The Global Programme to Enhance Reproductive Health Commodity Security

Annual Report 2013

Where we work

Arab States
Djibouti
Sudan
Yemen

Asia and the Pacific
Lao People's Democratic Republic
Myanmar
Nepal
Papua New Guinea
Timor-Leste

Latin America and the Caribbean
Bolivia
Haiti
Honduras

East and Southern Africa
Burundi
Democratic Republic of the Congo
Eritrea
Ethiopia
Kenya
Lesotho
Madagascar
Malawi
Mozambique
Rwanda
South Sudan
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

West and Central Africa
Benin
Burkina Faso
Cameroon
Central African Republic
Chad
Congo, Republic of
Côte d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Liberia
Mali
Mauritania
Niger
Nigeria
Sao Tome and Principe
Senegal
Sierra Leone
Togo

About this report: UNFPA has two Thematic Trust Funds designed to help programme countries address their development priorities: the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), and the Maternal Health Thematic Fund (MHTF). They provide donors with an opportunity and the flexibility to demonstrate their commitment to particular UNFPA thematic priorities.

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Cover photo: Bajenu Gokh (godmothers) and young mothers form a committee after training in Senegal.
Photo: UNFPA/Diouga Diery

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A young woman in Zambia distributes female condoms as part of a CONDOMIZE! event in 2013.

Credit: The Condomize Campaign/UNFPA

Message from the Executive Director, UNFPA

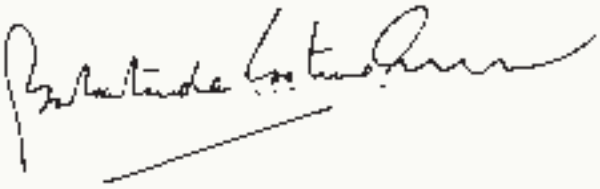
RHCS—Fundamental for the reproductive health agenda

The global agenda for sexual and reproductive health and reproductive rights provides far-reaching support to the Millennium Development Goals, the Programme of Action of the International Conference on Population and Development, and the emerging post-2015 development agenda. Reproductive health commodity security (RHCS) is an integral part of sexual and reproductive health and reproductive rights. UNFPA promotes RHCS as an effective strategy for supporting developing countries to keep promises made to poor and marginalized women and adolescent girls.

Rights-based voluntary family planning is one critical part of our mission. Preventing maternal death is also essential, and a steady and reliable supply of maternal health medicines saves lives during pregnancy and childbirth. When our work in family planning and maternal health converges, the positive impact is multiplied. Between one third and one half of maternal deaths can be prevented by family planning alone—and nearly all with the addition of skilled attendance at birth and emergency obstetric care.

The lives of millions of women and young people can be saved if key reproductive health commodities are more widely accessed and properly used. Quality of life can be improved for millions of women and adolescent girls if given the choice of when to have children and the chance to have an education.

I am pleased to present the 2013 annual report of our Global Programme to Enhance Reproductive Health Commodity Security. This thematic fund is an effective and efficient mechanism for commodity procurement and capacity development to ensure access and use of essential supplies for reproductive health in high-burden countries where support is needed most. Sustainability in RHCS supports sustainability in sexual and reproductive health and reproductive rights, and this is a cornerstone of sustainable human development.



Dr. Babatunde Osotimehin
Executive Director, UNFPA

Message from the Commodity Security Branch

Scaling up the programme

Significant progress has been made in enhancing the procurement of reproductive health supplies—as well as the capacity of national health systems to manage these supplies and to provide the related services for family planning, maternal health and HIV prevention. Countries utilizing sustained, multi-year support from UNFPA have achieved remarkable results. Dangerous stock-outs have been reduced. More health centres have more availability and choice of contraceptive and life-saving maternal health medicines. Family planning is increasingly being prioritized at the highest levels of national policies, plans and programmes. More developing country governments are allocating domestic resources for contraceptives.

Keeping the shelves stocked means no woman walks away empty-handed from her local family planning clinic or risks dying in childbirth for lack of medicine to stop haemorrhage or prevent sepsis. However, stocking these shelves is a complex task where national health systems are weak and reproductive health services do not reach the women and girls who need them most. UNFPA is leading the global effort to achieve reproductive health commodity security. We provide targeted support to governments and partners striving to achieve a level of 'security' when all individuals can obtain and use affordable, quality reproductive health commodities of their choice whenever they need them.

We launched the GPRHCS in 2007 to provide support for predictable, planned and sustainable country-driven action for securing essential supplies and ensuring their use. Though our commodity work had been significant for decades, a dramatically more systematic approach promised to reduce stock-outs and make a larger impact on health systems and services. In 2013, GPRHCS entered a new programming period with a major scaling up. Now all 46 countries are considered ready to make strategic use of the sustained, multi-year support given the 12 countries of the former Stream One category. The programme achieved an implementation rate of 95 per cent in 2013 on total expenditures of $164 million, with 66 per cent to commodities and 34 to capacity development. We delivered contraceptives and condoms worth a year of protection to 35 million couples.

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

Jagdish Upadhyay, Chief, Commodity Security Branch, Technical Division, UNFPA

Dr. Kechi Ogbuagu, Technical Adviser/Coordinator GPRHCS, UNFPA

Executive summary

The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) is a unique and effective mechanism for delivering results in developing countries. This UNFPA thematic fund has a focused mission to ensure a secure, steady and reliable supply of quality reproductive health commodities and improve access and use by strengthening national health systems and services. GPRHCS supports national action to reach poor and marginalized women and girls in countries with high unmet need for family planning and high rates of maternal death. GPRHCS is the only United Nations programme that specifically addresses reproductive health commodity security (RHCS). Our approach is strategic, catalytic and country-driven and draws on UNFPA's established expertise, strong partnerships and on-the-ground presence. GPRHCS procures contraceptives, condoms, medicine and equipment for family planning, HIV/STI prevention and maternal health services.

A year of transition and scaling up

The most important news of 2013 is the scaling up from a focus on 12 Stream One countries to an ambitious intensification of priority support to 46 countries – a major step supported by our donors. The total number of 46 countries in the programme remains the same and includes many of our former Stream Two countries. From 2007 to 2012, Stream One provided multi-year funding to develop sustainable supplies and systems for RHCS, Stream Two supported targeted initiatives to strengthen RHCS, and Stream Three supported emergency provision of commodities in case of stock-out or humanitarian crisis. Mongolia and Nicaragua have taken significant steps to improve access to RH commodities for their people with GPRHCS support in the past and, though no longer in the programme, possess resources for continued progress. The scale-up builds on measureable results achieved in our first five years of operation.

In 2013, we embarked on a new programming period 2013-2020, with a greater emphasis on partnership, young people and hard-to-reach populations and introducing a more robust Programme Monitoring Framework. Changes in governance and monitoring are also strengthening the programme. The 2013-2020 programme benefits from a new dimension in the management structure with the establishment of a Steering Commitment comprising donors and partners. The enhanced Programme Monitoring Framework tracks nearly 100 indicators to measure country progress towards RHCS. Several higher-level indicators use national-level data and reflect the overall progress and challenges by all who work for reproductive health. Many others are programme-specific. Data for measuring progress towards goals, outputs and outcomes are collected through annual country surveys of service delivery points (SDP) and annual country reporting questionnaires. Data presented in this annual report use results from 2013 country surveys completed by 20 countries[1] and questionnaires completed by 43 countries.[2]

This year of transition was facilitated by a no-cost extension of support. From 2014 to 2018 the funding need for GPRHCS will increase from $255 million to $311 million.

The results of this programme are due to the work and support of donor and developing country governments, UN agencies, non-governmental organizations (NGOs), civil society, the private sector and individuals willing to go the extra mile to reach the poorest and most vulnerable women and girls.

1 This number includes 9 of the 12 countries formerly categorized as Stream One. Mongolia and Nicaragua have graduated. Madagascar did not provide a Country Survey of service delivery points for 2013 though a report for 2014 is scheduled. Countries required to conduct the country survey for the first time numbered 36.

2 Those countries not submitting a questionnaire were Burundi, Djibouti and Yemen. A report for 2014 is scheduled. The questionnaires cover all UNFPA Thematic Trust Funds.

Key results: strategic interventions for impact

1. Progress in expanding family planning services is being achieved.

- Use of modern methods of family planning has continued its positive upward trend. The contraceptive prevalence rate has increased by 17.7 percentage points over three years in Rwanda, 14.5 percentage points over three years in Ethiopia, 8.9 percentage points over five years in Sierra Leone, 8.8 percentage points over six years in Liberia, and 8.1 percentage points over five years in Uganda;
- Demand for modern family planning is high in many GPRHCS countries, measured in unmet need for family planning and the contraceptive prevalence rate. Less than 50 per cent of demand is satisfied in 12 GPRHCS countries, indicating an urgent need to strengthen reproductive health supplies and systems.

2. Availability and choice are increasing where support is substantial and sustained.

- Three modern methods of contraception are available at more than 70 per cent of rural service delivery points (SDPs) in Burkina Faso, Côte d'Ivoire, Ethiopia, Gambia, Lao PDR, Nepal, Niger, Nigeria and Sierra Leone. Most countries reporting this progress were former Stream One countries, suggesting that substantial and sustained support has increased access where it is needed most, in hard-to-reach rural areas;
- At least five modern methods of contraception were available at 100 per cent of tertiary-level SDPs in Burkina Faso, Côte d'Ivoire, Ethiopia, Djibouti, Haiti, Nepal, Niger and Sierra Leone.

3. Steady essential maternal health supplies are saving mother's lives.

- Availability of seven life-saving medicines increased from 2012 to 2013 in Burkina Faso, Ethiopia, Haiti, Niger, Nigeria and Sierra Leone. GPRHCS procures essential supplies that save lives in before, during and after pregnancy—notably contraceptives, magnesium sulfate, misoprostol and oxytocin.

4. Family planning is saving and improving lives.

Contraceptives procured by GPRHCS amounted to 35 million couple years of protection in 2013, which have the potential of averting an estimated:

- 9.5 million unintended pregnancies
- 6.4 million unintended births
- 27,300 maternal deaths
- 1.1 million unsafe abortions

5. Better coordination is strengthening health systems.

- 70 per cent of GPRHCS countries have functional coordinating mechanisms for RHCS in place and being implemented under government leadership and with the involvement of relevant stakeholders. This is strengthening national leadership and ownership and ensuring a more coordinated approach to activities in-country.

6. Countries are taking a rights-based approach.

- 85 per cent of GPRHCS countries have national guidelines and protocols that include a rights-based approach to RHCS and family planning. In the past we measured existence of protocols that support quality service provision, the new indicator looks at whether they are based on the principles of human rights. This ensures action targets those most in need.

7. Countries demonstrate political will and commitment.

- 54 per cent of GPRHCS countries have budget lines for RH commodities, and allocations increased in Burkina Faso, Guinea, Lao PDR, Malawi, Mozambique, Nigeria and Uganda. This is a strong sign of commitment to RHCS. More countries are not only using their own resources for contraceptives but are also increasing the amounts allocated within their budget lines;
- 61 per cent have essential medicines lists that include both contraceptives and life-saving maternal health medicines, positioning countries for making essential supplies a priority and part of regular procurement to meet their people's needs.

8. Contraception for young people is on the agenda.

- 72 per cent of GPRHCS countries take young people's access to contraceptive services into consideration in health policies. This awareness of youth is good news because young people are the most underserved population.

- 89 per cent carried out resourced action plans for demand generation to reach young people, proof that policy is being taken to action.

9. Support in humanitarian settings is increasing.

- 22 senior technical humanitarian advisers were deployed in Level 2 and 3 humanitarian settings, through partnership, in countries including the Central African Republic, Chad, Niger and Nigeria to improve logistics and coordination and reduce gender-based violence;
- 1,146 personnel participated in training courses in 24 GPRHCS countries to implement the Minimum Initial Service Package (MISP) in humanitarian settings.

10. Training is building capacity for stronger health systems.

- 67 per cent of GPRHCS countries conducted training for family planning service provision, some 90 per cent on long-acting reversible methods. Training remains a critical intervention for strengthening systems and building national capacity;
- 23 national institutions and five regional institutions received capacity development support to integrate RHCS and family planning into training curricula. It is important that training be sustainable, and this is where institutions are supported to provide ongoing training in procurement and in the provision of quality health services.

11. Forecasting to avert stock-outs is a priority practice.

- 91 per cent of GPRHCS countries used nationals in government institutions to coordinate demand forecasting and 78 per cent to coordinate procurement processes. Quality, timely and regular RH commodity forecasting plays a very important role in averting stock-outs. Forecasting ensures countries have adequate supplies and prevents dangerous shortfalls. We have invested in making sure the skills for forecasting are in-country;
- 70 per cent made no ad hoc request for contraceptives, meaning essential items were on hand when needed, in contrast to years prior to the GPRHCS when sudden shortages endangered health and drove urgent procurement to fill gaps;
- 80 per cent used CHANNEL or another information tool for monitoring supplies. The use of computerized supply management can dramatically improve the availability of supplies;
- No stock-outs (shortages) of contraceptives were experienced in at least 50 per cent or more SDPs in the last six months of 2013 in Burkina Faso, Lao PDR, Nepal, Niger, Nigeria, Republic of Congo (Brazzaville) and Sierra Leone.

12. The programme is achieving more effective and efficient procurement.

- AccessRH reduced lead time for obstetric fistula kits by 87 per cent and for male condoms by 75 per cent compared with non-AccessRH sources;
- A 50 per cent price reduction in contraceptive implants followed a 'volume guarantee' agreement with manufactures. This was a collaborative effort of many partners, including UNFPA, to improve procurement efficiency.

13. Countries are expanding services for new users of family planning.

- 80 per cent of GPRHCS countries implemented demand generation activities to build understanding with information about family planning. Demand generation activities greatly contribute to national efforts to bring additional users to services, in support of FP2020 goals. Messages feature information about contraceptive methods, health impacts, benefits, rights and where to obtain reproductive health services;
- 89 per cent implemented resourced action plans to reach the hard-to-reach;
- 83 per cent provided information and carried out advocacy with radio, television, community leaders, condom promotion and IEC/BCC and engaged community health workers to disseminate family planning messages as part of demand generation;
- 56 per cent carried out integration of sexual and reproductive health and family planning services, helping to expand services in a more effective and efficient manner;
- Six cases studies on national markets for male condoms marked the introduction of the Total Market Approach, which seeks equity of access to RH commodities at an appropriate price. PSI produced the case studies with UNFPA on Botswana, Lesotho, Mali, South Africa, Swaziland and Uganda.

Financial summary

Total expenses and payments for the year were $164 million. This is a 27 per cent increase in disbursements compared with 2012 and amounts to an implementation rate of 95 per cent—the highest in the GPRHCS history. In line with past trends, 72 per cent of the total expenses went to Africa, with 39 per cent of funding going to East and Southern Africa and 33 per cent to West and Central Africa.

Total contributions mobilized were $64.5 million, including $44.8 million received for use in 2014. With the addition of $64.5 million in 2013, GPRHCS has mobilized $630 million between its launch in mid-2007 and the conclusion of its sixth year of operation in 2013.

Support for commodity procurement of $108.2 million accounted for 66 per cent of GPRHCS expenses. Support for capacity development of $55.8 million accounted for 34 per cent. This balance remained the same as in 2012.

Partnerships

Partnerships make possible the progress towards supply security reflected in GPRHCS results. Strengthening partnerships is an even higher priority in the new programming period, leveraging the convening role played by UNFPA and our leadership in reproductive health commodity security. In 2013, partnership activities engaged the UN Commission on Life-Saving Commodities, FP2020, Reproductive Health Supplies Coalition, USAID, the Bill & Melinda Gates Foundation, IPPF, JSI, MSI, PATH, PSI and Coordinated Assistance for Reproductive health supplies (CARhs), among others.

UNFPA served as a co-Chair of FP2020 Reference Group and intensively engaged in four working groups of FP2020 at global and country levels. UNFPA also participated in the Reproductive, Maternal, Newborn and Child Health (RMNCH) Steering Committee and Trust Fund with UNICEF and the World Health Organization (WHO). At the global level, GPRHCS continued to support UNFPA's lead role in convening partnerships and mobilizing countries to accelerate fulfilment of commitments on family planning. Highlights of the year include organizing a Ministerial Forum to review the progress on family planning with Women Deliver, supporting a high-level ministerial meeting on youth and family planning at the 2013 International Conference on Family Planning, and organizing a high-level forum on improving maternal health with the UN Special Envoy for Financing the Health MDGs. Also, UNFPA and the World Bank launched a project in the Sahel that relies on RH commodities and focuses on maternal and reproductive health and the rights and needs of adolescent girls.

Throughout the year, GPRHCS worked closely with many valued partners. Continuing to work through the GPRHCS, UNFPA looks forward to working with partners such as the Bill & Melinda Gates Foundation, CARhs, IPPF, MSI, JSI, PATH, PSI, USAID and the World Bank, among many others, in particular with in-country NGOs to ensure reproductive health commodity security in support of our shared goal of universal access to reproductive health.

A note on results

All of the results and achievements described in this report were accomplished with technical and financial support channeled by UNFPA through its flagship programme, the Global Programme to Enhance Reproductive Health Commodity Security. The GPRHCS works to fill the gaps that exist in commodities and capacity, seeking to target support catalytic and strategic ways to strengthen delivery of essential supplies and services for reproductive health. The specific activities are prioritized by the 46 programme countries themselves, according to their needs.

EXPENSES

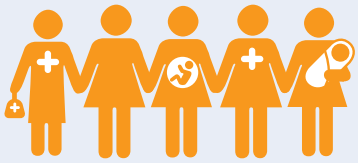
Total expenses 2013

$164 million total expenses in 2013

95% annual implementation rate
highest in the GPRHCS history

25% **Increase in disbursement over 2012**

GPRHCS at a glance



Contraceptives procured by GPRHCS amounted to
35 MILLION
couple years of protection provided.

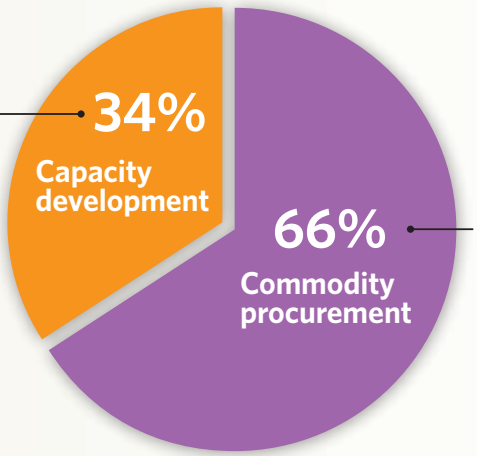
THIS CAN AVERT:

- **9.5 MILLION** unintended pregnancies
- **6.4 MILLION** unintended births
- **27,300** maternal deaths
- **1.1 MILLION** unsafe abortions

Since our launch in 2007, UNFPA's GPRHCS has mobilized
$630 MILLION
in financial contributions and procured contraceptives worth 121 million couple years of protection.

INVESTMENT

Support for capacity development of $55.8 million accounted for 34 per cent of GPRHCS expenses.



Support for commodity procurement of $108.2 million accounted for 66 per cent of GPRHCS expenses.

A staff member assists clients at CSI 17 Portes, an integrated health centre (Centre de Santé Intégrés) in Maradi, Niger.

Credit: UNFPA Niger

Introduction

"Help us create conditions where your daughters, your sisters and your wives have full equality. … Help us create families where mothers and fathers decide together how many children they want to have. The time to do this is now."

—UN Secretary-General Ban Ki-moon, November 2013,
Sahel Women's Empowerment and Demographics Project

UNFPA procures essential supplies for countries and works in partnership to help them strengthen health systems and services to empower couples to plan and space births, make motherhood safer and protect the reproductive rights of young people. These critical areas of intervention underpin sexual and reproductive health and reproductive rights and are carried out by UNFPA in 46 countries through our flagship programme—the Global Programme to Enhance Reproductive Health Commodity Security.

What GPRHCS does

GPRHCS contributes directly to achievement of MDG 5 A and B, improving maternal health and providing access to reproductive health, and indirectly aids achievement of MDG 3 (gender equality), MDG 4 (child survival) and MDG 6 (combat HIV). The GPRHCS goal is to achieve universal access to reproductive health commodities and family planning services and information. This goal is supported by action to achieve five strategic results (outputs). This framework tracks progress against close to 100 indicators.

Principles

GPRHCS was a key corporate priority for UNFPA in 2013 and is a critical component of the UNFPA Strategic Plan 2014-2017. *Choices Not Chance*, the UNFPA Family Planning Strategy, drives our corporate commitment to

How we work: strategic action for impact

OUTPUTS	ACTIONS
Improved enabling environment	Mobilize political and financial commitment, and integrate RHCS in national policies and allocations
Increased demand for RH commodities	Expand services through advocacy, demand generation and the Total Market Approach
Improved efficiency for procurement	Procure and deliver essential supplies to keep quality high, prices low and optimize delivery times
Improved access to quality RH/FP services	Scale up good practices for access, equity and method choice
Strengthened capacity and systems	Develop capacity of national health systems for supply chain management and service delivery

OUTCOME

Increased availability and utilization of reproductive health commodities in support of reproductive and sexual health services including family planning, especially for poor and marginalized women and girls.

devoting 40 per cent of programming resources to family planning; 20 GPRHCS countries are among the UNFPA humanitarian priority countries.

GPRHCS is anchored in human rights and stands on the key principles of the International Conference on Population and Development's Programme of Action (Cairo 1994), the Millennium Development Goals, the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. It contributes to delivery of the UN Secretary-General's Global Strategy on Women's and Children's Health, the UN Commission on Life-Saving Commodities for Women and Children, and the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). The programme positions UNFPA strongly in the post-2015 development agenda because it seeks to consolidate achievements under the current MDGs and ensure continued effort to address their unfinished business.

Building on experience

The decision to continue and expand GPRHCS recognized the programme's unique, pivotal and strategic role as an effective United Nations mechanism for delivering results to developing countries. In our first five years of operation, countries receiving significant levels of multi-year support achieved some impressive results:

- Higher rates of contraceptive prevalence mean that more individuals are using modern methods of contraception, supporting their right to plan their families;
- More service delivery points are keeping their shelves stocked, reporting fewer shortages, shortfalls or 'stock-outs' of reproductive health supplies;
- More health centres have more availability and choice of contraceptives and life-saving maternal health medicines;
- Family planning is increasingly being prioritized at the highest levels of national policies, plans and programmes; and
- More governments are allocating domestic resources for contraceptives.

From 2008 to 2012, the Global Programme supported 12 Stream One countries and 34 Stream Two countries, and provided additional ad-hoc support to Stream Three countries.[3]

For 2013-2020, lessons learned and on-the-ground experience informed the development of scaled-up programme that is more robust in many ways.

The new programme is...

- Increasing the number of focus countries from 12 to 46;
- Increasing funding and technical support to the countries;
- Remaining a catalytic source of funding that is flexible in addressing gaps;
- Developing deeper and smarter indicators to monitor performance;
- Collaborating more closely with donors in a new governance structure;
- Seeking stronger partnership globally and within countries to do better, in particular through innovative approaches, reaching the hard to reach, intensifying support for young people's access and women's empowerment;
- Devoting more effort to the Total Market Approach, inclusiveness and coordination of services across the board with many partners;
- Developing and approving more ambitious but also more focused work plans;
- Intensifying efforts to invest in partnerships, whether FP2020 or bi-laterally;
- Advocating stronger coordination mechanisms; and
- Strengthening national ownership and leadership.

Structure of the report

This technical report is organized according to the Programme Monitoring Framework. We present highlights of results selected from our extensive indicators, knowing that next year more progress can be tracked one year to the next. Further information is available in the Annex and will be posted online at www.unfpa.org/. A short version of this report is also in production for use in advocacy and resource mobilization.

- The **Goal section** places the GPRHCS contribution in the context of to the global effort to achieve universal access to reproductive health.
- The **Outcome section** looks at the availability and use of RH commodities for services that support this goal,

3 Support to countries 2007-2012 was organized into three categories. Stream One provided multi-year funding to a relatively small number of countries. These predictable and flexible funds were used to help countries develop more sustainable, human rights-based approaches to RHCS, thereby ensuring the reliable supply of reproductive health commodities and the concerted enhancement of national capacities and systems. Stream Two funding supported initiatives to strengthen several targeted elements of RHCS, based on the country context. Stream Three provided emergency funding for commodities in countries facing stock-outs for reasons such as poor planning, weak infrastructure and low in-country capacity. Stream Three also provided support for countries facing humanitarian situations. All Stream Three funding was used for commodities.

including data from GPRHCS surveys at service delivery points.

- **Five Output sections** showcase 2013 results in five areas: enabling environment, demand generation, procurement efficiency, service delivery and supply chain management. The Management Output is then reported.
- The **Partnerships and advocacy section** covers highlights of the year, acknowledging that many others are valued partners in important initiatives.
- The **Finance and resources section** provides data on expense and income.

About the data

As a core element of our planned expanded GPRHCS delivery, we developed a refined, robust and more extensive Programme Monitoring Framework for 2013-2020. The 2013 report is **a baseline year** under the framework, with tracking of interval progress then commencing with the 2014 report. Nonetheless, analysis of results over time is provided where possible.

An additional new dimension to reporting is the expansion of the annual country survey of service delivery points. Previously conducted only by the 12 Stream One countries conducted these surveys. Under the new programme, each of the 46 countries will conduct an annual survey. Because this is the new system's first year of implementation and as many countries required capacity development to conduct these, the process of completing the surveys is not yet complete. Therefore, a limitation of this years' report is that survey results are only discussed for those countries where the surveys have concluded and results are available. This means data are available from 20 countries. Arrangements are in place for surveys to be concluded in all of the 46 countries and detailed reporting for all 46 countries will be presented in the GPRHCS 2014 report.

Three levels of reporting: goal, outcome and output

1. **GOAL** – The goal level is also known as the 'impact' level. The indicators are maternal mortality ratio (MMR), adolescent birth rate (ABR) and the youth HIV prevalence rate. Data are sourced from national DHS reports, the UN Population Division and other sources.

2. **OUTCOME** – Data come from several sources. The indicators include contraceptive prevalence rate (CPR) and unmet need for family planning, using data from national DHS reports, the United Nations Population Division and other databases and technical publications by the UN and international development partners. Also, financial data from the *UNFPA External Procurement Support Report* and other Commodity Security Branch sources provide numbers on funding available to procure contraceptives.

   The most programme-specific outcome-level data come from **annual country surveys of service delivery points (SDPs).** These facility-based surveys are country-wide and supported by UNFPA, through GPRHCS. Each country hires a consultant to conduct the survey under the leadership of the national government, with the support of country coordinating committees. Each year a sample of facilities are selected at various levels (primary, secondary and tertiary).[4] The indicators are analysed and results made available. In some countries a representative sample of SDPs may number 10,000 facilities. Every country is asked to conduct this survey every year. In 2013, surveys were completed and submitted by 20 countries; many more are in progress for the first time and will be concluded in time for the 2014 reporting.

3. **OUTPUT** – The outputs or 'results' measured by GPRHCS cover many indicators in five key output areas: 1) enabling environment, 2) demand, 3) efficiency, 4) access and 5) capacity and systems. A management output is also reported. Output data come from annual country reporting questionnaires. Self-reporting on what was achieved for the year is carried out by various UNFPA offices. The questionnaires are completed by UNFPA Country Offices, Regional Offices and Headquarters and by other units such as the UNFPA Procurement Services Branch and Humanitarian Services Branch. In 2013, questionnaires were received from 43 of 46 GPRHCS implementing countries with the exception of Burundi, Djibouti and Yemen. (The questions address the GPRHCS Programme Monitoring Framework, included at the end of this report. Refer to the Framework for indicators, baselines, milestones and targets.)

4 Primary-level SDPs include clinics, health posts and community-based distribution through health workers. Primary care refers to the work of health care professionals who act a first point of consultation for patients within the health care system. Secondary-level SDPs may include larger clinics and hospitals where medical specialists and other health professionals who generally do not have first contact with patients. Tertiary-level SDPs may include larger regional hospitals where specialized consultative care and more advanced treatment is provided, usually for inpatients and on referral from a primary or secondary health care provider.

GOAL

Contribute to universal access to reproductive health

The efforts of UNFPA as well as many and diverse stakeholders (especially within countries) are reflected in maternal mortality ratio, youth HIV prevalence rate, and adolescent birth rate. GPRHCS uses these indicators to measure progress towards universal access to reproductive health.

Maternal mortality ratio

Globally, an estimated 289,000 women died from complications in pregnancy and childbirth in 2013. While this is down from 523,000 maternal deaths in 1990,[5] progress has been uneven around the world, with sub-Saharan Africa still accounting for 62 per cent of these deaths. According to the most recent estimates, developing countries account for 99 per cent (286,000) of the global maternal deaths (289,000). As shown in Figure 1, the estimated total maternal deaths in the 46 GPRHCS implementing countries declined from 268,000 in 2005 to 176,000 in 2013. In 2013, the maternal deaths in the 46 countries accounted for 61 per cent of global maternal deaths.

Poor women, including adolescent girls who are married early, women from minorities and those living in rural areas are much more likely to die than others. The maternal mortality ratio (MMR) has declined in the 46 countries supported by GPRHCS, most dramatically reduced by half in Sierra Leone. The estimated MMR for 2013 for the GPRHCS implementing countries ranged between 120 maternal deaths per 100,000 live births for Honduras to 1,100 maternal deaths per 100,000 live births for Sierra Leone.

Fewer women and girls are dying of causes related to pregnancy and childbirth—and lives are being saved at a faster pace. The average rate of reduction in MMR is highest in GPRHCS countries free from humanitarian situations, as might be expected, where it increased from 2.5 per cent (1990-2000) to 3.5 per cent (2000-2003). The rate also increased in GPRHCS countries with humanitarian crisis, improving from 2.0 per cent (1990-2000) to 2.6 per cent (2000-2003). All countries are making progress towards MDG 5, improving maternal health. Most will still need targeted support to achieve the MDG target.[6]

HIV prevalence

We work closely with governments and other partners to address HIV prevalence among young people, especially in the area of comprehensive condom programming and other HIV prevention strategies. GPRHCS contributes to prevention of HIV infection. HIV prevalence among young women ages 15-24 is at least 50 per cent more than their male counterparts in some GPRHCS countries, e.g. Lesotho, Malawi, Mozambique, Zambia and Zimbabwe.

5 Please note that the although the methodology employed for the 2013 estimates is similar to that for other years, there has been an increase in the global database used for 2013. Also the number of countries increased from 181 to 183. Therefore the estimates should be used for the interpretation of trends rather than comparing between years.

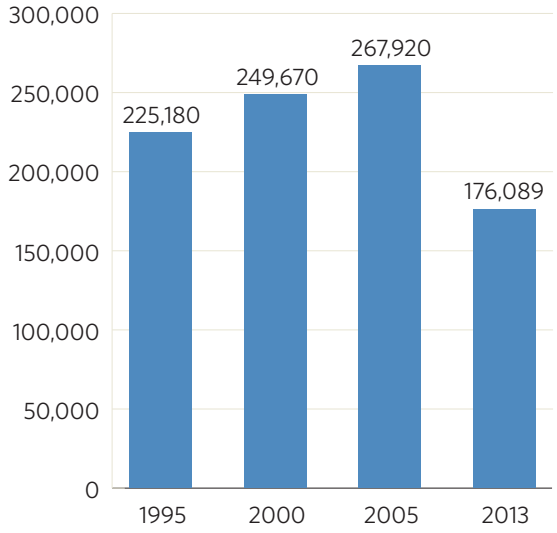
6 *Trends in Maternal Mortality: 1990 to 2013*, a country is considered to be 'on track' if the average annual rate of decline between 1990 and 2010 is 5.5 per cent or more. If the annual decline in MMR is between 2 per cent and 5.5 per cent, the country is consider to be 'making progress'.

Young men graduating from RH sensitization training.
Credit: UNFPA Senegal

Adolescent birth rate

Although progress has been made in reducing the birth rate among adolescents, more than 15 million out of 135 million live births worldwide were among women between the ages of 15 and 19. The situation is made worse by the fact that adolescent girls, in general, face greater barriers than do adult women in accessing reproductive health services. In the GPRHCS implementing countries, the adolescent birth rate (ABR) ranged from 17 per 1,000 women in Myanmar to 229 per 1,000 women in Central African Republic. The programme 2013-2020 places particular emphasis on providing access to RH commodities and services for adolescents and young people.

Figure 1: Total number of estimated maternal deaths in the 46 countries implementing the GPRHCS 1995–2013



Source: *Trends in Maternal Mortality: 1990 to 2013.* Estimates developed by WHO, UNICEF, UNFPA and the World Bank; See publications for 2001 (Annex Table F); 2004 (Annex Table G); 2007 (Annex 3); 2012 (Annex 1); and 2014 (Annex 1)

OUTCOME

Increased availability and use of reproductive health supplies

With more reproductive health supplies to offer, more people can be served, and more efforts can be made to inform communities about the benefits of family planning. To measure progress towards results under this outcome, GPRHCS considers the use of modern methods of contraception, demand satisfied for family planning, and access and availability at service delivery points.

Contraceptive prevalence rate: modern methods

Contraceptive prevalence rate (CPR) is a very important measure of the outcome of family planning interventions. CPR measures the proportion of women aged 15-49 who are using, or whose sexual partners are using, any modern method of contraception. The measure provides an indication of progress made in improving family planning and meeting the needs of women.

Figure 2 shows selected countries where modern CPR has increased between two successive Demographic and Health Surveys. For example, CPR has increased by 17.7 percentage points over three years in Rwanda, 14.5 percentage points over five years in Ethiopia, 8.9 percentage points over five years in Sierra Leone, 8.8 percentage points over six years in Liberia, and 8.1 percentage points over five years in Uganda. Overall, modern contraceptive prevalence rates in the GPRHCS implementing countries varies widely – with Honduras having the highest CPR at 63.8 per cent while Chad has the lowest CPR at 1.6 per cent. Seven countries have modern contraceptive prevalence rates of more than 40 per cent (Ethiopia, Honduras, Lesotho, Malawi, Nepal, Rwanda and Zimbabwe).

