DFID HEALTH RESOURCE CENTRE

Reproductive Health Commodity Security (RHCS) Country Case Studies Synthesis: Cambodia, Nigeria, Uganda and Zambia

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ACRONYMS AND ABBREVIATIONS

ARVs	Anti-Retroviral Drugs
B/CEOC	Basic and Comprehensive Essential Obstetric Care
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
FBO	Faith Based Organisation
FP	Family Planning
GFATM	Global Fund to Fight AIDS, TB and Malaria
HSR	Health Sector Reform
ICs	Injectable Contraceptives
IUD/IUCD	Intra-Uterine Contraceptive Device
MAP	World Bank's Multi-country AIDS Program
MCH	Maternal and Child Health
MICS	Multi Indicator Cluster Survey
MDG	Millennium Development Goals
MMR	Maternal Mortality Reduction
MVA	Manual Vacuum Aspiration
NEEDS	National Economic Empowerment and Development Strategy (Nigeria)
NGO	Non Government Organisation
OCs	Oral Contraceptives
PAC	Post Abortion Care
PHC	Primary Health Care
PEPFAR	President's Emergency Plan For HIV/AIDS Relief
PMTCT	Prevention of Mother to Child Transmission of HIV
PPPs	Public Private Partnerships
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RHCS	RH Commodity Security
RTI	Reproductive Tract Infection
SPARHCS	Strategic Pathway to RHCS
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
SWiM	Sector Wide Management (Cambodia)
TA	Technical Assistance
TFR	Total Fertility Rate
WB	World Bank

1 EXECUTIVE SUMMARY

1.1 Introduction and background

Secure and sustained access to quality and affordable commodity supplies is a critical driver of reproductive and sexual health, as it is for child health and communicable disease treatment and prevention. Improved access to these commodities is essential for the success of wider efforts to scale up health services, in order to achieve the Millennium Development Goals[1].

Meeting growing demands for commodities for reproductive health services requires adequate funding commitments, and close coordination among donors to avoid gaps or duplication. Strengthening collaboration is also in line with international commitments made in 2005 by the OECD Development Assistance Committee for harmonizing donor contributions, and for aligning these to government-driven policy and plans.

In 2005, DFID and the Netherlands Ministry of Foreign Affairs commissioned a series of studies to further inform dialogue and action on commodity security through the international Reproductive Health Supplies Coalition. These included a review of the international market for contraceptives and condoms, and country assessments of reproductive health commodity security (RHCS) issues in four low income countries (Cambodia, Nigeria, Uganda and Zambia), which represent a range of aid, financing and health reform environments, and a mix of reproductive health donors and supply channels.

This report aims to provide analysis of the key factors that influence the financing, procurement, forecasting, and supply of reproductive commodities; and how national and international agents interface and co-ordinate their activities. The report offers lessons learnt and recommendations relevant to national actors in similar settings, as well as country level perspectives on various proposals made in 2005 for strengthening RHCS at the global level.

A team of international and national consultants undertook the studies in September - October 2005. The team used a standard methodology developed for the case studies, drawing on existing data and documentation, as well as interviews with over 100 stakeholders in public, private and civil society sectors. The methodology included tracking a group of marker commodities to represent all those required for reproductive health services.

1.2 Country contexts

1.2.1 Reproductive health indicators

Indicators are poor in the four countries, with concerns about low or stagnating use of modern contraceptives. Preferred family size remains high especially in sub-Saharan Africa – low demand is linked to poverty, low female status and to social and religious norms.

Other reasons for low contraceptive use include limited access and weak supply systems, especially in rural areas; fears about side effects and high discontinuation

[1] Essential reproductive health commodities include drugs and supplies for safe motherhood and STI prevention and treatment services, and contraceptives and condoms (as defined by WHO and UNFPA).

rates (especially in Cambodia); and disapproval of using contraception by the woman, her husband or family. Financial and other access barriers to the poor are significant, with major differences in contraceptive use between the highest and lowest quintiles.

Significant numbers of users obtain their contraceptive supplies from the private sector, especially condoms and oral contraceptives. In these four low income countries, these are mainly socially marketed brands, distributed through private retail channels and not-for profit providers, rather than commercial products.

Maternal mortality remains high, along with low levels of skilled attendance or facility based births. Inadequate supplies are a contributing factor, along with lack of skilled human resources, and poor supervision and quality of care. For example, Uganda's decline in facility-based delivery in spite of the removal of user fees in 2001 has highlighted systemic failures in providing supplies and equipment, and in retaining qualified staff, who are motivated to deliver high standards of patient care.

1.2.2 Policy, aid and reform environments

Reproductive health is generally included in the countries' national poverty reduction and development plans. Reproductive health is among national health priorities, and included in the basic health package in Cambodia, Uganda. In Zambia, however the policy environment fails to gives priority to RH. National level policies do not give a prominence to RH, and several of the sector level policies and plans that directly relate to improving RH status and which could impact on commodity security, have not yet been finalised for implementation. Nigeria's new health sector reform strategy emphasises maternal health care, and includes access to emergency obstetric care, child spacing and other reproductive health services under this objective.

However, RHCS is referred to mainly in terms of ensuring equipment and drugs supply, and strengthening logistics systems. With the exception of Nigeria, the countries lack an explicit RHCS strategy. There is no agreed set of RHCS indicators, and such indicators do not generally feature in the reproductive health strategy, nor in the health sector performance measurement framework.

Progress in donor harmonisation and alignment with national health policy and plans is ongoing. Two of the countries, Uganda and Zambia, have had sector wide approaches since 2000, where the public health sector's activities are prioritised according to national policy and set out in a unified plan and budget. An approach to sector wide management is developing in Cambodia. Nigeria has initiated broad ranging health reforms, and DFID and the World Bank are planning sector/budget support for system strengthening at state level within the next few years.

In all four countries, significant parallel and project-based funding continues. HIV and AIDS, and other communicable disease programmes have received significant additional finance through the GFATM and other global partnerships and initiatives such as the USA's PEPFAR programme and the World Bank's Multi-country AIDS Program.

1.3 Key findings

1.3.1 Efforts to strengthen RHCS

Safe motherhood and STI commodities for the public sector tend to be subsumed within essential drugs budgets, and procured and supplied through government

channels, sometimes with support from donors such as DFID or the World Bank. They therefore tend to be subject to the same constraints that affect essential drug supply and distribution. Public sector contraceptive commodities are usually supplied centrally through third party procurement, using funds drawn from sources including national donor allocations and international funds such as those held by UNFPA. For the heavily subsidised social marketing programmes, which make a critical contribution to contraceptive prevalence, procurement also tends to be carried out by an international agent.

None of the national public sectors are directly responsible for purchasing the bulk of contraceptive supplies, whether with national or internationally sourced funding. Government agencies in all four countries are responsible for procuring ARVs and/or condoms using GFATM or World Bank funds, in accordance with those agencies' guidelines, as well as other essential drugs. In contrast, contraceptive commodities are procured on government's behalf by major donors or their agents, drawing on national or global level finance.

Donor dependence for contraceptive financing and procurement is high, and limited or zero finance is committed by governments. Of the four countries, only Cambodia is purchasing condoms for the public sector's family planning programme using government budget allocations. Uganda has allocated a domestic budget to contraceptives, but this is under-utilised. All the reproductive health programmes are in receipt of technical and project assistance, as well as commodity supplies. It was not possible to assess allocations of finance to commodities versus technical support, but the majority of reproductive health funds are invested in commodities rather than capacity building.

Financing and procurement tend be fragmented and poorly co-ordinated where there is more than one donor, as in Cambodia, Uganda and Zambia. With major donors using their own procurement methods, and operating on relatively short timescales for commitments, ministries of health must be responsive to several donor systems and transaction costs are increased. This is compounded by government and donor failure to develop a government-led planning and budgeting process where donor contributions complement those of government.

Efforts have been made in recent years to strengthen procurement, forecasting and supply systems. In Uganda, the emphasis has been on system strengthening, facilitated by a sector approach, which is enabling the integration of procurement and supply systems for drugs, contraceptives and other health commodities, thus reducing duplication.

Nigeria was the first country to undertake the multi-stakeholder process called Strategic Pathways to Achieve RHCS (SPARHCS), which resulted in an RHCS strategy, and improved supplies. Indeed, there are new plans to introduce a centrally funded and supplied safe delivery kit through the same system, in order to meet women's and facility needs for supplies and basic drugs that are often not available through the decentralised system.

Recent efforts in all four countries have focused on the introduction of the 'pull' system for ordering at facility level, to replace or complement the various push systems using standard drug kits, for example. Cambodia has introduced a computerized stock control system at the district level. However, there is weak local capacity, and limited finance and technical support available for on the job training. Accurate forecasting therefore remains poor in all four countries, largely due to

weaknesses in stock management and consumption monitoring and reporting, and to challenges in compiling supply data from multiple sources and in estimating demand.

1.3.2 Impact of wider policy and financing environments

There are opportunities for promoting reproductive health in context of national and international policy, and use of aid financing instruments. The issues appear to be receiving greater attention at higher levels among health policy makers and planners in all four countries, due to two main factors. First, there have been advocacy opportunities in Cambodia and Uganda for greater prominence where reproductive health is included and monitored in the poverty reduction and health sector strategies and the essential health package, and where progress is reviewed by multiple stakeholders as part of a sector management approach. Somewhat unusually, a contraceptive (an injectable, the most popular method among public sector clients) is one of six indicator drugs in Uganda for monitoring facility stockouts in the most recent Poverty Eradication Action Plan. Zambia's new PRS includes a section on addressing RH issues and could provide a spur to provide for needs that are not adequately addressed; in 2005 funding has been allocated to MoH and programmed in support of reduced maternal mortality.

Second, at least at national policy levels, there is increasing importance ascribed to strategies for meeting the MDGs, by donors and government, which includes access to commodities for maternal health. Although the emphasis is on reducing maternal mortality, rather than the broader sexual and reproductive health objectives which are not represented in the MDGs, this is offering opportunities for advocacy on wider issues, such as the role of birth spacing in maternal and child health.

Furthermore, efforts to strengthen the public sector health system as a whole have resulted in benefits for aspects of RHCS, such as integrated procurement and distribution, as described in the previous section.

A complex mix of incentives drives the behaviour of government and different donors. For example, there is concern in both Uganda and Zambia, that - given hard fiscal ceilings for the health budget - earmarked funds for AIDS and other communicable diseases are crowding out government allocations to other priorities. As a result of budgetary pressures, central budgets such as that of the reproductive health programme tend to be cut or under-spent, and donors respond by substituting government spending with off-budget funds. This also accords with some donor preferences for commodity or project support, rather than sector or budget support.

In Zambia, donor confidence in central government procurement and distribution procedures has been low, due to a series of poorly governed contracts issued by government for managing the medical stores. It is clear that donors must have confidence in procurement and distribution functions. Without transparent and accountable procurement agents, partners have little incentive to consider alternatives to supporting parallel and project-based financing of supplies.

The assessments also found that the longer term prognosis for funding is bleak. Financing and technical support have depended greatly on a few committed partners such as KfW (the German development bank), DFID, UNFPA and USAID. However, there are signs that some bilateral donors are withdrawing from national programme and commodity support, for various reasons. In Zambia and Uganda, DFID's shift to budget support will have major implications – it could enable strengthened engagement on broader health allocations, procurement and human resource functions but on the other hand, DFID could lose influence on reproductive as well as other health issues.

On a more positive note, the assessments also identified opportunities that could facilitate the mainstreaming of RHCS, including developing national financing mechanisms for drugs and other essential health commodities.

Uganda's arrangement with DANIDA to manage a mix of domestic and donor funds in a pooled account is one example. Funds can be rolled over year on year, enabling sufficient accumulation for large orders, and procurement is through the government system with relatively low transaction costs. Donor contributions or credits can be identified as additional to government funds and avoid the associated risks of fungibility and/or hard budget ceilings. Although operating only for drugs at present, such a mechanism offers clear potential for other commodity purchase as well. Nigeria's new national cost recovery fund for contraceptives and new proposals for a drug supply budget line in Zambia may offer similar opportunities.

1.3.3 Translation of policy commitments into action

Despite national policy objectives, the wider political will to really impact on RH continues to be questionable – any commitments remain mainly paper ones. Such implementation slippages are due to four linked factors: weak ownership, capacity, resource allocation and co-ordination at all levels; limited translation of national priorities into decentralised or devolved planning, budgeting and implementation processes; limited accountability for delivering on national priorities; and low demand by both consumers and their political representatives (to the extent of opposing demand creation by some local politicians in Uganda). Widespread capacity problems undermine the scope for achievement. These challenges apply not only to RH; other services are also affected by critical shortages in human resources, and problems in procurement and logistics management.

In three of the countries, government ownership of the problem of commodity security seems low. It appears to be undermined by donor approaches to providing support, even where the donor has contracted a third party agent to liaise with and procure on behalf of government, as KfW has done at request of the Cambodian authorities. Weak ownership is suggested by issues such as poor policy formulation, limited national resource allocation and programme capacity, and low commitment to implementation. Within the MoH in Zambia, it is not clear who is charged with addressing commodity security issues suggesting an overall lack of accountability. These issues are compounded by resource constraints, the ongoing crisis in human resources for health, especially in AIDS-affected countries, and challenges raised by devolved and decentralised systems.

Although implementation problems persist in Nigeria, government ownership appears higher. The withdrawal of USAID as a major donor in the 1990s had a profound impact on the public sector programme, resulting in greater commitment among reproductive health officials to building sustainable finance and capacity.

Capacity and political will at levels of decentralised or devolved authority are major drivers of reproductive health and RHCS. The assessments found major barriers to the translation and ownership of policy into workplans at district or state level (for Nigeria), where planning and implementation capacity is low and where reproductive health may not be prioritised among many competing issues.

There are also opportunities for action at all levels. In Uganda, the government has recently introduced a league table for district performance against national priorities. It will be important to monitor its effectiveness as a tool to help improve accountability and promote standards across the country. Greater political accountability for

improving safe motherhood services is being mobilised at local government and community levels as Nigeria responds to the MDGs.

1.3.4 National capacity and the role of development partners

Donor behaviour and style of engagement with national stakeholders are critical factors. It appears that government ownership and accountability for RHCS are undermined and discouraged, not necessarily by dependence on external funding but by the limited co-ordination, predictability and transparency displayed by international financing partners.

Effective government and donor co-ordination are critical, irrespective of financing sources. Three of the four countries have RHCS co-ordination groups (with one proposed in Zambia), in addition to reproductive health co-ordination groups. Membership tends to be public sector and donor dominated, so that wider market development issues in RHCS such as demand creation are not addressed. They also tend to be used mainly for information exchange, with limited effectiveness in co-ordinating government and donor activities for ensuring commodity security. Links or overlap with other relevant co-ordination groups, such as for condom programming, are weak.

UNFPA country offices are expanding their role in line with overall agency objectives, although there are opportunities to strengthen strategic contributions. In two of the countries, Cambodia and Zambia, the agency is working with health sector partners to support the integration of reproductive health into sector planning and implementation processes. In Uganda, it is contributing to the integrated distribution system.

Technical contributions by UNFPA to strengthening capacity are widely acknowledged. However, the agency is not yet offering significant support to facilitate overall government leadership in its broader strategic role in RHCS, for example in stewarding the total market, or in developing and building planning and co-ordination capacity. Reliance on a few key partners for technical as well as financial inputs increases system fragility, especially as it appears that some bilateral donors may be scaling down national RH commitments. The implications for UNFPA, as it becomes the sole provider of TA, are substantial.

