

# MAPPING

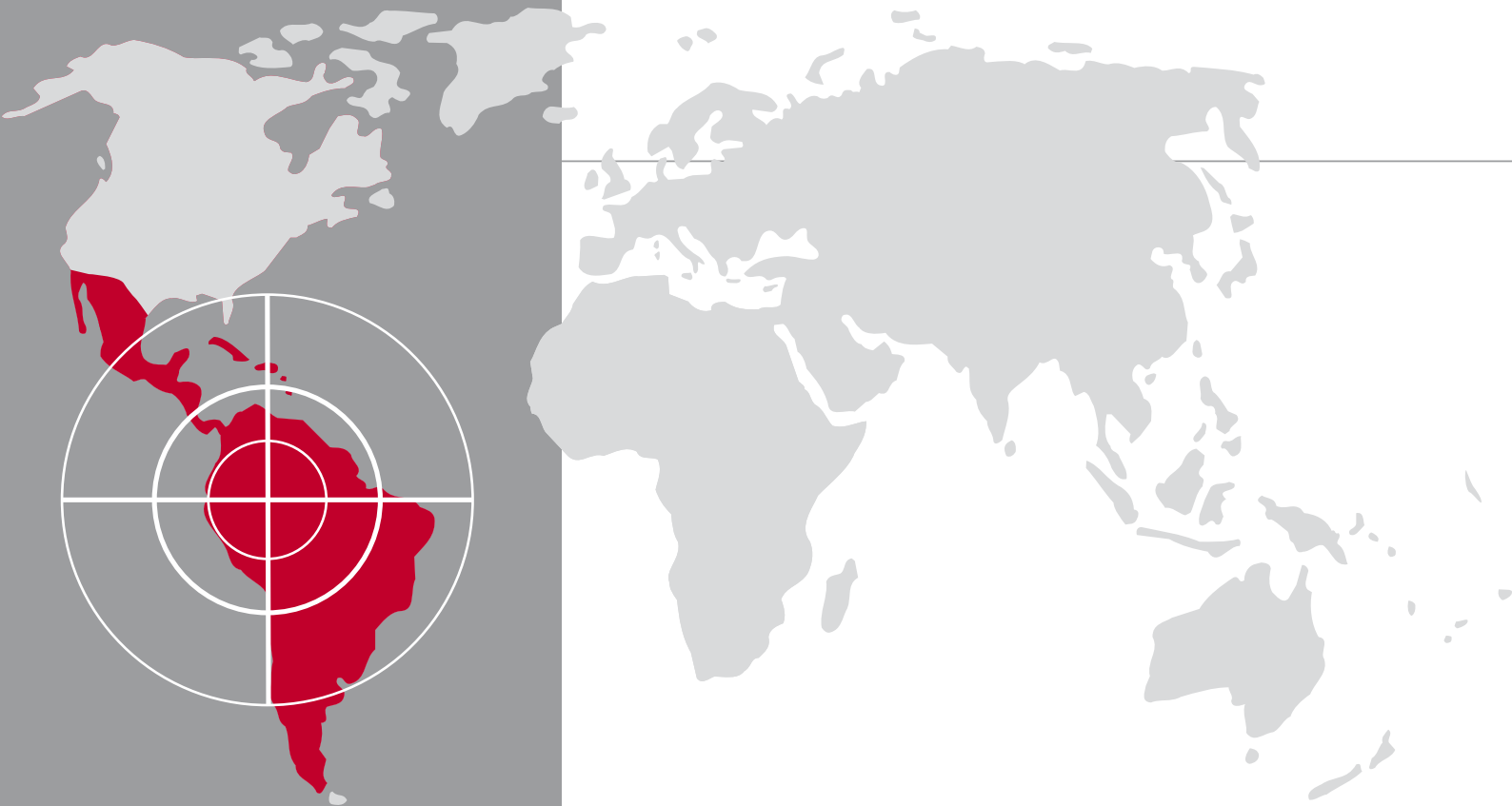
## Reproductive Health Supplies in Asia and the Pacific

# RHS

A mapping of procurement,  
funding, and policies



German Foundation for  
World Population (DSW)