Demand satisfied

Total demand for family planning is a measure that combines both CPR and unmet need for family planning. Generally, contraceptive prevalence rate is taken as an indicator for the 'total demand for family planning that is satisfied' (met need) while the 'demand that is not satisfied' constitutes the unmet need. The data tell us that:

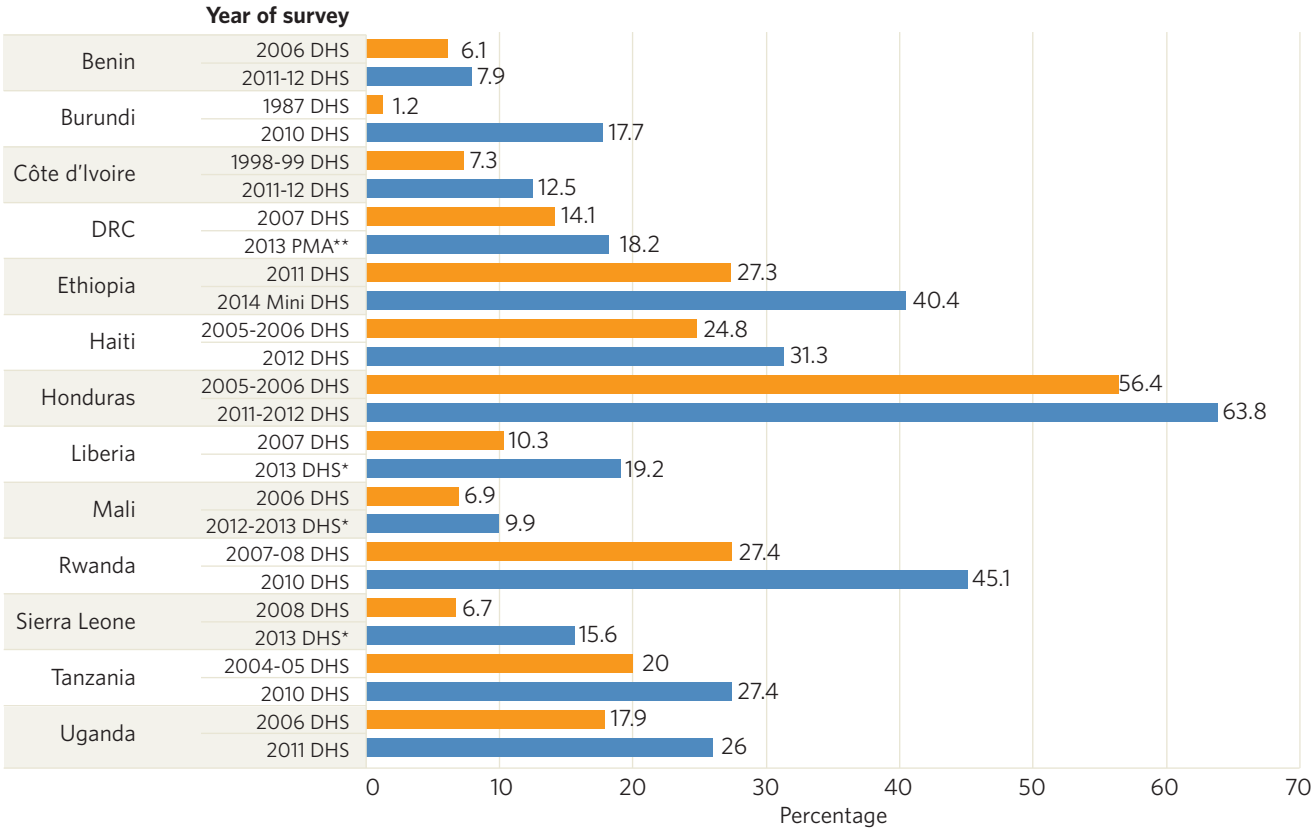
- Less than 50 per cent of demand is satisfied by modern methods of contraception in 11 GPRHCS countries.
- The percentage of demand satisfied is highest in Honduras (85.6 per cent) followed by Zimbabwe (79.7 per cent). It is lowest in Mauritania (13.7 per cent) and Guinea (16.3 per cent).

Access and availability: surveys at service delivery points

Through the GPRHCS, UNFPA works with many partners to including governments to ensure that RH commodities are available and used in support of the sexual and reproductive health of women and girls. To measure the result of this collective effort, GPRHCS looks closely at service delivery points (SDPs) to answer key questions: Do they offer a choice of modern contraceptives and maternal health medicines? Are shortages common, suggesting weak forecasting of needs? Are supplies at hand when needed, with a positive 'no-stock-out' rate?

UNFPA supports countries to conduct annual country surveys that focus on SDPs. The scale-up from 12 to 46 countries necessitated capacity building in countries tasked for the first time with this survey, many of which are ongoing. In this report, numbers of countries are given for service delivery point data from 18 annual country surveys for 2013.

Figure 2: Increase in modern CPR between two surveys in selected countries



* Preliminary DHS reports
** Performance monitoring and Accountability (PMA2020) 2013-14 surveys (see http://www.pma2020.org/)

Availability of contraceptives

Among the 20 countries that conducted country surveys, nine countries had at least three methods of modern contraception available in 75 per cent of SDPs nationally (Burkina Faso, Côte d'Ivoire, Ethiopia, Gambia, Guinea-Bissau, Nepal, Niger, Sierra Leone and Togo). Moving up from three to five methods, six countries had at least five methods available at more than 75 per cent of SDPs. As of 2016, the country surveys will set the measurement at five methods.

At the primary level, we tracked the availability of at least three modern contraceptive methods (increasing to five methods from 2016):

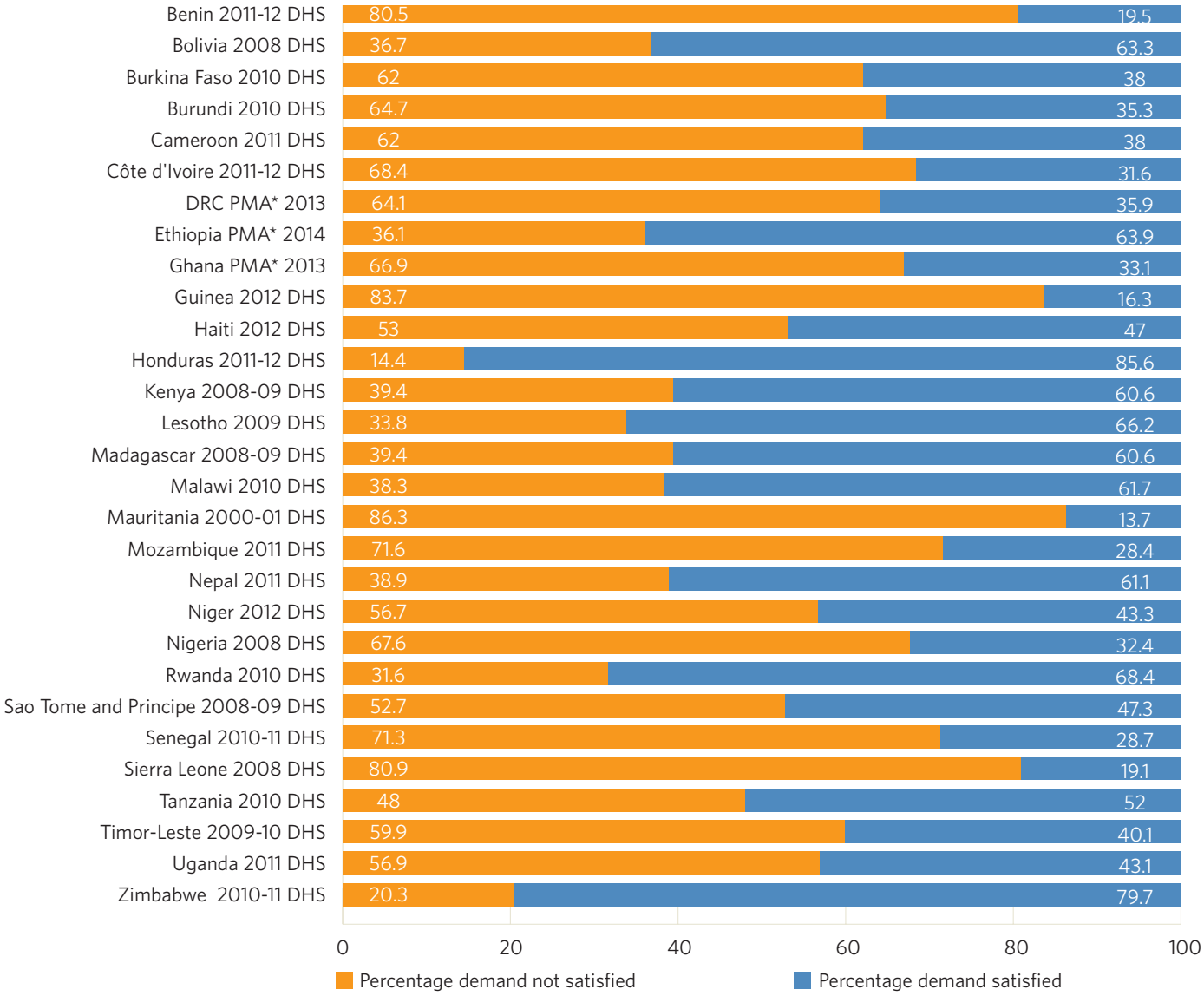
- More than 70 per cent of **rural** SDPs had three methods or more available in 12 countries (Burkina Faso, Côte d'Ivoire, Ethiopia, Gambia, Guinea-Bissau, Lao PDR, Mali, Mozambique, Nepal, Niger, Nigeria, Sierra Leone and Togo);
- Less than 50 per cent of rural SDPs had three methods available in Guinea, Liberia and Timor-Leste.

Breaking down the primary level into **rural and urban** service delivery points, we see that rural SDPs performed well.

- More than 70 per cent of rural SDPs had three methods or more available in 12 countries (Burkina Faso, Côte d'Ivoire, Ethiopia, Gambia, Guinea-Bissau, Lao PDR, Mali, Mozambique, Nepal, Niger, Nigeria, Sierra Leone and Togo);
- Less than 50 per cent of **rural** SDPs had three methods available in Guinea, Liberia and Timor-Leste.

Among the reasons why some primary level SDPs did not offer at least three modern methods of contraception, the most common reasons cited in the country surveys were low demand for some methods, lack of trained staff, delay in ordering, and late delivery. These reasons were cited in Haiti, Lao PDR, Nigeria and Sierra Leone. In Burkina Faso, emergency contraceptives were not available because they are not included in regular distribution networks. In the Gambia, limited method choice reflected limited demand generation for family planning in rural communities coupled with delays in transportation, such as a ferry crossing. In Honduras, oral and injectable contraceptives could

Figure 3: Percentage of demand for family planning satisfied by modern contraception in GPRHCS countries, recent surveys



ICF International, 2012. The DHS Program STATcompiler - http://www.statcompiler.com - 30 May 2014.

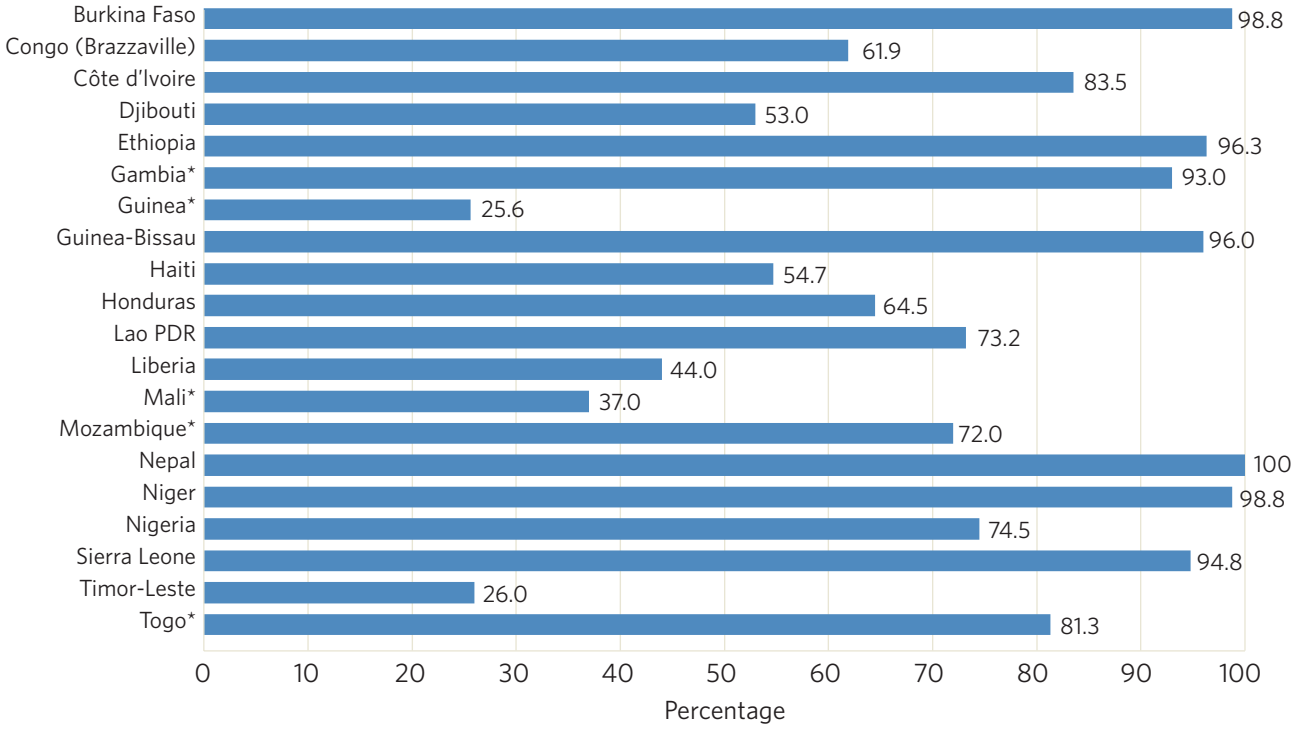
** Performance monitoring and Accountability (PMA2020) 2013-14 surveys (see http://www.pma2020.org/)

not be provided in some rural health centres because of the absence of a trained physician or dentist. Poor distribution mechanisms, as in Liberia, were behind the lack of availability in many facilities.

At the secondary- and tertiary-levels, commodity distribution networks are working efficiently at many service delivery points:

- More than 80 per cent of **secondary-level** SDPs in 10 countries offered at least five modern contraceptive methods in 2013 (Burkina Faso, Djibouti, Guinea, Honduras, Mali, Mozambique, Nepal, Niger, Togo and Timor-Leste). In Ethiopia, Nigeria and Sierra Leone, three methods were available in at least 80 per cent of secondary SDPs;
- 100 per cent of **tertiary-level** SDPs in 10 countries offered at least five modern contraceptive methods (Burkina Faso, Côte d'Ivoire, Djibouti, Guinea, Haiti, Mozambique, Nepal, Niger, Togo and Timor-Leste). Three methods were available in all tertiary SDPs in Ethiopia, Nigeria and Sierra Leone;
- Less method choice was available in four countries where 50 per cent or less of tertiary-level SDPs offered at least five methods (Gambia, Honduras, Mauritania and the Republic of Congo (Brazzaville).

Figure 4: Primary level service delivery points offering at least three modern methods of contraception, 2013



* Percentage of primary SDPs offering at least 5 methods

Source: GPRHCS 2013 country survey reports

Breaking down the secondary and tertiary SDPs in **urban areas**, eight countries had at least five methods available in at least 70 per cent of SDPs (Burkina Faso, Côte d'Ivoire, Honduras, Lao PDR, Mozambique, Nepal, Niger and Togo). Three methods were available in at least 70 per cent of urban SDPs in Nigeria and Sierra Leone. In **rural areas**, three countries had five methods available in at least 70 per cent of SDPs (Gambia, Togo and Niger).

Reasons why SDPs at secondary and tertiary levels did not offer at least five modern methods of contraception varied from country to country. Common reasons offered

Table 1: Secondary-and tertiary-level service delivery points offering at least five modern methods of contraception, 2013

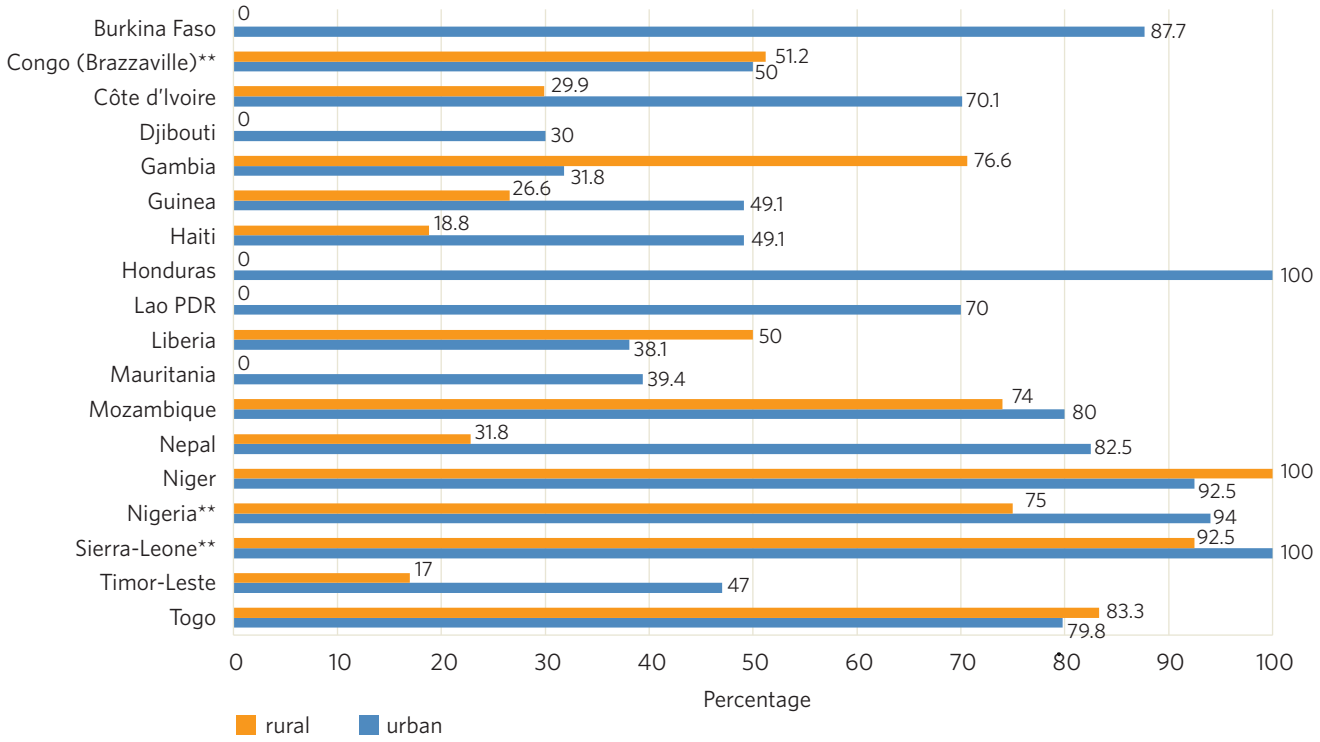
Country	Tertiary	Secondary
Burkina Faso	100	84.7
Congo (Brazzaville)**	16.7	29.2
Côte d'Ivoire	100	76.9
Ethiopia*	100	98.9
Djibouti	100	83.3
Gambia	11	51
Guinea	100	94
Haiti	100	69.7
Honduras	33.3	81.8
Lao PDR	68.2	15.8

Country	Tertiary	Secondary
Liberia	50	40.7
Mali	60	85
Mozambique	89	88
Mauritania	0	45.9
Nepal	100	100
Niger	100	92.1
Nigeria**	97.6	92.7
Sierra Leone**	100	100
Timor-Leste	100	80
Togo	100	100

** Three methods

Source: GPRHCS 2013 country survey reports

Figure 5: Secondary- and tertiary-level SDPs in rural and urban areas offering at least five modern methods of contraception, 2013



** Three methods for some countries

Source: GPRHCS 2013 country survey reports

included delays in resupply, transportation problems, lack of trained service providers and low demand. In some cases, a rapid increase in demand as result of awareness campaigns also had an impact. Specific methods such as female condoms and emergency contraception were in low demand in Burkina Faso, Congo (Brazzaville), Côte d'Ivoire, Haiti and Sierra Leone. In certain SDPs, methods such as implants and IUDs could not be offered due to the absence of qualified personnel. In two districts in Honduras, IUDs and implants were not provided because of the absence of trained staff; also, there was no female condom available on the market. Delays in the replenishment of products affected Côte d'Ivoire, Gambia and Haiti. In Nepal, delays in resupply from warehouses were the main reason for the lack of male condoms, oral contraception and injectables.

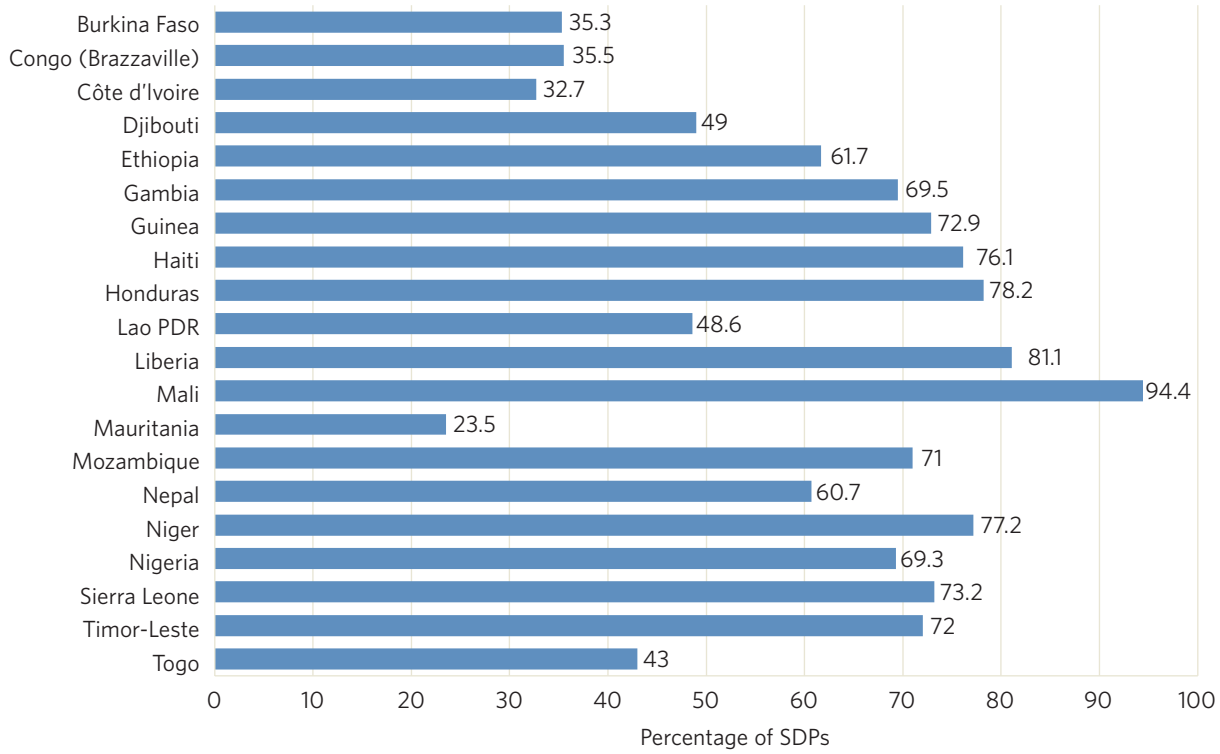
Availability of life-saving maternal health medicines

The top four causes of maternal death can be addressed with these proven interventions and a reliable supply of life-saving supplies: oxytocin and misoprostol to prevent and treat haemorrhage; magnesium sulfate to prevent and treat eclampsia; clean delivery kits and antibiotics to prevent and treat sepsis; and contraceptives to prevent unsafe abortions and misoprostol to treat their complications. GPRHCS surveys focused on ascertaining the availability of seven life-saving maternal/RH medicines at SDPs, including magnesium sulfate and oxytocin, subject to the provisions of national protocols and guidelines. As shown in Figure 6, country surveys at SDPs demonstrate the following results:

- More than 70 per cent of SDPs in nine countries had seven life-saving maternal health medicines available (Guinea 72.9 per cent, Haiti 76 per cent, Honduras 78 per cent, Liberia 81 per cent, Mali 94.4 per cent, Mozambique 71 per cent, Niger 77 per cent, Sierra Leone 73.2 per cent and Timor-Leste 72 per cent).
- Less than 40 per cent of SDPs in four countries had seven life-saving maternal health medicines available (Burkina Faso 35 per cent, Congo 36 per cent, Côte d'Ivoire 33 per cent and Mauritania 23.5 per cent).

Compared with last year, availability of seven life-saving medicines increased from 2012 to 2013 in Burkina Faso, Ethiopia, Haiti, Mali, Mozambique, Niger, Nigeria and

Figure 6: Service delivery points with seven life-saving maternal/RH medicines available, 2013



(Including magnesium sulfate and either misoprostol or oxytocin or both)

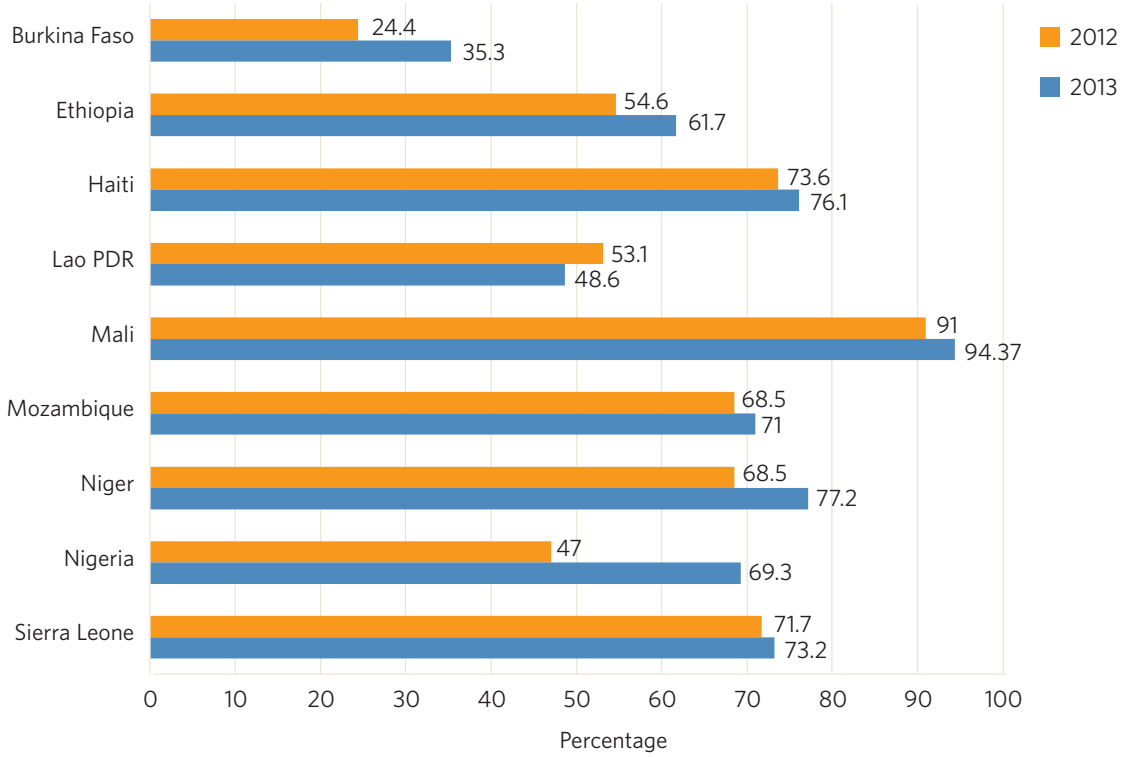
Table 2: Service delivery points where seven life-saving maternal/RH medicines are available, all levels, 2013*

Country	Tertiary	Secondary	Primary	National
Burkina Faso	100	92.9	22.8	35.3
Congo (Brazzaville)	50	70.8	20.6	35.5
Côte d'Ivoire	50	54.3	14.8	32.7
Ethiopia	73.3	69.2	26.7	61.7
Djibouti	100	86	38	49
Gambia	80	75	54.2	69.5
Guinea	100	94.7	69.2	72.9
Haiti	50	88.2	69.2	76.1
Honduras	100	100	69.4	78.2
Lao PDR	95.5	44.6	46.4	48.6
Liberia	100	96.7	74.7	81.1
Mali	100	97	92	94.4
Mauritania	50	35.8	9.5	23.5
Mozambique	89	95	63	71
Nepal	97.4	84.2	70.4	60.7
Niger	100	77.8	76	77.2
Nigeria	97.6	83.5	48.8	69.3
Sierra Leone	100	78.1	68.3	73.2
Timor-Leste	100	96	61	72
Togo	100	83.3	41.4	43

* From the WHO list, which must include magnesium sulfate and either misoprostol or oxytocin or both.

Source: GPRHCS 2013 Survey reports

Figure 7: Service delivery points over two years with seven life-saving maternal/RH medicines available, 2012 to 2013



(Including magnesium sulfate and either misoprostol or oxytocin or both)

Sierra Leone. It decreased in Lao PDR from 53.1 per cent in 2012 to 48.6 per cent in 2013.

Regarding availability by location (Table 2), 100 per cent of SDPs at the tertiary level had the medicines available in 10 countries (Burkina Faso, Djibouti, Guinea, Honduras, Liberia, Mali, Nepal, Niger, Sierra Leone, Timor-Leste and Togo).

The countries faced various challenges in providing a broad range of maternal health medicines. Specifically, in Burkina Faso, Cefixime was not part of the distribution system. In Sierra Leone, oxytocin and tetanus toxoid were not available at some SDPs because of the lack of cold chain. Challenges reaching rural areas in Nepal contributed to lack maternal health medicines in some rural SDPs. More general reasons for not offering certain medicines relate to weak supply systems causing delays in delivery and replenishment of stock, and the lack of trained staff to dispense certain medicines. Such reasons were cited in Côte d'Ivoire, Djibouti, Gambia, Haiti, Honduras, Lao PDR, Liberia, Niger, Nigeria, the Republic of Congo (Brazzaville) and Sierra Leone.

No stock-out of contraceptives

Shortages, shortfalls or 'stock-outs' can be disruptive and even deadly. Averting shortages of contraceptives is a central purpose of UNFPA's work to strengthen procurement and distribution systems. Countries are improving the functionality of their distribution and logistics systems; reviewing policy, building skills and infrastructure, and demonstrating commitment to supply security. Having 'no stock-outs' is a signal that a country's supply chain is working.

- 'No stock-out' of contraceptives was experienced in at least 50 per cent or more SDPs in the last six months of 2013 in Burkina Faso, Ethiopia, Lao PDR, Niger, Nigeria, Republic of Congo (Brazzaville) and Sierra Leone.

The situation improved in three countries 2012 to 2013:

- Burkina Faso's 'no stock-out' rate increased from 25 per cent to 80 per cent;
- Ethiopia's 'no stock-out' rate increased from 97.6 per cent to 99.5 per cent;
- Lao PDR's 'no stock-out' rate increased from 71 per cent to 81 per cent;
- Sierra Leone's 'no stock-out' rate increased from 44 per cent to 52 per cent.

Stock-out is an indicator than can fluctuate markedly from one year to the next. The causes of stock-out may go beyond the type of support provided by the GPRHCS, such as problems with roads and transportation, infrastructure or health sector management or lack of availability of adequate human resources. Even the timing of the annual country survey of service delivery points can influence survey results, due for example to the change of seasons, which affects remote areas in particular.

Also, several indicators in this area have changed from 2012 to 2013. The revised GPRHCS Programme Monitoring Framework increased the number of methods available from three methods to five methods at the secondary and tertiary levels. Another factor affecting the results reported this year is that we have moved the goal post, and in the revised framework are now looking at 50 per cent or 75 per cent as measures of achievement. Direct comparisons between 2012 and 2013 data is not possible, though this baseline year is the starting point for tracking progress in the future.

Reversals, however, were reported in Haiti, Niger and Nigeria between 2012 and 2013. Countries cited a number of reasons for the change. Reasons for the deteriorating rate in Haiti included low demand (39 per cent of cases), delay in delivery of commodities (32 per cent of cases), and delay in ordering commodities (14 per cent of cases). Niger cited low demand for male and female condoms, delays in re-supply of oral contraceptives and injectables among others; lack of trained staff to dispense IUDs and implants. One of the reasons given in Nigeria at district level included lack of supply from the central level, which was responsible for 17 per cent of stock-outs of male condoms, 24 per cent of female condom, 6 per cent of oral contraceptives, 5 per cent of implants). The country also reported a lack of requisitions for supplies.

Regarding SDPs at different levels in the health care system:

- There was progress in Burkina Faso, Ethiopia, Guinea, Lao PDR, Nepal and Niger, where 'no stock-out' rates were at least 60 per cent or higher in both secondary and tertiary SDPs. Better rates in their tertiary SDPs were reported by Congo (Brazzaville), Djibouti, Honduras, Niger, Nigeria, and Sierra Leone. Secondary SDPs showed higher 'no stock-out' rates than tertiary in Burkina Faso, Lao PDR and Sao Tome and Principe.
- 100 per cent 'no stock-out' rates showed steady supplies at both tertiary and secondary-level SDPs in Ethiopia.

