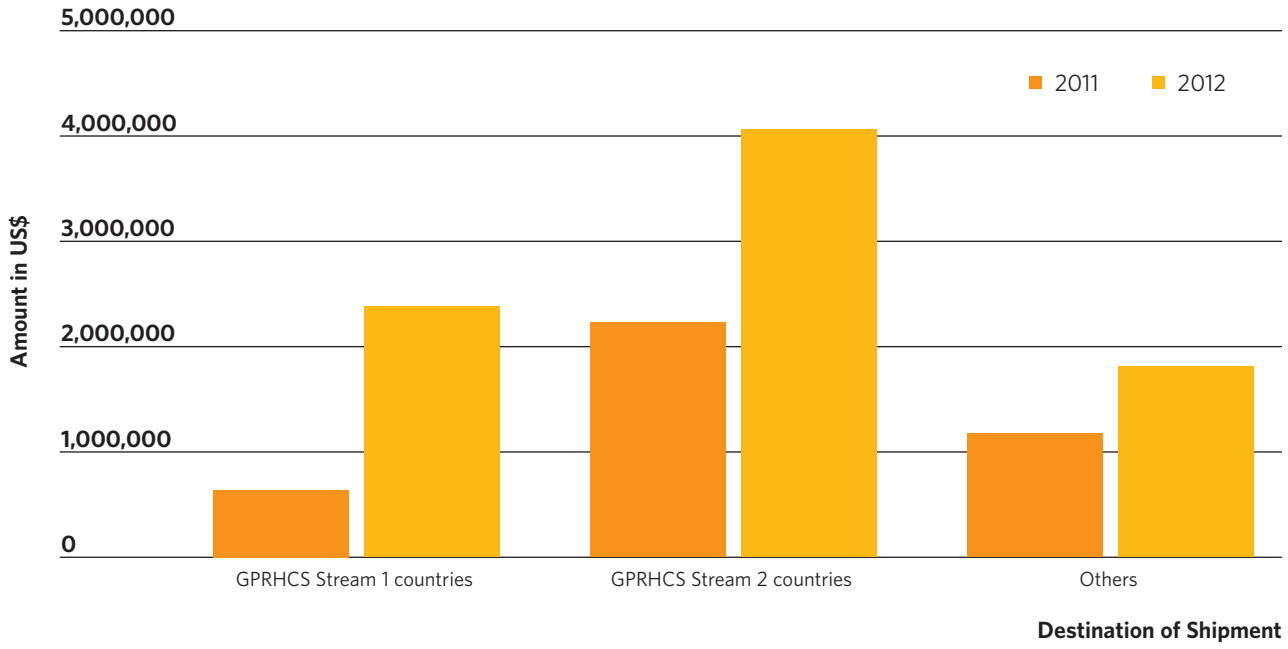
AccessRH is an innovative procurement mechanism supported by key global partners working in the area of procurement. This indicator measures the extent to which AccessRH has been adopted by countries for the procurement of RH commodities. It also assesses the extent to which the use of AccessRH has reduced the lead time by 20 per cent (time between ordering the commodity and its arrival in the country). The goal of AccessRH is to improve access to quality, affordable reproductive health commodities and reduce delivery times for government and NGO clients and to provide enhanced information for planning and tracking.

The Procurement Services Branch (PSB) continued to implement the AccessRH project under the auspices of the Reproductive Health Supplies Coalition (RHSC). In 2010, the Commodity Security Branch allocated $10 million to PSB to build inventory of reproductive health commodities (at manufacturers' warehouses) for easy and faster shipments to countries as and when orders are placed; this was followed by an additional $4 million in 2012.

Acess RH training for 27 specialists in medications procurement from five Central Asian countries was held October 2012 in Ashgabat, Turkmenistan

Of the $13.16 million spent in 2012, about $12.7 5 million was for procurement of 53mm standard male condoms and $68,000 was for 200,000 pieces of IUD CUT380A (which will be shipped in 2013). The balance of about $345,000 was spent on stock insurance and sampling and testing.

Figure 29: Cost of commodities (in US$) dispatched by AccessRH by destination of shipment, 2011 and 2012

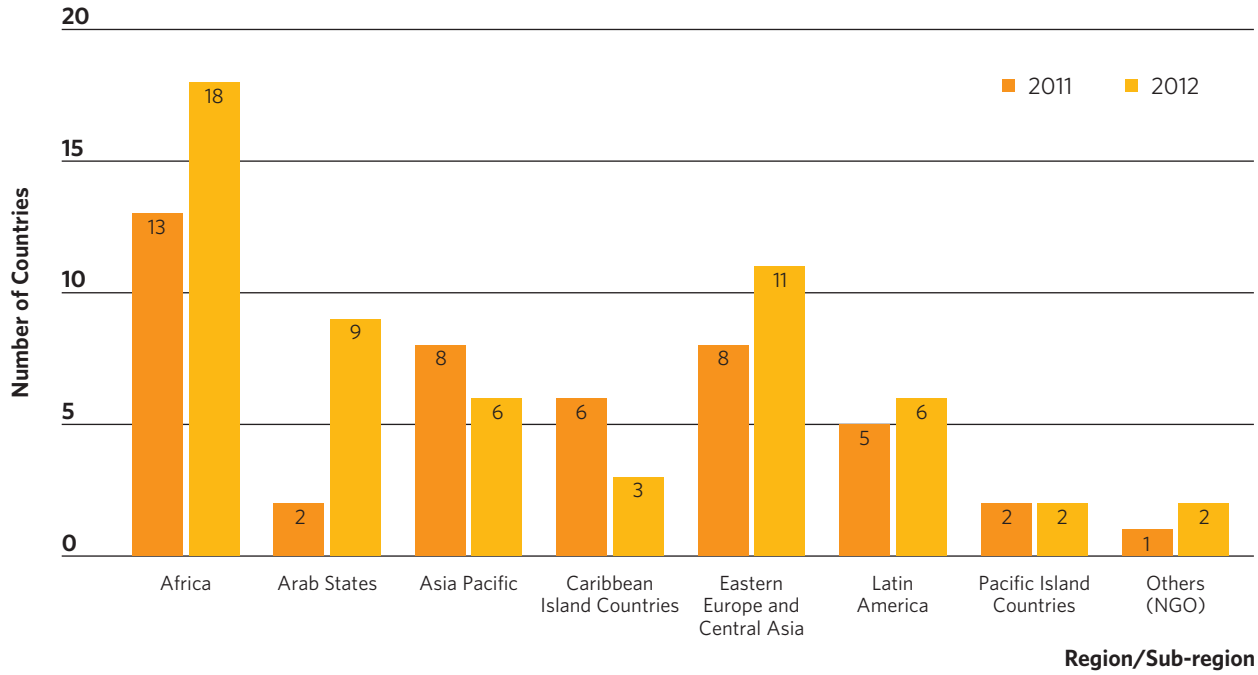


Source: "Table 2: AccessRH Project dispatched quantities as at 31st Dec 2012" in *PSB Update on CSB Funded Access RH Revolving Fund Quarterly Update 31st December 2012*

To date AccessRH has made 138 shipments to 79 countries. The number of GPRHCS and non-GPRHCS countries to which shipments were made increased in 2012 (Figure 29). Shipments to countries participating in the GPRHCS continued to account for a larger percentage of procurement through AccessRH. GPRHCS countries accounted for 78 per cent of the total procurement (of male condoms) in 2012, up from 71 per cent in 2011.

Shipments were also made on behalf of Third Party Clients (those that are not UNFPA Country Offices) including Ministries of Health, National AIDS Control Councils, international NGOs and United Nations agencies. Third Party Client shipments reached 57 countries by end of 2012 (Figure 30). The four major destinations of shipments on behalf of Third Party Clients were Africa (up from 29 per cent of the countries in 2011 to 32 per cent in 2012), Asia (down to 16 of the countries in 2012 compared to 18 in 2011), Eastern Europe and Central Asia (up to 19 per cent of the countries in 2012 compared to 18 in 2011) and Latin America (up to 11 per cent of the countries in 2012 compared to 4 per cent in 2011). The increased use of AccessRH by third parties was an encouraging show of confidence in the efficiency of the procurement process.

Figure 30: Number of countries to which third party clients made shipments through Access RH by region/sub-region in 2011 and 2012



Source: PSB datasheet

Reports from UNFPA's Procurement Services Branch indicate that clients with standard 53mm condom orders fulfilled from inventory receive their goods 10 to 14 weeks faster than clients ordering condoms which need to be produced when the order is placed. This indicates that AccessRH has is contributing to the reduction in Lead-time for the procurement of condoms. Additional information on AccessRH is available: www.myAccessRH.org.

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

The indicator measures the efforts of UNFPA-WHO partnership for ensuring quality supplies of IUDs and condoms from a set of prequalified and re-qualified manufactures. Seventeen male latex condom manufacturing sites were evaluated for prequalification or re-assessment for prequalification in 2012. No IUD evaluations carried out. As of 31 December 2012, 25 male condom factories and seven IUD factories had successfully completed the process. Additional factories were expected to be added to the list in the first half of 2013, following closure of inspection observations pending from 2012 inspections. The prequalification lists are dynamic and factories are added and removed accordingly; as such, the list changes multiple times during the year.

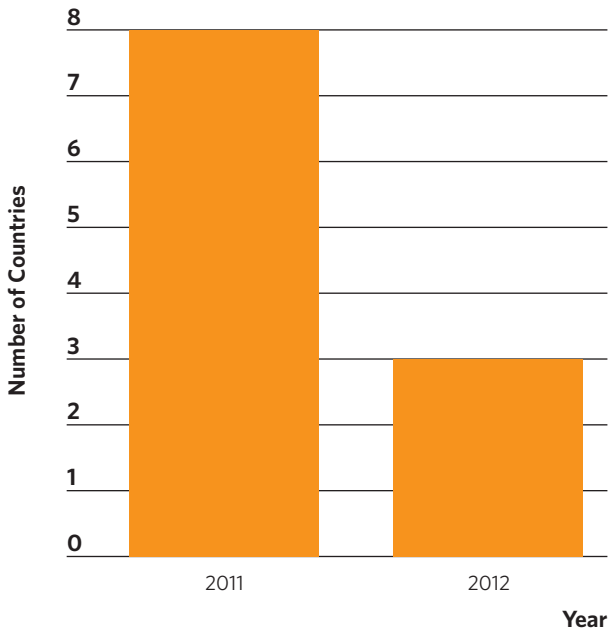
4.3 Number of Stream 1 countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian)

This indicator provides a proxy measurement of the extent to which countries effectively prepare procurement plans for their RH commodity needs at the beginning of the year such that no requests are made outside the plans (except for humanitarian situations). The capacity to make accurate long-term forecasts and establish procurement plans is a sign of stronger systems. Countries should then be able to accurately predict their commodity needs and place orders to avert stock-outs, or at least to eliminate the need to make ad hoc procurements.

Table 29: Stream 1 countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian), 2011 and 2012

Country	2011	2012
Burkina Faso	N	N
Ethiopia	Y	Y
Haiti	Y	N
Lao PDR	Y	N
Madagascar	Y	N
Mali	N	Y
Mongolia	Y	N
Mozambique	N	Y
Nicaragua	Y	N
Niger	Y	N
Nigeria	N	N
Sierra Leone	Y	N
Total for 'Yes'	**8**	**3**

Figure 31: Number of Stream 1 countries that made 'no ad hoc request' for commodities, 2011 and 2012



In 2010 and 2011, eight Stream 1 countries made no ad hoc requests for RH commodities. In other words, these countries made procurement requests according to plans and forecasts made at the beginning of the year. In 2012, only three countries made no ad hoc request for RH commodities (Table 35). The reasons for the increase in ad hoc requests vary from country to country. In Mali, armed conflict in the northern part of the country created an emergency situation which required adjustments in national budgets and procurement of goods. For Mozambique, ad hoc requests were the result of an increase in need created by awareness raising and demand generation activities undertaken during national health weeks. Also, service provider training of health professionals in family planning techniques triggered demand for additional quantities of IUDs; Mozambique experienced a shortage of IUDs and requested an additional 9,000 IUDs.

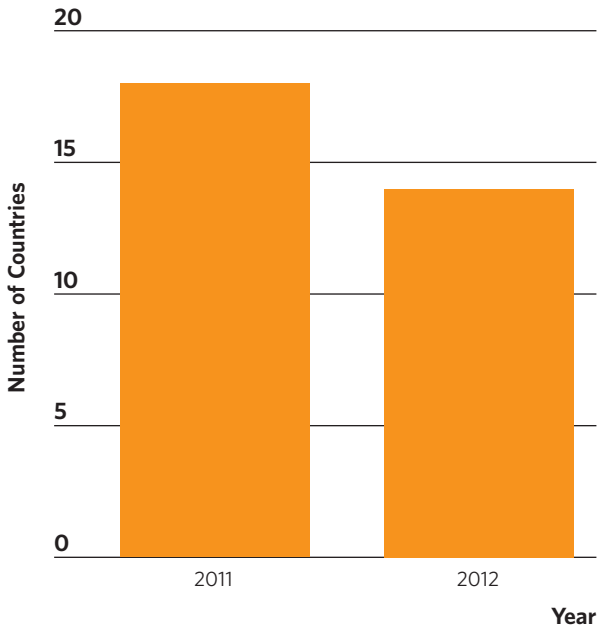
Key actions taken to prevent ad hoc requests include annual contraceptive forecasting led by government and with participation of all partners including UNFPA in Ethiopia; technical assistance provided by UNFPA to the Ministry of Public Health in Haiti for forecasting and quantification; strengthening of supply chain management and establishing monitoring and reporting system in Lao PDR; use of LMIS software (CHANNEL) to monitor stock distribution and having a functional logistics committee in place that provides forecasts for RH commodity needs; in Nigeria technical support received from USAID | DELIVER PROJECT has greatly enhanced stock monitoring to advert stock outs; and, in Sierra Leone an autonomous procurement and supply chain agency (crown agent) has been recruited to build and transfer skills to government personnel to ensure sustainability.

Table 30: Stream 2 countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian), 2011 and 2012

Country	Made 'no ad hoc request'	
	2011	2012
Benin	N	Y
Bolivia	Y	N
Botswana	Y	Y
Burundi	Y	N
Central Africa Republic	N	Y
Chad	N	N
Congo	Y	N
Côte d'Ivoire	N	N
Democratic Republic of Congo	N	Y
Djibouti	N	N
Ecuador	Y	N
Eritrea	N	Y
Gabon	Y	N
Gambia	N	Y
Ghana	Y	N
Guinea	Y	N
Guinea Bissau	Y	N
Lesotho	Y	N

Country	Made 'no ad hoc request'	
	2011	2012
Liberia	Y	N
Malawi	Y	N
Mauritania	Y	Y
Namibia	Y	N
Nigeria	N	N
Papua New Guinea	-	Y
Sao Tome and Principe	N	Y
Senegal	N	Y
South Sudan	N	N
Sudan	N	N
Swaziland	Y	Y
Timor Leste	N	N
Togo	N	Y
Uganda	Y	N
Yemen	N	Y
Zambia	Y	Y
Zimbabwe	Y	N
Total for 'Yes'	18	14

Figure 32: Number of Stream 2 countries that made 'no ad hoc request' for commodities, 2011 and 2012



The number of Stream 2 countries making 'no ad hoc request' decreased from 18 in 2011 to 14 in 2012 (Table 30 and Figure 32). There were several reasons for the increase in ad hoc requests. Botswana requested male condoms because there were issues with the quality of condoms produced by a local manufacturer. Gambia requested implants when the number of clients requesting implants increased. Mauritania requested Noristerat and Depo-Provera when they were on the verge of stock-out. Papua New Guinea stocks ran so low an emergency procurement was made. In Senegal, a flood displaced over 280 families and required emergency procurement of RH commodities including contraceptives to serve their needs. In Democratic Republic of Congo, the humanitarian situation in parts of the country required RH kits to respond to the emergencies.

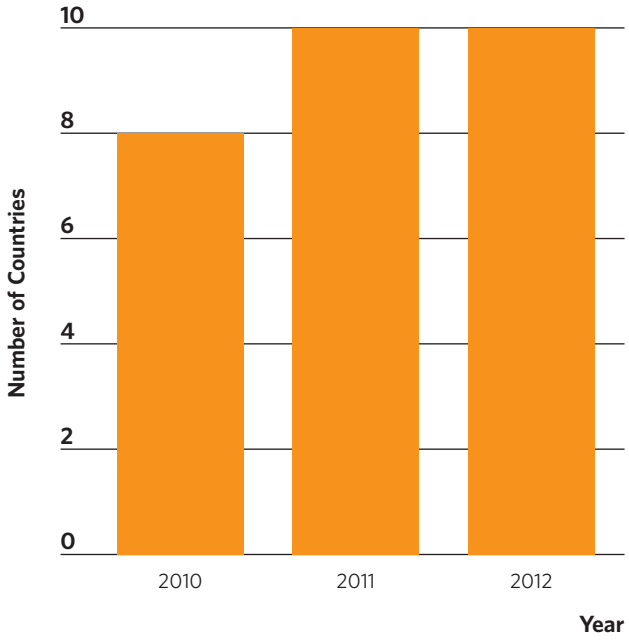
4.4 Number of Stream 1 countries forecasting for RH commodities using national technical expertise

This indicator assesses the existence of trained national staff, in government institutions, who are responsible for forecasting RH commodity needs for their respective countries. UNFPA works with governments and other partners to ensure that human capacity is built to carry out forecasting for RHCS as part of the overall strategy for contraceptive security.

Table 31: Stream 1 countries using national technical experts for forecasting, 2010 to 2012

Country	Expertise forecasting in MOH		
	2010	2011	2012
Burkina Faso	Y	Y	Y
Ethiopia	Y	Y	Y
Haiti	Y	Y	Y
Lao PDR	N	N	N
Madagascar	Y	Y	Y
Mali	Y	Y	Y
Mongolia	Y	Y	Y
Mozambique	N	Y	Y
Nicaragua	Y	Y	Y
Niger	N	Y	Y
Nigeria	-	N	N
Sierra Leone	Y	Y	Y
Total for 'Yes'	**8**	**10**	**10**

Figure 33: Stream 1 countries using national technical experts for forecasting of RH commodities



Ten Stream 1 countries had national technical expertise in the Ministry of Health or in other government agency for forecasting for RH commodities in 2012 – up from 8 in 2010 (Table 31 and Figure 33). The exception were Lao PDR and Nigeria, as in the previous year. In Nigeria, the actual process of forecasting was carried out by the USAID | DELIVER PROJECT with the participation of national staff. In Lao PDR, the process benefitted from technical assistance by UNFPA and UNICEF for RH commodity needs; and by the Global Funds through the Centre for HIV/STI (CHAS) for the forecast and procurement of condoms.

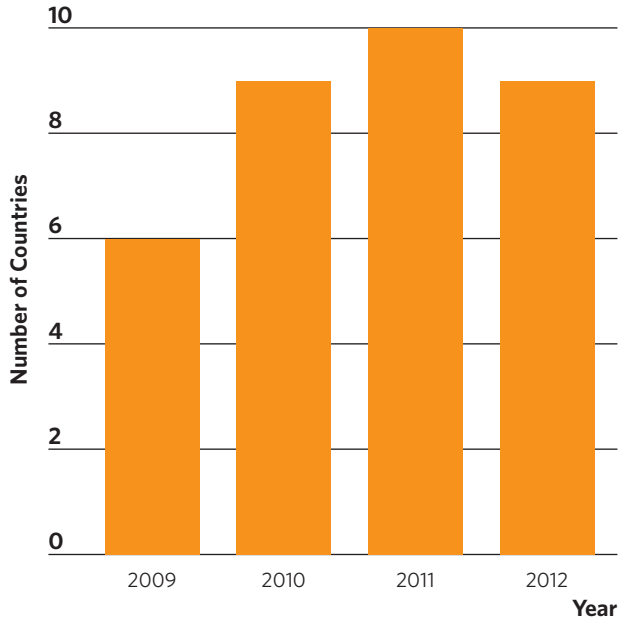
4.5 Number of Stream 1 countries managing procurement process with national technical expertise

This indicator assesses the existence of national human resource capacity for procurement of RH commodities in a government agency. It also provides an indication of steps taken to ensuring sustainability and country ownership and institutionalization of skills and capacities for RHCS.

Table 32: Stream 1 countries using national technical experts for procurement of RH commodities, 2009 to 2012

Country	Expertise for procurement of RH commodities			
	2009	2010	2011	2012
Burkina Faso	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y
Haiti	N	N	Y	N
Lao PDR	N	Y	N	N
Madagascar	Y	Y	Y	Y
Mali	N	Y	Y	Y
Mongolia	N	Y	Y	Y
Mozambique	N	N	Y	Y
Nicaragua	Y	Y	Y	Y
Niger	Y	Y	Y	Y
Nigeria	-	-	N	N
Sierra Leone	Y	Y	Y	Y
Total for 'Yes'	**6**	**9**	**10**	**9**

Figure 34: Stream 1 countries using national technical experts for procurement of RH commodities



The number of Stream 1 countries with national technical expertise increased from 9 in 2010 to 10 in 2011 and then to 9 countries in 2012, a decrease due to the lack in Haiti of such skilled national staff last year (Table 24).

4.6 Number of Stream 1 countries with functioning LMIS

This indicator seeks to ascertain the effectiveness of the logistics management information systems for tracking the distribution of RH commodities. It is expected that a functional logistics management information system will provide information on current and up-to-date stock levels; data on distribution of essential life-saving medicines; data on distribution of modern contraceptives; number of users for each modern contraceptive method; and product particulars including expiration date.

Table 33: Number of Stream 1 countries with functioning LMIS, 2011 and 2012

Country	Country has functioning LMIS		LMIS provides Figures on modern contraceptives		LMIS provides figures on lifesaving medicines		LMIS has information on Inventory and monthly consumption		LMIS has Information on stock status at all levels		LMIS has Information on expiry dates of all products		LMIS has Information on number of users of all products	
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
Burkina Faso	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N
Haiti	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y
Lao PDR	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	Y	N	Y
Madagascar	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mali	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	N	Y	Y	Y	N	N	N	N	Y	Y	Y	Y
Nicaragua	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Niger	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	N
Nigeria	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	N	N
Sierra Leone	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Total for 'Yes'	12	12	11	12	9	10	8	10	10	10	10	12	5	6

All Stream 1 countries had a functional LMIS in place in 2011 as well as in 2012, which was an improvement from 7 in 2010 (Table 33). There were variations in the level of functionality of the systems with respect to the ability of the system to provide data on modern contraceptives, lifesaving medicines, monthly consumption data, stock status at all levels and information on expiration dates of all products. Improvements in the functionality of the system in various areas were noted, yet overall only 6 of the 12 Stream 1 countries had systems capable of provide information on number of users of all products: Burkina Faso, Haiti, Lao PDR, Madagascar, Mongolia and Mozambique.

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

The indicator assesses the existence of a unified mechanism for managing all health supply systems that takes into account the procurement and distribution of RH commodities. This an important step in strengthening systems for RHCS. The aim is to integrate contraceptive commodity logistic systems into national systems that address the needs of the health system.

Table 34: Number of Stream 1 countries with co-ordinated approach towards integrated health supplies management system, 2011 and 2012

	Integrated supply management system exists		System includes an integrated procurement mechanism for contraceptives and RH medicines		System includes an integrated supply/distribution mechanism for contraceptives and RH medicines	
Country	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Burkina Faso	Y	Y	Y	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y
Haiti	N	N	na	na	na	Y
Lao PDR	N	N	na	na	na	na
Madagascar	Y	Y	N	N	Y	Y
Mali	Y	Y	N	N	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	N	Y	Y	Y
Nicaragua	Y	Y	Y	Y	Y	Y
Niger	Y	Y	Y	Y	Y	Y
Nigeria	N	Y	na	Y	na	N
Sierra Leone	Y	Y	N	Y	Y	Y
Total for 'Yes'	**9**	**10**	**5**	**8**	**9**	**10**

Ten Stream 1 countries had some form of a coordinated and integrated health supplies management system in 2012, not including Haiti and Lao PDR (Table 34). The number of countries with systems that included integrated procurement mechanisms for contraceptives and RH medicines increased from five in 2011 to eight in 2012: Burkina Faso, Ethiopia, Mongolia, Mozambique, Nicaragua, Niger, Nigeria and Sierra Leone. Ten countries in 2012 had systems that included integrated supply/distribution mechanisms for contraceptives and RH medicines (the exceptions being Lao PDR and Nigeria). In 2012, the supply management systems were more integrated regarding supply and distribution than for procurement mechanisms.