1.3.5 Essential commodity policy and supply

Contraceptive commodities are mainly included in national essential drug lists, but some essential safe motherhood commodities are missing, which has significant implications for maternal mortality reduction efforts. Missing products included magnesium sulphate, oxytocin and manual vacuum aspiration (MVA) equipment. In all the countries, there is a lack of information and strategy for addressing maternal health commodity security, although the importance of supplies is usually stressed in reproductive health policies.

Quality assurance of commodities is very limited, in light of weak drug regulatory capacity. Only in Nigeria, where strengthening the national regulatory authority has been a government priority, is there any routine action to address illegal and counterfeit imports, although commodities imported by UNFPA are not tested on entry. Condom testing equipment, owned by government, is housed and regularly deployed by the social marketing organisation.

Regulatory barriers to product entry do not appear to be significantly affecting market development at present. All essential drugs and condoms can enter Uganda and Zambia tax free (so long as they are packaged outside Zambia),

whether for public or private use. However, while products for public sector use are not subject to taxes and tariffs, in Nigeria social marketing and other not-for-profit importers often faced lengthy delays in obtaining Presidential exemptions, leading to costly import hold-ups.

Most procurement is done by international agencies which can support product registration, however there are some concerns. Given the small size of commercial markets, very few if any companies have independently registered products. The Cambodian assessment noted that not all products imported by donor agencies were registered as required, such as some branded products, whereas generic products, such as injectables were used by public or social marketing programmes, were licensed for use. In Zambia, scaling up the introduction of depo provera by USAID was delayed due to slow progress on registration by both the manufacturer and regulatory agency.

1.3.6 Role of the private sector

The assessments found that the formal and informal private sector plays a growing role in reproductive health commodity supply, mainly through social marketing and the faith based sector. Private services are often preferred by consumers because they are often more friendly and consumer oriented, more accessible in terms of distance to travel and associated costs, and may be better stocked than government facilities. Social marketing in particular has developed efficient distribution systems, often using commercial channels, as well as community based distribution with local organisations, for distribution of oral contraceptives and condoms in particular.

In sub-Saharan Africa, the faith based sector plays an important role in reproductive health service delivery – providers manage up to 40% of services in Nigeria, Zambia and Uganda. However, the faith based suppliers in Nigeria and Uganda neither stock nor supply contraceptives and condoms.

Leakage of public sector products to the private sector is perceived as a major constraint to private sector expansion. Although leakage from the public sector may not affect overall contraceptive prevalence, it compromises the targeting of public sector subsidy for the poorest. In addition, contraceptive leakage also implies wider abuse of the system, which has implications for governance and for the safe and effective use of all drugs.

Although there were some public-private linkages, the private sector's role is not fully or formally recognised by the public sector in any of the countries. At the same time, development and health policy emphasise increased collaboration with the private sector as an objective. However, so far, there is limited articulation of what such a strategic approach with private sector players might look like. The private sector offers further potential for further scaling up family planning programmes and improving RH service delivery, especially as part of a total market approach.

Increased public-private collaboration has implications for co-ordination bodies. For example, the Uganda assessment found that the RHCS Group did not include non-public sector groups such as the Family Planning Association of Uganda, and the Uganda Private Midwives Association.

1.3.7 Socio-cultural issues and demand creation

Demand creation for contraception remains a major challenge. Continuing low use of modern methods is influenced by a wider social, religious and political

environment that is not highly supportive of family planning. In all four countries, the terms 'child spacing' or 'birth spacing' are now used, which reflect religious and political preferences to avoid language that implies a) population control measures and b) influencing family size.

There is complex interplay between international and national factors. For example the US government's policy on abstinence is in line with that of many national opinion leaders in the three African countries. US finance for condoms is restricted to purchase and use by targeted groups such as sex workers, rather than the general population, which leads to reduced supplies, and mixed messages and confusion about the condom's role in prevention of pregnancy and disease – and may be linked to lack of condom promotion as a method of dual protection.

1.3.8 Reproductive health and HIV/AIDS

The national HIV and AIDS response has generated increased amounts of earmarked and/or projectised funds, together with high levels of political attention. The assessments found that opportunities for mainstreaming activities with existing sexual and reproductive (and other) health programmes have rarely been taken. In Zambia, the government has been strategic in using prevention of mother to child transmission initiatives (PMTCT) supported by the GFATM as a way of improving some aspects of reproductive health and there is joint activity between the national AIDS and RH programmes in Cambodia on PMTCT.

In general, there were weak linkages between agencies procuring condoms for HIV prevention and those procuring them for family planning. Separate procurement and distribution channels have been set up for ARVs and condoms in Cambodia and Uganda. The multiplication of agencies and funding sources for condoms, coupled with the need for quality assured sources and high consumer confidence, as well as factors referred to above, has led to complex challenges for managing and co-ordinating condom security, in Uganda for example.

1.3.9 Barriers to access

Demographic and health data indicate substantial differentials between the poorest and wealthier quintiles. Given high levels of poverty, strategies to ensure equity of access to RH services and supplies are of great concern.

However, in general there is little information on factors affecting access by the poor. In Cambodia, there is anecdotal evidence that people in the lowest economic quintiles access commodities from the private sector because of barriers to accessing public health facilities.

Nigeria's new cost recovery system involves charging a fee to all clients, irrespective of socio-economic status. Prices to consumers are set below those products provided by private and NGO providers. Informants were confident that the prices are low enough not to deter clients who visit a service provider. However, information is not available on how the poorest may be deterred by indirect cost barriers such as time and transport costs, as well as commodity prices.

1.4 Conclusions and recommendations: national level

While there have been some successes in efforts to strengthen commodity supply, there are continued limitations in national capacity to develop and implement policy and strategy, for procurement and supply management and forecasting, and for demand creation. These issues are compounded by resource

constraints, the ongoing crisis in human resources for health, especially in AIDS-affected countries, and challenges raised by devolved and decentralised systems.

The continuing and dominating role of external agencies in the financing and procurement of contraceptives tends to undermine ownership and discourage accountability by government. Third party procurement, ideally through international competitive bidding, may make sense in some contexts to achieve quality and volume efficiencies. However, government is rarely driving the process, there are serious inefficiencies due to poor co-ordination at national level and procurement processes are not always transparent to stakeholders. The combination of fragmented supply sources, poor co-ordination and weak logistics systems mean high levels of emergency procurement and stockouts.

Sector wide management, planning and review processes provide a critical opportunity for RHCS advocacy, especially if relevant indicators are included. Reliable supplies of commodities and equipment - as well as skilled staff at all levels, and a functioning referral system - are needed for increased utilisation, and better outcomes.

At least one key safe motherhood drug or other supply was missing from essential drug lists in all the countries, although most contraceptive commodities were included. Information about access and use of safe motherhood commodities at facility levels was also lacking, although UNFPA and WHO are planning some situation assessments with national partners. This is especially critical given the emphasis on the MDGs, and current socio-religious and political pressures that are contributing to lack of funding and provision. This particularly affects supplies for comprehensive and/or post abortion care and emergency contraception, which need to be provided in public and private sectors in line with national policy and law.

An MDG focus can result in de-emphasising family planning, and other reproductive health services, while stressing access to emergency obstetric care and immunisation. This is in spite of the fact that, for example, there is substantial evidence that child spacing improves both mother and children's health. Weak linkages between commodity supply for HIV/AIDS and reproductive health are reducing effectiveness and efficiency.

Low demand and utilisation is due to poverty and limited access, as well as affected by social, religious and political factors. In view of the challenging socio-cultural and political environment, especially in the three African countries, continued advocacy on repositioning RH among politicians, religious and other leaders, is critical.

DHS data indicates substantial differentials between the poorest and wealthier quintiles. However, in general there is little information on factors affecting access by the poor, or actions to address them. The assessments concur with recommendations of UNFPA and others for studies to assess access and willingness to pay, as a first step.

There is limited engagement between government and the private sector, despite the major contribution of social marketing. The role of the government as public health steward can be seen as a dual champion: to take care of the public sector on the one hand, but also to take a strategic overview of the whole market – public, social marketing, NGO and commercial - in order to ensure that all citizens have access to a choice of quality products at a price they can afford, with free distribution benefiting mainly the poorest. This is part of working towards a total

market approach, where the market is segmented according to ability to pay, with public, NGO, social marketing and commercial sectors playing a role most suited to their comparative advantage.

Recommendation 1: Continued advocacy is needed for inclusion of reproductive health and RHCS in national development and health policy and plans, backed up by domestic budget allocations, an RHCS group and a unified workplan.

The national RHCS co-ordination group has an important contribution to furthering operational and strategic aspects of commodity security, and should be the main forum for agreeing all donor activity relating to RHCS, delineating the roles and responsibilities of individual members of the RHCS Group.

One unified workplan is needed for all activities, including programmed commodity procurement, together with donor contributions, real or indicative commodity budgets and RHCS indicators (which could also inform selection of core indicators for RH and health sector performance assessment). Where a donor needs to procure under its own terms, or requires third party procurement, ensuring transparency and predictability is essential. Support is also needed to prioritise, budget and implement RH and RHCS activities at district or other decentralised levels, along with mechanisms to hold authorities to account such as scoreboards and league tables.

Recommendation 2: At national level, financing mechanisms are needed that facilitate more flexible and predictable donor financing, enable efficient procurement with lower transaction costs, and support an effective, government-led interface with international agencies. Critically, these types of mechanisms, such as commodity accounts, enable ownership of procurement by government, whether the function is contracted to an agency such as UNFPA or Crown Agents or done by government, and irrespective of the source of funds. To enable domestic and external buy-in, such mechanisms must be in line with both government procedures, and donor requirements.

Recommendation 3: Reproductive health and commodity security needs to be mainstreamed with efforts to strengthen wider health system and commodity supplies. In an uncertain funding environment, it is critical to transfer the responsibility for RH and RHCS from being a more or less vertical programme, into the remit of government and donors as a whole. Current emphasis on the need for increased harmonisation among donors, and alignment with government policy and plans, provides an opportunity to strengthen government ownership and implementation.

Recommendation 4: Financing and co-ordinating technical support to build capacity for national supply and distribution systems continues to be imperative. A wider issue concerns questions of integration with other supply and distribution systems. Where the overarching policy environment is driving towards integration, it is critical that donors and TA partners support this.

Recommendation 5: There are clear opportunities for UNFPA to enhance its wider strategic contribution. These include developing funding and TA arrangements focussed on priority issues, such as RHCS. UNFPA also needs competence not just in TA for RH and RHCS, but in wider roles as a sector player, in terms of integrated systems and service delivery. This is demanded by both trends in both funding modalities and by sector development objectives, and is in line with

overall UNFPA commitments to ensure that UNFPA country offices work more within sector wide approaches, including pooling funds

Recommendation 6: Advocacy efforts by WHO and UNFPA are urgently needed to ensure that commodity supplies for safe motherhood as well as other RH commodities are assured. It is recommended that national RH directors, UNFPA, WHO and others take any necessary steps to ensure that essential items are available, such as inclusion in the essential drug list and national supplies system, dialogue with procurers and distributors, and inclusion in training materials and activities as appropriate.

Recommendation 7: Government and other major stakeholders need to further their efforts to 'reposition reproductive health' as a key but neglected driver for the reduction of child and maternal mortality, as well as a priority in its own right.

Recommendation 8: There are opportunities for linking RH services with STI and HIV care, treatment and prevention, and a need to strengthen co-ordination of commodity supplies, especially condoms.

Recommendation 9: Innovative work should be continued on improving access through strengthening demand and accountability for service delivery.

Recommendation 10: Given high levels of poverty, addressing barriers to access by the poor to RH services and commodities is urgently needed.

Recommendation 11: The assessments recommend stronger public sector engagement with the overall market for RH commodities and with other providers, as a part of the government's national RHCS strategy. The urgent need for demand creation – which cuts across public and private sectors – may stimulate a more strategic approach to overall market development and developing the role of partnerships.

1.5 Conclusions and recommendations: global level

There have been several proposals in 2005, including in a study commissioned by the Bill & Melinda Gates Foundation, for increasing the predictability, transparency, coherence, co-ordination and volume of financing available at the global level for RH commodities.

The studies found that almost all procurement of contraceptives is carried out by donors or their agents, drawing on finance provided by either national or international donor sources. However, it is not clear that internationally aggregated purchasing of most reproductive health commodities is warranted. Market analysis indicates that, as with ARVs and condoms, international contraceptive markets can be competitively approached from the national level using effective procurement practices to achieve good prices and stable supply.

As well as funding shortfalls, the main challenges at country level relate to weak capacity and co-ordination, short term and uncertain financing, and poor governance. However, the assessment identified several financing mechanisms that could work effectively at national level to smooth volatility of unpredictable donor fund flows, and which could provide a vehicle for managing domestic and international contributions.

In terms of the national-international interface, the commodity financing procedures and arrangements of UNFPA and other agencies procuring for government appear opaque to stakeholders – there is limited knowledge of how global funding and procurement functions work (or indeed could work better). Even where procurement through international competitive bidding may offer best value for money, the studies found few examples where government has been able to effectively commission this procurement function to a third party agent to deliver on their own behalf.

Several observers have noted the highly redundant nature of quality assurance processes for contraceptives, and the difficulties facing generic market entry. Whether commodities are procured nationally or internationally, quality assurance is crucial. WHO and UNFPA have recently begun a programme to prequalify reproductive health medicines and commodities, following WHO's scheme for anti-retroviral products. Quality assurance of imported goods is ideally needed at national level, irrespective of the supplier and procurement agent.

Recommendation 12: Donors need to make more long term and predictable commitments to RH supplies, which should, over time, build national capacity for procurement and other supply functions. It is recommended that donors and government explore financing and procurement mechanisms that can work effectively at national level to smooth volatility of unpredictable donor fund flows, while also building government ownership and capacity. Even where these are weak, capacity building can be supported and procurement can still be contracted locally to a third party, as is planned in Zambia.

Recommendation 13: This review also finds a strong case for the continued pooling of finance at the global level for reproductive health commodities. International procurement will clearly continue to be appropriate in some cases, especially where there are proven price and quality benefits, and in light of current dependence on international procurement arrangements. In addition, global level finance that is targeted at key international priorities such as reproductive health (as with TB, AIDS and malaria) can complement investment in system strengthening support at national level.

Recommendation 14: Any global financing mechanism must be in line with international commitments to aid harmonisation and alignment, ideally building on the comparative advantages of existing aid instruments and agencies.

Recommendation 15: This study recommends that international efforts are accelerated to develop prequalification processes for manufacturers, in terms of offering quality and greater value for money. It is also recommended that, as procurement capacity develops, regional informed and co-ordinated buying approaches are promoted.

2 INTRODUCTION AND BACKGROUND

DFID and the Netherlands Ministry of Foreign Affairs, together with many other players, are engaged at national and international levels in efforts to improve reproductive health. This is part of wider efforts for scaling up health and education services, in order to achieve the Millennium Development Goals.

Secure and sustained access to quality commodity supplies is a critical driver of reproductive health, just as it is for child health and communicable disease control. Meeting growing demands for reproductive health commodities requires adequate funding commitments, and close coordination among donors to avoid gaps or duplication. Strengthening collaboration is also needed to meet international commitments for increasing aid effectiveness by harmonising donor contributions, and aligning these to government-driven policy and plans[2].

Global co-ordination and financing aspects of reproductive health commodities are addressed at the international level by the Reproductive Health Supplies Coalition. Established in 2004, the RHSC comprises representatives of donor and implementing organisations and constituencies (including developing countries), and is a forum for sharing information, data and research findings.

As members of the Coalition, DFID and the Netherlands Ministry of Foreign Affairs commissioned country studies in four low income countries, Cambodia, Nigeria, Uganda and Zambia, in order to contribute towards an improved understanding of RH commodity security issues[3]. The studies aim to provide evidence for action at country and/or international levels, and to inform dialogue with bilateral and multilateral donors and implementing agencies on the resolution of RH commodity supply crises.