Table 3: Percentage of SDPs reporting 'no stock-out' of contraceptives within the last six months

Country	2010	2011	2012	2013
Burkina Faso	81.3	12.8	25.1	79.9
Congo (Brazzaville)	-	-	-	50
Côte d'Ivoire	-	-	-	3.3
Ethiopia	99.2	98.8	97.6	99.5
Djibouti	-	-	-	25
Gambia	-	-	-	32.6
Haiti	52.5	26.4	42.6	26.4
Honduras	-	-	-	32.1
Lao PDR	36	84	71.1	81.2
Liberia	-	-	-	24.5
Mali	46	31	57	56.5
Nepal	-	-	-	79.9
Niger	99.1	85	97.3	65.3
Nigeria*	-	44	67.4	50.5
Sierra Leone	41.4	35.4	44	52.3
Timor-Leste	-	-	-	26
Togo				7.7

* No stock-out in the last 3 months for 2013

A woman receives information about her contraceptive method of choice.
Credit: UNFPA Ethiopia

BOX 1 Scaling up for a long-acting family planning method in Ethiopia

"After discussing with my husband about my schooling in the coming years and to have a child after then we decided that Implanon would be the best method for us," says a woman, 20, in the Oromia Region. Another client said, "I want to space my births. I would rather take care of the child I have and think of the next when our capacity is better. I feel comfortable using this."

Ethiopia has made remarkable progress in increasing access to family planning services. One family planning method that has been at the heart of the country's increasing contraceptive prevalence rate is Implanon. Implanon is a long-acting reversible method that releases a controlled amount of the hormone progestin for three years. This helps to prevent pregnancies. The Government's Implanon Scale-up Initiative aims to reach rural areas with huge unmet need for family planning.

UNFPA supports the programme through the Global Programme to Enhance Reproductive Health Commodity Security. Training in the simple insertion is provided to Health Extension Workers (HEW): more than 17,500 HEWs have been trained and 1.8 million implants have been inserted as of May 2013. More training and kits including required supplies are planned for an initiative that continues to perform, its success due in part to the emphasis on the community level.

A Woreda Women's Affairs officer in Tigray summarized local opinion: "Previously the community had misconceptions about Implanon, like it can cause sterility. But nowadays the community awareness has increased. A large number of women are getting Implanon. This is because those short-acting methods are easy to forget. Currently, the implementation of Implanon by Health Extension Workers is highly acceptable to the community."

Source: MOH and UNFPA booklet, 2013

Figure 8: SDPs reporting 'no stock-out' of contraceptives within last six months, 2010-2013

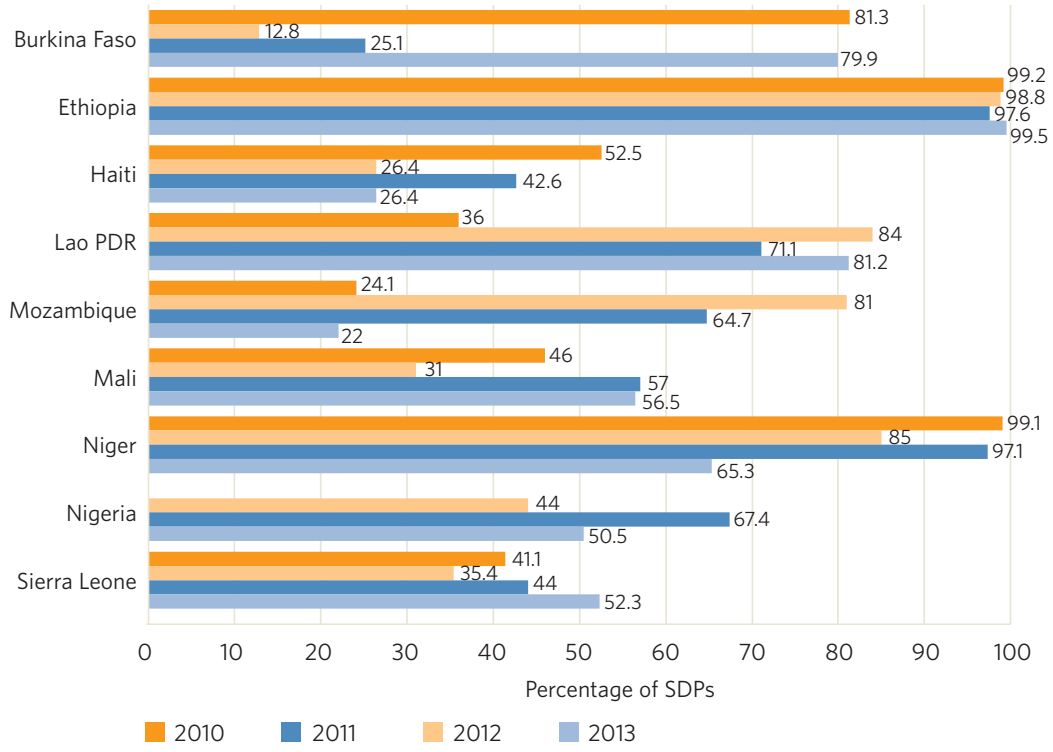


Figure 9: Tertiary and secondary SDPs reporting 'no stock-out' of contraceptives within the last six months by location of SDP in 2013

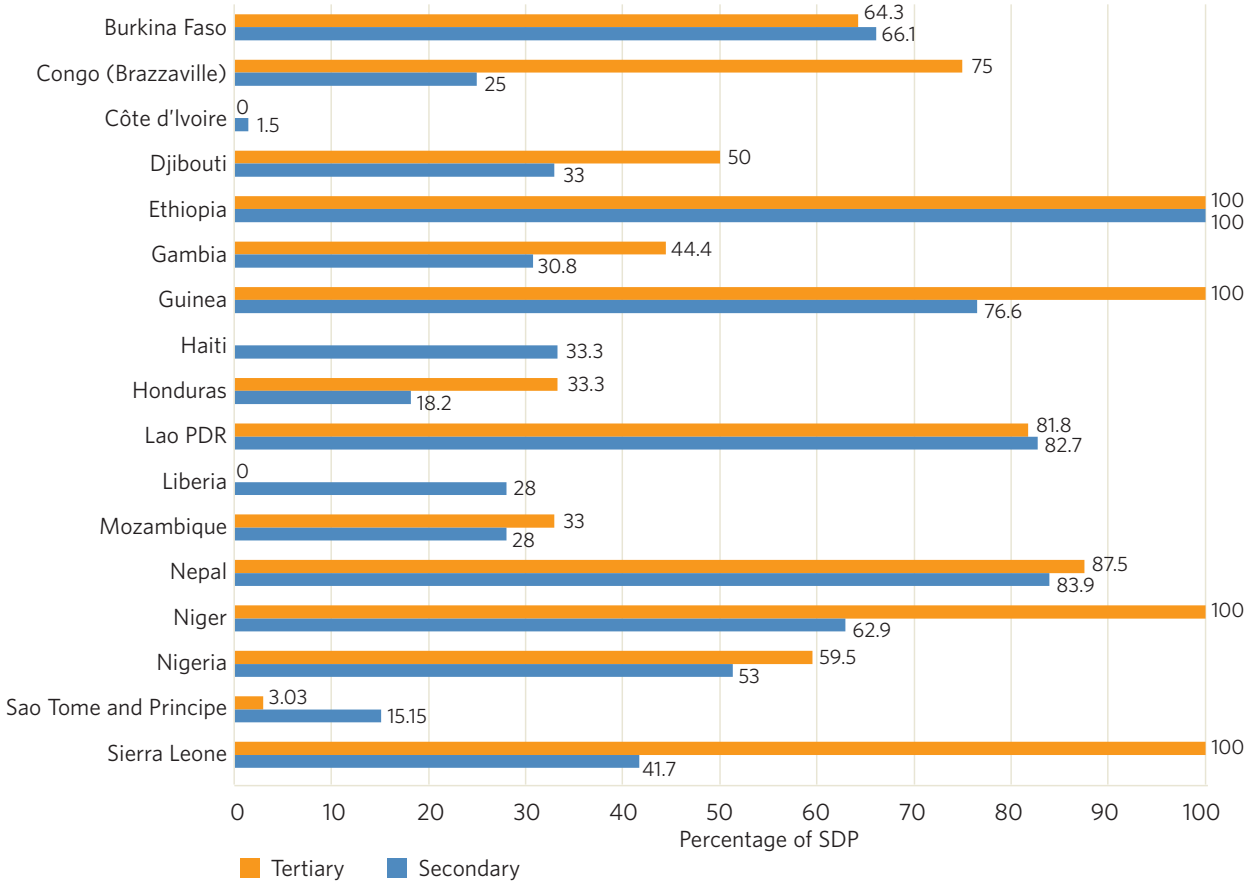
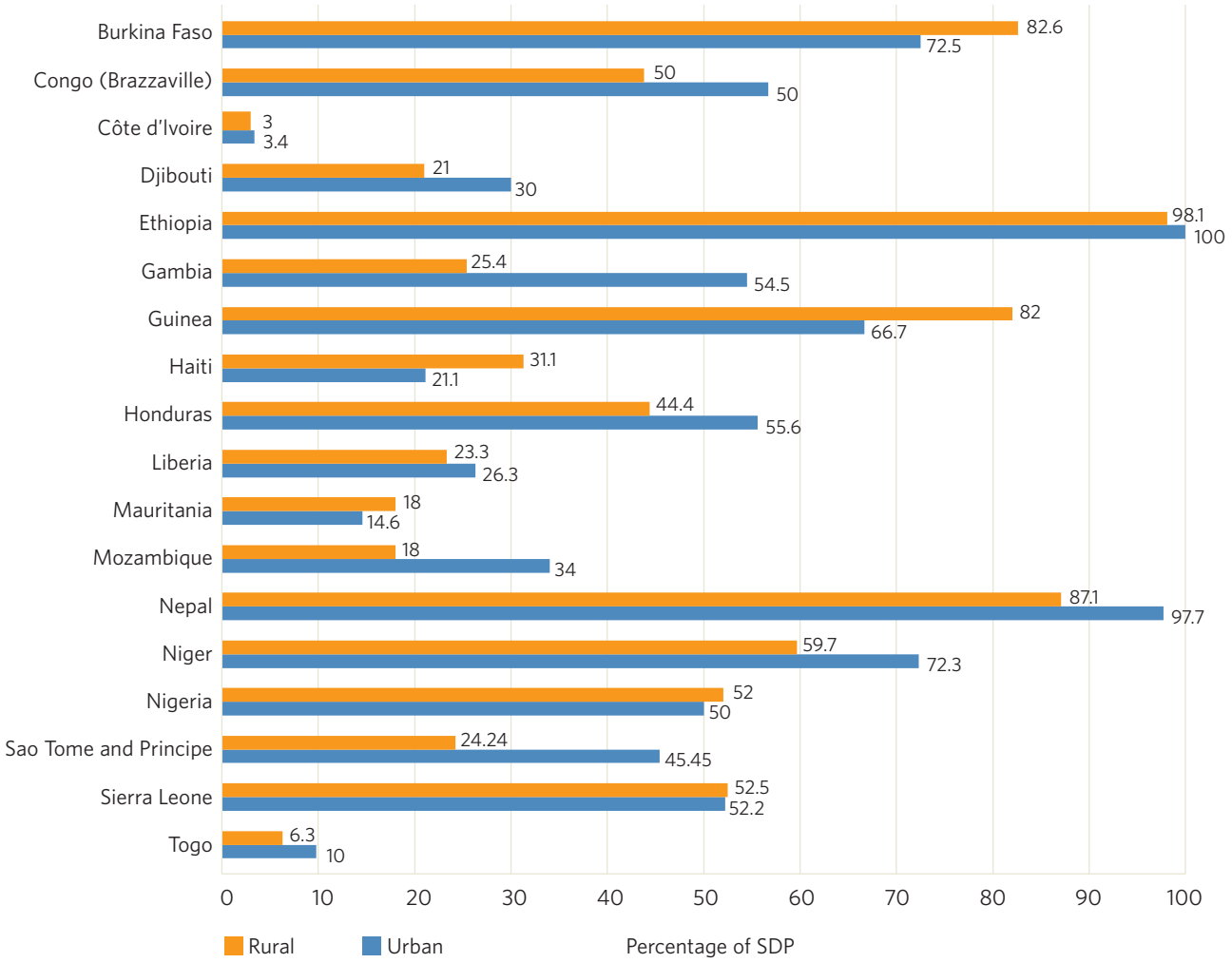


Figure 10: Urban and rural SDPs reporting 'no stock-out' of contraceptives within the last six months by location, 2013



Regarding urban and rural locations, the 'no stock-out' rate was higher in rural areas than urban areas in Burkina Faso, Haiti, Nigeria and Sierra Leone (former Stream One countries) as well as Guinea and Mauritania (former Stream Two countries). This exciting progress in rural areas in these three countries reflects sustained GPRHCS support to reach vulnerable groups in hard-to-reach rural areas in the first phase of the programme. More commonly, 'no stock-out' rates were better in urban areas than in rural areas in Congo (Brazzaville), Côte d'Ivoire, Djibouti, Ethiopia, Gambia, Honduras, Liberia, Mozambique, Nepal, Niger, Sao Tome and Principe, and Togo.

Shortages of contraceptives occurred for various reasons that need to be addressed in a comprehensive way. Many are the same reasons as given in previous years. For example, low demand for commodities such as male and female condoms contributed to stock-outs in Burkina Faso and Congo; also, lack of equipment and trained staff and equipment contributed to stock-outs of IUDs. Lack of demand for emergency contraception, female condom and male condoms contributed to stock-outs reported in all regions of Côte d'Ivoire (rural and urban settings). In Djibouti, because there is only one centre providing implants, other centres report a stock-out because they are not providing the service even though national protocols allow them to. Likewise in Honduras, implants and IUDs are not provided in some SDPs because of the lack of trained personnel though they are expected to provide the service. Stock-outs of long-acting contraceptives in Liberia were attributed to low client demand and lack of trained staff. For Nepal, IUDs and implants are more likely to experience a shortfall than other supplies, especially in rural areas.

This horse-drawn cart belongs to the Dodel health outpost in Senegal.
Credit: UNFPA/Diouga Diery

BOX 2 How Bajenu Gokh 'godmothers' and a horse-drawn cart save lives

"I call it the horse-cart of hope, the one that has saved lives, including that of my wife and my baby," says Dramane Bocar Mbodj. When his wife, Asta Gaye, started labour, he summoned the 'Bajenu Gokh' or village godmother. Asta was bleeding too much. Her godmother immediately took Asta to the traditional birth attendant and then accompanied the couple as they rushed to the health outpost in Dodel by horse-drawn cart.

The cart was provided to the outpost by UNFPA, which also provided an ambulance in distant Nianga Idy, as one of many initiatives with the Women's Health, Education and Prevention Strategies Alliance (WHEPSA). The people of rural Dodel and remote neighbouring communities (16,888 inhabitants in total) have organized themselves around community health counsellors and computerized management of contraceptive products through CHANNEL, UNFPA-developed software.

"All childbirths now happen at the Health Huts or at Dodel's health outpost where there are well-trained traditional birth attendants, community health agents and Bajenu Gokhs," explained Mamadou Fall, a Chief Nurse.

A couple in Senegal leave the health facility with their newborn, delivered by C-section.
Credit: UNFPA/Diouga Diery

OUTPUTS

OUTPUT 1

Improved enabling environment

Fostering an enabling environment is an ongoing process of mobilizing political will and financial resources and fostering national ownership. GPRHCS supports advocacy for political commitment, policy and strategy formulation, coordination, partnership, and practices for more sustainable environmental impact. A number of indicators measure progress towards achieving Output 1: *An enabled environment for reproductive health commodity security, including family planning, at national, regional and global levels:*

- Number of countries with:
  - national sexual and reproductive health and reproductive rights guidelines and protocols which include rights-based approaches to RHCS and family planning more broadly;
  - functional national RHCS coordination mechanism;
  - national budget allocation for RH commodities.
- Evidence of support to and collaboration with NGOs for the scaling up of RHCS/FP;
- Number of national institutions supported to integrate RHCS issues in training curricula.

1.1 A strong year for policy and strategy interventions

Mobilization for family planning and the sprint to achieve MDG 5 made 2013 strong year for advocacy. UNFPA supported advocacy initiatives in all GPRHCS implementing countries and continued to lead global and national efforts to mainstream RHCS in national and global policy and strategy. More than half of the 46 countries supported have achieved all of the indicators under this intervention area.

- 32 of 46 countries have functional coordinating mechanisms for RHCS. These committees, meeting at least twice a year, were under the leadership of government, with membership drawn from donor agencies, UN agencies, civil society organizations, NGOs, the private sector and other stakeholders;
- 28 of 46 countries had essential medicines lists (EMLs) containing all reproductive health commodities (both contraceptive and life-saving maternal health medicines). Specifically, the EML contained contraceptives in 31 countries, and maternal health medicines in 30 countries. Extra support to help countries register their reproductive health medicines was initiated at the end of 2013 with new tools and a strategy led by the UNFPA Procurement Services Branch to improve monitoring and reporting on progress of registration;
- 39 countries have national guidelines and protocols that include a rights-based approach to RHCS and family planning;
- 33 countries have policies in place that take into consideration young people's access to contraceptive services.

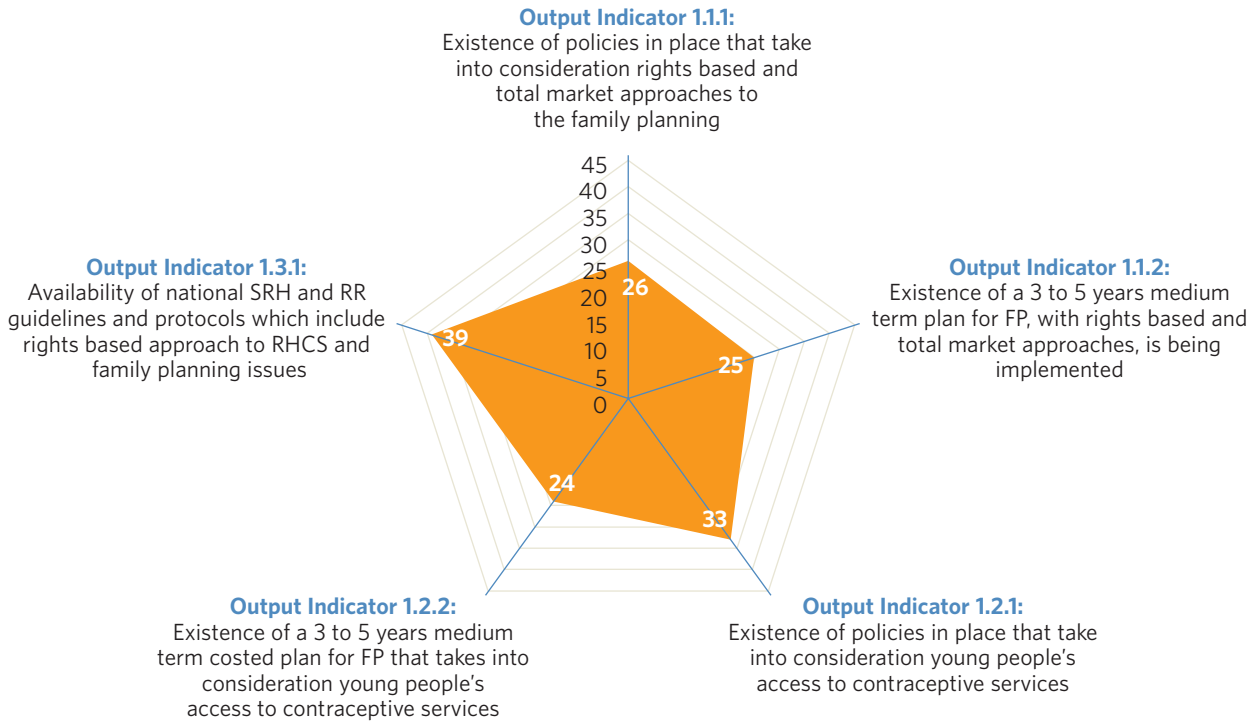
Selected country examples demonstrate governmental leadership and support to RHCS, as in the following four

Addressing teenage pregnancy.
Credit: UNFPA Sierra Leone

examples. In Haiti, a presidential decree for family planning was adopted along with the launch of a national family planning campaign. In Burkina Faso, the First Lady launched National Family Planning Week in June 2013, focusing on the role of family planning in reducing maternal death. Central African Republic launched the new 'Ita Ouali' training initiative to reduce maternal death through promotion of reproductive health information and services, under the patronage of the Head of State of the Transition, with commitment from women leaders. In Sierra Leone, the country's President launched the national strategy for the reduction of teenage pregnancy in May 2013, a multi-sectoral strategy that secured inclusion of teenage pregnancy in the national poverty reduction strategy. Also, the First Lady attended a two-day consultative forum to engage traditional religious leaders on the issue.

With support from UNFPA many countries made a significant progress in developing costed action plans on RHCS and family planning, and by revising national policies and strategies related to RHCS to remove legal barriers to RH commodities. For example, Nepal repositioned family planning with a costed strategy and a revised RHCS strategy. In Uganda, UNFPA advocacy for task-shifting and an alternative mechanism for distribution of public sector contraceptives through the private sector resulted in amendment of national policy and service guidelines to allow community-based distribution of injectable contraceptives. Uganda also held a national family planning symposium while developing a plan to scale-up family planning delivery. Mozambique approved its strategic plan for pharmaceutical logistics, integrating RHCS indicators. Zimbabwe conducted a situational analysis of the national family planning programme, prepared a costed action plan, and launched a strategic plan for life skills, sexuality and HIV education. Chad validated its first national document on family planning policy. Liberia completed its RHCS strategy and plan. Mali aligned its national RHCS strategic plan with the 2014-2018 programming cycle. Mauritania developed and validated a five-year family planning plan. Niger adopted a national plan to reposition family planning 2013-2020. The Democratic Republic of the Congo developed the first multi-sectoral Family Planning Strategic Plan 2014-2020, with the support of UNFPA, provincial

Figure 11: Country achievement in policy and strategy, GPRHCS 2013



Five output indicators give a picture of policy and strategy showing that overall performance supports an enabling environment for RHCS.

Source: Information provided by UNFPA Country Offices for GPRHCS reporting 2013.

health and gender ministers, and all partners involved in the family planning activities.

Meetings of coordinating bodies help keep RHCS on track. In Nepal, UNFPA co-convened governmental family planning meetings and lead the RHCS thematic working group among external donor partners. In Liberia, institutionalization of the RHCS coordinating body was established with terms of reference under the leadership of the Ministry of Health. In Mozambique, the RHCS Task Force continued to capture consensus among government and partners around issues from forecasting to monthly monitoring of warehouse stocks of contraceptives. In Guinea, a functional national committee for forecasting RH commodity needs was established with 20 national specialists.

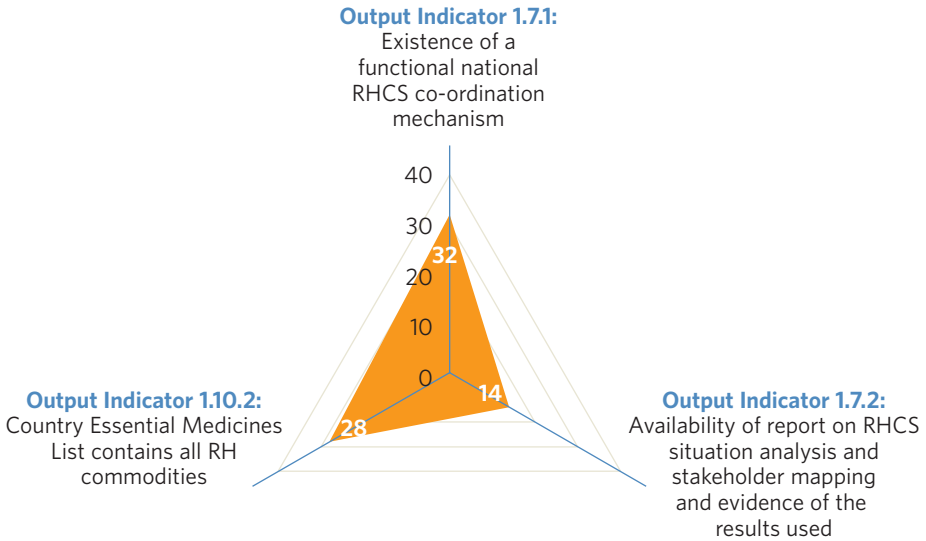
1.2 National budget allocations

Allocations to RHCS and associated expenses are tracked as one of the key measures of government commitment to ensuring commodity security. Allocations from national budget lines for reproductive health supplies ranged from $25,000 each in Benin and Lao PDR to $28.2 million in Ethiopia in 2013.

- 25 of 46 countries had budget line allocations in 2013 for either contraceptives, maternal health medicines or both (see Annex). Of these countries, 14 spent all funds as planned; four spent part of the amount allocated, as planned; seven did not spend the amount allocated;
- $37.7 million to procure contraceptives was allocated by the 25 countries bringing the final total spent to $38.3 million (Ethiopia and Tanzania spent slightly more than they allocated);
- $33.6 million to procure maternal health medicines was allocated by the 25 countries, though they spent only $13.7 million (40 per cent).

Lao PDR and Myanmar increased allocations for contraceptives and other RH commodities. Malawi increased its allocation from MK 1 million in 2012 to MK 26.1 million in 2013, reflecting stronger governmental commitment. Mozambique's state budget covered for the first time 6.5 per cent of contraceptives needs. Advocacy by family planning and RHCS committees in Uganda contributed to an increase from US$ 3.3 million in 2011/12 to US$ 6.9 million in 2012/13. Benin restored its contraceptives allocation, with funding of 50 million FCFA. Burkina Faso increased its contraceptives allocation to US$ 3 million in 2013, up from US$ 978,000 in 2008. Guinea committed to increasing its allocation from US$ 200,000 to US$ 743,500 per year 2014-2018. Nigeria increased by 300 per cent its annual US$ 3 million for contraceptives with

Figure 12: Country-level coordination and partnership, GPRHCS 2013



More progress has been made in establishing coordinating mechanisms and essential medicines lists than on the use of RHCS situation analysis and mapping.

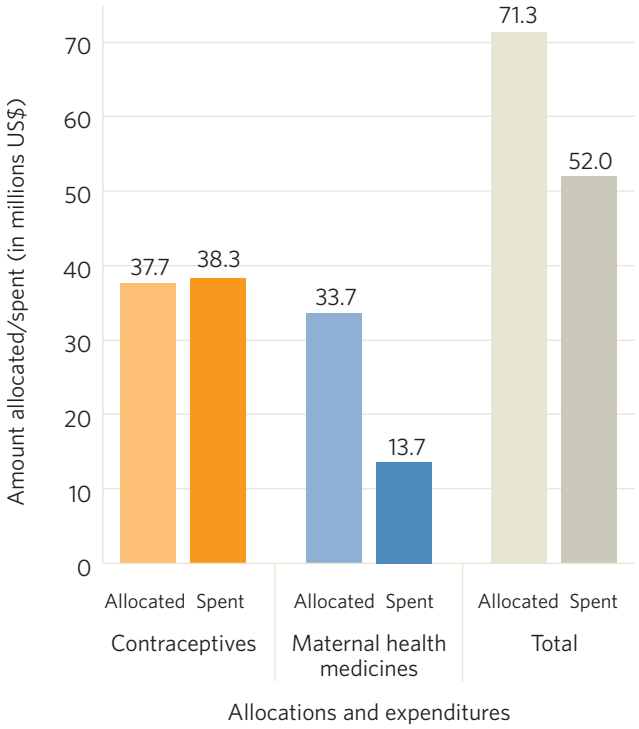
Source: Information provided by UNFPA Country Offices for GPRHCS reporting 2013.

an additional annual US$ 8.4 million pledged 2012-2014, though manufacturing lead time delayed receipt of funds in 2013. Turkmenistan signed an MOU to fund contraceptives as of 2014. As a result of joint efforts made by UNFPA and other partners including parliamentarians and civil society, the Government of the Democratic Republic of the Congo allocated US$ 460,000 for the purchase contraceptives in 2013 and it is expected that this amount will be increased in 2014.

1.3 Training institutions: national capacity development

Strengthening the capacity of national institutions to promote integrated RHCS helps to sustain a positive environment for sustainable progress, especially in the area of capacity development for service providers.

Figure 13: Amounts allocated and spent in national budgets for procurement of RH commodities, GPRHCS 2013



Slightly more was spent than allocated for the procurement of contraceptives, and 40 per cent less was spent than allocated for maternal health medicines.

Source: Information provided by UNFPA Country Offices for GPRHCS reporting 2013.

- 23 national institutions received GPRHCS support in 2013 to integrate RHCS and family planning into training curricula, including for procurement. Draft curricula are being finalized in two countries (Guinea-Bissau and Sao Tome and Principe) and are pending adoption by institutions in two more (Chad and Burkina Faso).
- 10 countries received support to integrate the issues into the core curricula of approved courses in a number of training institutions, e.g. Burkina Faso supply chain and logistics management training at L'Institut National de formation des agents de santé and L'UFR des Sciences Pharmaceutiques et Biologiques, and Ethiopia pharmaceutical logistics supply at the University of Addis Ababa.
- 13 countries received support for training institutions to provide instruction in specific areas, for example: comprehensive condom programming in Lesotho; implant insertion and removal in Malawi, community health extension workers for injectable contraceptives in Nigeria, training of trainers for long-acting reversible contraceptives and for scaling up provision of magnesium sulfate in Nigeria; and training of trainers for family planning service deliver in Togo.

Many additional training activities focused on computerized logistics management in Burkina Faso, Côte d'Ivoire, Madagascar, Mozambique and Sao Tome and Principe. Also, training course in family planning service delivery were supported by GPRHCS at the Schools for Nursing and Midwifery in Gambia, Colleges of Health Sciences in Malawi, Écoles de Formation en Santé in Niger, and Zambia's School of Nursing. In Mali, UNFPA supported the training of trainers on family planning in the country's highest-level midwifery school. (For more on training, please see Output 4.)

OUTPUT 2

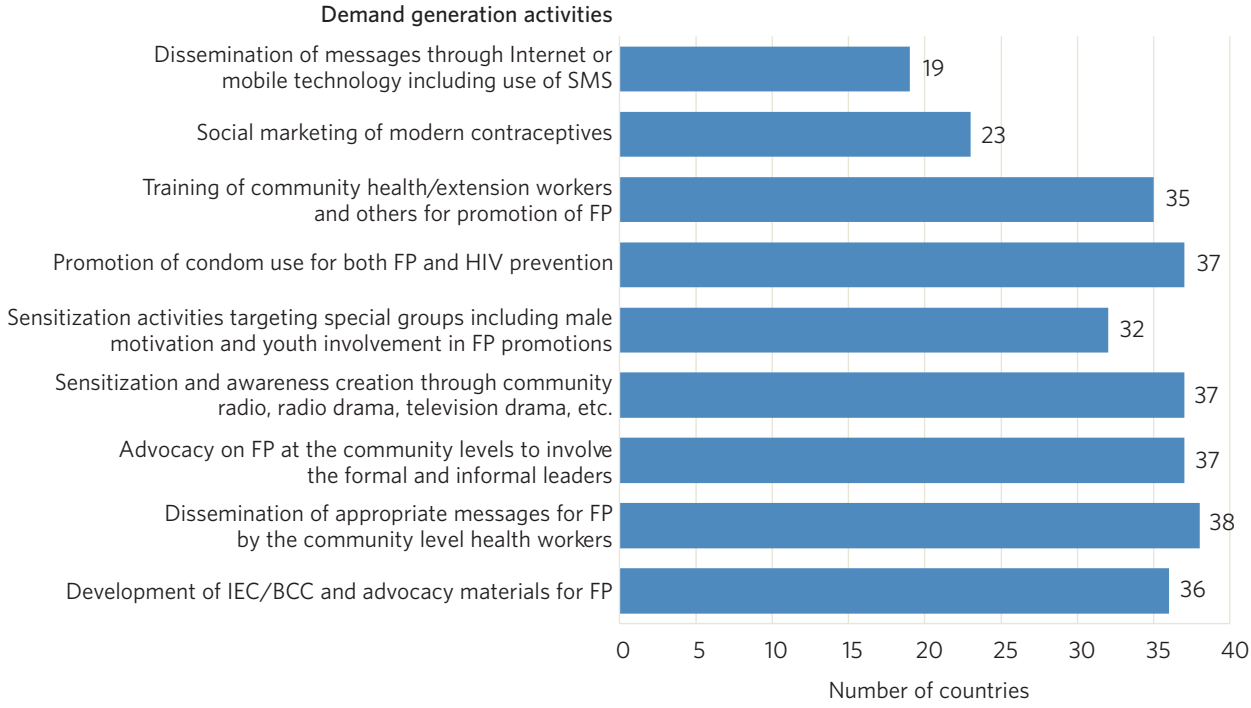
Increased demand for reproductive health commodities

Awareness raising, education, advocacy and community mobilization, and Total Market Approach are interventions that drive expansion of much-needed services. Approaches are rights-based, evidence-based, and sensitive to gender and culture. The framework tracks many indicators to measure progress towards Output 2: *Increased demand for reproductive health commodities, by poor and marginalized women and girls*:

- Number of countries in which at least five elements of demand generation for family planning are supported;
- Number of countries where partners are implementing specific initiatives to reach the poor and marginalized women and girls.

Effective programmes on demand generation included a broad spectrum of practices such as the Total Market Approach, health communication, outreach and community mobilization focusing on youth and adolescents.

Figure 14: Number of countries where demand generation activity was supported, 2013



Countries are highly engaged in demand generation and advocacy interventions to inform and empower individuals for family planning.

Source: Information provided by UNFPA Country Offices for GPRHCS reporting 2013.

2.1 Broad range of demand generation activities

Demand generation builds understanding among individuals and couples about their rights and needs to access and use quality family planning services. A wide variety of demand generation activities took place in 2013:

- More than 80 per cent of the 46 Global Programme countries implemented demand generation for family planning and RHCS in 2013;
- 41 countries carried out resourced action plans to reach young people, poor women and women and girls in hard-to-reach places;
- 38 countries engaged community health workers to better disseminate family planning messages;
- 37 countries carried out advocacy with formal and informal community leaders, radio and TV programming, condom promotion interventions, and for development of information, education and communication and behaviour change communication (IEC/BCC) materials;
- 23 countries used social marketing strategies to generate demand for contraceptives;
- 19 countries supported the use of Internet or mobile technology (including use of SMS) to disseminate family planning messages.