The number of countries with systems that included integrated procurement mechanisms and integrated supply and distribution mechanisms for RH commodities (contraceptives and RH medicines) increased from five in 2011 to seven in 2012: Burkina Faso, Ethiopia, Mongolia, Mozambique, Nicaragua, Niger and Sierra Leone.

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

Use of an information management tool has strengthened the health supply management system in many countries. It has often entailed adopting or adapting a computer-based programme to serve the needs of the country and at a higher level, ensuring that it is web-based and available to a wider audience and updated regularly.

Table 35: Number of Stream 1 countries adopting/adapting a health supply chain management information tool

Country	Country adopted supply management tools		
	2010	2011	2012
Burkina Faso	Y	Y	Y
Ethiopia	Y	Y	Y
Haiti	Y	Y	Y
Lao PDR	Y	Y	Y
Madagascar	Y	Y	Y
Mali	Y	Y	Y
Mongolia	Y	Y	Y
Mozambique	Y	Y	Y
Nicaragua	Y	Y	Y
Niger	Y	Y	Y
Nigeria	-	Y	Y
Sierra Leone	Y	Y	Y
Total for 'Yes'	**11**	**12**	**12**

In Stream 1 countries, GPRHCS continued to support countries to improve on their supply management systems. The number of Stream 1 countries that have adopted and are using some form of computerized health supply chain management information system increase from 10 in 2010 and to 12 in 2011 and 2012 (Table 35). Ten countries adopted CHANNEL, the computer software developed by UNFPA, and two countries adopted PIPELINE (Mozambique and Nigeria).

Box 4: Strengthening the delivery system

To ensure a secure, steady and reliable supply of RH commodities, countries make it a priority to improve their logistics management information systems, often with computer software and training, and to mainstream RHCS within their national health systems.

A civil society partnership for monitoring health supplies in Sierra Leone

Members of a civil society organization (CSO) are closely monitoring health commodities in Sierra Leone – from the quay and airport to the central medical store, district medical stores and peripheral health units. Theft of drugs is down, availability of supplies at facilities is up, and access to health services and medicines has improved. The Government introduced the civil society component to enhance its newly computerized system for tracking and managing essential supplies. It also made a first-ever budget allocation to RH commodities in 2011 and pursued inclusion of family planning in national policies.

Logistics management information systems – and warehouses that work in Madagascar

Before and after photos of a warehouse in Taolagnaro, Madagascar, are representative of improvements at five warehouses in 2012. Such investment in the national health system infrastructure is part of a wide variety of RHCS actions in 2012 – from a new manual on family planning to revision of the national RHCS strategy, to inclusion of RH issues in medical and pharmaceutical schools, to the acquisition of trucks to transport essential supplies. In Madagascar, the government adopted CHANNEL computer software for control, transparency and follow-up in the management of health supplies. This supported improvement across the board. CPR in Madagascar rose by 11 percentage points from 2004 to 2009, to reach 29.2 per cent. This remarkable increase stands in contrast to the country's relatively stagnant rates during the years leading up to strategic GPRHCS support. Unmet need declined from 24 per cent in 2004 to 19 per cent in 2009 and 2010. Access to appropriate methods is improving: The percentage of service delivery points (SDPs) offering at least three modern contraceptive methods improved in Madagascar from 30.8 per cent 2009 to 47.8 per cent in 2010 to 97.2 per cent in 2011. More shelves are reliably stocked: Clinics and other service delivery points reported 'no stock-out' of contraceptives at 63.3 per cent in 2008, 74.4 per cent in 2009, 79.6 per cent in 2010 and 90.8 per cent of SDPs in 2011. Choice of method is better assured, with the

availability of three modern methods from 50 per cent in 2010 to 97.3 per cent in 2011 at primary-level SDPs. Key medicines are available: All the tertiary-level SDPs (100 per cent) in Madagascar had the five life-saving medicines for maternal and reproductive health available in 2011. After major investment in its logistic management information system over the previous two years, by the end of 2010 Madagascar had a functional LMIS capable of providing inventory and monthly consumption data.

In **Haiti**, three monitoring missions covering a sample of 14 of a total 34 sites using computer software (CHANNEL) in their logistics management information system were conducted in 2012, finding challenges due to the mobility of trained personnel and electrical outages. The Ministry of Health called on regional pharmacists to be more committed and for the strengthening of all CHANNEL sites to serve as the national system providing monthly stock information to the central level. An RHCS Technical Monitoring Committee of key donors and the Ministry's partners was created to oversee the annual national survey for tracking the GPRHCS indicators, holding a November workshop to improve coordination at the institutional and MOH departmental levels.

In **Mali**, laboratory and medical equipment aided services in community health centers in the Kayes region, along with hundreds of family planning counseling cards to raise awareness. A new national comprehensive condom programming work plan, partnership between UNFPA and NGOs resolved an implant stock-out early in the year, and UNFPA accelerated procurement of RH supplies that helped to compensate for the withdrawal of donor during the crisis and helped to keep shelves stocked with contraceptives.

The central warehouse in **Nicaragua** is at the centre of efforts to strengthen the entire logistics management system. Overloaded by increasing demand, the Health Supplies Center (CIPS) benefitted from technical assistance from PRISMA, a regional partner: diagnostic analysis, development of a comprehensive

plan, reorganization, operational manuals, information system design, staff capacity building training, and funding mobilization.

In **Ethiopia** in 2012, the Pharmaceuticals Fund Supply Agency continued to improve the integration of family planning commodities in its overall supply management, and its hubs are taking over storage, distribution and inventory management – a dramatic improvement over formerly lengthy and uncoordinated supply lines. The GPRHCS also supported procurement of computers, printers and inventory control cards as part of logistics and information management systems.

A situational diagnostic of the logistics system in **Panama** in 2012 provided a starting point for a plan to close gaps that currently lead to supply shortfalls. Support for these efforts was retained despite a change in MOH leadership. Efforts to secure more health personnel trained in the implementation of the family planning decision-making tool focused on two regions. A national inventory was conducted as part of an analysis of the availability of contraceptives and reproductive health essential medicines in Panama MOH facilities.

In **El Salvador**, the reorganization and systematization of supplies and basic medicines for sexual and reproductive health care was one result of an RH commodity security strategy implemented with UNFPA support at the Santa Gertrudis Hospital of San Vicente, under the MoH. Limited access to medicines

for maternity services had caused dangerous delay in obstetric emergencies, and daily and monthly monitoring was implemented to ensure availability.

In **Boliva** in 2012, four training sessions in the operation of the logistic management information system and the storage of contraceptives were held for personnel of health facilities and FIMs.

In **Sao Tome and Principe**, 17 new reproductive health service providers were trained and 28 reproductive health service providers were refreshed on LMIS, ensuring that LMIS is functioning at all levels to maintain the availability of reproductive health commodities. Training three central-level managers as trainers in CHANNEL has increased the capacity of national institutions to deliver high-quality, integrated sexual and reproductive health services.

Despite severe budgetary restrictions since 2011, **Sudan** invested in both its physical and human resource infrastructure in 2012 to enhance reproductive health commodity service and supply networks. With regards to physical improvements of service delivery points, four health centers were rehabilitated and equipped in Blue Nile state, and warehouses in two states—Kassala and Gadarif—were rehabilitated to improve their storage capacity. LMIS capacity was strengthened in these three states through training of 190 RH and pharmaceutical staff. Forty MoH staff pariticpating in supply chain management training.

Guinea (Conakry) faced significant challenges in operating LMIS/CHANNEL for reproductive health commodity security and distribution: outlying areas lacked sufficient electrical service to run the computers. With funding from Catholic Relief Services, 19 of 33 prefectures were equipped with solar energy sources, allowing UNFPA-supported CHANNEL software to be put into place for reproductive health supply management while CRS utilized CHANNEL to aid in distribution of health-protecting mosquito netting.

CHAPTER FIVE: MAINSTREAMING RHCS WITHIN UNFPA CORE BUSINESS

Andrea, owner of a street garments stall in Uruguay, shows condoms she received for free through a nationwide agreement of the Ministry of Health and UNFPA. Photo: UNFPA/Manuela Aldabe

The indicators under the output 'RHCS mainstreamed into UNFPA core business' keep track of progress made by UNFPA to integrate RHCS issues into the organization's programming processes. The output also focuses efforts made by UNFPA to make RHCS a priority issue within the United Nations planning documents and partnership processes at the country level. Through the GPRHCS, UNFPA supports advocacy for resource mobilization and mobilizes resources, provides technical and other capacity building support to government and other partners and helps to build partnership in support of RHCS activities.

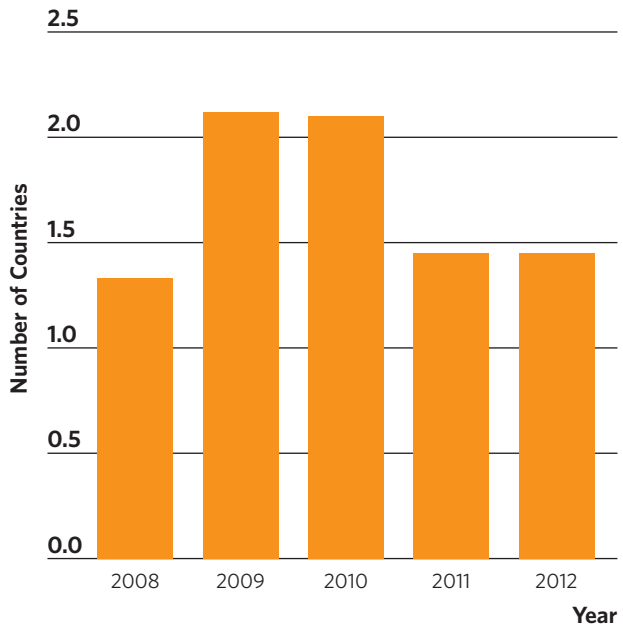
Output 4:

RHCS mainstreamed into UNFPA core business (UN reform environment)

5.1 Expenditure of UNFPA/CSB core resources for RHCS increased

UNFPA support to the Commodity Security Branch (CSB) – the branch within the agency that manages its RH commodity security functions continued to ensure UNFPA's continuous engagement on RHCS in 2012. The amount that UNFPA provided from its core resources for implementing RHCS activities in CSB decreased in 2012, reflecting an overall reduction in total core funds available to UNFPA this year, and the need to sustain programme delivery in other areas. The amount allocated to CSB has fluctuated somewhat over time, with $1.33 million in 2008, $2.12 million in 2009, $2.1 in 2010, $1.45 million in 2011 and $1.45 million in 2012 (Figure 40). The reduction is largely the cause of reduced total core funds available to UNFPA and the need to sustain programme delivery in other areas.

Figure 35: Amount allocated to UNFPA Commodity Security Branch (million $)



5.2 GPRHCS planning takes into account lessons learned in RHCS mainstreaming

Sustained programming requires building on achievements and scaling up lessons learned. This indicator is used to look at the areas in which the countries are using lessons learned from previous implementations to build on current and future interventions. In both 2011 and 2012, 11 Stream 1 countries (except Haiti) took into account lessons learned in the previous year for the implementation of the programme in the current year (Table 36).

Table 36: GPRHCS planning for Stream 1 countries takes into account lessons learned, 2011 and 2012

Name Country	2011	2012
Burkina Faso	Y	Y
Ethiopia	Y	Y
Haiti	N	Y
Lao PDR	Y	Y
Madagascar	Y	Y
Mali	Y	Y
Mongolia	Y	Y
Mozambique	Y	N
Nicaragua	Y	Y
Niger	Y	Y
Nigeria	Y	Y
Sierra Leone	Y	Y
Total for 'Yes'	**11**	**11**

Examples of activities in 2012 included building on procurement training to strengthen capacity in Burkina Faso; strengthening partnerships with stakeholders through regular meetings to share information develop strategies for problem solving in Ethiopia; and providing support to the Food and Drug Department (chair of the FDD Technical Working Group) to initiate the Supply Task Force led by MPSC to meet regularly and to ensure mainstreaming of RHCS in Lao PDR. Madagascar equipped health districts with IT equipment and then installed solar energy equipment

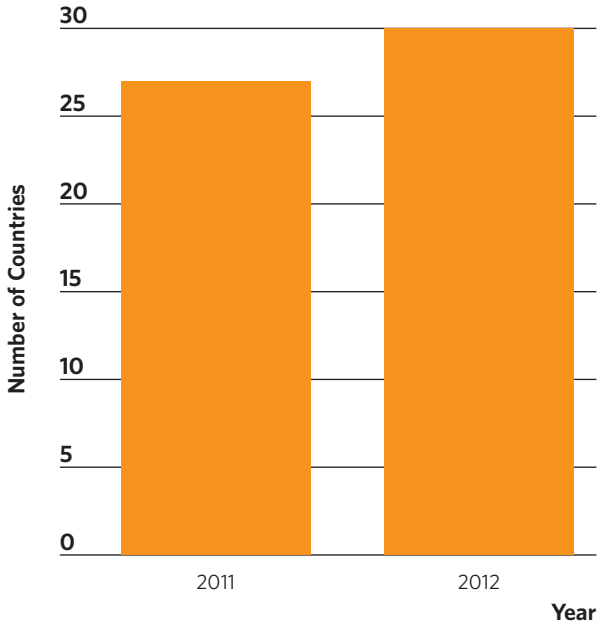
to ensure that work flow was not interrupted by power outages, improving timely reporting on commodities. In Sierra Leone, CHANNEL was adapted to suit local needs, which has resulted in better commodity management and forecasting. Additional efforts were also put into developing the low capacity of government staff to use and manage CHANNEL, which was identified as a major issue last year.

In Stream 2 countries, the number of countries taking lessons learned in into account increased from 27 in 2011 to 30 in 2012 (Table 39 and Figure 41). In the Central African Republic, problems posed by the weak logistics system were addressed when UNFPA helped to bring together partners, including NGOs, to improve the system, contributing to a stronger distribution network and better communications between warehouses and health facilities in project areas.

Table 37: GPRHCS planning in in 2011 for Stream 2 countries takes into account lessons learned, 2011 and 2012

Name Country	2011	2012
Benin	Y	Y
Bolivia	Y	Y
Botswana	Y	Y
Burundi	Y	Y
Central Africa Republic	Y	Y
Chad	Y	Y
Congo	Y	Y
Côte d'Ivoire	Y	Y
Democratic Republic of Congo	Y	Y
Djibouti	N	Y
Ecuador	Y	Y
Eritrea	N	N
Gabon	N	Y
Gambia	Y	Y
Ghana	Y	Y
Guinea	Y	Y
Guinea Bissau	Y	Y
Lesotho	Y	Y
Liberia	Y	Y
Malawi	Y	Y
Mauritania	Y	Y
Namibia	N	N
Nigeria		
Papua New Guinea	Y	Y
Sao Tome et Principe	Y	Y
Senegal	Y	Y
South Sudan	Y	Y
Sudan	N	Y
Swaziland	Y	Y
Timor Leste	N	N
Togo	Y	Y
Uganda	Y	Y
Yemen	N	N
Zambia	Y	Y
Zimbabwe	Y	Y
Total for 'Yes'	**27**	**30**

Figure 36: GPRHCS Stream 2 countries take into account lessons learned for planning, 2011 and 2012



The implementation of the lessons learned into succeeding programing years has enabled each country to build on successes and to address challenges. The issues for Stream 2 included intensification of the monitoring of RHCS activities in Benin to track stock levels and respond to needs. In Chad, CHANNEL was introduced to improve the logistic information management system and a procurement plan was formulated to respond to country needs.

In the area of logistics management, Democratic Republic of Congo used CHANNEL to strengthen weaknesses in the supply chain management of essential drugs, to enhance distribution and reporting on availability of commodities. Côte d'Ivoire addressed logistics management challenges by efforts to strengthen national capacity to ensure government leadership and sustainability.

Many countries strengthened partnerships for RHCS. In Burundi, partnership with KFW was strengthened for the procurement of contraceptives to ensure sustained availability. In Ecuador, GPRHCS funds were used to build on policy dialogue, advocacy and national capacity building efforts that continued in 2012 to enhance credibility with high-level Government officials as well as technical MoH staff. The RHCS coordinating committee in Guinea was supported to ensure better information sharing among partners and coordination with partners including the World Bank. Liberia continued to collaborate with USAID on RHCS issues, improving timely forecasting for RHCs and ensuring joint funding of interventions, which has helped to minimize ad-hoc requests for normal programme activities in recent years.

In the area of programme planning, an acute shortage of condoms in 2012 in Uganda provided useful lessons that later ensured the allocation of funds for condom procurement in the Joint Program on Population in Uganda for 2013. In Sudan, lessons learned about the need for early planning and engagement of partners were applied to timely preparations for 2013, and plans and estimates of RHCs needs were developed with involvement and consultations of partners. In the Central African Republic, evaluation of the 2008-2012 Strategic Plan provided recommendations that were used to improve RHCS interventions for 2013-2017. In Guinea Bissau, joint planning activities increased participation by the Government and strengthened its leadership in programme planning and implementation.

Lessons learned about scaling up community outreach enabled Lesotho to work more effectively with NGOs, which have been shown to be quicker and have a comparative advantage in reaching communities with condom messages. In 2012, Lesotho's partnership with PSI was scaled up and engagement of additional NGO partners was planned for 2013 and beyond. In Ghana, continuous and active community engagement continued to help generate demand for contraceptives. Distribution of RHCS through mobile networks was identified for scaling up in Togo based on positive results achieved last year in ensuring that communities in hard-to-reach areas can access services.

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

UNFPA Country Offices work within partnership frameworks in each country, including UN Country Teams, to ensure that RHCS issues are included into strategic initiatives. Each year UNFPA Country Offices are asked to report on their efforts to ensure RHCS priorities are integrated into UN programming processes.

Table 38: Stream 1 countries with RHCS priorities included in CCA, UNDAF, CPD, CPAP and AWP, 2010 to 2011

	RHCS included in CCA			RHCS included in UNDAF			RHCS included in CPD			RHCS included in CPAP			RHCS included in AWP		
Country	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ethiopia	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Haiti	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Lao PDR	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Madagascar	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mali	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mongolia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mozambique	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nicaragua	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Niger	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y
Sierra Leone	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**3**	**9**	**11**	**10**	**12**	**12**	**11**	**12**	**12**	**11**	**12**	**12**	**11**	**12**	**12**

* Nigeria was designated as a Stream 1 Country in 2011, thus information for 2010 are in the Stream 2 Table

Table 39: Stream 2 countries with RHCS priorities included in CCA, UNDAF, CPD, CPAP and AWP, 2010 to 2012

Country	RHCS included in CCA			RHCS included in UNDAF			RHCS included in CPD			RHCS included in CPAP			RHCS included in AWP		
	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012
Benin	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Bolivia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Botswana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burundi	N	N	Y	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Central Africa Republic	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chad	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Congo	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DRC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Djibouti	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ecuador	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Eritrea	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gabon	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gambia	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Ghana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Guinea	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Guinea Bissau	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lesotho	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Country	RHCS included in CCA			RHCS included in UNDAF			RHCS included in CPD			RHCS included in CPAP			RHCS included in AWP		
	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012
Liberia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Malawi	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mauritania	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Namibia	N	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria	Y	-	-	Y	-	-	Y	-	-	Y	-	-	Y	-	-
Papua New Guinea	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y
Sao Tome and Principe	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Senegal	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
South Sudan	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y
Sudan	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y
Swaziland	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Timor Leste	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y
Togo	-	Y	N	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y
Uganda	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Yemen	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y	-	Y	Y
Zambia	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Zimbabwe	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total for 'Yes'	**21**	**33**	**33**	**26**	**33**	**34**	**25**	**34**	**34**	**29**	**34**	**34**	**29**	**34**	**34**

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

The number of Stream 1 countries with RHCS issues integrated in CCAs increased from 9 in 2011 to 11 in 2012 (Table 38). In both years, all 12 countries reported that RHCS issues were included in UNDAF, CPD, CPAP and AWP documents.

The number of Stream 2 countries with RHCS issues integrated into CCAs remained unchanged, at 33 countries for 2011 and 2012 (Table 39). As of 2012, all 34 Stream 2 countries had RHCS integrated in UNDAFs, CPDs, CPAPs and AWPs, an increase over previous years.

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

This indicator is used to assess steps taken by UNFPA Country Offices to provide additional resources from core funds or to mobilize other sources for the implementation of RHCS. The aim is to report on efforts made to mobilize additional resources to complement GPRHCS funding for country-level interventions.

In 2012, two Stream 1 countries (Lao PDR and Mali) reported that funds allocated to RHCS activities from Country Office funds decreased compared to 2011. For two other countries (Haiti and Mongolia) the resource allocations remained the same in 2011 and 2012. In both years, eight countries increased budget allocations.

Seven Stream 2 countries (Central Africa Republic, Chad, Congo, DRC, Ecuador, Namibia and Sudan) reported that Country Offices allocated fewer resources for RHCS interventions in 2012. Funds allocated to RHCS increased in 22 Stream 2 countries.

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

As part of the UN Country Teams, it is the role of UNFPA to ensure that key reproductive health issues including RHCS are integrated in Joint UN Programmes. This defines a common area of intervention for the UN Agencies to work on jointly. The number of Stream 1 countries that had Joint UN Programmes for sexual and reproductive health and maternal and newborn health that included RHCS increased from 10 countries in 2011 to 12 countries in 2012. The number of Stream 2 countries that had UN Joint Programmes for SRH and MNH with RHCS issues included in them decreased from 18 in 2011 to 13 countries in 2012.

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

The highlights of actions taken by UNFPA at the regional level in 2012, often in collaboration with stakeholders in the region, are presented below.

The GPRHCS provided support through UNFPA Regional and Sub Regional Offices to work with regional organizations so that they can offer technical assistance for RHCS to countries where needed. Most often this collaboration, at the technical level, contributed to the building of institutional capacity or focused on improving programme implementation strategies.

The **Asia Pacific Regional Office** (APRO) continued collaboration with the University of Health Sciences, Mongolia to improve on teaching skills after the introduction of modules on RHCS into the curriculum for pharmacists. In 2012, a workshop was held to strengthen the facilitation skills of the teaching staff. Also, APRO worked with International Council on Management of Population Programmes and other partners to collaborate with the Tamil Nadu Medical Supplies Corporation and Indian Institute of Health Management and research for capacity development at the regional level.

In the **Latin America and Caribbean region,** three regional implementing partners—PROMSEX/FLASOG, Reprolatina and PRISMA/CIES— have over the years contributed to the attainment of relevant outcomes and outputs through advocacy and technical assistance provided to the majority of countries. Specific contributions by regional implementing partners to outcomes and outputs in 2012 are outlined below.

- PROMSEX/FLASOG centered its efforts on supporting country-level advocacy on sexual and reproductive health issues including on emergency contraception and the use of misoprostol in Peru, Panama and Ecuador. The efforts targeted health personnel and community leaders in rural indigenous regions where Spanish is not spoken. Other issues addressed also include gender violence, family planning, use of condoms for dual protection (family planning and prevention of STDs/HIV) in Panama and Peru.

- REPROLATINA provided support to implement the WHO Family Planning Technical Guidelines, especially the Decision-Making Tool for family planning clients and service providers, which has served as a key resource material for El Salvador, Honduras, Panama, Peru, and Uruguay. Efforts continued to focus on adolescents, for whom contraceptive acceptance and continuation rate have improved. Integration of reproductive health services for adolescents are considered a priority within the countries receiving technical assistance from Reprolatina.