## Acknowledgements

This mapping of reproductive health (RH) supplies in the Asia and Pacific regions was created for the RH Supplies Workshop in Nusa Dua, Bali. This workshop was conducted by Project Resource Mobilization and Awareness (Project RMA) a partnership of Population Action International (PAI), the German Foundation for World Population (DSW), and the International Planned Parenthood Federation (IPPF). The mapping provides an insight into the situation regarding RH supplies in the region, and is a starting point for gathering further information related to access to RH supplies. The mapping research was carried out by Martin Kuehn and guided by Caroline Jane Kent and Sabine Weber of DSW. DSW would like to thank staff at the three partner organizations, including Adem Alo, Susan Anderson, Jessica Bernstein, Suzanne Ehlers, Tirsit Grishaw, Mona Herbert, Caroline Kwamboka, Elizabeth Leahy, Matthew Lindley, Mercedes Mas de Xaxas, Gilbert Mworira, Sarah Shaw, and Kate Tibone. The Reproductive Health Interchange (RHI), including Jane Feinberg, Marie Tien, and Mimi Whitehouse, also provided invaluable inputs. Moreover, we want to thank the Asia Pacific Alliance for ICPD (APA) and Family Planning International, New Zealand, our collaborating partners on project activities in the Asia and Pacific region, for their invaluable assistance.



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## Regional context and policy environment

At the International Conference on Population and Development (ICPD) in 1994 in Cairo, government representatives adopted a Programme of Action that seeks to integrate population concerns into all economic and social activities. According to the UNFPA, China, Malaysia and Thailand have demonstrated significant progress towards achieving ICPD goals. The Democratic People's Republic of Korea, Indonesia, Mongolia, the Philippines and Vietnam have all made considerable progress towards achieving ICPD goals. Bangladesh, Bhutan, Cambodia, India, Lao PDR (Laos), the Democratic Republic of Myanmar, Nepal, Pakistan, Papua New Guinea, Timor-Leste, and the islands in the Pacific Region are in most need of assistance to realize ICPD goals (UNFPA, 2007).

People in the Asia and Pacific region are still reporting that they do not receive consistent, suitable, quality reproductive health (RH) supplies, information and services. Several reasons have been identified for this: poor communication between and within countries; a lack of donor coordination and communication; a lack of political will; and a lack of workforce development (SupplyNews #11, 2009). For example, locally branded male condoms are available in the Pacific region, but female condoms are not. Intrauterine Devices (IUDs) are often unavailable due to a lack of skilled staff. Even natural fertility methods are poorly taught.

### 1.1 Contraceptive prevalence rate and unmet need for family planning

Maternal mortality, Contraceptive Prevalence Rate (CPR)<sup>1</sup> and unmet need for family planning (FP)<sup>2</sup> are indicators that can provide an overview of the situation regarding RH. One possible way to improve RH is to ensure the availability of RH supplies. In Asia, the CPR regarding all methods is 67 per cent; regarding modern methods, it is 61 per cent (PRB).

In South Central Asia, CPRs for modern methods are low in all countries, while maternal mortality is high throughout the region. The highest maternal mortality rates are in Timor-Leste and Laos. In Laos, this corresponds with a high unmet need for FP and a low CPR, while Timor-Leste has the lowest unmet need of all countries in the region. In spite of low maternal mortality rates and relatively high CPRs for modern methods in Thailand, the unmet need for FP is quite high (see Table 1).

Data are not available for most countries in the Pacific region, due to a lack of staff capacity to collect and analyse data, but several issues are still known. There is a lack of staff to manage supplies and develop policies. Resources to strengthen quality services are insufficient. This results in problems in obtaining consistent, quality RH services and information. Young people experience particular problems; conservative and religious beliefs make them stay away from RH facilities. Access is also limited for communities on outer islands and in rural areas (APA).

There are significant disparities between the countries across the region. Unmet need for FP and the CPR of modern methods vary between geographic regions, both within countries and among population groups. In Nepal, people living in remote mountain areas have to walk for up to a day to reach health care services. Forced marriages for young people, and the resulting early pregnancies, increase the risk of complications during pregnancy and birth (Engender Health Nepal).

In the Philippines, poor women need particular assistance to prevent unintended pregnancies. Poor women, who constitute one third of all women aged 15–49, account for more than half of the unmet need for contraception (Guttmacher, 2009). Access to modern methods in the Philippines is a particular problem for women from small islands without health centres (IPPF News, 2009).

1 The proportion of women of a reproductive age who are using – or whose partner is using – a contraceptive method at a given point in time.

2 The percentage of women who are married or in a union who were fecund but were not using contraception at the time of the survey, and yet reported not wanting any more children or wanting to delay their next child.

**Table 1: Unmet need for FP and CPR of modern methods in Asia**

	Unmet need for FP in %	CPR modern methods in %
<b>East Asia</b>	–	85
China	–	90
<b>South Central Asia</b>	–	46
Bangladesh	11	48
Bhutan	–	31
India	13	49
Nepal	24	44
Pakistan	33	22
<b>Southeast Asia</b>	–	53
Cambodia	25	27
Indonesia	9	57
Laos	40	29
Malaysia	–	29,8
Myanmar	20	33
Philippines	17	34
Thailand	23	70
Timor-Leste	4	9
Vietnam	5	68

Sources: Unmet need: Population Reference Bureau;  
CPR: Population Reference Bureau; PAI 2008.

