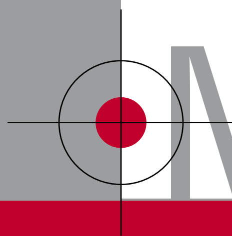
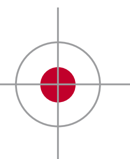


MAPPING

Reproductive Health Supplies in East Africa

RHS

A mapping of procurement, funding, and policies



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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. UNFPA has a list of countries and sorts them into the following categories: countries that need most assistance to reach the ICPD goals; those that have made considerable progress towards achieving the ICPD goals; and those that have made significant progress towards achieving the ICPD goals. This mapping is about Burundi, Ethiopia, Kenya, Rwanda, Tanzania and Uganda, all of which belong to the first group – countries that need most assistance (UNFPA, 2005).

1.1 Contraceptive prevalence rate and unmet need for family planning

Maternal mortality, contraceptive prevalence rate (CPR) [1] and unmet need for family planning (FP) [2] are indicators that can provide an overview of the situation regarding reproductive health (RH). One possibility for improving RH is ensuring the availability of RH supplies.

In the countries analyzed in this mapping, the CPR of modern methods is low, as it is in most sub-Saharan African countries (14.8 per cent). The CPR of modern contraceptives ranges from 8.4 per cent in Burundi to 31.5 per cent in Kenya (see Table1). The UN's *World Contraceptive Use* report provides rates of annual change in the prevalence of modern methods (UN, 2007). The annual increase from 1997 to 2007 was between 0.1 per cent in Burundi and Kenya and 1.2 per cent in Ethiopia. In Tanzania and Uganda, the rates increased by 0.7 per cent and in Rwanda by 0.5 per cent. The CPR for modern methods increased from 10.3 per cent in 2005 to 27.4 per cent in 2008 (NISR, 2006; MOH Rwanda). In Tanzania, the CPR of modern methods increased from 16.9 per cent in 1999 to 20 per cent in 2005 (NBS Tanzania, 2005). According to the RHI, Uganda's CPR for modern methods declined slightly between 2001 and 2006, from 18.2 per cent to 17.9 per cent. This is different from the UN data, however.

Annual changes from 1997 to 2007 of the use of traditional methods are akin to those of modern methods. In Uganda and Tanzania, the annual changes are only slightly lower at 0.6 per cent. But in Burundi, the prevalence of traditional methods increased by 1.6 per cent annually, while the CPR of modern methods increased only 0.1 per cent.

Injectables are the preferred contraceptive method in the region, and their use is increasing. In Tanzania, their share is 8.3 per cent, followed by oral pills (5.9 per cent) and male condoms (2 per cent). In Kenya, the use of injectables increased from 11.8 per cent in 1998 to 14.3 per cent in 2004. In Uganda, use increased from 6.4 per cent in 2001 to 10.2 per cent in 2006. Injectables are the preferred method in Rwanda and Burundi, too (15.2 per cent in Rwanda and 4.7 per cent in Burundi).

The use of implants is also increasing. In Kenya, their use doubled from 0.8 per cent in 1998 to 1.7 per cent in 2003. In Tanzania, their use was negligible in 2005 but recent RHI data suggests an increase in their use. The use of other methods in the region is declining slightly. For example, the use of the pill in Kenya declined from 8.85 per cent in 1998 to 7.5 per cent in 2003 (MOH Kenya, 2005). Furthermore, RHI data show that a large portion of RH supplies procured for Kenya between 2005 and 2009 are injectables (RHI).

In spite of the increasing use of contraceptives in East Africa, fertility rates (the actual average number of children born to a woman over her lifetime) remain high. In Kenya, fertility rates increased slightly between 1998 (4.7 births per woman) and 2003 (4.9 births per woman). In Rwanda and Tanzania, the rates remain high at 5.5; in Burundi, the rate is 5.4 births per woman.

Unmet need for FP is high in the region (see Table 1). In 2006, it ranged from 21.8 per cent in Tanzania to 40.6 per cent in Uganda. In Uganda, unmet need for FP was lower in 2001 at 34.6 per cent (RHInterchange,

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 (UN, 2008).