- PRISMA/CIES focused on capacity-building interventions for strengthening supply chain management. The target audience was the logistics management staff and the health programme coordinators of the public and private institutions of the region. PRISMA/CIES also worked in collaboration with UNFPA Country Offices to address bottlenecks in distribution systems for RH commodities and provide RHCS and logistics training.

In **West Africa**, support was provided to strengthen national systems and national capacities in international procurement and logistics management in 17 countries. It also strengthened national capacities in community-based interventions for family planning using regional institutions (CEFOREP) in Niger, Chad and Togo. A youth network (AfriYAN) conducted an assessment in five countries (Gabon, Guinea-Bissau, Central African Republic, Chad and Senegal) regarding access to quality SRH/FP services and to RH commodities for youth.

The **Pacific Sub Regional Office** (PSRO) partnered with University of Canberra and FNU to continue to roll out RHCS training packages in selected Pacific Island countries. The Fiji National University co-facilitated selected sessions and is now slated to be a key capacity building partner for RHCS training packages.

5.7 Activities of Regional Offices and clusters

This section focuses on actions taken by the regional offices to provide technical assistance, build capacity and strengthen partnerships for RHCS interventions. This section also provides information on achievements in regions whose countries are not part of Streams 1 and 2, such as Eastern European and Central Asian countries, the Caribbean and countries in the Arab State sub-region.

Western and Central Africa

In 2012, the UNFPA Sub Regional Office in Dakar, Senegal, received 29 requests from countries for integrated programmatic and technical support (IPTS), all of which were addressed during the year either through support provided by the RHCS Advisers, consultants or institutions. The office implemented training in procurement capacity building for the GPRHCS. A regional meeting on the West and Central Africa regional Early Warning System (EWS) for contraceptives welcomed 43 participants from 15 countries of the region in an event organized by the USAID/DELIVER project with inputs from UNFPA. A special effort was made in the documentation of good practices to enhance the visibility of the GPRHCS and show results in maternal health, RHCS and family planning programmes. Feature articles were subsequently produced as well as videos in two languages. A training workshop on strengthening country capacity to use CHANNEL gathered 33 participants from 12 West and Central African countries, including central warehouses managers, logistics managers from the Ministry of Health, consultants and RHCS focal points from UNFPA. This training-of-trainers focused on CHANNEL and CCM as tools for managing and planning RH commodity needs in order to secure availability of RH commodities and to reduce stock-outs.

Pacific Island Countries

The Pacific Sub Regional Office located in Suva, Fuji, supported 15 countries in the region to strengthen capacity for RHCS. Specific actions included creation of RHCS training packages at primary and secondary/ tertiary levels of health care delivery. The approach requires a multi-year, multi-level and multi-pronged approach in building the capacity of the in-country distribution systems over time. There was an investigation of the Depo Provera stock-outs in Vanuatu, Kiribati and Tonga, and recommendations were made to avert similar situations and towards building the management and technical capacity in Vanuatu to deal with such situations.

Eastern Europe and Central Asia

The Sub Regional Office in Kazakhstan provides support for RHCS activities to a cluster of UNFPA Country Offices in Eastern Europe and Central Asia. In 2012, more than 25 high-level government officials from 16 countries in Eastern Europe and Central Asia met in Brussels with representatives from UNFPA and the International Planned Parenthood Federation European Network to discuss ways to improve reproductive health commodity security in the region. Participants considered a survey taken in 2011, the results of which were also shared in 2012 in a series of country-level consultations in Armenia, Bosnia & Herzegovina, Bulgaria, Macedonia, Serbia, Azerbaijan and Kazakhstan. Evidence-based advocacy carried the survey findings to decision makers. Steps were taken to establish a formal working relationship with key partners in Central Asia, with a new concept note on the establishment of a Partnership Platform leading to an agreement to establish a Secretariat for the partnership. A three-day study tour was organized for 10 delegates from Central Asian countries to the ministry of Health of Malaysia, to understand the structure and functionality of the health supply chain. In addition, an AccessRH Regional Training was held in October for representatives of government healthcare offices and the Ministry of Finance to learn how to use the AccessRH system.

East and Southern Africa

The UNFPA Sub Regional Office in Johannesburg, South Africa, continued to support Country Office efforts to work with government and partners to strengthen capacity and deliver on RHCS. Country Offices were encouraged to provide information on their national commodity stock situation by registering and updating the Country Commodity Manager (CCM) software. An assessment of the status of national RHCS strategic plans was undertaken during the year to identify implementation challenges, finding that much of the progress observed in RHCS is mainly at national levels while sub-national mechanisms and capacities remain weak; further, though budget lines have been established, funds are not allocated. New this year, quarterly teleconferences updated the SRO with the Country Office experience. Also in 2012, a fact-finding mission examined the circumstances that led to the condom shortage in Kenya and made specific recommendations to avert similar situations. To mobilize resources, the office provided technical support to develop a proposal to the Packard Foundation that won a grant of $2,280,000 for two years to increase access to family planning information and services among young people in selected geographical regions of Kenya, Tanzania and Uganda, by using innovative interventions to leverage large-scale shift in policy and programming.

Caribbean countries

The UNFPA Sub Regional Office for the Caribbean located in Jamaica implemented a Reproductive Health Commodity Security programme to assist governments. In 2012, the office organized a Sub-Regional Meeting on Model Legislation on Adolescent Sexual and Reproductive Health and Rights. Partners including the University of West Indies Law School revised legislation on access to reproductive health services by adolescents in the countries of the Organization of East Caribbean States. There was also

training for health care workers on the management of contraceptive services and supplies in Guyana, where the Ministry of Health requested an RHCS assessment, now in progress. A series of training activities on contraceptive technology took place with 68 leaders of the Caribbean Midwives Association in Trinidad and Tobago, with the involvement of local Ministry of Health and nursing school staff. The offices also supported training in how to use the DMT Family Planning Tool, rolling out the tool in the Dutch-speaking Caribbean and supporting local community organizations to integrate family planning in community based activities in Suriname. A related Training of Trainers was conducted for participants from Curacao, Aruba, Bonaire, St. Maarten and St. Eustatius. By December, 117 health workers had received training. An IEC/BCC campaign provided information to adolescents at risk of pregnancy in rural Suriname.

South East Asia

The Asia Pacific Regional Office located in Bangkok, Thailand worked with country offices and partners in the region to implement various activities in 2012 including working on improving the quality of care in family planning, in collaboration with WHO. Two capacity development workshops gathered senior policy makers and programme officers from five high fertility countries in South Asia. Another workshop for 40 senior managers from national RH departments addressed RHCS logistics management and strengthening HIV-SRH linkages, including comprehensive condom programming. In collaboration with ICOMP, the office convened a regional consultation on the causes and determinants of unmet need for family planning in the region. For the event, APRO commissioned nine thematic review/ research papers on the unmet need in the region. New partnerships were pursued in 2012, in addition to ongoing collaboration with ICOMP, ARROW, PSI and JSI. A system to monitor the stock situation at the Central Warehouse level in each country of the region was implemented, asking the Country Office RHCS focal point to contact warehouse managers quarterly and report back to the regional office.

Arab States

In 2012, the Arab States Regional Office in Cairo, Egypt, worked with countries to promote and strengthen capacity for RHCS in the region. ASRO supported Yemen in developing a five-year government-led roadmap to establish an RHCS programme as recommended in Yemen's National RH Strategy. An LMIS design workshop was organized to include development partners and logisticians and LMIS experts. Additionally, the reproductive health thematic group and the RHCS sub-group resumed their regular meetings in 2012 after a disruption in 2011 due to the security situation in Yemen. Based on RHCS needs assessments that were conducted in Iraq and Sudan in 2011, ASRO supported these two countries in developing and finalizing their RHCS national strategic plans in 2012 and the beginning of their implementation. In Iraq, a national reproductive health and family planning strategy was formulated and endorsed by the Ministry of Health in 2010, and RHCS needs assessment was conducted in 2011, and an RHCS national strategy was formulated in 2012. ASRO brokered technical assistance for capacity building in Morocco for forecasting its RH commodities. ASRO identified and added to its consultant roster additional consultants who can provide technical assistance and do capacity building in the Arab region in the various elements of the RHCS and in Arabic and French. A regional RHCS training of trainers workshop in 2012 introduced RHCS to participants from six Anglophone middle income countries.

Latin America and the Caribbean

For the Latin American region, the office in Panama has been instrumental in working with partners and governments on reproductive health commodity security. In 2012, meetings and consultations supported regional initiatives including the Mesoamerican meeting with International Development Bank, the annual LAC RHCS Forum Coordination Mechanism meeting to prepare for the 2013 LAC RHCS Forum Assembly. The Population and Development Special Committee Meeting carried out by the Latin American Economic Commission (CEPAL) and UNFPA in Quito in July 2012 received technical support from UNFPA. At the country level, Ecuador used GPRHCS funds to document its position, mainly related to the Inter Sectorial Family Planning National Strategy. The office was also engaged in 2012 in updating and progressively implementing family planning norms, protocols, and quality standards as well as elaborated sexual and reproductive health practical clinical guidelines.

Technical assistance in GPRHCS countries in Comprehensive Condom Programming (CCP) generated demand, especially among adolescents and young people. A Regional CCP Workshop convoked 20 LAC countries with 43 participants from Ministries of Health and UNFPA country HIV and RHCS Focal Points. Within the LMIS approach, a Regional Humanitarian Logistics Strategy was developed in 2012. Also, 51 participants from 13 countries were trained as trainers (TOT) on Minimum Initial Service Package (MISP) for RH through two sub regional TOTs. Expert teams per country were formed during the training, on reproductive health and emergencies. The office continued to be engaged in the LAC RHCS Forum, an open and frank space to exchange experiences in RHCS aspects with key multi and bi-lateral donors, international NGOs, and other UN agencies, such as the Pan American Health Organization (PAHO). UNFPA currently holds the Presidency of the Coordination Mechanism. Close collaboration mechanisms with regional and sub-regional implementing partners such as PROMSEX/FLASOG, Reprolatina, and PRISMA/CIES strengthened RHCS advocacy, norms and protocols.

Box 5: Provide training to build skills

Every step of the supply chain has an impact on reproductive health commodity security. In 2012, UNFPA continued developing the human resources capacity of national staff, pharmacists and warehouse managers in forecasting, procurement storage and distribution – and to build the skills of health workers charged with providing reproductive health information and services.

Updating primary health care providers in Kyrgyzstan

Following a strategic assessment in 2011 on the prevention of unintended pregnancies and unsafe abortion in Kyrgyzstan, a training of trainers course enhanced knowledge within the health workforce on the medical criteria for safe and effective use of various types of contraception. Participants received training in how to counsel clients in the choice and correct use of contraceptives. It followed and assessment carried out by the Ministry of Health, UNFPA and WHO/Europe. The results of

the assessment clearly indicated a need to improve the knowledge of primary health care providers on contraceptives. The trainers ranged from academics at postgraduate level to midwives who provide family planning services. Cascade training of primary health care providers supported by UNFPA Kyrgyzstan started in September 2012.

More country examples

South-South development cooperation proved positive in **Mongolia**, where knowledge exchange built confidence in efforts to enhance RHCS, drawing on support from the UNFPA Asia Pacific Regional Office, training by an Indonesian counterpart, a study tour in Ethiopia, and forecasting training in The Netherlands. A state-owned health institution has been critical to sustainability and long-term impact of RHCS efforts focused on extensive training and institutionalization of RHCS studies at university level. In 2012, the numbers of participants trained in RHCS continued to increase, reaching not only pharmacists, logisticians, RH coordinators and health department officials but also midwives and family planning centre staff who have learned about forecasting to prevent stock-outs.

RHCS efforts in **Haiti** benefitted from the Rwandan RHCS experience through a study visit with eight participants drawn from the Ministry, the Haitian Parliament and women´s organizations. One outcome of the trip was creation of the network of Parliamentarians on Population and Development supported by UNFPA.

Capacity building training in **Ethiopia** in 2012 focusing on family planning was provided to 539 participants from public health facilities. Also, 270 participants from military health facilities and private pharmaceutical import and wholesale were trained on the supply management of medical equipment and medical supplies. In collaboration with AAU/School of Public Health, 50 university post-graduate students and 54 undergraduate students received RHCS training in supply chain management systems and advocacy.

Training in the use of the family planning decision-making tool has reached one quarter of health facilities nationwide in **Lao PDR**, enhancing the capacity of health providers to provide quality counseling. In the most remote rural areas where there are few facilities or staff to train, UNFPA continued to support family planning service provision through community-based distribution agents who have their own tailor-made tools to assist them.

Training in **Turkmenistan** in 2012 focused on procurement using AccessRH. Also this year, the national data collection system was strengthened through introduction of an updated set of indicators on RHCS coverage as a result of a study tour to Malaysia by two national specialists. The percentage of RH specialists trained to manage supplies using CHANNEL increased to 93 per cent in 2012 and installation of the computer software was accomplished in 89 per cent of the national system for reproductive health. Training on counselling on modern methods of contraception was offered to RH specialist in 50 service delivery points across the country.

Liberia has engaged in a wide spectrum of training activities to increase demand for and access to RHCS. In 2012, UNFPA supported the Liberian Ministry of Health in training 50 health workers in Grand Cape Mount County to provide adolescent and youth-friendly family planning services; trained 50 health workers in Bomi County on the use of LMIS; trained local media personnel to improve reporting of reproductive and maternal health issues; and trained 112 Community Health Volunteers in Montserrado and Bong Counties to distribute family planning commodities. UNFPA also supported the Ministry of Education in training 70 high school students and 10 teachers in family planning and counseling schools as part of a programme to improve access of high school students to family planning information and services.

CHAPTER SIX: ADVOCACY, PARTNERSHIP AND MARKET SHAPING

A midwife provides family planning counseling at the national health centre in Niamey. Credit: UNFPA Niger/Tagaza Djibo

Among the many important activities that UNFPA engages in at the global level, the GPRHCS supported activities in 2012 critical for reproductive health commodity security and family planning – including a groundbreaking Summit and a new family planning strategy. In this section, selected initiatives and activities carried out with partners working towards common goals are highlighted.

6.1 London Summit on Family Planning

The London Summit, organized by the Government of the United Kingdom and the Bill & Melinda Gates Foundation with UNFPA and other partners, mobilized resources that can help 120 million more women in developing countries gain access to voluntary family planning by 2020.

On World Population Day, 11 July 2012, the London Summit on Family Planning launched an unprecedented initiative to meet the need for modern family planning in developing countries. UNFPA, which has combined global advocacy on family planning with funding support and practical help to nations for over 40 years, urged donors and United Nations member countries to help produce the estimated $4.1 billion that is still needed every year to fully meet the need for modern contraceptive methods in the developing world. During the Summit, donor countries and foundations together pledged $2.6 billion; developing countries, on the other hand, pledged to increase their support to family planning.

UNFPA welcomed the concrete commitment of resources and political will made at the summit and committed to increasing the proportion of its programme funds for family planning from 25 per cent to 40 per cent.

6.2 Family Planning 2020

To deliver on the commitments made at the London Summit on Family Planning held in July 2012, participants established the FP2020 initiative. The summit was hosted by the UK Government and the Bill & Melinda Gates Foundation with UNFPA, now co-chair of the FP2020 reference group. The aim is to reach 120 million more women and girls in the world's poorest countries with access to voluntary family planning information, contraceptives, and services by 2020.

FP2020 will:[7]

- Track progress and report on financial and policy commitments made at the Summit, linking with established accountability processes for the UN Secretary General's Every Woman Every Child strategy;
- Monitor and report on global and country progress toward the FP2020 Summit goals;
- Identify obstacles and barriers to achieving Summit goals and recommend solutions;
- Ensure promotion of voluntary family planning and concrete measures to prevent coercion and discrimination, and ensure respect for human rights;
- Ensure data availability to support all of the above, consistent with country processes and sharing data, such as through a global score card; and
- Publish an annual report to update the global community on progress and challenges.

Coordinating Structure for FP2020:

- A high-level group of FP2020 Champions to provide leadership, influence and support on behalf of FP2020.
- An 18-member Reference Group, initially to be chaired by the United Nations Population Fund (UNFPA) and the Bill & Melinda Gates Foundation (BMGF), and comprising of countries, donor partners, civil society and technical partners and agencies, to set overall strategic direction for FP2020, drive coordination among stakeholders and be accountable for reaching 120 million additional women by 2020.
- A small, dedicated Task Team, reporting to the Reference Group and hosted by the UN Foundation, that is responsible for day-to-day implementation of FP2020 activities.
- Four Working Groups, to provide technical advice and support: Performance Monitoring and Accountability; Rights and Empowerment; Market Dynamics; and Country Engagement.

7 http://www.londonfamilyplanningsummit.co.uk/fp2020more.php

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

The UN Commission on Life-Saving Commodities for Women and Children (the Commission) has taken on the challenge outlined in the United Nations (UN) Secretary-General's Global Strategy for Women and Children's Health of saving lives through improving equitable access to life saving commodities. The Commission is a part of the Every Woman, Every Child (EWEC) movement and has the overall goal to increase access to simple life-saving commodities in 50 of the poorest countries that account for more than 80 per cent of all maternal and child deaths.

The Commission's report, published on 26 September 2012, identified 13 essential commodities that could save the lives of millions of women and children and made 10 recommendations for how to get these commodities to those who need them the most. An implementation plan that builds on the Commission's analyses and recommendations, applying them to the 13 commodities and providing crosscutting and commodity specific actions, was also developed.

Approximately 100 Ministers of Health, heads of UN agencies, funds and programs, and heads and representatives of civil society gathered in Abuja, Nigeria in October 2012 for the first UN Commission on Life Saving Commodities Technical and Ministerial meeting. This meeting was aimed at developing and shaping the detailed country level implementation plans that reflect country priorities and needs.

UNFPA is leading in three critical areas together with co-hosting the secretariat with UNICEF. UNFPA convenes initiatives Female Condom implementation plan. UNFPA also jointly convenes, with USAID, initiatives around supply awareness and three implementation plans for maternal health commodities-Oxytocin, Misoprostol and $MgSO_4$.

UNFPA is working with political leaders and partners to foster the implementation of recommendations made by the UN Commission on Life-Saving Commodities for Women and Children and help ensure access to these critical supplies, save lives and improve the health of women, children and young people.[8]

6.4 Meeting of the 46 countries of the GPRHCS to plan 2012-2018

The workshop held 8 to 11 November 2012 in Benin served as a forum for discussion and exchange among the representatives of 46 countries. It addressed a specific set of objective to optimize the launching of the second phase of the Global Programme to Enhance Reproductive Health Commodity Security. The main objective of the meeting was to design an optimal mechanism at Country Office level to enhance reproductive health commodity supply and contribute to the UNFPA mission of delivering a world where every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled.

The meeting brought together UNFPA Representatives, RHCS focal points, staff from Regional Offices and Sub-regional Offices and the Executive Management. The meeting addressed a number of specific objectives, including opportunities to discuss and share information on key drivers of UNFPA's integrated response to reproductive health commodity security and define UNFPA's appropriate role, notably with regard to monitoring at country level. The event also provided UNFPA Country Offices, in countries where applicable, the opportunity to share information and data that can contribute to the elaboration of GPRHCS Phase 2, on the basis of achievements and lessons learned from the implementation of GPRHCS 2007-2013. Participants discussed positioning UNFPA country offices to engage with partners and governments around the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), rolling out the UNFPA Family Planning strategy, and the London Summit on Family Planning.

8 For more information on the Commission, visit www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities

6.5 Bill and Melinda Gates support for Strengthening Transition Planning and Advocacy at UNFPA

UNFPA organized a technical consultation on advocacy for family planning with 18 countries receiving support through a project of the Bill & Melinda Gates Foundation project and UNFPA and, in most cases, implementing UNFPA's Global Programme to Enhance Reproductive Health Commodity Security. The meeting was held in Dar es Salaam, Tanzania, in June 2012. The objective was to share experiences in implementing reproductive health interventions, including family planning, and set the pace for strengthening UNFPA's global role in ensuring universal access to reproductive health commodities, especially modern contraceptives. The meeting was part of the project 'Strengthening Transition Planning and Advocacy at UNFPA'. The project received a grant of $1.5 million from the Bill & Melinda Gates Foundation for a number of reform activities to improve UNFPA's strategic intervention in 18 target countries with high unmet need for family planning.

The agenda focused on two main areas: (1) building on lessons learned by countries participating in the GPRHCS and (2) planning for the consolidation of UNFPA's lead role in family planning through its reform process, as supported by the Bill & Melinda Gates Foundation. Participants at the meeting emphasized the great need for UNFPA to give visibility to its remarkable contribution in reproductive health and family planning by effectively documenting and disseminating its successes, good practices and lessons learned. They acknowledged the need to strengthen advocacy to increase resources and create an enabling policy environment for family planning, with such advocacy efforts building on partnerships and enhanced collaboration.

The meeting produced agreement on next steps in the form of 'advocacy action plans' and identified time-bound tasks in order to expedite the reform process that will strengthen the role of UNFPA as a global leader in family planning. The group agreed that priority areas for action are to: (1) Finalize structural and operational processes within the organization to facilitate prioritization of family planning among donors and at country level; (2) Understand the country context to maximize impact from the various interventions, especially policy dialogue and advocacy; and (3) Situate UNFPA strategically as a global leader in family planning, which requires increased resources.

6.6 Joint Interagency Work on Priority Medicines for Mothers and Children

This list of priority life-saving medicines for women and children was developed in 2011 by the World Health Organization departments of Essential Medicines and Health Products; Maternal, Newborn, Child and Adolescent Health; and Reproductive Health and Research, and UNFPA and UNICEF to help countries and partners select and make available those medicines that will have the biggest impact on reducing maternal, newborn and child morbidity and mortality.

In 2012, the priority medicines for mothers and children 2011 list was updated following the expert committee meeting and the release of new treatment guidelines and feedback from partners. The title of this updated list was renamed as **Priority Life-saving Medicines for Women and Children**.[9] The updated version includes a section on contraception with the lists of all modern methods for family planning.

9 The list can be accessed at http://apps.who.int/iris/bitstream/10665/75154/1/WHO_EMP_MAR_2012.1_eng.pdf

6.7 Emergency stock-outs and humanitarian response

UNFPA South Sudan Deputy Representative delivers RH kits to implementing partners, February 2012

Through the GPRHCS Stream 3 mechanism, UNFPA provided emergency funding for commodities in countries facing stock-outs for reasons such as poor planning, weak infrastructure and low in-country capacity. Stream 3 also provided support for countries facing humanitarian situations, including natural or man-made disasters. In humanitarian settings, the GPRHCS works closely with UNFPA's Humanitarian Response Branch and the United Nations High Commissioner for Refugees. The joint UNFPA-UNHCR Commodities Initiative continued in 2012. UNFPA, in collaboration with the Humanitarian and Fragile Contexts Branch and Procurement Services Branch, in partnership with the UNHCR provided male and female condoms, RH-Kits and other essential life-saving commodities to selected countries with conflict, post-conflict, refugees and displaced populations. In 2012, GPRHCS provided assistance under its Stream 3 funding mechanism to Belize, Cape Verde, Cuba, Dominican Republic, Honduras, Iran, Kenya, Kosovo, Morocco, Pakistan, Panama, Peru, Philippines, Sri Lanka, Tanzania, Tunisia and Zanzibar, along with partners IPPF, MSI and PSI.

The GPRHCS also contributed to strengthening in the UNFPA Humanitarian Response Strategy, an approach that is fully aligned with the revised Strategic Plan. As whole, in 2012, UNFPA responded to 30 countries which were or are in a state of emergency or crisis. This response addressed the needs of displaced populations in Syria and the Syrian refugees in neighbouring countries, promoted a focus on gender-based violence and other reproductive health and rights concerns at the pledging conference in Kuwait, and assessed how better to respond to the crises in the Sahel region where massive population displacements have been experienced as a result of conflict and of environmental degradation particularly in Niger, Chad, Mauritania, Mali, Burkina Faso and parts of Cameroon, Gambia and Senegal.