## 1.2 Reproductive health supplies policies

Most governments in the region have established policy frameworks, including health laws, that support reproductive rights. Furthermore, the governments ratified various international declarations and treaties, like the Millennium Declaration and the ICPD Programme of Action, which request the establishment of maternal and child health and ensure access to RH services and supplies. One issue that favours CS is the inclusion of sexual and reproductive rights in constitutional texts; this strengthens them in public policies. But Nepal is the only country in the region that included reproductive rights as a human right in its constitutional texts. This inclusion resulted from successful advocacy by the Center and the Forum for Women, Law and Development, according to the Center for Reproductive Rights website (Center for Reproductive Rights, 2008). Some countries have implemented FP in the past. For example, the Philippines implemented a FP programme that included sterilization, but moved away from it. The same is true for Malaysia. In contrast, Vietnam and Indonesia are still implementing FP

The policy environments regarding RH supplies in some countries are less favourable than those regarding more general sexual and reproductive health and rights. Some governments do not support the promotion of modern contraceptive methods due to conservative ideologies and religious grounds, for example in the Philippines and Malaysia. Other countries, including Bangladesh, Pakistan and Vietnam, prioritize FP in their politics and aim to improve access to RH supplies.

The situation regarding RH supplies is unfavourable in Southeast Asia. In the Philippines, Manila's mayor issued an executive order in 2000 that banned city health centres and hospitals from providing contraception, including condoms and birth control pills (Fanselow-Fujimara and O'Neill, 2007). Even though contraception is not banned across the country, there is no accessible public funding from the Department of Health (DOH). USAID-funded condoms were distributed freely in places other than Manila, but since funding stopped in 2008, contraception has been unavailable in large areas. A RH Bill is before the Philippine Congress, but catholic officials are working against it, using excommunication to stop politicians from supporting the bill. Public support for contraception is overwhelming, however, and

many activists have high hopes for the upcoming elections (Gender Across Borders blog, 2009). In spite of this conservative opposition the DOH continues to give away condoms, or prophylactics, to help prevent the spread of sexually transmitted diseases.

The situation is similar in Indonesia, where condom use is not promoted due to conservative and religious reasons. In 2004, the Sentani Commitment was established to promote condom use among high-risk groups, but this document is non-binding for the government (USAID, 2007).

The Bangladeshi government has prioritized contraceptives in many of its national policy documents. For example, the 2002 National Contraceptive Security Strategy included a 20-point strategy to increase the efficiency and sustainability of supply distribution. But while the government prioritizes population and FP, policies lack indicators that help to ensure RH supplies. For example, the National Health Policy in 2008 identified the need to increase the CPR, but sets out no indicators for CPRs or contraceptive stock-outs (PAI, 2009). The National HIV and AIDS and Sexually Transmitted Infection Policy from 1995 does not explicitly address contraceptives, but highlights the importance of linking HIV and AIDS with RH services and strategies. After successful advocacy by the Family Planning Association of Bangladesh, the Government of Bangladesh decided to start local condom production in January 2010. But the production company is facing difficulties, with insufficient raw materials and human resources (Dhaka News, 2010). Elsewhere in South Central Asia, Pakistan's population policy seeks to reduce fertility by improving access to and quality of RH services.

In the Pacific region, the absence of political will to address sexual and reproductive health issues creates an unfavourable environment for the promotion of modern methods. As a response to several RH issues in the Pacific, health ministers adopted the Pacific Plan of Action in 2003. Its goal is to ensure access to the "widest range of reproductive health services and commodities" (APA). Most Pacific island countries have integrated RH services into their primary health care system. Fiji has already achieved most of the ICPD goals and is expected to achieve the MDGs by 2015 (UNFPA Pacific).

In Nicaragua, in 2003, the CS committee was constituted by the Ministry of Health (MOH), the Social Security Institute, NGOs, and donor agencies. A CS strategic plan and a proposed implementation plan were also developed. Further examples are the National Plan on Maternal Mortality (2007), the National Strategic Plan on HIV/AIDS (2006), and the National Strategy for Sexual and Reproductive Health (2008) which sets the target of increasing the prevalence rate of modern contraceptives to 75 per cent and includes reproductive health as a human right. The Government of Nicaragua recognizes population dynamics as an important part of the fight against poverty (UNFPA Nicaragua). But after the 2005 political crisis, political support for RH decreased and the government's attitude towards RH supplies was unclear.