Table 1: Unmet need for FP and CPR of modern methods in East Africa

	Unmet need for FP in %	CPR modern methods in %
Burundi	29,4	8,4
Ethiopi	33,8	13,9
Kenya	24,5	31,5
Rwanda	37,9	27,4
Tanzania	21,8	20,0
Uganda	40,6	17,9

Source: Unmet need: UN, 2008; CPR: Population Reference Bureau.

2009 I). An article published in *The Guardian* newspaper (2009) suggested several reasons for Uganda having the highest unmet need for contraception in East Africa. These include religious beliefs, limited access to FP services, and opposition from partners. This unmet need is highest among illiterate women, and the country lacks the resources to address the problem. UN data shows that the unmet need for contraception is nearly twice as high in Uganda as in Tanzania, while the CPR of modern methods is pretty similar.

Unmet need for FP is highest among women who are least educated and living in rural areas. In Ethiopia, for example, unmet need is twice as high in rural areas than in urban areas. In all countries except Rwanda, unmet need is significantly higher in rural than in urban settings (USAID, 2005; PRB, 2009).

1.2 Reproductive health supplies policies

Governments in the region have established policy frameworks, including health laws, which support reproductive rights. Furthermore, the governments have ratified various international declarations and treaties, including the Millennium Declaration and the ICPD Programme of Action, that requests the establishment of maternal and child health care and ensures access to RH services and supplies.

In Ethiopia, there are various national polices and strategies, including a health policy, an HIV/AIDS policy, an education policy, a women's policy, as well as the National Sexual and Reproductive Health Strategy. Furthermore, a *Roadmap for Maternal, Newborn and Child Health* was enacted in 2007. According to PAI (2009), one improvement that could be made is an official strategy on contraceptive security (CS). Since February 2009, it has been very difficult for civil society organizations to work in Ethiopia. A new law prevents organizations which receive more than 10 per cent of their funding from abroad from involvement in human rights, gender equality and conflict resolution.

In Kenya, the Plan of Action to implement a new National Population Policy for Sustainable Development focuses on population, development and RH. According to this plan, population is integrated into the development process. The government recognized a "less than desirable state of reproductive health and that reproductive health services remain a major problem in the country" (NCPD, 2001).

Furthermore, the Adolescent Reproductive Health and Development Policy, was developed in line with the recommendations of the ICPD conference in 1994. The policy was developed to bring into focus key adolescent RH issues, including HIV, teenage pregnancies and unsafe abortion. The Ministry of Health (MOH) states that itself and the National Coordinating Agency for Population and Development "will play leadership roles in coordinating stakeholders and resource mobilization for implementing the Policy" and that it "will ensure the provision of adolescent-friendly reproductive health information and services at all levels of health care delivery" (MOH Kenya, 2005). The implementation of the National HIV and AIDS Strategic Plan is supported by the National Aids Control Council. This support is financed by the International Development Agency and DFID (DSW, 2008).

In Tanzania, the Poverty Reduction Plan includes a strategy devoted to the promotion and protection of RH. Furthermore, a Roadmap for Maternal, Newborn and Child Health was launched in 2007. But the Roadmap is not widely known at the district level and its secretariat remains inactive (PAI, 2009). The Population Policy from 1992 addresses maternal and child mortality. Reproductive and child health is one of five major components of the National Essential Health Package, and has its own set of essential interventions that include the need to provide comprehensive FP services at all levels.

In Burundi, a new RH bill is to be passed. But the version which was developed in 2009 included several articles that violate human rights. For example, it included an article "to suspend fertility for mentally handicapped people" (AllAfrica, 2009).

In Rwanda, commitment to CS appears to be quite strong, indicated by the presence of a specific CS strategy for 2005–2010. Furthermore, the country has an active national Commodity Security Committee, which includes members from the MOH, donors, non-governmental organizations (NGOs), and commercial sector organizations.

In Uganda, RH is among the nation's health priorities. The Reproductive Health Policy aims to lower maternal mortality. In the Uganda Poverty Eradication Action Plan, the government recognizes population and reproductive issues as important for poverty reduction (UNFPA Uganda, 2009). The Plan includes the provision of RH commodities, including free essential drug supplies for pregnant women and increased contraceptive supply. Further policies that address RH are the National Family Planning Advocacy Strategy in Support of RH, and the Roadmap for Reduction of Maternal and Neonatal Mortality (PAI, 2009).