6.8 Coordinated Assistance for Reproductive Health Supplies (CARhs)

The Coordinated Assistance for Reproductive Health Supplies (CARhs) Group working under the aegis of the System Strengthening Working Group of the Reproductive Health Supplies Coalition (RHSC) continue to work at global and country levels to resolve bottlenecks around the procurement and delivery of contraceptives and condoms in various countries. Members of CARhs[10] help to coordinate the efforts and response of the global donor community during through monthly meeting where members share information, identify possible countries where shortages might occur and work out coordinated efforts to address the problems.

Between January and December 2012, the CARhs addressed 512 separate issues relating to supply information. The 115 issues where the CARhs group intervened in 2012 were a) 87 issues where the group provided valuable information that helped resolve stock problems; and, b) 28 where instances where the group took action to address stock shipment situations. The 28 specific actions taken resulted in i) the creation of 22 new shipments; ii) four situations where shipments were expedited; and iii) two instances when shipments were cancelled.

10 UNFPA (Commodity Security Branch and Procurement Services Branch), USAID, RH Interchange Secretariat, and USAID | DELIVER Project and others working on an ad hoc basis (including the World Bank, KfW, the UN Foundation (Pledge Guarantee for Health staff), the RHSC and)MSI

6.9 Reproductive Health Supplies Coalition

The Reproductive Health Supplies Coalition (RHSC) is a global partnership of 150 plus public, private, and non-governmental organizations dedicated to ensuring that all people in low- and middle-income countries can access and use affordable, high-quality supplies to ensure their better reproductive health.

UNFPA is a leading member of the Coalition with two staff members on the Executive Committee.

In 2012, the RHSC continue to function through its three working groups (The Market Development Approaches Working Group; Resource Mobilization and Awareness Working Group; and, the Systems Strengthening Working Group) to address various issues. RHSC actively involved in the London Family Planning 2020 Summit and has been actively engaged in the post-summit initiatives.

6.10 Marie Stopes International (MSI)

Marie Stopes International (MSI) has a longstanding partnership with UNFPA to support reproductive health programming, impact on international policy and ensure reproductive health commodities. Since 2009 the UNFPA-MSI partnership has provided poor women and men in underserved communities with access to essential high quality family planning services.

In 2012, MSI was provided family planning commodities worth approximately $6.8 million USD. The commodities provided by end of November 2012 were composed of Oral Contraceptives (1,079,562); Injectables (21,600 pieces); Inter-Uterine Devices (IUDs) (83,900 pieces); Implants (281,508 pieces); Female Condoms (289,000 pieces); and, Male condoms (306,432 pieces). The total estimated CYPs provided by the UNFPA donation to Marie Stopes Tanzania was about 46,817. MSI's Impact 2 model estimates that these CYPs will avert an estimated i) 21,178 unintended pregnancies; 2,886 unsafe abortions; and, 96 maternal deaths. The commodities sent to Marie Stopes Tanzania (MST) contributed to making long-acting and permanent (LAPM) methods available to women in hard to reach rural locations and urban slums, provided by our clinical outreach teams. In Bolivia, the customs clearance procedures have been strengthened and action taken to properly management the packaging, storage, handling and distribution of the commodities.

6.11 International Planned Parenthood Federation (IPPF)

In his letter to UNFPA Executive Director on the 26 July 2011, the Director General of IPPF requested that UNFPA consider a donation of commodities to the value of $2,000,000 to support the delivery of family planning and reproductive health programmes across the globe as set out in an annual work plan submitted to the Commodity Security Branch. Included was an indicative list of commodities from IPPF. UNFPA's Executive Director agreed to this request and a Letter of Understanding was signed between both parties in November 2011.

All of the RH Commodities were received in Northampton between December 2011 and June 2012. To date all the commodities have been allocated to Member Associations (Mas) within the project timescales. In the distribution of the commodities, preference was given to the UNFPA GPRHCS Stream 1 and 2 Countries. The requests made by the MAs far exceeded the available commodities which indicatives that there were shortfalls in addressing the need in the countries. Generally, the provision of these RH Commodities by UNFPA has had a substantial impact on IPPF's MAs ability to deliver and indeed increase reproductive health services to low and middle income clients.

6.12 AccessRH

In 2012, Procurement Services Branch (PSB) continues to implement the AccessRH strategy in three main areas i) orders placement; ii) shipments; and iii) cataloguing and information. Regarding o*rders placed for inventory, a*t year-end 2012, 576,230 gross of 53mm male condoms remain available in warehouses following shipments already made – see sections 2.3.1 of this report. The remaining ordered stock (550,000 gross Male Condoms and 200,000 IUDs) are being produced and will be available for

shipment in 2013. Regarding shipments to clients, to date, 138 shipments have been dispatched to clients in 79 countries using AccessRH stock. Recipients comprise both UNFPA offices and third party clients. These shipments total a quantity of 2,541,516 gross (equating to 365,978,304 individual condoms. Clients with standard 53mm condom orders fulfilled from inventory receive their goods 10-14 weeks faster than clients ordering condoms needing to be produced when the order is placed.

Beyond activities related to procurement and shipment of products, AccessRH continues to refine its processes and documentation and improve the Catalog's offerings and other services. These are publicly available through the web site www.myAccessRH.org. The project is also heavily involved in developing technological tools for client use as well as understanding and addressing potential client limitations to AccessRH use. PSB continues its plans to increase the number of items offered to clients from stock. The results from the External Review of AccessRH indicate that AccessRH should continue to explore products for inventory – particularly when substantial lead time reduction or supply stability can result. The current plans include:

- *Oral contraceptives:* PSB had planned to purchase two oral contraceptives for AccessRH stock (Microgynon and Microlut). However, following late 2011 discussions with Bayer Schering, PSB has been exploring a mechanism by which UNFPA can access stock from Bayer without having to purchase that stock in advance. Initial stock under this model came under UNFPA's control in June 2011, but requires no advance financing. The AccessRH team is in the process of gathering metrics on how lead times are improved with this inventory. A large September order for the Philippines has consumed production of Microgynon until early 2013, resulting in other back-orders filled from inventory.

- *IUDs:* Though lead times are relatively short for this product, AccessRH has begun building stock to respond to orders even faster – and prepare for an increase in IUD requests as the method mix bundling concept receives more attention. As costs are low and shelf life long, risk is low.

- *Female condoms:* Female condoms are another product PSB has been exploring as an inventory item for over a year. Female Health Company's (FHC) response time was normally within the contractual production lead time, until massive support of FC2 by donors in 2011 consumed all production. Holding an inventory of female condoms can provide better responsiveness, and dovetails with DFID and other support of female condom programming. UNFPA is reviewing the results of the recent female condom bid, in which FHC and Cupid expressed willingness to hold AccessRH stock. In conjunction with the Technical Division, PSB is working to understand potential demand and registration for the Cupid product in view of holding inventory.

- *Injectable contraceptives:* Discussions with Pfizer in 2011 and 2012 with respect to holding Depo-Provera in inventory suggested that they would require a significant price increase to consider holding inventory. Furthermore, Pfizer's provision of Depo-Provera has degraded, 2012 quantities available to UNFPA were drastically reduced, and available 2013 quantities are nearly fully booked. PSB continues working through the Reproductive Health Supplies Coalition to assess, escalate, and resolve the situation of this widely-demanded product (and/or shift demand to other products/methods). UNFPA is now considering holding Bayer Schering's Noristerat. Though historical demand for the product has been low in comparison to Depo-Provera, the Depo situation is driving significant increases of Noristerat, so inventories may improve lead times.

- *Contraceptive implants:* Merck's Implanon and Bayer Schering's Jadelle have had high order volumes in 2011 and 2012, and the CHAI-led donor coalition is focused on these long-acting reversible contraceptives (LARCs) – including multi-year funding/volume commitments. As the production capacities are generally good, lead times low, and

in-country pipelines potentially full, AccessRH will hold off on building implant inventory at this time.

- *Other products:* In conjunction with ERP, Prequalification, and other task force work, products are considered for inventory. In particular, an emergency contraceptive would be an ideal product and is being investigated. Helm's Petogen and Sino Implant would also be ideal (if quality is suitable). Consideration of the year-approval ERP provides against the age of stocks is also important. PSB is reviewing progress with the maternal health drugs, fistula kits, and other products in view of addition to inventory.

6.13 Prequalification of male and female condoms and IUDs; Quality Assurance Policy for RH Medicines

The second Expert Review Panel for Reproductive Health Medicines (ERP/RHM) took place in 2012 as a collaborative effort between UNFPA and WHO, and as a key part of the DFID-funded project on Quality Assurance of Reproductive Health Medicines (QuRHM). The Expert Review Panel is an independent technical body composed of external experts and hosted by the Unit of Quality and Safety of Medicines of WHO's Department of Essential Medicines and Health Products. Its role is to provide an independent assessment that will result in objection or non-objection for procurement. Products with no objection for procurement will be available for procurement for an interim time; in the meantime, prequalification or SRA-approved status is acquired.

In addition to UNFPA and WHO, the QuRHM project also involves the Concept Foundation, an NGO, in the role of providing technical assistance to reproductive health manufacturers. The main goal of this project is to increase the number of possible procurement sources of quality assessed and approved hormonal contraceptives and maternal health medicines. Seventeen manufacturers responded to the call for quality review of dossiers in June 2012 under the Expert Review Panel mechanism. From this review, twelve products received a positive recommendation from the ERP. The submissions received included combined oral contraceptives, progestogen-only pills, injectable hormonal contraceptives, emergency contraceptives, oxytocin, misoprostol and mifepristone.

Two ERPs were scheduled for 2013, continuing this project with the aim of increasing the number of possible procurement sources of quality assessed and approved RH medicines. UNFPA will be working continuously to encourage submissions to both ERPs with emphasis and focus on the critical products, i.e. DMPA, other injectables, emergency contraception, oxytocin and magnesium sulphate.

In 2012, UNFPA continued management of the Prequalification Schemes for male latex condoms, female condoms and IUDs as it has done since delegation of the scheme by WHO, who remains the normative leader, in 2005. The scheme is well-established with the aim of making publically available a list of prequalified sources that , in principle, have been deemed acceptable for bulk procurement for the public sector and expanding the number of prequalified suppliers from all geographical regions. The rigorous process involves document review, factory inspections and sampling and testing of products with periodic re-qualifications every three years. In 2012, 17 male latex condom manufacturing sites were evaluated for prequalification or re-assessment for prequalification. There were no IUD evaluations carried out. Twenty five male condom, two female condom, and seven IUD factories have successfully completed the process as of 31 December 2012, with additional factories expected to be added to the lists in the first half of 2013 pending closure of inspection observations from 2012 inspections. The prequalification lists are dynamic and factories are added and removed accordingly and as such the list changes multiple times during the calendar year.

Publication of the WHO/UNFPA Female Condom Generic Specification, Prequalification and Guidelines for Procurement in late 2012 was the culmination of a lengthy consultative process with technical experts and female condoms stakeholders globally. It was presented to manufacturers, procurement agencies, national regulatory authorities, and NGOs for approval at a workshop in Bangkok in January 2012.

The workshop was a forum to inform all involved stakeholders of the components of the female condom prequalification scheme and to discuss the formulation of the specifications prior to finalization. The workshop also aimed to enhance the capacity of female condom manufacturer's potential to become prequalified. One new female condom design and manufacturing site was prequalified in 2012, bring the total to two prequalified sites.

Efforts also continued in 2012 to focus on capacity building and knowledge-sharing with Ministries of Health and Regulatory Authorities. Workshops were held in collaboration with WHO and FHI360 that concentrated on WHO/UNFPA sampling and testing procedures for reproductive health medicines, condoms and IUDs, and best practices in laboratory management (e.g. accreditation, sampling, testing protocols and procedures to ensure the quality of reproductive health commodities). A total of 16 countries from the West Africa region and 15 countries from the Asia region participated in workshops held in 2012.

6.14 The UNFPA Family Planning Strategy: Choices Not Chance

Throughout every region in the developing world, and in pockets of disparity in middle income countries, family planning is a priority with the promise of profound benefits. Family planning's benefits range from improved maternal and child health to increased education and empowerment for women, to more financially secure families, to stronger national economies. Family planning never stands alone: it stands alongside emergency obstetric and newborn care, and skilled attendance at birth. It is part and parcel of human development strategies, having earned its place as one of the most cost-effective health investments a country can make. Making voluntary rights-based family planning available to everyone in developing countries would not only save and improve lives, it would reduce costs for maternal and newborn health care by $11.3 billion annually.

The UNFPA Family Planning Strategy, articulated in 2012 and approved in 2013, is focusing on low income countries with the highest levels of unmet need for family planning. The strategy is to accelerate access to family planning information, services and supplies as a matter of human rights.

The UNFPA Family Planning Strategy 2012-2020 outlines how the Fund will engage with all UNFPA programme countries to ensure that the countries receive optimum support based on comprehensive review of their situations and critical needs. The guiding principles of the strategy are: universal human rights; equality and non-discrimination; gender equality and equity; access for adolescents and young people to comprehensive sexuality education and youth-friendly services; evidence-based, national relevance and sustainability; accountability and transparency; and, innovation, efficiency, quality and results.

The goal of the Strategy is to achieve universal access to rights-based family planning as part of sexual and reproductive health and reproductive rights; and the outcome is increased access to and use of human rights-based family planning from 2012 to 2020. To achieve the outcome UNFPA will encourage provision of contraception in line with national priorities and within its mandate in support of sexual and reproductive health services as agreed in the ICPD Programme of Action. The outputs of the strategy are:

- Output 1: Enabled environments for human rights-based family planning as an integral part of sexual and reproductive health and rights;
- Output 2: Increased demand for family planning according to client's reproductive health intentions;
- Output 3: Improved availability and reliable supply of quality contraceptives;
- Output 4: Improved availability of good quality, human rights-based, family planning services;
- Output 5: Strengthened information systems pertaining to family planning.

While the RHCS and family planning policy spheres overlap significantly, both have elements outside the scope of the other. The Global Programme will make an important contribution to country efforts to ensure universal access to family planning as an integral part of sexual and reproductive health. Action plans were drawn up for its implementation, and the strategy was finalized in 2013.

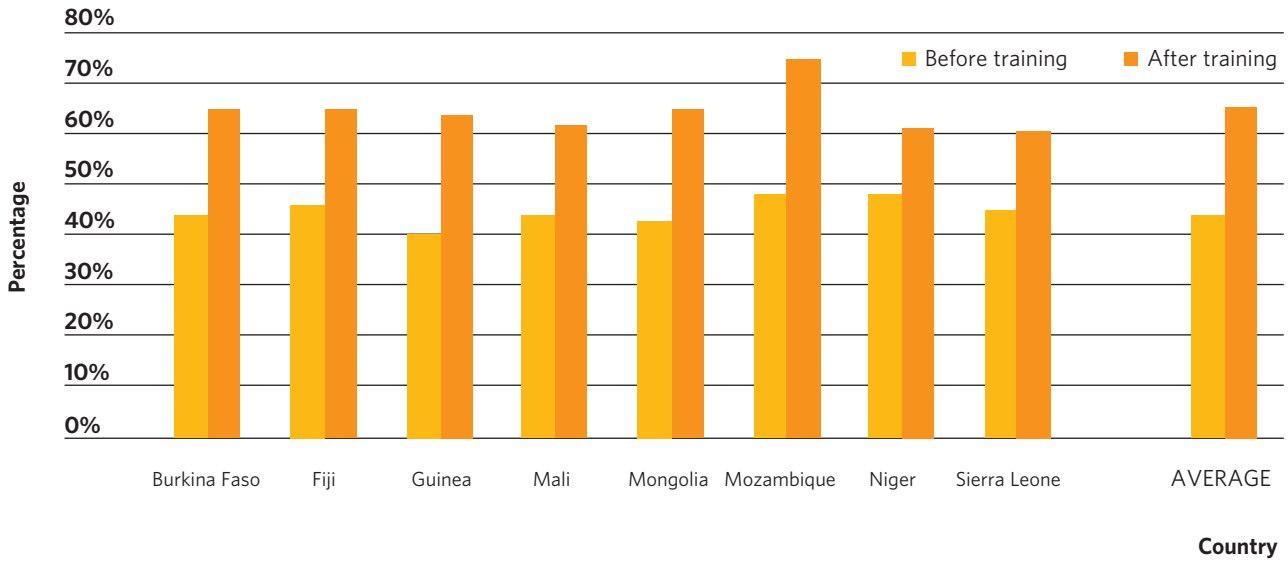
6.15 Capacity building in procurement

Capacity building initiatives in procurement increased in 2012, including quarterly newsletters, a dashboard showcasing country progress, an e-learning course and a series of successful procurement training workshops. The workshops were implemented in four countries (Burkina Faso, Guinea, Niger and Sierra Leone), with pre- and post-workshop assessment showing an average knowledge growth of 21 per cent. These four events met the annual target for the first time. Some 110 participants received training and 20 trainers were trained to assist with the exercises, presentations and group work.

The workshops sensitized participants to issues of the environment, corruption mitigation, quality enhancement and more effective methods of procurement. Another objective was to encourage the procurement community to form a network through which improvements can be jointly recommended. As a result of the workshops, three countries have developed networks: Burkina Faso, Niger and Sierra Leone. The networks will contribute to additional capacity building and, through setting priorities and advancing the agenda for expert instruction, contribute to the development of reforms through the national academic institutions by building their capacity. Network activities include the identification of national institutions where training can be anchored in the future, including institution-to-institution training supported by the GPRHCS, which will contribute to RHCS sustainability, access and system strengthening.

The procurement training workshops contributed to improved understanding of key procurement issues at country level. In each of the countries, there was at least a 15 per cent increase in the participants reporting an improved understanding of key procurement issues after each training session (Figure 37).

Figure 37: Percentage of participants reporting change in their understanding of key procurement issues before and after training sessions in selected countries



UNFPA has joined with other partners to conduct a gap analysis regarding procurement capacity to support the process of institutionalization. The UNFPA Procurement Services Branch had made plans to engage expert institutions at the international level, seek to provide professionalized certification, and identify institutions in countries for capacity development.

In 2012, an e-learning course on procurement was produced for partners and shared on a website in four languages. The Level 1 e-learning module is the first of its kind available to external partners and incorporates interactive learning with a generated certificate. The course is available in a total of six languages, also on CDs and USB keys for countries with connectivity issues. Three new modules are planned for 2013.

6.16 Condom programming

UNFPA is the lead agency in the United Nations system for all aspects of condom programming. Condoms must be universally available - either free or at low cost - and marketed widely to motivate people to use them. They are the only method available that offers dual protection from HIV and other sexually transmitted infections as well as unintended pregnancy. UNFPA promotes comprehensive condom programming (CCP), which seeks to ensure that those at risk of STIs, HIV, and unintended pregnancy are motivated to use male and/or female condoms; have access to quality condoms; have accurate condom information and knowledge; use condoms correctly and consistently.

Comprehensive condom programming is an integrated approach consisting of leadership and coordination of partners, demand, supply and support functions. In UNFPA, support for CCP is provided by the HIV/AIDS Branch, in close collaboration with the GPRHCS, the Humanitarian Services branch and the Procurement Services branch. These four entities have distinct but complementary roles and responsibilities. UNFPA plays a key role in the Global Condom Initiative (GCI), which was launched in 2005 to increase both demand for and supply of condoms at the national level. CCP activities include support for governments of low- and middle-income countries to work in several areas:

- advocate for the removal of laws and policies that prevent condom access and utilization by young people and key populations such as sex workers, men who have sex with men, and transgender people;
- establish a budget line for male and female condoms; and
- allocate adequate national financial and human resources to procure and programme these commodities. This includes motivating users, strengthening service providers and developing educational materials to promote consistent and correct condom use.

Below are CCP highlights in 2012.

Assessments

Priority countries in the East and Southern Africa Region reported substantial progress in condom programming in 2012, according to the UBRAF Joint Programming Monitoring System (JPMS) reports. Twelve of from the 15 priority countries carried out strategic work on strengthening CCP with a focus on young people, and three of these countries (Mozambique, Tanzania and Uganda) strengthened the coordination and management of the condom programme through reviving their condom committees and/or task forces. Six of the 15 countries reported that an assessment of their condom programme was being supported. Situation assessments were conducted in Ethiopia, Swaziland and Zambia and a programme review was completed in Zimbabwe. Sub-national bottleneck assessments were undertaken in Lesotho and Tanzania. Four countries updated their national condom strategy (Botswana, Kenya, Lesotho and Namibia) and two countries undertook activities to strengthen condom planning and the supply system (Rwanda and Zambia). In addition, four countries (Ethiopia, Lesotho, Malawi and Swaziland) reported UNCT support to condom promotion and demand creation activities. In Central Africa Republic, a CCP assessment and an RHCS situation analysis provided information for the design of strategies to integrate CCP into the RHCS strategic plan 2013-2017.

Capacity development/strengthening

In Latin America, a regional workshop funded and facilitated by UNFPA gathered 43 participants from 20 countries, including Ministry of Health staff, USAID, social marketing organizations and UNFPA HIV and RHCS focal points. On the agenda were integration of comprehensive condom programming, including understanding the principal of condom demand generation; quality assurance and laboratory testing; and a brief introduction to quantification and forecasting. Since the training, several countries have included activities in their 2013 work plans to improve access to and use of male and female condoms.

Fifty participants from 13 countries attended a CCP training workshop organized by the UNFPA East and Southern Africa Regional Office and headquarters. The workshop addressed the four pillars of CCP and how to improve condom quantification, forecasting, procurement, warehousing and distribution. The workshop also included a training session on CCM. Participants reached consensus on post-shipment testing of condoms in the region, and a sub-regional position paper was endorsed and shared with the Regional Economic Communities. Several countries incorporated activities from the trainings into their 2013 work plans. Progress made in CCP at country level since the workshop will be assessed by UNFPA.

In Malawi and Swaziland, UNFPA commissioned two back-to-back skill-building workshops on condom demand generation for young people. Participants at the events in November and December 2012 were selected from Ministry of Health, Ministry of Education, Ministry of Youth and Sports, local NGOs, local staff of Population Services International (PSI), youth representatives, UNFPA Country Office specialists on HIV, behaviour change communication officers, and young people. Both countries committed to finalizing the market mix strategies outlined during the workshops, which- includes defining a new market strategy for promotion of condoms to young people, developing attractive condom brands, expanding distribution points, and adding a nominal fee to public sector condoms (free is seen as cheap). Photo: 2012 Swaziland's new male condom brand

Global Condom Initiative

After joining the Global Condom Initiative (GCI) in 2005, UNFPA has intensified the programming of male and female condoms through UNFPA Country Offices and NGOs in Africa, Asia, Latin America, Europe and the Middle East. Success was varied. To address this situation, UNFPA contracted an outside vendor to develop a Global Demand Generation Strategy for male and female condoms. This strategy was validated by the UNFPA Demand Generation Working Group in Washington D.C. in August 2010, followed by validation and field testing at a regional workshop in the Caribbean in October.

The Framework serves as an evidence-base for generating demand for male and female condoms. UNFPA and its partner NGOs have been using the framework as a foundation for the development of country/regional demand generation strategies and work plans with the aim of promoting the utilization of male and female condoms. It includes a global literature review of male and female condom promotions; planning tools which reflect international best practices; an evidence-based methodology; and sample plans.

Global Awareness Campaign

The CONDOMIZE! Campaign is an initiative of the UNFPA and The Condom Project aiming at raising awareness about the importance of condom use in a lively and engaging way. It is a very colorful, lively and dynamic gathering. The Campaign is a free space for people to dialogue, dance, get educated and collect 'cool' educational materials for their community or national programmes.

The 2012 CONDOMIZE! Campaign was held in in Washington, DC from 22-27 July, during the XIX International AIDS Conference, which was attended by 30,000 people from more than 100 countries. The Campaign featured Michel Sidibe in the opening speech and distributed a number of items:

- 850,000 condoms and 100,000 female condoms;
- 6,500 colorful fabric condom case discs containing information on the correct use of condoms and

Two of 45 Condomize! Dancers at the AIDS Conference.

lubricants in Amharic, Arabic, Chinese, English, French, Russian, Spanish and Sign Language;
- 10,000 t-shirts with a message "Live, Love, CONDOMIZE!";
- 30,000 CONDOMIZE! branded hand fans.