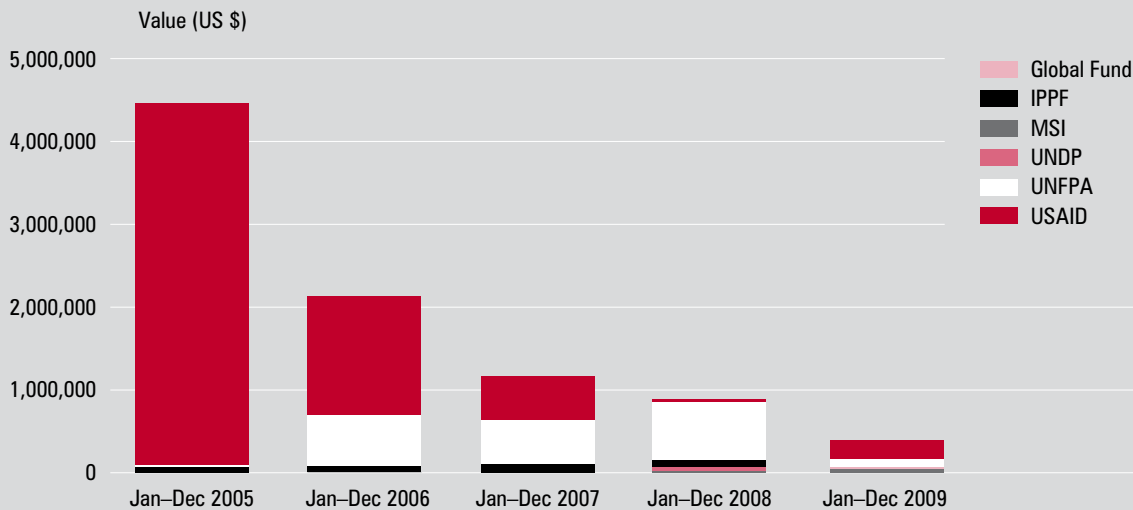
The political situation has also been unstable in other countries in the region during the last decade. This resulted in about ten political crises that created uncertainty regarding policies on RH supplies. In Honduras, for example, the CS committee includes the MOH, women's groups, the Honduran Institute for Social Security, the Honduran Association for Family Planning, USAID and UNFPA, WHO, and the Finance Secretariat. Also, HIV/AIDS was a top government priority, with efforts to reduce the number of new HIV infections made since the late 1980s (USAID, 2005). But in June 2009, the military coup worsened the situation for sexual and reproductive health and rights (SRHR) in the country.

## 2

## Financing

For decades, countries in the Asia and Pacific region have relied on international donors to meet the contraceptive needs of their populations. As donations, especially from USAID, are being phased out, countries will have to find alternative financing options. Financing and procurement are already, or will soon be, the responsibility of national governments in the region. But the existence of public sector funding does not mean that it meets the need. This is only possible if the government provides strong political support for contraceptive security (CS) and secures funding for contraceptive procurement through a budget line item (USAID, 2006). But even if this is the case, budget line items for RH supplies are often drawn from pooled health sector or general budget funds and may remain largely under spent (PAI, 2009).

**Figure 1: Value summary by contraceptive funding source for Philippines**



Source: <http://rhi.rhsupplies.org>

## 2.1 Donor phase-out and public funding

Donors are phasing out FP programmes for several different reasons. Resources are redirected to countries with the greatest need, because the global demand for funding is higher than the currently available funding for FP. Furthermore, funding is increasing for disease-specific initiatives such as HIV/AIDS and malaria. Donors expect governments to take responsibility for meeting the health care needs of their populations, for example by mobilizing all potential sources of financing to purchase the necessary RH supplies. Governments may require capacity building assistance to use data and information to forecast and plan for contraceptive purchases (RHSC Advocacy Toolkit).

If donors phase out their funding, alternatives have to be found, for example public funding from governments. Across the region, the range of general government expenditures on health as percentage of total government expenditure is large. In Central Asia, expenditures are lowest in India (3.4 per cent) but nearly double in Bhutan (7.3 per cent), Bangladesh (7.4 per cent), and Nepal (9.2 per cent). In Southeast Asia, Myanmar has a share even lower than India (1.8 per cent), while the highest is in Timor-Leste (16.4 per cent). In the Pacific, Fiji has the lowest share (9.1 per cent) and Tuvalu has the highest (16.1 per cent).