The availability of RH supplies in Uganda is one of the objectives of the National Family Planning Advocacy Strategy. The Population Policy in 2008 aimed to reduce unmet need for FP by promoting RH commodity security. A CS strategy has been set up for the period from 2009 to 2014. This strategy addresses policies, coordination, political and financial commitment, financing, commodity security, demand and utilization of services, logistics, and monitoring and evaluation.

A Health Sector Wide Approach (SWAp) aims to increase the CPR by providing universal access to condoms, an increased availability of emergency contraception, and preventing stock outs. Uganda's Reproductive Health Contraceptive Security Strategy addresses commodity security, especially the policy environment, commitment for reproductive health commodity security (RHCS) and commodities for RHCS (MOH Uganda, 2008). The RHCS Committee was set up in 2005. It includes the Reproductive Health Division from the MOH, the Ministry of Finance, the National Medical Stores, the NGO sector, and social marketing organizations. The committee is working towards improving communications among the donors and the government; forecasting is already coordinated, for example. The MOH includes a Condom Coordination Unit which aims to improve the supply chain in the distribution of condoms between districts and health facilities (PAI, 2009). But there is disinterest and occasional opposition at high political levels in Uganda, which hamper the implementation of these policies. For example, it is often perceived that the fast-growing population will be a major driver for economic growth (PAI, 2009). According to the DFID (2006), reasons that prevent the successful implementations of policies include:

- weak ownership, capacity, resource allocation and coordination at all levels
- limited translation of national priorities into decentralized or devolved planning, budgeting and implementation processes
- limited accountability for delivering on national priorities
- low demand by both consumers and their political representatives.

Tanzania does not have a CS strategy like Uganda, but some policies address RH supplies. A Contraceptive Security Working Group has been set up, consisting of the MOH, donors, NGOs, and commercial sector organizations. The National Family Planning Implementation Plan also includes a CS component (RHInterchange, 2009 II). The Reproductive Health Policy aims to increase the CPR and points out unmet need for FP and the provision of supplies included in the Essential Drug List (EDL). The Health Sector Strategic Plan asks for the continuous supply of contraceptives and recognizes the low CPR. The Roadmap for Maternal, Newborn and Child Health also addresses RH supplies but, as stated above, is unknown at district levels.

In Kenya, the National Contraceptive Commodity Security Strategy (NCCCS) 2007–2012 might contribute towards the achievement of the National Health Sector Strategic Plan II. This plan includes RH as a priority area. The NCCCS addresses the challenges of CS by focusing on several components, including coordination, commitment, financing, capacity, and client demand and utilization.

In some parts of the region, conservative opposition is a problem for CS; religious groups are fighting against promotion of modern FP methods. In Burundi, churches in some areas are engaged in campaigns against FP (Health Africa, 2009). Opposition to FP is also common in Uganda, where some politicians oppose the creation of demand; in Tanzania, some officials still do not consider FP an integral component of the health system.

2 Financing

According to the East, Central and Southern African (ECSA) Health Community, governments in the region are heavily dependent on donor funds to supply contraceptives. If donors phase out their funding, alternative donors or the governments themselves have to finance RH supplies.