A week-long preconference entitled "Bring the City to the Conference and the Conference to the City" was designed to educate selected MSM and sex workers communities about condoms and lubricants and to provide them with private sector condoms. In addition, Community Dialogue Sessions were held daily on topics such as young people and condoms, female condoms, and a game show-style Condom Challenge. Forty-five young CONDOMIZE! Dancers attracted large crowds with every flash mob performance. For more information visit: www.condomize.org/condomize/events_aids_readmore/

Country progress reports 2012

In Benin, CHANNEL implementation processes estimated a need for 2 million condoms for 2013. Steps were taken for improved availability and inventory management of condoms at the CAME, health district distribution depots, and sites where STIs and HIV/AIDS are managed. Condom distribution through community relays has improved availability.

In Bolivia, the Ministry of Health and Sports, UNFPA and PROSALUD launched a situational analysis of access and use of male and female condoms at national level in capital cities, intermediate cities and rural area. The results will be used in the development of a national strategic plan for both male and female condoms.

In Burkina Faso, activities often carried out with the partner PROMACO included advocacy meetings for 90 leaders of women's associations in villages. Training for 180 women in demonstration of the correct and consistent use of female condoms went on to reach 2,788 women and men, and training of 15 disc jockeys in Ouagadougou et Bobo-Dioulasso reached some 5,300 young people.

In Ethiopia, UNFPA in collaboration with DKT Ethiopia, Wise up and Timeret Lehiwot Ethiopia, implemented the CONDOMIZE! Campaign at the 13th World Congress on Public Health, Addis Ababa, April 2012. The occasion promoted the campaign to thousands of participants from 168 countries. A similar activity took place during a family planning symposium in November. Photo: The CONDOMIZE! Zone at the World Congress in Addis Ababa, Ethiopia

In Gabon, UNFPA continued to develop a national social marketing strategy, following the adoption last year of the CCP national plan. Through UNFPA, approximately 2 million male condoms and 60,000 female condoms were procured in 2012.

In Guinea, 1,000 soldiers and their families benefitted from sensitization on the benefits of consistent condom us, and the country instituted distribution of condoms through the army.

In Liberia, demand creation, youth-friendly centres, and community-based distribution were among the year's CCP activities. A total of 112 Community Health Volunteers (CHVs) were trained in Montserrado

and Bong to distribute family planning commodities. Five large high schools in and near Monrovia were the focus of a project by the Ministry of Health with support from UNFPA for IEC/BCC on family planning and other RH issues, with training for peer education and counseling.

In Madagascar, the CCP strategy paper was presented and approved at forum of partners in May 2012. Its principle activities have already been included in the national HIV/AIDS strategy.

In Mali, the design of a national CCP work plan 2013-2017 enhanced opportunities to foster supply and demand. Through UNFPA, 3,960,000 male condoms were procured in 2012.

In Mongolia, in collaboration with the Marie Stopes International, UNFPA continued to support female condom social marketing and an STI/HIV prevention project provided trainings of service providers, social marketing distributors and local NGOs on male and female condom promotion. Such training took place in many locations, including border areas with China, mining areas and larger cities.

In Mozambique, the ten steps of CCP have been incorporated into Mozambique's HIV prevention strategy. In 2012, support strengthened forecasting and requisition from the provinces and identified additional points of condom distribution to reach adolescents and youth and sex workers. Through the *Projecto Inclusão* and the youth associations AMODEFA and COALIZÃO, correct and consistent use of condoms was promoted through youth-friendly services and peer educators for various groups including young people in and out of school, in the community and at night clinics for sex workers. Also, regular provision of male and female condoms is a central component for Geração Biz, a programme UNFPA has supported for more than a decade.

In Namibia, training of trainers continued to enhance access for young people to information on sexual and reproductive health and rights. Monitoring was stepped up to ensure that at least three modern methods of contraception would be available at all service delivery points. A stakeholder workshop in December was held to validate the National Condom Strategy, expected to be approved in 2013.

In Nicaragua, a project of three universities hosted a leadership development workshop for 150 leaders, leading to 23,225 students informed, sensitized and trained in the correct and consistent condom use. Eighteen kiosks were established.

In Sierra Leone in 2012, the National Comprehensive Condom Programming strategic plan was reviewed and validated to include among other things, the provision of youth friendly condoms. Throughout the year a total of 1, 964,000 male condoms and 853,000 female condoms were distributed throughout the country with the help of all partners. Training on condom distribution and promotion and related RH issues engaged stakeholders including 80 condom vendors and 195 community advocates/ condom focal points from government offices. Ninety traditional leaders were trained as Community peer educators and advocates for SRH and young people. More than 100 religious leaders joined a national interreligious AIDS network.

In South Sudan, more than 911,600 condoms were distributed through a network of partners as part of the emergency programme response through the distribution of RH kits. UNFPA South Sudan and the Ministry of Health also participated in the UNFPA-supported workshop in Rwanda on strengthening comprehensive condom programming, held for UNFPA and MoH staff and focal points. The National Comprehensive Condom Programming Strategy was finalized and validated.

CHAPTER SEVEN: BY THE NUMBERS

RHCS training exercise in Mali. Credit: UNFPA Mali

7.1 Programme Management

The programme management indicators of the GPRHCS Performance Monitoring Framework are used to assess the timely completion of tasks and occurrence of key programming events. The indicators are useful in tracking and reporting on the adherence to guidelines and completion of tasks at country, regional and headquarters level which underpin the smooth running and management of the programme during the year.

Table 40: Programme management indicators, 2010 to 2012

No	Programme Management Indicator	Achievement for 2010		Achievement for 2011		Achievement for 2012	
		Number of countries	%	Number of countries	%	Number of countries	%
1	Number of countries achieving at least 60% of work plan outputs	40 out of 45 countries (11 Stream 1 countries) (29 Stream 2 countries)	88.9 100 85.3	45 out of 46 countries (12 Stream 1 countries) (33 Stream 2 countries)	98.0 100 97.0	41 out of 46 countries (12 Stream 1 countries) (29 Stream 2 countries)	89.1 100 85.3
2	Number of Country Offices with completed and budgeted annual work plan by end of December each year	42 out of 45 countries (11 Stream 1 countries) (31 Stream 2 countries)	93.3 100 91.2	34 out of 46 countries (9 Stream 1 countries) (25 Stream 2 countries)	74.0 75.0 74.0	30 out of 46 countries (10 Stream 1 countries) (20 Stream 2 countries)	65.2 83.3 58.8
3	Number of Country Offices submitting mid-year progress report to respective regional offices by 15 June each year	11 out of 11 Stream 1 countries	100	12 out of 12 Stream 1 countries	100	12 out of 12 Stream 1 countries	100
4	Number of Country Offices submitting completed annual narrative programme report to respective Regional Offices by 15 December	42 out of 45 countries (11 Stream 1 countries) (31 Stream 2 countries)	93.3 100 91.3	35 out of 46 countries (10 Stream 1 countries) (25 Stream 2 countries)	76.0 83.0 74.0	36 out of 46 countries (11 Stream 1 countries) (25 Stream 2 countries)	73.5 91.7 78.3
5	Number of Country Offices submitting completed financial report to respective Regional Offices by 15 December	5 out of 45 countries	10.0	10 out of 46 countries	22.0	12 out of 46 countries (5 Stream 1 countries) (7 Stream 2 countries)	26.1 41.7 30.6
6	Number of Regional Offices submitting reviewed AWPs to Technical Division/HQ by mid-January	5 out of 7 regional offices	71.4	5 out of 7 regional offices	71.0	4 out of 7 regional offices	57.1

No	Programme Management Indicator	Achievement for 2010		Achievement for 2011		Achievement for 2012	
		Number of countries	%	Number of countries	%	Number of countries	%
7	Number of Regional Offices submitting mid-year report by mid-July and annual report by mid-January to Technical Division/HQ	5 out of 7 regional offices	71.4	5 out of 7 regional offices	71.0	4 out of 7 regional offices	57.1
8	Country work plans reviewed and allocation made by HQ by 1st week of March	37 out of 45 countries (10 Stream 1 countries) (27 Stream 2 countries)	82.2 90.9 79.4	35 out of 46 countries (11 Stream 1 countries) (24 Stream 2 countries	71.0 76.0 92.0	32 out of 46 countries (10 Stream 1 countries) (22 Stream 2 countries	69.6 83.3 64.7
9	Semi-annual and annual progress review/planning meeting organized for all GPRHCS Stream 1 countries by CSB/TD	2 meetings held	100	1 meeting held	50.0	1 meeting held	50.0
10	Consolidated annual GPRHCS report (programmatic and financial) prepared by end of March of following year by HQ	1 consolidated annual report prepared	100	1 consolidated annual report prepared	100	1 consolidated annual report prepared	100

In 2012, the average implementation rate for the GPRHCS countries was 86 per cent - down from 89 per cent in 2011. Stream 1 countries had an average implementation rate of 92 per cent in 2012. Also the average implementation rate for Stream 2 countries in 2012 was 88 per cent; and for Stream 3 countries it was 80 per cent.

Table 40 shows the performance scores relating to the ten management indicators of the GPRHCS M&E Framework. The percentage of countries that reported implementation of 60 per cent or more of the annual work plan activities decreased from 98 per cent in 2011 to 89 per cent in 2011 – all of the decrease was among stream 2 countries. In 2012 there was also a decrease in the percentage of countries submitting budgeted work plans to their respective regional offices from 74 per cent in 2011 to 65 per cent in 2012.

As has been the case for 2010 and 2011, all the Stream 1 countries submitted mid-year progress reports in 2012. These reports were reviewed internally to track progress and take subsequent action for the second half of the year. For 2012, no mid-year review meeting was held.

For 2012 the percentage of GPRHCS countries that submitted annual programme reports to their respective regional offices with copies to CSB by

December 2012 was 73.5 per cent (36 out of 46 countries including 11 stream 21 countries) down from 76 per cent in 2011. The regional offices and CSB provided comments and inputs before the reports were finalized. In the case of financial reporting, about three-fourth of all the countries did not submit financial reports as planned due to the fact that financial closure does not end until end of March. The delay in submission of financial reports were also necessitated by the reports cover all commitments and expenses for the year which provides management with information to assess implementation rates and report on expenditures for each output area.

Each year, the regional offices prepare and submit annual work plans and annual reports. For 2012, out of the 7 UNFPA regional/sub-regional offices five prepared and submitted annual work plans to CSB for consideration and funding; compared to five regional/sub-regional offices in 2011. Also four regional offices submitted midyear and annual reports by the set dates on the activities implemented in 2012.

In the absence of a meeting to peer reviewed the work plans, CSB and the regional offices worked with each country office to finalise work plans and ensure funding is available for programme implementation in 2013. Countries were required to prepare a four year strategic work plan for the period 2013 to 2016 from which the extracted AWPs for 2013. The long term plans will serve as a guide for long time implementation of scalled up activities for RHCS and family planning. By the end of 2012, thirty two out of forty six countries – including 11 stream one countries (about 67 per cent of all the countries) had their work plans reviewed and funded by the first week of March 2013.

In 2012, only one meeting was held for GPRHCS planning. The meeting was held in Cotonou, Benin, from 4-13 November 2012. The meeting brought together UNFPA Representatives and RHCS focal persons from 46 focus countries; RHCS advisors in regional and sub-regional offices and staff from CSB, OED, Programme Division and PSB (Copenhagen).

The meeting was used to provide opportunity for UNFPA country offices in focus countries to share information and provide inputs for the design of the next phase of the GPRHCS. Also other key issues were discussed such as the New Family Planning Strategy and country engagement around FP2020.

In line with the results and indicators of the GPRHCS Performance Monitoring Framework this Annual Report 2012 serves as a means of verification that a consolidated report was prepared to provide information programme implementation for the year. As usual this report provides additional information from 2012 implementation to build on results reported in previous years and provides information for the update of the results framework.

7.2 Commodity purchases and benefits

Every year UNFPA through the GPRHCS assists countries with procurement of reproductive health commodities including contraceptives, condoms, maternal health medicines and RH kits. The commodities are a very important component of the support to countries as they work to strengthen systems and make services and products available to the neediest population.

Allocation of funds for commodity purchases

Country commodity needs are addressed through well-structured steps with the involvement of various parties including governments. The first step taken is for staff in the UNFPA staff CO to work with government counterparts, mostly in the Ministry of Health; and other partners to determine the type and quantities of supplies required. Once the country need has been determined, it becomes the basis for all further actions. The second step involves UNFPA country offices submitting the requests to GPRHCS for consideration. All the country submissions are then analysed, having in mind trends in support previously provided, resource availability and outstanding procurement (yet to be delivered) for that country.

Generally the validation process involves staff at UNFPA's Country Offices, Regional Advisors, Procurement Services Branch, and other branches at

headquarters; Ministry of Health officials and officials from other public health offices. Once the request has been validated, the Global Programme coordinates UNFPA's response to each country requests with those of other major donors, including USAID, World Bank, and the RH Supplies Coalition to share information and avoid duplications. When all this is done, GPRHCS works with the Procurement Services Branch of UNFPA to place orders and ship commodities to the countries. Steps are taken to ensure that the activities are carried out speedily to ensure requests are met in a timely manner and that shortfalls for RHCs are averted.

What kind of 'commodities' are provided?

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

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

Essential life-saving maternal/RH medicines: This is largely based on the *WHO Priority life-saving medicines, for women and children, 2012;* the priority medicines are: i) Oxytocin, ii) Misoprostol, iii) Sodium chloride, iv) Sodium lactate compound solution, v) Magnesium sulphate, vi) Calcium gluconate, vii) Hydralazine, viii) Methyldopa, ix) Ampicillin, x) Gentamicin, xi) Metronidazole, xii) Mifepristone, xiii) Azithromycin, xiv) Cefixime, xv) Benzathine Benzylpenicillin, xvi) Nifedipine, xvii) Dexamethasone, xviii) Betamethasone, and ixx) Tetanus toxoid. For further information please see http://www.who.int/reproductivehealth/publications/general/emp_mar2012.1/en/index.html

Emergency RH Kits for conflict, post conflict and emergency situations

Medical devices/equipment and supplies on case by case basis_

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

Contraceptives and condoms

Tables 41 and 42 show the total quantities of the various contraceptive and condoms that were provided to the Streams 1, 2 and 3 countries for 2012. Details of specific commodities provided to each country are presented in the annex. More injectables were procured for Stream 1 countries more than the other streams combined and that nearly 70 per cent of the Emergency orals were procured for Stream 3 countries. While more male condoms were procured for Stream 2 countries than the other countries combined, about 50 per cent of all female condoms were procured for Stream 3 countries procured, compared to only 11 per cent for Stream 1 countries.

Table 41: Total contraceptives provided to all countries in 2012

STREAM	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency oral (doses)	Implant	
					1-Rod (pieces)	2-Rod (pieces)
Stream 1	12,675,600	558,500	14,665,440	36,000	634,176	343,200
Stream 2	3,927,300	1,283,500	13,253,732	91,800	206,912	487,200
Stream 3	4,290,000	489,000	1,514,160	287,280	212,866	481,100
Total	**20,892,900**	**2,331,000**	**29,433,332**	**415,080**	**1,053,954**	**1,311,500**

Table 42: Total male and female condoms provided to all countries in 2012

Stream	Male Condom (pieces)	Female Condom (pieces)
Stream 1	160,394,400	1,533,000
Stream 2	273,700,800	5,855,000
Stream 3	5,630,400	7,062,000
Total	**439,725,600**	**14,450,000**

Benefits of commodities supplied - CYP

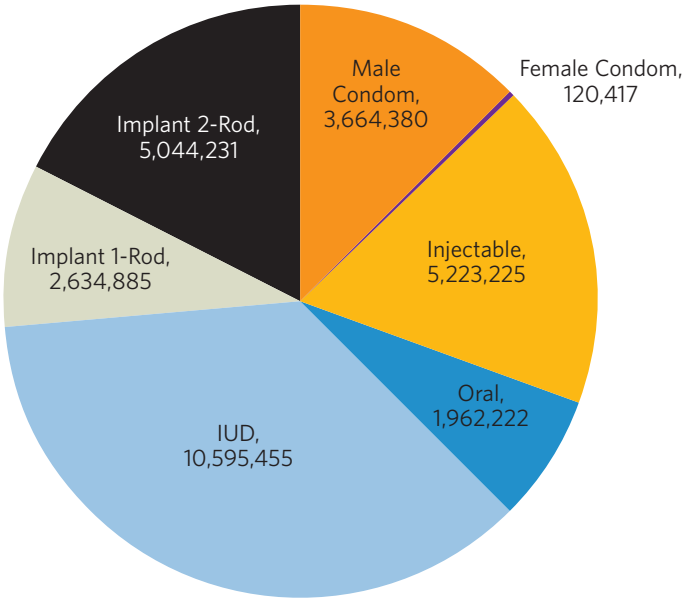
While figures on stock out of commodities gives an indication of whether the commodities are readily available and CPR enables us to measure the extent to which the commodities are actually used for family planning; the couple year protection (CYP) is a quick way of assessing the benefits of the procurement figures. CYP is the number of couples protected from unwanted pregnancy for one year.

Table 43: Total CYPs for contraceptives and condoms provided for all countries in 2012

Stream	All contraceptives	Condom (Male and Female)	Total
Stream 1	9,590,672	1,349,395	10,940,067
Stream 2	10,090,624	2,329,632	12,420,256
Stream 3	5,778,721	105,770	5,884,491
Total	**25,460,017**	**3,784,797**	**29,244,814**

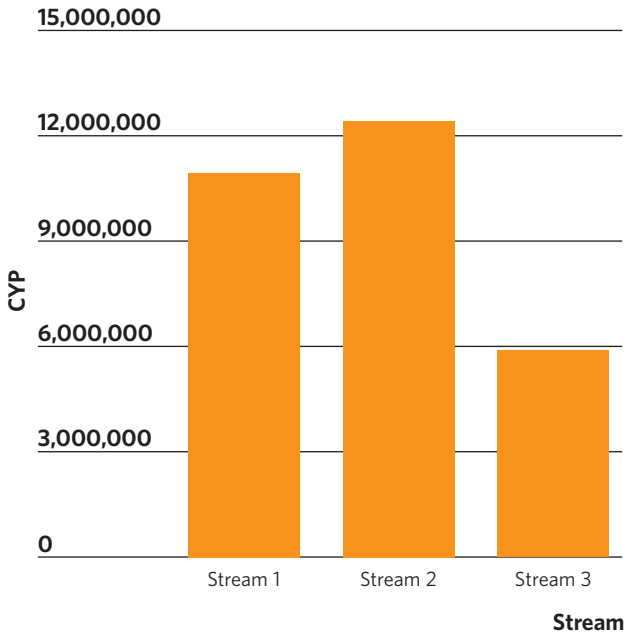
Contraceptives procured amounted to 29.2 million CYPs in 2012 – more than double the 11.45 million CYPs for 2011 (Table 39). IUDs provided the highest amount of CYPs at 1.6 million followed by implants at 7.6 million (Figure 38). As of this year, implants were the second-highest contributor of CYPs; up from third place in 2011. Procurement of female condoms continued to contribute the least CYP, though the amount increased from 29,525 CYP in 2011 to 120,417 CYP in 2012.

Figure 38: Total CYP for contraceptives and condoms provided for all countries in 2012



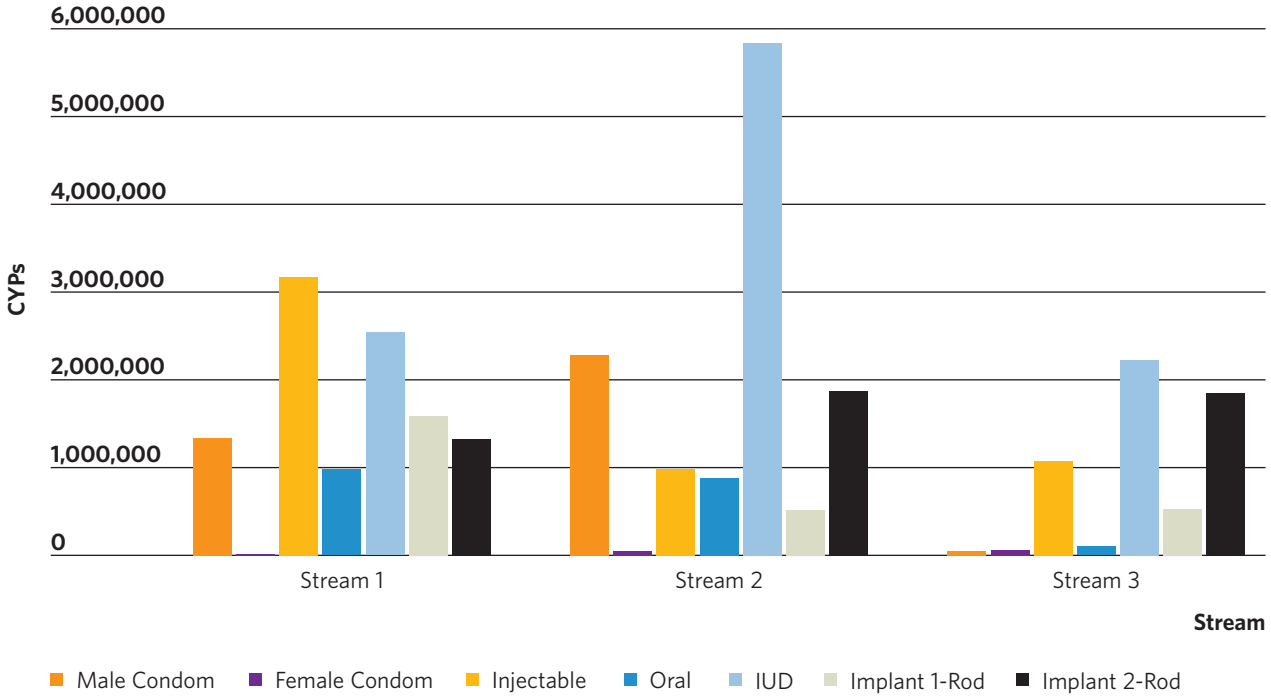
The procurement of contraceptives Stream 1 countries amounted to 10.9 million CYP for Stream 1 countries and 12.4 million CYP for Stream 2 countries (Figure 39).

Figure 39: Total CYP for contraceptives and condoms provided for all countries by Stream in 2012



IUDs accounted for a disproportionate amount of CYP in Stream 2 countries in 2012 and was one of the main contributors in the other countries (Figure 40). Injectables were the highest contributor of CYP in Stream 1 countries, more than in the other streams.

Figure 40: CYPs for contraceptives and condoms provided by stream in 2012



The CYPs for contraceptives and condoms procured in 2012 for countries in streams 1, 2 and 3 are presented in tables in the annex.

Trends in CYP – 2008 to 2012

Data for 2008 to 2012 indicate that contraceptives and condoms procured through GPRHCs for this period amounted to 86 million CYPs (Figure 41 and Table 43). IUDs were the highest contributor (38.3 per cent of the total CYPs). The other main contributors were injectable followed by implants, male condoms and oral pills. Female condoms contributed 0.3 per cent of the total CYPs for the entire period.

