

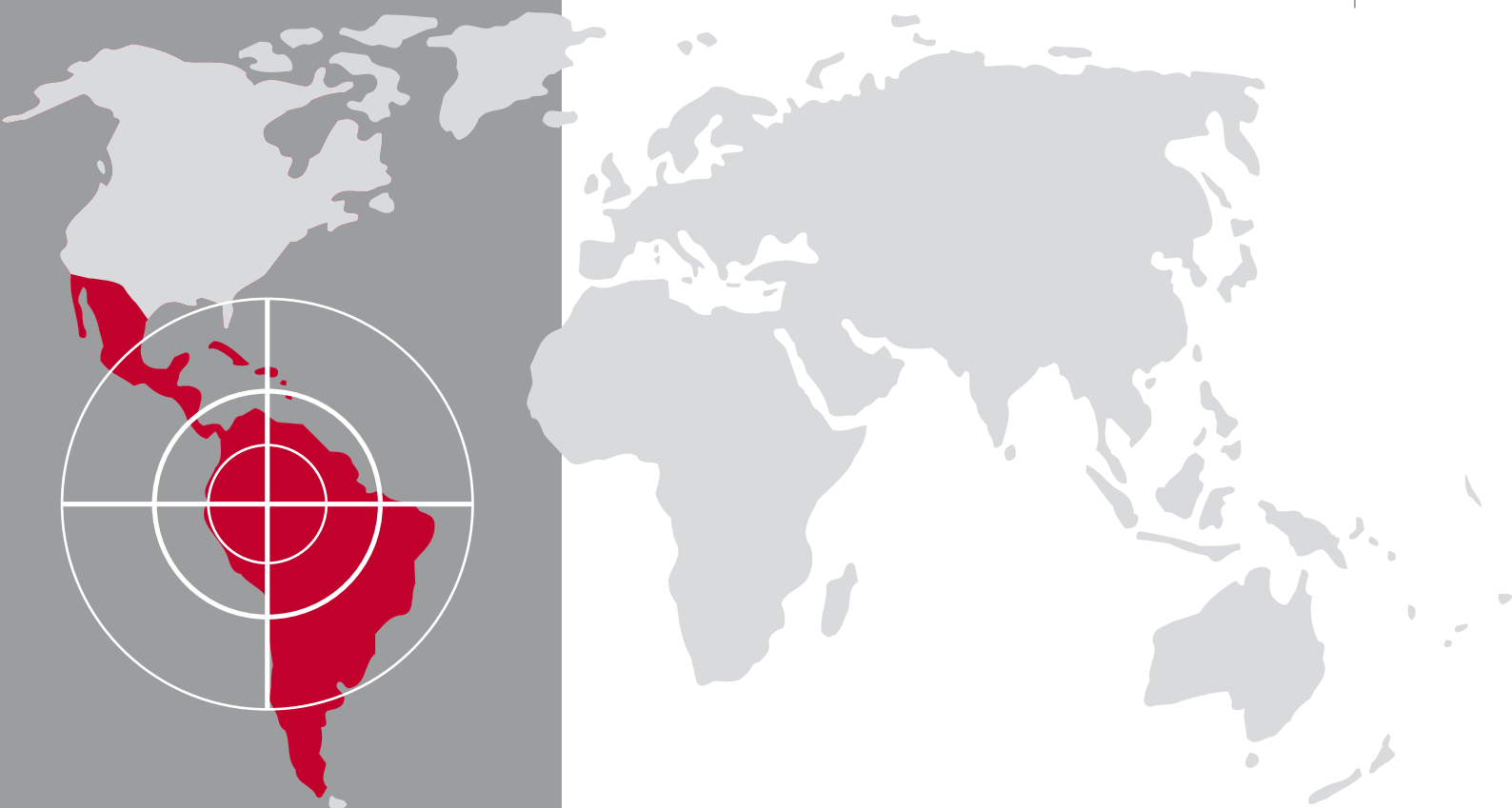


# MAPPING

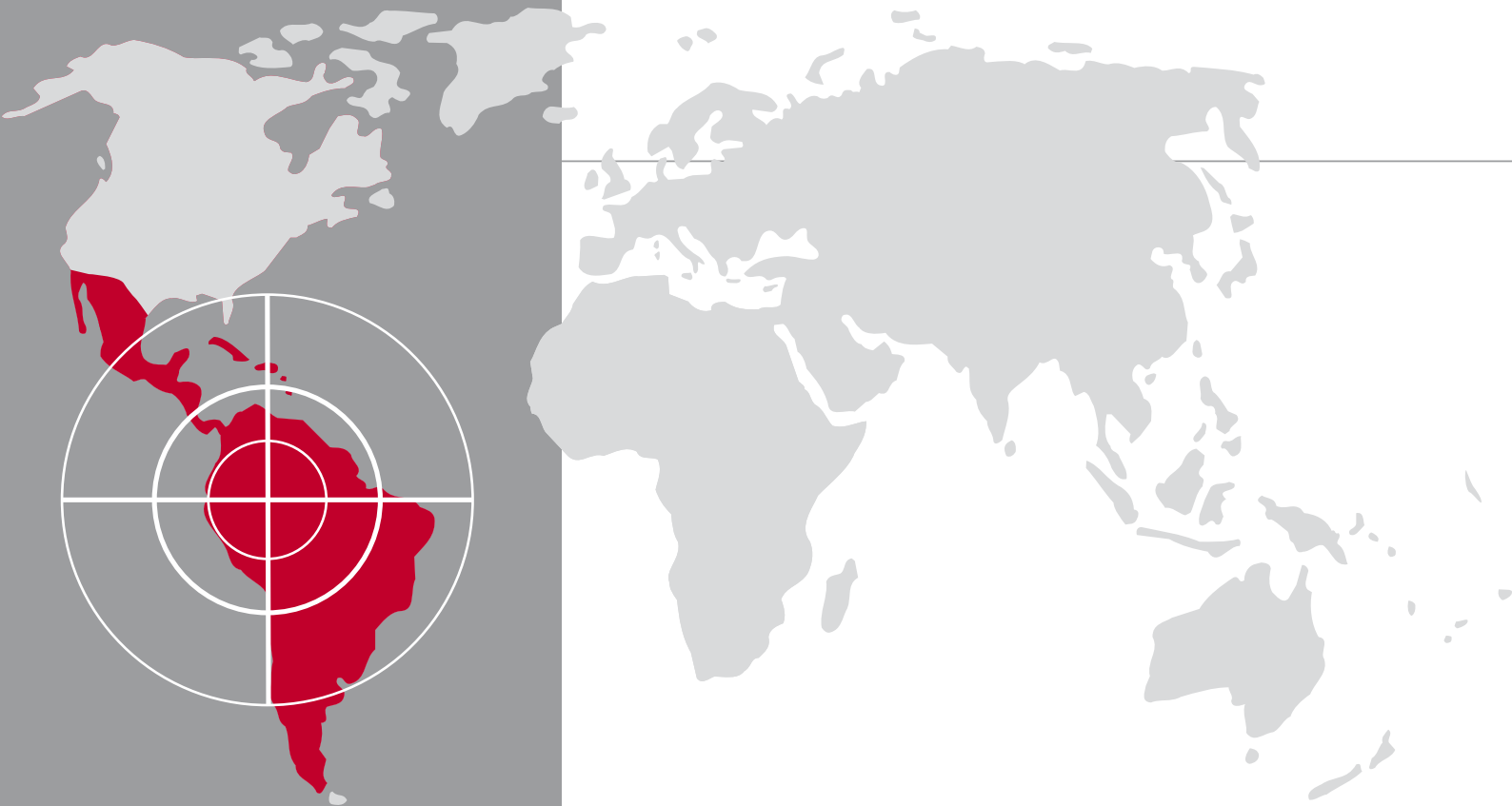
## Reproductive Health Supplies in Latin America and the Caribbean

# RHS

A mapping of procurement,  
funding, and policies



German Foundation for  
World Population (DSW)



## Acknowledgements

This mapping of reproductive health supplies in Latin America and the Caribbean (LAC) was created for the “RH Supplies Workshop” in Santiago, Chile. This workshop was coordinated 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 Latin American and Caribbean Women’s Health Network (LACWHN), our collaborating partners on project activities in the region, and the participants of the above mentioned workshop, for their invaluable assistance.



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# Content

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<b>1. Regional context and policy environment</b>	<b>2</b>
1.1 Contraceptive prevalence rate and unmet need for family planning	2
1.2 Reproductive health supplies policies	3
<b>2. Financing</b>	<b>5</b>
2.1 Donor phase-out and public funding	6
2.2 Share of funding sources	7
<b>3. Procurement of reproductive health supplies</b>	<b>8</b>
3.1 Essential drug lists	9
3.2 The contraceptive supply chain in the Contraceptive Security Index	9
<b>4. Advocacy entry points</b>	<b>10</b>
List of abbreviations	11
Bibliography	12
Imprint	13

## 1

## 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, Bolivia, Haiti and Nicaragua are the Latin American countries that need the most assistance to reach the ICPD goals. Brazil, the English- and Dutch-Speaking Caribbean, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Panama, Paraguay, Peru, Uruguay and Venezuela have made considerable progress towards achieving the ICPD goals. Argentina, Chile, Cuba and Mexico have all made significant progress (UNFPA, 2008). With regard to maternal health, Guatemala must be added to those that need the most assistance, as the lifetime risk for maternal health in Guatemala is as high as in Nicaragua.