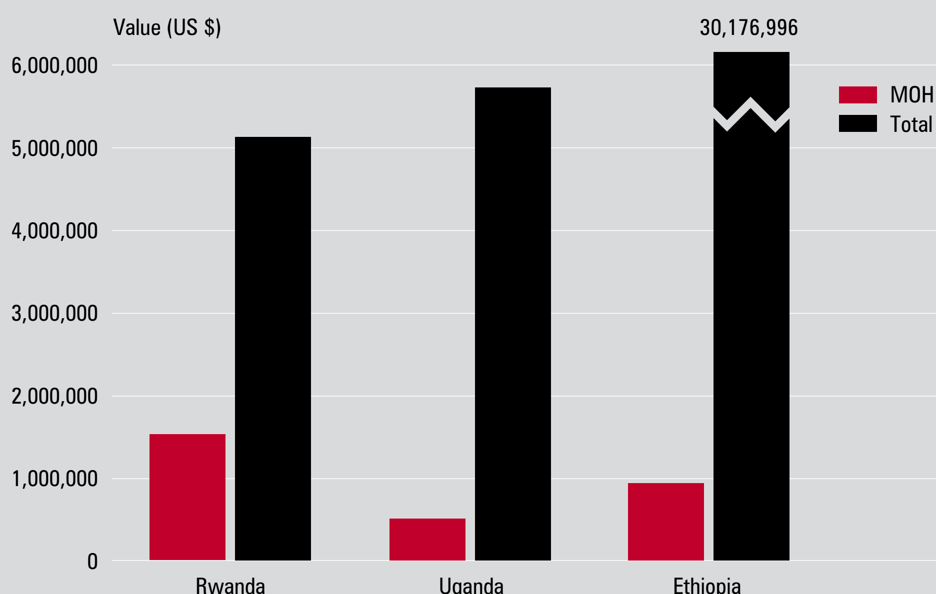
2.1 Donor phase-out and public funding

Burundi, Ethiopia, Kenya, Rwanda, Tanzania and Uganda all use public sector funding for contraceptives. But the existence of public sector funding does not mean that it meets the need. According to USAID (2006), this is only possible if the government provides strong political support for CS and secures funding for contraceptive procurement through a budget line item. Kenya, Rwanda, Tanzania and Uganda have established a budget line item. But even where this is the case, budget line items for RH supplies are often drawn from pooled health sector or general budget funds and they may remain largely under spent (PAI, 2009).

Governments' health expenditures remain low in East Africa, except in Rwanda. In 2006, the governments of Uganda, Ethiopia, and Tanzania spent 10 per cent, 10.6 per cent, and 13.2 per cent respectively on health as a percentage of total government expenditures. These shares are much higher than Burundi (2.3 per cent) and Kenya (6.1 per cent), but still low compared to the share of Rwanda's share of health expenditures (27.3 per cent) (WHO 2010).

Figure 1 shows the share of Ministries of Health for Contraceptives in Rwanda, Uganda and Ethiopia. In Uganda, the current financing gap for contraceptives is estimated at 30 per cent and planned to be reduced to 5 per cent by 2014 (PAI, 2009). According to Uganda's National Reproductive Health Commodity Security Coordinator, Uganda's contribution towards funding FP is less than 5 per cent. The few resources allocated to financing FP programmes are not always received by the MOH; only 20 per cent are actually delivered (The Guardian, 2009).

Figure 1: Ministry of Health Contraceptive Funding Share (Jan–Dec 2008)



Source: http://rhi.rhsupplies.org

2.2 Share of funding sources

The limited amount of government financing for contraceptives corresponds with an overall decline in government expenditures on health.

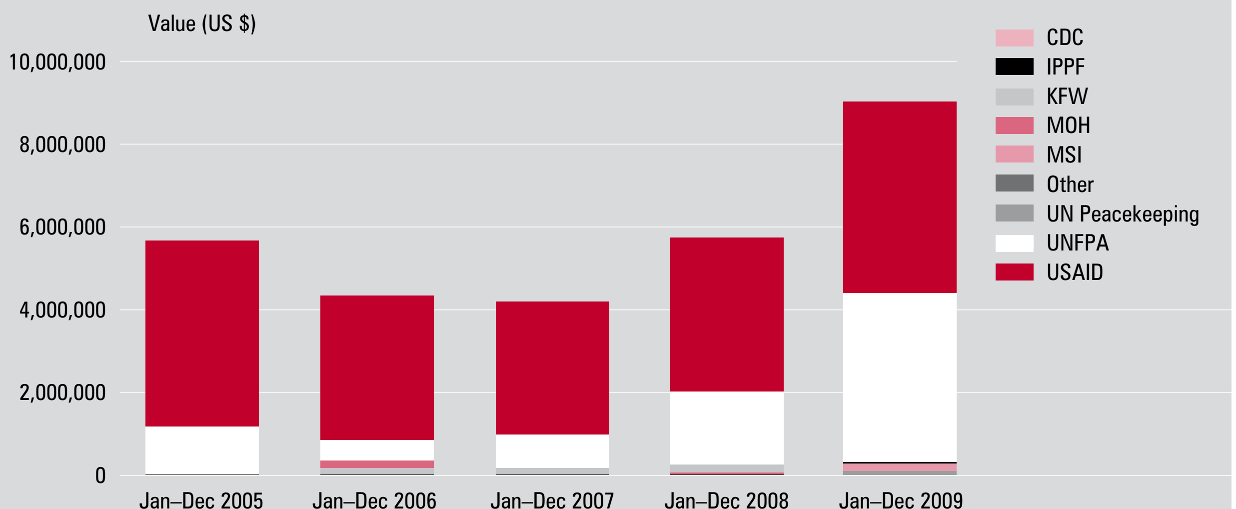
Figure 2 shows the share of all expenditures that Uganda's MOH spent on RH supplies. In the fiscal year 2007–2008, the government established a budget line item for the procurement of contraceptives. The government also funded 14 per cent, or US$ 280,000, of total spending for public sector contraceptives through the use of internally generated funds (USAID, 2009). In 2008, other funding sources were led by USAID (US$ 3.7 million) and UNFPA (US$ 1.8 million). Other sources, including IPPF, KFW and MSI, funded a total of US$ 260,000 in contraceptives (RHInterchange, 2009). In Uganda, central ministries as well as local councils or districts may allocate funding for contraceptives, which creates multiple financing streams.