Some governments or MOHs report to RHI, including Fiji, India, Nepal and Pakistan. Nepal's government increased the share of funding for contraceptive procurement. In 2002, the government financed 5 per cent of total contraceptive funding needs; this increased to 88 per cent in 2008 (US\$ 2.56 million) (USAID Deliver). The Ministry of Health and Population (MOHP) plans to procure 100 per cent of public sector needs in the future (Tien, 2009). Nepal allocated internally generated money for each year during the period 2007–11.

In 2007, the Philippines created a budget line item for FP that includes US\$ 4 million for RH supplies, for use in the national FP programme (USAID Deliver). The money is sub-allocated to the local government units for purchasing RH supplies, and the local government units decide whether or not to procure locally (Gutmacher, 2009). A Gutmacher study states that funding for RH supplies needs to be doubled to meet the unmet need of modern contraceptives in the Philippines (IPPF news, 2009).

In Indonesia, contraceptives will be financed by local governments in the future, after responsibility for CS was shifted to local governments. In some cases, successful advocacy resulted in an official recognition that FP services are an integral part of the districts' basic health care, and district governments allocate annual budgets to purchase contraceptives (USAID Deliver, 2005).

In Bangladesh, donors including CIDA, DFID, KFW, RNE, UNFPA and USAID supplied almost all the contraceptives used until 1998. Today, a large pooled fund is used, financed by the government and development partners including the World Bank, DFID, the Netherlands and the EU. According to PAI, the government is considering using long-term funding to address CS. While there is no financial constraint for the FP programme, a lack of information limits the ability of the Directorate General of Family Planning (DGFP) to plan in the long term. For example, the government planned to use internally generated funds to procure condoms for the first time in 2008–2009, but the local manufacturer was unable to provide the necessary supplies (PAI, 2009). According to USAID, Bangladesh meets more than 60 per cent of its public sector demand for contraceptive procurement through a combination of World Bank credits and basket funds. But the public sector supplies only about half of all modern methods used in Bangladesh, while the private sector has a large share for pills and condoms (USAID Deliver).

In the Pacific island countries, only a few MOHs have established budget lines for RH supplies; most countries remain dependent on donors for supplies (APA). In Fiji, health is a large sector within government expenditure, and HIV and AIDS activities and contraceptives are included in the health budget. The MOH is funding contraceptives, but the biggest share is still funded by UNFPA (about 2/3rds according to UNFPA, and 4/5ths according to the RHI).

An alternative funding mechanism is debt conversion, under which creditor countries forgo a portion of their claims if the beneficiary country invests a part of this in local programmes that have been approved by The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The Debt2Health programme uses debt conversion. The first debt conversion agreements were settled between Germany (as creditor) and Indonesia and Pakistan (as recipient countries).

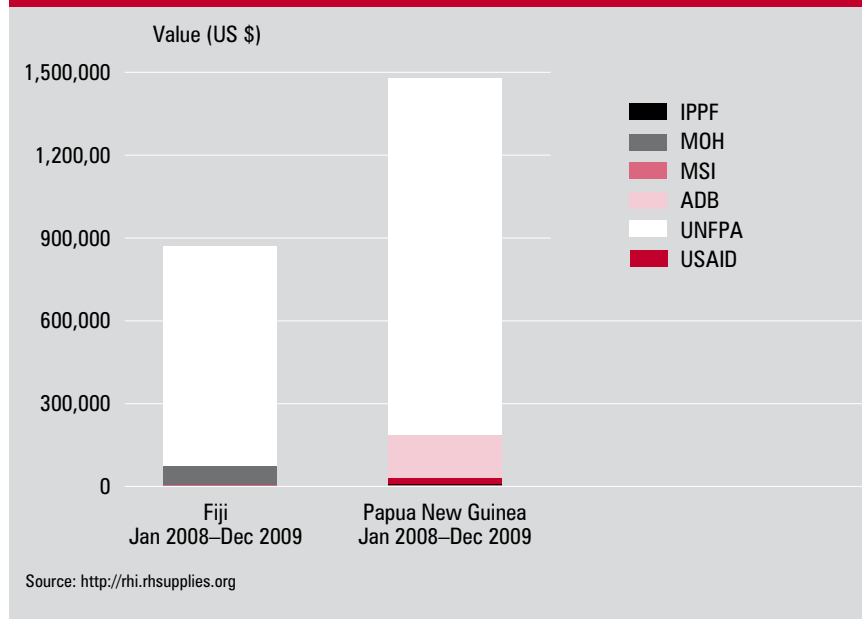
In 2007, the German and Indonesian governments signed an agreement to cancel € 50 million of Indonesia's debt to finance national health programmes. In 2008, the governments of Pakistan and Germany signed a similar agreement, which states that Germany cancels 40 million of debts and Pakistan invests € 20 million in health programmes approved by GFATM (The Global Fund, w/o year).