This synthesis report provides a summary and analysis of factors influencing reproductive health commodity security issues in the four countries. The country selection enabled an overview of RHCS issues in a range of aid, financing and health reform environments in diverse low income settings, with a mix of RH donors and supply channels. The case studies focus on the policy, institutional and financial context for RH supplies and explore three key issues:

- how and why efforts to strengthen procurement and supply systems have been more or less successful;
- how systems are evolving within wider aid and policy environments (eg new aid instruments and the MDGs, health reform processes, increased focus on governance and accountability, more resources);
- the country level interface with global procurement and financing mechanisms.

The synthesis aims to provide analysis of how the wider socio-political, aid and reform environments influence key issues and processes in financing, procurement, forecasting, distribution and demand for RH commodities. The analysis also offers commentary on various proposals made in 2005 for strengthening RHCS at international and national levels. These include options set out in the study by Mercer

[2] OECD DAC Paris Declaration: Aid effectiveness: ownership, harmonisation, alignment, results and mutual accountability, March 2005

[3] Two complementary country studies, financed by the European Commission were also undertaken in 2005 (India and Mozambique).

Management Consulting commissioned by the B&M Gates Foundation, by UNFPA for a Global Programme for RHCS, and the exploration of various market development approaches by members of the Reproductive Health Supplies Coalition.

In accordance with widely accepted usage, RHCS is attained when: 'all individuals can choose, obtain and use affordable, quality reproductive health commodities, whenever they need them.' RH commodities are defined by UNFPA and WHO as those required for the prevention and management of reproductive tract infections, for obstetric and maternal health care (including for management of complications of unsafe abortion and for comprehensive abortion services where the law permits) and contraceptives including emergency contraception, and male and female condoms.

A team of international and national consultants undertook the studies in September - October 2005. The team used the standard methodology developed for the case studies, drawing on existing supplies data and documentation, as well as interviews with over 100 stakeholders in public, private and civil society sectors. The methodology included tracking a group of marker commodities to represent those required for reproductive health services.

Summary TORs and methodology are at Annex 1, and documents referred to at Annex 2. The four case studies are available separately in Annex 3.

3 OVERVIEW OF COUNTRY CONTEXTS

3.1 Reproductive health issues

There is concern about low or stagnating contraceptive prevalence rates (CPR) in all four countries, due to a mixture of supply and demand factors. Use of modern contraceptive methods among currently married women ranges from only 8% in Nigeria (2003) to 19% in Cambodia (2000), 23% in Uganda (2001), and 34% in Zambia (2001). Use is higher among higher income, educated and urban women, and in wealthier regions. Although most data are not current, other than in Cambodia, there is little evidence of any major changes since the last national demographic and health survey (DHS).

Low demand is linked both to poverty and to social and religious norms (Bongaarts 2004). Preferred family size remains high in much of sub-Saharan Africa. Knowledge of modern contraceptive methods tends to be high, and ever-use tends to be much higher than current use among married women (for example, over one third of married women in Nigeria).

Poor access is also a factor. Unmet need, where women want to space or limit number of births, but do not use contraception, is an indicator of limited access as well as potential demand. It is lower in Nigeria, at only 17%, but increases to 27% in Zambia, nearly 33% in Cambodia and 35% in Uganda. Reasons for lack of use are various, but include limited geographical access, especially in rural areas; fears about side effects and high discontinuation rates (especially in Cambodia); and disapproval of using contraception by the woman, her husband or family. Facility stockouts are a major disincentive. In Nigeria, a JSI/Deliver rapid assessment in 2001/02 revealed high levels of stockout of contraceptives in the public sector – three quarters of facilities visited lacked oral contraceptives (OCs), 60% lacked condoms, and half lacked injectables (ICs).

Significant numbers of users obtain their contraceptive supplies from the private sector, especially condoms and oral contraceptives. As shown in Table 2, these are mainly socially marketed brands, distributed through the retail and NGO sectors, rather than commercial products.

Although there is little data on service utilisation by different socio-economic groups, financial and other access barriers to the poor are clearly an issue. The DHS in Nigeria shows major differences between the rich and the poor – ranging from only 7% CPR in the lowest quintile to 30% in the highest.

As shown in Table 1, maternal mortality remains high, along with low levels of skilled attendance or facility based births, in all four countries. Contributing factors range across the three delays[4], but lack of skilled human resources, poor supervision and quality of care and inadequate supplies are highlighted in all four country case studies. Uganda has seen declining levels of facility delivery, from over 25% in 1999 to 20% in 2002/3, despite the removal of user fees. This has highlighted low consumer confidence, which is linked to systemic failures in providing supplies and equipment, and in retaining qualified and motivated staff with high standards of patient care.

[4] Pregnancy-related mortality is mainly due to three delays in accessing care: (1) deciding to seek appropriate medical help for an obstetric emergency; (2) reaching an appropriate obstetric facility; and (3) receiving adequate care when a facility is reached.

Table 1: Reproductive health indicators

Country	RH indicators					
	Maternal mortality ratio	Facility based births	Total fertility rate	CPR (mod)	Unmet need	HIV prevalence (15-49)
Cambodia	437	32%	4	19%	33%	1.9%
Nigeria	704	33%	5.7	8%	17%	5%
Uganda	505	20%	6.9	23%	35%	4.1%
Zambia	729	Under 25%	5.9	34%	27%	16.5%

Sources: Cambodia DHS 2000; Nigeria DHS 2003, MICS 1999; Zambia DHS 2001; Uganda DHS 2001; Uganda PEAP 2004

Table 2: Market shares for main modern contraceptive methods

Coverage/ market share 2004	Male condoms			Oral contraceptives			Injectable contraceptives			Emergency contraception			Intra-uterine contraceptive devices (IUCDs)		
	Pub	SM	Com	Pub	SM	Com	Pub	SM	Com	Pub	SM	Com	Pub	SM	Com
Cambodia	9%	88%	3%	52%	38%	10%	65%	11%	24%						
Nigeria	3%	81%	16%	18%	74%	8%	48%	46%	6%	0%*	75%	23%	63%	36%	1%
Uganda					64%			65%							
Zambia	49%	47%	4%												

Note: PSI data. Pub = public; SM = social marketing; Com = commercial
Public sector includes smaller % for NGO sector (publicly sourced commodities)
**Plus 2% emergency contraceptives by NGOs, Nigeria*

3.2 Policy, aid and reform environments

Key features of the four countries are summarised in Table 3. This highlights several major similarities and differences with respect to the context and the agents that are driving RHCS responses.

Poverty reduction, health and reproductive health policy: In three of the four countries, poverty reduction strategies or their equivalents feature the links between health, reproductive health and poverty, and make a strong commitment to improving RH services in the context of the MDGs. For example, Uganda's Poverty Eradication Action Plan includes the provision of RH commodities, including free essential drug supplies for pregnant women and increased contraceptive supply. However, Zambia's current PRSP does not feature links between poverty and reproductive health, and there is no linkage with the sector plan.

Reproductive health is among national health priorities in each country, included in the basic health package in Cambodia, Uganda and Zambia. With the exception of Zambia, health sector policy and plans include the main components of reproductive health. In Zambia, national level policies do not give a prominence to RH, and several of the sector level policies and plans that directly relate to improving RH status and which could impact on commodity security, have not yet been finalised and implemented.

Table 3: Policy, financing and institutional context

	National policy environment	Aid environment and major players	Financing, procurement and distribution arrangements	Public-private sector issues
Cambodia	RH highlighted in new draft PRSP, health and RH policy and strategy. Safe motherhood and child spacing prioritised during heath sector review in 2005. No clear RHCS strategy in new national RH plan. Contraceptive security working group includes public, social marketing and NGO members.	Support to health sector plan though joint donor Health Sector Support Project, including UNFPA. Vertical MOH programmes have strong presence and parallel funding. Sector wide management in development (SWiM).	KfW is major donor, with a German procurement agent supplying public sector at request of government with internationally tendered contraceptives; support likely to phase out Safe motherhood commodities purchased through MOH essential drugs system. GFATM projects use separate procurement systems. Contraceptive logistics system *may* expand to support drug distribution, but weak capacity.	Social marketing has substantial market share. Weak interface with public sector. Limited commercial market.
Nigeria	National development strategy (NEEDS) highlights MDGs. Major health sector reforms initiated, RH services are under maternal health objective. Service delivery devolved to state and local government where capacity limited. National health programmes fragmented and underfunded. No budget line but RHCS strategy developed through Strategic Pathways to Achieve RHCS (SPARHCS)	No donor support to national or state budgets. DFID and WB planning sector/budget support for system strengthening to states. USAID and CIDA are main RH funders, implemented through technical agencies (Deliver, Enhanse etc) and UNFPA respectively. DFID and USAID fund the large social marketing programme.	Contraceptives and condoms procured centrally by UNFPA using mix of country and global funding. Condoms also to be supplied through World Bank MAP, to be procured by government. Procurement and distribution of most other commodities (safe motherhood and STIs), through weak decentralised drug supply systems. New delivery kit proposed for central supply and distribution. Weak reported and forecasting, but performance improving.	Major social marketing programme. FBOs supply 40% of health services, but national supplier does not stock contraceptives and condoms. Limited but consultative public-private interface through RHCS Group. Very limited commercial market (attributed to high leakage rates)
Uganda	RH highlighted in Poverty Eradication Action Plan and Health Sector Strategic Plan. Injectable contraceptive included as one of six marker drugs in the PEAP monitoring framework. Contraceptive security working group but no RHCS strategy.	SWAp since 2000. Poverty Action Fund is the main conduit for budget support and debt relief funding, channelled to both central and decentralised district budget lines. Several donors provide parallel financing and use their own procurement processes, for RH and other central and district activities.	Government committed about 1/3 contraceptive procurement budget in 2002/03, but underspent. Products supplied in kind by USAID and UNFPA. Safe motherhood and STI drugs supplied through government channels, purchased with funds in MOH/DANIDA earmarked drug account. Condoms procured with World Bank finance by MOH. Integrated commodity distribution, but weak capacity at facility level to manage pull system.	Significant social marketing programmes for condoms and contraceptives run by several organisations, including MSI voucher scheme for STIs. Faith based supplier does not distribute contraceptives and condoms. Limited commercial market. Public-private leakage estimated at 10%.
Zambia	RH, including maternal health, is in PRSP, but national level policies do not give RH or RHCS high profile or have not been finalised. Key services are included in basic package. No RHCS strategy, commodity working group proposed.	SWAp since 2000, plus major reforms to separate policy making (MOH) and operational function (CBOH) – now being reversed. High levels of parallel funding often to district based activities, where little co-ordination with public sector.	No budget. Contraceptives and condoms supplied by donors including DFID, UNFPA, USAID, and others – weak co-ordination. History of troubled government procurement and distribution has led to parallel systems. Progress now possible through reputable third party procurement and govt. commitment to a drug budget line, to incl. RH commodities. Weak capacity at central and district levels.	Significant social marketing programmes. RH programme has made some efforts to liaise and co-ordinate. Over 40% health services delivered under contract to govt. by FBOs – supplier does distribute contraceptives and condoms.

However, the PRS includes a section on addressing RH issues and could provide a spur to provide for needs that are not adequately addressed; in 2005 funding has been allocated to MoH and programmed support of achieving better maternal mortality. Health sector performance assessment frameworks include RH objectives, along with indicators such as attended delivery and use of modern contraceptive methods. Nigeria's new health sector reform strategy emphasises maternal health care, and includes access to emergency obstetric care, child spacing and other RH services under this objective.

RHCS policy and strategy: RHCS features in national health and RH strategies, but is referred to mainly in terms of ensuring equipment and drugs supply, and strengthening logistics systems. With the exception of Nigeria, the countries lack an explicit RHCS strategy. The countries also lack a fully developed set of RHCS indicators that relate to policy, financing, supply, logistics and distribution, and utilisation, that have been agreed by government and development partners. RHCS indicators do not generally feature in the RH strategy, nor in the health sector performance measurement framework. However, somewhat unusually in Uganda, an injectable, the most popular public sector contraceptive, is one of six indicator drugs for monitoring facility stockouts in the new Poverty Eradication Action Plan (Uganda's PRSP). This gives RH commodity security an important profile.

Decentralisation and governance roles: The degree of decentralisation (or devolution) of governance and service delivery functions, is a key driver of progress in implementing RH policy. National ministries of health are playing increasingly limited roles in managing and delivering services (as opposed to strengthening their policy making and other stewardship functions such as standard setting and performance assessment). Responsibility for health service delivery is fully devolved to state and local government levels in Nigeria. It is decentralised to provincial or district authorities in the other three countries, usually under line management of the ministry of health, but often with accountabilities to local elected governments, who therefore have some influence on priority setting and resource allocation. Capacities tend to be weaker at lower levels, and resources limited.

Aid financing and reform efforts: Progress in donor harmonisation and alignment with national health policy and plans is ongoing, but depends on national context. Two of the countries, Uganda and Zambia, have had sector wide approaches since 2000, where the public health sector's activities are prioritised according to national policy and set out in a unified plan and budget.

In Uganda, the Poverty Action Fund (PAF) is the main conduit for budget support and debt relief funding. It is a 'virtual fund' in that PAF resources are part of general government budget resources, including domestic allocations, and sector and budget support. PAF allocations represent over two-thirds of the health sector budget (although out turns are lower than this) and are channelled to both central and district budget lines. In practice the SWAp remains a 'broad church' in that several donors continue to provide parallel financing and use their own procurement processes, for RH and other central and district activities.

Donor partners in Zambia continue to support the government's sector strategy, although progress has been troubled, in particular concerning lack of donor confidence in government procurement arrangements. The focus has been on strengthening systems and management capacities, supported by channelling funds through pooled donor baskets at central, district and hospital levels. A Central Board of Health was set up to implement new reforms, with the MOH taking the stewardship

and policy making role. However, major reforms to merge the two bodies were initiated in 2005, bringing inevitable change management challenges.

Cambodia's MoH has a sector-wide management approach (the SWiM) to support the National Health Strategic Plan, and to coordinate the national programmes and donor activities, through a national planning and review process, backed up by the multi-donor Health Sector Support Project (HSSP). The majority of funding is still off-budget to national, vertically managed programmes, including RH.

In Nigeria, the new government has launched a major health sector reform programme. Following decades of military rule, Nigeria's health system is weak, poorly co-ordinated and fragmented, with very limited capacity to plan and deliver services at state and local government levels. At Federal level, a number of vertical programmes operate, including RH, TB, immunisation, and ARV treatment. All donor funding is currently off-budget, and channelled through technical assistance, implementing partners and UN agencies, but there are World Bank and DFID plans to provide social sector and budget support at state level within the next two years.

A range of aid modalities and channels influences the implementation of RH and RHCS policy. It is important to note that parallel financing to projects and technical assistance, and direct procurement providing commodities in kind, are used by donors in all the countries, including those with significant health sector financing through a SWAp.

Examples include:

- project based activities with government (eg WHO district pilots in Nigeria, Zambia and Uganda; district based programmes in Zambia supported by UNFPA, WHO, CIDA, GTZ, DCI Ireland, UNICEF)
- geographically based project support to civil society (USAID Compass)
- technical assistance to national RH policy and developing an enabling environment (USAID Policy Project, now Enhanse; international NGOs; DFID Uganda through the RH Unit in Zambia)
- technical assistance and finances for health policy and systems (eg PATHS Nigeria)
- technical assistance to improving national supply and distribution (Deliver in Nigeria and Uganda; an NGO in Cambodia, both supported by USAID; UNFPA technical assistance)
- direct procurement on behalf of, and donation of RH commodities (USAID, UNFPA, KfW) and other health supplies (DFID PATHS Nigeria)
- financial assistance and direct procurement for social marketing affiliates (implemented by PSI, MSI, SFH, funded by USAID, DFID and KfW)

Moreover, in all four countries there have been recent significant increases in project funding to AIDS and other communicable diseases through global health partnerships such as the GFATM, and other major health initiatives such as PEPFAR and the World Bank's Multi-country AIDS Program. Such global funding increased public expenditure on health in the four countries from nearly 50% (Cambodia) to over 100% (Zambia) (DFID HSRC 2004). Funded activities tend to be through vertical programme channels and project-based.