The Tanzanian government has allocated a budget line for contraceptives since 2002, and has included its own internally generated funding as a line item since 2005 (PAI, 2009). The budget line item represented more than half of the total budget for RH supplies in 2006–07 and about 75 per cent in 2008–2009. But funding for contraceptives remains fragile. The central budgeting process is not sufficiently flexible to adapt financial allocations to changing or rising needs. Funding is currently shifting from specific funding to health sector and general funding. Local authorities can receive and use additional funding for RH supplies through the share of health sector basket funds allocated to districts (PAI, 2009).

This results in a situation like that found in Uganda: central ministries, as well as local councils or districts, can allocate funding for contraceptives, which creates multiple financing streams. In the 2008–2009 fiscal year, total funding for contraceptives fell short of the actual need by 27 per cent. Until October 2009, none of the US$ 1.3 million that has been allocated by the Tanzanian government for the 2009–2010 fiscal year has been released (RHInterchange, 2009 II). But advocacy by the Project RMA member organization UMATI led to increased funding for RH, and the government has since decided to increase funding for FP supplies to US$ 7.26 million in 2009–10. This is the amount the CS committee has recommended as the minimum needed for the procurement of contraceptives for this period.

In Kenya, the government uses its own funds to procure contraceptives, and it plans to increase its contribution. Donor funding is channelled to government departments and agencies as well as to NGOs. International donor funding increased in 2009. According to RHI, USAID and UNFPA increased their

Figure 2: Value summary by contraceptive funding source for Uganda



Source: http://rhi.rhsupplies.org

funding significantly to become the largest funding sources, providing US$ 8.4 million and US$ 14 million respectively between 2005 and 2009. The Global Fund has provided US$ 2.6 million for male condoms since 2008. The International Contraceptive Access (ICA) Foundation has provided US$ 153,600 worth of intra-uterine devices since 2007. DFID has provided US$ 3.5 million for contraceptives since 2006, and since 2005 funding has also been provided by MSI (US$ 314,000), IPPF (US$ 76,000) and KFW (US$ 13,165). Stakeholders will need to work closely together to determine future commodity requirements and funding commitments from both the government and its partners to ensure continuous availability of financing for RH supplies (RHInterchange, 2009 IV).

Donor funding is increasing in Rwanda. Like in Tanzania, the MOH is funding a relatively large share of RH supplies. Of the total amount spent on public sector contraceptives in the 2009 fiscal year (US$ 6.8 million), USAID and UNFPA provided 66.3 per cent of the total funding in the form of in-kind donations. Of the remaining 33.7 per cent, 21.7 per cent came from internally generated funds provided by the government, while DFID and the Global Fund provided 78.3 per cent. The Global Fund contribution (a three-year commitment for US$ 2.4 million starting in 2008) is unique as it is used to fund contraceptives for both FP and HIV prevention programmes. The integration of RH and HIV services is a priority in Rwanda and the MOH strongly advocated for this funding to ensure there would be adequate financing for contraceptives in the future (RHInterchange, 2009 III). It is believed that Rwanda is the first country to use Global Fund money for contraceptives (USAID Deliver II, 2008).