### 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 may provide an overview of the situation regarding reproductive health (RH). One possible way to improve RH is to ensure the availability of RH supplies. In LAC, the CPR regarding all methods is 71 per cent; regarding modern methods, it is 64 per cent (PRB, 2009).

The lifetime risk of maternal mortality is high throughout Central America. The highest rates are found in the region between Guatemala and Nicaragua. Here, a higher rate of maternal mortality goes with a higher rate of unmet need for FP and a lower prevalence of contraceptives. Guatemala has the highest lifetime risk of maternal mortality, the highest unmet need for FP, and the lowest prevalence of modern methods. According to the Guttmacher Institute, one-third to one-half of young women who are sexually active have an unmet need for modern methods of contraception in El Salvador, Guatemala, Honduras and Nicaragua. In these countries, the

level of unmet need is higher among single women than married women, and is especially high among adolescent women (Guttmacher, 2008). The CPR is 68 per cent in Central America and 63 per cent for modern methods, and higher CPRs correspond with a lower share of traditional methods. Across Central America, CPRs increased between 1995 and 2008, with the most notable increases in Nicaragua (25 per cent) and Honduras (21 per cent) (IPPF WHR, 2009).

In South America, Bolivia, Colombia, Ecuador, Paraguay, and Peru are geographically connected and all have a high maternal mortality rate. But these countries, with the exception of Bolivia, have a low unmet need for FP. CPR is high at 68 per cent in Colombia, while it is only 35 per cent in Bolivia. The prevalence of traditional contraception methods is not decreasing with higher CPRs, however; this is similar to Central America. For example, Peru has a high CPR of all methods of 71 per cent, but only 48 per cent use modern methods. CPRs increased in South America from 1995 to 2008; the biggest increase was in Paraguay (26 per cent) and the lowest was in Brazil (13 per cent).

In the Caribbean, Haiti has the highest rates of maternal mortality and unmet need for FP; the CPR of modern methods in Haiti is also the lowest in the Caribbean. Maternal mortality rates are also high in the Dominican Republic and Jamaica, while unmet need for FP is lower and CPR is relatively high in these countries. Besides Haiti, the CPR of modern methods is low in Trinidad and Tobago, where the lifetime risk of maternal mortality is also low. CPRs increased in the Caribbean overall, but fell in Trinidad and Tobago (-11 per cent) and fell at rates between 5 per cent in Cuba and 16 per cent in Haiti. Haiti still has the lowest CPR in the Caribbean.

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 South and Central America**

	Unmet need for FP in %	CPR modern methods in %
<b>Central America</b>	–	<b>63</b>
Belize	–	49
Costa Rica	–	72
El Salvador	8,9	66
Guatemala	28	34
Honduras	16	56
Mexico	19	67
Nicaragua	15	70
Panama	–	–
<b>South America</b>	<b>5</b>	<b>65</b>
Bolivia	23	35
Brazil	0	70
Chile	–	58
Colombia	6	68
Ecuador	5	59
Paraguay	6,6	71
Peru	8	48
Uruguay	–	75
Venezuela	–	62
<b>Caribbean</b>	<b>23</b>	<b>55</b>
Bahamas	–	60
Cuba	8	72
Dominican Rep.	11	60
Haiti	37	25
Jamaica	14,2	66
Trinidad and Tobago	32,5	38

Source: Unmet need: Population Reference Bureau (Mexico, El Salvador: PAI 2008); CPR: Population Reference Bureau (for the Bahamas: PAI 2008).

Married women who are poor, less educated or living in rural areas have poorer access to FP methods than married women who are not poor, educated or living in urban areas. In LAC countries, the perception that the risk of getting pregnant is low is the most common reason for not using contraception, even if an unmet need exists by definition, while opposition to FP is low (with the exception of Haiti) (Sedgh et al, 2007). A 2009 study states that in 13 LAC countries, the fertility rates of women aged between 15 and 19 increased. The biggest increase occurred in Brazil, followed by Colombia and the Dominican Republic, which are the countries with the lowest Total Fertility Rate (TFR) (Cavenaghi and Diniz, 2009).