Figure 41: Total CYP for contraceptives and condoms provided for all countries, 2008 to 2012

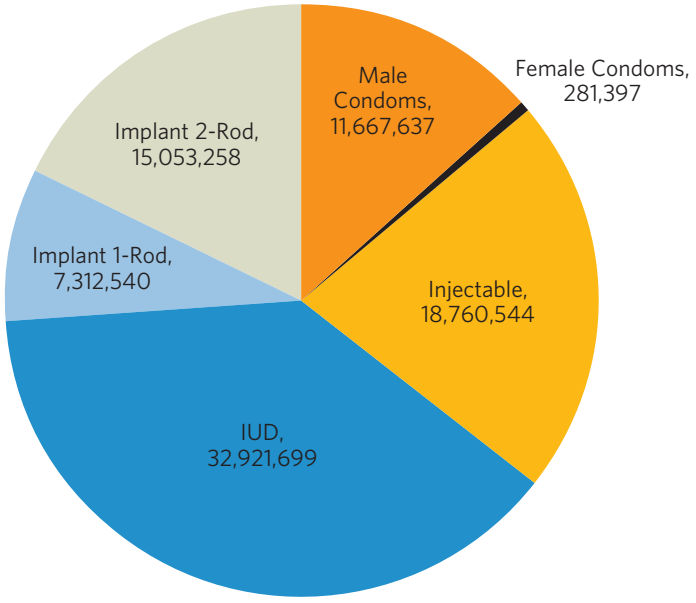
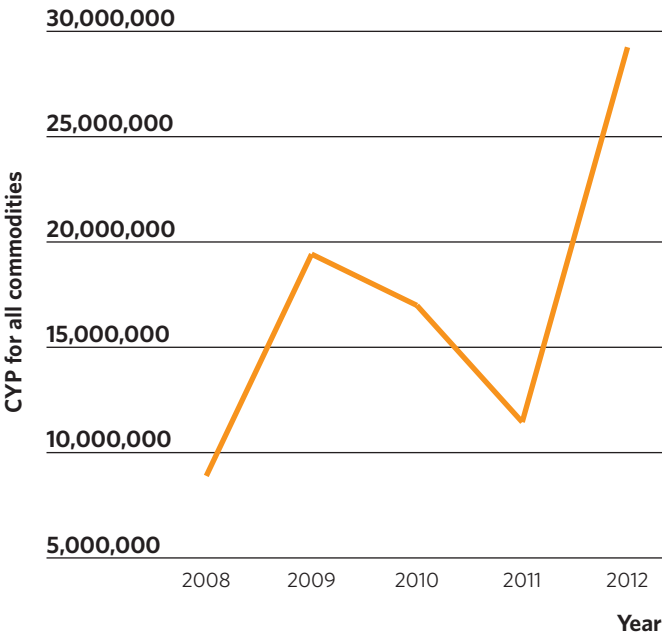


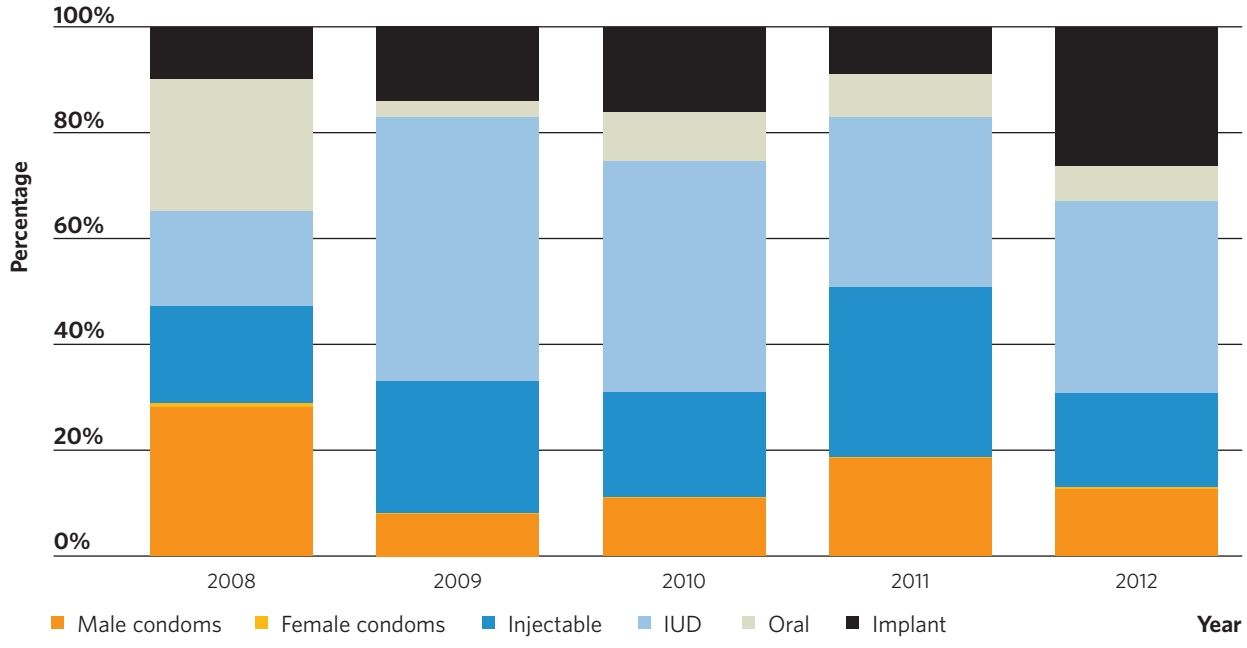
Figure 42: Trends in total CYP for contraceptives and condoms provided for all countries, 2008 to 2012



CYP for the contraceptives and condoms procured by the GPRHCS increased from 8.9 million in 2008 to 19.4 million in 2009 and declined to 11.45 million in 2011 (Figure 42). The amount of CYP provided to the GPRHCS countries increased to an all-time high of 29.2 CYP million in 2012. For each of the years 2008 to 2012, the IUD, injectables and male condoms were the main contributors of CYP (Figure 43). While the contribution of pills was high in 2008 it was subsequently reduced for the other years. CYP contributed by implants have continued to show a general increase since 2008.

The male condom dropped from the highest contributor of CYPs in 2008 to fourth place, after IUDs, implants and injectables in 2012 (Figure 43). IUD has remained the highest contributor of CYPs based on contraceptives and condoms procured by GPRHCS for the countries, with the exception of 2008. Procurement figures for female condoms indicated minimal CYP throughout the reporting period.

Figure 43: Percentage of distribution of CYP for the contraceptives and condoms provided for all countries, 2008 to 2012



7.3 Finance

UNFPA's flagship thematic fund, the Global Programme to Enhance Reproductive Health Commodity Security, received its highest level of financial support to date in 2012, allowing the programme to respond to the many requests for support received from countries. Every year, country requests for support far exceed the funds available, reflecting not only the vast need for essential supplies but also the close engagement of UNFPA as a trusted development partner for governments seeking to implement RHCS-related initiatives.

7.3.1 Amount available for 2012

GPRHCS funds available for 2012 totaled $329.9 million. This total included $55.9 million specifically assigned by a number of donors for procurement and capacity building for implants and female condoms. The $329.9 million was made up of: (a) $148.5 million **carried over from 2011**; and (b) $181.4 million of **contributions received in 2012**. The date by which the funds were received or on account had a significant impact on programming and fund allocation, with contributions later in the year carried over for use in the next year.

Carryover of funds

A breakdown of the $148.5 million carried over from 2011 to 2012 is shown in Table 43. Some $113.5 million (or 76.4 per cent of the carried over amount) was received from donors in the fourth quarter of 2011. Another $7.3 million (4.9 per cent) of the amount carried over were funds returned by countries because they could not implement planned activities. Other carried over funds included amounts deposited into the GPRHCS account during the second and third quarters, interests earned, and a $22 million buffer stock reserved to address emergency stock-outs issues (as necessary) and for planned global activities.

The GPRHCS makes every effort to ensure that allocated funds are used optimally. Fund programming is an involved, iterative process, carried out in close collaboration between UNFPA and the national authorities of the country receiving support. Typically, this process is largely completed by the end of the first quarter. For this reason, for optimal programming, funds ideally need to be on account in first quarter of the year. While some funds received in the second quarter can still be effectively programmed, most funds received in the third and fourth quarters must be carried over to the following year. Depending on when funds are received, the amount carried over can be large, as it was this year.

Table 44: Breakdown of amount carried over from 2011 to 2012

	Source of carry over	Amount in $	Percentage
Donor Resources by date received in 2011			
i)	DFID UK (October 2011)	19,623,233.91	13.22
ii)	DFID UK (November 2011)	55,910,543.13	37.65
iii)	Netherlands (December 2011)	3,847,973.00	2.591
iv)	Denmark (December 2011)	8,965,393.58	6.038
v)	European Commission (December 2011)	25,137,746.67	16.93
	Sub-total	**113,484,890.29**	**76.43**

	Source of carry over	Amount in $	Percentage
Donor Resources by date received in 2011			
Funds allocated from other UNFPA programme fund codes to GPRHCS fund code (ZZT05) at the end of 2012		4,800,000	3.233
Interest accrued by end 2011		900,000	0.606
Capacity development activities		7,300,000	4.916
Amount reserved to respond to possible emergency stock-outs (including CARhr interventions) and for global level activities in 2012		22,000,000	14.82
	Total amount carried over	**148,484,890.29**	**100.00**

Contributions received in 2012

The GPRHCS received $181.4 million from donors in 2012. Of this total, the programme received 17.7 per cent in the first quarter, 11.2 per cent in the second quarter and 10.8 per cent in the third quarter. The remaining 60.2 per cent of the 2012 contribution—a total of $109.4 million—was received in December 2012 and was used in 2013.

Table 45: Breakdown of amount received in 2012

Donor	Date received	Amount	Percentage
European Commission	January 2012	17,774,659.16	9.796
DFID UK	January 2012	7,716,049.38	4.253
European Commission	January 2012	6,583,622.24	3.628
Liechtenstein	January 2012	32,002.00	0.018
DFID UK	May 2012	20,325,203.25	11.2
	Sub-total for first half of 2012	**52,431,536.03**	**28.9**
DFID UK	August 2012	19,623,233.00	10.81
DFID UK	December 2012	59,550,562.71	32.82
European Commission	December 2012	10,240,259.74	5.644
Netherlands	December 2012	39,596,300.00	21.82
Private contributor	December 2012	3,607.00	0.002
	Sub-total for second half of 2012	**129,013,962.45**	**71.1**
TOTAL		**181,445,498.48**	**100**

7.3.2 Expenditure by the GPRHCS in 2012

Overall expenditure reached $129 million in 2012. Approximately $85 million was used to procure reproductive health commodities and $44 million to fund capacity development activities.

As in previous years, GPRHCS expenditures in 2012 focused on commodity provision and capacity development. Reproductive health commodities procured included contraceptives, including male and female condoms, life-saving maternal health medicines and other supplies and equipment. Funds for capacity building went towards meeting the needs of countries in areas such as human capacity building including training; institutional capacity building; national plans and policies; supply chain management; family planning demand creation, awareness raising and advocacy; support for reproductive health service delivery; surveys and documentation; partnerships; and programme management, supervision and monitoring.

7.3.3 Two special factors affected expenditure reporting for 2012

New IPSAS rules

UNFPA operationalized full compliance with the International Public Sector Accounting Standards (IPSAS) in 2012. Under IPSAS, transactions are recorded as **expenditures** only when the goods and services are delivered and receipts issued. In other words, resources are recorded as expended in IPSAS after receipts are issued, which is after the transaction is concluded. Therefore, some receipts will be issued in 2013. This major change in accounting procedures dramatically lowered the level of GPRHCS expenditure in 2012. Approximately $13 million in commodities procured in 2012 will be recorded as expenditures only when the goods are delivered in 2013. The expenditure figures in this report are in accordance with IPSAS and are, therefore, not strictly comparable with the figures from previous years.

At the beginning of the year, the GPRHCS programmed, allocated and committed for programme activities during the period January to April 2012 a total of $180.6 million (including $148.5 million carried over from 2011 and $32.1 million of new contributions received in January 2012).

Process of fulfillment

The level of reported 2012 expenditure was also lowered by delays in the procurement of Depo Provera, a three-month injectable contraceptive. Although requests for approximately 18 million vials worth some $14 million were received, the requests were only partially fulfilled due to a lack of supply on the part of the manufacturer. Funds committed by the GPRHCS for this purpose were therefore not utilized in 2012. Until the goods are delivered, these committed resources will not be recorded in IPSAS as expenditure. It is anticipated that delivery will take place during 2013. Currently, Pfizer is the only supplier of a quality-assured three-month injectable contraceptive and its low production capacity for Depo Provera is having a negative impact on meeting country demand for this product.

In addition, lengthy procurement processes also led to a number of GPRHCS transactions being recorded in 2013 rather than 2012, in compliance with IPSAS. When the GPRHCS receives funds in the first or second quarter, an order is placed through the UNFPA Procurement Branch, which then issues a purchase order. The lead time for most of the commodities is between 12 to 21 weeks, depending on the type of commodity. This lead time is counted from the dispatch date of the purchase order and can be longer depending on commodity type. More time may be required (for example, for specialized medical equipment) in cases that require extra steps such as the soliciting of bids as part of an International Competitive Bidding (ITB) process, followed by an internal review process. Additional steps include bid evaluation/opening, evaluation of the prices and specifications and payment terms, and a technical review meeting.

7.3.4 GPRHCS expenditure 2007-2012

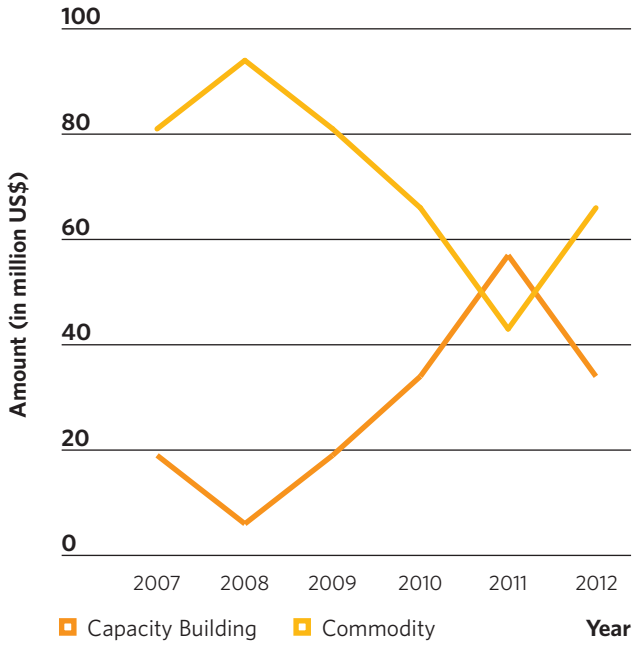
GPRHCS financial data from the period 2007-12 provides context for the 2012 expenditures. Total expenditure, shown in Table 45, was $17.8 million in 2007 which increased to $87.1 million in 2009 and reached $129 million in 2012.

Table 46: Amount and per cent expended per component and per year (US$)

Component	2007		2008		2009		2010		2011		2012		Total (2007 to 2012)	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Commodities	14,500,000	81.3	25,635,786	94.2	70,259,604	80.7	61,771,480	66.0	32,442,226	42.5	85,497,007	66.1	290,106,103	67.2
Capacity Building	3,333,000	18.7	1,591,088	5.8	16,830,201	19.3	31,780,105	34.0	43,818,543	57.5	43,938,371	33.9	141,291,308	32.8
Total	**17,833,000**	**100.0**	**27,226,874**	**100.0**	**87,089,805**	**100.0**	**93,551,585**	**100.0**	**76,260,769**	**100.0**	**129,435,378**	**100.0**	**431,397,411**	**100.0**

Table 45 shows that for the period 2007 to 2012, expenditure on commodities totaled $290 million (69.7 per cent of total expenditures for the period) and expenditure on capacity building totaled $141 million (accounting for 30.3 per cent of total expenditures for the period).

Figure 44: Percentage GPRHCS expenditure for commodities and capacity building, 2007 to 2012*



Expenditure on commodities increased slightly from 81 per cent in 2007 to 94 per cent in 2008 but declined steadily to reach an all-time low of 43 per cent in 2011 before increasing again to 66 per cent in 2012 (Figure 44). For capacity building, the reverse was the case (by definition), with related expenditures decreasing from 19 per cent in 2007 to 6 per cent in 2008 and increasing steadily to an all-time high of 57 per cent in 2011 before decreasing to 34 per cent in 2012. The increase in expenditures for commodities in 2012 was mainly due to the increased expenditures for the procurement of implants and female condoms, as dictated by the terms governing the use of additional funds provided to the GPRHCS by a number of donors.

Expenditures for capacity building interventions at the country level were highest in 2010 at 75.6 per cent (Table 46). Of total expenditures for 2009 to 2012, country-level interventions accounted for the highest expenditures (67.5 per cent), followed by support to the UNFPA pre-qualification programme for condoms and IUDs and for AccessRH (11.3 per cent) and

global level/headquarters (10.7 per cent). The Arab States and Eastern Europe Regional Offices accounted for the least expenditures for the period as less funds tend to be provided to these regional offices.

7.3.5 Trends in commodity provision and capacity development

Table 47: Breakdown of capacity building expenditure 2009 to 2012

Region or component	2009		2010		2011		2012		Total	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Africa Regional Offices	875,589	5.20	1,523,808	4.79	948,147	2.16	1,404,014	3.20	4,751,558	3.48
Arab States	99,593	0.59	104,651	0.33	421,032	0.96	91,095	0.21	716,371	0.53
Asia and Pacific	756,783	4.50	805,949	2.54	1,126,588	2.57	462,130	1.05	3,151,450	2.31
Eastern Europe	180,316	1.07	310,573	0.98	342,937	0.78	341,700	0.78	1,175,526	0.86
Latin America and the Caribbean	640,754	3.81	1,482,512	4.66	1,065,740	2.43	1,413,235	3.22	4,602,241	3.37
Country level	12,482,476	74.17	23,946,158	75.35	26,604,000	60.71	29,034,172	66.08	92,066,806	67.51
Global level	775,388	4.61	1,783,722	5.61	6,546,483	14.94	5,442,374	12.39	14,547,967	10.67
Pre-qualification and AccessRH	1,019,302	6.06	1,822,731	5.74	6,763,616	15.44	5,749,651	13.09	15,355,300	11.26
Total	16,830,201	100.00	31,780,104	100.00	43,818,543	100.00	43,938,371	100.00	136,367,219	100.00

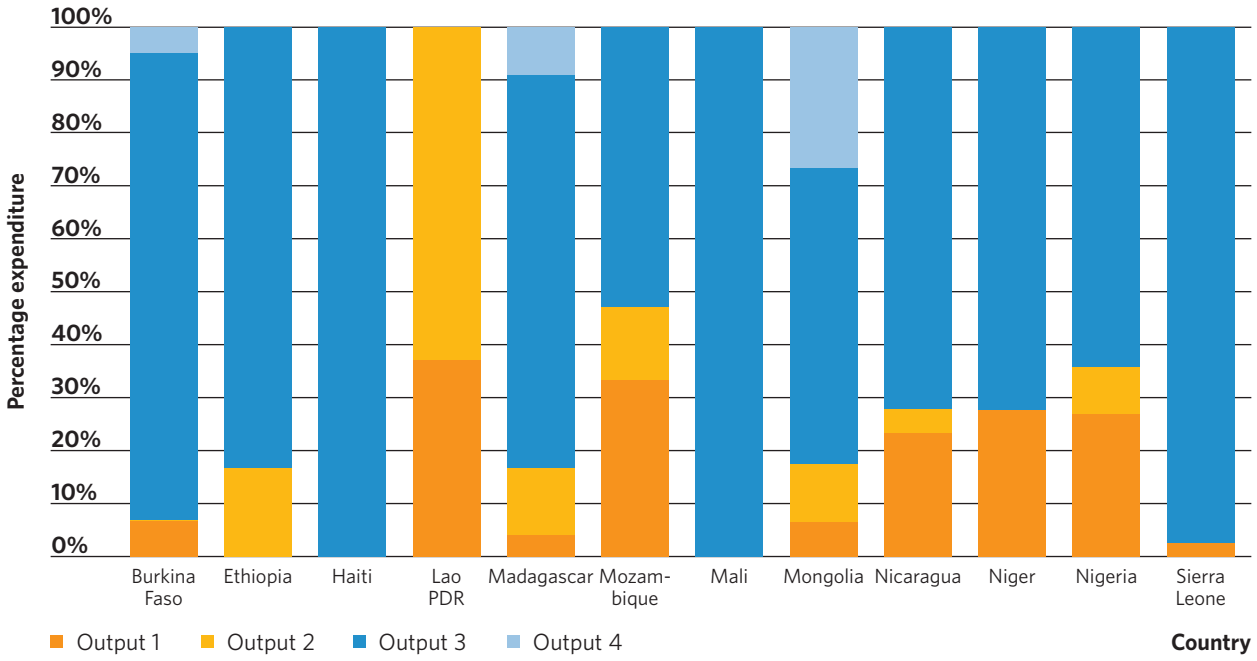
7.3.6 Linking resources to results

The GPRHCS has reported on country performance since 2009, based on the indicators and results in the Performance Monitoring Framework. With country work plans prepared with strict reference to the GPRHCS monitoring framework, it has become possible to report on the amount of resources spent by countries on each of the four output areas:

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

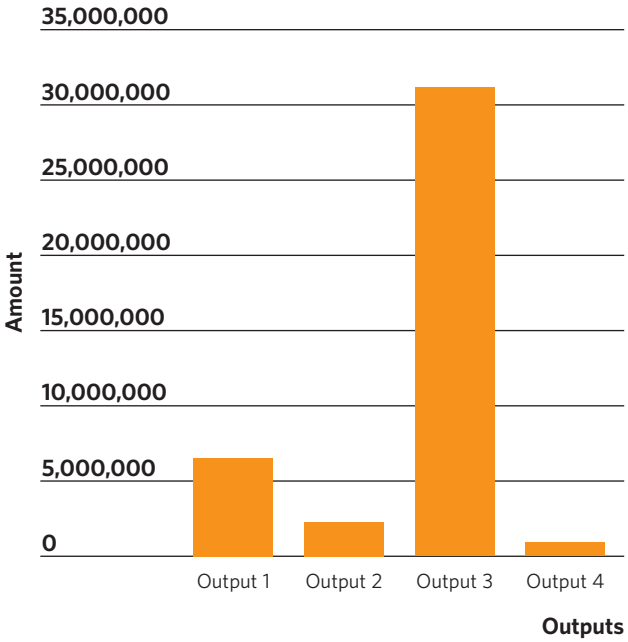
In almost all Stream 1 countries, most of the GPRHCS resources were invested in output 3 for capacity and systems strengthening (Figure 45). The exception was Lao PDR, where the interventions were largely focused on outputs 1 and 2. All GPRHCS support in 2012 was directed output 3 in Haiti and Mali. Close to 98 per cent of the resources were spent on output 3 in Sierra Leone. Investment in output 3 was higher in Mongolia than in any other country.

Figure 45: Percentage distribution of GPRHCS Stream 1 country expenditures per output for 2012



The amount allocated to each country, the breakdown of expenditures for each country by output, and the related implementation rates are reported in the Annex. The overall implementation rate was 82 per cent. The implementation rate was higher for GPRHCS Stream 1 and Stream 3 countries (89 per cent) followed by Stream 2 countries (87 per cent) and regional and global level interventions (71 per cent).