In Ethiopia, four main sources finance health services: federal and regional governments; Official Development Assistance (ODA) from bilateral and multilateral donors; NGOs; and private contributions (PASDEP, 2007). According to RHI data, the main donors are the World Bank, USAID and UNFPA. Donor funding has increased in recent years. RHInterchange data shows that donations made by the World Bank quadrupled from 2007–8 to 2008–9. A statement of the UN Economic and Social Council (ECOSOC) – that a doubling of aid is needed to achieve the Millennium Development Goals (MDGs) – might have helped (UN ECOSOC, 2007).

In Burundi, RHI data shows the three major donors of contraceptives were UNFPA, USAID and IPPF. Since 2005, UNFPA has funded a total of US$ 1.9 million in contraceptives, USAID provided male condoms to the value of US$ 357,000, and IPPF provided US$ 20,500. USAID did not report any funding since 2006, while UNFPA significantly increased its funding (RHInterchange, 2009 V).

An alternative funding mechanism is debt conversion. Debt conversion means that creditor countries forgo a portion of their claims if the beneficiary country invests a part of it in local programmes which have been approved by the Global Fund (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria). The Debt2Health programme uses this mechanism. The first agreements have been settled between Germany (as creditor) and Indonesia and Pakistan (as recipient countries). If the multilateral creditors of Burundi, Rwanda, Tanzania and Uganda decide to participate in Debt2Health, they could all benefit from this opportunity, as they have received full Heavily Indebted Poor Countries (HIPC) debt relief. Kenya, as the only non-HIPC country, has been selected as one of four countries worldwide to be part of the pilot phase of the Debt2Health programme (The Global Fund, w/o year).

3 Procurement of reproductive health supplies

The governments of Kenya and Uganda shifted from in-kind donor contributions to government-managed financing and procurement of contraceptives. In Kenya, the Director for Public Health and Sanitation improved the availability of RH supplies and reduced stock-outs. This resulted from a coordinated effort among the Ministry of Public Health and Sanitation, the Division of Reproductive Health, the Kenya Medical Supplies Agency (KEMSA), the Family Planning Working Group, the Reproductive Health Interagency Coordinating Committee, and a higher level policy group.

The main purpose of setting up KEMSA was to enable the MOH to develop a viable commercial service to procure drugs and medical supplies, and to provide an economic and efficient source of drugs and medical supplies for public health institutions. But since its inception in 2000, KEMSA has experienced budgetary constraints, a lack of moving and handling equipment, a shortage of qualified personnel, and inadequate storage and holding facilities (depots) in outlying regions. These limitations have resulted in a need to extensively build local capacity and establish an effective coordinating mechanism to mobilize both financial and political resources. This will ensure the sustainable supply and distribution of contraceptive commodities.

The programme managers of the MOH, in collaboration with KEMSA and the Chief Pharmacist of the MOH, perform an annual quantification exercise to determine the volume of supplies to be procured in Kenya. A major threat to contraceptive procurement has been the shift in priorities and resources to HIV/AIDS programmes over RH supplies and commodities. Over the last two decades, HIV/AIDS programmes have threatened to reverse the historic gains made by Kenya's once-strong FP programme. Most HIV/AIDS prevention and care efforts have evolved as vertical programmes that do not provide traditional RH services.

Contraceptive commodities require a lead time for ordering, a reasonable level of stock to draw from and buffer stocks to maintain constant and steady supply. This is complicated, however, because Kenya has several different donors, all of whom have different lead times, delivery protocols and lengths of commitment. There are challenges on the demand side, too. For example, there is limited information about sexual and reproductive health rights, which limits the types and uptake of contraception. There is also a correlation between education levels and CPR; socio-cultural, gender and economic issues also affect access. Limited youth-friendly services also play a significant role, as the young people who need RH supplies the most shy away from mainstream service delivery points (DSW Kenya, 2010). As in most of the region, stock-outs still occur and the MOH recently blamed donors for not delivering in time (Health Kenya, 2009). Distribution centers lack awareness about the needs of the population, which hampers improvements in logistics.