## 1.2 Reproductive health supplies policies

A favourable policy environment is important to realize a secure supply of RH supplies. The rise of generally “leftist” leaders and parties across Latin America, which began in Venezuela with Hugo Chavez’ election in 1998, raised hopes for a favourable environment for reproductive rights. But the political spectrum of these governments is large and a left government does not necessarily mean greater support for reproductive rights and supplies. Restrictive abortion laws still exist in the region and, combined with the unavailability of RH supplies, result in a high number of unsafe illegal abortions. The policy environment regarding RH supplies in the LAC region has improved, especially for the most vulnerable populations, but conservative opposition is still working against favourable laws, and political crises also pose a threat.

According to USAID, the policy environment for RH supplies in the LAC region has improved, particularly for poor and underserved populations (USAID, 2008). In Mexico for example, there is a set of government programmes relevant to RH supplies. The National Health Programme includes FP, promotes the use of condoms among young people, and specifies the goal of a CPR of 75 per cent, to be achieved through information, education and communication. The Family Planning and Contraception Programme is designed to ensure access to information and reproductive health services, to reduce the gaps which affect the most vulnerable groups (PAI, 2009).

In El Salvador, a leftist government was elected in March 2009 – the first time since the civil war and after several extreme right governments. As the new governing party is traditionally supporting women’s sexual and reproductive rights, it can be expected to create a more favourable environment for working on reproductive rights and supplies. In Paraguay, the Contraceptive Security Strategy and Implementation Plan (2006–2010) includes monitoring and evaluating progress made towards achieving Contraceptive Security (CS) in Paraguay (USAID, 2006 II). A CS committee is advocating for securing financial resources for contraceptives and strengthening logistics management capacities. CS committees also exist in Bolivia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua and Peru.

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.

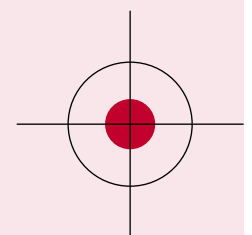
The political situation has also been unstable in other countries in the region during the last decade. This resulted in about ten political crises that created uncertainty regarding policies on RH supplies. In Honduras, for example, the CS committee includes the MOH, women's groups, the Honduran Institute 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.

## Conservative opposition

Besides political crises, there is another threat to CS policies: conservative opposition. Conservative powers such as the Catholic Church often use their political power to prevent laws that are favourable for CS. In Nicaragua, the municipal elections in November 2008, which were followed by political tensions, led the government to act against abortion and family planning to keep the Catholic Church on its side.

In Peru, the conservative ruling elites, the Catholic Church and the resistance to authoritarian policies are important issues for reproductive rights. The reproductive rights debate has been intense in recent years. As the political parties have no established position regarding reproductive rights, it is easy for conservative groups to influence public opinion. Many political parties lack any real grassroots support and prefer not to work against the Catholic Church (Caceres et al, 2008). HRW criticizes the Peruvian authorities for failing to adequately inform women of their rights to reproductive health care information and services.

In Uruguay, a bill entitled "Project for the Law to Defend Sexual and Reproductive Health", which addresses the legalization of abortion and the promotion and protection of sexual and reproductive health, has been approved by legislature. But Tamaré Vázquez, the first leftist president, vetoed the decision, overriding both chambers of Parliament (LACWHN). In Chile, the conservative Constitutional Court decided that the national regulations on fertility are against the constitution. The suit was brought before the court by "pro-life" parliamentarians (LACWHN II). In contrast, the Brazilian government gives out 65 million free condoms during the carnival season (The Huffington Post, 2009).