2.2 Increasing access to services

Under the GPRHCS, demand generation empowers women, adolescent girls and young people to access and use contraceptives information and services. In Nepal, demand generation and capacity building in focused districts has contributed to an increase in average CPR of 3.85 per cent, compared with a national CPR increment of 2 per cent in 2013 (HMIS 2012/2013). Thanks to demand generation efforts, Mozambique experienced high call for implants, with significant expansion of implants to more health facilities: Procurement increased from the first order for 5,000 implants in 2012 to 94,000 implants in 2013. In South Sudan, community mobilization reports found that the scores of clients taking satisfaction surveys increased from 50 to 79 per cent over the previous year.

Benin added almost 20,000 new users of modern contraceptive methods this year, generated by increased engagement of community leaders, administrative officials, civil society organization and social mobilization activities including a television series on family planning, maternal health, gender-based violence and young people's reproductive health. A week-long national communications campaign in Guinea registered 1,276 new users of family planning, 88 per cent choosing long-acting methods. In Mali, interactive radio programmes on birth spacing and family planning reached humanitarian sites contributing to increased utilization of contraceptives: 32,941 women received implants and 9,971 IUDs; 1,665 received tubal litigation.

Young mother considers a choice of contraceptives.
Credit: UNFPA Burundi

In the Democratic Republic of the Congo, 565,866 new and 81,340 continuing acceptors were provided with family planning supplies and services in 2013 through UNFPA support. In Burundi, use of RH services among youth increased from 40,849 in 2012 to 63,266 as of November 2013 due to a targeted approach to increase knowledge and access to contraceptives and sexual and reproductive health services among adolescents and young people. In Kenya, a project was initiated to increase uptake of family planning services among the Muslim community in Malindi district, with sensitization of local religious leaders, and Muslim leaders/scholars were supported to tour Egypt to learn best practice on increasing family planning uptake among the Muslim community.

2.3 Total Market Approach (TMA)

UNFPA has embraced the Total Market Approach to help promote and facilitate partnership, alignment and collaboration across the public and private sectors in the effort to increase access and availability of contraceptives and RH

Members of the Husbands' School meet in Maiki, Maradi, Niger.
Credit: UNFPA-APA

BOX 3 Husbands' Schools in Niger and beyond

"Here in Maiki, since the setting up of the Husbands' School in 2011, the number of women using family planning methods has increased," said Almoustapha Boubacar, health centre manager.

At the integrated health centre of Maiki (above), a village in the region of Maradi, discussions are held in a warehouse built on the courtyard of the health centre. Launched in the region of Zinder in 2008, the 'schools' are forums where married men meet to discuss and champion awareness-raising efforts on family planning and other issues related to reproductive health. The concept, which started modestly, has spread and thrived in other regions and to other countries.

Some 300 Husbands' Schools have been established since 2008, with 3,600 husbands as participants. Indicators for reproductive health were better where the Schools were in place. In Tuomodi district, for example, 18 new schools with 18 coaches were established, along with training for nine trainers to create more schools and 16 supervisors to provide coaching for school members. Equipment provided to the schools for outreach activities included televisions, video players, megaphones, chairs, tables, benches, inverters and power strips. Significant increases in uptake of family planning and maternal health services continue to be reported. Also, more traditional religious leaders in Niger added their signatures to the Niamey Declaration to raise awareness for family planning, increasing the number from 90 in 2012 to 130 in 2013. In Côte d'Ivoire, the number of Husbands' Schools operating rose to 22 schools in 2013.

One of six TMA case studies.
Credit: PSI

products, including specifically male condoms for dual protection. This concept was new to GPRHCS this year. Efforts engaged 15 key organizations working in TMA, with strong involvement by USAID; a second consultative meeting was held with USAID in June 2013.

A key issue is equity of access at an appropriate price, starting from free-of-charge with rising cost contributions for those able to pay. Responsibility for coordination and leadership of a Total Market Approach lies squarely with government, in its stewardship role for public health.

- UNFPA worked with PSI to produce case studies that were presented at global consultation hosted by UNFPA in 2013. PSI produced case studies on national markets for male condoms in six countries: Botswana, Lesotho, Mali, South Africa, Swaziland and Uganda.

In Eastern Europe and Central Asia, the Total Market Approach was launched at the regional level with support from GPRHCS and rolled out by national governments (http://eeca.unfpa.org/topics/total-market-approach). In Nepal, a market survey of male condom brands from public, private and NGO sources was part of TMA programming. At the global level, GPRHCS has planned with partners to create a compendium of resources in the area of TMA, social jmarketing, franchising, vouchers, insurance and other approaches. Orientation tools for TMA at national level are also in development. The aim is to achieve better alignment and partnership, reinforcing the role of government in its allocation of resources for services.

2.4 Health communication: radio, television and newspaper

Health communication is an important aspect of demand generation activity, encompassing multimedia channels and approaches from information, education and communication (IEC) and behaviour change communication (BCC). Among many initiatives in 2013, journalists in Sudan identified sensitive vocabulary for reproductive health issues for use in media reporting. Also in Sudan, UNFPA supported national advocacy with NGOs, CBOs and private sector institutions to enhance partnership and bring more partners to plan, finance and implement the RHCS interventions. In Guinea, a partnership with national television and rural radio produced programming in French and three local languages on family planning and other RH issues. Uganda's national media campaign to promote male and female condoms for dual protection reached some 29 million

Multimedia campaign enlivens training.
Credit: UNFPA Côte d'Ivoire

radio listeners and nearly 9 million TV viewers. Rwanda conducted a week-long campaign to mark World Vasectomy Day, with 73 surgeries performed. In Côte d'Ivoire, a multimedia campaign with radio and community-based distribution agents, health workers and local community leaders provided a demand generation component to accompany a 3-5 day training workshop for integrated reproductive health services.

In Burkina Faso, nine journalists joined a 'press caravan' touring six regions in the country to conduct interviews about family planning with politicians, religious leaders and public health administrators. The reporters represented leading national media, including print, television and rural radio, providing leaders with a large audience for their messages supporting family planning. The tour was part of the second National Family Planning Week, which was opened by the country's First Lady on 14 June. Burkina's popular nationwide radio soap opera 'Adventures of Foula' continued to reach vast audiences.

Two new dramatic series in Nigeria produced with the Population Media Centre and MTV Staying Alive are expected to reach over one million people with life-saving information on family planning and maternal health and reduction of early marriage. Two 78-episode radio serial dramas with a running time of 15 minutes per episode in Hausa and Pidgin English are running from November 2013 through 2014. In addition to supporting this project, UNFPA also supported the SHUGA programming series to reach young people with messages on sexual and reproductive health. With eight radio and eight TV episodes, and related social media and mobile phone components, SHUGA was launched 1 December 2013 and is being broadcast on more than 70 channels worldwide.

2.5 Reaching adolescents and young people

In Djibouti, strengthening the Y-Peer programme and mutual monitoring at the community level increased condom distribution to vulnerable populations lacking access to health services. Young couples about to marry in Lao PDR benefited from an intervention supporting the provision of family planning counselling and check-ups by Village Chiefs who also helped to prevent under-age marriages. The country also distributed 5,000 copies of a comic book to improve condom use among young people and produced

A journalist in Sierra Leone, in Mapaki, Northern Province.
Credit: UNFPA/Sulaiman Stephens

a drama based on the book for public event performances. In Zimbabwe, 930 behaviour change facilitators received training in 26 districts to conduct awareness sessions on family planning, film screenings reached more than 15,000 young people, and peer educators called attention to youth-friendly services at 37 service delivery points.

The First Lady of Mozambique led a public debate on teen pregnancy in August 2013, with more than 150 young participants and 10 members of the parliamentary youth cabinet, provincial youth council representatives and many others. At an international trade fair, young Mozambicans distributed 2,600 male and 1,700 female condoms with IEC materials.

Peer educators of young people in Nigeria's Kaduna and Adamawa States were supported with behaviour change communication materials from partner NGOs. Peer-to-peer small group discussion using films and radio drama series reached 2,200 young people. Outreach by youth for youth distributed 3,258 male condoms and reached 1,039 young people.

SMS information exchanges in Burundi with 18 youth-friendly health centres delivered 10,000 messages on the day of the UNFPA State of World Population launch. Also in Burundi, a game show on five popular radio stations marked World Population Day, the Kamenge Youth Centre produced radio programming, and music concerts reached some 3,000 youth with family planning messages.

Speakers at an interfaith meeting on family planning; behind them, bicycles equipped with backpacks are ready for use by community-based distribution agents.

Credit: UNFPA Burundi

BOX 4 Burundi views family planning as part of poverty reduction

"Giving birth to children that we are able to educate until maturity. This means that we need to limit births, so that the living can find a suitable and sufficient living space," says Thomas Muhanazi, 45, a cook and evangelical pastor who had a vasectomy three years ago.

Burundi has a national policy to reduce the fertility rate and increase use of modern contraception. Unmet need for family planning remains high at 31 per cent though progress is seen in contraceptive prevalence, which has almost quadrupled in seven years from 7.3 per cent in 2006 to 27 per cent in 2013. UNFPA is the country's main partner for reproductive health, with sustained GPRHCS support. Family planning services are available in 90 per cent of public facilities, no stock-out have been reported at the central level since 2006, and 91 per cent of service delivery points report no stock-outs of all types of contraceptives in the past six months. CHANNEL software is used to forecast supplies in 95.5 per cent of districts. Training has developed capacity among 1,474 health providers 2005-2012.

Religious barriers, gender-based violence, the vulnerability of adolescent girls, and rumours and misinformation about family planning remain challenges. Yet new clients quickly see the benefits:

"We have five boys and it's enough for our incomes and after benefiting from counselling my wife and I decide to undergo a vasectomy and are now very happy," said one young father.

OUTPUT 3

Improved efficiency for procurement

UNFPA is the lead agency within the UN system for the procurement of reproductive health commodities, channeling about half of this work through GPRHCS. Making procurement processes efficient and environmentally friendly, and delivering an appropriate method mix of quality commodities to countries based on their needs are UNFPA priorities. Progress towards Output 3: *Improved efficiency for procurement and supply of reproductive health commodities, global-level* is measured with the following indicators:

- Percentage of lead time reduced through procurement of RH commodities using AccessRH;
- Number of LTAs in operation during the year for hormonal contraceptives;
- Volume of Third Party Procurement;
- Number of factories agreeing to and fully implementing ISO14001;
- Couple years of protection (CYP) for contraceptives and condoms procured by UNFPA.[7]

3.1 Market shaping

Healthier markets for reproductive health supplies are the aim of market shaping activities. For UNFPA and partners, shaping the market helps to ensure adequate supply of appropriate, quality reproductive health supplies at low and sustainable prices for developing countries. It reduces prices, improves supply security, fosters innovation and promotes quality assurance. GPRHCS started developing a strategy in 2013 to facilitate the emergence of healthy markets for quality RH supplies, in particular for the different contraceptive methods (e.g. condoms, IUDs and the full-range of hormonal contraceptives) and for the key life-saving maternal health drugs (e.g. misoprostol, oxytocin and magnesium sulfate). Market shaping builds on the significant past and present work of other organizations and initiatives, making coordination and linkages a priority.

3.2 Volume guarantee for implants

UNFPA has played a key role in procurement of contraceptives at negotiated prices from key manufacturers. The aim of this work is to support the UN Commission on Life-Saving Commodities' first recommendation: *Share global markets: By 2013 effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities an optimal price and demand.* The Government of Norway, DFID (UK) and the Bill & Melinda Gates Foundation have worked in partnership with UNFPA, working through the GPRHCS due to its several comparative advantages.

In early 2013, **a volume guarantee agreement** contributed to unit price reductions of 50 per cent from as much as $18.5 to as low as $8.5 for contraceptive implants, a long-acting reversible contraceptive method. UNFPA support included procurement of approximately 2 million units of Jadelle and two million units of Implanon. The guarantee was signed by a consortium of donors with a manufacturer. The partners acknowledged the need to invest in global and national systems in terms of procurement, supply chain, health workforce and demand creation. They also noted the importance of ensuring that the focus on contraceptive implants was embedded in national family planning programmes where women and men are offered a choice of modern contraceptive methods.

7 CYP refers to the estimated protection provided by contraceptive methods during a one-year period based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.

3.3 Quality of products

Quality of RH products is ensured through a process of collaboration between the World Health Organization prequalification process (WHO-PQP) and the Expert Review Panel (ERP) process managed indirectly by UNFPA, through liaison with the WHO ERP coordinator. It entails provision of technical guidance on the submission process for manufacturers and on procurement requirements, assessment, and meetings and workshops to build capacity.

- By the end of 2013, manufacturers prequalified by WHO included: 10 sources of hormonal contraceptives; 25 sources of male condoms; 2 sources of female condoms; and 5 sources of IUDS.
- 15 manufacturers made submissions to ERP in 2013, all of which passed the screening process; 9 were approved.

3.4 Procurement efficiency through AccessRH

AccessRH[8] is a reproductive health procurement and information service managed by UNFPA. It works to improve access to quality, affordable sexual and reproductive health commodities and reduce delivery times for low- and middle-income country government and NGO clients. Information on $2.3 billion of global contraceptive orders for more than 140 countries was made available by AccessRH in 2013 through its unique website, myAccessRH.org. In 2013:

- AccessRH made $41 million in shipments of RH commodities to 87 countries in 2013, including supplies worth $14.9 million to 36 GPRHCS countries. Of this, $20 million (49 per cent of the total) was dispatched to Africa, while Latin America accounted for $2.9 million (28 per cent);
- Lead time was reduced by 14 weeks (87 per cent) for obstetric fistula kits and 9 weeks (75 per cent) for male condoms, compared with commodities dispatched from non-AccessRH sources;
- 13 long-term agreements (LTAs) existed for WHO prequalified RH commodities, though only 6 LTAs received orders in 2013;
- 3 LTAs were in place for ERP-assessed commodities, and all 3 LTAs received orders for commodities.

Lead time for AccessRH ranges between 2 and 3 weeks (3 weeks for male condoms, 2 weeks for female condoms, IUDs and fistula kits). In contrast, lead time for commodities dispatched from non-AccessRH sources ranged from 2 to 16 weeks (12 weeks for male condoms, 10 weeks for female condoms, 2 weeks for IUDs and 16 weeks for fistula kits). AccessRH has reduced lead time by 75 per cent for male condoms and 87.5 per cent for fistula kits. UNFPA's prices for RH commodities compare favourably with those of other procurers and are considerably lower than what the end-user has to pay at the local market.

3.5 Third party procurement

The Procurement Services Branch in Copenhagen not only procures RH supplies for UNFPA offices but also provides procurement services to third parties, especially for contraceptives. Third parties may include other UN agencies, national governments and NGOs. In 2013, UNFPA's third party procurement (TPP) amounted to $32.8 million, including $19.2 million for male condoms, $1.6 million for female condoms, $3.5 million for oral contraception, $5.3 million for injectables, $0.3 million for IUDs, $2.5 million for implants, and $0.4 million for emergency contraception. Male condoms constituted 58.5 per cent of the third party procurement value.

3.6 Contraceptives and condoms procured: quantity and mix

GPRHCS constitutes approximately half of all procurement in UNFPA and an even greater proportion of the contraceptive category. (The contraceptive category includes condoms for dual protection from pregnancy and HIV and other sexually transmitted infections.) This year, more than 60 per cent of CYP delivered by UNFPA was channeled through GPRHCS.

- $148 million was spent by UNFPA on the procurement of modern contraceptives in 2013; of this total, $78.5 million was through GPRHCS;
- 57.7 million couple years of protection were provided by total UNFPA contraceptive procurement in 2013; of this, 35 million CYP were through GPRHCS;
- The average cost per CYP was $2.57 for UNFPA and $2.24 for GPRHCS. GPRHCS expended 50 per cent of resources on long-term methods compared with 34 per cent for UNFPA.

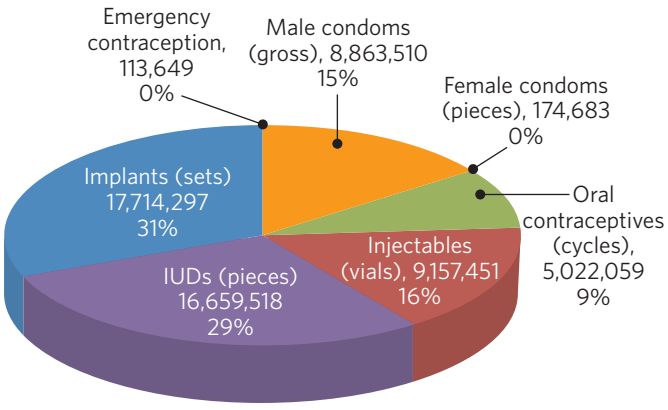
8 The AccessRH concept was developed by the Reproductive Health Supplies Coalition, is managed by UNFPA, and has been funded by the Bill & Melinda Gates Foundation, the European Union, the German Federal Ministry for Economic Cooperation and Development (BMZ), and through in-kind support from the US Agency for International Development (USAID) (see http://www.myaccessrh.org/).

Table 4: CYP and cost of contraceptives procured using resources from UNFPA as a whole and resources from GPRHCS only

Commodity	Quantity		Total Cost		Total CYP		Cost per CYP	
	All UNFPA	GPRHCS only	All UNFPA	GPRHCS only	All UNFPA	GPRHCS only	All UNFPA	GPRHCS only
Male condoms (gross)	7,386,258	1,644,000	$29,635,830	$6,155,136	8,863,510	1,972,800	$3.34	$3.12
Female condoms (pieces)	20,962,000	15,557,000	$11,200,510	$8,867,490	174,683	129,642	$64.12	$68.40
Oral contraceptives (cycles)	75,330,888	32,992,896	$22,224,247	$8,908,082	5,022,059	2,199,526	$4.43	$4.05
Injectables (vials)	36,629,805	19,698,500	$33,444,154	$14,773,875	9,157,451	4,924,625	$3.65	$3.00
IUDs (pieces)	3,665,094	2,476,000	$1,181,928	$916,120	16,659,518	11,254,545	$0.08	$0.08
Implants (sets)	5,523,350	4,551,676	$49,467,076	$38,689,246	17,714,297	14,597,978	$2.79	$2.65
Emergency contraception	1,357,753	216,000	$889,818	$216,000	113,649	18,080	$7.83	$11.95
Total			**$148,043,563**	**$78,525,949**	**57,705,167**	**35,097,196**	**$2.57**	**$2.24**

The piloting of a new injectable contraceptive, Sayana Press, is a partnership of the Bill & Melinda Gates Foundation, DFID (UK), Pfizer, PATH, UNFPA and USAID. In 2013, this partner consortium made initial funding commitments to support the costs of provider training, communications, product procurement, and distribution in the pilot introduction countries. The product is being added to the modern contraceptive range to address unmet need, generate new users, and support improved continuation of family planning. It is an addition to the family planning method mix for extending access and increasing use in resource-constrained settings.

Figure 15: CYP for contraceptives procured using resources from UNFPA as a whole, 2013



UNFPA provided 57.7 million CYP of which 35 million were through GPRHCS

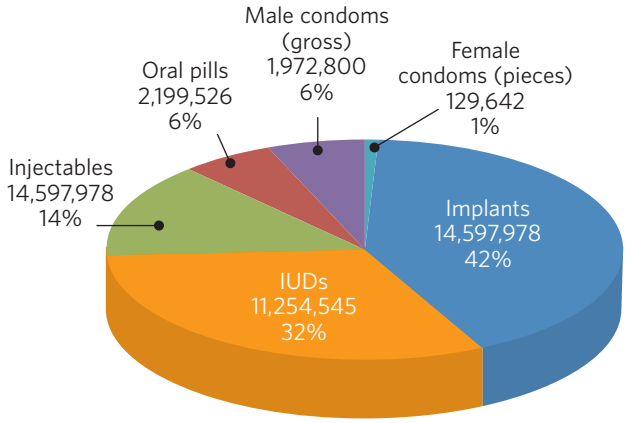
Source: Procurement Services Branch, UNFPA Copenhagen

The composition of the method mix for GPRHCS and UNFPA as a whole are similar. The long-acting reversible methods (implant and IUD) constituted 60 per cent of the CYP for UNFPA but 74 per cent of the CYP for GPRHCS. For both, three contraceptives (female condoms, oral contraceptive and emergency contraceptives) combined did not contribute less than 10 per cent of CYP.

3.7 Contraceptives and condoms: approvals

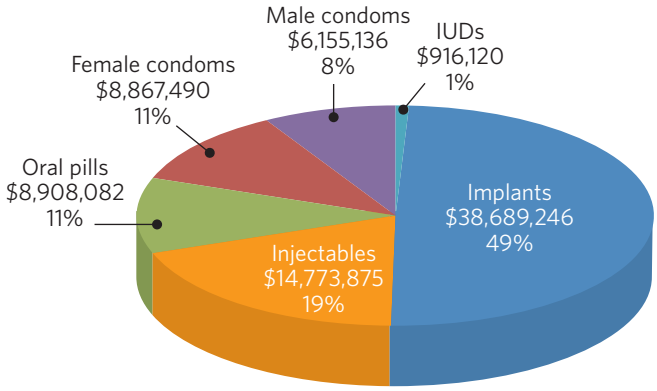
Each year UNFPA Country Office staff work with government counterparts, mostly in the Ministry of Health, and other partners to determine the type and quantities of supplies required. This establishes a measure of country need. Second, UNFPA Country Offices then submit the requests to GPRHCS for consideration. All submissions are received, analysed and validated. Once the validation process is complete, GPRHCS coordinates UNFPA's response to each request with other major donors. GPRHCS

Figure 16: CYP for contraceptives procured by GPRHCS, 2013 approvals



GPRHCS provided contraceptives worth 35 million CYP in 2013
Total 35,079,117 CYP

Figure 17: Expense by methods, GPRHCS approvals 2013



GPRHCS provided contraceptives valued at $78.5 million in 2013
Total $78,309,949

then works with UNFPA's Procurement Services Branch to place orders and ship commodities to the countries. Steps are taken to ensure requests are met in a timely manner and that shortfalls for RH commodities are averted. (See Annex for tables providing detailed information on units, CYP and cost for GPRHCS approvals.)

GPRHCS procured supplies worth 35 million couple years of protection in 2013. This has the potential to avert:

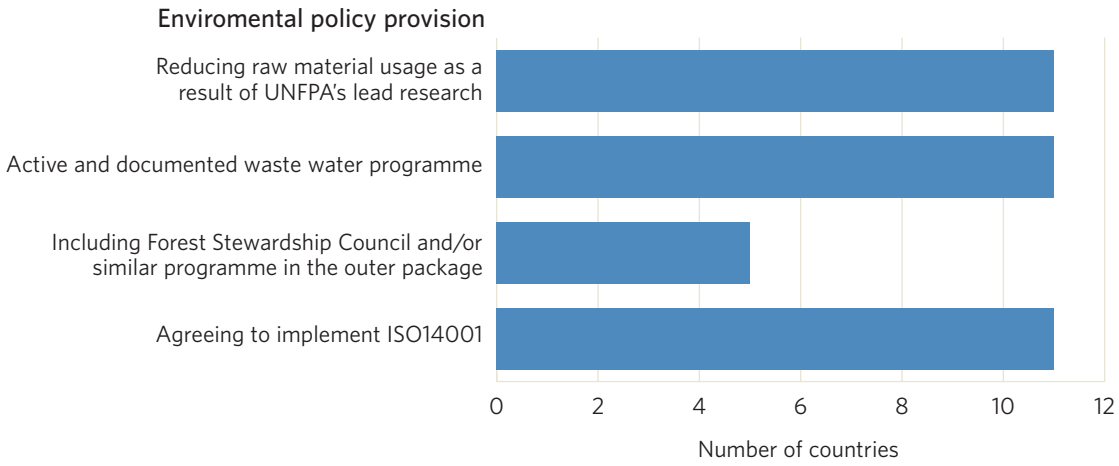
- 9.5 million unintended pregnancies
- 6.4 million unintended births
- 27,300 maternal deaths
- 1.1 million unsafe abortions

The impact was estimated using the Marie Stopes International, Impact Estimator 1.2; 2011.

3.8 "Green" procurement

UNFPA, through its Procurement Services Branch, works with suppliers to implement sound environmental impact provisions, including by ensuring that manufactures know about and conform to these provisions. UNFPA worked with 11 manufacturers in 2013 that have agreed to and are implementing ISO14001, which is the internationally recognized standard for the environmental management of businesses and prescribes controls for those activities that have an effect on the environment. The 11 manufacturers have active and documented waste water programmes and have agreed to reduce raw material usage.

Figure 18: Number of factories complying with UNFPA's environmental policy provision in 2013



OUTPUT 4

Improved access to quality reproductive health and family planning services

Dismantling the barriers to access to family planning information, services and supplies requires action on many fronts. For this purpose, UNFPA supports the efforts of government and other partners to strengthen youth-friendly services, enhance community-based services, and provide services in humanitarian settings. Also key are efforts to integrate sexual and reproductive health and family planning services, and institutionalize training to further sustain gains. We partner with NGOs, community-service organizations, faith-based organizations, youth groups and the private sector to improve populations' access to services. Several indicators measure progress towards Output 4: *Improved access to quality reproductive health/family planning services for poor and marginalized women and girls:*

- 26 of 46 countries too critical steps to integrate sexual and reproductive health and family planning services into their health services;
- 12 of the 46 countries are now implementing a broad range of interventions to reach young people, the poor, those in humanitarian situations, and other hard-to-reach communities.[9]

4.1 Youth-friendly services

In Haiti, seven youth centres were operational and accessed by more than 80,000 young people in 2013. Burundi increased the number of facilities offering youth-friendly services for reproductive health from four to 18 in 2013, benefiting 631,266 users. In Liberia, there were eight youth centres and five health facilities that provided youth-friendly services reaching 68,900 young people in 2013. Madagascar's activities for integrating family planning services improved access through 17 new youth-friendly centres by partnering with an NGO consortium and leading to 4,537 new users of family planning methods.

4.2 Community-based distribution

Community-based distribution of RH information, services and supplies played a key role in increasing access to family planning in many countries in 2013 – among these Burkina Faso, Central Africa Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Gambia, Guinea, Kenya, Lao PDR and Malawi and Mali. A special focus was placed on access for urban slums dwellers in Kenya, use of the Village Health Volunteers and committees in Lao PDR, advocacy in Malawi for long-acting and reversible contraceptives, outreach through satellite clinics and seasonal camps for voluntary sterilization in Nepal, and use of mobile clinics in Togo.

In Lesotho, outreach services were conducted in seven hard-to-reach areas in seven districts: 1,000 men and 1,740 women were reached with family planning and HIV services. In Rwanda, community-based provision of family planning by community health workers (CHW) was scaled up in two new districts, Nyamasheke and Ngororero, including training for 2,044 community health workers to offer family planning methods such as injectables, pills, condoms and CycleBeads in their respective communities. Community-based distribution increased in the Republic

9 Benin, Burkina Faso, Chad, Ethiopia, Haiti, Lesotho, Mali, Myanmar, Niger, Rwanda, Senegal and Uganda.

Mobile clinics aid community-based distribution in Togo.
Credit: UNFPA Togo

of Congo (Brazzaville) with 279 new agents trained in 2013 in collaboration with the Congolese Association for Family Planning, some 8,580 women reached through awareness-raising sessions, and family planning introduced into workplaces in the Sangha district. In Timor-Leste, UNFPA provided medical equipment to 45 family planning rooms in community health centres. In Madagascar, mobile outreach activities with SMS in nine priority regions contributed to 1,092 new users of IUDs and 3,935 new users of implants plus ligatures and vasectomies.

In Burkina Faso, nationwide community-based distribution covered almost all health districts and regions in 2013, with capacity development undertaken for 18 NGOs and 161 local associations – with 1,238 trainers and 7,008 agents in place, both groups 47 per cent female. Nearly 100,000 information, communication and education (IEC) activities were realized; 9,012 people referred for family planning services; and contraceptives distributed worth some 6,223 couple years of protection.

In Mozambique, the UNFPA Country Office supported community-based family planning in two provinces through AMODEFA (an IPPF affiliate) and with the collaboration of the Provincial Directorate of Health. The MOBIZ project was launched in 2013, using social marketing techniques and Movercado (an integrated platform developed by PSI). The project is focused on family planning for youth and behavioural change and builds on and integrates with the Geração Biz programme for Mozambican youth aged 10-24.[10]

10 The Geração Biz programme responds to the sexual and reproductive health needs of Mozambican youth aged 10–24 through activities developed with young people at schools and in communities, equipping youth with relevant information and skills, including education towards HIV prevention, life skills and access to clinical services.

RH supplies and delivery bicycles in Madagascar.
Credit UNFPA Madagascar

Liberia scaled up community-based distribution of family planning to 46 communities, reaching 64,098 beneficiaries in 2013. Market-based family planning services in 12 urban and four rural local markets continued through collaboration with IPPF.

In Lao PDR, training expanded the number of community-based distribution agents who visit individual families in hard-to-reach villages, each serving four to six villages. In Savannakhet Province, for example, 31 new community-based distribution agents received training and some 9,000 women used family planning services. Door-to-door service offering at least three methods increase villagers' confidence. In Nong District, oral contraceptive uptake increased from 40 per cent to 62 per cent from 2012 to 2013.

In Guinea, 2,000 community health workers were equipped with bicycles, clothing and equipment to supply integrated community-based family planning to 1,000

Mobile clinics bring family planning to villages in Liberia.
Credit: UNFPA Liberia

villages, while eight regional pharmacy inspectors were equipped with motorcycles for their monitoring of LMIS and product availability at service delivery points.

4.3 Humanitarian preparedness and response

Alongside other funding sources, UNFPA provides support through GPRHCS to those caught up in natural disasters, armed conflict or in other fragile contexts. Development of a guidance document on 'Post-Emergency Reproductive Health Commodity Security' was initiated in 2013, using the Syria crisis as case study. This guidance is designed to assist UNFPA Country Offices work with Ministries of Health to move the emphasis on from the provision of RH kits (the 'push' factor) to sustainable RH commodity management based on consumption and demand (the 'pull' factor). Methodologies and tools for forecasting demand, supply and use of RH kits in humanitarian and fragile contexts are under development. These will also support estimation of costs to meet the unmet need for RH commodities in these settings. This work began in 2013 and is scheduled for completion in 2014.

In 2013 training to increase the capacity of partners and UNFPA staff to deliver effectively in emergency settings was a major emphasis:

- 1,146 personnel participated in training courses in 24 GPRHCS countries[11] on implementation of the Minimum Initial Service Package (MISP) in humanitarian settings. Support provided included funding of participation, technical guidance, training materials, and RH kits for the trainees. Of these trainees, 54 per cent of these trainees received comprehensive MISP training; 29 per cent received RH coordinator training; and 10 per cent also received specific training in adolescent sexual and reproductive health.
- 916 people in 22 GPRHCS countries participated in training on management of programmes to reduce gender-based violence in emergency situations.[12]

The Norwegian Refugee Council (NRC) deployed 22 staff members to assist GPRHCS programme countries

Peer educators rehearse a drama providing family planning information at a UNFPA youth-friendly site in a camp for internally displaced persons in Juba, South Sudan.
Credit: UNFPA/Tim McKulka

in the 'acute' phase of an emergency, helping to address any bottle necks and establish a more reliable system for RH commodity distribution. Those deployed served as humanitarian coordinators in Central African Republic, Chad, Niger and Nigeria; logistics officers in Syria; and gender-based violence coordinators in Democratic Republic of Congo. This partnership will continue and expand in 2014 and the years ahead to complement UNFPA's own 'surge' capacity.

In South Sudan, a review process led to a list of 'do-able' action developed by the Ministry of Health and RHCS partners such as: establish a technical working group to monitor RHCS; develop a national rollout of misoprostol to prevent post-partum haemorrhage; institute an IEC/BCC campaign to increase acceptance of contraception; maintain delivery of RH commodities through the existing vertical system manage by UNFPA; and focus on provision of contraceptives for which there is demand. Also, in Sudan, GPRHCS supported the rehabilitation of training institutions and service delivery points for maternal health and family planning.

In Myanmar, six 'women-friendly spaces' were established in refugee camps. MISP training was accompanied by awareness training on maternal and child health for traditional birth attendants and midwives. Auxiliary midwife training included a six-month course for 40 participants at Buthidaung and Sittwe (Dapaing). Also, 83 health workers

11 Benin, CAR, Côte d'Ivoire, Djibouti, DRC, Ethiopia, Ghana, Haiti, Kenya, Madagascar, Mali, Mauritania, Myanmar, Mozambique, Nepal, Papua New Guinea, Rwanda, Sao Tome and Principe, Senegal, South Sudan, Sudan, Timor-Leste, Uganda and Yemen.

12 Bolivia, Burkina Faso, CAR, Chad, Congo, Côte d'Ivoire, DRC, Ethiopia, Guinea, Kenya, Madagascar, Mali, Mauritania, Myanmar, Nepal, Niger, South Sudan, Sudan, Yemen and Zimbabwe.

Refugee women receive UNFPA bags with supplies.
Credit: UNFPA Myanmar

and peer educators were trained to provide basic counselling services, organized by AFXB.

Responding to the 2012 floods in Nigeria, funds allocated by the United Nations Central Emergency Response Fund helped procure essential supplies such as emergency RH kits and dignity kits and support gender-responsive training in sexual and reproductive health.

4.4 Capacity development for regional institutions

At the regional level, we worked closely with organizations and institutions to intensify and expand their commitment to RHCS and family planning.

- 5 regional institutions received technical and financial support in 2013: two in Asia, two in Africa and the Inter-Governmental Authority on Development (IGAD);
- 6 regional training institutions[13] worked with UNFPA to provide training to 99 participants from governments and NGOs in Africa on RHCS, supply chain management, and international procurement;
- 4 of the 6 regional training institutions used curricula on integrated RHCS and family planning issues incorporated in their regular courses and programmes.