In Uganda, efforts have been made in recent years to strengthen procurement, forecasting and supply chains. The performance and capacity of the National Medical Stores in carrying out international procurement, managing supplies and cooperation with the MOH has improved. Today, like in Tanzania, Uganda has an integrated distribution and logistics management information system (LMIS). While local facilities order stocks from the National Medical Stores, delivery is organized centrally, mainly by the Reproductive Health Commodity Security Coordination Committee, which consists of part of the MOH and NGOs.

In spite of these improvements, stock-outs have still occurred frequently in recent years. The MOH must deal with several donors, and the main donors still use their own procurement methods. The contributions by main donors are not consistently reported to the government and the donors' timescales are too short for the MOH to be able to integrate donations into its planning process. This raises transaction costs (DFID, 2006). According to PAI, Uganda plans for all procurement forecasts to be done in coordination with the government and donors and a five-year RH supplies procurement plan to be created (PAI, 2009).

Tanzania shifted to an integrated logistics system and demand is perceived locally. A number of key federal agencies regulate policy, financing and logistics, while authority for facility operations and local health plans rests at the district level with the local government authorities (LGAs). The centralized Reproductive and Child Health Section of the Ministry of Health and Social Welfare is a vertical programme with its own financing and procurement. Forecasting and logistics are managed by the Pharmaceutical Support Unit, while local councils design and implement local health plans, following guidelines provided by the central institutions.

Procurement and distribution are managed by the Medical Stores Department. The government's quality of forecasting, procurement and logistics functions is improving, but external technical assistance is still needed. Currently, the Medical Stores Department forecasts the needs in collaboration with the USAID | DELIVER Project. But contraceptives stock-outs still occur in Tanzania, because of poor infrastructure, limited government budget, donor withdrawal, and poor forecasting of contraceptive needs (PAI, 2009). To prevent this, advocates are working on forming Contraceptive Security Committees in certain districts. A Contraceptive Security Working Group has been active since 2004.

In Ethiopia, the MOH plays a key role in managing and controlling RH supplies, and local and international NGOs support and supply contraceptives. In particular, MSI, DKT and the Family Guidance Association of Ethiopia (FGAE) play an important role through their clinics both in urban and rural areas. The government has allowed the tax-free importing of RH supplies and they are largely purchased and imported by the government, as well as by donor agencies like MSI and DKT.

High costs and stock-outs are problems in East Africa. For example, female condoms are scarce and expensive in Rwanda. One female condom is available for the price of a box of male condoms, if it is available at all (The New Times, 2009). Furthermore, there are problems with the quality of contraceptives. For example, UNFPA imported 10 million condoms to Tanzania in 2002, but these were blocked by the government after samples were confirmed to be defect. In 2004, a national condom shortage occurred because a popular brand of government-subsidised condoms failed safety standards and were recalled. In 2009, locally stocked brands of condoms in Kenya failed an electronic test and leaked when filled with water (PlusNews, 2009). In Burundi, a contraceptive stock-out occurred in 2007 when a key donor failed to replenish stock of various family planning methods (Health Africa 2009).

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, 2000). These drugs are listed on essential drug lists (EDL). Having RH supplies on EDLs assures their legitimacy and increases their availability to those who most need them. The concept ensures the best medicines for the available resources. Due to economies of scale, concentration on a limited number of essential drugs lowers prices.

The EDLs of Tanzania and Kenya include only a single contraceptive method – oral contraceptives. Kenya's 2003 EDL does not include new types of supplies for FP that are critical for meeting the projected contraceptive commodity needs in Kenya (DSW Kenya, 2010). Uganda's EDL, which was issued in 2001, includes oral contraceptives, implants and injectables. Ethiopia's EDL includes various contraceptives, including combined oral contraceptives and progestogen-only contraceptives, as well as male and female condoms, diaphragms, gels and foams (WHO Africa).

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, LMIS, forecasting, procurement and contraceptive policy[3]. Procurement includes the use of forecasts for short-term procurement.

The contraceptive supply chains of Rwanda and Tanzania have been rated highly, with 17.1 and 17.6 out of 20 possible points respectively. In contrast, Ethiopia's supply chain is rated at 8.6 points. The supply chains in Kenya and Uganda are rated at 14 and 15 points. The high ratings for Rwanda and Tanzania result from good ratings across the criteria. In Kenya, storage, distribution and procurement are rated poorly, while LMIS and forecasting are rated highly. Uganda's ratings are akin to those of Kenya's, but storage and distribution are rated as poor.