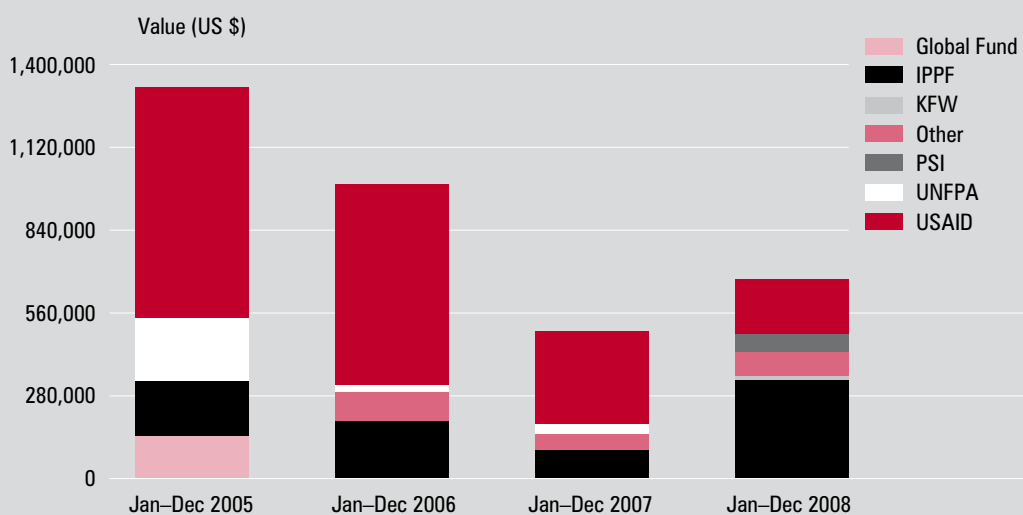


## 2

## Financing

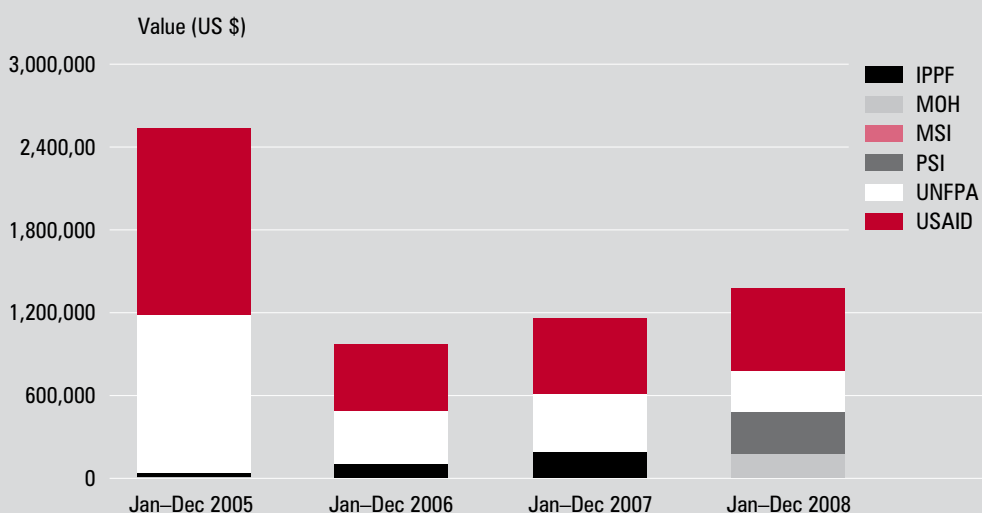
LAC countries have relied on donors from international agencies to meet the contraceptive needs of their populations for decades, and most countries still rely on donor funding. But some countries, including Ecuador and Peru, no longer receive donations from big donors like USAID. Most countries now provide public funding for RH supplies. But funding is not ensured in every case; only Ecuador gives family planning a protected status that guarantees funding. Budget line items often remain under spent, while in other cases, the government funds 100 per cent of its public sector contraceptive procurement needs.

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



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

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



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

## 2.1 Donor phase-out and public funding

In El Salvador and Guatemala, the value of total donated contraceptives rose between 2005 and 2008. However, it declined in Honduras and Nicaragua because of USAID's phase-out. USAID's phase-out and the share of the single donors, as far as they submit data to the Reproductive Health Interchange (RHI), is illustrated for Honduras and Nicaragua (Figures 1 and 2). If donors phase out their funding, alternative donors or governments themselves have to finance RH supplies.

Governments' health expenditures in the regions are diverse. In all countries in Central America, the share of expenditure on health as a percentage of total government expenditures is higher than 10 per cent, with the lowest in Belize (10.9 per cent) and the highest in Costa Rica (21.5 per cent) in 2006. The shares are lower in South America, with half of countries' share below 10 per cent. The highest shares are found in Peru (13.8 per cent), Chile (14.1 per cent), and Argentina (14.2 per cent), while in Trinidad and Tobago (6.9 per cent), Brazil (7.2 per cent), and Ecuador (7.3 per cent) shares are only of half of these numbers (WHO, 2010).

In 11 out of the 14 Latin American countries analyzed by USAID, public sector funding is used to finance contraceptive needs. These are Brazil, Chile, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Paraguay and Peru. Table 2 provides an overview of which countries use public funding. In 2006 and 2007, the CS committee in Nicaragua successfully advocated for government allocations of US\$ 110,000 to purchase contraceptives through UNFPA (USAID, 2008).

The existence of public sector funding does not mean that it meets the need. According to USAID, this is only possible if the government provides strong political support for CS and secures funding for contraceptive procurement through a budget line item (USAID, 2006 V). Even if 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 II). For example, in 2006, El Salvador's MOH funded only 53 per cent of its annual contraceptive needs. In Nicaragua, a budget line item has been specified in a proposal submitted by the MOH, but it is too early to claim a specific line item for contraceptives in the national budget (PAI, 2009 III).