4.5 Institutionalizing training for family planning

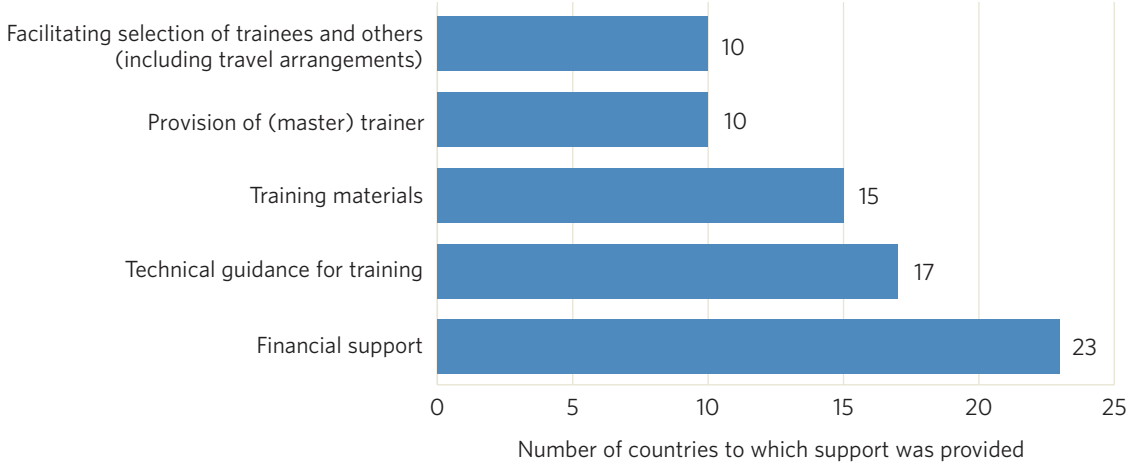
At the country level, GPRHCS supports the institutionalization of training activities for RH and family planning. The objective is to strengthen training institutions and work with other partners to ensure that skilled human resources are available at all levels to scale-up family planning interventions.

- 31 of 46 GPRHCS countries supported various aspects of training for family planning service provision: 90 per cent of training focused on provision of long-acting reversible methods.

Training also focused on family planning counselling and communication, how to provide youth-friendly services, and shaping policy and regulatory frameworks. Financial support was the main form of support provided by UNFPA through the GPRHCS for training, followed by the provision of technical guidance and making training materials available.

13 IHMR and RSMSC in Jaipur, India; Fuji National University, Suva; University of Papua New Guinea, Port Moresby; CEFOREP in Chad, Mali, Niger and Togo; and Mauritius Institute of Health.

Figure 19: Aspects of training for family planning supported



Students participate in a session at a youth-friendly centre in Lagos.
Credit: UNFPA-APA

BOX 5 'Hello Lagos' is a centre for young people

"There is a real risk to a life and a career in the event of sex before marriage," said teenager Grace Ndubuisi.

A sensitization initiative of the Lagos state government, Hello Lagos focuses on adolescent and youth sexual reproductive health. The youth-friendly centre offers solutions for young girls, many of whom die during abortion operations conducted by 'quack' doctors. The Hello Lagos centre is training health personnel to provide more youth-friendly services. It also handles rape cases and provides services such as e-counselling, school outreach programmes, capacity building, computer training, skill acquisition, talks and referral services where the need arises.

The 2008 Nigeria Demographic and Health Survey identified teenage pregnancy as a major health concern because of the high mortality ratio which stood at 822 per 100,000 live births. UNFPA will increase support to expand this kind of intervention in Lagos' densely populated commercial centres.

Ngozi Nwosu, 16, says Hello Lagos sensitized her to the dangers of early sex and prevents her from caving into the pressure from her partner.

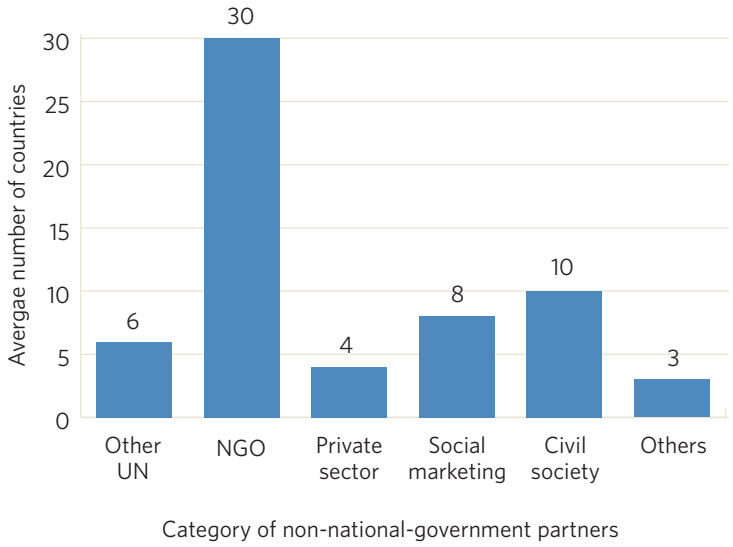
UNFPA supported the training of service providers in 33 GPRHCS implementing countries.

- 7,025 persons participated in training in 2013 for the provision of long-acting contraceptive methods to clients; of which 30 per cent were male and 70 per cent were female. Numbers trained ranged from 7 in Sao Tome and Principe to 962 service providers in Ethiopia.

The beneficiaries of the training interventions were nurses and midwives in Benin, Cameroon, Eritrea, Guinea, Guinea-Bissau, Liberia, Sierra Leone and Zambia; doctors, nurses, midwives in Bolivia, Myanmar, Niger and Nepal; community-based distributors in Côte d'Ivoire; public health students in Ethiopia; midwives, community midwives, nurses and tutors in Ghana. Most of this training was conducted in partnership with in-country NGOs.

Service providers received training in five counties of Liberia on long-acting reversible family planning methods and RH commodity management and reporting. In Lao PDR, capacity building strengthened health centre staff in quality family planning service provision, including through training on IUD insertion. Uganda engaged in large-scale training of service providers particularly in long-acting methods of contraception so as to keep pace with demand as availability of supplies increased. Training to improve the quality of family planning services in Nepal reached doctors, nurses and paramedics in remote districts, focusing on services for implants, IUDs, non-scalpel vasectomy and mini laparotomy for tubal litigation. In Timor-Leste, focal points from national institutions attended a regional workshop of quality of care in family planning; training was later conducted in 26 health facilities in 13 districts. In Bolivia, personnel from nine departments in the MOH participated in training that

Figure 20: Collaborating to scale up provision of family planning services, average number of countries, 2013



strengthened capacities in contraceptive technology for the introduction of the female condom, implants and other modern methods. In Congo DRC, 53 doctors, pharmacists, nurses and midwives received training in implant insertion and removal in Kinshasa and Bandundu provinces.

4.6 Working with NGOs and other partners

UNFPA also works with other UN agencies, NGOs, youth groups and other civil society organizations including faith-based organizations and with the private sector to strengthen their capacity to engage in the provision of RH/FP information and services in support of efforts to scale up family planning in various countries.

A family planning sign points to a market site in Liberia.
Credit: UNFPA-APA

BOX 6 Expanding access to family planning services in Liberia

"More people are becoming interested in family planning methods," says Juma Boakai, a site supervisor. "I don't want to bear a child now so family planning is my best option for a solution," says a client, Deborah Doe, 30, who uses contraceptive injectables.

A UNFPA-funded market project improves access and use of sexual and reproductive health services, including counselling, contraceptives and referrals. The project expanded from eight urban daily market sites in 2010 to 12 sites in 2012, all run by the Planned Parenthood Association of Liberia.

The market clinics have yield promising results. The number of family planning services provided increased from 45,663 in 2011 (12 months) to 103,075 in 2012-2013 (18 months). Young people, usually underserved in traditional service delivery points, represented 40 per cent of clients, of which 62 per cent were young women. Liberia has one of the highest rates of maternal mortality in Africa, along with high rates of adolescent pregnancy and unmet need for family planning.

"I have four children, two of whom are out of high school," says a male client, Roland Tuazama, who purchased condoms at the Waterside Market. "I don't want any more children now and condoms are the most effective means to be sure of this. They also leave me feeling protected from sexually transmissible diseases."

OUTPUT 5

Strengthened supply chain management

This output area focuses on country level interventions to improve demand forecasting and procurement, distribution, and monitoring of stock levels. Output 4 seeks *Strengthened capacity and systems for supply chain management.* Through the GPRHCS, UNFPA has supported governments to strengthen supply chain management systems through training of nationals in key areas including demand forecasting, procurement, warehouse improvement and stock/inventory management and reporting. Support has helped countries to adopt and operationalize health management information tools for stock monitoring. GPRHCS is currently strengthening and systemizing our approach to forecasting.

Key indicators are used to measure progress: availability of trained nationals for demand forecasting and procurement working in government institutions; absence of ad hoc requests for commodities; existence of a functional logistics management information system; and number of countries with unified systems for health supply chain management that includes RH commodities.

5.1 Forecasting and procurement

UNFPA, through the GPRHCS, worked at both country and global level to strengthen supply chain management; including demand forecasting and long-term procurement planning.

- 36 of the 46 GPRHCS implementing countries had in place a mechanism where the government is leading demand forecasting processes for contraceptives.
- In addition, 26 countries had trained national personnel in government institutions to lead and coordinate the demand forecasting process.

In-country procurement was led by the government in 22 out of 46 countries, and in 16 other countries, the government was a key participant in procurement planning for RH commodities. Trained national personnel were in place to lead and coordinate procurement in 16 of these countries.

UNFPA also liaised across countries for joint procurement planning, involving all in-country partners. The results of this work will be aggregated into a global data base that UNFPA's Procurement Services Branch is establishing.

Procurement is carried out jointly (between government and in-country partners) in 21 countries, but in 7 countries, although the partners jointly plan, the actual procurement is carried out separately:

- 13 of 46 countries have developed three to five year (medium term) forecasting plans which are updated and validated regularly;
- 18 countries jointly prepare annual forecasting;
- 32 countries did not make any ad hoc (i.e. unplanned) requests for RH commodities.

The 11 countries that did make ad hoc requests did so for various reasons, including underestimation of needs in Chad, Tanzania and Timor-Leste; an increase in demand for family planning service due to successful demand generation in Côte d'Ivoire and Lesotho; the consequence of ordering of sub-standard condoms in Ghana; lack of

Figure 21: Government leadership and existence of national personnel trained for demand forecasting for contraceptives, 2013

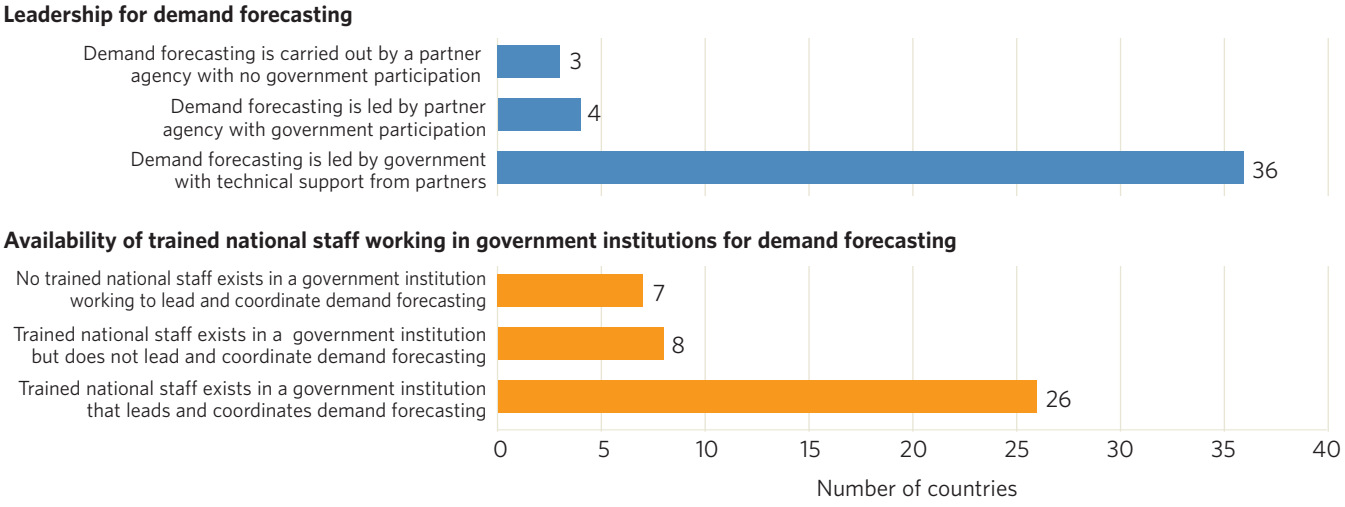


Figure 22: Government leadership and existence of national personnel trained for procurement of RH commodities, 2013

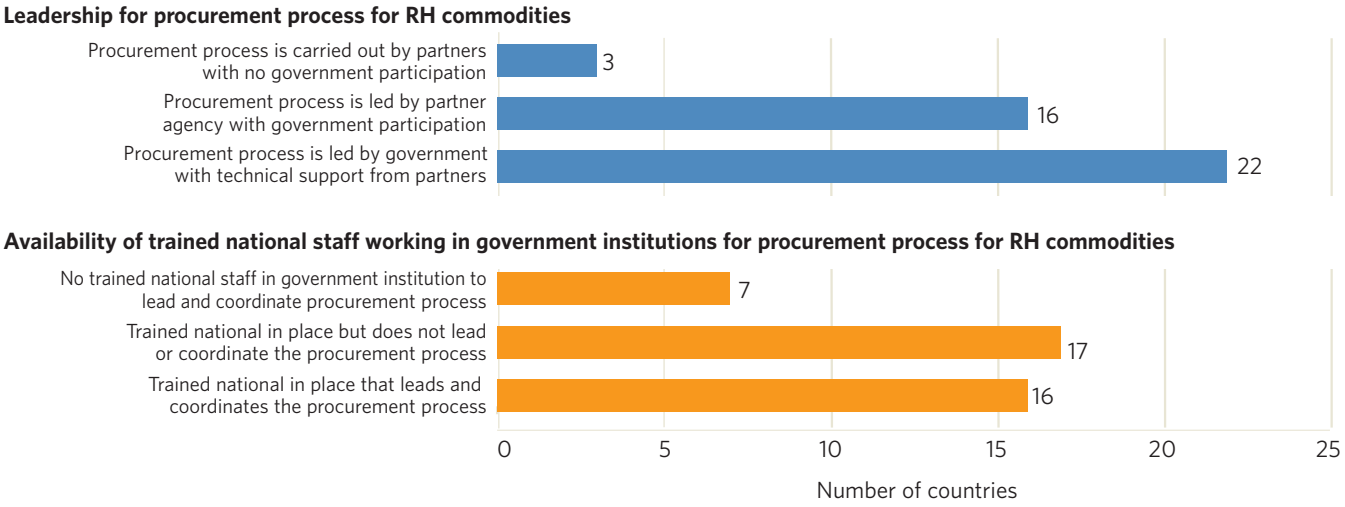
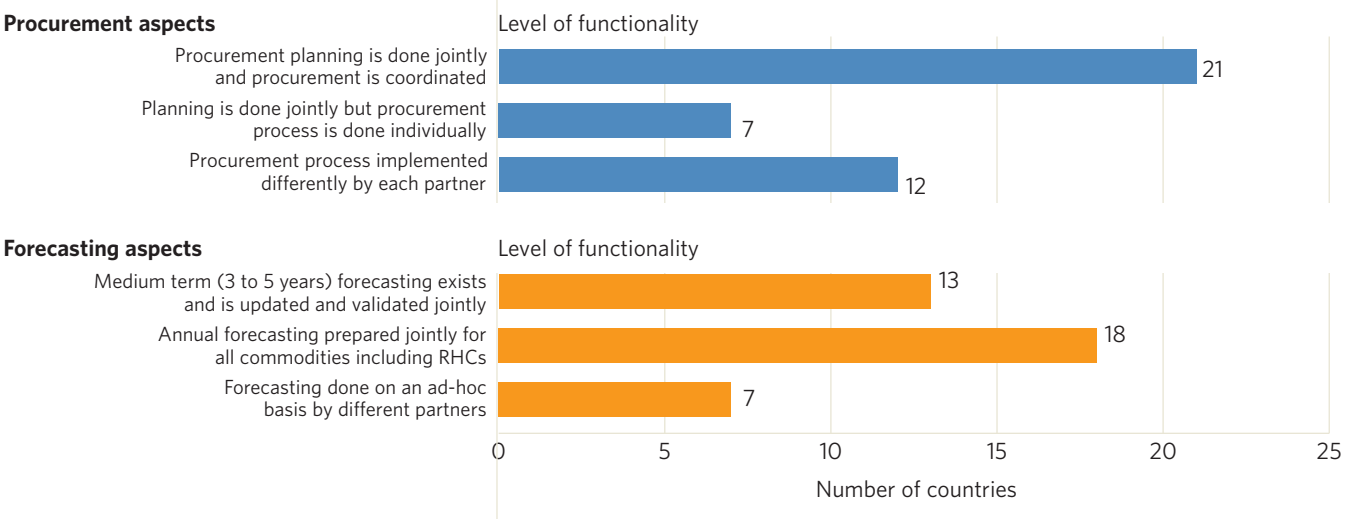


Figure 23: Functionality of procurement and forecasting systems



funds for procurement in Honduras; and delays in the procurement process in Gambia and Kenya. Steps taken to address these anomalies involved the government in 75 per cent of the cases. Such steps included UNFPA facilitating procurement and air freighting of commodities in Gambia; streamlining of procurement processes in Ghana; review of quantification process based on consumption from CMS data in Kenya; and development in Niger of a nationwide stock monitoring system by the Government and UNFPA, for which four teams were established in 2013.

5.2 Procurement capacity building

UNFPA, through the GPRHCS supported five institutions in two countries for different aspects of procurement capacity building. The institutions include Niger's *Ecole Superieur de Commerce et d'Administration des Entreprises* (ESCAE) and *Ecole National d'Administration et de la Magistrature* (ENAM); and in Sierra Leone, the Institute of Public Administration and Management (IPAM) Institute of Advanced Management and Technology (IAMTECH) and Fourah Bay College. In Niger, the intervention was focused on building sustainable procurement. The focus in Sierra Leone was on 'gap analyses with respect to enhancing understanding of current institutional deficiencies for procurement training.

In May 2013, the UNFPA Country Office in the Republic of Congo (Brazzaville) commissioned a GPRHCS Procurement Capacity Development workshop and included the neighbouring governments and UNFPA Country Offices of the Democratic Republic of Congo and Gabon. The purpose of the workshop was to expose the countries to 12 modules covering all procurement-related subjects ranging from quality, environmental and ethical issues, to practical and efficient tendering and contracting in the interest of achieving economies of scale. The group then recommended further training, implementation and development of the WHO Good Governance for Medicines Programme. Responding to this, UNFPA's Procurement Services Branch developed an online course in collaboration with WHO that is expected to be launched in 2014. (All online courses are also available on CD or USB.) Also in 2013, UNFPA provided funding through GPRHCS to People that Deliver (PtD), a global partnership initiative of 80 organizations that supports national workforce capacity for a sustainable health supply chain management. A similar workshop was organized for MOH staff in Congo DRC.

5.3 E-learning for procurement

UNFPA through the Procurement Services Branch provides multi-lingual e-Learning courses for interested individuals and is equipped to support governments, in any language, wishing to improve their capacity for procurement. The development of the 'Introduction to Procurement' e-learning module in 2012 was expanded to include a number of additional languages in 2013. The module has been published in seven languages, including Arabic, and Mongolian, too, which demonstrates that such modules can be provided in almost all languages at relatively low cost.

- In 2013, 110 individuals obtained certificates after passing the online course in procurement.

Three new modules were initiated in 2013 contributing to strengthening of 'bottom-up' as well as 'top-down' approaches. These are designed to interact with the learner and carry them forward from basic principles to more

Web pages from UNFPA's e-learning for procurement

complex ideas, all the way up to the governance level. The 'trilogy' consists of: Ethics in Procurement, Quality Assurance, and Good Governance for Medicines—WHO programme. WHO and UNFPA enjoyed successful collaboration developing this module together and all modules will be available through hyperlinks on the WHO website, reaching many more in need of this training.

5.4 Systems for stock monitoring (LMIS)

To support more efficient stock monitoring, UNFPA through the GPRHCS works to strengthen logistics management information systems (LMIS).

- 32 countries out of 46 (70 per cent) had a form of logistics management information system in place in 2013.

LMIS can generate distribution data for all modern contraceptives in 26 countries and for all MH medicines in 20 countries. The system can generate information on number of users per product (17 countries); monthly consumption data (29 countries); stock information for SDPs and warehouses (21 countries; and, expiry date for the products (26 countries).

Substantial support was given to the development of a computer database in Djibouti to track information about the continuum of care for woman and to support logistics management for RH commodities. Lao also conducted a workshop on RHCS action plans for target provinces and the central level, plus extra LMIS training in Savannakhet province. Nepal strengthened computerized supply management with training in all 75 health districts. Burkina Faso emphasized LMIS as a strategic plan priority and 2013 held a capacity development workshop with 45 pharmacists from 13 countries in West and Central Africa. In Niger, a monitoring system covering the eight regions and 42 health districts of Niger is to be operationalized with bi-annual monitoring missions carried out jointly by UNFPA and government and 'on-the-job-training' and the immediate resolution of observed problems. Four interdisciplinary teams were created in 2013 to conduct the monitoring. Indicators such as stock-out rates and use of CHANNEL and method choice have improved significantly since the exercise, which created teams for family planning with district managers.

5.5 Computerized management

In addition to having a functional LMIS in place, countries are supported to adopt and operationalize a system for stock-level monitoring for RH commodities.

- 37 of 46 (80 per cent) countries used some form of health supply chain management information tool for monitoring RH commodities (e.g. CHANNEL, PIPELINE, CCM, etc.).

The LMIS was used solely for RH commodities in 18 countries and for wider range of health commodities in 19 countries. In 26 countries the system was managed by the government compared with 8 countries where it was managed by a development partner. The systems in 28 countries were housed on stand-alone computers, compared with 6 countries where the system was web-based. In 32 of the 46 GPRHCS countries the system was used for decision making.

More than 1,200 health services providers in Tanzania received training in the national eLMIS (electronic LMIS)

Figure 24: Number of countries by distribution information generated from LMIS for RH commodities

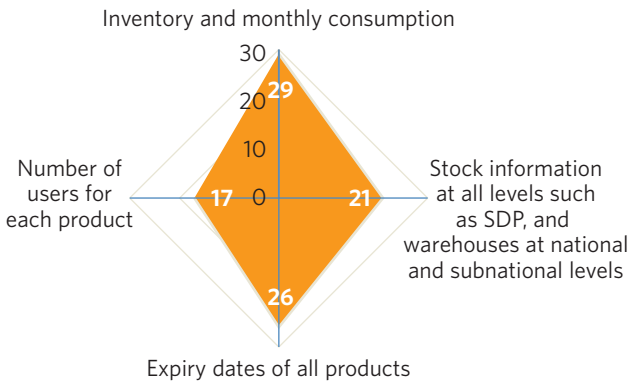
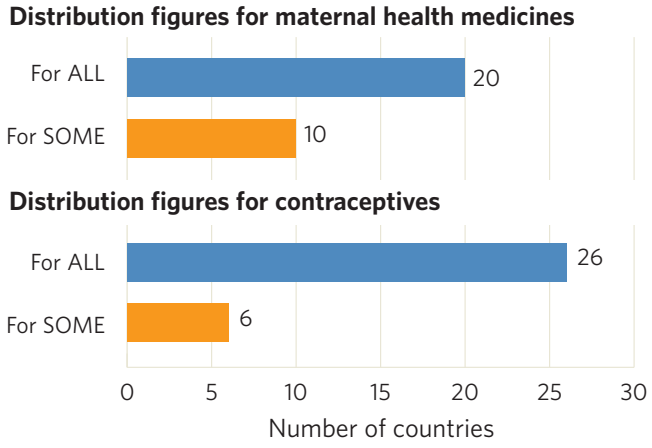


Figure 25: Additional information that can be generated from the LMIS



Improvements to warehouses, like this one in Sierra Leone, enhance the supply chain.

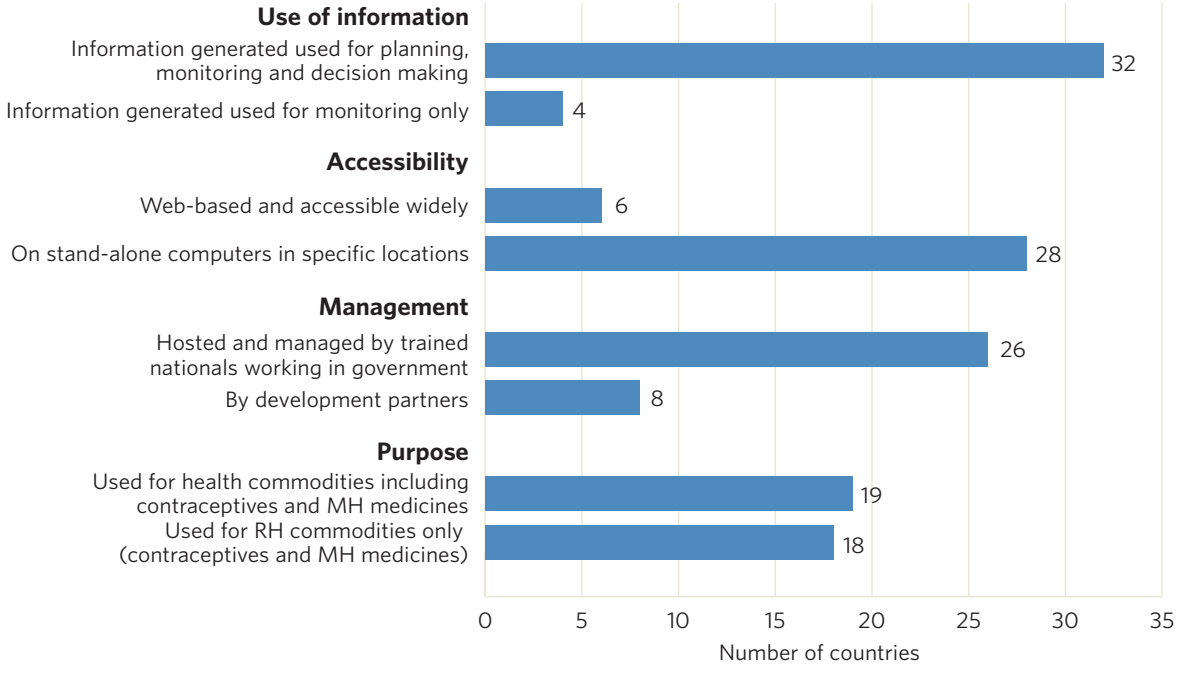
Credit: UNFPA Sierra Leone

system. Advocacy in Lesotho addressing the Ministry of Health led to an agreement enabling modification of CHANNEL software to be used in public health facilities to strengthen LMIS. In the Gambia, use of CHANNEL software to generate consumption data improved forecasting of RH commodities and prevented stock-outs; CHANNEL has been adopted by the Ministry of Health as the software of choice and has improved the LMIS and integrated the supply chain management. In Kenya, use of SMS for stock monitoring continued, through Pharm Access Africa Limited.

Warehouse maintenance often goes along with other improvements for a more functional supply system. Sierra Leone renovated a warehouse, Mauritania revamped two warehouses, and Nigeria completed renovation of its central warehouse. In Honduras, training workshops on good warehousing practices helped to protect the quality of contraceptives and other RH commodities. In Mozambique, where UNFPA is the main supplier of contraceptives, an information system for warehouse management and commodity tracking known as MACS was installed at the central warehouse and SIMAM was installed at 10 Provincial-level warehouses. In 2013, a matrix was distributed to guide quantification and requisition practices.

Malawi improved supply management at health facility level with LMIS training for 68 health surveillance assistants and 30 pharmacy technicians. Such training has increased data accuracy on reproductive health commodities from 60 to 90 per cent. Training in CHANNEL and ACCPAC software also continued. Training for LMIS in Ethiopia continued, and UNFPA co-chaired the quarterly Pharmaceutical Logistic Partners Meeting. Uzbekistan expanded computerized supply management (CLMIS) nationwide in 2013.

Figure 26: Features of the health supply chain management information tool for monitoring RH commodities



Members of a civil society organization monitor health supplies at Bumpe, Sierra Leone.
Credit: UNFPA Sierra Leone

BOX 7 Seeing results in Sierra Leone

High-level government support and innovative approaches are behind improvements in family planning and maternal health in Sierra Leone. For example, the UNFPA-supported Solar Suitcase project provides light to maternity wards and provides electricity essential to the cold chain, in particular for life-saving medicines such as oxytocin. In 2013 another 42 suitcases were delivered and installed, bringing the total to 60 suitcases in 13 health districts. Also, the ongoing monitoring of health supplies by a civil society group, the Health For All Coalition, continues to improve transparency and accountability and remove barriers at the port for contraceptives and life-saving maternal health commodities.

In 2013, the First Lady of Sierra Leone continued her support for RHCS and adolescent sexual and reproductive health. Achievements included engagement of traditional leaders in a teenage pregnancy strategy, development of a National Family Planning Manual for Service Providers, MOH standardization of a training curriculum in long-acting reversible contraceptives, training 730 traditional birth attendants and 40 male advocates through the Community Wellness Advocacy Groups in five new districts, establishment of a National Pharmaceutical Procurement Unit and Sierra Leone Procurement Network, and upgrading of CHANNEL software for computerized supply management. Availability and method choice improved from 2012 to 2013: service delivery points offering at least three modern methods of contraceptives increased from 88.9 to 96.5 per cent; those with 'no stock-outs' within the last six months improved from 41.1 to 47.7 per cent; and those with seven life-saving maternal health drugs available increased from 71.6 to 73.2 per cent.

MANAGEMENT OUTPUT

Improved programme coordination and management

The programme's implementation is assessed against management deliverables that focus on timely completion of tasks at country, regional and global levels. Such tasks pertain to data generation and use, resources mobilization, programme steering, human resources, programme review, monitoring, evaluation, reporting, and dissemination of information.

A Steering Committee was constituted in 2013 to support governance of and transparency in implementation of the GPRHCS. With its membership drawn from donors and other key global partners, this new forum, co-chaired by the UNFPA Executive Director, provides members with the opportunity to participate in programme review processes; support action to resolve bottlenecks; and provide technical and specialized knowledge support services.

UNFPA held an interdivisional working group meeting to discuss modalities for effective communication about and implementation of the programme across all levels of the organization – country, region and headquarters. (See table in Annex for more information.)

- 30 of 46 country work plans were approved on time for implementation;
- The average implementation rate for GPRHCS was 95 per cent;
- $64.5 million mobilized in 2013;
- An evaluability assessment study of the programme was initiated and planned for 2014.

Regional activities

Asia-Pacific Regional Office (APRO)

UNFPA's work on many fronts strengthened national systems for reproductive health commodity security in Asia and the Pacific. Highlights include development of national RHCS/FP strategies in Bangladesh, Bhutan and Nepal (ongoing); facilitation of national-level advocacy efforts to promote family planning in Papua New Guinea (national family planning conference); and development of a 'Position Paper on Family Planning' and an 'Action Plan on Expanding Contraceptive Choice for Familiy Planning' in Lao PDR. APRO conducted an assessment of regional institutions with potential for developing them as regional training centres for family planning and RHCS/supply chain management for countries in the region. APRO also contributed to the development of a framework for procurement of RH commodities developed jointly by UNFPA's Procurement Services Branch and Commodity Security Branch.

Enhanced national capacity for quality family planning services was accomplished through a regional workshop for senior programme managers on Improving the Quality of Care in Family Planning (including counselling skills) with support from WHO for selected countries in Southeast Asia. Other activities included a partnership with WHO to prepare country advocacy briefs on family planning; development of a concept paper on a new family planning-friendly health centre initiative; and a joint regional workshop on improving the quality of care in family planning. Other initiatives included monitoring of stock balances at the central warehouse levels in all countries of the region on a quarterly basis; the conduct of a regional review of the PPP on social marketing and social franchising experiences in countries of the region; and the assessment of the quality of care gaps from the perceptive of senior family planning programme managers from selected countries. Recommendations on these initiatives were shared with UNFPA Country Offices and partners.

Latin America and Caribbean Regional Office (LACRO)

UNFPA's Latin America and Caribbean Regional Office contributed to strengthening capacities of the ministries of

health in five countries (Ecuador, Honduras, Nicaragua, Panama and Uruguay) for development and management of LMIS. Other 2013 highlights included documentation of best practices in family planning and RHCS in eight countries. LACRO also supported the incorporation of quality of care protocols using evidence-based standards with evaluation and monitoring in five countries (Bolivia, El Salvador, Panama, Peru and Uruguay).

Inter-agency and regional partnerships were strengthened through four regional meetings with PAHO, IADB, USAID, World Bank, IPPF, RH Supplies Coalition and FOROLAC, including governmental participation.

East and Southern Africa Regional Office (ESARO)

Enhanced commitment to FP2020 was evident in 2013 in Burundi, Democratic Republic of Congo, Ethiopia, Rwanda, South Africa and Tanzania. Additional 'choices and costed' implementation plans for implants, integration and innovation using a Total Market Approach were developed this year. The ESARO Fast Track Initiatives targeted 15 more countries in the region for sustained, multi-year GPRHCS support. Condom Quality Assurance (standards) was addressed in the East, Southern and Horn of Africa. Leadership and partnerships were strengthened with IPPF and the Regional Economic Communities (RECs include EAC, SADC, IGAD and more). Youth-friendly health services were a focus, with an emphasis placed on contraceptives for youth, through collaboration with Packard and DFID (UK), including condom branding.

To strengthen institutional capacity, ESARO partnered with MIH and Empower School of Public Health to develop and teach a procurement course that included five East and Southern African countries. The course was titled 'Certificate Course in International Procurement and Supply Chain Management'. Support was provided by consultants trained in demand generation for RH services and family planning knowledge and experience sharing. The Regional RHCS thematic working group, led by the RECs, worked with the UNFPA Procurement Services Branch to conduct an assessment of laboratories for quality testing of RH commodities.

PSI Total Market Approach studies were completed for Botswana, Mali, Lesotho, South Africa, Swaziland and Uganda. This contributed to case studies that describe the market for male condoms in six African countries and the roles of the public, social marketing, and commercial sectors in those markets. Results from the case studies were presented to other countries of the region at a workshop in Johannesburg.