4 FINDINGS AND KEY ISSUES

4.1 Efforts to strengthen financing, procurement and supply

Sub-categories of RH commodity supplies are treated differently, depending on the organisation of financing and procurement channels. Contraceptive commodities for the public sector are usually supplied centrally through third party procurement, using funds drawn from sources including national donor allocations and international funds such as those held by UNFPA.

Commodities for safe motherhood and STIs are subsumed within essential drugs budgets. Safe motherhood and STI commodities tend to be procured and supplied through the channels used for other essential drugs, mainly by central government or other national bodies, as well as through decentralised processes at facility and other levels in the health system. Donors such as the World Bank and DFID may be involved in funding them.

None of the countries' public sectors are directly purchasing contraceptive supplies, whether with national or international funding. Figure 1 shows that procurement and financing functions are undertaken by international or national bodies. Government agencies in all four countries are responsible for procuring ARVs and/or condoms, in accordance with GFATM or World Bank guidelines, as well as other essential drugs. In contrast, of the four countries, although Uganda has made government budget allocations to contraceptive procurement, only Cambodia purchases commodities (condoms) for the public sector with domestic finance. Contraceptive commodities are procured by major donors, or contracted out by them to third party agents, drawing on bilateral or global level finance. Procurement practices vary: most donors specify international competitive bidding while others, notably the US, specify US manufacturers (although there are signs of increasing flexibility).

For contraceptives, donor dependence is high. Domestic budgetary commitments to contraceptives range from extremely low in Cambodia, near zero in Nigeria and Zambia, to about one third of the US$1 million contraceptive budget in Uganda (although this was underspent in 2004). However, it is often difficult to disaggregate RH and RHCS from other budget lines in basic health care, thus making it difficult to identify RH budgets. In Uganda, from 1997 to 2003 there has been significant increased allocation to primary health care, from only 5% of overall health spending to 42% in 2003. RH is not costed as a separate programme within the sector plan because of the way that service delivery and budgeting is decentralised and because of the increasing integration of services at district level and below. This makes it impossible to say to what extent budgets and expenditures on RH have increased. An RH accounts tracking study is under consideration, in order to gain a better understanding of expenditures.

Where contraceptive commodities are externally procured and provided by agencies in kind, national stakeholders may not be aware of the total budgetary value, which has implications for budgeting and financial planning. In Nigeria, all public sector contraceptives, and some condom procurement, are financed by UNFPA on behalf of government, drawing on country programme and CIDA funds, as well as global level UNFPA funds. However, the total figure for commodities procured for 2004 was not available. This included US$2.5 million of procurements using country funds, and products ordered in kind (value not reported to national level), both procured through UNFPA HQ.

All the reproductive health programmes are in receipt of technical and project assistance, as well as commodity supplies. It was not possible to assess relative allocations to commodities versus technical support, for reasons given above, but it is estimated that the majority of funds are invested in commodities. Overall, UNFPA estimates that 90% of its commodity related finance is funding direct procurement, rather than capacity building (Schwanenflugel 2005).

Figure 1: Procurement and financing functions

	Procurement by national body ***Govt. or local agent***	**Procurement by international body**
National financing ***Donor and government finance at country level***	Uganda's budget for RH includes an allocation for commodity procurement, to be carried out by government. Most essential drugs (including safe motherhood and STIs) are procured by government, through national budget allocations. Cambodia purchases some condoms, KfW contracts a third party agent at request of government using bilateral funds in Cambodia Third party procurement and funds pooling planned in Zambia. Uganda procures condoms with WB funds; Nigeria plans to.	National donor funds support procurement by UNFPA in Nigeria (CIDA) and Zambia (DFID). USAID allocates bilateral funds and procures for MOH in Uganda and Zambia.
International financing ***Eg UNFPA and GFATM***	Zambia, Uganda and Cambodia procure condoms with GFATM funds. Nigeria procures ARVs with GFATM funds.	International pooled funds support contraceptive procurement in the four countries (by UNFPA).

Financing and procurement tend be fragmented and poorly co-ordinated, where there is more than one donor, as in Cambodia, Uganda and Zambia. The RH division in Uganda relies upon a variety of external sources for funding contraceptives in addition to government allocations. Its two main donors, USAID and UNFPA, neither pool their aid and nor are their contributions represented in the government budget as earmarked funds or credit lines. This is despite the stated aim of the government to direct as much support as possible through its budget. Donor contributions are effectively off-budget and not consistently reported to government.

With major donors such as USAID using their own procurement methods, and operating on relatively short timescales for commitments (in contrast to commitments for budget support which may be up to five years), MoH transaction costs are increased, in terms of being responsive to several donor systems. This is compounded by a way of working in which government and donors are failing to develop a government-led planning and budgeting process that adds up to a meaningful whole.

A similar situation holds in Zambia. Although commitments are made readily, partner agencies are perceived to be maintaining their own systems and failing to co-ordinate their activities, despite recommendations made by the national donor-government procurement working group. Both UNFPA, acting as a procurement agent, and DFID have been criticised for insufficient communication with government. In 2005 47

million condoms financed by DFID arrived unexpectedly in the medical stores, creating problems with storage and distribution.

Donor confidence in the Zambian government's procurement and distribution procedures has been low, due to a series of poorly governed contracts issued by government for managing the medical stores. Confidence has been further undermined by lack of clear responsibility for procurement functions in the MOH and CBOH, which should be resolved during the 2005 merger. A recent review of government tenders revealed more than five different procedures in use at national level. Such issues have given partners such as UNFPA, DFID, UNICEF and USAID little incentive to consider alternatives to parallel and project based financing of supplies. Several procurement and distribution arrangements have developed, including for equipment for manual vacuum aspiration (for post abortion care), for example, supplied through the University Teaching Hospital.

In Cambodia, high levels of fragmentation also persist, despite government and donor desire to rationalise approaches. All public sector contraceptive supplies are funded and procured by the donor community, principally by KfW. Under agreement with the government, procurement is undertaken on government behalf, and in liaison with the relevant departments, by external consultants based in Germany. Several donors procure supplies for social marketing. GFATM procurement of condoms and commodities for the diagnosis and treatment of STIs is through the Fund's principal recipient, which, although being in the MoH, uses external agencies rather than the national procurement unit. Commodities for safe motherhood are purchased through the annual budget allocation to the MoH. National hospitals, provinces and operating districts can procure directly, according to a specified competitive tender procedure, and through the MOH procurement unit, drawing on funds allocated from the national budget as well as internally generated user fees.

Box 1: Government of Uganda's contraceptive and drug financing arrangements

The MoH is allocated a central budget for RH which allocates funds for about a third of public sector contraceptives, done for the first time in 2002. These funds are available for the districts to order free of charge. As a Poverty Action Fund budget line, it should be afforded various benefits, such as protection from in year budget cuts in favour of other budget lines, and more rigorous reporting and monitoring to ensure that the funds are spent as planned. In practice however the procurement budget has been progressively under spent, for example by about 50% in the last financial year.

One reason for this lies in difficulties of linking procurement with resource availability and the need for economies in scale in procurement. Government funds need to be accumulated in order to be able to place international orders, and usually reach sufficient levels just before the last month of the financial year. Any unspent funds held must be returned at year end. Timely procurement within that narrow window is essential, but not always possible.

In contrast, drugs are funded through an arrangement between DANIDA and the MoH for pooling earmarked finance. Donor and domestic funds are kept in a separate account that is not subject to claw back at the end of the year. PAF funded conditional cash grants plus a central credit arrangement are allocated to each district's drug budget line, including drugs for safe motherhood and STIs. The credit lines for the amounts indicated in the district budgets are held at National Medical Stores on behalf of each district, based on the same equity formula for district grant allocations, and with some sensitivity to population and poverty levels. As districts order drug supplies the amounts are deducted from their credit lines at NMS, which is in turn reimbursed from the MoH/DANIDA account.

The funds can therefore only be used for drugs, thereby offering protection and generating consistently high utilisation rates (more than 75% in all cases in 2003/04). In contrast, there was a marked under-spending of the conditional cash grants allocated to drugs, despite the guidelines on conditional grant usage which preclude spending on other items. This drug

financing system enables both government and donor requirements to be met, and facilitates government led procurement processes, as well as national budget allocations.

Table 4. Efforts to strengthen RHCS: promising developments and limitations

	Promising developments	Limitations
Cambodia	PRS, health strategy and new sector wide approach giving priority to reproductive health; highlighted in 2005 joint sector review. Sector wide management donor group includes UNFPA. Commodity security working group with public and NGO members. Contraceptive logistics system developed and functioning. Significant and effective social marketing sector.	Public sector lacking ownership of RHCS – undermined by lack of a clear RHCS strategy and budget line, and a donor-led commodity security working group; weak public sector procurement capacity; logistics system managed by NGO, contracted by USAID; limited capacity at facility level. Possible risks of donor withdrawal; and funding shortfalls. Separate procurement system developed by GFATM principal recipient; separate condom group and programming. Limited co-ordination with social marketing – missed opportunities to develop demand across public and private sectors. Low demand, low prioritisation and weak accountability at local level.
Nigeria	Emphasis on maternal health in the national development strategy and health reform plan gives opportunity to advocate for RH, which is included under MH objective, new budget line for MH RHCS strategy developed through Strategic Pathways to Achieve RHCS, includes wide range of stakeholders (SPARHCS); safe delivery kits planned through not funded. Investment in logistics and revolving funds resulting in reduced stockouts at facility level and improved forecasting. Growing efforts to build support among religious organisations for RH, and increase demand Efforts to increase accountability for safe motherhood at state and local levels. Significant social marketing and faith based sector	MDG focus has missed opportunities for highlighting wider RH issues (emphasis on maternal mortality reduction and immunisation). No budget line for RHCS. Funding only secured until 2008; funding shortfalls for TA Safe motherhood and STI commodities supplied through the decentralised system for essential drugs, regarded as weak RHCS group used mainly for consultation/information, not strategic development; weak links with national AIDS programme and council Limited co-ordination with social marketing – missed opportunities to develop demand across public and private sectors Contraceptives and condoms not distributed by faith based supplier Low demand and weak accountability at state and local government level.
Uganda	RH in PRS and health sector plan, and RHCS highlighted in SWAp planning and review processes. Contraceptive included as indicator drug at facility level in the PRS monitoring framework; significant contraceptive budget line in the ringfenced Poverty Action Fund. Commodity security working group but no RHCS strategy. Efforts to strengthen and integrate government procurement, forecasting and distribution functions, using the new 'pull' system at facility level Ringfenced drug budget line enables value for money procurement and has resulted in increased utilisation by facilities. Already includes safe motherhood and STI products; has potential to include contraceptives Significant social marketing and faith based sector	Government focus on gap filling and shopping around donors for commodities, rather than strategic and co-ordinated planning; fiscal issues appear to reduce ability to use allocated budget Multiple donors responding to short term requests, often through financing emergency procurements, contributions not represented in government budget Possible risks of donor withdrawal; funding shortfalls Limited co-ordination with social marketing – missed opportunities to develop demand across public and private sectors Contraceptives and condoms not distributed by faith based supplier Low demand and weak accountability at district level.
Zambia	Key RH services included in basic package UNFPA has contributed to the SWAp, increasing leverage and influence RHCS group proposed. Potential to increase RHCS through donor agreement for reputable third party procurement, capacity building, and govt. commitment to rationalising procurement functions and institutionalising a drug budget line, including RH commodities, including finance and in kind donations. Significant social marketing and faith based sector – latter supplies RH commodities incl. condoms, using a revolving drugs and commodities fund.	Lack of clear prioritisation and linkages between RH in PRS and sector plan; health sector funding fragmented especially at district level despite SWAp No RHCS strategy or commodity budget; limited central capacity Possible risks of donor withdrawal; funding shortfalls Several RH donors - lack of donor confidence in government procurement and distribution procedures resulting in parallel financing channels for commodities and poor co-ordination of procurements and technical assistance. Weak capacity for forecasting and for using new pull system. Low demand and weak accountability at district level. Limited co-ordination with social marketing – missed opportunities to develop demand across public and private sectors

Significant efforts have been made in recent years to strengthen procurement and supply systems. Approaches vary, depending on the reform context and aid modalities in operation (see table 4).

Emphasis on health system strengthening, facilitated by a sector approach, is enabling progress with integrating procurement and supply systems, thus reducing duplication. The Ugandan government's sector strategy includes the integration of procurement functions. Progress has been made. Donors such as DANIDA have invested in improving capacity and performance of the national medical stores to carry out international procurement, to manage supplies, and to streamline working arrangements between MoH and the national medical stores (NMS). Although the NMS is reported to be only operating at about 60% capacity, there is evidence of improved performance. RH drugs for safe motherhood are funded, forecast and procured through the pharmacy division, which manages essential drug supply in MoH, with NMS acting as procurement agent.

In Zambia, the contract for managing the medical stores has been awarded to Crown Agents, and includes a capacity building component. The government is also proposing the introduction of a new drug supply budget line, managed centrally and overseen by a joint donor-government committee. The budget line would include in-kind contributions, including for contraceptives and hence enable a more harmonised approach to commodity financing, as well as timely and value for money procurement for a unified list of essential commodities.

The new drug supply budget line and the proposed national procurement planning in Zambia should improve integrated systems and will start to remove the need for the fragmented interim arrangements. Donor buy-in to pooled funding is critically dependent on improved confidence in the revitalised procurement function. Co-ordinating financing, ordering, procurement and distribution will also require improved communication between different departments, including RH, in the MOH, the Central Board of Health, and the medical stores. Greater transparency and a rational integration of procurement functions will be a key test of the extent to which the government can and will address fundamental problems in the system.

There have also been efforts to strengthen forecasting, although capacity remains limited in all four countries, largely due to weaknesses in stock management and consumption monitoring and reporting, and challenges in compiling supply data from multiple sources and in estimating demand. There is also a lack of long term projections, except in Nigeria, where estimates to 2015 were developed as part of the SPARHCS process.

Recent efforts in all four countries have focused on the introduction of new 'pull' system for ordering at facility level, to replace or complement the various push systems using standard drug kits, for example. Box 2 describes Nigeria's recent successes, as well as continuing challenges, in revitalising its national vertical supply and logistics system for contraceptives and condoms through the SPARCHS process.

The pull system is designed to minimise wastage and improve stock control, but it is highly dependent on local capacity for forecasting, supply and stock management, plus adequate supervision and monitoring. This is a major change for most providers, and there is limited finance and TA available for on the job training. Monitoring and supervision, and adequate funds to enable, for example, transportation of supplies rather than recourse to patient ambulances, are needed.

However, Uganda's integrated distribution and logistics management information system represents a significant achievement in line with the unified approach to commodity supply set out in the health sector plan. The fact that depo provera (an injectable contraceptive) is one of six indicator drugs for facility stock outs in the new poverty reduction strategy gives RH commodity security an important profile. High utilisation rates for the ring fenced drug credit lines indicate a good response to the new system both by NMS and facilities ordering drugs.