**Table 2: Public sector funding for contraceptives**

Central America	
Costa Rica	Yes (at least since 1993)
El Salvador	Yes (since 2003)
Guatemala	Yes (since 2007)
Honduras	Yes, through IDB loan
Mexico	Yes (at least since 1996)
Nicaragua	No
South America	
Bolivia	No
Brazil	Yes (at least since 2000)
Chile	Yes (at least since 1995)
Colombia	Yes (at least since 1995)
Ecuador	Yes (protected)
Paraguay	Yes (since 2002)
Peru	Yes (at least since 1999)
Caribbean	
Dominican Rep.	Yes

Source: USAID 2006.

In Bolivia, the municipalities are responsible for securing adequate funding for purchasing supplies, as the state transferred authority regarding all aspects of family planning to local governments at the district level (USAID, 2006). This is similar to Mexico, where since 2001 there has been no specific budget line item for supplies. Instead, they are subsumed into the general RH budget of social security organizations or the health budgets of states. This leads to fragmented and uncertain decisions on quantities and mechanisms for purchasing RH supplies. The Directorate of Family Planning (DFP) of the Secretariat of Health coordinates with the states to assure adequate funding, but this is only partially successful (PAI, 2009 II).

Only Ecuador gives FP a protected status that guarantees the availability of funding every year, even if there is no specific budget line item for contraceptives. The Solidarity Fund guarantees minimum funding of US\$15 million annually for maternal and child health services, including contraceptives (USAID, 2006; USAID, 2006 V).

## 2.2 Share of funding sources

According to RHI, the donors with the biggest share of funding in LAC are UNFPA, USAID, IPPF and the Global Fund. In Nicaragua, the biggest share of contraceptive donations was provided by USAID and UNFPA, with a smaller portion from IPPF. The government's own portion (public funding) decreased and is only 1 per cent (USAID Deliver, 2008), while the share of donor funding increased. But several factors led to reduced aid by a set of donors in Nicaragua, including: planned phase-outs; donors' negative responses to the plan to stop vertical funding and donate to the health sector or general budget instead, and; political disputes following the November 2008 elections. RHI also states that USAID's donations to Honduras decreased drastically, while IPPF's share and the absolute value of donations increased. According to USAID, the government funds 100 per cent of its public sector contraceptive procurement needs. Guatemala has progressively increased funding for public sector needs from 2 per cent in 2002 to 40 per cent in 2005, and is committed to funding 100 per cent by 2009 (USAID Deliver, 2008).

Peru started to use public funds in 1999 because of USAID's phase out. Since 2005, the government has financed 100 per cent of the contraceptives distributed by public health systems (USAID, 2006). This is also the case in Ecuador. Cuba, the Dominican Republic, Haiti, and Trinidad and Tobago still rely on donor funding. In the Dominican Republic, USAID phased out in 2007 and the MOH began funding in 2005. According to USAID, the Dominican Republic now covers 100 per cent of its contraceptive needs. In Jamaica, the MOH and UNFPA are the funding sources with the biggest share. USAID's share has been low here since 2004, while in Trinidad and Tobago the value of USAID's donations is rising, with the highest donation in 2009.

In Cuba, UNFPA and the Global Fund are the main donors. UNFPA's absolute value and portion increased in 2008, nearly doubling the value of total donations in Cuba. In Haiti, USAID was the donor with the biggest share of donations in the past, but it is now UNFPA. USAID still donates but its share and absolute value has decreased in recent years. Haiti will probably continue to rely on donor funding in the coming decade, due to the devastating earthquake in January 2010.

An alternative funding mechanism is debt conversions. One programme using this mechanism is the Debt2Health programme. Debt conversion means that creditor countries forgo a portion of their claims if the beneficiary country invests part of this in local programmes approved by the Global Fund. The first agreements of this kind have been created between Germany (as creditor) and Indonesia and Pakistan (as recipient countries). If the countries' multilateral creditors decide to participate in Debt2Health, Bolivia, Haiti, Honduras, Guyana and Nicaragua could benefit (The Global Fund, w/o year).

## 3

## Procurement of reproductive health supplies

The procurement of RH supplies can be centralized, whereby one agency, for example the national MOH, is responsible for negotiating a bulk price for contraceptives, which are then distributed countrywide. Alternatively, countries may operate decentralized procurement, in which the state and local entities procure supplies independently from each other. In most LAC countries, varying models of decentralization of the health sector are already completed, are in progress, or are being planned (USAID, 2006 IV).

During this process, it is often not specified in which ways RH supplies are to be financed, procured or managed (RHSC, 2009). Centralized procurement, which may result in lower prices for contraceptives because of economies of scale, is used in the geographically connected group of Costa Rica, El Salvador, Guatemala and Nicaragua. In Mexico, procurement is partly pooled. In South America, most countries do not use centralized procurement, for example Bolivia, Brazil, Ecuador and Colombia.