West and Central Africa (WCARO)

The West and Central Africa sub-region is seeing increased demand for family planning; a strengthened national supply chain; and enhanced public, private and civil society partnerships. CPR increases are noted in several countries.

Some $23.5 million was allocated for capacity development for RHCS and family planning in 2013. GPRHCS provided support to develop and implement national strategic plans for RHCS under government leadership and with stakeholders and partners. Regional priorities were identified in a process building political will and commitment. The key priority identified was the scale-up of community-based services for sexual and reproductive health using integrated approaches, both for service delivery and supply chain strengthening to reduce stock-outs. Demand generation activities continued to convey accurate information and attract new users of modern contraceptives, notably through innovative approaches such as the Bajenu Gokh (Senegal) and the Husbands' School (Niger, Côte d'Ivoire, Sierra Leone).

More than $30 million in RH commodities were procured through the GPRHCS in West and Central Africa. Improvements in contraceptive availability continued in 11 countries where Governments have adopted computerized supply management (CHANNEL software) at central, regional and district levels. A regional training workshop to modify CHANNEL for country needs gathered 43 participants from central warehouses, MoH and UNFPA Country Offices in 12 countries. Also, institutional support was provided to CEFOREP for family planning in Central African Republic, Chad, Niger and Togo to increase access to and availability of contraceptives. WCARO supported the development and validation of Sayana Press introduction plans in Burkina Faso, Niger and Senegal, among seven countries where the progestin-only injectable contraceptive is being introduced on a pilot basis.

Reproductive health is discussed at meetings of Husbands' Schools, like this one in the village of Bande, Niger.
Credit: UNFPA Niger.

Partnership and advocacy

UNFPA is a convenor and a leader in promoting secure and reliable supplies and services for family planning and maternal health. UNFPA supports and strengthens other organizations working in this area. For example, UNFPA has fostered relationships with IPPF, USAID and the World Bank to coordinate and collaborate at country level and global level to achieve results. UNFPA is moving from implementation or funding mode to a more strategic role with our longstanding partners in the field of RHCS such as JSI, MSI, PATH and PSI—managing stronger partnerships at many levels to work together towards common goals and visions. Our focus on expanding and enhancing partnerships includes those we already work with, those who work in family planning but may not have collaborated with UNFPA closely in the past, new non-traditional partners in family planning, and emerging partners in the private sector. Further, the role of UNFPA as a convenor and leader contributes to establishing an enabling environment that helps partners to do their good work. For example, advocacy efforts have contributed to stronger policies, strategies and laws; national allocations to procure contraceptives; and the establishment of national coordinating bodies.

GPRHCS benefited from partnerships with many organizations, fostering coordinated action and progress on reproductive health commodity security and family planning. Selected partnerships and advocacy activities are highlighted here for 2013.

UN Commission on Life-Saving Commodities for Women and Children—UNFPA took the lead on female condoms and co-chaired work on the three maternal health commodities (oxytocin, magnesium sulfate and misoprostol) and the cross-cutting recommendation on supply. At a meeting in November, Commission working groups were incorporated within existing groups such as FP2020 and the RH Supplies Coalition.

From 2012 through 2013, the Commission's role shifted to a focus on implementation. The Commission issued its final report in September 2012 with 10 recommendations, the implementation of which won support from Norway. Working groups and technical reference groups formed. Nigerian President Goodluck Jonathan (co-chair of the Commission with the Executive Director of UNFPA) hosted an international meeting at which the Abuja Declaration was signed, with countries committing to the development of commodity-focused plans (the eight pathfinder countries). During 2013, the scope of work quickly extended beyond the Commission's 10 recommendations to encompass the work of the H4+. This shift broadened the Commission's mechanisms into structures and process for reproductive, maternal, newborn and child health (RMNCH).

RMNCH Steering Committee and Trust Fund—Initially, the 10 recommendations of the UN Commission on Life-Saving Commodities shaped the main focus of this mechanism. In 2013, UNFPA participated in the establishment of the RMNCH Steering Committee, which has evolved into a broad platform of RMNCH-related partnerships and initiatives. Among other activities, UNFPA provided support to the eight pathfinder countries for RMNCH including through supporting harmonizing activities across the H4+ agencies and with GPRHCS. UNFPA supported the RMNCH Strategy Coordination Team, hosted by UNICEF in New York, by providing one financial and one technical position. To assist in managing contributions, the RMNCH Trust Fund was established at UNFPA. It operates as a pass-through mechanism for funds (at 1 per cent overhead) to UN agencies.

USAID—In July 2013, the UNFPA Executive Director and the USAID Administrator issued a letter to their respective staff announcing their commitment to strengthen collaboration between the two organizations, with particular focus on the work on family planning. This announcement resulted in the establishment of thematic groups which will ensure regular collaboration on key strategic areas of work. Specific actions to further strengthen collaboration in the field were identified and are being implemented.

Partnerships for family planning

At the global level, UNFPA continued to play a lead role in family planning convening partnerships and mobilizing countries to accelerate fulfilment of commitments on family planning.

FP2020—UNFPA remains strongly engaged in the Family Planning 2020 platform at all organizational levels: UNFPA's Executive Director is co-chair of the FP2020 Reference Group; UNFPA is co-leading, together with USAID, the Country Engagement Working Group, which is central to the FP2020 architecture; UNFPA representation is also ensured in the other FP2020 Working Groups, and UNFPA Country Representatives are serving as FP2020 donor focal points in countries (along with heads of other organizations). The Country Engagement Working Group has been particularly pivotal in ensuring that countries could be fully supported through the provision of financial and technical assistance. Work conducted through the FP2020 platform fully leverages and complements the work conducted through the GPRHCS. In collaboration with partners at country level, UNFPA supported governments to make commitments and develop national family planning plans. In November 2013, five countries made new commitments to FP2020, bringing the total of country pledges up to 29. The governments of Benin, the Democratic Republic of Congo, Guinea, Mauritania and Myanmar announced major new national family planning commitments.

Ministerial Forum—UNFPA in collaboration with Women Deliver organized a Ministerial Forum in May 2013 to review the progress on family planning, and to build consensus among countries on global priorities to improve access to family planning, especially for most disadvantaged population. Ministerial officials and youth delegates from 16 developing countries and representatives of development organizations attended the meeting. Most of the successes shared by national delegates were initiated and scaled up with support from GPRHCS. For example, the task shifting initiative in Ethiopia was supported by GPRHCS to extend provision of implants through the Health Extension Workers, and Niger's successful programme on men's engagement, Husbands' School, was scaled up with support from GPRHCS. The Forum concluded with a call to action that emphasized acceptability, accessibility, affordability and quality of contraceptive services and information, especially for young girls.

2013 International Conference on Family Planning (ICFP)—This Conference in Addis Ababa celebrated successes that were achieved in family planning around the world, shared recent evidence on effective programmes and discussed issues that still need to be addressed. The ICFP provided a platform to build momentum and generate new commitments to the family planning agenda. UNFPA participated in preparations at global, regional

The Bill & Melinda Gates Foundation—A project on family planning and advocacy in 18 countries was funded through a grant to UNFPA by the Bill & Melinda Gates Foundation. The project, which built on GPRHCS, was successfully completed in 2013. UNFPA secured four additional grants, which also complement and build on GPRHCS: two grants are for the procurement of a new injectable contraceptive, Sayana Press, in Burkina Faso, Niger, Senegal and Uganda; one grant is for the provision of capacity building in support of the Sayana Press introduction in Burkina Faso and Niger; and one grant is for strengthening supply chain management of contraceptives which includes in-country work in Burkina Faso, Cameroon, Niger and Togo as well as harmonization of procurement practices.

IPPF—At the Women Deliver conference held in Kuala Lumpur 2013, UNFPA and IPPF launched a joint initiative in nine countries to provide technical support and quality assurance and address family planning needs of adolescents, especially vulnerable adolescents. The initiative's objective is to strengthen advocacy efforts to increase political and financial commitments for family planning and for improving access to sexual and reproductive health services and reproductive rights for vulnerable adolescents and youth in Bolivia, Burkina Faso, Côte d'Ivoire, DRC, Ethiopia, Kenya, Liberia, Nigeria and South Sudan. Joint annual work plans have been developed and are being implemented, with agreements to expand to 13 countries.

and country levels to ensure that government commitments to rights-based family planning are strengthened, best practices are shared by countries, and key messages are delivered by national delegations, youth activists and the UNFPA team.

At the Lumumba Health Centre in Kisumu, Kenya, a young couple chooses a family planning method to space births.
Credit: UNFPA/Erick-Christian Ahounou

High-level ministerial meeting on youth— During the ICFP, UNFPA supported a high-level ministerial meeting on the theme of 'The Youth Dividend – Return on Investment in Family Planning'. The meeting brought together about 35 policymakers, including Ministers of Finance and Planning, Health, and Youth; members of parliament and experts from sub-Saharan Africa. Many strategies to increase access of young people to contraceptive services presented and discussed by the countries were based on experiences built through GPRHCS-supported country programmes. These strategies included boys and men engagement (Husbands' School); mobile services for youth (Burkina Faso), active engagement of faith-based organizations and religious leaders in family planning (Kenya), and advocacy for policies supportive for access of youth to contraceptives (Côte d'Ivoire and Nigeria).

Good practices—To capture good practices in family planning, GPRHCS also supported numerous countries to document their successes in 2013. A brochure on good practices was published with stories from Burkina Faso, Côte d'Ivoire, Ecuador, Ethiopia, Haiti, Kenya, Lao PDR, Mozambique, Niger, Philippines, Sierra Leone and South Sudan.

Operational guide for *Choices Not Chance*—GPRHCS is a key vehicle for the roll out of the UNFPA family planning strategy *Choices Not Chance*. In order to support countries to scale up family planning practices and ensure human rights integration in family planning services provision, GPRHCS supported development of an operational guide 'Ten Steps' and a technical guide on human rights in family planning. Both tools will be disseminated in 2014.

PSI—UNFPA entered into a formal partnership with PSI to conduct studies on Total Market Approach for male condoms. In 2013, six innovative country studies were developed as a result this collaboration and a global consultation took place with a view to strengthen collaboration on how to best leverage the Total Market Approach to improve equity and sustainability of family planning efforts, targeting underserved and marginalized. The case studies illustrate the universe of need for condoms, levels of use, socioeconomic equity among users, and the market presence of condoms for reproductive health and HIV prevention.

JSI—UNFPA partnered with JSI to 'reach the last mile' at community level with contraceptives and maternal and newborn life-saving medicines in areas with high maternal mortality such as in Northern Nigeria. The experience, initially limited to Sokoto and Bauchi States, is to be scaled up to five more States in Northern Nigeria. A global MOU was signed with JSI for country support in capacity development and system strengthening, including for supply chain management, research and training.

MSI—MSI is an implementing partner in many countries relied on to provide family planning services to young people and hard-to-reach populations, as in refugee camps in Sudan in 2013. A more comprehensive MOU is being developed as of early 2014.

Coordinated Assistance for Reproductive health supplies (CARhs)—This group offers a key supply partnership to avert stock-outs.

- To alleviate and avert shortages in five countries, the CARhs group coordinated pending orders and existing stock and UNFPA allocated 2 million units of Depo Provera following cooperation with USAID, USAID Deliver and Pfizer.
- 227 requests for assistance were addressed by CARhs in 2013, of which 194 (85 per cent) were assigned outcomes.
- 128 requests for information and requests for action on 66 issues were processed, with 69 per cent of the issues resolved within two months. However, some requests took up to six or nine months for CARhs to resolve, as in the 2013 example of Ethiopia's request to purchase emergency contraceptives.

The group also added new members from the Implants Access Initiative at John Snow Inc., and in June finalized its new PPMR Data Access Policy.

High-level forum on accelerating MDG 5—UNFPA and the UN Special Envoy for Financing the Health MDGs organized a high level forum on improving maternal health, MDG 5, during the UN General Assembly in September 2013. The forum focused on the need to rapidly scale up access to reproductive health commodities, in particular those identified by the UN Commission on Life-Saving Commodities for Women and Children, to support effective RH interventions. Participants included donors, partner agencies and leaders from countries with high maternal mortality ratios. Globally, 10 countries account for more than 60 per cent of maternal deaths, the 'high-burden' countries. South Asia and sub-Saharan Africa account for almost 90 per cent of the burden. Four preventable and treatable conditions cause 70 per cent of maternal deaths. Several ways of making MDG 5 a reality were proposed at the meeting, including the introduction of new products (contraceptive implants, misoprostol) and new product formulations; new delivery methods (e.g. task-shifting, Community Health Workers); cash transfers and results-based financing that addresses financial barriers to reproductive and maternal health services; and new ways of tracking progress (e.g. SMS stock-outs reporting).

UNFPA's Executive Director underscored that progress towards MDG 5 falls short of the agreed targets and called for accelerated actions to reduce maternal mortality by 75 per cent by the year 2015. This 'last mile' scale-up effort should further inform the post-2015 development agenda and sexual and reproductive health in particular. UNFPA estimated that the total cost for the RH commodities required for the scale-up would come to $650 million for 2014-2015.

- To reach MDG 5 we need to prevent 120,000 maternal deaths, including 18,000 deaths among girls 15-19 years old.

Panellists, including UN Secretary-General Ban Ki-moon; the UN Secretary-General's Special Envoy for Financing the Health MDGs and for Malaria, Ray Chambers; and Ministers of Health from Ethiopia, India and Nigeria discussed key lessons learned and success stories. Following the event, UNFPA committed to work with high-burden countries and develop costed MDG 5 scale-up plans, suited to their specific contexts and building on lessons learned and innovations from other parts of the world. UNFPA will organize follow-up meetings and discussions with these countries.

New 'demographic dividend' project relies on RH commodities—A new regional initiative by the World Bank Group and UNFPA is set to improve maternal and reproductive health and address issues related to adolescent girls in the Sahel. The launch in November was attended by leaders from five international organizations—the United Nations, World Bank, African Union, African Development Bank and European Union. The World Bank's $200 million Sahel Women's Empowerment and Demographics Project—which builds on its existing $150 million in commitments over the next two years for maternal and child health in the region—will improve the availability and affordability of reproductive health commodities, strengthen specialized training centres for rural-based midwifery and nursing services, and pilot and share knowledge on adolescent girls' initiatives. Of the Bank's new funding, $100 million has been committed to UNFPA, which will help to create the preconditions for a demographic dividend by addressing fertility levels, population growth, gender equality and access to reproductive health commodities and services.

Advocacy and information: the CONDOMIZE! campaign

When used correctly and consistently, condoms prevent over 90 per cent of HIV, STIs and unintended pregnancy. The CONDOMIZE! Campaign is a joint initiative of UNFPA and The Condom Project (TCP), an American NGO. This dynamic, energetic and colourful set of global and national condom awareness campaigns gained tremendous visibility in 2012 and 2013. It benefited from the involvement of Michel Sidibe, Executive Director of UNAIDS and Dr. Babatunde Osotimehin, Executive Director of UNFPA. It was profiled in international media including *The New York Times, The Times*, CNN and BBC. Governments have requested a focus on young people, recognizing a lack of information and services to protect their health.

In 2013, highlights included events around the International Conference on AIDS and STIs in Africa (ICASA) and country campaigns in Malawi and Zambia, among many other activities. In Zambia, the First Lady and Ministry representatives expressed strong support for the campaign, wearing condom pins, speaking on the topic, and attending activities—as did the UNAIDS Country Coordinator, UNFPA Representative and many other dignitaries. In Malawi, representatives from the Ministries of Health and of Youth, National AIDS Council (NAC) and National Youth Council joined the UNFPA Country Office throughout the campaign.

An example from Malawi

The two-week CONDOMIZE campaign in Malawi reached 12,000 students (65 per cent male and 35 per cent female) and distributed 93,600 male condoms and 6,000 female condoms. The effort supported de-stigmatization of condoms among adolescents and young people.

Media training for 15 radio stations, newspapers and social media websites covered culturally relevant issues related to sexuality, condom use, and resistance to condom promotion in Malawi, which reports the highest rate of teen pregnancy in Africa. Journalists filed numerous stories. Training for health service providers described how to implement a CONDOMIZE! campaign, and introduced available products, condom education, and techniques for de-stigmatization and negotiation. Participants included 60 community health workers and 30 members of organizations serving young people, sex workers and people living with HIV. Training for entertainers resulted in 30 artists developing messaging on myths, misconceptions and misperceptions about condom use, then integrating them into the performances and songs of the campaign. 2,500 university students in Blantyre, where HIV rates are high, participated in condom education and distributed colourful promotional T-shirts, condoms, lubricants, sunglasses, art pins and temporary tattoos. Mobile clinics staffed for HIV counselling and testing were provided by the National AIDS Council.

Youth in Malawi provide condom information.
Credit: Condomize!

HIV in Africa conference events

Some 10,000 participants attended the ICASA from 7 to 11 December 2013 in Cape Town, South Africa. Prior to the event, a three-week pre-conference community programme in the city and surrounding townships focused on the skill-building of representatives from local and regional HIV/AIDS service organizations, youth, sex workers, service providers and individuals infected, affected and at-risk of HIV. 'All about Condoms' workshops were held for clinic service providers and staff serving a population of 580,000 in the Mitchell's Plain Health District. The campaign even joined a circus in Khayelitsha Township. ICASA highlights included:

- 2 million condoms distributed in 100 hours in Cape Town and its townships;
- Distribution of 5,000 T-shirts and 7,000 pairs of sunglasses branded CONDOMIZE!
- Distribution of pictograms with videos and animations on condom use;
- Delivery of the first-ever plenary session on condoms at ICASA, presented by the UNFPA Senior Adviser;
- South-South cooperation facilitated by bringing Zambian trainers to ICASA in South Africa, now leaders of CONDOMIZE! Zambia.

UNFPA-provided health supplies are stacked in the warehouse at Juba Teaching Hospital.

Photo: UNFPA South Sudan/Tim McKulka

Finance and resources

The 2013 implementation rate of 95 per cent was the programme's best performance to date. Not only were resources available effectively deployed, but they were also efficiently spent, ensuring that more could be achieved with the same amount of support.

Funds available

The cash balance at the beginning of 2013 was $164,110,188. It was made up of $109.4 million in donor contributions received in December 2012, $13.2 million committed in firm and binding purchase orders (but not yet recorded as an expense) and $41.5 million non-allocated funds.[14]

Total income was **$65,399,041**. This includes cash contributions received in 2013 plus accrued interest this year.[15] It should be noted that $44,836,956 was received in December 2013 to be used in 2014.

Total cash available for the year was **$229,509,229** or $184,672,273 if the December contribution of $44,836,956 is excluded.

Total expenses and payments for the year were **$164,105,765.** This is a 27 per cent increase in disbursements as compared with 2012 and gives an end-year balance of $65,403,465, or $20,566,509 if the December contribution is excluded. Of the remaining balance, $11,525,566 had been committed via firm and binding purchase orders that will only be recorded as expense in early 2014, when the goods have been paid and handed over to the implementing partners. Thus, when excluding the $44,836,956 December contribution, only $9,040,943 was not-allocated by the end of the year. This results in an implementation rate of **95 per cent**—the highest in the GPRHCS history. In practical terms, it is difficult to aim for a higher implementation rate. Unspent funds which have been allocated for programme activities or commodity procurement are generally returned to the budget only late in the year, making it difficult for them to be reprogrammed within the same calendar year. Having some funds in reserve also allows for immediate action in case of major humanitarian crises.

14 The main reasons for the unallocated resources at year-end 2012 have to do with a shortage in supply of the injectible contraceptive, Depo Provera. Also, unused resources allocated for programme or procurement activities were returned to the budget shortly before year-end, which was too late for them to be reprogrammed.

15 Total contributions revenue was $115,759,978 but the payments collected within 2013 plus accrued interest added up to $65,399,041.

Table 5: Cash flow summary, 2013 (in US$)

Beginning cash balance as of 1 January 2013	164,110,188
Contributions	64,523,250
Interest	875,791
Total cash available for the year	229,509,229
Total expenses and payments*	164,105,765
End balance	**65,403,465**
End balance, excluding December donor contribution of $45 million**	20,566,509
Committed in Purchase Orders (POs)***	11,525,566
Non-allocated by the end of 2013	9,040,943

* Including all activities and commodities which have been finalized, paid and handed over to the implementing partner as well as fluctuations in inventory (goods in transit/stock), Property Plant and Equipment (PPE), i.e. assets and Operating Funds Accounts Balance (OFA). In the certified financial statement "total expenses" are $154,871,869 whereas here $164,105,765 is from a more inclusive cash flow analysis with the listed items.

** $45 million in contributions were received in December 2013 but intended for the 2014 programme.

*** Purchase Orders (POs) are firm and binding orders. According to International Public Sector Accounting Standards they are not considered an expense until UNFPA has taken ownership of the goods.

Use of funds: breakdown by region

In 2013, GPRHCS provided financial and technical support to 46 focus countries, with some additional ad hoc support provided on request to other countries, including humanitarian situations and regional clusters. In line with past trends, 72 per cent of the total expenses of $164 million were spent

Table 6: Expenses by region and per support type, commodity and capacity building (in US$)

Region	Commodity	Capacity building*	Total	Percentage
Arab States	3,135,784	1,061,284	4,197,067	3%
Asia and the Pacific	4,366,339	1,501,339	5,867,677	4%
Eastern Europe and Central Asia	2,056,863	916,595	2,973,458	2%
East and Southern Africa	50,569,325	12,910,690	63,480,318	39%
GPRHCS headquarters	3,119,527	10,789,423	13,908,949	8%
Latin America and the Caribbean	7,230,132	5,179,044	12,409,176	8%
NGO headquarters	7,695,432	-	7,695,432	5%
West and Central Africa	30,079,401	23,494,286	53,573,688	33%
Total	**108,252,802**	**55,852,660**	**164,105,765**	**100%**

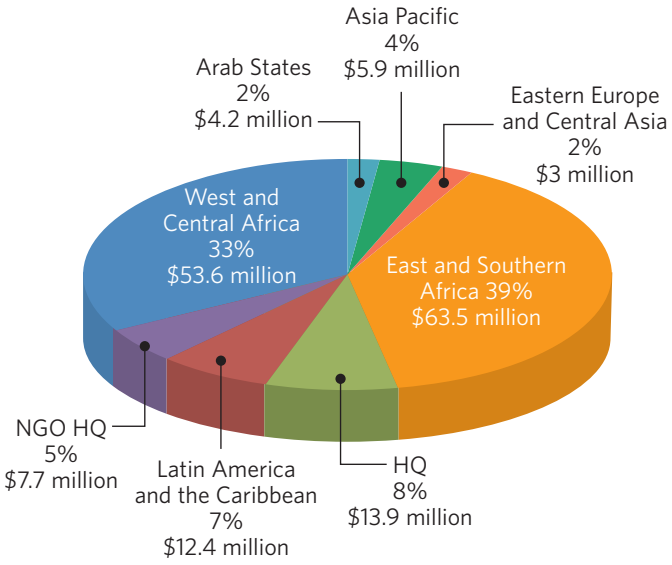
* (including human resources)

in Africa, with East and Southern Africa receiving 39 per cent of the funding, and West and Central Africa receiving 33 per cent. Headquarters expenses accounted for 13 per cent of the total, though more than one third of these HQ funds were used to support NGOs.

Use of funds: Commodities vs. capacity building

Support for commodity procurement of $108,252,803 accounted for 66 per cent of GPRHCS expenses. Support for capacity development of $55,852,962 accounted for 34 per cent. This is the same as in 2012. The split is in line with country needs as estimated in the GPRHCS Programme Monitoring Framework 2013-2020.

Figure 27: Expenses by region, percentage in US$ million



A wide range of reproductive health supplies is procured each year. In 2013, the largest expense was for implants followed by male and female condoms, used for both family planning and HIV prevention. Of the total $108 million for RH commodities procured, contraceptives and condoms accounted for $78.5 million and essential medicines, medical equipment, transport and testing services and other expenses accounted for the remainder.

Figure 28 shows the historical trend of the breakdown between capacity building and commodities. In both 2012 and 2013, 66 per cent of GPRHCS funding was spent on commodities. This is in line with proposals made during development of the 2013-2020 programme framework for 60 per cent of resources to be allocated to commodities.

Breakdown by outputs and interventions

The majority of the resources were spent on GPRHCS Output 3, reflecting the programme's large commodity procurement component. Expenses are otherwise spread fairly

Table 7: Commodity procurement compared with capacity building

Type of expense	US$	Percentage
Commodities	108,252,803	66%
Capacity building (incl. HR)*	55,852,962	34%
Total	**164,105,765**	**100%**

* HR (human resources) costs constitute $7.3 million of capacity building activities. Approximately 90 per cent of HR costs are estimated to be programmatic in nature (Programme/Technical/Supply) and 10 per cent are for administrative and finance positions.

Table 8: Breakdown by interventions, GPRHCS 2013 total expense

Interventions	Expense ($)	Expense (per cent of output total)
Output 1 - Improved enabling environment		
Policy and strategy	7,549,378	72%
Country-level coordination and partnership	1,504,104	14%
Product availability	1,475,695	14%
	10,527,880	**100%**
Output 2 - Increased demand for RHCS		
Demand generation for family planning	9,261,149	90%
Advocacy	973,137	10%
	10,234,286	**100%**
Output 3 - Improved efficiency for procurement (including RH commodities)		
Quantity and mix	108,252,803	94%
Quality of products	4,922,227	4%
Procurement efficiency	1,484,371	1%
	114,659,401	**100%**
Output 4 - Improved access to quality RH/FP services		
Capacity building	9,300,776	87%
Integration	1,338,306	13%
	10,639,082	**100%**
Output 5 - Strengthened supply chain management		
Stock monitoring	3,175,440	54%
Quality of products	2,669,492	46%
	5,844,932	**100%**
Management Output - Improved programme coordination and management		
Human resources	7,318,835	60%
Programme monitoring and evaluation	2,290,624	19%
Capacity building and data generation	1,789,894	15%
Meetings	377,685	3%
Programme review	360,630	3%
Programme steering	61,219	1%
	12,198,458	**100%**
GPRHCS TOTAL	**164,105,765**	

equally between the other outputs with Output 1 at $10.5 million, Output 2 at $10.2 million, Output 4 at $10.6 million and the Management Output at $12.2 million. Only 4 per cent was spent on Output 5 at $5.8 million.

An analysis of the interventions carried out under each output is presented above. The analysis is based on data from 21 representative countries as well as all procurement data for the entire programme.

Disbursement of funds throughout the year

Funds were promptly disbursed: 91 per cent of all funds were committed during the two first quarters of the year. Sixty per cent of the funds for commodity procurement were committed by the first quarter; by the end of the second quarter, 93 per cent of the funds for commodities had been allocated. The same pattern can be seen for capacity

Figure 28: Trend in commodities versus capacity building expenses, GPRHCS total expense, 2007–2013

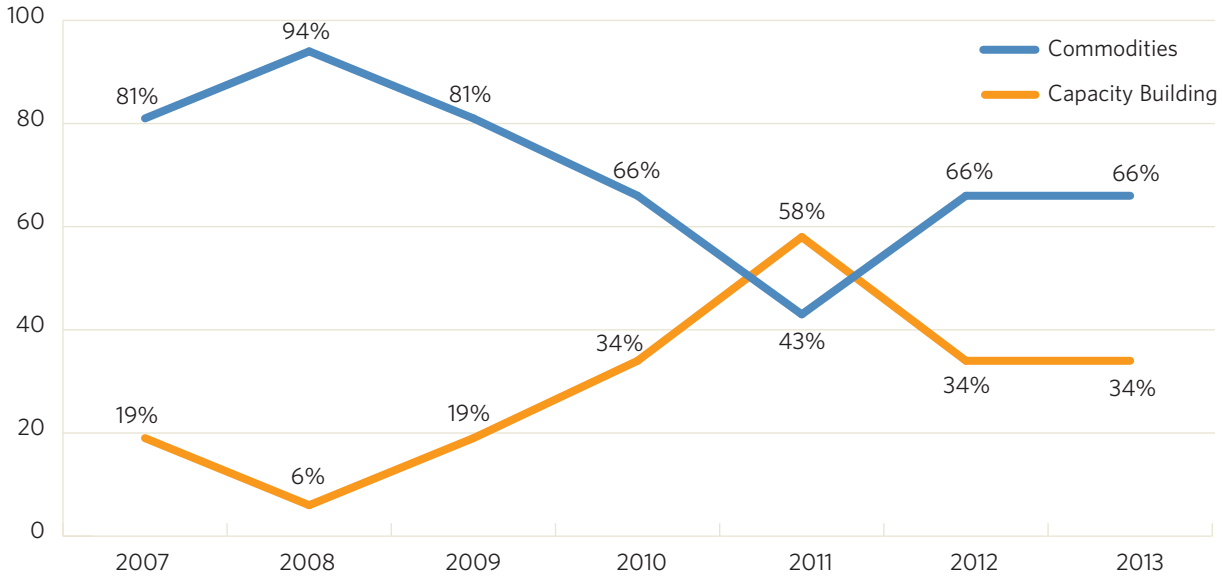
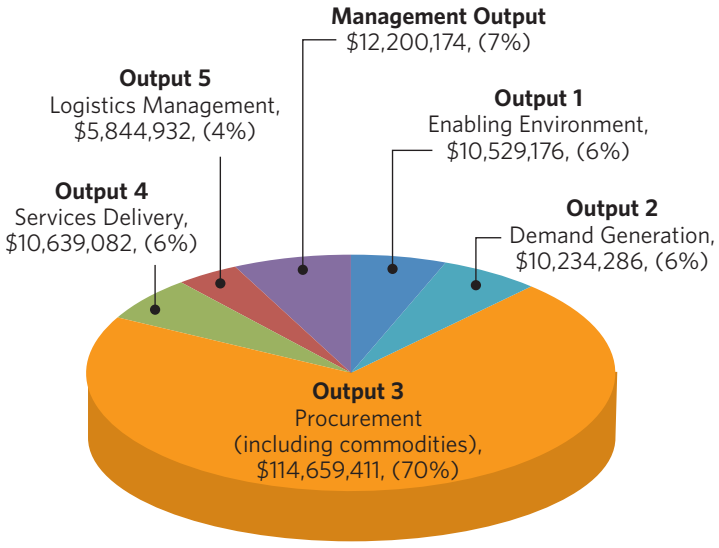


Figure 29: Breakdown by output, GPRHCS 2013 total expense



building activities, with 21 per cent of total capacity building funds disbursed to the country offices in January 2013. An additional 66 per cent of capacity building support was committed by the second quarter. The remaining 13 per cent of capacity building resources were committed in the third and fourth quarter.

The total sum of commitments exceeds the actual amount of expenses by approximately 10 per cent. The reason is that when an order for commodities is placed, the funds will be committed in the form of a requisition. The requisition will book the highest possible price expected to be paid for a given order. In the case of condoms, for example, UNFPA uses seven different manufacturers. The requisition will reserve an amount using the highest price among the seven condom manufacturers to ensure that there is sufficient funding to pay the manufacturer. The excess of funds will only be released back to the budget at a later stage when the purchase order is dispatched or, in the case of inventory orders, when the goods are delivered. When the funds have been returned to the budget they can be reprogrammed. This means that in order to spend $100 it is necessary to commit $110 to $120 in the initial requisition phase. The implication is that it is important to have sufficient available funds in the beginning of the year. It also explains why it is very difficult to reach an implementation rate of 100 per cent.

Figure 30: Percentage of funds committed by GPRHCS per quarter

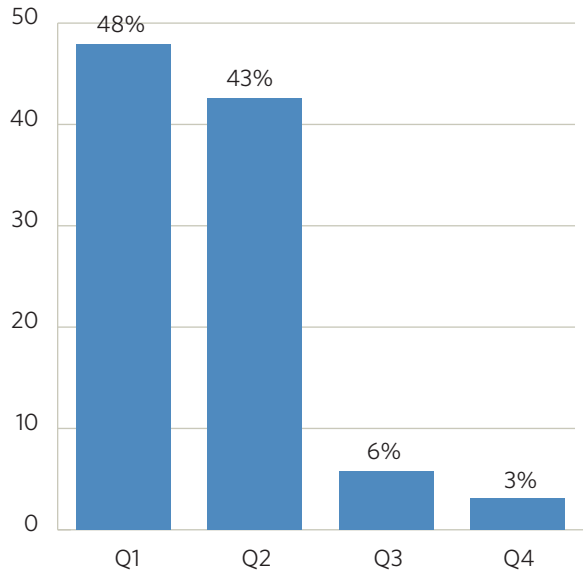
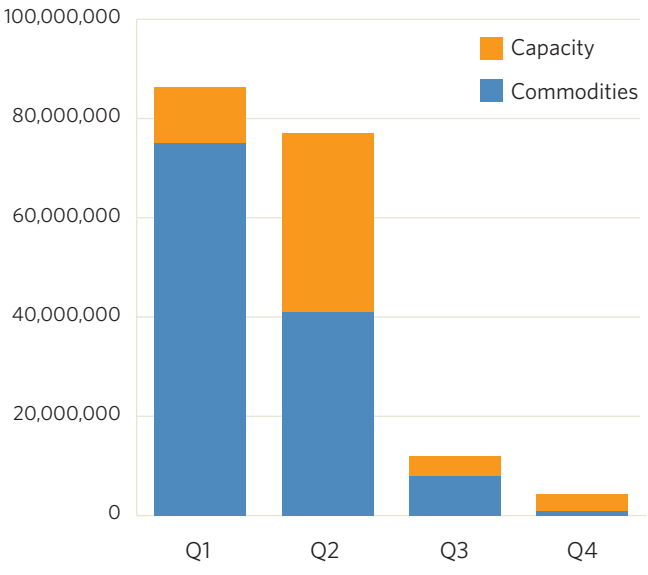


Figure 31: Funds committed by GPRHCS to commodities and capacity building, per quarter



Donor contributions

From its launch in mid-2007 through December 2013, GPRHCS has mobilized almost $630 million in generous support from donors among whom, over the years, have included Australia, Canada, Denmark, European Commission, Finland, France, Ireland, Liechtenstein, Luxembourg, Netherlands, Norway, Spain, Spain (Catalonia), United Kingdom, and private and individual contributors. GPRHCS received $64,523,250 from donors in 2013. It should be noted that contributions received in December 2012 and committed to programming for 2013 included funds from DFID UK, the European Commission, the Netherlands and a private contributor. The Global Programmes' beginning cash balance was $164,110,188 in 2013. Of this amount, $96,971,718 originated from DFID UK contributions received in 2012. In line with the donor's preference, the DFID UK contribution was allocated in 2013 to the procurement of commodities and related services such as transport and pre-shipment inspection and testing.