In Cambodia, although contraceptive logistics are reasonably well managed, there has been limited progress towards including other commodity supply systems. The national 'district drug inventory database' was developed by the NGO, RACHA, with funding from USAID. As a KfW report noted in 2004: 'After eight years of cooperation between the government's essential drugs programme and RACHA, efficient logistics management for operational districts and at national level has almost reached maturity and the system is internationally recognized. It is now operational in 61 of the 76 operational districts…. However, it takes substantial effort in support to maintain the computer based system functioning in so many peripheral units.'

So far, despite its name, the Cambodian system is only used for contraceptives, but stakeholders aim to integrate all reproductive health commodities, and other essential drugs. This is complex, with the different procurement and supply channels that have not been incorporated fully into the essential drugs function. In addition there are concerns that technical capacity remains in the contracted NGO, rather than strengthening capacity in the MoH.

Zambia's limited capacity in the RH Unit means that it is difficult to see how with present staffing the RHU could strengthen policies, or support their implementation. This is likely to be exacerbated by the reintegration of MoH and CBoH which may reduce capacity at the centre because of changes in staff terms and conditions leading to staff resignations and demotivation. These capacity problems come at a time when the growing human resources problem in Zambia continues to undermine efforts for improvement.

Box 2: 'Strategic Pathways to Achieving RHCS': SPARHCS in Nigeria

In line with Nigeria's devolved system, most essential drugs and supplies (including for safe motherhood and STIs) are purchased at state and facility level. There is widely reported lack of transparency, and limited economies of scale or use of quality assured sources. Although government is supporting the revival of drug revolving funds, facility supplies are erratic and weak, dependent on out-of-pocket (patient) finance, and frequent emergency local procurement. Certain vertical programmes at national level, including for TB, immunisation, receive in-kind products centrally, and store and distribute them, although supply and distribution management systems are weak. ARVs are the only major drug procured at national level.

Nigeria's recent efforts to strengthen the contraceptive supply system in the public sector are therefore positive. These efforts can be in part attributed to the legacy of the pre-1999 military government. The withdrawal of USAID as the major funder in 1995, following the international de-certification of Nigeria, had a profound and devastating impact on RHCS, and brought questions of finance and sustainability to the fore. The Federal ministry's RH Unit director made a request for Nigeria to be the first country to adapt the Strategic Pathway to RHCS process, following the 2001 Istanbul commodity security conference.

The process resulted in four major outputs:

- *a thorough assessment and understanding of the problems and challenges for the six components of RHCS (finance, policy, logistics, service delivery, demand and co-ordination)*
- *a consensus among the major government and development partners about short and medium term actions needed, with special focus on re-designing and re-introducing the Commodity Logistics Management System (CLMS).*
- *an RHCS strategy – the Strategic Plan for Reproductive Health Commodity Security 2003 – 2007, plus projections to 2015.*
- *new funding from CIDA, supplemented by commodities financed by the UNFPA country programme and global trust fund*

Its initial success was due to the combination of strong government leadership by the RH Unit, co-ordinated technical inputs provided by JSI Deliver and UNFPA, and by the engagement and involvement of stakeholders across public, civil society and social marketing sectors. The RHCS Stakeholder Group continues to be consulted on major issues.

In terms of results, there have been improvements in availability at service delivery points – availability of most commodities is above 75% at all levels. This is in contrast to an assessment in 2001/02, which revealed equally high stockout levels.

Concerns about donor dependence and sustainability also led to the introduction of a four level cost recovery system, which is enabling the ring fencing of funds at each level to support purchase from the next level, as well as transport and supervision. At national level, a small reserve fund is accumulating. Discussions about use of the funds are in process – for example as a revolving purchase fund, a reserve in case of donor withdrawal, support for infrastructure development or the introduction of new commodities.

However, there are also serious challenges. The focus has been on supply systems, with less emphasis on the enabling policy environment and demand creation. There is limited funding for training in some states, and the new pull system is demanding on facility staff. Reporting and stock management at all levels is weak, which severely limits accurate forecasting and appropriate stocking. Funding shortfalls are likely, unless other donors support procurement and capacity building. Overall, government capacity to forecast, budget and plan for commodity supply is growing, but still has limitations. There is no national budget line, and national donor funding is not sufficient to meet needs. UNFPA draws on international sources through its global funds.

4.2 Impact of wider policy and reform environments

RH appears to be receiving greater attention at higher levels among health policy makers and planners in all four countries, due to two main factors. First, there have been advocacy opportunities for greater prominence where it is included and monitored in the PRSP, health sector strategy and the essential health package, and where progress is reviewed by multiple stakeholders as part of a sector management approach.

Second, at least at national policy levels, there is increasing importance ascribed to strategies for meeting the MDGs, by donors and government. Although the MDG emphasis is on reducing maternal mortality, rather than the broader RH objectives which are not represented in the MDGs, this has offered opportunities for advocacy on prioritising RHCS.

In Cambodia, the joint health sector review, which involves major stakeholders across government, civil society and donors, highlighted reproductive health in 2005. It identified access to emergency obstetric care, skilled attendance at delivery and birth spacing as three of the five priorities for the ministry of health.

Similarly in Uganda, high maternal mortality and total fertility rates, coupled with the low contraceptive prevalence, have ensured that reproductive health has featured during recent annual health sector reviews. In 2003 the negative impact of commodity stockouts on efforts to reduce maternal mortality was highlighted, as well as shortages of contraceptives contributing to low levels of family planning usage. In the National Health Assembly of 2004 the donor statement highlighted concern over the high fertility rate and population growth, emphasising the need for political backing to address maternal mortality. There was also a specific resolution by the assembly as a whole that district health managers should prioritise the procurement of RH supplies.

Zambia's new PRS includes a section on addressing RH issues and could provide a spur to provide for needs that are not adequately addressed; in 2005 funding has been allocated to MoH and programmed in support of reduced maternal mortality.

Emphasis by the Nigerian government and donors on the MDGs, and in particular on reduction of maternal and child mortality is resulting in increased attention and resource mobilisation. There is substantial dependence on external funding across all Federal government departments, and RH as seen as one of the 'donor driven' programmes. Following strategic advocacy by the RH Unit for a newly named budget line for maternal mortality reduction, RH was allocated a budget at Federal level for the first time in recent years (albeit nominal) in 2004. However, there is a risk that the stress in the national health sector reform programme and by major donors such as DFID and the World Bank, on improving access to essential obstetric care may crowd out other RH components. On the other hand, this focus is also presenting an opportunity for re-positioning RH that some advocates are exploiting positively.

Furthermore, efforts to strengthen the public health system as a whole have resulted in benefits for aspects of RHCS in some countries. These include support to integrated procurement and distribution systems, as described in the previous section.

Wider reforms in the health system in Uganda have been important for commodity security. Government allocations through the Poverty Action Fund are an important step. Although problems remain with the health management information system, it is now more reliable. Regular remuneration has increased staff motivation to provide better services and operate the distribution system. The ending of user fees in 2001 has had a major impact on attendance at outpatient health facilities which should lead to higher contraceptive use, such as injectable contraceptive use (although figures remain low for facility based births).

The assessment found that in Zambia, the sector wide environment has provided a forum for raising concerns about integrated systems issues such as medical stores performance. In many ways, the SWAp and wider reforms have not greatly affected RH – major donors continue to engage with the small RH team as part of support to parallel projects, often using separate monitoring arrangements. In general, the strong systems focus is also felt to have been to the detriment of technical improvements in services, including RH.

Nigeria's situation is somewhat different, where a ring fenced approach to RHCS is being taken. There are continuing fears that family planning is seen as an 'appendage', which will not be prioritised if a choice must be made between drugs and contraceptive purchase and supply (if included in an integrated drug fund or logistics system for example). This is not surprising given the weaknesses in the health system at state level, poor access to other commodities such as essential

drugs, concerns about the marginalisation of family planning in the face of public health emergencies, and continued donor support to vertical programmes at Federal level, including new ARV programming.

In effect, a highly verticalised system has been re-introduced in Nigeria for contraceptive supply (operating in a similar way to that of the TB programme, for example). Indeed, there are new plans to introduce a centrally funded and supplied safe delivery kit through the same system, in order to meet women's and facility needs for supplies and basic drugs that are often not available through the decentralised drugs supply system.

However, donors are unlikely to provide on-budget support at federal level in the near future. DFID and the World Bank are planning to focus on 'lead states' from 2006, to support public sector reform and public private partnerships through a range of aid modalities, including sector and budget support at state level. While federal and international resources for RHCS will continue to be critical, additional resources may be leveraged at state level.

4.3 Challenges of translating policy commitments into action

Despite national policy objectives, the wider political will to really impact on RH continues to be questionable – any commitments remain mainly paper ones. Many interviewees cited the persistently poor maternal mortality figures and low rates of family planning uptake as evidence that there is insufficient commitment to translate policy into action – so called 'implementation slippages'.

Such slippages can be primarily attributed to four linked factors: weak ownership, planning, resource allocation and co-ordination at all levels; limited translation of national priorities into decentralised or devolved planning, budgeting and implementation processes; limited accountability for delivering on national priorities; and low demand by both consumers and their political representatives (to the extent of opposing demand creation in some contexts).

In Uganda, the national health sector and reproductive health strategies provide a basis on which to make concrete costed action plans to address both RH and commodity security. However, the lack of financing certainty, coupled with donor behaviour means that the RH programme's annual workplan takes the form of a budget, with the prime aim of factoring in donor contributions and identifying the resource gap.

While the two main financing partners develop plans with Ugandan government, these tend to be oriented towards their own particular priorities. So whilst the aims of the RH strategy are laudable, and despite the close relationship between RH division and its donors, the annual plan of work does not enable the co-ordination of donor inputs to meet supply and other programme needs on a stable and predictable basis. Moreover although indicators are identified, there are no baselines or targets for the activities in the strategy which makes it difficult to translate into annual workplans, and means that monitoring has been poor.

A similar situation holds in Nigeria – although the RH and RHCS strategic framework provides solid overall direction, and the RU Unit has developed an RHCS operational plan for 2005/06, there is no overall picture or map to guide and maximise effort and to support strategic dialogue among partners at national or state levels (although it must be noted that this is true too of other national programmes).

Capacity and political will at levels of decentralised or delegated authority are major drivers of RH and RHCS. The assessments found major barriers to the translation and ownership of policy into district level workplans in Uganda and Zambia where planning and implementation capacity is low and where RH may not be prioritised among so many competing issues. This is often exacerbated by district based activities for communicable diseases funded through global partnerships, and bi and multi-lateral partners. In Uganda, the government has recently introduced a league table for district performance against national priorities. It will be important to monitor its effectiveness as a tool to help promote standards and improve accountability and consistency of performance across the country.

However, there are also opportunities for action. For example, greater political accountability for improving safe motherhood is being mobilised as state governments in Nigeria respond to the MDGs, which provides opportunities for advocacy on repositioning RH.

4.4 National capacity and role of development partners

Donor behaviour and their style of engagement with national stakeholders are critical factors, given high donor dependence for commodities. It appears that government ownership and accountability for RHCS are undermined and discouraged, not necessarily by dependence on external funding but by the limited co-ordination, predictability and transparency displayed by international financing partners.

In Uganda, domestic finance accounts for a third of the commodity budget. However, external support tends to be only programmed for a maximum of two years, and uncertainty over long term donor funding is a constant issue. Reliance on USAID is increasing, meeting over 60% of national commodity requirements in 2004, compared to 30% in 2002. However, USAID may be faced with uncertainty in its own RH commodity budget. While UNFPA's Uganda country office is felt to have been responsive to and supportive of country needs, the assessment found that procedural requirements at headquarters, and the lack of certainty and the need to negotiate central commitments increases insecurity. The Ugandan government therefore 'shops around' its donors in order to mobilise support for various contraceptive commodities, followed by 'gap filling', drawing on domestic resources. This results in frequent and unnecessary emergency procurements.

In Zambia, donor dependence has effectively undermined government responsibility, and has led to RHCS being seen as a donor, rather than a national, problem. Separate donor systems have increased transaction costs and inhibited capacity development.

Effective government and donor co-ordination are essential, irrespective of financing sources. Three of the four countries have RHCS co-ordination groups (with one proposed in Zambia), in addition to RH co-ordination groups. Membership tends to be public sector dominated, so that wider market issues in RHCS such as demand creation are not addressed. They also tend to be used mainly for information exchange, with limited effectiveness in co-ordinating government and donor activities for ensuring commodity security.

In Cambodia, the case study found that the working group was set up at the request of KfW, the main supplier to the public sector. Although UNFPA is playing a significant role in assisting the group in taking the agenda forward and building its

capacity, its strength is tending to decrease government ownership, mandate and capacity.

Although Nigeria is nearly 100% dependent on external funding, the experience with the SPARHCS process, and a strong RHCS Technical Team has helped government and partners develop a reasonably well co-ordinated and transparent approach to managing supply and technical support to the public sector. The situation is simplified in that contraceptive commodity procurement is handled by one agency, UNFPA. However, other financing sources are expanding the condom supply, notably through the World Bank's Multi-country AIDS Program as well as UNFPA, and new socially marketed brands are introduced. The assessment found limited co-ordination of condom programming.

In Uganda, recent improvements in formalising the joint working group, involving donors, the reproductive health division and the national medical stores have been important in promoting better coordination between various procurement and funding arrangements, for the full range of RH commodities. This has been particularly important on the issue of stock outs. Regular meetings of the group, common review of stock levels and other data, and increased emphasis of information sharing has certainly contributed towards an increased focus on commodity security.

UNFPA, and USAID funded collaborating agencies play essential roles in providing technical support for supply and logistics systems strengthening by government. For USAID, this is mainly through the Deliver project in Uganda and Nigeria, and an NGO, RACHA in Cambodia. In Nigeria, although there is good co-ordination between UNFPA and Deliver with government, USAID and UNFPA focal states overlap, which means that resources are not optimally distributed.

DFID has also provided support through TA to the RH units in Uganda and Zambia, and the now ended family planning and HIV logistics project in Zambia, which was based in the pharmacy unit in an attempt to support an integrated approach.

UNFPA country offices are expanding their role in line with overall agency objectives, although there are opportunities to strengthen strategic contributions. In two of the countries, the agency is working with health sector partners to support the integration of reproductive health into health sector planning. In Cambodia, UNFPA joined the sector wide management process in 2004 in order to ensure that UNFPA funding for safe motherhood and birth spacing are integrated into central level workplan review and disbursal of funding within the annual provincial health operational plans, with full ownership and responsibility by the MOH for these services. UNFPA in Zambia provides a small contribution to the national basket fund, which is regarded as an important lever for RH in integrated services, and also supports the inclusion of RH commodities in the drug supply budget line.

Technical contributions by UNFPA to the SPARHCS process in Nigeria and to the joint development of the unified logistics management system are critically important and widely recognised. However, the agency is not yet offering significant support to facilitate overall government leadership in its broader strategic role in RHCS, for example in stewarding the overall market, or in building planning capacity at state level. It is noted that neither the role of, nor links with, the private sector and social marketing, are mentioned in UNFPA's current country programme plan, although its work with NGOs is emphasised. Although reflecting results-based management approaches, the plan's language indicates the mindset of an external player with its

own objectives, rather than a means of buying into and supporting country-led processes[5].

Reliance on a few key partners for technical as well as financial inputs increases system fragility, especially as it appears that USAID may be scaling down national RH commitments. The implications for UNFPA, as it becomes the sole provider of TA, are substantial. In line with the broader trend for integration in Zambia for example, UNFPA proposals for placing technical support in the RH unit will aim to provide support for systems integration, not just for FP commodities.

4.5 Factors affecting national RHCS financing

The studies found a complex mix of incentives driving the behaviour of government and different donors. The country assessments highlighted both risks and opportunities in relation to developments in national and international aid architecture.