In the Dominican Republic, El Salvador, Guatemala, Nicaragua, Paraguay and Peru, the MOH already use UNFPA as a procurement agent, while Honduras is switching to UNFPA. Mexico procures via UNFPA and local agents simultaneously. Local and international procurement agents are used by the MOH in Chile, Colombia and Costa Rica, while Brazil and Ecuador only use local procurement agents. Bolivia's MOH does not use any procurement agent because of its decentralized system.

In Bolivia, the local governments at the district level are now responsible for FP programmes, after authority was transferred in the health care reform framework. Local governments have to secure funding, manage forecasts and procure contraceptives. All FP methods currently distributed in Bolivia, in the public and NGO sectors, come from international donors, as municipalities have not included a budget for supplies. Because of the municipalities' autonomy to procure RH supplies locally and separately, in some cases from nearby pharmacies, bulk price negotiations do not take place and they do not take advantage of economies of scale (USAID, 2006 III).

In El Salvador, procurement decisions are made at the local level, while the MOH has the capacity to ensure cost-effective procurement (USAID, 2006 III). By doing so, the MOH has access to high quality supplies and takes advantage of economies of scale. The single systems forecast their needs, and the central MOH implements a mechanism that summarizes the single needs of the systems and negotiates bulk prices. Financial resources for the systems are pooled and payment takes place as one action. The MOH

**Table 3: Procurement in LAC**

	<b>MOH procurement agent</b>	<b>Centralized pooled procurement</b>
<b>Bolivia</b>	None	No
<b>Brazil</b>	Local	No
<b>Chile</b>	Local and International	Yes
<b>Colombia</b>	Local and International	No
<b>Costa Rica</b>	Local and International	Yes
<b>Dominican Rep.</b>	UNFPA	Yes
<b>Ecuador</b>	Local	No
<b>El Salvador</b>	UNFPA	Yes
<b>Guatemala</b>	UNFPA	Yes
<b>Honduras</b>	UNDP, switching to UNFPA	Yes
<b>Mexico</b>	UNFPA and Local	Optional
<b>Nicaragua</b>	UNFPA planned	Yes
<b>Paraguay</b>	UNFPA planned	Yes
<b>Peru</b>	UNFPA	Yes

Source: USAID 2006.

health system is currently divided into five regions, which consist of 27 basic integrated health care systems (SIBASIs). These receive and manage their own budget. While essential medicines and supplies are procured locally, contraceptives have been procured through the UNFPA since 2004. This led to savings of US\$3 million in 2004 and 2005. Condoms are procured locally, because they are not much more expensive to buy from local suppliers (USAID, 2006 V).

Mexico combines a mix of these options. In 2002, 16 of 32 states procured contraceptives from UNFPA, but difficulties in meeting UNFPA's requirements – such as paying in advance – led to four states withdrawing. The national Mexican Social Security Institute (IMSS)

decided not to participate in procurement from UNFPA and instead purchases from national providers. The states procure independently and purchase from domestic and foreign manufacturers, national and regional distributors and pharmacy stores. However, this reduces quantities and leads to stock shortages (stock outs). The DPF and UNFPA still seem to be trying to create a system for the acquisition in which all federal Secretariats of Health (SSA) can participate (PAI, 2009 II).

The case of the Dominican Republic shows that bulk procurement may result in huge price decreases. The MOH's agreement with UNFPA in 2003 led to prices that were only 1/16 of the price of local suppliers. But because of a health reform process, it is unclear which procurement mechanisms will be available in the future (USAID, 2006).

### 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 are listed on essential drug lists (EDLs). Having RH supplies on EDLs assures their legitimacy and increases their availability for those who most need them. The concept allows countries to get the best medicines for the available resources. The concentration on a limited number of essential drugs lowers prices, due to economies of scale. Bolivia, Brazil Colombia, the Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay and Peru all have an EDL that includes contraceptives. In Ecuador and Costa Rica, only some contraceptives are included (USAID, 2006). Even if RH supplies are included in EDLs, the monitoring of an EDL might be necessary to ensure that RH supplies are not removed.

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

The USAID Deliver Contraceptive Security Index rates contraceptive supply chains by their storage and distribution, Logistics Management Information Systems (LMIS), forecasting, procurement and contraceptive policy (the facilitation of open markets which offers the possibility to import contraceptives). The contraceptive supply chains of El Salvador, Guatemala, Mexico and Nicaragua have been rated relatively highly. This results from a very good LMIS and forecasting in Guatemala, highly rated forecasting and procurement in Nicaragua, while Mexico has good rating in every aspect. In contrast, Honduras' supply chain is poorly rated (7,3 of 20 points). This results from poor ratings in all aspects except for the contraceptive policy, which is high because contraceptive imports are facilitated.