Table 9: Contributions to GPRHCS received in 2013

Receipt month	Donor	Received amount in US$
January	Luxembourg	542,741
February	Denmark	2,728,761
May	Norway	12,037,833
August	Liechtenstein	15,873
August	Luxembourg	530,504
September	European Commission	3,515,086
September	Spain (Catalonia)	265,252
December	Netherlands	44,836,957
Other contributions		49,943
Total contribution		**64,523,250**

Forward-looking financial situation

The GPRHCS estimated annual financial needs, presented in Table 10, will increase from $255 million in 2014 to $311 million in 2018. Increased donor pledges and contributions are needed to ensure that the GPRHCS can continue to provide much-needed support to developing countries.

Table 10: Estimated funding needs for GPRHCS

2014	2015	2016	2017	2018
$255 million	$274 million	$290 million	$300 million	$311 million

Photo: UNFPA South Sudan/Tim McKulka

Conclusion

In 2013, UNFPA worked more comprehensively with more countries than ever before to bring the benefits of reproductive health commodity security to women and girls who need it most. This year GPRHCS took an exciting yet challenging leap. No longer designating 12 Stream One and 34 Stream Two countries with different levels of support, the GPRHCS has scaled up to extend sustained support to all 46 countries. The accomplishments of 2013 centred on introducing this new phase, liaising with countries to understand and implement the programme, and supporting them to carry out improved performance monitoring. Being asked to conduct a survey of service delivery points was a first-time experience in 36 countries. The survey and other annual reporting tools will help to establish statistical baselines for measuring results. It was, in many regards, a baseline year, and most specifically in regard to data due to the revision and strengthening of indicators in the GPRHCS Programme Monitoring Framework.

This was a strong year for advocacy not only in GPRHCS countries but globally, where the international community asserted the critical importance of reproductive health commodities to achieving the goals of FP2020 and MDG 5 A and B and in the context of the emerging post-2015 development agenda. For GPRHCS, this meant that partnerships became even more important. We explored partnerships with the private sector as we strove to work innovatively with the Total Market Approach and volume guarantees. We also worked with humanitarian partners to support RH supplies and services in fragile settings. We facilitated partnerships at country-level where weakness in supply systems and reproductive health services can only be sustainably addressed by effective partnership at all levels. Our advocacy efforts—combined with strong partnerships—helped to create an enabling environment. Building a strong Steering Committee also contributed to efforts to minimize risks.

Even in this baseline year, continued results for RHCS are evident. The work planned for 2013-2020 will demonstrate concrete progress on many of the results we seek. Our optimism is grounded in the accomplishments of countries in our 2007-2012 programme, and energized by the excitement of the first year of an expanded and even more robust 2013-2020 programme.

Reasons for this optimism are many.

Since its launch in 2007, the UNFPA Global Programme to Enhance Reproductive Health Commodity Security has established itself as a landmark programme with clear comparative advantages. GPRHCS…

- Is the ***only*** **United Nations** programme that **specifically** addresses RHCS, and UNFPA's flagship programme to ensure access to a reliable supply of contraceptives, condoms, medicine and equipment for family planning, HIV/STI prevention and maternal health services.
- **Is anchored to key principles** of the International Conference on Population and Development's Programme of Action (Cairo 1994), Millennium Development Goals, Paris Declaration on Aid Effectiveness, Accra Agenda for Action. It also contributes to efforts including among others the UN Secretary General's Global Strategy on Women's and Children's Health, UN Commission on Life-Saving Commodities for Women and Children, and Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA).

- Benefits from the **experience and track-record** in sexual and reproductive health that UNFPA, as the lead UN agency tasked with delivering MDG 5 and ICPD commitments, has nurtured and supported for over 40 years. UNFPA has a critical role in advancing MDG 5 and the related Millennium Development Goals through global and national level advocacy and delivery in 129 countries (including countries where no other organization has presence). As the UN agency mandated with family planning and reproductive health, UNFPA also plays a key role in FP2020.
- Focuses on **46 priority countries** with high unmet need, in five geographical regions.
- Provides a **unique set of combined interventions** to ensure sustainability: improves enabling environments, increases demand for RHCS, improves efficiency for procurement, improve access to reproductive health and family planning services and strengthens national capacity and systems.
- Offers a **platform for market-shaping activities.** We work with partners in the countries to build a Total Market Approach to RH commodity security.
- Leverages UNFPA's **comparative advantage in procurement** as high-volume buyer and pooler of significant donor resources, maximizing buying power and ensuring value for money.
- Has a proven track record in **capacity building for procurement and supply chain management**, policy dialogue with governments and strategies to increase access for poor and vulnerable populations.
- Offers **unique reach and influencing ability at country and regional level.** Thanks to UNFPA's intergovernmental mandate to work on family planning and reproductive health, and its long-term credibility, GPRHCS enjoys unique relationships with government partners. We also work with regional, political and economic institutions.
- Operates through **strategic partnerships** with UN agencies, donor and partner governments, non-governmental organizations (NGOs), community-based organizations, civil society groups, faith-based organizations and the private sector. Examples of key partners include: Reproductive Health Supplies Coalition, FP2020, USAID, the Bill & Melinda Gates Foundation, World Bank, JSI, PSI, IPPF, PPFA and other valued partners.
- Is **structured as a thematic trust fund,** a performance-based and flexible mechanism which provides donors with the opportunity to target their commitment to a particular thematic priority, allows for pooled multi-year funding and ensures more timely and flexible use of resources to address specific country needs.
- Benefits from a **dedicated Steering Committee** that gives donors **full oversight** of the programme.
- Benefits from a **strong management structure,** through a strong and capable management team with a diversified skills set; staff at country, regional and global level; and direct and regular guidance provided by UNFPA Senior Management.
- Ensures transparency and accountability through a **rigorous Programme Monitoring Framework** that allows stakeholders to clearly track progress and monitor results achieved.
- Presents an **overall moderate** risk that will be managed through regular identification and assessment of risk, and implementation of risk-mitigating actions.

In the coming years, this kind of question will guide the GPRHCS: "What is the vision of reproductive health supply security in your country and how can we most strategically support you over a number of years?" As from the start, national ownership and leadership will be critical to this country-driven process, as will be the programme management's understanding of country situations and reproductive health needs. Among the many areas of GPRHCS support, a country may decide to focus on just one, two or three high-impact aspects of RHCS and seek to sustain progress. Working together, programme countries and UNFPA will strategically target financial and technical support to strengthen weaknesses, and position this support as a catalyst for improving health systems.

With sustained support, we know GPRHCS countries will make weak supply systems stronger, keep shelves stocked longer, and train service providers to go farther to reach those otherwise left out and left behind—the hardest-to-reach groups including adolescents. Donors and partners make these results possible and the weight they give to the impact that RHCS brings to the lives of women and young people in particular means we have been able to develop a very specific and catalytic approach to delivering country level and local support. To all who make GPRHCS a truly effective, efficient and adaptive channel for delivering tangible results for reproductive health and rights, we say thank you.

Annex 1: Total capacity development expense 2013, US$

Country	Capacity building (including Cap, OFA, human resources) in US$
Afghanistan	159,368.88
Angola	109,040.98
ASRO	27,710.54
Benin	534,246.68
Bolivia	515,701.26
Botswana	217,731.19
Burkina Faso	3,476,266.78
Burundi	1,027,833.63
Caribbean	(9,070.78)
Central African Republic	146,953.71
Chad	1,557,984.67
Comoros	17,273.38
Congo (Brazzaville)	497,420.01
Congo DRC (Kinshasa)	1,009,700.15
Côte D'Ivoire	1,529,147.48
Djibouti	239,046.15
Ecuador	649,121.22
EECARO	475,977.10
El Salvador - San Salvador	4,986.25
ESARO	1,184,498.64
Ethiopia	2,767,585.04
Gabon	571,157.58
Gambia	915,450.41
Georgia	53,467.27
Ghana	260,891.87
Guinea	962,855.62
Guinea-Bissau	175,953.37
Haiti	1,215,572.85
Honduras	300,413.25
Kenya	166,751.60
Kyrgyzstan	92,683.12
LACRO	1,267,285.55
Laos	424,727.34
Lesotho	505,821.53
Liberia	365,263.14
Madagascar	1,377,269.29
Malawi	230,603.94
Mali	218,858.87

COUNTRY	Capacity building (including Cap, OFA, human resources) in US$
Mauritania	165,565.03
Mongolia	303,434.04
Mozambique	1,053,412.43
Namibia	180,388.63
Nepal	136,051.08
Nicaragua	588,374.07
Niger	3,402,000.02
Nigeria	2,939,711.66
Panama	3,192.68
Papua New Guinea	186,450.08
Peru	24,696.59
Procurement Services Branch	1,363,138.31
Pacific Sub-Regional Office–Fiji	268,331.35
Rwanda	203,703.33
Sao Tome and Principe	36,313.94
Senegal	1,266,776.63
Sierra Leone	3,170,401.16
Somalia	392,294.32
South Africa - Johannesburg	34,286.84
South Sudan	429,284.82
SRO JAMAICA	584,118.18
Sudan - Khartoum	402,232.80
Swaziland	721,084.73
Tajikistan	68,761.95
Tanzania	256,632.77
Timor-Leste	22,975.79
Togo	906,261.36
Turkmenistan	25,505.28
Uganda	278,834.51
Ukraine	158,575.48
UNFPA	9,426,587.37
Uruguay	34,652.64
Uzbekistan	41,624.40
WCARO	394,806.22
Zambia	333,623.13
Zimbabwe	805,329.62
Total	**$55,852,962.79**

Annex 2: Units approved, contraceptives and condoms, GPRHCS approvals 2013

Country	Condoms, female Units (pieces)	Condoms, male Units (pieces)	Injectables Units (vials)	IUDs Units (pieces)	Oral pills Units (cycles)	Implants Units (sets)
Asia and the Pacific						
Papua New Guinea	0	0	0	0	0	16,600
Timor-Leste	0	1,584,000	110,000	0	85,680	100
Georgia	0	1,440,000	0	0	0	0
Iran	25,000	6,004,800	0	0	0	7,000
Lao PDR	0	655,200	279,200	0	120,960	0
Mongolia	5,000	1,440,000	60,000	10,000	150,480	17,744
Pacific Islands	72,000	0	240,000	2,000	296,640	23,800
Philippines	0	0	0	0	0	40,000
Sri Lanka	0	0	0	0	0	110,000
Viet Nam	500,000	0	0	0	0	0
Subtotal	**602,000**	**11,124,000**	**689,200**	**12,000**	**653,760**	**215,244**
Arab States						
Djibouti	5,000	208,800	7,600	500	7,200	640
occupied Palestinian territory	2,000	4,500,000	0	21,000	306,000	1,200
Somalia	0	0	0	0	105,240	0
Sudan	0	0	0	0	2,156,292	17,600
Yemen	0	540,000	334,000	61,500	0	14,656
Morocco	0	201,600	0	0	0	0
Subtotal	**7,000**	**5,450,400**	**341,600**	**83,000**	**2,574,732**	**34,096**
Eastern Europe and Central Asia						
Kyrgyzstan	0	0	15,000	0	570,300	0
Tajikistan	0	2,088,000	61,000	105,000	165,600	0
Turkmenistan	0	417,600	0	0	0	0
Uzbekistan	0	4,003,200	300,000	800,000	1,080,720	0
Subtotal	**0**	**6,508,800**	**376,000**	**905,000**	**1,816,620**	**0**
East and Southern Africa						
Angola	22,000	0	150,000	0	164,160	22,000
Comoros	0	1,252,800	93,300	500	45,360	1,600
Congo DRC	379,000	0	97,000	0	0	80,000
Eritrea	0	0	0	0	50,400	0
Ethiopia	0	0	706,000	0	3,847,680	1,061,960
Kenya	750,000	0	0	0	0	50,024
Lesotho	200,000	0	100,000	0	0	100
Madagascar	500,000	3,009,600	3,437,600	26,000	2,088,720	207,680
Malawi	113,000	0	450,000	0	0	184,048
Mozambique	1,000,000	29,448,000	0	16,000	6,404,400	50,000
Namibia	310,000	0	0	0	0	0
Rwanda	72,000	0	436,400	0	0	25,000

Annex 2: Units approved, contraceptives and condoms, GPRHCS approvals 2013 (continued)

Country	Condoms, female Units (pieces)	Condoms, male Units (pieces)	Injectables Units (vials)	IUDs Units (pieces)	Oral pills Units (cycles)	Implants Units (sets)
East and Southern Africa (continued)						
South Sudan	50,000	0	55,000	0	450,000	10,940
Swaziland	0	0	80,400	0	0	25,000
Tanzania	350,000	0	0	0	0	94,016
Uganda	3,000,000	0	1,010,000	0	0	400,032
Zambia	0	0	0	0	0	70,000
Zanzibar	0	0	0	0	0	3,136
Zimbabwe	0	0	1,420,000	6,000	0	209,400
Subtotal	**6,746,000**	**33,710,400**	**8,035,700**	**48,500**	**13,050,720**	**2,494,936**
Latin America and the Caribbean						
Bolivia	125,000	2,282,400	500,000	70,000	429,840	55,000
Caribbean	85,000	1,800,000	0	0	0	0
Colombia	0	1,296,000	0	0	0	0
Costa Rica	40,000	0	0	0	0	0
Dominican Republic	5,000	72,000	0	0	0	100,032
Haiti	0	9,576,000	400,000	0	223,920	1,700
Honduras	3,000	11,505,600	630,000	0	529,920	3,008
Nicaragua	0	4,003,200	120,000	7,500	724,320	0
Peru	262,000	0	0	0	0	0
Uruguay	0	0	0	0	0	3,000
Subtotal	**520,000**	**30,535,200**	**1,650,000**	**77,500**	**1,908,000**	**162,740**
West and Central Africa						
Benin	10,000	1,000,800	0	9,000	180,000	20,000
Burkina Faso	0	0	250,000	39,000	314,640	227,900
Burundi	0	0	600,000	0	469,440	0
Cameroon	800,000	41,572,800	918,000	120,000	2,600,640	0
Cape Verde	40,000	0	0	0	0	25,000
Central African Republic	582,000	10,036,800	183,000	1,500	994,704	6,000
Chad	150,000	1,267,200	494,400	13,000	2,142,720	37,400
Congo Republic	150,000	0	0	500	0	928
Côte d'Ivoire	100,000	5,500,800	240,000	0	0	7,000
Gabon	0	2,001,600	2,600	0	80,640	100
Gambia	10,000	1,000,800	110,000	5,000	200,160	5,000
Ghana	0	13,255,200	2,326,400	0	0	0
Guinea	20,000	3,002,400	50,000	4,000	0	13,000
Guinea-Bissau	17,000	0	17,000	5,500	3,960	20,000
Liberia	70,000	0	244,800	0	400,320	11,200
Mauritania	15,000	16,128,000	156,700	0	726,480	5,120

(continued)

Annex 2: Units approved, contraceptives and condoms, GPRHCS approvals 2013 (continued)

Country	Condoms, female Units (pieces)	Condoms, male Units (pieces)	Injectables Units (vials)	IUDs Units (pieces)	Oral pills Units (cycles)	Implants Units (sets)
West and Central Africa (continued)						
Niger	64,000	0	503,400	0	2,237,040	90,016
Nigeria	5,000,000	11,872,800	360,000	0	0	161,088
Sao Tome and Principe	8,000	0	10,200	0	3,600	500
Senegal	0	0	0	24,500	0	0
Sierra Leone	12,000	10,000,800	533,000	18,000	1,300,320	35,000
Togo	33,000	5,054,400	606,500	29,500	108,960	57,200
Subtotal	**7,081,000**	**121,694,400**	**7,606,000**	**269,500**	**11,763,624**	**722,452**
NGO partners						
DKT	0	0	0	0	0	126,500
IPPF	500,000	26,352,000	1,000,000	352,000	1,225,440	138,000
MSI	0	0	0	700,000	0	545,276
MVP	101,000	1,360,800	0	28,500	0	0
PSI	0	0	0	0	0	112,432
Subtotal	**601,000**	**27,712,800**	**1,000,000**	**1,080,500**	**1,225,440**	**922,208**
Global total	**15,557,000**	**236,736,000**	**19,698,500**	**2,476,000**	**32,992,896**	**4,551,676**

Annex 3: CYP (couple years of protection) by method, GPRHCS approvals 2013

Country	Condoms, female	Condoms, male	Injectables	IUDs	Oral pills	Implants
Asia and the Pacific						
Papua New Guinea	0	0	0	0	0	63,846
Timor-Leste	0	13,200	27,500	0	5,712	385
Georgia	0	12,000	0	0	0	0
Iran	208	50,040	0	0	0	26,923
Lao PDR	0	5,460	69,800	0	8,064	0
Mongolia	42	12,000	15,000	45,455	10,032	57,822
Pacific Islands	600	0	60,000	9,091	19,776	91,538
Philippines	0	0	0	0	0	100,000
Sri Lanka	0	0	0	0	0	423,077
Viet Nam	4,167	0	0	0	0	0
Subtotal	**5,017**	**92,700**	**172,300**	**54,545**	**43,584**	**763,591**
Arab States						
Djibouti	42	1,740	1,900	2,273	480	1,600
occupied Palestinian territory	17	37,500	0	95,455	20,400	4,615
Somalia	0	0	0	0	7,016	0
Sudan	0	0	0	0	143,753	44,000
Yemen	0	4,500	83,500	279,545	0	36,640
Morocco	0	1,680	0	0	0	0
Subtotal	**58**	**45,420**	**85,400**	**377,273**	**171,649**	**86,855**
Eastern Europe and Central Asia						
Kyrgyzstan	0	0	3,750	0	38,020	0
Tajikistan	0	17,400	15,250	477,273	11,040	0
Turkmenistan	0	3,480	0	0	0	0
Uzbekistan	0	33,360	75,000	3,636,364	72,048	0
Subtotal	**0**	**54,240**	**94,000**	**4,113,636**	**121,108**	**0**
East and Southern Africa						
Angola	183	0	37,500	0	10,944	84,615
Comoros	0	10,440	23,325	2,273	3,024	4,000
Congo DRC	3,158	0	24,250	0	0	307,692
Eritrea	0	0	0	0	3,360	0
Ethiopia	0	0	176,500	0	256,512	2,926,554
Kenya	6,250	0	0	0	0	158,714
Lesotho	1,667	0	25,000	0	0	385
Madagascar	4,167	25,080	859,400	118,182	139,248	519,200
Malawi	942	0	112,500	0	0	586,658
Mozambique	8,333	245,400	0	72,727	426,960	192,308
Namibia	2,583	0	0	0	0	0

(continued)

Annex 3: CYP by method, GPRHCS approvals 2013 (continued)

Country	Condoms, female	Condoms, male	Injectables	IUDs	Oral pills	Implants
East and Southern Africa (continued)						
Rwanda	600	0	109,100	0	0	96,154
South Sudan	417	0	13,750	0	30,000	34,754
Swaziland	0	0	20,100	0	0	96,154
Tanzania	2,917	0	0	0	0	235,040
Uganda	25,000	0	252,500	0	0	1,134,695
Zambia	0	0	0	0	0	269,231
Zanzibar	0	0	0	0	0	7,840
Zimbabwe	0	0	355,000	27,273	0	805,385
Subtotal	**56,217**	**280,920**	**2,008,925**	**220,455**	**870,048**	**7,459,378**
Latin America and the Caribbean						
Bolivia	1,042	19,020	125,000	318,182	28,656	211,538
Caribbean	708	15,000	0	0	0	0
Colombia	0	10,800	0	0	0	0
Costa Rica	333	0	0	0	0	0
Dominican Republic	42	600	0	0	0	250,080
Haiti	0	79,800	100,000	0	14,928	6,538
Honduras	25	95,880	157,500	0	35,328	7,520
Nicaragua	0	33,360	30,000	34,091	48,288	0
Peru	2,183	0	0	0	0	0
Uruguay	0	0	0	0	0	11,538
Subtotal	**4,333**	**254,460**	**412,500**	**352,273**	**127,200**	**487,215**
West and Central Africa						
Benin	83	8,340	0	40,909	12,000	76,923
Burkina Faso	0	0	62,500	177,273	20,976	876,538
Burundi	0	0	150,000	0	31,296	0
Cameroon	6,667	346,440	229,500	545,455	173,376	0
Cape Verde	333	0	0	0	0	96,154
Central African Republic	4,850	83,640	45,750	6,818	66,314	23,077
Chad	1,250	10,560	123,600	59,091	142,848	143,846
Congo Republic	1,250	0	0	2,273	0	3,397
Côte d'Ivoire	833	45,840	60,000	0	0	26,923
Gabon	0	16,680	650	0	5,376	385
Gambia	83	8,340	27,500	22,727	13,344	19,231
Ghana	0	110,460	581,600	0	0	0
Guinea	167	25,020	12,500	18,182	0	50,000
Guinea-Bissau	142	0	4,250	25,000	264	76,923
Liberia	583	0	61,200	0	26,688	43,077

Annex 3: CYP by method, GPRHCS approvals 2013 (continued)

Country	Condoms, female	Condoms, male	Injectables	IUDs	Oral pills	Implants
West and Central Africa (continued)						
Mauritania	125	134,400	39,175	0	48,432	14,954
Niger	533	0	125,850	0	149,136	251,963
Nigeria	41,667	98,940	90,000	0	0	456,566
Sao Tome and Principe	67	0	2,550	0	240	1,923
Senegal	0	0	0	111,364	0	0
Sierra Leone	100	83,340	133,250	81,818	86,688	134,615
Togo	275	42,120	151,625	134,091	7,264	220,000
Subtotal	**59,008**	**1,014,120**	**1,901,500**	**1,225,000**	**784,242**	**2,516,495**
NGO partners						
DKT	0	0	0	0	0	486,538
IPPF	4,167	219,600	250,000	1,600,000	81,696	530,769
MSI	0	0	0	3,181,818	0	1,861,671
MVP	842	11,340	0	129,545	0	0
PSI	0	0	0	0	0	405,465
Subtotal	**5,008**	**230,940**	**250,000**	**4,911,364**	**81,696**	**3,284,443**
Global total	**129,642**	**1,972,800**	**4,924,625**	**11,254,545**	**2,199,526**	**14,597,978**

TOTAL CYP = 35,079,117

Annex 4: Expense (cost) of contraceptives and condoms, GPRHCS approvals 2013

Country	Condoms, female	Condoms, male	Injectables	IUDs	Oral pills	Implants
Asia and the Pacific						
Papua New Guinea	$0	$0	$0	$0	$0	$141,100
Timor-Leste	$0	$41,184	$82,500	$0	$23,134	$850
Georgia	$0	$37,440	$0	$0	$0	$0
Iran	$14,250	$156,125	$0	$0	$0	$59,500
Lao PDR	$0	$17,035	$209,400	$0	$32,659	$0
Mongolia	$2,850	$37,440	$45,000	$3,700	$40,630	$150,824
Pacific Islands	$41,040	$0	$180,000	$740	$80,093	$202,300
Philippines	$0	$0	$0	$0	$0	$340,000
Sri Lanka	$0	$0	$0	$0	$0	$935,000
Viet Nam	$285,000	$0	$0	$0	$0	$0
Subtotal	**$343,140**	**$289,224**	**$516,900**	**$4,440**	**$176,515**	**$1,829,574**
Arab States						
Djibouti	$2,850	$5,429	$5,700	$185	$1,944	$5,440
occupied Palestinian territory	$1,140	$117,000	$0	$7,770	$82,620	$10,200
Somalia	$0	$0	$0	$0	$28,415	$0
Sudan	$0	$0	$0	$0	$582,199	$149,600
Yemen	$0	$14,040	$250,500	$22,755	$0	$124,576
Morocco	$0	$5,242	$0	$0	$0	$0
Subtotal	**$3,990**	**$141,710**	**$256,200**	**$30,710**	**$695,178**	**$289,816**
Eastern Europe and Central Asia						
Kyrgyzstan	$0	$0	$11,250	$0	$153,981	$0
Tajikistan	$0	$54,288	$45,750	$38,850	$44,712	$0
Turkmenistan	$0	$10,858	$0	$0	$0	$0
Uzbekistan	$0	$104,083	$225,000	$296,000	$291,794	$0
Subtotal	**$0**	**$169,229**	**$282,000**	**$334,850**	**$490,487**	**$0**
East and Southern Africa						
Angola	$12,540	$0	$112,500	$0	$44,323	$187,000
Comoros	$0	$32,573	$69,975	$185	$12,247	$13,600
Congo DRC	$216,030	$0	$72,750	$0	$0	$680,000
Eritrea	$0	$0	$0	$0	$13,608	$0
Ethiopia	$0	$0	$529,500	$0	$1,038,874	$9,026,660
Kenya	$427,500	$0	$0	$0	$0	$425,204
Lesotho	$114,000	$0	$75,000	$0	$0	$850
Madagascar	$285,000	$78,250	$2,578,200	$9,620	$563,954	$1,765,280
Malawi	$64,410	$0	$337,500	$0	$0	$1,564,408
Mozambique	$570,000	$765,648	$0	$5,920	$1,729,188	$425,000
Namibia	$176,700	$0	$0	$0	$0	$0
Rwanda	$41,040	$0	$327,300	$0	$0	$212,500

Annex 4: Expense (cost) of contraceptives and condoms, GPRHCS approvals 2013 (continued)

Country	Condoms, female	Condoms, male	Injectables	IUDs	Oral pills	Implants
East and Southern Africa (continued)						
South Sudan	$28,500	$0	$41,250	$0	$121,500	$92,990
Swaziland	$0	$0	$60,300	$0	$0	$212,500
Tanzania	$199,500	$0	$0	$0	$0	$799,136
Uganda	$1,710,000	$0	$757,500	$0	$0	$3,400,272
Zambia	$0	$0	$0	$0	$0	$595,000
Zanzibar	$0	$0	$0	$0	$0	$26,656
Zimbabwe	$0	$0	$1,065,000	$2,220	$0	$1,779,900
Subtotal	**$3,845,220**	**$876,470**	**$6,026,775**	**$17,945**	**$3,523,694**	**$21,206,956**
Latin America and the Caribbean						
Bolivia	$71,250	$59,342	$375,000	$25,900	$116,057	$467,500
Caribbean	$48,450	$46,800	$0	$0	$0	$0
Colombia	$0	$33,696	$0	$0	$0	$0
Costa Rica	$22,800	$0	$0	$0	$0	$0
Dominican Republic	$2,850	$1,872	$0	$0	$0	$850,272
Haiti	$0	$248,976	$300,000	$0	$60,458	$14,450
Honduras	$1,710	$299,146	$472,500	$0	$143,078	$25,568
Nicaragua	$0	$104,083	$90,000	$2,775	$195,566	$0
Peru	$149,340	$0	$0	$0	$0	$0
Uruguay	$0	$0	$0	$0	$0	$25,500
Subtotal	**$296,400**	**$793,915**	**$1,237,500**	**$28,675**	**$515,160**	**$1,383,290**
West and Central Africa						
Benin	$5,700	$26,021	$0	$3,330	$48,600	$170,000
Burkina Faso	$0	$0	$187,500	$14,430	$84,953	$1,937,150
Burundi	$0	$0	$450,000	$0	$126,749	$0
Cameroon	$456,000	$1,080,893	$688,500	$44,400	$702,173	$0
Cape Verde	$22,800	$0	$0	$0	$0	$212,500
Central African Republic	$331,740	$260,957	$137,250	$555	$268,570	$51,000
Chad	$85,500	$32,947	$370,800	$4,810	$578,534	$317,900
Congo Republic	$85,500	$0	$0	$185	$0	$7,888
Côte d'Ivoire	$57,000	$143,021	$180,000	$0	$0	$59,500
Gabon	$0	$52,042	$1,950	$0	$21,773	$850
Gambia	$5,700	$26,021	$82,500	$1,850	$54,043	$42,500
Ghana	$0	$344,635	$1,744,800	$0	$0	$0
Guinea	$11,400	$78,062	$37,500	$1,480	$0	$110,500
Guinea-Bissau	$9,690	$0	$12,750	$2,035	$1,069	$170,000
Liberia	$39,900	$0	$183,600	$0	$108,086	$95,200
Mauritania	$8,550	$419,328	$117,525	$0	$196,150	$43,520
Niger	$36,480	$0	$377,550	$0	$604,001	$765,136

(continued)

Annex 4: Expense (cost) of contraceptives and condoms, GPRHCS approvals 2013 (continued)

Country	Condoms, female	Condoms, male	Injectables	IUDs	Oral pills	Implants
West and Central Africa (continued)						
Nigeria	$2,850,000	$308,693	$270,000	$0	$0	$1,369,248
Sao Tome and Principe	$4,560	$0	$7,650	$0	$972	$4,250
Senegal	$0	$0	$0	$9,065	$0	$0
Sierra Leone	$6,840	$260,021	$399,750	$6,660	$351,086	$297,500
Togo	$18,810	$131,414	$454,875	$10,915	$29,419	$486,200
Subtotal	**$4,036,170**	**$3,164,054**	**$5,704,500**	**$99,715**	**$3,176,178**	**$6,140,842**
NGO partners						
DKT	$0	$0	$0	$0	$0	$1,075,250
IPPF	$285,000	$685,152	$750,000	$130,240	$330,869	$1,173,000
MSI	$0	$0	$0	$259,000	$0	$4,634,846
MVP	$57,570	$35,381	$0	$10,545	$0	$0
PSI	$0	$0	$0	$0	$0	$955,672
Subtotal	**$342,570**	**$720,533**	**$750,000**	**$399,785**	**$330,869**	**$7,838,768**
Global total	**$8,867,490**	**$6,155,136**	**$14,773,875**	**$916,120**	**$8,908,082**	**$38,689,246**

TOTAL EXPENSE GPRHCS APPROVALS 2013 = $78,309,949

Annex 5: National budget allocations for RH commodities

Amounts allocated and spent in national budgets for procurement of reproductive health commodities in GPRHCS countries, 2013 (in US$)

	Contraceptives		Maternal health medicines		Total	
Country	Allocated	Spent	Allocated	Spent	Allocated	Spent
Benin	25,000	25,000	–	–	25,000	25,000
Bolivia	2,936,320	936,000	6,500,000	3,066,020	P9,436,320	4,002,020
Burkina Faso	1,000,000	1,000,000	–	–	1,000,000	1,000,000
Burundi	–	–	–	–	–	–
Cameroon	360,000	0	–	–	360,000	0
Central Africa Republic	–	–	–	–	–	–
Chad	–	–	–	–	–	–
Congo (Brazzaville)	130,000	130,000	0	0	130,000	130,000
Côte d'Ivoire	–	–	–	–	–	–
Democratic Republic of Congo	460,000	0	–	–	460,000	0
Djibouti	–	–	–	–	–	–
Eritrea	–	–	–	–	–	–
Ethiopia	14,741,947	23,559,849	6,921,800	4,688,714	21,663,747	28,248,563
Gambia	26,316	26,316	26,316	26,316	52,631	52,631
Ghana	–	–	–	–	–	–
Guinea	–	–	200,000	0	200,000	0
Guinea-Bissau	–	–	–	–	–	–
Haiti	–	–	–	–	–	–
Honduras	1,123,103	0	–	–	1,123,103	0
Kenya	–	–	–	–	–	–
Lao PDR	25,000	25,000	–	–	25,000	25,000
Lesotho	300,000	200,000	2,000,000	1,500,000	2,300,000	1,700,000
Liberia	–	–	–	–	–	–
Madagascar	–	–	–	–	–	–
Malawi	–	–	–	–	–	–
Mali	745,384	0	2,116,000	0	2,861,384	0
Mauritania	–	–	–	–	–	–
Mozambique	449,835	449,835	–	–	449,835	449,835
Myanmar	1,200,000	1,200,000	–	–	1,200,000	1,200,000
Nepal	4,200,000	0	–	–	4,200,000	0
Niger	400,000	400,000	–	–	400,000	400,000
Nigeria	3,000,000	3,000,000	11,500,000	0	14,500,000	3,000,000
Papua New Guinea	–	–	–	–	–	–
Rwanda	650,000	650,000	–	–	650,000	650,000
Sao Tome and Principe	–	–	–	–	–	–
Senegal	200,000	0	0	0	200,000	0
Sierra Leone	–	–	–	–	–	–

(continued)

Annex 5: National budget allocations for RH commodities (continued)

	Contraceptives		Maternal health medicines		Total	
Country	Allocated	Spent	Allocated	Spent	Allocated	Spent
South Sudan	–	–	–	–	–	–
Sudan	–	–	1,000,000	1,000,000	1,000,000	1,000,000
Tanzania	2,500,000	3,387,000	–	–	2,500,000	3,387,000
Timor-Leste	–	–	–	–	–	–
Togo	60,000	0	2,200,000	2,200,000	2,260,000	2,200,000
Uganda	3,300,000	3,300,000	–	–	3,300,000	3,300,000
Yemen	–	–	–	–	–	–
Zambia	0	0	1,200,000	1,200,000	1,200,000	1,200,000
Zimbabwe	–	–	–	–	–	–
Total	**$37,832,905**	**$38,289,000**	**$33,664,116**	**$13,681,049**	**$71,497,020**	**$51,970,049**