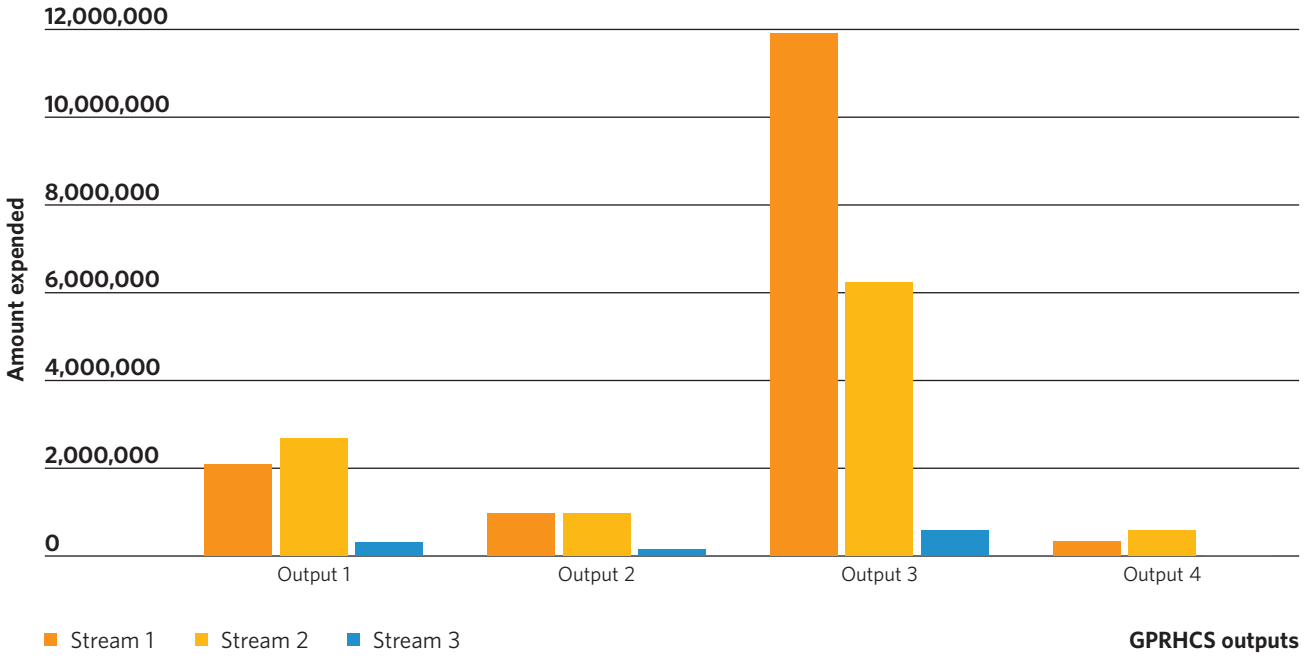
Figure 46: GPRHCS capacity building expenditures by output in 2012



Expenditure on output 3 (capacity and systems strengthened for RHCS) was higher across all the Streams than for the other outputs (Figure 46). The interventions supported included improving the skills of nationals in important logistics functions such as forecasting, procurement and LMIS. These elements, in combination, form the foundation of capacity building for sustainable country-driven systems for the distribution and management of reproductive health commodities.

In 2012, more funds were spent on output 3 (capacity and systems strengthened for RHCS) than on any other output across all three funding streams (Figure 47).

Figure 47: GPRHCS resources expended by output and by stream for 2012



7.3.7 The need for predictable and timely multi-year funding commitments

Resources were allocated through the GPRHCS to procure commodities and support capacity development in the 12 Stream 1 and 36 Stream 2 countries in 2012. In the future, multi-year funding commitments—and particularly receipt of funds during the first-quarter—would assist the GPRHCS in allocating funds for programme interventions in a predictable manner, reduce the carryover of funds to the following year and optimize the use of these precious resources.

CONCLUSION AND WAY FORWARD

Members of the 'School for Husbands' project in Niger hold a session on family planning. Credit: UNFPA Niger

The comprehensive nature of the strategic interventions supported by UNFPA through the Global Programme have been a point for reflection as we conclude not only 2012 but the first five years of implementation. The impact of **86 million couple years of protection** provided by contraceptives procured through the GPRHCS 2008-2012 is one highly important aspect of success on the supply side. But so much more happened on the way to the warehouse: success in expanding access to services, securing the financial and political commitment of all parties, enhancing the skills of service providers, improving the quality of services, increasing demand for family planning and sexual and reproductive health services and generally contributing to the development of stronger health systems in many countries where the programme provided valuable support to ensure rights to family planning are made real.

Through the GPRHCS, UNFPA has catalyzed action against a framework for results. Advocacy spurred the creation of policies, plans, programmes and contraceptive budget lines as part of new national commitments to RHCS. Support to improve logistics management information systems contributed to stronger national health systems. Capacity development though training and South-South knowledge exchange contributed to stronger supply systems as well as services – services for rights-based planning, maternal health and HIV prevention. Support to behaviour change communication and community-based distribution initiatives contributed to stronger demand and increasing use of modern methods of contraception.

Given the opportunity to continue this important work, what could be done differently or better? The past five years have been challenging but also rewarding. Along the way, many lessons were learned and in 2012 this learning was applied in the process of developing a new programme to begin in 2013. One clear lesson learned is that sustained, multi-year support yields measurable results. When significant investments in capacity development are combined with the large-scale provision of contraceptives and other RH supplies, results can be measured at the national level and even district levels— like increases in contraceptive prevalence rates and the associated health benefits. A major factor in success in any country was strong government support for RHCS, strong policy and programming in RH and maternal health, and a functional health systems at community level which, lacking, required construction of parallel systems.

The GPRHCS experience has shown that no single intervention will achieve RH commodity security; a combination of efforts yields results. Commodity provision and capacity development should also be combined with demand generation, reaching underserved communities, and other focus areas. Action from several different directions contributed to the common goal of RHCS, and in each there were lessons learned. In advocacy, for example, lessons included the importance of winning high-level support, sharing compelling stories and good practices, and using evidence to add impact. Experience affirmed the importance of considering social and cultural dimensions to ensure that clients' perspectives are included in programme planning, and to work with government and partners to go the extra mile, beyond the district level, to provide information, services and supplies in poor, rural, remote and indigenous communities.

Other complex challenges to achieving RHCS related to access and equity, adoption of a total market approach and demand generation at community level, high turnover in human resources after training, reversals of progress due to armed conflict or natural disaster, and differences in country situations that influence their RH priorities.

A more rigorous evaluation process and a more robust framework are two of the results of this process of reflection. The GPRHCS Performance Monitoring Framework not only tracked progress, it facilitated accountability for results and resources. A great deal of attention to detail was invested in the development of the new framework for the programme, with input from donors and partners. Continued use of tools like the software program CHANNEL and the CCM will also make the programme more effective and efficient. Likewise, annual surveys funded by the GPRHCS have generated important information for planning and advocacy.

The importance of coordination, cooperation and integration were demonstrated throughout implementation. In many ways, the next phase will focus on strengthening the capacity of regional and country offices to be effective partners and respond to the needs of countries in a timely manner. Greater emphasis will be placed on creating an enabling environment for non-governmental organizations and the private sector to provide services. There are plans for more efforts to work systematically with non-state partners in stepping up efforts, for example, to ensure whole market approaches, meeting the needs of marginalized and underserved populations such as rural populations and adolescents and youth.

The past five years have been challenging but rewarding, and the GPRHCS team at UNFPA is confident that through working together with countries, and further strengthening collaboration and partnership, the new programme will deliver. How it will deliver is most concisely described in terms of its goals, outputs and outcomes: the new Performance Monitoring Framework. The top-level goal is to contribute to universal access to reproductive health commodities and family planning services and information within the context of sexual and reproductive health and reproductive rights by 2020 for improved quality of life. Contributing to this goal will be one key outcome: Increased availability and utilization of RH commodities and family planning services and information in support of reproductive health intentions. A management output tracks improved financial commitment and programme management.

From its launch in mid-2007 to conclusion in 2012, this thematic fund offered a framework that proved catalytic for national action. Collaboration and partnership have helped to set the stage for enduring security in reproductive health commodities. The heart of this approach will continue, with provision to expand on success and make improvements. Strategic emphasis will be placed on capacity development to strengthen national health systems for RHCS and family planning, procurement to avoid dangerous shortages or stock-outs, and close collaboration with governments and other vital partners to strengthen sustainable systems. Working together, we are succeeding in expanding access to modern family planning and with it the promise of profound benefits to women, men, young people and their communities. The programme is a comprehensive contribution to the UNFPA mission of delivering a world where every pregnancy is wanted, every child birth is safe, and every young person's potential is fulfilled.

Annex 1: Contraceptives provided to Stream 1, 2 and 3 countries

Table 48: Contraceptives provided to Stream 1 countries in 2012

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency Oral (doses)	Implant	
					1-Rod (pieces)	2-Rod (pieces)
Burkina Faso	272,400	14,500	2,200,800		10,048	100,000
Ethiopia	6,720,000		1,023,840		455,680	70,000
Haiti	354,000	1,000	280,800			6,000
Lao PDR	605,400	8,000	2,057,760	3,600		
Madagascar	2,652,400	4,500	2,413,440	21,600	120,320	
Mali	307,200	5,000	2,972,880			69,700
Mongolia	120,000	30,000	352,800	10,800	5,120	5,000
Mozambique	768,000	7,500	2,724,480			15,000
Nicaragua	376,200	5,500	329,040			
Niger	200,000	10,000	309,600		3,008	
Nigeria	300,000	472,500			40,000	77,500
TOTAL	12,675,600	558,500	14,665,440	36,000	634,176	343,200

Table 49: Contraceptives provided to Stream 2 countries in 2012

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency Oral (doses)	Implant	
					1-Rod (pieces)	2-Rod (pieces)
Angola	150,000		20,160	10,800		5,000
Bolivia	500,000					7,000
Botswana	216,000					
Burundi			489,600	18,000		120,000
Caribbean	150,000	2,000	50,400			
Central African Republic	198,400	1,000	1,031,664			13,600
Chad	30,000	1,000				15,000
Congo DRC	544,000	24,000	2,720,880	45,000		40,000
Congo Republic					128	300
Côte d'Ivoire	400,000	10,000	864,000		6,400	5,000
Djibouti	50,000	500	72,000			
Eritrea			21,600			100
Gabon	5,000		50,400			100
Gambia						5,000
Ghana	525,600					28,000
Guinea	100,000	2,000	240,480			2,000
Guinea Bissau						10,000
Kazakhstan	1,000	10,000	44,688	5,400		
Kyrgyzstan	5,600	255,000	421,920			

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency Oral (doses)	Implant	
					1-Rod (pieces)	2-Rod (pieces)
Liberia						18,000
Malawi					15,040	15,000
Mauritania	13,400					
Namibia	2,000					
Papua New Guinea						5,000
Sao Tome	15,000		118,800			6,100
Senegal		9,000			5,056	30,000
Sudan	141,800	9,000	3,644,300		15,040	
Swaziland	225,500					
Tajikistan	41,500	140,000	407,520			
Timor Leste						2,000
Togo			27,000			22,500
Uganda					157,248	
Uzbekistan	375,000	800,000	840,960			
Yemen	100,000	20,000	876,960		8,000	
Zambia	137,500		1,310,400	12,600		25,000
Zimbabwe						112,500
TOTAL	**3,927,300**	**1,283,500**	**13,253,732**	**91,800**	**206,912**	**487,200**

Table 50: Contraceptives provided to Stream 3 countries in 2012

Countries	Injectable (vials)	IUD (pieces)	Oral (cycles)	Emergency Oral (doses)	Implant	
					1-Rod (pieces)	2-Rod (pieces)
Belize					3,008	
Cape Verde	20,000	1,000	210,960			10,000
Cuba						20,000
Dominican Republic					5,506	
Honduras					2,048	
IPPF					5,824	9,200
Iran						7,000
Kenya	3,500,000					
Kosovo		10,000	80,640	10,080		
Morocco					2,048	
MSI	710,000	460,000	1,222,560	277,200	103,040	201,600
Pakistan					10,048	
Panama					192	200
Peru	60,000	18,000			34,048	
Philippines					1,536	
PSI						160,300
Sri Lanka						72,800
Tanzania					38,016	
Tunisia					3,008	
Zanzibar					4,544	
TOTAL	**4,290,000**	**489,000**	**1,514,160**	**287,280**	**212,866**	**481,100**

Table 51: Condoms (male and female) provided to Stream 1 countries in 2012

Countries	Male Condom (pieces)	Female Condom (pieces)
Burkina Faso	15,004,800	
Ethiopia	24,019,200	
Haiti	27,633,600	
Madagascar	3,002,400	500,000
Mali	5,976,000	23,000
Mongolia	2,880,000	10,000
Mozambique	68,400,000	1,000,000
Nicaragua	1,605,600	
Nigeria	11,872,800	
TOTAL	**160,394,400**	**1,533,000**

Table 52: Condoms (male and female) provided to Stream 2 countries in 2012

Countries	Male Condom (pieces)	Female Condom (pieces)
Angola		5,000
Benin		40,000
Bolivia		30,000
Botswana	46,843,200	
Burundi	5,652,000	160,000
Caribbean	1,504,800	76,000
Central African Republic	3,002,400	400,000
Congo DRC	56,001,600	800,000
Congo Republic		150,000
Côte d'Ivoire	10,800,000	800,000
Djibouti	2,764,800	5,000
Ecuador		2,000
Gabon	4,017,600	50,000
Guinea	4,320,000	200,000
Kazakhstan	216,000	10,000
Kyrgyzstan	24,019,200	
Lesotho		200,000
Malawi		700,000
Namibia		300,000
Papua New Guinea		300,000
Sao Tome	1,677,600	9,000
Sudan	2,916,000	
Swaziland		161,000
Tajikistan	1,785,600	
Togo	2,001,600	
Turkmenistan		7,000
Uganda	64,800,000	
Uzbekistan	3,002,400	
Yemen	72,000	
Zambia	38,304,000	1,450,000
TOTAL	**273,700,800**	**5,855,000**

Table 53: Condoms (male and female) provided to Stream 3 countries in 2012

Countries	Male Condom (pieces)	Female Condom (pieces)
Albania	576,000	
Argentina		50,000
Armenia	504,000	
Cape Verde	2,800,800	32,000
Colombia		634,000
Comoros		12,000
Costa Rica		40,000
Cuba		50,000
Dominican Republic		25,000
Guatemala		20,000
Iran	288,000	
Kosovo	1,000,800	
Mauritius		60,000
MSI	460,800	350,000
Pakistan		10,000
Paraguay		10,000
Peru		140,000
Philippines		100,000
Serbia		10,000
Seychelles		4,000
South Africa		5,000,000
Thailand		200,000
Uruguay		315,000
TOTAL	**5,630,400**	**7,062,000**

Table 54: CYP from Contraceptives provided to Stream 1 countries in 2012

Countries	Injectable CYP	IUD CYP	Oral CYP	Implant		Total Contraceptive CYP
				1-Rod CYP	2-Rod CYP	
Burkina Faso	68,100	48,333	146,720	33,493	500,000	796,647
Ethiopia	1,680,000		68,256	1,518,933	350,000	3,617,189
Haiti	88,500	3,333	18,720		30,000	140,553
Lao PDR	151,350	26,667	137,184			315,201
Madagascar	663,100	15,000	160,896	401,067		1,240,063
Mali	76,800	16,667	198,192		348,500	640,159
Mongolia	30,000	100,000	23,520	17,067	25,000	195,587
Mozambique	192,000	25,000	181,632		75,000	473,632
Nicaragua	94,050	18,333	21,936			134,319
Niger	50,000	33,333	20,640	10,027		114,000
Nigeria	75,000	1,575,000		133,333	387,500	2,170,833
TOTAL	**3,168,900**	**1,861,667**	**977,696**	**2,113,920**	**1,716,000**	**9,838,183**

Table 55: CYP from Contraceptives provided to Stream 2 countries in 2012

Countries	Injectable CYP	IUD CYP	Oral CYP	Implant		Total Contraceptive CYP
				1-Rod CYP	2-Rod CYP	
Angola	37,500		1,344		25,000	63,844
Bolivia	125,000				35,000	160,000
Botswana	54,000					54,000
Burundi			32,640		600,000	632,640
Caribbean	37,500	6,667	3,360			47,527
Central African Republic	49,600	3,333	68,778		68,000	189,711
Chad	7,500	3,333			75,000	85,833
Congo DRC	136,000	80,000	181,392		200,000	597,392
Congo Republic				427	1,500	1,927
Côte d'Ivoire	100,000	33,333	57,600	21,333	25,000	237,267
Djibouti	12,500	1,667	4,800			18,967
Eritrea			1,440		500	1,940
Gabon	1,250		3,360		500	5,110
Gambia					25,000	25,000
Ghana	131,400				140,000	271,400
Guinea	25,000	6,667	16,032		10,000	57,699
Guinea Bissau					50,000	50,000
Kazakhstan	250	33,333	2,979			36,563

Countries	Injectable CYP	IUD CYP	Oral CYP	Implant		Total Contraceptive CYP
				1-Rod CYP	2-Rod CYP	
Kyrgyzstan	1,400	850,000	28,128			879,528
Liberia					90,000	90,000
Malawi				50,133	75,000	125,133
Mauritania	3,350					3,350
Namibia	500					500
Papua New Guinea					25,000	25,000
Sao Tome	3,750		7,920		30,500	42,170
Senegal		30,000		16,853	150,000	196,853
Sudan	35,450	30,000	242,953	50,133		358,537
Swaziland	56,375					56,375
Tajikistan	10,375	466,667	27,168			504,210
Timor Leste					10,000	10,000
Togo			1,800		112,500	114,300
Uganda				524,160		524,160
Uzbekistan	93,750	2,666,667	56,064			2,816,481
Yemen	25,000	66,667	58,464	26,667		176,797
Zambia	34,375		87,360		125,000	246,735
Zimbabwe					562,500	562,500
TOTAL	**981,825**	**4,278,333**	**883,582**	**689,707**	**2,436,000**	**9,269,447**

Table 56: CYP from Contraceptives provided to Stream 3 countries in 2012

Countries	Injectable CYP	IUD CYP	Oral CYP	Implant		Total Contraceptive CYP
				1-Rod CYP	2-Rod CYP	
Belize				10,027		10,027
Cape Verde	5,000	3,333	14,064		50,000	72,397
Cuba					100,000	100,000
Dominican Republic				18,353		18,353
Honduras				6,827		6,827
IPPF				19,413	46,000	65,413
Iran					35,000	35,000
Kenya	875,000					875,000
Kosovo		33,333	5,376			38,709
Morocco				6,827		6,827
MSI	177,500	1,533,333	81,504	343,467	1,008,000	3,143,804
Pakistan				33,493		33,493
Panama				640	1,000	1,640
Peru	15,000	60,000		113,493		188,493
Philippines				5,120		5,120
PSI					801,500	801,500
Sri Lanka					364,000	364,000
Tanzania				126,720		126,720
Tunisia				10,027		10,027
Zanzibar				15,147		15,147
TOTAL	**1,072,500**	**1,630,000**	**100,944**	**709,553**	**2,405,500**	**5,918,497**

Table 57: CYP from male and female condoms provided to Stream 1 countries in 2012

Countries	Male Condom CYP	Female Condom CYP	Total Condom CYP
Burkina Faso	125,040		125,040
Ethiopia	200,160		200,160
Haiti	230,280		230,280
Madagascar	25,020	4,167	29,187
Mali	49,800	192	49,992
Mongolia	24,000	83	24,083
Mozambique	570,000	8,333	578,333
Nicaragua	13,380		13,380
Nigeria	98,940		98,940
TOTAL	1,336,620	12,775	1,349,395

Table 58: CYP from male and female condoms provided to Stream 2 countries in 2012

Countries	Male Condom CYP	Female Condom CYP	Total Condom CYP
Angola		42	42
Benin		333	333
Bolivia		250	250
Botswana	390,360		390,360
Burundi	47,100	1,333	48,433
Caribbean	12,540	633	13,173
Central African Republic	25,020	3,333	28,353
Congo DRC	466,680	6,667	473,347
Congo Republic		1,250	1,250
Côte d'Ivoire	90,000	6,667	96,667
Djibouti	23,040	42	23,082
Ecuador		17	17
Gabon	33,480	417	33,897
Guinea	36,000	1,667	37,667
Kazakhstan	1,800	83	1,883
Kyrgyzstan	200,160		200,160
Lesotho		1,667	1,667
Malawi		5,833	5,833
Namibia		2,500	2,500
Papua New Guinea		2,500	2,500
Sao Tome	13,980	75	14,055
Sudan	24,300		24,300
Swaziland		1,342	1,342
Tajikistan	14,880		14,880
Togo	16,680		16,680
Turkmenistan		58	58
Uganda	540,000		540,000
Uzbekistan	25,020		25,020
Yemen	600		600
Zambia	319,200	12,083	331,283
TOTAL	**2,280,840**	**48,792**	**2,329,632**

Table 59: CYP from male and female condoms provided to Stream 3 countries in 2012

Countries	Male Condom CYP	Female Condom CYP	Total Condom CYP
Albania	4,800		4,800
Argentina		417	417
Armenia	4,200		4,200
Cape Verde	23,340	267	23,607
Colombia		5,283	5,283
Comoros		100	100
Costa Rica		333	333
Cuba		417	417
Dominican Republic		208	208
Guatemala		167	167
Iran	2,400		2,400
Kosovo	8,340		8,340
Mauritius		500	500
MSI	3,840	2,917	6,757
Pakistan		83	83
Paraguay		83	83
Peru		1,167	1,167
Philippines		833	833
Serbia		83	83
Seychelles		33	33
South Africa		41,667	41,667
Thailand		1,667	1,667
Uruguay		2,625	2,625
TOTAL	**46,920**	**58,850**	**105,770**

Table 60: trends and composition of CYP provided to all countries for condoms and contraceptives, 2008 to 2012

Year	Commodity						Total
	Male condoms	Female condoms	injectable	IUD	Oral	Implant	
2008	2,503,300	59,312	1,637,778	1,586,663	2,233,333	872,727	8,893,113
2009	1,541,776	20,481	4,855,778	9,666,667	613,333	2,724,242	19,422,277
2010	1,846,881	51,662	3,369,353	7,391,747	1,575,869	2,752,027	16,987,539
2011	2,111,300	29,525	3,674,410	3,681,167	927,783	1,025,146	11,449,331
2012	3,664,380	120,417	5,223,225	10,595,455	1,962,222	7,679,116	29,244,815
Total	**11,667,637**	**281,397**	**18,760,544**	**32,921,699**	**7,312,540**	**15,053,258**	**85,997,075**

Table 61: Breakdown of amount allocated, amounts expended by outputs and implementation rate for 2012

Countries	Allocation and disbursement	Output 1. Country RHCS strategic plans developed, co-ordinated and implemented by government with their partners	Output 2: Political and financial commitment for RHCS enhanced	Output 3: Capacity and systems strengthened for RHCS	Output 4: RHCS mainstreamed into UNFPA core business (UN reform environment)	Indirect cost/ Programme management	Total expenditure	Implementation rate
STREAM 1 COUNTRIES								
Burkina Faso	3,441,355	213,115	5,723	2,775,186	153,438	223,454	3,370,916	98%
Ethiopia	1,246,550	-	156,428	776,061	-	64,027	996,516	80%
Haiti	475,566	-	-	406,768	-	28,455	435,223	92%
Lao PDR	432,717	128,242	217,176	-	-	24,182	369,600	85%
Madagascar	1,730,190	48,701	150,836	891,428	107,609	112,011	1,310,586	76%
Mozambique	1,622,210	468,519	195,669	744,351	-	95,333	1,503,872	93%
Mali	395,227	-	-	37,638	-	9,210	46,848	12%
Mongolia	317,255	14,544	24,758	125,738	59,832	8,660	233,532	74%
Nicaragua	922,185	192,495	36,813	593,527	-	57,158	879,993	95%
Niger	1,860,102	407,263	-	1,061,518	-	102,496	1,571,276	84%
Nigeria	2,362,000	525,912	176,077	1,256,779	-	137,083	2,095,851	89%
Sierra Leone	3,535,140	86,175	-	3,233,478	-	223,594	3,543,247	100%
Sub-total Stream 1	**18,340,497**	**2,084,965**	**963,480**	**11,902,472**	**320,879**	**1,085,662**	**16,357,458**	**89%**

Countries	Allocation and disbursement	Output 1. Country RHCS strategic plans developed, co-ordinated and implemented by government with their partners	Output 2: Political and financial commitment for RHCS enhanced	Output 3: Capacity and systems strengthened for RHCS	Output 4: RHCS mainstreamed into UNFPA core business (UN reform environment)	Indirect cost/ Programme management	Total expenditure	Implementation rate
STREAM 2 COUNTRIES								
Angola	171,104	-	-	114,779	-	8,035	122,814	72%
Benin	530,548	(4,721)	-	212,076	69,522	19,098	295,974	56%
Bolivia	723,842	354,235	28,894	216,316	-	41,971	641,417	89%
Botswana - Gaborone	235,448	121,961	83,873	(29,378)	-	14,411	190,867	81%
Burundi - Bujumbura	435,276	-	-	99,045	307,860	27,171	434,076	100%
Central African Republic	149,701	38,025	4,857	27,596	-	9,589	80,067	53%
Chad	383,462	85,518	102,444	83,345	-	19,271	290,578	76%
Congo - Brazzaville	291,941	114,960	2,933	91,182	-	14,963	224,038	77%
Congo D. R. - Kinshasa	1,070,000	169,572	222,980	582,874	-	70,470	1,045,896	98%
Cote d'Ivoire	816,027	450,283	-	174,125	-	43,519	667,927	82%
Djibouti	74,900	7,322	-	400		541	8,263	11%
Ecuador	713,183	612,329	-	0	-	42,863	655,192	92%
Eritrea - Asmara	17,409	-	-	8,420	-	-	8,420	48%
Jamaica - Carribean	412,870	-	-	-	-	356,849	356,849	86%
Gabon	376,218	192,666	-	155,938	-	24,402	373,007	99%
Gambia	930,900	-	-	828,669	-	65,163	893,832	96%