## 2.2 Share of funding sources

According to RHI, the donors providing the biggest share of contraceptives to Asia and the Pacific are USAID, CIDA and DFID. USAID's absolute amount of donations is decreasing, but its share is increasing as other donors cut funding. In Malaysia, for example, IPPF, the donor with the biggest share, has been decreasing its funding since 2007. In Indonesia, UNFPA's share increased when USAID phased out, but UNFPA cut down its funding from US\$ 1.3 million in 2005 to about US\$ 14,000 in 2007 and US\$ 580,000 in 2008. In the Philippines, UNFPA increased its annual donations up to 2008, while USAID, which has provided the biggest share of free contraceptives in the country over the last 30 years, began to phase out its donation programme in 2004. USAID's share, its phase out and the general decline of donations are illustrated in Figure 1.

A regional UNFPA office in Fiji is responsible for the fourteen island countries in the Pacific region (including Fiji). A UNFPA-managed regional warehouse distributes RH supplies to the other island countries (UNFPA country profiles). The main donors are UNFPA and the Ministry of Health (MOH) (see figure 2). Papua New Guinea does not receive supplies from the central warehouse, as a separate country office handles its own administration. Here, UNFPA funds nearly 100 per cent of the amount reported to the RHI, while USAID's last donations were reported in 2007.

**Figure 2: Value summary by contraceptive funding source for Pacific**



## 3

## Procurement of reproductive health supplies

Centralizing the procurement of RH supplies means that one agency, for example the MOH in a country, is responsible for acquiring or negotiating a bulk price for all contraceptives, which are then distributed countrywide. Due to economies of scale, centralized procurement may result in lower prices for contraceptives. However, decentralized procurement is often used because decision makers are closer to the population and the population's demand for RH supplies can better be met than in a centralized setting. In a decentralized procurement setting, regional or local entities from procure supplies independently from each other.

To meet needs more effectively, decentralization of the health sector has taken place, or is still occurring, in many Asian and Pacific countries. Many problems may occur during decentralization, including competition for funding with other priorities, and problems that arise when responsibilities are shifted from central to local governments. For example, the relationship between central and local governments might be difficult, or local governments lack support from the central government (USAID Deliver, 2005). In addition, donor phase outs may coincide with decentralization.

Procurement is centralized in Bangladesh and India. In India, the central government or the Ministry of Health and Family Welfare (MOHFW) procures and supplies each state's contraceptive needs; the states do not procure any contraceptives at their level. In Bangladesh, procurement is centralized and organized by the DGFP. A wide range of contraceptive methods are available through several channels, including public sector clinics, the private sector (including pharmacies and shops), NGOs and community health workers. NGOs have the same priority when government stock is distributed (PAI, 2009).

Stock-outs still occur in Bangladesh. In 2004 and 2005, the amount of international procurement decreased and, by June 2006, the national stock of condoms, oral contraceptives, injectables and IUDs had fallen below the critical six-month level. In 2008, condom stock-outs could only be averted by an expensive emergency shipment of 6 million condoms, funded by USAID (Bates, 2008). Further reasons that lead to stock-outs in Bangladesh include: a lack of technical capacity and procurement knowledge; a high staff turnover and transfer rate, which creates a knowledge and experience gap; bureaucratic delays within the MOHFW and DGFP; and a lack of commitment to prompt decision-making and lengthy review processes at the MOHFW and the World Bank (Dickens, 2008; PAI, 2009). The distribution of RH supplies is dominated by the public sector and the Social

Marketing Company (SMC), which provides around 31 per cent of all modern methods, while the commercial sector's share is small (Bates, 2008).

In Vietnam, the population and health sectors have been devolved from the center to the provinces to bring services closer to the people and to meet their needs. Every element of the multi-agency structure reports horizontally to the coordinating People's Committee, and vertically within its own structure (UNFPA, 2000). But according to UNFPA, the contraceptive commodity situation in Vietnam is insecure and a long-term strategy must be developed to deal with the situation (Vietnam News, 2006).

In the Philippines, provincial and local governments are responsible for procuring RH supplies. As resources are limited, local governments have started to segment the market. Free contraceptives are currently available to non-poor people as well as poor people, which means that poor people have to compete with those who can afford contraceptives. It is planned to make people who can afford contraceptives pay for them (Sarley et al, 2006). Currently, approximately 75 per cent of users rely on the free contraceptives provided by USAID (Tien, 2009).