There is a major concern in both Uganda and Zambia, that - given hard fiscal ceilings for the health sector in the national medium term expenditure framework - earmarked funds to AIDS and other communicable diseases are crowding out government allocations to other priorities. As a result of budgetary pressures, central budgets such as that of the RH programme tend to be cut or underspent. Although the RH and RH commodity supply line in the Uganda MoH budget is a PAF item, and should therefore have protection against cuts and reallocation, the budget continues to be underspent (by 50% in 2004). Donors respond by substituting government spending with off-budget funds, TA and supplies. This also accords with some donor preferences for commodity or project support, rather than sector or budget support.

On budget resources should offer better flexibility and more predictability for the RH Department. However, in this aid environment, for the RH programme, the comparative predictability of donor funding becomes more attractive than resources allocated through the PAF. In practice it is easier for the programme to mobilise resources from traditional 'RH donors'. The donors are ready to step in when necessary and they can respond quickly to emergency procurement needs. There is also not the pressure to spend within the year to ensure that government money does not revert to the centre.

The assessments found that the longer term prognosis for RH funding is bleak. RH financing and technical support has depended greatly on a few committed partners. However, there are signs that these donors appear to be withdrawing from RH programme and commodity support. Priorities are changing for a range of reasons – USAID in Zambia and Uganda is reducing project based RH funding and TA, and KfW is likely to phase out its public sector support in Cambodia. Some donors are moving upstream, to budget support, such as DFID. In Zambia and Uganda, for example DFID's shift to budget support will have major implications – it could enable strengthened engagement on broader health allocations, procurement and HR functions but on the other hand, DFID could lose influence on RH as well as other health issues.

On a more positive note, the assessments also highlighted opportunities for developing national financing mechanisms that could facilitate the mainstreaming of RH, and pooling of funds.

[5] UNFPA Nigeria RH Sub programme 2002-2007

Uganda's arrangement with DANIDA to manage a mix of domestic and donor funds in a separate bank account is one example. Funds can be rolled over year on year, enabling sufficient accumulation for large orders, and procurement is through the government system with relatively low transaction costs. Although operating only for drugs at present, such a mechanism offers clear potential for other commodity purchase and supply as well.

In the current climate in Uganda, and in other contexts where sector wide approaches are developing, this is an attractive model for the RH programme and some donors to go some way towards sector support, through earmarking funds or credits to a government owned mechanism. Donor contributions or credits can be identified as additional to government funds rather than part of budget support, and avoid the associated risks of fungibility and/or hard budget ceilings. New proposals for a drug supply budget line in Zambia may offer similar opportunities. It is very clear that donor confidence in government's ability to manage national procurement arrangements is a critical pre-condition to such arrangements.

The newly established ring fenced fund in Nigeria, arising from the national cost recovery scheme, represents a significant step towards reducing government dependence on external finance (albeit mainly of symbolic value at present). It also could provide an opportunity for channelling matching finance (from development partners or debt relief sources) to commodity purchase in the medium term, for example to build a national revolving fund that is managed by Federal government for RH commodity supply. A similar example in the faith based sector is offered in Zambia, where the church health association has a drug revolving fund for use by its member organisations. This was seedfunded by DANIDA, and is now self-sustaining within its current scope.

Critically, these types of mechanisms enable ownership of procurement by government, whether the function is delegated to an agency such as UNFPA or Crown Agents or done by government, and irrespective of the source of funds. Such mechanisms are in line with both government procedures and the requirements of some donors for attributable results, and enable timely and value-for-money procurement. It also enables agencies to procure internationally on behalf of government, in terms of ensuring quality and economies of scale.

4.6 Essential commodity policy and supply

Although contraceptive commodities were mainly included in national essential drug lists, some essential safe motherhood commodities were missing, which has significant implications for maternal mortality reduction efforts.

In all the countries, there is a lack of information and strategy for addressing maternal health commodity security, although the importance of supplies is usually stressed in reproductive health policies. At the strategic level, the new Roadmap for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Zambia, developed with UNFPA, WHO and other UN agencies, acknowledged the importance of essential supplies to save lives but does not offer any specific strategies to address the problems of commodity security. Data on access to and use of essential supplies and equipment, including MVA equipment, for safe motherhood at facility level is often lacking.

The Nigerian assessment found that magnesium sulphate is not on the essential drug list. Although on the essential drug lists in Zambia and Uganda, it was not widely available nor used for treatment and prevention of pre-eclampsia or eclampsia

all the three African countries. However, the faith based supplier in Nigeria, CHANPHARM, had obtained a special waiver for its importation and facilities were using it. Problems with supply and use of magnesium sulphate are also documented for other sub-Saharan countries, as recently reported in the BMJ (Sevene et al 2005).

In Uganda, oxytocin and misoprostol were not on the essential drug list, and misoprostol and MVA equipment were also missing in Zambia. In Cambodia, misoprostol was not available at the central medical stores, although it has been on the essential drug list since 2002, and it is not registered in Nigeria for pregnancy related indications. This is due in part to the fact that, in Cambodia, there has not been an attempt to address comprehensive abortion care, despite its legality. More broadly, there is a lack of experience in using the drug for induction of labour and treatment of post-partum haemorrhage.

The study found reasonable contraceptive method choice in all four countries, with methods such as the single rod implant and emergency contraceptive being introduced in Cambodia. Some attempts have been made to introduce the female condom, but it is clear that significant provider training and consumer marketing will be needed. In both Cambodia and Nigeria, the female condom is being introduced into the public sector programme with UNFPA support. The social marketing of the female condom has been piloted in Cambodia, and future steps are to be decided by the MoH and its partners. In Nigeria the social marketing organisation has recently stepped up supply and promotion of the female condom, although take up is slow.

Access to emergency contraception is limited, although it is included in national policy. In Nigeria, for example, the MOH has withdrawn the emergency contraceptive pill from its supply chain, reportedly due to low demand and anxieties about abuse. There are concerns about this decision, given that the method is prescribed and provided by trained staff, and is part of the national RH policy. Emergency contraception is provided through the private sector by the social marketing organisation. While legal and provided for in policy, there are similar concerns for provision of comprehensive abortion care (including post abortion care). Access to manual vacuum aspiration equipment, and trained providers at peripheral facilities in its use, is extremely limited, although efforts are being made in all four countries to improve provision by NGOs and UNFPA with government.

Regulatory barriers to product entry do not appear to be significantly affecting market development at present. All essential drugs and condoms can enter Uganda and Zambia tax free (so long as they are packaged outside Zambia), whether for public or private use. However, while products for public sector use are not subject to taxes and tariffs, in Nigeria social marketing and other not-for-profit importers often faced lengthy delays in obtaining Presidential exemptions, leading to costly import hold-ups.

Most procurement is done by international agencies which can support product registration. The Cambodian assessment noted that not all products imported by donor agencies were registered as required, such as some branded products, whereas generic products, such as injectables were used by public or social marketing programmes, were licensed for use. Given the small size of commercial markets, very few if any companies have independently registered products.

In Zambia, scaling up the introduction of depo provera by USAID was delayed due to slow progress on registration by both the manufacturer and regulatory agency.

Quality assurance of commodities is very limited, in light of weak drug regulatory capacity. Contraceptive and other commodities are rarely tested upon arrival in country. In Uganda, the World Bank has funded condom testing equipment, but there are concerns about the slow process which threatens secure supply. Only in Nigeria, where the national regulatory authority has been a government priority, is there any routine action to address illegal and counterfeit imports. Condom testing equipment is owned by government, and housed by the social marketing organisation.

4.7 The role of the private sector

The assessments found that the formal and informal private sector plays a growing role in reproductive health commodity supply, in common with many developing countries. Private services are often preferred by consumers because they are often more friendly and consumer oriented, more accessible in terms of distance to travel and associated costs, and may be better stocked than government facilities.

Private sector supply is mainly through social marketing. Social marketing supply is dominated by condoms and oral contraceptives, as products that require consumer education but not highly skilled service providers (as for IUDs). For oral contraceptives and condoms through private and not for profit providers, social marketing is as least as important, and often more so in terms of market share as the public sector (see table 2). Social marketing programmes also continue to be critical in behaviour change communication and demand creation activities. The market for commercial brands is still small.

Social marketing accounts for nearly three-quarters of OCs sold or distributed in Nigeria, 64% in Uganda and 38% in Cambodia. For condoms, social marketing makes up over 80% of reported condom use in Nigeria, and nearly 90% in Cambodia. Coverage is lower in Zambia, where government and NGOs have an equal share of the market.

In the four countries, the main funders are USAID, KfW and DFID. Social marketing programmes use the NGO 'own brand' model, where products are procured and overbranded by the organisation. They are managed by the large international NGOs such as PSI, DKT, Futures or MSI, or by their national affiliates and local NGOs, such as Society for Family Health (SFH) in Nigeria, which is linked with PSI.

SFH in Nigeria is regarded as one of the most efficient social marketing programmes in the world. It has over 40 registered private sector distributors, and 16 detailers (promoters and trainers), working out of nine depots. It users a cash and carry system, with no credit provided to retailers. Although it provides training to providers, this does not amount to a formal accreditation scheme.

Marie Stopes International (MSI) in Uganda work with the HIV/AIDS Control Program to socially market condoms through community based distribution. MSI also issues STI treatment vouchers which enable clients to access full treatment in health facilities including private for profit, regardless of price. In Zambia, the PSI affiliate, SFH works in all nine provinces, where it has links with local district health management teams, providing extra supplies in case of stockouts. IPPF affiliates and other NGOs also play an important role in service provision, often in hard to reach

communities. Similarly, PSI is considered to have made considerable progress in meeting demand through social marketing in Cambodia.

In sub-Saharan Africa, the faith based sector has a major influence on RHCS – providers manage up to 40% of services in Nigeria, Zambia and Uganda. Where these are Catholic denominations, contraceptives and condoms are rarely available, although some tolerate condom use for disease prevention. The faith based suppliers in Nigeria (CHANPHARM) and Uganda (Joint Medical Stores) neither stock not supply contraceptives and condoms. However, CHAZ (the Churches Association of Zambia) obtains its commodities from the government medical stores, and supplies to member institutions as required.

Commercial market shares remain smaller for most products, but are increasing. Condoms, for example have increased to 16% in Nigeria, and OCs and ICs, respectively to 10% and 24% in Cambodia. Overall little is known about the role and extent of the organised and informal for profit private sector in providing RH commodities. However, the assessment in Nigeria also noted that over ten condom brands are registered with the national regulatory agency, and over 60 are present in the market.

Leakage of public sector products to the private sector is perceived as a major constraint to private sector expansion. For example in Nigeria, the local representative of a major pharmaceutical company cites the negative impact of leakages of public sector commodities as the principal reason for low commercial imports. Leaked public sector commodities are provided in commercial outlets at only 10% of regular commercial prices, a finding verified during several pharmacy visits. In Uganda, leakage is estimated at about one tenth of the total public sector supply. Leakage of oral and injectable contraceptives from the public sector in the provinces to pharmacies in the capital was observed in Cambodia.

Although leakage from the public sector may not affect overall contraceptive prevalence, it compromises the targeting of public sector subsidy for the poorest. In addition, contraceptive leakage also implies wider abuse of the system, which has implications for governance and for the safe and effective use of all drugs.

Although there were some public-private linkages, the private sector's role is not fully or formally recognised by the public sector in any of the countries. At the same time, national development and health policy emphasises increased collaboration with the private sector as an objective. Examples include Nigeria's new PPP policy, Cambodia's reproductive health strategy and the Ugandan government's new resource mobilisation strategy in which the private sector may be given a prominent role, through the Population Secretariat.

However, so far, there is limited articulation of what such a strategic approach with private sector players might look like. There is also evidence, in Nigeria for example, of public sector territoriality and competitiveness with the social marketing programme. The recent plateau in the growth rate in socially marketed condom sales is perceived as a success by the public sector in increasing the demand for its own products, rather than a possibly concerning overall market trend.

The rationale for greater public-private sector engagement is strong. The private sector offers further potential for further scaling up family planning programmes and improving RH service delivery, especially to hard to reach groups. Examples include Uganda's pilot with KfW to develop output-based aid voucher schemes to enable purchase of safe delivery services from public and private

midwives and MSI's STI vouchers, and Nigeria's Q Quality accreditation scheme for retailers of socially marketed products.

Increased public-private collaboration has implications for co-ordination bodies. For example, the Uganda assessment found that the RHCS Group did not include non-public sector groups such as the Family Planning Association of Uganda, and the Uganda Private Midwives Association.

4.8 Socio-cultural issues and demand creation

Demand creation for contraception remains a major challenge, while the supply side in the case study countries is benefiting to greater or lesser extent from various system strengthening efforts. Low demand is due to poverty, and other social and economic factors, such as lack of women's empowerment, the need for children in rural economies and high infant mortality. Family planning is still widely perceived as a woman's responsibility, and interventions have largely focused on women without taking account of the need for a supportive role by their partners.

Continuing low use of modern methods is also influenced by a wider social, religious and political environment that is not highly supportive of family planning. In all four countries, 'child spacing' or 'birth spacing' is now used, terms which reflect preferences to avoid language that implies a) population control measures and b) interfering in family size. The Uganda assessment found that people are receiving contradictory messages. Some local politicians oppose family planning, attempting to influence resource allocations for FP programmes and even advocating for incentives to women to have children. Such advocacy for larger families has been linked to desires to increase local votes in democratising but still highly patrimonial societies.

As described in Box 3, in Nigeria there is a complex interplay between international and national factors, with for example the US government's policy on abstinence being in line with that of many national opinion leaders, including in the RH field. Restrictions of US finance to condom promotion (and purchase) for at risk groups such as sex workers (as opposed to the general population) leads to reduced supplies, and mixed messages and confusion about the condom's role in pregnancy and disease prevention – and may be linked to lack of condom promotion as a method of dual protection. Similar issues are affecting supply in Uganda, which has been documented elsewhere (CHANGE 2005).

Although respondents in Cambodia considered that there were few political barriers to the implementation of national policy at the community level, there are some political sensitivities over wider population policy issues, including on family planning (named 'birth spacing'), sterilization, and potential and actual conflicts of interest regarding public sector development among high ranking policy makers. Moreover, there is a high discontinuation of use of modern methods of contraception, particularly in rural areas, because of side-effects.

Systems strengthening activities at local government level in Nigeria are building local accountability to improve safe motherhood services. Advocacy among political and religious leaders has led to pressure on local government to improve local facilities. DFID and World Bank finance are used to purchase essential equipment and supplies, provide technical support and training. Some communities have set up emergency loan schemes to meet transport and other costs, and families are developing delivery plans (including obtaining the husband's signature in advance for

permission to travel). Rural transport union members have been mobilised to help with referral transport where needed, and trained in life saving skills.

Box 3: Nigeria: challenges for demand creation

Advocacy among both opinion leaders and consumers must be tailored to the Nigerian context, which is affected by a complex mix of national and international influences. Christian and Muslim religious leaders and scholars are major players in the success or failure of policy advocacy efforts, and in shaping consumer demand for RH services, especially family planning and condom use. As a major donor, the US government's position on RH issues is another influence, felt indirectly, as well as directly expressed in financing restrictions. (For example, USAID does not finance condoms and emergency contraception in the jointly funded social marketing programme with DFID). It is also noted that the recent social marketing campaign (financed by USAID) to promote child spacing excluded condoms, despite government policy on use of condoms for dual protection. However, the National Action Committee on AIDS is taking an independent stance with regard to the US position, with the chair publishing a letter in the New York Times recently.