Source: Information provided by UNFPA Country Offices for GPRHCS reporting 2013

Annex 6: Maternal mortality ratio in GPRHCS countries, 1990 to 2013

	Maternal mortality ratio (MMR = maternal deaths per 100,000 live births)				
Country	1990	1995	2000	2005	2013
Benin	600	520	490	420	340
Bolivia	510	420	330	270	200
Burkina Faso	770	680	580	500	400
Burundi	1300	1300	1000	910	740
Cameroon	720	760	740	690	590
Central African Republic	1,200	1,200	1,200	1,100	880
Chad	1,700	1,600	1,500	1,200	980
Congo (Brazzaville)	670	650	610	530	410
Côte d'Ivoire	740	710	670	750	720
Democratic Republic of Congo	1,000	1,100	1,100	930	730
Djibouti	400	390	360	310	230
Eritrea	1,700	1,000	670	530	380
Ethiopia	1,400	1,200	990	740	420
Gambia	710	660	580	510	430
Ghana	760	650	570	470	380
Guinea	1,100	1,000	950	800	650
Guinea-Bissau	930	790	840	760	560
Haiti	670	580	510	470	380
Honduras	290	200	150	130	120
Kenya	490	530	570	550	400
Lao PDR	1,100	830	600	410	220
Lesotho	720	630	680	670	490
Liberia	1,200	1,600	1,100	880	640
Madagascar	740	640	550	530	440
Malawi	1,100	870	750	570	510
Mali	1,100	1,000	860	710	550
Mauritania	630	550	480	400	320
Mozambique	1,300	1,100	870	680	480
Myanmar	580	470	360	260	200
Nepal	790	580	430	310	190
Niger	1,000	920	850	760	630
Nigeria	1,200	1,100	950	740	560
Papua New Guinea	470	370	340	280	220
Rwanda	1,400	1,400	1,000	610	320
Sao Tome and Principe	410	360	300	260	210
Senegal	530	510	480	420	320
Sierra Leone	2,300	2,400	2,200	1,600	1,100
South Sudan	1,800	1,500	1,200	1,000	730
Sudan	720	640	540	460	360
Tanzania	910	890	770	610	410
Timor-Leste	1,200	1,000	680	500	270
Togo	660	660	580	510	450
Uganda	780	740	650	510	360
Yemen	460	420	370	330	270
Zambia	580	630	610	430	280
Zimbabwe	520	550	680	740	470

Source: *Trends in Maternal Mortality: 1990 to 2013;*
Estimates Developed by WHO, UNICEF, UNFPA and the World Bank; See Annex 2, pages 35 to 43

Annex 7: Status of implementation for Management Output

Improved programme coordination and management

Intervention area	Management indicators	Status/achievement for 2013
Support for data generation and use	Number of staff of government and partner institutions trained to generate data for programme monitoring	1,448
	Availability of data from research on supply, demand, access and use of FP for programme and policy design	6
	Survey reports and data on RH commodity availability	14
	Availability of results from specialized surveys on key thematic issues	No specialized study conducted
Resource mobilization and allocation	Amount mobilized from partners for GPRHCS interventions	$64.5 million
	New donors making multi-year commitments and contribution to RHCS and FP	None
	Evidence of UNFPA meeting FP2020 commitments	percentage allocated to FP for 2013
	Amount of UNFPA Core Funds allocated to Commodity Security Branch (CSB)	
Programme steering	Functional steering committee in place (composed of donors and partners, with TORs, monthly meetings held and decisions taken)	Yes
Human resources	Number of staff dedicated to RHCS/FP by location and with desired skills gap	
Programme review	Number of CO, RO and partner annual work plans (AWPs) finalized and funded by mid-February of the current year	30/46 countries and 3 partners
	100% of country work plans reviewed at least two times per year (mid and end of year)	AWPs reviewed once a year in 2013
	Implementation rate for GPRHCS work plan outputs	95 per cent
Programme monitoring and evaluation	Findings available from monitoring field visits	-
	Recommendations and lessons learned available from routine monitoring interventions	-
	Number of evaluation activities coordinated and finalized as planned	Evaluability study initiated
	Reports with recommendations on the outcomes of financial monitoring	-
	Monitoring framework with updated results on milestones	Update Framework available and included in the programme document
	Availability of TOR, institutional framework and strategy to ensure independent evaluation	-
	Availability of inception report for independent evaluation of the programme with evaluability criteria/issues and plan of work	Evaluability assessment research planned and will take place in 2014
	Programme mid-term evaluation results and recommendations published and disseminated	-
	Programme end-term evaluation results and recommendations published and disseminated	-

GPRHCS Programme Monitoring Framework 2013–2020

Baselines, Milestones and Targets

Global Programme to Enhance Reproductive Health Commodity Security

ABBREVIATIONS

CO	country office
CPR	contraceptive prevalence rate
CSB	Commodity Security Branch, UNFPA
CYP	couple years of protection
EML	Essential Medicines List
ERP	Expert Review Panel
HC	hormonal contraceptive
HFCB	Humanitarian and Fragile Contexts Branch
ISO	International Organization for Standardization
LTA	long term agreement
MH	maternal health
MSI	Management Science International
N/A	not applicable
PQ	Prequalification
PQP	WHO Prequalification of Medicines Programme
PSB	Procurement Services Branch, UNFPA
QA	quality assurance
RO	regional office
RR	reproductive rights
SDP	service delivery point
SGS	Société Générale de Surveillance
SRH	sexual and reproductive health
TPP	third party procurement

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
Goal: Contribute to universal access to reproductive health																	
Maternal mortality ratio (per 100,000 live births)	Based on data for 46 countries in *Trends in Maternal Mortality: 1990 to 2010* (WHO, UNICEF, UNFPA, and the World Bank) (2012)	**418**	399		380		362		343		324		305		**286**		Concerted efforts by all partners for improvement in quality of care for reproductive health, including family planning
HIV prevalence rate (including disaggregated data on youth HIV prevalence rate)	MDG Reports and other related UN publications	**1.69**	1.58		1.48		1.37		1.27		1.16		1.06		**0.95**		
Adolescent birth rate	MDG Reports and other related UN publications	**50.36**	49.95		49.54		49.12		48.71		48.30		47.89		**47.48**		
Outcome: Increased availability and utilization of RH commodities in support of reproductive and sexual health services including family planning, especially for poor and marginalized women and girls.																	
Use																	
Unmet need for family planning	MDG Reports and other related UN publications Weighted average for unmet need for family planning for the 46 GPRHCS countries	**24.60**	24.35		24.10		23.85		20.58		19.83		19.08		**18.32**		
Contraceptive prevalence rate (CPR) for modern methods (disaggregated by quintile, urban-rural, education)		**20.2**	21.7		23.2		24.7		26.7		28.7		30.7		**32.7**		Government resource allocation for family planning is improved and donor support sustained; stronger partnership among stakeholders including public-private Financial crisis; cultural and other barriers persist; poor infrastructure; political and environmental crisis
Demand for modern contraception satisfied (disaggregated by quintile, urban-rural, education)	Estimates based on CPR and unmet need for family planning	**45.1**	47.1		49.1		50.9		56.5		59.1		61.7		**64.1**		

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
OUTCOME (continued)																	
Method mix score (including disaggregated data for prevalence of long-term and short-term methods)	Estimates based on data from *World Contraceptive Use 2012*	**8.8**	9.0		9.1		9.2		9.3		9.5		9.6		**9.7**		Government resource allocation for family planning is improved and donor support sustained; stronger partnership among stakeholders including public-private Financial crisis; cultural and other barriers persist; poor infrastructure; political and environmental crisis
Additional women with modern methods of contraception reported through FP2020 Reference Group	FP2020 Reference Group and Monitoring and Accountability Working Group	8.4	21		34		52		69		86		103		**120**		
Availability of reproductive health commodities																	
Number of countries with 85 per cent of tertiary and secondary level service delivery points (SDPs) offering at least five modern methods of contraception	GPRHCS country surveys of SDPs	**11/46**	17/46		19/46		24/46		29/46		33/46		38/46		**42/46**		
Number of countries with 85 per cent of primary level service delivery points offering at least three methods in 2013 and increasing to five modern methods in 2016 and beyond	GPRHCS country surveys of SDPs	**10/46**	15/46		19/46		24/46		29/46		33/46		38/46		**46/46**		
Number of countries with seven life-saving maternal/RH medicines from the WHO list[1] available in all facilities providing delivery services (this must include magnesium sulfate and either misoprostol or oxytocin or both) (disaggregated for urban-rural and type of SDPs)	GPRHCS country surveys of SDPs	**0/46**	8/46		10/46		15/46		18/46		22/46		26/46		**30/46**		Country coordination, and government commitment to ensuring product availability and averting stock-outs
Number of countries with 60 percent of SDPs with no stock-out of contraceptives in the last six months (disaggregated for urban-rural and type of SDPs)	GPRHCS country surveys of SDPs	**8/46**	11/46		14/46		18/46		23/46		27/46		32/46		**35/46**		
Percentage of GPRHCS supported countries that have met their FP2020 commitments	FP2020 Reference Group and Country Engagement working Group	**0**	To be provided by FP2020		To be provided by FP2020		To be provided by FP2020		To be provided by FP2020		To be provided by FP2020		To be provided by FP2020		**To be provided by FP2020**		Government and partner commitment to FP2020 at global and national levels
Programme Output 1: An enabled environment for RHCS, including family planning, at national, regional and global levels																	
Policy and strategy																	
Number of countries with policies in place that take into consideration rights-based and total market approaches to family planning	GPRHCS annual questionnaires and reporting	**26**	33		35		38		40		46		46		**46**		Resource availability, country coordination and stronger partnerships
Number of countries where a 3–5 year medium-term plan for family planning, with rights-based and total market approaches, is being implemented	GPRHCS annual questionnaires and reporting	**25**	28		32		35		42		45		46		**46**		

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
POLICY AND STRATEGY (continued)																	
Number of countries with family planning policies in place that take into consideration young people's access to contraceptive services	GPRHCS annual questionnaires and reporting	**33**	34		36		39		42		44		46		**46**		
Number of countries with a 3–5 year medium-term costed plan for family planning that takes into consideration young people's access to contraceptive services	GPRHCS annual questionnaires and reporting	**24**	35		32		44		46		46		46		**46**		Resource availability, country coordination and stronger partnerships
Number of countries with national SRH and RR guidelines and protocols which include a rights-based approach to RHCS and family planning issues	GPRHCS annual questionnaires and reporting	**39**	42		46		46		46		46		46		**46**		
Regional-level interventions																	
Evidence of commitment and support to RHCS and family planning among partners (e.g. AUC, IGAD, ECOWAS and EAC)	GPRHCS annual questionnaires and reporting	**4**	8		10		15		15		15		15		**15**		Stronger partnership, capacity and institutional commitment to family planning and RHCS
Number of regional institutions supported to integrate RHCS issues in training curricular	GPRHCS annual questionnaires and reporting	**5**	10		12		15		15		15		15		**15**		
Global partnerships (support to global partners)																	
Evidence of support to and collaboration with NGOs for the scaling up of RHCS and family planning (e.g. Marie Stopes International and IPPF)	GPRHCS annual questionnaires and reporting	**8**	12		15		20		20		20		20		**20**		Stronger partnership and institutional commitment to family planning and RHCS
Country-level coordination and partnership																	
Number of countries with a functional national RHCS coordination mechanism (with inclusive membership including private sector, and terms of reference, minutes of meetings, follow-up action points)	GPRHCS annual questionnaires and reporting	**45**	45		45		45		45		46		46		**46**		
Number of countries where RHCS situation analysis and stakeholder mapping is conducted and results used for planning and programming	GPRHCS annual questionnaires and reporting	**14**	18		24		33		40		44		46		**46**		Resource availability, capacity, country coordination and stronger partnerships
Number of countries supported by CARhs to resolve problems and avert stock out or overstock of situations	GPRHCS annual questionnaires and reporting	**25**	30		35		40		42		44		46		**46**		
Number of national institutions supported to integrate RHCS issues in training curricular including for procurement	GPRHCS annual questionnaires and reporting	**17**	22		28		35		40		42		44		**46**		

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
COUNTRY-LEVEL COORDINATION AND PARTNERSHIP (continued)																	
Number of persons trained in RHCS issues by type of training topic	GPRHCS annual questionnaires and reporting	**38**	40		45		50		55		60		60		**60**		Resource availability, capacity of training institutions and country commitment
Product availability																	
Number of countries with all RH commodities (modern contraceptives and life-saving maternal/RH medicines) in country EML	GPRHCS annual questionnaires and reporting	**42**	42		44		46		46		46		46		**46**		Resource availability, country coordination and stronger partnerships
Percentage of countries where WHO prequalified/ ERP approved RH commodities (modern contraceptives and life-saving maternal/RH medicines) are registered	UNFPA Procurement Services Branch (PSB) with data established by WHO	**70%**	75%		80%		85%		90%		95%		100%		**100%**		Assumption is that the RH commodities under PQ and ERP are the same as those in each country's EML (in terms of combinations and strengths)
National budget allocations for contraceptives																	
Number of countries with increased national budget allocation for reproductive health commodities and the resources expended as planned	GPRHCS annual questionnaires and reporting	**27**	29		32		38		40		44		46		**46**		Resource availability, country coordination and stronger partnerships
Environmental risk mitigation																	
Number of countries where the finalized UNFPA Guidance Note on Disposal of Maternal Health (MH) medicines is available and disseminated to partners including government	GPRHCS annual questionnaires and reporting	**3**	10		25		35		40		46		46		**46**		
Availability of report on the assessment of country guidelines and protocols on disposal of MH medicines for benchmarking and programming	GPRHCS annual questionnaires and reporting	**0**	12		28		38		42		44		46		**46**		Resource availability, capacity, country commitment and stronger partnerships
Number of countries where guidelines and protocols on disposal of MH medicines are update in line with contents of UNFPA Guidance Note	GPRHCS annual questionnaires and reporting	**0**	10		26		35		44		46		46		**46**		
Programme Output 2: Increased demand for RH commodities, by poor and marginalized women and girls																	
Advocacy																	
Number of countries with specific initiatives and implementation plans to improve family planning access for the poor and marginalized women and girls	GPRHCS annual questionnaires and reporting	**37**	40		44		46		46		46		46		**46**		Resource availability, capacity, country commitment, coordination and stronger partnerships

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
Demand generation for family planning																	
Number of countries where partners are implementing specific initiatives to reach the poor and marginalized women and girls	GPRHCS annual questionnaires and reporting	**37**	40		44		46		46		46		46		**46**		Resource availability, capacity, country commitment and stronger partnerships
Number of countries in which least five elements of demand generation for family planning are supported	GPRHCS annual questionnaires and reporting	**22**	35		40		44		46		46		46		**46**		
Programme Output 3: Improved efficiency for procurement and supply of reproductive health commodities (global-level focus)																	
Quality of products																	
Number of WHO pre-qualified/ERP assessed hormonal contraceptives for use by UNFPA and partners	Based on WHO Expert Review Panel (ERP) for Reproductive Health Medicines, categories for hormonal contraceptives (HC)	**HC 16**	HC 19		HC 21		HC 23		HC 24		HC 25		HC 25		**HC 25**		For hormonal contraceptives (HC), numbers may fluctuate due to new additions and delisting. An assumption is made that there will be constant and reliable technical support to HC manufacturers to maintain pre-qualification (PQ).
Procurement efficiency																	
Number of countries and clients using AccessRH[3] for procurement of RH commodities (disaggregated by GPRHCS countries and non GPRHCS countries)	AccessRH served 116 clients in 84 countries in 2012. Of these, 52 clients were located in 36 GPRHCS countries. The tentative target is a 10% increase, with 5% in GPRHCS countries.	**128 clients in 92 countries, including 55 clients in 38 GPRHCS countries**	134 clients in 97 countries, including 57 clients in 40 GPRHCS		141 clients in 102 countries, including 59 in 40 GPRHCS		148 clients in 107 countries, including 60 in 40 GPRHCS		149 clients in 109 countries, including 60 in 40 GPRHCS		150 clients in 110 countries, including 60 in 40 GPRHCS		150 clients in 110 countries, including 60 in 40 GPRHCS		**150 clients in 110 countries, including 60 in 40 GPRHCS**		Funding for staff, outreach travel and activities
Percentage of lead time reduced through procurement of reproductive health commodities using AccessRH[4]	For each item, this is measured by average weeks' lead time saved by shipping from AccessRH inventory (as compared to fresh production orders).	**Male condoms 12 weeks, Oral contraceptives 1–2 weeks, TBD for IUDs, female condoms and others**	Similar to prior year; Changes based on products stocked		continue		continue		continue		continue		continue		**Male condoms 12 weeks, Oral contraceptives 1–2 weeks, others TBD; Based on products stocked**		2013–2020 figures assume full funding of AccessRH Scenario C 2013-2016, and 3 positions afterwards
Number of LTAs in operation during the year for hormonal contraceptives (HCs)	2013 baseline: 16 LTAs with 9 suppliers for 23 hormonal contraceptive products	**16 LTAs with 9 suppliers for 23 hormonal contraceptive products;**	19 LTAs with 11 suppliers for 26 HC products		21 LTAs with 11 suppliers for 28 HC products		23 LTAs with 11 suppliers for 30 HC products		24 LTAs with 12 suppliers for 31 HC products		25 LTAs with 12 suppliers for 32 HC products		25 LTAs with 12 suppliers for 32 HC products		**25 LTAs with 12 suppliers for 32 HC products**		2013–2020 figures assume full funding of manpower and project budget in implementing required activities to increase the number of products and suppliers and LTAs to meet the demand of the supply generated by programme

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
PROCUREMENT EFFICIENCY (continued)																	
Percentage of UNFPA contraceptive prices that compares favourably with those of other large procurers such as USAID	UNFPA actual prices compared to USAID and MSI for calendar year, where UNFPA price is equal or less than others	**60** **2013 in progress**	70		75		80		80		80		85		**90**		Assumes UNFPA-USAID joint negotiations beginning 2015
Volume of third party procurement (TPP)	2012 baseline = $43.5M TPP, GCCP, and Inventory 5%; Income based on calendar year shipments.	**$43.5 million** **2013 in progress**	$45.7 million		$48 million		$49.2 million		$50 million		$50 million		$50 million		**$50 million**		2013–2020 figures assume full funding of AccessRH Scenario C 2013–2016, and 3 positions afterwards
Green procurement																	
Number of factories agreeing to and fully implementing ISO14001	Verification from pre-qualification process	**11**	12		13		14		15		16		17		**18**		
Number of factories including FSC and/or similar programme in the outer packages	Verification from pre-qualification process, purchase orders (entered at Req. stage), SGS and similar pre-shipment testing	**11**		12	13		14		15		16		17		**18**		
Number of factories with active and documented waste water programmes	Verification from pre-qualification process, random inspections and request for paper documentation	**5**		6	7		8		9		10		11		**12**		Budget available (budget increase of minimum 15% per year required, as these budgets are currently under budgeted. Must have minimum one staff within PSB working on Green Procurement issues. Currently only a consultant is hired on a temporary basis, which is unsustainable.
Number of factories reducing raw material usage as a result of UNFPA lead research	Verification from pre-qualification process, purchase orders (entered at Req. stage), SGS and similar pre-shipment testing	**11**		12	13		14		15		16		17		**18**		
Quantity and mix for commodities procured																	
Total couple years of protection (CYP) (in millions) for contraceptives and condoms procured by UNFPA (disaggregated for GPRHCS funds)	UNFPA procurement data and *External Procurement Support Report*	**57.7** **35.1**	58.5 35.3		59.4 35.9		59.8 36.4		60.1 36.9		60.5 37.5		60.6 38.0				Resource availability, volume guarantee, national budget allocations, absorptive capacity of countries and stronger partnerships
Cost per CYP	UNFPA procurement data and *External Procurement Support Report*	**$2.24**	$2.22		$2.20		$2.18		$2.16		$2.14		$2.12				

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
Programme Output 4: Improved access to quality RH/FP services for poor and marginalized women and girls																	
Integration																	
Number of countries where RH/FP services are integrated with gender, HIV and maternal health to reach specific poor and marginalized population groups	GPRHCS annual questionnaires and reporting	**26**	35		40		46		46		46		46		**46**		Resource availability, capacity, country commitment and stronger partnerships
Humanitarian setting																	
Recommendations available on demand, supply and use of RH Kits	GPRHCS annual questionnaires and reporting	**In Progress; One study done for Syria. This will partly inform the global study which will be carried out by JSI**	Draft report available		Recommendations agreed upon and implemented		Recommendations agreed upon and implemented		Recommendations agreed upon and implemented		Recommendations agreed upon and implemented		Recommendations agreed upon and implemented		**Recommendations agreed upon and implemented**		Resource availability, country humanitarian situations for data collection, stronger partnerships
Number of partners (including government, private sector and NGOs) and UNFPA staff whose capacity to implement the Minimum Initial Service Package (MISP) was strengthened in priority countries most vulnerable based on OCHA focus model	GPRHCS annual questionnaires and reporting	**2,565**	3,591		4,617		5,643		6,669		7,695		8,921		**9,747**		
Number of staff (nationals) hired to support implementation of MISP for coordination, monitoring and support distribution of RH kits to implementing partners and for the utilization of the RH kits in 20 priority countries	GPRHCS annual questionnaires and reporting	**99**	119		140		160		180		220		240		**280**		Resource availability, country capacity, commitment and stronger partnerships
Dedicated SRH and gender-based violence surge capacity roster available for implementation of the MISP in humanitarian settings in order to coordinate and monitor the quality of SRH services	GPRHCS annual questionnaires and reporting	**35**	49		63		77		91		105		120		**135**		
Number of academic, training and research institutions Strengthened to deliver MISP, clinical management of rape, training and other modules	GPRHCS annual questionnaires and reporting	**1**	2		5		7		12		19		22		**25**		
Evidence and Quality Assurance of kits contents updated to reflect needs in conflict and humanitarian settings	Updated Interagency RH Kits manual QA is made to LTA suppliers	**80% of contents meeting specifications**	81%		90%		93%		95%		95%		95%		**95%**		Quality assurance assessment is done according to MQ AS

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
HUMANITARIAN SETTING (continued)																	
Number of staff already hired by UNFPA who are part of internal humanitarian roster trained on RH Kits and family planning for provision of support during acute phase of an emergency	DHR reports	**30**	30		35		35		40		40		45		**45**		Resource availability, country capacity, UNFPA management commitment to humanitarian issues
Number of implementing partners supplied with RH Kits for programming in humanitarian and fragile context (disaggregated by public, private and NGO sectors)	GPRHCS annual questionnaires and reporting	**34**	38		43		47		52		56		61		**65**		Resource availability, country capacity, commitment and stronger partnerships
Number of women and/or girls reached in humanitarian settings through RH kits and services utilization and dissemination	GPRHCS annual questionnaires and reporting	**2.1 million**	2.5 million		2.9 million		3.3 million		3.7 million		4.2 million		4.6 million		**5.0 million**		
Capacity building																	
Number of institutions supported to carry out training of service providers for task shifting for RH and FP service provision	UNFPA Commodity Security Branch (CSB)	**35**	46		48		55		60		65		80		**90**		Resource availability, capacity, country commitment and stronger partnerships
Number and type of non-state actors providing RHCS/FP services to ensure access for poor and marginalized women and girls	GPRHCS annual questionnaires and reporting	**52**	65		80		90		100		110		120		**150**		
Total number of persons trained, for the year, to provided long term long term contraceptive methods to client	GPRHCS annual questionnaires and reporting	**7,025**	7,075		7,100		7,150		7,200		7,250		7,300		**7,350**		
Number of skilled personnel providing FP services	GPRHCS annual questionnaires and reporting	**72,532**	73,000		74,000		75,000		76,500		78,000		79,000		**80,000**		
Programme Output 5: Strengthened capacity and systems for supply chain management																	
Demand forecasting and procurement																	
Number of countries where demand forecasting for contraceptives is led and coordinated by trained nationals working in government institutions.	GPRHCS annual questionnaires and reporting	**34**	34		38		42		46		46		46		**46**		
Number of countries where procurement process for RH commodities is led and coordinated by trained nationals working in government institutions	GPRHCS annual questionnaires and reporting	**23**	28		32		36		40		44		46		**46**		Resource availability, capacity, country commitment and stronger partnerships
Number of countries submitting long-term forecast data in UNFPA's global forecast database	GPRHCS annual questionnaires and reporting	**0**	5		15		25		35		46		46		**46**		

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
DEMAND FORECASTING AND PROCUREMENT (continued)																	
Number of countries with functioning national-level system for forecasting and procurement of heath commodities that include RH commodities	GPRHCS annual questionnaires and reporting	**8**	23		50		50		50		50		50		**50**		Resource availability, capacity, country commitment and stronger partnerships
Number of countries making 'no ad hoc requests' to UNFPA for commodities (except in humanitarian contexts)	GPRHCS annual questionnaires and reporting	**17**	15		12		10		8		5		5		**5**		
Number of national institutions strengthened through partnerships with expert, international institutions	GPRHCS annual questionnaires and reporting	**2**	3		3		5		5		5		3		**3**		Resource availability, capacity of institutions, country commitment and stronger partnerships
Number of countries/ individuals using e-learning platform to build knowledge.	GPRHCS annual questionnaires and reporting	**100**	300		300		300		300		300		300		**300**		Resource availability, capacity, availability of internet services
Stock monitoring																	
Number of countries with functional logistics management information system (LMIS)	GPRHCS annual questionnaires and reporting	**12**	18		25		32		40		40		40		**40**		
Number of countries using a health supply chain management information tool for monitoring RH commodities (e.g. CHANNEL, PIPELINE, CCM etc.)	GPRHCS annual questionnaires and reporting	**12**	18		25		35		42		46		46		**46**		
Management Output: Improved programme coordination and management																	
Support for data generation and use																	
Number of countries where staff of government and partner institutions are trained to generate data for programme monitoring	GPRHCS annual questionnaires and reporting	**20**	25		35		46		46		46		46		**46**		Resource availability, capacity, country commitment and stronger partnerships
Number of countries with data on supply, demand, access and use of FP for programme and policy design	GPRHCS annual questionnaires and reporting	**14**	15		25		36		42		46		46		**46**		Resource availability, capacity and stronger coordination
Survey reports on RH commodity availability	GPRHCS annual questionnaires and reporting	**20**	40		46		46		46		46		46		**46**		
Number of specialized studies on key thematic issues conducted per year	GPRHCS annual questionnaires and reporting	**0**	2		5		10		10		8		5		**5**		
Resource mobilization and allocation																	
Amount mobilized from partners for GPRHCS interventions	GPRHCS annual questionnaires and reporting	**$65.49 million**	$150 million		$200 million		$200 million		$200 million		$200 million		$200 million		**$200 million**		Stronger partnerships and availability and implementation of a resource mobilization strategy
New donors making multi-year commitments and contribution to RHCS and family planning	GPRHCS annual questionnaires and reporting	**0**	1		2		2		2		2		2		**2**		

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
RESOURCE MOBILIZATION AND ALLOCATION (continued)																	
Evidence of UNFPA meeting FP2020 commitments	GPRHCS annual questionnaires and reporting	**40% allocation to FP, and playing a leading role in FP2020 (reference group, task team and working groups)**	continue		continue		continue		continue		continue		continue		**40% allocation to family planning, and playing a lead role in FP2020**		Resource availability, capacity, commitment to FP and stronger partnerships
Amount of UNFPA Core Funds allocated to CSB	GPRHCS annual questionnaires and reporting	**$1.86 million (0.4% of UNFPA total budget)**	continue		continue		continue		continue		continue		continue		**0.4% of UNFPA total budget**		Resource availability, and institutional commitment
Programme steering																	
Functional steering committee in place (composed of donors and partners, with TORs, minutes of meetings held and decisions taken)	GPRHCS annual questionnaires and reporting	**Yes; Plans made for the formation of a Steering Committee**	Steering Committee functional		continue		continue		continue		continue		continue		**Steering Committee functional**		Commitment and stronger partnerships
Human resources																	
Number of staff dedicated to RHCS/FP by location and with desired skills gap	GPRHCS annual questionnaires and reporting	**120**	120		130		130		130		130		130		**130**		Resource availability, capacity, commitment to family planning
Programme review																	
Number of CO, RO and partner annual work plans (AWPs) finalized and funded by mid-February of the current year	GPRHCS annual questionnaires and reporting	**15**	18		20		24		30		35		40		**40**		Capacity and coordination and management at global, regional and country levels
100% of country work plans reviewed at least two times per year (mid and end of year)	GPRHCS annual questionnaires and reporting	**100% once a year**	100% twice a year		continue		continue		continue		continue		continue		**100% twice a year**		
Number of countries achieving at least 60 per cent of work plan outputs	GPRHCS annual questionnaires and reporting	**45**	46		46		46		46		46		46		**46**		Implementation capacity and coordination and management at global, regional and country levels
Programme monitoring and evaluation																	
Findings and lessons-learned available from field visits	GPRHCS annual questionnaires and reporting	**0**	2		3		3		3		3		3		**3**		Timely programme planning and review
Recommendations on key monitoring interventions	GPRHCS annual questionnaires and reporting	**0**	1		1		1		1		1		1		**1**		
Number of evaluation activities coordinated and finalized as planned	GPRHCS annual questionnaires and reporting	**1 Evaluability assessment planned**	1		1		1		1		1		1		**1**		Timely activity planning and collaboration with Evaluation Office
Reports with recommendations on the outcomes of financial monitoring	GPRHCS annual questionnaires and reporting	**Not applicable**	Yes; Evaluability Assessment recommenda-tions available		Yes		Yes		Yes		Yes		Yes		**Yes**		Timely activity planning and review and coordination with countries

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
Monitoring framework with updated results on milestones	GPRHCS annual questionnaires and reporting	**Not applicable**	Yes; With recommen-dations from evaluability assessment		no		no		no		Yes	With recom-menda-tions from mid-term evalua-tion	no		**no**		Timely activity planning and review and coordination with countries
Availability of TOR, institutional framework and strategy to ensure independent evaluation	GPRHCS annual questionnaires and reporting	**Not Applicable**	Yes; From evaluability assessment		Yes		Yes		Yes		Yes		Yes		**Yes**		Timely activity planning and collaboration with Evaluation Office
Availability of inception report for independent evaluation of the programme with evaluability criteria/ issues and plan of work	GPRHCS annual questionnaires and reporting	**Available**	Evaluability assessment recommenda-tions adopted and imple-mented		N/A		N/A		N/A		N/A		N/A		**N/A**		Timely activity planning and review and coordination with countries
Programme mid-term evaluation results and recommendations published and disseminated	GPRHCS annual questionnaires and reporting	**N/A**	N/A		N/A		Mid-term review initiated		Mid-term review recom-mendations adopted and implemented		N/A		N/A		**N/A**		
Programme end-term evaluation results and recommendations published and disseminated	GPRHCS annual questionnaires and reporting	**N/A**	N/A		N/A		N/A		N/A		N/A		End-term evaluation review initiated		**End-term review recom-mendations adopted and implemented**		
Programme reporting																	
Number of UNFPA Country Offices submitting mid-year progress report to respective regional offices by 15 July each year	GPRHCS annual questionnaires and reporting	**45**	46		46		46		46		46		46		**46**		Timely activity planning and review and coordination with countries and regions
Number of Country Offices submitting completed annual narrative programme report to respective to regional offices by 15 January of the following year	GPRHCS annual questionnaires and reporting	**45**	46		46		46		46		46		46		**46**		
Number of Country Offices submitting completed financial report to respective Regional Offices by 15 January of the following year	GPRHCS annual questionnaires and reporting	**45**	46		46		46		46		46		46		**46**		
Number of UNFPA Regional Offices submitting mid-year report by mid-July and annual report by mid-January to Technical Division/HQ	GPRHCS annual questionnaires and reporting	**5**	6		6		6		7		7		7		**7**		
Meetings																	
Semi-annual meetings held	GPRHCS annual questionnaires and reporting	**1**	1		1		1		1		1		1		**1**		Resource availability, coordination with countries and regions and approval from UNFPA management
Annual progress review/ planning meetings organized	GPRHCS annual questionnaires and reporting	**1**	1		1		1		1		1		1		**1**		

Results and indicators	Means of verification	BASELINE	MILESTONES (2014 TO 2019)												TARGETS		Risks and assumptions
		2013	2014		2015		2016		2017		2018		2019		2020		
		Implemented	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	
MEETINGS (continued)																	
IDWG meetings held	GPRHCS annual questionnaires and reporting	**1**	2		2		2		2		2		2		**2**		Coordination with and strong commitment of IDWG members
Steering Committee meetings held	GPRHCS annual questionnaires and reporting	**2**	2		2		2		2		2		2		**2**		Coordination with and strong commitment of Steering Committee members
Dissemination of programme results																	
Consolidated annual RHCS report (programmatic and financial) prepared by end of April of following year by HQ	GPRHCS annual questionnaires and reporting	**1**	1		1		1		1		1		1		**1**		Resource availability and coordination with countries and regions
Consolidated annual RHCS report (programmatic and financial) published and disseminated by 30 September of following year by HQ	GPRHCS annual questionnaires and reporting	**1**	1		1		1		1		1		1		**1**		
Availability of good practice and lessons learned documentation based on programme results	GPRHCS annual questionnaires and reporting	**2**	2		3		3		3		4		4		**4**		Resource availability and coordination with and commitment of countries and regions
Evidence of dissemination of programme results in various medium (e.g. audio, video, photos) in hard-copy and web-based	GPRHCS annual questionnaires and reporting	**1**	1		2		2		2		2		2		**2**		Resource availability and coordination with countries and regions; and establishment and use of publication platforms

Footnotes

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

2 UNFPA will continue to work with partners to establish consensus for the measurement of this and other indicators, the outcome of which will be reflected in this framework.

3 AccessRH procurement and information service was launched in 2010 and a) offers affordable, quality RH supplies to meet needs of low- and middle income governments and NGO needs; b) improve delivery times to clients; c) contraceptive order and shipment information available to countries by decreasing the lead time and ensuring quality with competitive lower prices will have 'value for money' to the clients. 2013–2020 figures assume full funding of AccessRH Scenario C 2013–2016, and three positions afterwards.

4 In 2011–2012, for example, AccessRH reduced wait time for male condoms from 15 weeks to 12 weeks, and reduced Microgynon and Microlut from an average of 6 weeks to 1–2 weeks.

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