The supply chains in the South American countries are rated worse than those in Central America. The best ratings are for Bolivia and Peru, which result from good procurement practices in Bolivia and good storage and distribution in Peru. The ratings for Colombia and Paraguay are relatively poor, resulting from low rated storage and distribution, LMIS and procurement in Paraguay and very poorly rated LMIS in Colombia.

In the Caribbean, Haiti's contraceptive supply chain is rated highly, especially for procurement but its overall contraceptive security rating is the lowest of all rated LAC countries. The Dominican Republic's supply chain has a low rating, resulting from poor LMIS, forecasting and procurement.

The combination of centralized procurement and local determination of needs by local actors, as is done in El Salvador, combines the advantages of the different options for procuring RH supplies. In this approach, it is possible to determine needs more exactly, as institutions can act countrywide and bulk negotiations lead to better prices due to economics of scale. Most LAC countries include RH supplies on their EDLs, but they must ensure that these supplies are kept on these lists, and that a wide array of options are included if this is not yet the case. The differences in the ratings of each country's supply chains by USAID's Contraceptive Security Index show that weaknesses are found in different aspects of the supply chains in individual countries.

## 4

## Advocacy entry points

This mapping of RH supplies in the LAC region was created for a RH Supplies Workshop to provide insights into the situation regarding reproductive health supplies in the region. During the workshop, the advocacy toolkit and guide 'Leading Voices in Securing Reproductive Health Supplies' (RHSC 2009) 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 each country's own needs, and a set of tools, including policy briefs, PowerPoint presentations and advocacy planning guides.

To include reproductive rights in the constitution is an important step towards gaining CS and preventing stock-outs, as it strengthens these rights in public policies. To ensure the availability of RH supplies, especially for the least-educated or rural populations who often have the poorest access to them, projections of the need for RH supplies are required. These projections can be gathered by CS or coordination committees, which already exist in several countries in the region. The MOH should lead 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 their creation. 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 in the EDL of the country. Furthermore, a CS strategy that helps to ensure an adequate supply should be developed and implemented if it does not exist.

As many donors phase out their health funding, countries have to rely on other sources or generate funds internally. But even if they generate their own funds, this is not always sufficient. Internally generated funds have to be allocated to contraceptives as well. Governments should create budget lines to secure funding for RH supplies. If public funding has been implemented, the government has to give FP a protected status to ensure that the funds are not reallocated to other budget lines. This is currently only happening in Honduras. The budget line item can be used to monitor the government's commitment to contraceptives and helps to track funding. In the case that local authorities receive their own funding parallel to federal funding, they have to spend these funds on RH supplies rather than relying on federal financing. Funding has to be secured, especially in

an environment of decentralization that is found in a number of countries in the region.

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

Including RH supplies on EDLs is very helpful for achieving a sufficient supply. If there is no EDL, 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. Some LAC countries have an EDL which includes RH supplies, but some (such as Costa Rica) include only a small number of methods. The WHO model list of essential medicines can be used as a role model for developing EDLs, as it includes a wide array of contraceptives.

One way to make the government aware of issues that concern you is to reach supportive members of the government, or supporters who might be able to influence or who have contact to government members. These might be parliamentarians, friends or members of their family. In some countries in the LAC region, conservative powers like the Catholic Church use their political powers to influence the public opinion. For this reason, it is important to make the public and stakeholders aware of your issues and to provide figures and numbers that demonstrate the urgency of the issues.



## List of abbreviations

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<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CS</b>	Contraceptive Security
<b>DPF</b>	Directorate of Family Planning
<b>DSW</b>	German Foundation for World Population
<b>EDL</b>	Essential Drug List
<b>FP</b>	Family Planning
<b>HIV</b>	Human Immunodeficiency Virus
<b>HRW</b>	Human Rights Watch
<b>ICPD</b>	International Conference on Population and Development
<b>IMSS</b>	Mexican Social Security Institute
<b>IPPF</b>	International Planned Parenthood Federation
<b>LAC</b>	Latin America and the Caribbean
<b>LACWHN</b>	Latin American and Caribbean Women's Health Network
<b>LMIS</b>	Logistics Management Information System
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Non-governmental Organization
<b>PAI</b>	Population Action International
<b>PRB</b>	Population Reference Bureau
<b>RH</b>	Reproductive Health
<b>RHI</b>	Reproductive Health Interchange
<b>SIBASI</b>	Sistema Básico de Salud Integral
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>SSA</b>	Secretariat of Health
<b>TFR</b>	Total Fertility Rate
<b>UNAIDS</b>	The Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization



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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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