Many Nigerians independently hold similar views to that of the US Congress, supporting the stress on abstinence, for example. Radio advertisements promoting condoms were suspended for four months in 2001 by the Advertising Practitioners Council of Nigeria, a Nigerian government organization. Nigerian states that operate under Islamic law (shari'a) have seen similar restrictions. The Nigeria Abstinence Coalition, an umbrella body of individuals, organizations, and agencies promoting abstinence-until-marriage education in Nigeria, was launched in 2004 and includes representatives of over twenty-five non-governmental and faith-based organizations.

Several government and other informants felt that there had been too much stress on condoms in past, and that the 'A' had been left out of 'ABC'. The 2003 National HIV/AIDS Policy takes a balanced view, stating that 'the use of condoms as a method of preventing HIV/AIDS shall be promoted through appropriate education', and that 'all mass media marketing of condoms shall promote abstinence and mutual fidelity as the best protection'. The 'Zip-up' abstinence campaign introduced by SFH in consultation with others is in line with the National HIV/AIDS Policy. It also reflects most FBO views and, by taking these into account, is felt to be an important way to engage them.

Although the Churches Health Association (CHAN) has an HIV/AIDS policy, there has been little open dialogue among members on RH issues more widely (apart from safe motherhood) and no condom or family planning promotion. It is also often stated that, at facility level, practice varies considerably, and both contraceptives and condoms may be available. The role of condoms in disease prevention, rather than as a contraceptive, is accepted among some providers. Several years ago, a post abortion care project was introduced to five centres, but has been discontinued, due to lack of initial engagement and insufficient consensus among its members. CHANPHARM, CHAN's independent drugs distribution agent, neither stocks nor supplies contraceptives nor condoms to its members.

In follow up to the regional West African Reproductive Health Network's conference in early 2005 on repositioning family planning, the government and NGO partners hosted a national FBO conference on maternal mortality reduction and repositioning reproductive health. A new national faith based advisory council has been set up, to improve dialogue and consensus development.

Recent efforts by NGOs and government, funded by USAID, have also engaged Muslim leaders in developing a supportive position statement on RH policy. The approach included a study visit to Bangladesh, where a range of RH services are perceived as compatible with Islamic law. However, some concerns continue to be expressed about the motives of the US government in funding RH in Muslim communities.

4.9 Reproductive health and HIV/AIDS

The four countries are in receipt of funds for HIV and AIDS, through the GFATM, PEPFAR and other funders. Not withstanding the severity of the epidemics in Uganda and Zambia, in all four countries the national response has generated increased amounts of earmarked and/or projectised funds, together with high levels of political attention.

National aids control programmes, in addition to the newer multi-sectoral national AIDS commissions, have substantial domestic as well as international funding, and tend to be larger and have more capacity and authority than RH units and departments. New finance has been provided especially for ARVs and treatment programmes, rather than prevention. Whilst acknowledging the importance of AIDS treatment, increased focus on access to ARVs has tended to shape the development of a rather vertical and overly dominant HIV/AIDS response, including the development of new parallel systems for procuring and distributing AIDS related commodities.

It is clear that the HIV/AIDS response is in receipt of higher domestic and external allocations. There is also some evidence in Uganda and Zambia to suggest that additional funding for AIDS and other diseases is substituting for government budget for other issues, where there are hard budget ceilings for the health sector. There is less evidence to show that this has affected RH more than any other public health programmes that are not in receipt of additional finance. However, it is also the case that RH is one of the few national programmes featuring in most national essential packages that is not targeted for resource mobilisation by any global partnership.

The assessments also found that opportunities for mainstreaming activities with existing sexual and reproductive (and other) health programmes have rarely been taken, with some exceptions. In Zambia, the government has been strategic in using the PMTCT initiatives supported by the GFATM as a way of improving some aspects of RH, and the presence of the two GFATM financed staff in the RHU are a useful asset, even though their focus is very much on the PMTCT programme. There was some joint programming for PMTCT in Cambodia.

Box 5: Condoms for preventing pregnancy and HIV in Cambodia

The link between programmes using the same commodities, condoms for HIV and family planning, has been poor in terms of coordination and implementation. Members of the two working groups that deal with condoms, the NCHADS (the national AIDS Programme) and contraceptive security working groups have begun to attend each other's meetings. Whilst the National AIDS Authority plays a coordination role between HIV/AIDS and RH, this interaction appears to be limited, asides from a joint PMTCT programme. Condom supply is mainly through social marketing, and the new GFATM funded programme, managed by NCHADS.

Challenges to an integrated approach to condom programming are highlighted in current proposals for condom programming. The socially marketed 'Number 1' condom played a key role in reducing the incidence of HIV, particularly in commercial sex work. However, it became stigmatized because of its association with sex work and difficult to market among married couples or people in stable relationships. Subsequently, a new condom was branded with the generic name, 'OK' (which is also used for the socially marketed oral contraceptive), targeted to married women and couples. The socially marketed OK condom is widely available.

Significant HIV infection in Cambodia is now taking place among married women and newborn children. In order to give condom use a higher visibility in the prevention of HIV among married women, the NAA is proposing to develop and market a new brand of condom to be used in campaigns against HIV infection to differentiate them from those being used to prevent pregnancy. However, other stakeholders in government and partners such as UNFPA

feel that, instead of trying to sell two identical products to the same target group, there should be a major information campaign explaining that condoms, as a dual protection method, can prevent both pregnancy and HIV/STIs (and include the option of a hormonal method of contraception as well).

In all the countries, there were weak linkages between agencies procuring condoms for HIV prevention and those procuring them for family planning, and little co-ordination regarding promotion and branding, or for integration of RH into HIV/AIDS or vice versa (see box 5). It is notable that separate procurement and distribution channels have been set up for ARVs and other AIDS specific commodities in Cambodia and Uganda for example. The multiplication of agencies and funding sources for condoms, coupled with the need for quality assured sources and high consumer confidence, has led to complex challenges for managing security, as illustrated in the recent Uganda experience (box 6).

Box 6: Uganda's condom crisis: an example of commodity insecurity
Uganda, a country which has had internationally acclaimed success in its HIV programming of which condom distribution was an essential part, has a major condom crisis. The availability of condoms has been hit by problems arising in condom procurement.

Under the HIV programme, the MoH uses World Bank funds to procure condoms according to WB rules. Other condom supplies are provided by USAID and with the support of the Global Fund. Condoms are both given away free (Engabu brand) or sold through social marketing initiatives. In late 2004 the Engabu brand was found to have faults in some of the batches and therefore the government withdrew them from its system with the result that there has been a shortage until early 2005.

DFID, SIDA, DANIDA and DCI (Ireland) stepped in with emergency resources to purchase 20 million condoms which are now being distributed. This, plus a recently approved procurement by USAID of 34 million condoms (23 million for public sector, 11 million for social marketing) should cover the minimum requirement of 5 million condoms used per month up until December 2005.

However longer term problems remain. Although the Global Fund order of 76 million condoms (55 for the public sector, 21 million for social marketing) had gone ahead prior to the current suspension after an audit, there are concerns that delivery to Uganda may be affected. In response UNAIDS has strongly advised GoU "to develop a long term strategy to ensure that condoms are procured and distributed on a timely basis". UNAIDS also expressed concern that the government's plan to now carry out quality checks on import is very slow and will further delay disbursement of condoms already arrived in Uganda. The issue is complicated by the reported influence of national and international moves to promote abstinence and fidelity, reducing political and official will to improving supply security (CHANGE 2005).

4.10 Barriers to access

Demographic and health data indicate substantial differentials between the poorest and wealthier quintiles. Given high levels of poverty, strategies to ensure equity of access to RH services and supplies are of great concern.

However, in general there is little information on factors affecting access by the poor. In Cambodia, there is anecdotal evidence that people in the lowest economic quintiles access commodities from the private sector because of barriers to accessing public health facilities.

Nigeria's new cost recovery system involves charging a fee to all clients, irrespective of socio-economic status. Prices to consumers are set below those products provided by private and NGO providers. Informants were confident that the prices are

low enough not to deter clients who visit a service provider. However, information is not available on how the poorest may be deterred by indirect cost barriers such as time and transport costs, as well as commodity prices.

4.11 Comments on proposed global level functions

4.11.1 Global financing mechanisms

There have been several proposals in 2005 for increasing the predictability, transparency, coherence, co-ordination and volume of financing available at the global level for RH commodities. These include a new stability fund, suggested by the Mercer Management Consulting study for Gates, and UNFPA's new Global Programme for RHCS. This report does not provide a detailed commentary on these proposals, but offers a few observations on the value of such mechanisms and how they might work effectively from a country's perspective.

Section 4.1 highlights the fact that almost all procurement of contraceptives takes place at international level, drawing on finance provided by either national or international sources. However, it is not clear that internationally aggregated purchasing of most reproductive health commodities is warranted. Schwanenflugel (2005) contrasted contraceptive markets with the markets for vaccines and combination therapies for malaria, showing that whereas the latter's market characteristics justified internationally aggregated purchasing well in advance of needed supply, contraceptive markets can be approached at a national level using effective procurement practices to achieve good prices and stable supply.

As well as funding shortfalls, the main challenges at country level relate to weak capacity and co-ordination, short term and uncertain financing, and poor governance. The combination of fragmented supply sources, poor co-ordination and weak logistics systems mean high levels of emergency procurement and stockouts. In Uganda and Zambia, there have been persistent problems with stockouts resulting in expensive emergency procurement by donors. The Zambian experience clearly illustrates that donors must have confidence in government capacity before considering direct financing of procurement. Section 4.5 illustrates several financing mechanisms that could work effectively at national level to smooth volatility of unpredictable donor fund flows, and which could provide a vehicle for managing domestic and international contributions.

In terms of the national-international interface, the commodity financing procedures and arrangements of UNFPA and other donors appear opaque to stakeholders – there is limited knowledge of how global funding and procurement functions work (or indeed could work better). Even where international procurement may offer best value for money, the studies found few examples where government had been able to commission a third party agent to deliver this procurement function on their behalf. There appear to be uncertainties about the status, amounts and sources of funding commitments available at the international level through UNFPA's trust funds, for example. This tended to result in requests at short notice for 'emergencies', which could have been avoided, and the actual cost of commodities procured was not always known.

4.11.2 Informed buying/procurement exchange

Informed buying and a regional or international procurement exchange were proposed in the Mercer study. As part of the WAHO Co-ordinated Informed Buying initiative for RHCS, WAHO and its member states and donor agencies such as

USAID and UNFPA, are assessing the potential for informed buying at regional level of RHCs, and a strategy was presented late in 2005 to member governments[7]. One of several country assessments was carried out in Nigeria. It focuses almost exclusively on ARVs, and explicitly excludes contraceptive commodities from its analysis, finding that there are no intentions for government to fund or procure locally. It states that contraceptives have typically been donated and procured externally, so 'no savings could be made through informed buying'.

However, depending on how procurement and financing practices at national and regional levels develop, there was interest expressed in further exploring potential for informed and co-ordinated buying and other approaches to increasing price information transparency.

4.11.3 Quality assurance and prequalification of suppliers

The Mercer study and other observers have noted the highly redundant nature of quality assurance processes for contraceptives, and the difficulties facing generic market entry. Whether procured nationally or internationally, quality assurance is crucial. Quality assurance of import batches is ideally needed at national level, irrespective of the supplier and procurement agent (but this was only carried out for commodities imported by the social marketing organisation in Nigeria).

There is, as yet, no agreed prequalification system among donor agencies and governments that ensures that commodities meet international quality standards of manufacture. There is still limited procurement from generic companies, although UNFPA has begun purchasing oral and injectable contraceptives and KfW, injectables, from a few generic manufacturers.

WHO and UNFPA have recently begun a programme to improve the quality of reproductive health medicines and commodities, following WHO's scheme for anti-retroviral products[8]. They are developing an international procedure for the prequalification of reproductive health product manufacturers both research based and generic, based on: harmonized specifications, norms and standards; joint UN/WHO inspections of manufacturing sites; and capacity building of national manufacturers of reproductive health products as well as medicines regulators.

Stakeholders at national levels welcome such a development, in terms of offering quality and greater value for money. Although suppliers would still have to fulfil national requirements, the registration process may be accelerated.

[7] Informed buying means benchmarking against pricing information obtained from suppliers and purchasers, nationally, regionally or internationally. There are several international sources and pricing guides on the internet for ARVs and other essential drugs, but price information for contraceptives is less easily available (Schwanenflugel 2005).

[8] WHO 'prequalifies' drugs for the treatment of HIV/AIDS, malaria and TB as a precondition for procurement by UN Agencies, the GFATM and others. Under its Prequalification Project, WHO evaluates product data and information provided by all manufacturers and suppliers; and undertakes a GMP inspection of the manufacturing sites. Products and manufacturing sites which meet WHO standards are included in a list of suppliers whose products are considered to be acceptable for procurement. Condom manufacturers are prequalified by UNFPA, and vaccines by WHO and Unicef.

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Steps to facilitate government ownership

Section 4 highlights some successes in efforts to strengthen commodity supply, but also documents continued limitations in national capacity to develop and implement policy and strategy, for procurement and supply management and forecasting, and for demand creation. These issues are compounded by resource constraints, the ongoing crisis in human resources for health, especially in AIDS-affected countries, and challenges raised by devolved and decentralised systems.

The continuing and dominating role of external agencies in the financing and procurement of contraceptives tends to undermine ownership and discourage accountability by government. Government ownership of the problem of RH commodity security seems to be low, and appears to be undermined by donor approaches to providing support. Weak ownership is suggested by issues such as poor policy formulation and implementation, limited national programme capacity, and low commitment to implementation. International or national third party procurement may make sense in some contexts in terms of quality and volume efficiencies. However, government is rarely driving the process, there are serious inefficiencies due to poor co-ordination at national level and procurement processes are not always transparent to stakeholders.

Sector wide management, planning and review processes provide a critical opportunity for RHCS advocacy, especially if relevant indicators are included. Reliable supplies of commodities and equipment - as well as skilled staff at all levels, and a functioning referral system - are needed for higher service utilisation, and better outcomes.

Recommendation 1a: A national budgeted RH plan is needed that includes donor contributions, real or indicative commodity budgets or a full set of RHCS indicators.

- Continued stress and advocacy for inclusion of RH and RHCS in national development and health policy and plans, coupled with domestic budget allocation.
- Support to RH divisions or units to develop a government led annual planning and budgeting exercise which fits in with the national planning cycle and produces one unified workplan for all activities under RH.
- The unified plan should include programmed commodity procurement based on timely forecasting, and all projects, TA and commodities funded by donors. Performance indicators and review should include any donor funded activities so that donors do not have to rely on separate monitoring arrangements.
- Consideration by RH donor partners of how their own operating processes can be more in line with government planning cycles and budgeting processes. Where a donor needs to procure under its own terms, or requires third part procurement, ensuring transparency and predictability through indicative credit lines and supply information, are essential.
- An RHCS plan and one agreed set of RHCS indicators (which could also inform selection of core indicators for RH and health sector performance assessment).
- Continued technical support to RH units, essential drugs programmes, national stores and other relevant bodies, working towards integrated systems where directed by the overall policy environment.

- Support to prioritise, budget and implement RH and RHCS activities at district or other decentralised levels, and public accountability mechanisms to hold authorities to account such as scoreboards and league tables.

Recommendation 1b: The national RHCS co-ordination group has a critical role in furthering commodity security, and needs the following characteristics.

- The group's formal TORs should mandate its role as the main forum for agreeing all donor activity relating to RHCS, delineating the roles and responsibilities of individual members of the RHCS Group. Such TORs will help foster partner relationships with government that promote greater ownership of commodity security problems and solutions by government, and reduce the tendency of some donors to operate as parallel working partners.
- The RHCS group should consider not just operational issues and immediate coordination problems, but endeavour to take on a more strategic vision, to see how it can influence the wider environment. Links and/or involvement with other groups involved in commodity procurement, such as the national AIDS programme or sector wide procurement groups, are essential.
- Membership of, or regular meetings with, non-government bodies, such as social marketing organisations, faith based suppliers and private provider associations should be considered.