Supply chains in the Pacific region are complex and urgently need improved donor coordination and communication. NGOs, private organizations and multilateral agencies are procuring and providing RH supplies and services in the region. Large NGOs such as IPPF and MSI independently manage and distribute RH supplies to their clinics. This system runs separately from the MOHs. But some smaller, independent clinics cover MOH in-country supply shortfalls, and vice versa (FPI, 2008).

The MOH in Fiji provides a UNFPA-managed regional warehouse for RH supplies. This warehouse is part of the Pacific Plan of Action, and 14 Pacific island countries receive supplies from it at no cost. Stock-outs still occur in the countries, as many storage facilities are poorly managed. Locally run

services have to deal with enormous resource strains because the supply chains are very complex. In some cases, expired supplies have been distributed. In particular, the reporting requirements are very resource intensive (APA). According to FPI, local facilities are poorly managed, with inadequate space and stock monitoring systems, and perishable supplies stored without any temperature control (FPI, 2008). These factors all contribute to stock-outs.

### 3.1 Essential drug lists

Essential drugs are those “that satisfy the priority health care needs of the population. Essential medicines are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage forms, with assured quality and at a price the individual and the community can afford” (WHO, 2008). These are listed on Essential drug lists (EDL). Having RH supplies on an EDL assures their legitimacy and increases their availability to those who need them the most. The concept enables countries to get the best medicines from their available resources. Due to economies of scale, concentrating on a limited number of essential drugs lowers prices.

In Bangladesh, the EDL was fully revised for the first time in 2008 but still includes only two contraceptive methods, condoms and oral contraceptives (PAI, 2009). Nepal’s EDL contains three oral hormonal contraceptives, one injectable hormonal contraceptive, two IUDs, condoms and an implantable contraceptive (Nepal Essential Drug List). India’s national EDL contains condoms, hormonal and copper IUDs (India Essential Drug List, 2003). Malaysia has an EDL that includes contraceptives, but not condoms (Malaysia Essential Drug List). In contrast, Pakistan’s EDL includes a wide array of contraceptives, including condoms (Pakistan Essential Drug List, 2003).

Vanuatu and 13 other Pacific islands are included in the EC/ACP/WHO Partnership on Pharmaceutical Policies. This project aims to increase access to essential drugs and create and/or update EDLs. The project is guided by the Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region, 2005–2010 (WHO, 2008). Fiji has already adopted the WHO’s model list of essential medicines, which includes contraceptives (Australian Prescriber, 2004).

### 3.2 The contraceptive supply chain in the Contraceptive Security Index

The USAID/Deliver Contraceptive Security Index rates contraceptive supply chains by storage and distribution, Logistics Management Information Systems, forecasting, procurement and contraceptive policy<sup>3</sup> (USAID, 2006).

The supply chains of Bangladesh and Nepal received the highest possible results in every indicator except contraceptive policy. For India, no data is available except for contraceptive policy, where it achieved 4 out of 4 points. Indonesia’s storage and distribution, forecasting and contraceptive policy are rated highly, while the monitoring and procurement are poorly rated. Pakistan’s supply chain only achieved good results in procurement and contraceptive policy, while the Philippines achieved good results in all indicators except forecasting and contraceptive policy, as the amount of imported contraceptives is limited. Vietnam’s supply chain is rated as “good” in all aspects except the procurement of contraceptives (Contraceptive Security Index, 2006 I). For the Pacific region, these data are not available, but supply chains in the island countries are very complex due to a large number of actors, whose actions are not well coordinated.

<sup>3</sup> The latter means the facilitation of open markets which offers the possibility to import contraceptives

## 4

## Advocacy entry points

This mapping was created for a RH supplies workshop to provide insights into the situation regarding reproductive health supplies in the Asia and Pacific region. During the workshop, the advocacy toolkit and guide *Leading Voices in Securing Reproductive Health Supplies* was introduced and used. This is a practical, evidence-based tool designed to raise awareness and foster policy change for increased commitment to reproductive health supplies. This valuable resource draws upon successful advocacy initiatives and lessons learned in contraceptive security. It provides an essential guide to advocacy communications and messages, a range of five global supply shortage scenarios, adaptable to your country's own needs, and a set of tools including policy briefs, PowerPoint presentations and advocacy planning guides.