Ethiopia's low rating results from low ratings across the criteria, except in forecasting. The rating for contraceptive policy is particularly low, resulting from the limited possibilities to import contraceptives and the low rating of contraceptive procurement. The differences in these ratings show that weaknesses are found in different aspects of the supply chains of RH supplies in different countries.

3 The facilitation of open markets, which offers the possibility to import contraceptives.

4 Advocacy entry points

This mapping of RH supplies in East Africa was created for a RH Supplies Workshop to provide insights into the situation regarding RH supplies in the 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 achieving CS and preventing stock-outs, as it strengthens them in public policies. Projections of the need for RH supplies are also needed to improve the availability of supplies, especially for least educated or rural populations who have poorest access. 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 such committees do not exist, advocating for their creation is a possible entry point. If a CS committee already exists, as in Uganda, Kenya and Rwanda, they can advocate for certain aspects of CS, for example the availability of a certain method which is not yet available, or its inclusion in the EDL of the country. Furthermore, a CS strategy that helps to ensure an adequate contraceptive supply should be developed and implemented if it does not exist.

As donors phase out their funding in most cases, countries have to rely on other sources or generate funds internally. But as stated above, generating their own funds is not always sufficient. This funding has to be allocated to contraceptives. Governments should create budget lines to secure funding for RH supplies, and ensure that this funding is actually spent on RH supplies. 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 might be convinced to spend these funds on RH supplies rather than relying on the federal financing. If public funding has been implemented, it is essential to ensure that governments keep funding, and do not reallocate money to other budget lines. One possibility is to advocate for stakeholders to work together to ensure continuous funding.

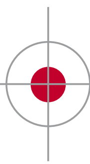
Governments should participate in a debt conversion mechanism, if they fulfil the requirements. This could mobilize additional funding, as creditors forgo a portion of their debt claims if the government spends a portion of this on development issues. This additional funding might be allocated to RH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

Including RH supplies on EDLs is very helpful for ensuring a sufficient supply. If there is no list, advocating for the creation of one is a possible entry point. If such a list exists, it should include a wide array of different methods. It is not important that it includes a huge amount of different products of the same kind; limiting the number of essential supplies 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. For example, the EDLs of Tanzania and Kenya include only oral contraceptives. Making stakeholders aware of this drawback is another advocacy entry point. The WHO model list of essential medicines can be used as a role model for developing EDLs, as it includes contraceptives.

One 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 with 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 issue, and to provide figures and numbers which demonstrate the urgency of the issue to stakeholders.

List of abbreviations

AIDS Acquired Immunodeficiency Syndrome
CPR Contraceptive Prevalence Rate
CS Contraceptive Security
DFID UK Department for International Development
DKT DKT Ethiopia
DSW German Foundation for World Population
ECSA East, Central and Southern African Health Community
EDL Essential Drug List
FGAE Family Guidance Association of Ethiopia
FP Family Planning
HIPC Heavily Indebted Poor Countries
HIV Human Immunodeficiency Virus
ICA International Contracetptive Access Foundation
ICPD International Conference on Population and Development
KEMSA Kenya Medical Supplies Agency
KFW Kreditanstalt für Wiederaufbau
LGA Local Government Authority
LMIS Logistics Management Information System
MDG Millennium Development Goal
MOH Ministry of Health
MSI Marie Stopes International
NCCCS National Contraceptive Commodity Security Strategy
NCPD National Council for Population and Development
NGO Non-governmental Organization
PAI Population Action International
RCHS Reproductive and Child Health Section
RH Reproductive Health
RHI Reproductive Health Interchange
RMA Resource Mobilization and Awareness
SWAp Sector Wide Approach
UMATI Uzazi no Malezi Bora Tanzania
UN United Nations
UNFPA United Nations Population Fund
USAID United States Agency for International Development



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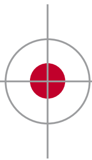
The German Foundation for World Population (DSW) is an international development organisation, with offices in Germany, Belgium, Ethiopia, Kenya, Tanzania, and Uganda. DSW's main goal is to help people free themselves from poverty. For this purpose we support family planning and sexual and reproductive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