Recommendation 2: At national level, financing mechanisms are needed that facilitate more flexible and predictable donor financing, enable efficient procurement with lower transaction costs, and support an effective, government-led interface with international agencies.

Critically, these types of mechanisms enable ownership of procurement by government, whether the function is contracted to an agency such as UNFPA or Crown Agents or done by government, and irrespective of the source of funds. To enable domestic and external buy-in by agencies such as UNFPA, such mechanisms must be in line with both government procedures, and donor requirements.

Key points are listed below.

- Ringfenced commodity accounts or revolving drug funds managed by government appear to be a useful mechanism, enabling year on year rollover of funds and therefore timely and high volume procurement.
- When an integrated fund with other health commodities is possible, a sub-account for contraceptives could be further designated, if necessary to counter any anxieties about marginalisation.
- Virtual budget or credit lines can be indicated, in instances where international or national third party procurement will deliver best value for money, and funds are held and deployed by agencies such as UNFPA or Crown Agents on government's behalf.
- Consideration could be given to expanding any existing commodity accounts to include RH drugs and contraceptives, or to establishing new mechanisms if needed.

Recommendation 3: It is recommended that reproductive health and commodity security are mainstreamed with efforts to strengthen wider health system and commodity supplies. A vertical approach tends to dominate RH programming, and several RH donors are also planning to shift their support to other areas. In this uncertain environment, it is critical to shift the responsibility for RH and

RHCS from being a more or less vertical programme, into the remit of government and donors as a whole. Current emphasis on the need for increased harmonisation among donors, and alignment with government policy and plans, provides an opportunity to strengthen government ownership and implementation.

Recommendation 4: Financing and co-ordinating technical support to build capacity for national supply and distribution systems continues to be imperative. There is high dependence on USAID funded technical support (mainly through Deliver) and UNFPA. A critical dynamic is therefore the technical performance of these two agencies, and their ability to work together, with government. Above all agencies need to strengthen the technical capacity of staff at all levels, and ensure that the annual reproductive health workplan identifies needs, and allocates or earmarks resources, possibly through an accompanying TA plan. A wider issue concerns questions of integration with other supply and distribution systems, and the development of new parallel systems for distributing AIDS related commodities. Where the overarching policy environment is driving towards integration and a unified system, it is critical that donors and TA partners support this.

Recommendation 5: There are clear opportunities for UNFPA to enhance its wider strategic contribution. These include developing funding and TA arrangements focused on priority issues, such as RHCS, as opposed to running separate and resource consuming district based programmes. UNFPA's good practice in relation to sector management arrangements in Zambia and Cambodia, and integration initiatives in Uganda is encouraging. This approach is in line with UNFPA reform commitments to ensure that UNFPA country offices work more within sector wide approaches, including pooling funds. UNFPA also needs competence not just in TA for RH and RHCS, but in wider roles as a sector player, in terms of integrated systems and service delivery. This is demanded by both trends in both funding modalities and by sector development objectives.

5.2 Access to essential commodities

At least one key safe motherhood drug or other supply was missing from essential drug lists in all the countries, although most contraceptive commodities were included. Information about access and use of safe motherhood commodities at facility levels was also lacking, although UNFPA and WHO are planning some situation assessments with national partners.

Recommendation 6: Advocacy efforts by WHO and UNFPA are urgently needed to ensure that commodity supplies for safe motherhood as well as other RH commodities are assured. This is especially critical given the emphasis on the MDGs, and current socio-religious and political pressures that are contributing to lack of funding and provision. This particularly affects new methods such as the female condom, and supplies for comprehensive and/or post abortion care and emergency contraception, to which access needs to be promoted in public and private sectors in line with national policy and law.

It is recommended that national RH directors, UNFPA, WHO and others take any necessary steps to ensure that essential items are available, such as inclusion in the essential drug list and national supplies system, dialogue with procurers and distributors, and inclusion in training materials and activities as appropriate.

5.3 Repositioning reproductive health

Reproductive health commodities have a key role in achieving the MDGs. Reducing maternal and child mortality, two of the health MDGs, are strongly emphasised by both governments and donors. However, although there is substantial evidence that child spacing improves both mother and children's health, the MDG focus can result in less emphasis on family planning, while stressing access to emergency obstetric care and immunisation services[9]. This is a missed opportunity for addressing wider RH issues.

Recommendation 7: Government and other major stakeholders need to further their efforts to make reproductive and sexual health a priority by 'repositioning RH' as a key but neglected driver for the reduction of child and maternal mortality.

Recommendation 8: There are also many opportunities to be taken for linking RH services with STI and HIV care, treatment and prevention, and for strengthening co-ordination of commodity supplies, especially condoms. In particular strategies for improving adolescent RH and HIV/STI services, and increasing coverage of PMTCT services hold potential, as demonstrated in Zambia and Cambodia.

5.4 Demand creation and equity

In view of the challenging socio-cultural and political environment, especially in the three African countries, continued advocacy on repositioning RH among politicians, religious and other leaders, is critical.

Recommendation 9: Innovative work should continue on improving access through addressing the long and short routes of accountability – making policy makers and providers more accountable to people, by strengthening informed demand among people as both consumers and citizens, and their leaders or representatives.

Recommendation 10: Addressing barriers to access by the poor to RH services and commodities is urgently needed. In each of the countries, UNFPA and others are proposing studies to assess access and willingness to pay by the poorest. This is highly recommended, and may have implications for cost recovery and community based distribution schemes, given the inequity in use shown in national demographic and health surveys, and high percentages of people living in poverty.

5.5 Strengthening government stewardship

Social marketing and service provision through NGOs and private retail outlets plays a critical and extensive role in both commodity supply and demand creation. Although the private sector contributes greatly to reproductive health, the assessments found that – although there was some public-private engagement - this was not fully or formally recognised by the public sector in any of the countries. At the same time, national development and health policy emphasise increased collaboration with the private sector as an objective.

[9] The evidence indicates that 3 to 5 year birth intervals are associated with the lowest risk of death among children and better nutritional status. Birth intervals of less than 14 months are associated with a 250% increased risk of maternal death, compared to 27 to 32 month birth intervals. A birth interval of about 36 months is linked with best outcomes for both mother and child. USAID Bureau for Global Health 2002.

Recommendation 11: The assessments recommend stronger public sector engagement with the overall market for RHCs and with other providers. ***The need for demand creation – which cuts across public and private sectors – could stimulate a more strategic approach*** to overall market development and developing the role of partnerships. The role of the government as public health steward can be seen as a dual champion: to take care of the public sector on the one hand, but also to take a strategic overview of the whole market – public, social marketing, NGO and commercial - in order to ensure that all citizens have access to a choice of quality products at a price they can afford, with free distribution benefiting mainly the poorest.

Stronger collaboration would benefit demand creation and the use of marketing techniques, tackling product entry, advertising and other regulatory issues, and ensuring a co-ordinated approach to commodity procurement and programming, especially condoms. This can all be part of working towards a total market approach, where the market is segmented according to ability to pay, with public, NGO, social marketing and commercial sectors playing an appropriate role.

Consideration should be given to designing a facilitated process at national level, led by government, to support stakeholder dialogue and strategy formulation. Such an approach would have significant implications for the range of stakeholders involved in RCHS planning and co-ordination.

5.6 International financing issues

Various proposals were made in 2005 to meet the need to increase the predictability, transparency, coherence, co-ordination and volume of financing available at the global level for RH commodities, including a study commissioned by the Bill & Melinda Gates Foundation in 2005. Two other proposals have been for informed buying initiatives or procurement exchanges and prequalification of manufacturers (see section 4.11).

The country studies found that most contraceptive procurement is carried out by international agencies on behalf on governments, even though there is limited market rationale for internationally aggregated purchasing of most reproductive health commodities. For contraceptives, along with first line ARVs, condoms and many other essential drugs, there is reasonable competition, many products are off patent, and the market is large (including the private sector). Given market characteristics, contraceptive markets can be approached at a national level using effective procurement practices to achieve good prices and stable supply[10]. However, it is also the case that the potential effectiveness of government procurement and supply functions remain limited by funding gaps and shortfalls, and by weak capacity and governance.

Recommendation 12: Donors need to make more long term and predictable commitments to RH supplies, which should, over time, build national capacity for procurement. It is recommended that donors and government explore financing and procurement mechanisms that can work effectively at national level to smooth volatility of unpredictable donor fund flows, while also building government ownership

[10] In accordance with DAC aid effectiveness commitments, alignment includes progressively relying on country systems for procurement when possible, and adopting harmonised procedures and building country capacity in the meantime. Countries themselves may choose to take advantage of procurement pooling mechanisms or third party procurement to obtain economies of scale.

and capacity. Capacity building can be supported and the procurement function contracted locally to a third party.

Recommendation 13: This review also finds a strong case for the continued pooling of finance at the global level to support reproductive health commodity security. Procurement by international agents will clearly continue to be appropriate in some cases, especially where there are proven economies of scale and quality advantages, and in light of current dependence on international procurement arrangements. In addition, global level finance that is targeted at key development priorities such as reproductive health (as with TB, AIDS and malaria) can complement system strengthening support at national level.

Recommendation 14: Any global financing mechanism must be in line with international commitments to aid harmonisation, ideally building on the comparative advantages of existing aid instruments and agencies.

Based on these assessments, and on experience with global health partnerships and procurement mechanisms, any mechanism is recommended to have the following characteristics.

- Developing country participation in any advisory or governance arrangements.
- Clear purpose and measurable objectives, which include support to capacity building and developing financial sustainability plans.
- Donor commitments made at least two to five years in advance for national supplies, perhaps in line with matching national government commitments.
- A ring fenced emergency fund for short term gap filling, when a supplier fails to deliver at short notice or a country experiences conflict or other crisis.
- Transparency in management and operations, including clear and simple procedures for countries to access funds at international level.
- Up to date information on order and shipment progress, and on commodity costs, to enable national planning, budgeting and review.

Recommendation 15: This study recommends that efforts underway are further accelerated to develop prequalification processes for manufacturers, in terms of offering quality and greater value for money. Whether procured nationally or internationally, quality assurance is crucial. This is already provided for some products such as ARVs and condoms through prequalification at the international level by WHO and UNFPA respectively, and is under development for contraceptives. Once this process has approved several companies, it is recommended that they are considered for future generic supplies for both the public and social marketing sectors.

It is also recommended that, as national procurement capacity develops, regional informed and co-ordinated buying approaches are also promoted to ensure value for money (as the West African Health Organisation is currently doing with support from agencies such as UNFPA and USAID).

ANNEX 1: SUMMARY TORS

Reproductive Health Commodity Security
DFID Country assessments Sept-Oct 2005

Background
There is a shortage of reproductive health supplies in many developing countries. Some countries are in a permanent state of emergency supply. Problems with local level forecasting, financing, logistics and procurement are common. Often RH supplies are not seen as a priority and are not accounted for in the national budgets.

Some donors who have traditionally procured and delivered supplies are now turning to direct budget support or health SWAps. However, countries do not always have access to the necessary resources so that they can take over the previously donor controlled functions. Donors are not helping the situation with their lack of commitment to long-term predictable funds for RH supplies. There is also uncertainty about whether international funding and procurement are the best way to resolve the problems. There may be an argument for strengthening the country level response or for supporting regional level procurement.

There is international movement in shape of the Reproductive Health Supplies Coalition to provide more sustainable and long term funding for RH supplies, and to improve coordination and in making existing channels more effective.

Country assessments
The country assessments aim to explore issues in RHCS at country level and to contribute towards improved understanding of RH commodity security within the wider policy environment and support for sexual and reproductive health, and a sustainable response to RH commodity security through:

1. Applying a 'drivers of change' lens to the agents, structures and institutions involved in selected case study countries and examining the impact of new aid mechanisms including budget support and health SWAps on commodity security
2. Providing the evidence for dialogue and consensus building with bilateral and multilateral donors towards effective resolution of RH supply crises.
3. Supporting selected country offices by undertaking detailed country studies that lead to specific proposals for action at country and/or international level.

The assessments are concerned with the policy, institutional and financial context and processes for RH supplies. They will not aim to obtain in-depth data on procurement, forecasting and logistics systems in the country. This data should already exist as part of a SPARCHS analysis, UNFPA and other analysis, or government national data. The consultants will use this existing data and draw on existing RH supplies strategies to focus interviews and analyse the situation.

The studies will place emphasis on exploring and analysing:

- How and where the efforts to strengthen procurement systems (including demand estimation and forecasting) have succeeded and/or been less effective.
- How procurement, financing and supply systems are evolving and improving in the framework of changing aid architecture (new aid instruments, increased focus on governance and accountability, increased resources, etc.).
- Country level interface with global procurement and financing organisations and country level perceptions of how well international bodies support supply security.
- The political economy that influences RH commodity security. Factors that enable and/or constrain RH commodity security will be identified.
- How key recommendations put forward in recent international studies might improve the country level situation – what are the best ways forward?

Approach
The work is undertaken in four phases, principally comprised of the following:

- Through consultation and document review, Phase I resulted in proposals for country selection and methodology for subsequent phases.
- Phase II will involve four country based case studies (Cambodia, Uganda, Zambia and Nigeria), the start to a synthesis process, and further consultation.
- Phase III will involve synthesis of country study findings and consultation
- Phase IV will involve wider dissemination of the study findings.

Note: Definition of commodity security

For the purposes of this study the following definition of commodity security is used.

- ***Commodities are available:*** The products are available at the level of service delivery points they are required; are provided by appropriately trained personnel; and without interruptions of supply.
- ***Commodities are affordable:*** The products are available at a price the user can afford. Where they are provided free-of-charge or at a subsidized price, the necessary quantities can be afforded by the purchaser, usually the public sector.
- ***Commodities are of appropriate quality:*** The products meet appropriate international quality standards.
- ***There is sufficient choice:*** This applies primarily to contraception, both in terms of the type of hormonal contraceptives available and between different contraceptive methods. It allows individuals to choose those preparations they feel most comfortable with in terms of side-effects and ease of use, as well as the ability to select methods appropriate for different times in their reproductive life.

Marker commodities list for assessment

The following list will act as markers for assessment. This covers the range of drugs, diagnostics and devices that are necessary for reproductive health. They include those products required for the prevention, diagnosis and treatment of disease, such as STIs and HIV; pregnancy and safe delivery; abortion; and the choice and timing of family size. WHO and UNFPA are currently finalizing a full list of reproductive health commodities.

Contraceptives:

- combined oral contraceptives
- emergency contraceptive pills
- injectable contraceptives
- sterilization kits
- IUDs
- condoms (male)
- condoms (female)

Note: A range of contraceptive products is listed in order to assess issues of choice. It does not include products that are only available at generally unaffordable price, such as vaginal rings, hormonal patches, implants and the levonorgestrel-releasing IUD.

HIV and other STIs:

- Diagnostic tests
- Condoms

Note: The key products included are those required for diagnosis of HIV and STIs. ARVs are excluded because of a concern that they will dominate the assessment. However, they will be addressed to the degree that their presence/absence creates opportunities or threats to supply security of other reproductive health commodities.

Maternal health care:

- Lignocaine (local anaesthetic)
- ferrous sulphate (to treat anaemia)
- folic acid (ditto)
- magnesium sulphate (to treat eclampsia)
- oxytocin (to facilitate labour)
- misoprostol (to treat post-partum haemorrhage and manage early abortion)
- manual vacuum aspiration (MVA) equipment

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