Countries	Allocation and disbursement	Output 1. Country RHCS strategic plans developed, co-ordinated and implemented by government with their partners	Output 2: Political and financial commitment for RHCS enhanced	Output 3: Capacity and systems strengthened for RHCS	Output 4: RHCS mainstreamed into UNFPA core business (UN reform environment)	Indirect cost/ Programme management	Total expenditure	Implementation rate
Ghana	154,023	-	11,691	127,737	-	9,440	148,868	97%
Guinea Conakry	572,450	115,885	50,372	352,673	-	36,229	555,159	97%
Guinea Bissau	85,600	-	-	62,989	-	4,409	67,398	79%
Lesotho - Maseru	239,329	-	-	214,381	-	14,625	229,006	96%
Liberia	270,845	86,390	-	149,326	-	-	235,716	87%
Malawi - Lilongwe	186,851	30,506	-	123,370	-	5,977	159,853	86%
Mauritania	108,650	-	-	32,084	23,378	3,882	59,345	55%
Namibia - Windhoek	196,880	1,125	38,064	155,714		10,789	205,691	104%
Sao Tome & Principe	80,250	-	-	72,919	-	5,104	78,024	97%
Senegal - Dakar	1,114,907	-	251,663	657,773	-	-	909,436	82%
Sudan - Juba	133,533	15,332	-	85,409	-	338	101,079	76%
Sudan - Khartoum	405,420	26,265	76,569	223,072	41,763	22,623	390,292	96%
Swaziland - Mbabane	401,271	94,155	337	256,918	-	12,751	364,161	91%
Timor Leste	106,364	41,047	-	51,379	-	6,470	98,896	93%
Togo	1,018,930	2,038	-	703,984	142,601	63,081	911,704	89%
Uganda - Kampala	214,534	-	27,833	140,331	-	11,399	179,563	84%
Zambia - Lusaka	272,987	16,733	-	215,455	-	16,253	248,441	91%

Countries	Allocation and disbursement	Output 1. Country RHCS strategic plans developed, co-ordinated and implemented by government with their partners	Output 2: Political and financial commitment for RHCS enhanced	Output 3: Capacity and systems strengthened for RHCS	Output 4: RHCS mainstreamed into UNFPA core business (UN reform environment)	Indirect cost/ Programme management	Total expenditure	Implementation rate
Zimbabwe - Harare	348,781	106,426	61,908	137,294	-	20,881	326,510	94%
Sub-total Stream 2	13,244,432	2,678,051	964,418	6,328,196	585,124	1,002,569	11,558,357	87%
OTHERS								
Brazil	32,100	-	-	29,072	-	2,035	31,107	97%
Comoros - Moroni	100,000	40,504	-	42,115	-	8,541	91,161	91%
El Salvador	207,290	146,683	-		-	10,268	156,951	76%
Equatorial Guinea	38,520	-	-	33,131	-	551	33,681	87%
Panama	160,500	-	-	141,988	-	9,939	151,927	95%
Peru	161,945	-	151,238	-	-	10,737	161,974	100%
South Africa - Pretoria	199,700	-	-	128,619	-	4,491	133,110	67%
Uruguay	139,100	118,359	-	-	18,864	2,090	139,313	100%
Uzbekistan	44,940	-	-	41,825	-	2,928	44,753	100%
Turkmenistan	74,633	-	-	68,037	-	4,763	72,799	98%
Tajikistan	53,500	-	-	49,935	-	3,495	53,431	100%
Kyrgyzstan	48,150	-	-	44,998	-	3,150	48,148	100%
Sub-total Stream 3	**1,260,378**	**305,546**	**151,238**	**579,721**	**18,864**	**62,987**	**1,118,356**	**89%**

Countries	Allocation and disbursement	Output 1. Country RHCS strategic plans developed, co-ordinated and implemented by government with their partners	Output 2: Political and financial commitment for RHCS enhanced	Output 3: Capacity and systems strengthened for RHCS	Output 4: RHCS mainstreamed into UNFPA core business (UN reform environment)	Indirect cost/ Programme management	Total expenditure	Implementation rate
OTHERS								
Sub-Regional Office - Johannesburg	1,548,174		75,451	1,311,198		17,365	1,404,014	91%
Fiji, Suva	436,668	-	-	431,088	-	31,041	462,130	106%
LACRO	1,439,093	1,261,738	60,598		-	90,900	1,413,235	98%
ASRO	137,617	-	-	89,263	-	1,832	91,095	66%
Pre-qualification & Access RH	9,040,938	-	-	5,373,506	-	376,145	5,749,651	64%
EECARO	352,851	185,411	63,000	70,935	-	22,354	341,700	97%
Global Level	8,000,000	-	-	5,061,407	-	380,967	5,442,374	68%
Sub-total Others	20,955,341	1,447,149	199,049	12,337,397	-	920,604	14,904,199	71%
TOTAL	**53,800,647**	**6,515,712**	**2,278,184**	**31,147,785**	**924,867**	**3,071,822**	**43,938,371**	**82%**

Table 62: 2012 Summary Updates for the UNFPA Global Programme to Enhance Reproductive Health Commodity Security

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
Goal[1]: Universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2011 for improved quality of life							
Adolescent birth rate	52.6 per 1000 girls aged 15-19[2] (2005)	Not applicable	Not applicable	Not applicable	**Not applicable**	MDG Target 5.B: Achieve by 2015, universal access to reproductive health	DHS, World Population Prospects: the 2006 Revision, UN Population Division, Programme Division Database
Maternal mortality ratio	400 per 100,000 live births[2] (2005)	Not applicable	Not applicable	Not applicable	**Not applicable**	MDG Target 5.A: Reduce by three quarters, between 1990 and 2015	DHS, WHO, MICS, World Mortality 2007, UN Population Division
Youth HIV prevalence rate	0.6% female; 0.4% male[2] (2007)	Not applicable	Not applicable	Not applicable	**Not applicable**	MDG Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/ AIDS	DHS, UNAIDS/ 2008 Report on the Global AIDS Epidemic
Outcome[3]: Increased availability, access and utilisation of RHCs[4] for voluntary family planning, HIV/STI prevention and maternal health services in the GPRHCS focus countries							
1. Average unmet need for family planning (45 countries)	23.8%[5]		Not applicable	Not applicable	**Not applicable**	15%	DHS, UN Population Division and UNFPA Programme Division & PRB databases
2. Average contraceptive prevalence rate of modern methods (45 countries)	15.6%[5]		Not applicable	Not applicable	**Not applicable**	22.5%	DHS, UNFPA Programme Division & PRB databases

*The Goal and some outcome indicators are MDG and UNFPA DRF related. For these measurement of progress is attributable to concerted efforts made by all partners, including the wider UNFPA. Therefore indication of progress under the GPRHCS is Not Applicable. Data is provided on progress for the Output Indicators for which the GPRHCS is directly accountable.

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

2 UNFPA Strategic Plan and DRF 2008-13

3 In line with UNFPA strategic plan, UNFPA is not responsible for, but contributes to, the achievements of outcomes

4 Modern contraceptive methods, essential life-saving maternal/RH medicines and related equipment

5 Based on data for 45 GPRHCS countries drawn from PRB data sheet, weighted average

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
3. Number of Stream 1 countries with Service Delivery Points (SDPs) offering at least three modern methods of contraceptives	3/9	5/11	10/11 In 2010 GPRHCS instituted the conduct of a survey in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines. The results for 2010 are therefore not to be directly compared to previous years when countries had adopted different methodologies for providing the information Also, the definition used in 2010 was more stringent than in the past (75% is needed for "Yes")	11/12 Results from 2011 GPRHCS Surveys conducted in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines. As per the indicator definition which was finalized and applied in 2010, 75% is needed for "Yes"	**12/12** **Results from 2011 GPRHCS Surveys conducted in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines.** **As per the indicator definition which was finalized and applied in 2010, 75% is needed for "Yes"**	13/15	Country surveys and national information systems, COAR
4. Number of Stream 1 countries where 5 life-saving maternal / RH medicines from UNFPA list[6] is available in all facilities providing delivery services (This indicator was applicable up to 2012) Number of Stream 1 countries where 7 life-saving maternal/RH medicines (Magnesium Sulphate and Oxytocin plus any other five) from the WHO list[7] is available in all facilities providing delivery services (This indicator was adopted for 2012 reporting)	3/9	5/11	1/11 In 2010 GPRHCS instituted the conduct of a survey in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines. The results for 2010 are therefore not to be directly compared to previous years when countries had adopted different methodologies for providing the information Also, the definition used in 2010 was more stringent than in the past (100% is needed for "Yes")	1/12 Results from 2011 GPRHCS Surveys conducted in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines. As per the indicator definition which was finalized and applied in 2010, 100% is needed for "Yes"	**With the publication of the 2012 WHO list of medicines, this indicator was redefined as indicated below. The results are therefore not comparable to previous years** **0/12** **Results from 2012 GPRHCS Surveys conducted in all Stream 1 As per the indicator definition which was finalized and applied in 2012, 100% is needed for "Yes"**	13/15	RHCS Survey, EmOC survey, other special surveys, COAR

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

7 According to the WHO Priority life-saving medicines, for women and children, 2012; the priority medicines are: i) Oxytocin, ii) Misoprostol, iii) Sodium chloride, iv) Sodium lactate compound solution, v) Magnesium sulphate, vi) Calcium gluconate, vii) Hydralazine, viii) Methyldopa, ix) Ampicillin, x) Gentamicin, xi) Metronidazole, xii) Mifepristone, xiii) Azithromycin, xiv) Cefixime, xv) Benzathine Benzylpenicillin, xvi) Nifedipine, xvii) Dexamethasone, xviii) Betamethasone, and ixx) Tetanus toxoid. The list can be accessed at http://www.who.int/reproductivehealth/publications/general/emp_mar2012.1/en/index.html Please note that for this survey a) Sodium chloride and Sodium lactate compound solution are alternates; and that b) Dexamethasone is an alternate to Betamethasone

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
5. Number of Stream 1 countries with Service Delivery Points with 'no stock-outs' of contraceptives within last 6 months[8]	3/9	6/11	6/11 In 2010 GPRHCS instituted the conduct of a survey in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines. The results for 2010 are therefore not to be directly compared to previous years when countries had adopted different methodologies for providing the information Also the indicator definition which was finalized and applied in 2010 was more stringent than previous years (60% is needed for "Yes")	6/12 Results from 2011 GPRHCS Surveys conducted in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines. As per the indicator definition which was finalized and applied in 2010, 60% is needed for "Yes"	**8/12** **Results from 2012 GPRHCS Surveys conducted in all Stream 1 countries for 3 Outcome indicators, according to a more robust standardized methodology and guidelines.** **As per the indicator definition which was finalized and applied in 2010, 60% is needed for "Yes"**	13/15	Country reports, RHCS Survey, other special surveys, COAR
6. Funding available globally for contraceptives / condoms	$214m	$238.8m	235.6m	323.3m[9]	**288.16 m**[10]	$303 m[11]	RH Interchange; donor support database
Output 1: Country RHCS strategic plans developed, coordinated and implemented by government with their partners							
1. Number of countries where RHCS strategy is integrated with national RH/SRH, HIV/AIDS, Gender, & Reproductive Rights strategies (45 countries)	12	18	20 RHCS in all three sectoral strategies (RH only = 37; HIV/AIDS only = 33; Gender only = 21)	31 RHCS in all three sectoral strategies (RH only = 46; HIV/ AIDS only = 42; Gender only = 31)	**37 RHCS in all three sectoral strategies (RH only = 46; HIV/AIDS only = 42; Gender only = 37)**	34[12]	

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

9 Includes data on two additional donors in 2011 - DKT International (53.1m) and The Global Fund to fight AIDS, Tuberculosis and Malaria (11.5m)

10 2012 data available for DFID, Global Fund, IPPF, MSI, PSI, UNFPA and USAID but not for DKT and KFW

11 RH Supplies Coalition (RHSC) projected figure for 2012

12 34 of 45countries represent approximately 75 percent of target countries.

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
2. Number of countries with strategy implemented (National strategy/action plan for RHCS implemented) (45 countries)	5	6	34	41	**43**	34	COAR, programme progress reports, Programme Division Database
3. Number of countries with functional co-ordination mechanism on RHCS or RHCS is included in broader coordination mechanism (45 countries)	20	32	28 functioning as per Criteria (exists in 35 countries)	43 functioning as per Criteria (exists in 46 countries)	**45/46 Functioning as per Criteria (exists in 46 countries)**	34	
4. Number of countries with essential RH commodities in EML (Contraceptives and life saving maternal/RH medicines in EML) (45 countries)	25	36	31 with all contraceptives and maternal/RH medicines included (37 with selected inclusions as per national protocols)	41 with both contraceptives and maternal/RH medicines included (41 with contraceptives only; and, 44 with RH Medicines only)	**42 with both contraceptives and maternal/RH medicines included** **42 contains only contraceptives and 46 contains MH medicines**	45	
Output 2: Political and financial commitment for RHCS enhanced							
1. Funding mobilised for GPRHCS on a reliable basis (e.g. multi-year pledges)	$57.4m (2008)	$73.8m	$100.5m	$144.9m	**$118.4m**	$150m annually	UNFPA Resource Mobilisation Branch data
2. UNFPA signed MOUs with Stream 1 country governments	0	4	11/11	12/12	**12/12**	15	GPRHCS Annual Report and signed MOUs

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
3. RHCS mainstreamed in regional policies and strategies through UNFPA work with global, bilateral and regional organizations/ partners (Regional Economic Communities)	RHCS in 2 regional strategies and others (e.g. Asian Forum for Parliamentarians for Population Development (AFPPD) , other similar Regional Forums)	2	4 [i) West African Health Organisation (WAHO); ii) East African Community (EAC); iii) Intergovernmental Authority on Development (IGAD); iv) Southern African Development Community Parliament (SADC/ PF)]	2 [i) East African Community (EAC); ii) Inter-governmental Authority on Development (IGAD)	**4** **[i) West African Health Organisation (WAHO); ii) East African Community (EAC); iii) Intergovernmental Authority on Development (IGAD); iv) Southern African Development Community Parliament (SADC/PF)]**	6	GPRHCS Annual Report, REC policy and strategy RECs/Fora reports, websites, plans
4. Number of countries with RHCS priorities included in (45 countries) a) PRS b) Health sector policy and plan	 13 25	 13 30	 35 38	 46 46	 **46** **46**	 22[13] 45	COAR, country documents, Programme Division Data
5. Number of countries maintaining allocation within SRH/RHCs budget line for contraceptives (45 countries)	18	23	22 with amount allocated either increased or remaining the same (Budget line exists in 27 countries)	28 with amount allocated either increased or remaining the same (Budget line exists in 31 countries)	**27 with amount allocated either increased or remaining the same** **(Budget line exists in 36 countries)**	34	COAR, country documents, MTEFs, Programme Division
Output 3: Capacity and systems strengthened for RHCS							
1. Number of countries using AccessRH[14] for procurement of RHCs resulting 20% reduction in lead time (45 countries)	0/2009		Not applicable	39 countries (71% of the 55 countries to which shipments were dispatched in 2011)	**35 countries (44% of the 79 countries to which shipments were dispatched in 2012)**	22	UNFPA PSB data, RHInterchange

13 22 of 45 countries represent approximately 50%

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

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
2. Number of pre-qualified suppliers of IUDs and condoms for use by UNFPA and partners	22 condom suppliers, 8 IUD factories[15]	22	31 (23 for condoms and 8 for IUD)	34 (26 for condoms and 8 for IUD)	**34 (26 for condoms and 8 for IUD)**	26 condoms 8 IUD factories	UNFPA/WHO data
3. Number of Stream 1 Countries making 'no ad hoc requests' to UNFPA for commodities (non-humanitarian)	3 of 5	5/11	8/11	8/12	**3/12 (in 2012 countries were encouraged to make additional requests for contraceptives especially implants**	13 of 15	Annual Country Report, National LMIS Reports
4. Number of Stream 1 Countries forecasting for RHCs using national technical expertise	2 of 5	7 of 11	8/11	10/12	**10/12**	12 of 15	Annual Country Report, National LMIS Reports
5. Number of Stream 1 Countries managing procurement process with national technical expertise	2 of 5	6 of 11	9/11	10/12	**9/12**	10 of 15	Annual Country Report, National LMIS Reports
6. Number of Stream 1 Countries with functioning Logistics Management Information System (LMIS)	3 of 5	7 of 11	8/11	12/12	**12/12**	12 of 15	Annual Country Report, National LMIS Reports

15 Eight (8) is the total number of IUD factories globally.

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
7. Number of Stream 1 Countries with co-ordinated approach towards integrated health supplies management system	0 of 5	10 of 11	6/11 The indicator definition which was finalized and applied in 2010 was more stringent than previous years. For 2010, a country is judged as having satisfied the conditions for this indicator if it had (a) a unified mechanism for managing all health supply systems; (b) the system takes into account the procurement of RHCs (modern contraceptives and priority medicines); and, (c) the system takes into account the distribution of RHCs (modern contraceptives and the priority medicines)	9/12	**10/12**	13 of 15	Annual Country Report, National LMIS Reports
8. Number of Stream 1 countries adopting/adapting a Health Supply Chain Management information tool (e.g. CHANNEL, PIPELINE) into national system	3 of 5	8 of 11	11/11	12/12	**12/12**	12 of 15	Annual Country Report, National LMIS Reports, Programme Division Data
Output 4: RHCS mainstreamed into UNFPA core business (UN reform environment)							
1. Expenditure of UNFPA /CSB core resources for RHCS increased)	$ 1.94m	$2.12 (0.43% of UNFPA Core Resources)	$2.10m (0.42% of UNFPA Core Resources)	$1.45m (0.39% of UNFPA Core Resources)	**$1.45m** **(0.33% of UNFPA Core Resources)**	$2.5	UNFPA Financial Reports, ATLAS Analysis, COAR, Planning Reports
2. GPRHCS planning takes into account lessons learned in RHCS mainstreaming (45 countries)	11	22	28	38	**41**	45	COAR, Planning Reports

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
3. Number of countries with RHCS priorities included in (45 countries): CCA[16] UNDAF[16] CPD CPAP	0 20 40 40	3 29 42 43	24 35 36 40 Data for 2010 derived from GPRHCS country reporting questionnaire which is different from previous years when data was obtained from the Country Office Annual Reporting modality put in place by UNFPA Programme Division	42 45 46 46 Data for 2011 derived from GPRHCS country reporting questionnaire as in 2011	**44** **46** **46** **46** **Data for 2012 derived from GPRHCS country reporting questionnaire as in 2012**	22 45 45 45	Programme Division Database, COAR, CSB annual reporting
4. Number of UNFPA Country Offices with increasing funds allocated to RHCS (45 countries)	5	Not available	29	30	**30**	12	Programme Division Database
5. Number of countries with all the relevant joint UN programmes for SRH and MNH that include RHCS (45 countries)	3	Not available	20	28	**25**	10	Programme Division Database

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

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
6. Number of national/ regional institutions providing quality technical assistance on RHCS in the areas of Training and Workshops, Advocacy, Monitoring & Progress Reviews, and Programme Development with countries (1 in each of 5 regions)	2	Not available	5 i)Mauritius Institute of Health (MIH); ii) Indonesia's National Population and Family Planning Board (BKKBN); iii) Latin American Federation of. Obstetrics and Gynaecology Societies (FLASOG); iv) Centro de Investigacion, Educacion y Servicios (CIES); v) Publicaciones y Revistas Sociales y Humanísticas (PRISMA)	8 i) Eastern and Southern African Management Institute (ESAMI) in Arusha, Tanzania; ii) Federación Latinoamericana de Sociedades de Obstetricia y Ginecología (FLASOG); iii) PRISMA in Peru; iv) Center of Research and Health Studies at the Universidad Nacional Autonoma de Nicaragua (UNAN CIES); v) International Council on Management of Population Programs (ICOMP); vi) School of Pharmacy (University of Medical Sciences, Ulaanbaatar) in Mongolia; vii) University of Canberra, Australia School of Public Health; and, viii) Addis Ababa University, Ethiopia	**8** **i) Federación Latinoamericana de Sociedades de Obstetricia y Ginecología (FLASOG); ii) PRISMA in Peru; iii) Center of Research and Health Studies at the Universidad Nacional Autonoma de Nicaragua (UNAN CIES); iv) International Council on Management of Population Programs (ICOMP); v) Tamil Nadu Medical Supplies Corporation; vi) Fiji National University, Suva; vii) Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP); and viii) African Youth and Adolescents Network (AfriYAN)**	5	GPRHCS reports, Regional Office Reports
Programme Management[17]							
1. Number of countries achieving at least 60% of workplan outputs (45 countries)	Not available	27 (2009)	40/45	45/46	**45/46**	45	GPRHCS reports, Country monitoring reports

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

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
2. Number of country offices with completed and budgeted Annual Workplan by end of December each year (45 countries)	Not available	25 (2009)	42/45	34/46	**34/46**	45	GPRHCS reports, Country monitoring reports
3. Number of country offices submitting mid-year progress report to respective regional offices by 15 June each year (45 countries)	Not available	25 (2009)	11/45	12/46	**12/46**	45	
4. Number of country offices submitting completed annual narrative programme report to respective Regional Offices by 15 December (45 countries)	Not available	25 (2009)	42/45	35/46	**35/46**	45	GPRHCS reports, Country monitoring reports
5. Number of country offices submitting completed financial report to respective Regional Offices by 15 December (45 countries)	Not available	25 (2009)	5/45 Financial year ends on 31st December, so countries find it difficult to send in reports by 15th December	10/46	**10/46**	45	GPRHCS reports, Country monitoring reports
6. Number of Regional Offices submitting reviewed AWPs to Technical Division/ HQ by mid January (5 Regional Offices)	Not available	3/5 (2009)	5/7	5/7	**5/7**	5	GPRHCS reports, Country monitoring reports

Indicators	Baseline (data/end 2008 or otherwise indicated)	2009 progress data (output level only)*	2010 Progress (output level only)*	2011 Progress (output level only)*	2012 Progress (output level only)*	Target (data/ end 2013)	Source of data
7. Number of Regional Offices submitting mid-year report by mid July and annual report of mid January to Technical Division/HQ (5 Regional Offices)	Not available	1/5 (2009)	5/7	5/7	**5/7**	5	RO reports
8. Country work plans reviewed and allocation made By HQ by 1st week of March[18]	Not available	0/1 (2009)	1/1	1/1	**1/1**	1	CSB/HQ report
9. Semi-annual and annual progress review/planning meeting organized for all GPRHCS Stream 1 counties by CSB/TD	Not available	2/2 (2009)	2/2	1/2 The annual joint planning meeting for 2011 reporting could not be held because of the need to realign the thematic funds planning process with the cluster system that emerged as the agencies strategy for programme delivery and for implementing the Executive Director's Business Plan.	**1/2** **A planning meeting of all GPRHCS countries was held in Benin in November 2012**	2/2	CSB/HQ report
10. Consolidated annual GPRHCS report (programmatic and financial) prepared by end of March of following year by HQ	Not available	1/1 (2009)	1/1	1/1	**1/1**	1/1	CSB/HQ report

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

LIST OF ACRONYMS

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

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

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