Including reproductive rights in the constitution is an important step towards gaining CS and preventing stock-outs, as it strengthens them in public policies. As currently only Nepal includes reproductive rights in its constitution, advocating for their inclusion in constitutions is an important entry point. Projections of the need for RH supplies are needed to improve the availability of these supplies, especially for least educated or rural populations who have poorest access to them. These projections could be gathered by CS or coordination committees. The MOH in a country should take leadership of the committee, which should be clearly connected to the government and donors. To keep the committee working, active coordination is required among all stakeholders. If a CS committee does not yet exist, a possible entry point is to advocate for the creation of one. If a CS committee already exists, it can advocate for certain aspects of CS, for example the availability of a certain method which is not yet available, or its inclusion on the EDL of the country. Furthermore, a long-term CS strategy, which helps to ensure an adequate supply, should be developed and implemented if it does not already exist.

As donors phase out their funding in most cases, countries have to rely on other sources or generate funds internally. But even if they generate their own funds, these might not be sufficient; internally generated funds must be allocated to contraceptives. Governments should create budget lines to secure funding for RH supplies. If public funding has been implemented, the government must give FP a protected status to assure that the funds are not reallocated to other budget lines. The budget line item can be used to monitor the government's commitment to contraceptives, and helps to track funding. If local authorities receive their own funding parallel to federal funding, they must spend these funds on RH supplies rather than relying on the federal financing.

Governments should participate in a debt conversion mechanism, if they fulfil the requirements. This could mobilize additional funding, as creditors forgo a portion of their debt claims if the government spends a portion of this on development issues. This additional funding should be allocated to RH supplies.

Including RH supplies on EDLs is very helpful for ensuring a sufficient supply. If there is no EDL in a country, advocating for the creation of one is a possible entry point. If such a list exists, it should include a wide array of different contraceptive methods. For example, Bangladesh's EDL includes only two methods of contraception. It is not important that the list includes a huge number of different products of the same kind; limiting the number of essential supplies of one method helps to lower prices, due to economies of scale. Some key stakeholders might be unaware that the EDL in their country does not include the full range of RH supplies. The WHO model list of essential medicines can be used as a role model for developing EDL, as it includes contraceptives.

One possible way to make the government aware of your issues is to reach supportive members of the government, supporters who might be able to influence, or those who have contact to members of the government. These might be parliamentarians, friends or members of their family. Other possibilities are to make the public and stakeholders aware of your issues and to provide figures and numbers that demonstrate the urgency of the issues to stakeholders.



## List of abbreviations

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<b>ACP</b>	African Caribbean and Pacific countries
<b>ADB</b>	Asian Development Bank
<b>CIDA</b>	Canadian International Development Agency
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CS</b>	Contraceptive Security
<b>DFID</b>	UK Department for International Development
<b>DGFP</b>	Directorate General of Family Planning
<b>DOH</b>	Department of Health
<b>DSW</b>	German Foundation for World Population
<b>EC</b>	European Commission
<b>EDL</b>	Essential Drug List
<b>EU</b>	European Union
<b>GFATM</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>ICPD</b>	International Conference on Population and Development
<b>IUD</b>	Intrauterine device
<b>KFW</b>	Kreditanstalt für Wiederaufbau
<b>MDG</b>	Millennium Development Goal
<b>MOHFW</b>	Ministry of Health and Family Welfare
<b>MOHP</b>	Ministry of Health and Population
<b>MOPW</b>	Ministry of Population Welfare
<b>MSI</b>	Marie Stopes International
<b>NGO</b>	Non-governmental Organization
<b>PAI</b>	Population Action International
<b>RH</b>	Reproductive Health
<b>RHI</b>	Reproductive Health Interchange
<b>RNE</b>	The Royal Netherlands Embassy
<b>SMC</b>	Social Marketing Company
<b>STI</b>	Sexually Transmitted Infection
<b>UNESCAP</b>	United Nations Economic and Social Commission for Asia and the Pacific
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Emergency Fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization



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**Imprint****Publisher**

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**IBAN: DE56 2504 0066 0383 8380 00**

**BIC: COBADEFF 250**

**Commerzbank Hannover**

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**Design**

Simone Schmidt, Hannover

» IBAN: DE56 2504 0066 0383 8380 00  
BIC: COBADEFF 250  
Commerzbank Hannover

The German Foundation for World Population (DSW) is an international development organisation, with offices in Germany, Belgium, Ethiopia, Kenya, Tanzania, and Uganda. DSW's main goal is to help people free themselves from poverty. For this purpose we support family planning and sexual and reproductive health projects in Africa and Asia.

Our premise is simple: only if people are able to protect themselves from unwanted pregnancies and HIV/AIDS do they have the chance to lead a healthier and better life. In this respect reaching young people is key. Young people are the parents of tomorrow and crucial to the development of their country. Investing in their health means investing in a better future.



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